



# Analysis of Federal Funding Authorities & Research Into Other State Activities

Minnesota Waiver Reimagine Project  
Study 1, Tasks 2.2 and 2.3





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The Human Services Research Institute ([www.hsri.org](http://www.hsri.org)) is a nonprofit, mission-driven organization that works with government agencies and others to improve health and human services and systems, enhance the quality of data to guide policy, and engage stakeholders to effect meaningful systems change.

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# Executive Summary

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The Minnesota Department of Human Services, Disability Services Division (DSD) is looking to improve system structures to give people more choice and control over the services they receive. As part of that effort, DSD has commissioned two studies from a study team composed of HSRI and its partners.

Study 1 will determine potential options for reconfiguring four Medicaid Home and Community Based Services (HCBS) waivers associated with people with disabilities. Study 2 will determine a unified individual budgeting model for the proposed reconfiguration—one that meets the needs of individuals who are self-directing and those who are not.

This paper presents research findings from Study 1. Here, we share the results of our examination into available Medicaid funding authorities and exemplary reconfiguration or consolidation efforts undertaken by other states (Tasks 2.3 and 2.2, respectively, in the project scope of work).

## Summary Findings

- States have a number of Medicaid funding authorities available to them which can facilitate delivery of long-term services and supports. Each authority carries with it different opportunities and hurdles, and there is no prescription for which authority a state must or should use to meet its particular goals.
- In fact, states we examined for this study used a variety of waiver and state plan authorities to achieve desired outcomes. The type of waiver authority a state selected was based not only on the state's overall goals but also on contextual factors. The process often begins by defining the target population and the state's priorities related to serving that population.
- States recognized that efforts to reorganize LTSS structures can cause some amount of disruption, and worked to mitigate impacts on end-users of the system. The strategies they used included making incremental changes over time, working to ensure that no particular group would be disenfranchised under a new configuration by understanding key differences in service needs by population, developing a phase-in strategy, and, if necessary, responding to the concerns of stakeholders by changing course or making adjustments.
- States invest significant time and effort to prepare for consolidation or reconfiguration by aligning system components prior to implementation. This requires work to coordinate components of a program, assess differences, and develop a plan to make adjustments accordingly. The timeframe necessary to conduct this type of evaluation and make incremental changes to policy and

practice took on average at least 2-5 years in advance of rollout in states reviewed for this report.

- States stressed the importance of developing an effective communication strategy. Many states described significant efforts related to statewide listening tours, meeting with key stakeholder organizations such as provider associations, disability rights, and other advocacy groups, and providing means for ongoing communication. Related to this, some states provide training on new technology solutions, services, and policies and procedures for state staff at all levels, managed care organizations, service providers, and others.
- States designed mechanisms to track system performance to evaluate the degree to which the overall goals were met by the selected strategy and to make course corrections as necessary.



## Findings – Federal Funding Authorities

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What follows primarily is a description of the Medicaid waiver authorities that might be used to consolidate the four HCBS waivers in Minnesota, as well as information pertaining to the selected state inquiries. First though, we provide a brief overview of Medicaid as an historical underpinning for the current options.

### Medicaid – An Overview

President Lyndon Baines Johnson signed the Social Security Amendments of 1965 into law on July 30, 1965, at the Harry S. Truman Presidential Library in Independence, Missouri. This new law enacted Medicare and Medicaid. Medicaid funds became available to states on January 1, 1966.

Medicaid expanded on the Kerr-Mills, Old-Age Assistance, and Medical Assistance for the Aged programs to include individuals under age 65 who received welfare benefits. As originally constructed, Medicaid also aimed to provide health services to:

- parents and children receiving Aid to Families with Dependent Children;
- the blind receiving Aid to the Blind; and
- the disabled receiving Aid to the Permanently and Totally Disabled.

At the time of enactment in 1965, approximately 8 million people were estimated to be eligible for Medicaid. In December 2017, over 68 million individuals were enrolled in Medicaid in 50 states and the District of Columbia.

Medicaid is a federal–state partnership. States operating Medicaid programs within broad federal guidelines receive federal financial participation (FFP) for eligible services provided to eligible individuals. In addition to receiving FFP for service costs, states can receive administrative reimbursement for certain activities and systems that further the proper and efficient administration of the Medicaid State Plan.

To appreciate the contemporary context for Medicaid, it is important to understand a few key milestones that laid the foundation for the current authorities enabling home and community-based services (HCBS):

- **1965**—The Medicaid Program, authorized under Title XIX of the Social Security Act, was enacted to provide health care services to low-income children deprived of parental support, their caretaker relatives, the elderly, the blind, and individuals with disabilities. The program includes nursing facility services as a mandatory benefit.
- **1967**—Early Periodic Screening Diagnosis and Treatment, which is the established entitlement to a comprehensive Medicaid health services benefit for all children under age 21, is established.

- **1971**—Congressional authorization for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) services as a state plan option under Medicaid allowed states to receive federal matching funds for institutional services for individuals that had been funded with state or local government money.
- **1972**—Medicaid eligibility for elderly, blind, and disabled residents of a state can be linked to eligibility for the newly enacted federal SSI program if a state chooses.
- **1981**—Freedom of choice waivers under 1915(b) of the Social Security Act (enabling managed care and limitation of providers) and HCBS waivers under 1915(c) of the Social Security Act are established, with the latter enabling community-based care for those who, but for the provision of such care, would require institutional services.

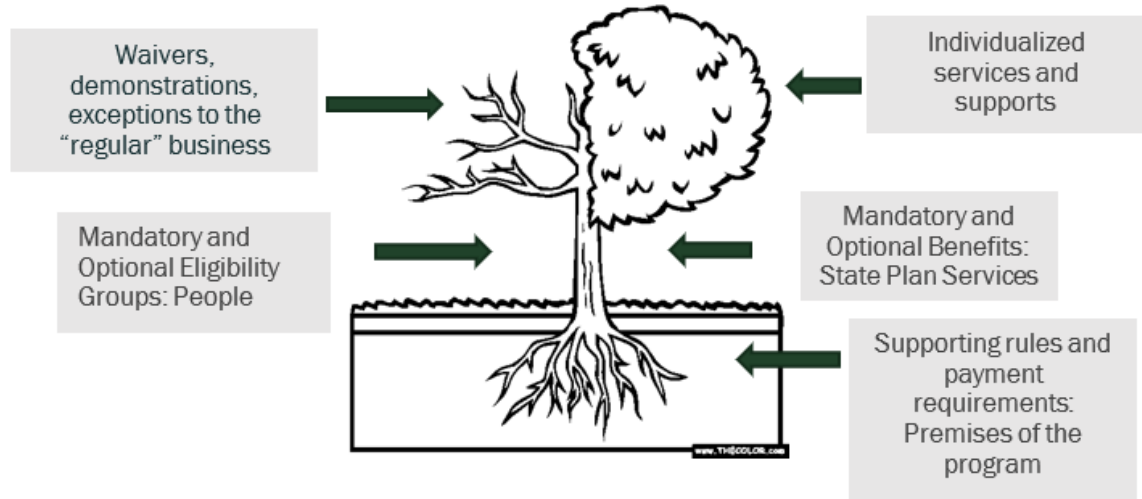
This last element in this list—the addition of the HCBS programs in 1981—served as a key catalyst toward the deinstitutionalization of individuals with intellectual and developmental disabilities and the ability of individuals with medically complex support needs to receive services in their homes and communities.

To understand a particular state’s service delivery system for individuals with disabilities and individuals who are aging, it is important to review the totality of the Medicaid program. To participate in Medicaid, states must offer a specific set of services (mandatory benefits) and may choose to offer additional services (optional benefits). Similarly, states must cover some populations within the state (mandatory eligibility categories) and may choose to offer eligibility to additional groups of individuals (optional eligibility categories). All Medicaid programs generally must operate within a standard set of requirements, though Congress has periodically enacted waiver authority for some of those rules.

The following figure, which depicts the Medicaid program as a tree, is intended to help illustrate the program’s structure. In it, the tree’s roots represent the underpinning rules of the statute that apply to all Medicaid programs (largely but not exclusively contained at Section 1902 and Section 1903 of the Social Security Act). The tree’s trunk represents the Medicaid State Plan and eligibility groups (mandatory and optional) which serve as the backbone for the available service array and recipient pool within any state. The branches of the tree represent waivers or deviations from standard practice that are available at state discretion. Finally, the leaves on the tree represent the individually tailored supports and services available to individuals receiving services through Medicaid.

Figure 1

Medicaid programs share the same underlying structure.



## Authorities for HCBS

Here, we provide information on four options available to states for the design and delivery of HCBS to individuals requiring long-term services and supports. This section concludes with a discussion of the application of a managed care operational framework to these authorities and on selected considerations particular to each authority.

Importantly, all of the authorities described herein operate within the broader context of Medicaid, and their specific design must reflect the underlying Medicaid operation within the state.

The predominant vehicles for the delivery of HCBS in Medicaid are described below. Each of the authorities listed has its own unique statutory attributes; however, through rulemaking and policy, the Centers for Medicare & Medicaid Services (CMS) has aligned certain operational requirements when not prevented by statutory construction. For example, each of the authorities below has similar expectations with regard to person-centered planning requirements, conflict of interest provisions, and settings in which home and community-based services are provided.

## Medicaid Waiver Authorities

Section 1915(c)  
HCBS Waivers

Section 1915(i)  
HCBS as a State Plan Option

Section 1915(k)  
Community First Choice Option

Section 1115  
Research and Demonstration



Before a state determines which authority to utilize, there should be a clear articulation of the problem to be solved and/or the goals to be achieved. This exercise should include identification of the population(s) the state seeks to serve, service array, attributes to build or maintain for the system, and flexibilities or systemic operations sought for the benefit. All of these factors will inform the state's analysis on the best authority or configuration of authorities to achieve the state's overall objectives. Notably, none of the authorities delineated below permit the coverage of room and board for individuals served. And, unless otherwise noted, all other requirements, including tribal notification, apply.

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## Section 1915(c) HCBS Waivers

### Authority Overview

Section 1915(c) HCBS waivers became available for state use pursuant to the passage of the Omnibus Budget Reconciliation Act (OBRA) of 1981. Under the HCBS waiver program, states can elect to furnish under Medicaid, as an alternative to institutional care, a broad array of services (excluding room and board) that are not otherwise covered under the Medicaid program. Passage of this statute represented a first step toward recognizing that many individuals at risk of institutionalization can be supported in their homes and communities, thereby preserving their independence and bonds to family and friends, at a cost not higher than institutional care, either on an individual or aggregate basis.

Section 1915(c) permits the Secretary of Health and Human Services to grant waivers of three provisions of the Medicaid statute (Title XIX of Social Security Act) so that a state may operate an HCBS waiver:

- **Section 1902(a)(10)(B) (Comparability).** Waiver of this provision permits a state to limit the provision of HCBS waiver services to Medicaid beneficiaries who require the level of care of an institutional setting and are in the target group(s) specified in the waiver, as well as offer services to waiver participants that are not provided to other Medicaid beneficiaries. All HCBS waivers operate under a waiver of this statutory provision;
- **Section 1902(a)(1) (Statewide).** The Secretary may grant a waiver of this provision of the Act in order to permit a state to limit the operation of a waiver to specified geographic areas of the state; and,
- **Section 1902(a)(10)(C)(i)(III) (Income and Resources for the Medically Needy).** A state may request a waiver of this provision in order to apply institutional income and resource "eligibility" rules for medically needy in the community who otherwise qualify for waiver services.

Section 1915(c) does not give the Secretary the authority to waive any other provisions of the Act. Therefore, all other pertinent Medicaid statutory requirements apply to the operation of a waiver.

In addition, pursuant to final regulations published in 2014, states must meet new regulatory requirements related to:

- Person-centered planning and service delivery;
- Conflict of interest requirements; and
- Settings where HCBS can be provided (these specific provisions, which defined HCBS settings, included a transition period for existing programs; states have until 2022 to achieve full compliance with the regulation)

### Target Populations

The regulations at 42 CFR 441.301(b)(6) indicate that the target groups served in any 1915(c) waiver

*[b]e limited to one or more of the following target groups or any subgroup thereof that the State may define:*

- (i) Aged or disabled, or both.*
- (ii) Individuals with Intellectual or Developmental Disabilities, or both.*
- (iii) Mentally ill.*

This language includes an important change put in place through the final regulations related to HCBS that became effective March 17, 2014. Specifically, these regulations removed a previous regulatory impediment to states wishing to serve more than one of the target groups under a single 1915(c) waiver. Now states may design HCBS programs that meet the needs of multiple target groups, a benefit to states interested in serving multiple groups within a single waiver or a state that seeks maximum administrative simplicity while furthering person-centered approaches to service delivery by ensuring individuals, regardless of a particular diagnosis, receive the services they need.

### Clinical Eligibility Parameters

To be eligible for a Section 1915(c) waiver, all individuals would require, without the waiver, services provided in an institutional setting—a hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities (ICF/IID). This is referred to as meeting an institutional level of care. In addition, for individuals to enroll in the waiver, they must be a member of the state-identified target group, be within the identified age range stipulated in the waiver, and meet any additional targeting criteria specified by the state. These additional targeting criteria may include:

- the nature or type of disability;
- specific diseases or conditions; and
- functional limitations (e.g., extent of assistance required in activities of daily [ADLs] and/or instrumental activities of daily living [IADLs])

These additional criteria may also include risk factors or historical patterns of utilization to hone the group served in the waiver program. For example, a number of states have designed additional targeting criteria for individuals with developmental disabilities who may have a history of or be at imminent risk for psychiatric hospitalizations to enable the service of individuals who may have existing, but potentially undiagnosed, co-occurring mental health conditions.

#### Financial Eligibility Parameters

Financial eligibility for a waiver generally aligns with the state’s overall Medicaid eligibility. In fact, to participate in a waiver, a person must be a member of a Medicaid eligibility group (e.g., SSI beneficiaries) that a state has decided to include in the waiver and meet all clinical eligibility criteria. A state may include a Medicaid eligibility group in the waiver only when it includes the same group in its Medicaid State Plan.

One particular eligibility group, while still covered in the state plan, is unique to the waiver: individuals who would not be eligible for Medicaid except in an institutional setting (e.g., the special income level group). When this group is included in the waiver, institutional eligibility rules, which are usually more generous than the “community rules” that apply to typical Medicaid eligibility categories, may be used in the community. This group is referred to as the “special home and community-based services waiver eligibility group” as provided in 42 CFR §435.217. Sometimes this group may be referred to as the “217” group. For this group, states may decide to allow individuals to be eligible with income up to 300% of the SSI federal benefit rate (FBR). If a state covers this group, it must indicate how it will conduct post-eligibility treatment of income.

Notably, financial eligibility and post-eligibility in Medicaid is particularly complex, especially for individuals in eligibility groups that typically require long-term services and supports as their income and resources are both considered. For that reason, engaging with state-specific eligibility experts on particular consideration is essential.

#### Potential Service Array

In 1915(c) HCBS waivers, there are four primary categories of services a state can offer:

- **Statutory services.** Services that are specifically authorized or otherwise included in §1915(c) of the Act. Statutory services are:
  - Case management services
  - Homemaker services
  - Home health aide services
  - Personal care services
  - Adult day health care services
  - Habilitation services
  - Respite care services
  - Mental health services, including:
    - Day Treatment
    - Psychosocial Rehabilitation Services
    - Clinic Services

In addition, the statute also permits states to cover the rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant.

- **Other services.** Services that are not identified specifically in the statute but that the state has requested and defined. The state must include a description of how the service is cost effective and necessary for waiver participants to avoid institutionalization.
- **Extended state plan services.** Services included in the waiver that are the same as, or similar to, benefits covered under 1905(a) state plan benefits. Extended state plan benefits must be over and above that which is available under the state plan. For children, there are not typically a wide array of available extended state plan benefits in the waiver since children under 21—through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit—are able to receive all medically necessary 1905(a) services whether the state has elected to cover them in the approved state plan or not.
- **Supports for participant direction.** Typically fiscal management services if not covered as an administrative activity, and/or support broker services to assist the individuals who have elected to direct some or all of their services to understand rights, risk, and responsibilities of self-direction.

#### Availability of Self-Direction

States may make participant direction opportunities available to individuals enrolled in the waiver. States may design the opportunities for self-direction along a continuum, from allowing individuals to select workers in a co-employment/agency-with-choice model to a full array of responsibilities including becoming the employer of record and managing the budget within state-specified parameters. In 1915(c) waivers, no cash benefits may be provided to individuals, and states must make fiscal management services available to assist the individual in aspects of being an employer and managing budgets. States must also indicate how they support individuals in self-direction to gain an understanding of all of the rights, responsibilities, and other aspects of managing services. This is often called support brokerage services, and may be carried out as an individual service, as a component of case management, or as a function that is included in the financial management service activities.

States may indicate in the waiver which services are available for self-direction and must also indicate how individuals will be supported to disenroll from self-direction without interruption in needed services. This support includes the identification of criteria for involuntary termination from directing one's own services.

#### Geographic Limitations, If Any

A state may request a waiver of statewideness in order to furnish waiver services only to eligible persons who reside in specific geographic areas (e.g., state planning regions or human services catchment areas) or political subdivisions (e.g., counties or municipalities) of the state. The request for a waiver of statewideness may also

provide for the phase-in of the waiver by geographic area by waiver year. For example, a state may provide that the waiver is in effect in specified counties during its first year of operation but will be in effect statewide during the second and subsequent years of the waiver.

#### Limitation on Number of Individuals Served

States have the ability to limit the number of individuals served in a waiver and must indicate in the waiver the maximum number of individuals to be served in each waiver year. States may upwardly adjust this number through a waiver amendment if needed. States may not limit numbers within a waiver and cannot cap a number of individuals served based on target or eligibility group. States may, however, dedicate reserved capacity for certain groups of individuals (such as individuals in crisis or individuals aging-out of another program) to ensure adequate waiver capacity for prioritized groups of individuals.

#### Renewal Requirements

Initial waivers are typically approved for a three-year period. Waivers are renewed every five years thereafter with satisfactory demonstration that the waiver is operating in compliance with all federal requirements. States may request an initial approval period of five years if the waiver provides services for individuals who are dually eligible for Medicare and Medicaid.

Importantly, since the promulgation of the final HCBS regulations in 2014, any new waiver approved must be in full compliance with the totality of the final regulations, including the settings requirements, prior to the effective date of the waiver.

#### Cost/Financial Tests

States using 1915(c) waivers must demonstrate that the waiver is *cost neutral*. The average per participant expenditures for the waiver and non-waiver Medicaid services must be no more costly than the average per person costs of furnishing institutional (and other Medicaid State Plan) services to persons who require the same level of care. States may choose to calculate cost neutrality on an individual or aggregate basis, so long as the waiver in its entirety is less costly than it would be to serve the individuals in the waiver in corresponding institutional settings.

#### Administrative and Reporting Requirements and Public Notice Requirements

States must submit evidence of ongoing quality and cost neutrality on an annual basis. This reporting is done through the use of the CMS 372 form, which requires the submission of service-specific actual utilization data as well as information related to the overall performance of the waiver related to key quality expectations.

## Quality Assurance/Quality Improvement

In 1915(c) HCBS waivers, states must design a quality improvement strategy that minimally demonstrates compliance with six basic assurances that are set forth in statute. Specifically, states must demonstrate that the waiver is compliant with the following:

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

CMS has set forth sub-assurances for each of the statutory assurances above, and the state must identify performance measures that, taken individually or collectively, have face validity in demonstrating compliance with the applicable sub-assurance. States must use these measures as discovery tools, and, when problems are identified, must take steps toward individual remediation. CMS expects states to further analyze available data to devise systemic improvement strategies and/or performance improvement projects to address any areas of deficiency.

States must report on their quality activities in their annual CMS 372 report and must submit a comprehensive evidence package to CMS 24 months prior to renewal of the waiver. CMS will review all available data, remediation strategies and systemic improvement information and provide an assessment of the waiver's overall compliance.

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## Section 1915(i) HCBS as a State Plan Option

### Authority Overview

Originally enacted in the Deficit Reduction Act of 2005 and amended in the Patient Protection and Affordable Care Act of 2010, Section 1915(i) of the Social Security Act provides an optional state plan benefit for the delivery of HCBS. Given the long history of success and cost-efficacy of HCBS, the passage of the Americans with Disabilities Act, and the Supreme Court's *Olmstead* decision, this addition to the Medicaid State Plan is a manifestation of long-contended assertions that states should be able to include HCBS in Medicaid without the need for a waiver.

States can offer the same array of services under 1915(i) that are available under the HCBS waiver program. 1915(i) benefits are not tied to an institutional level of care, and access to the 1915(i) must be less stringent than access to the 1915(c) waiver program. In 1915(i), states can forgo the application of certain otherwise applicable Medicaid provisions:

- **Comparability of Services (Section 1902(a)(10)(B) ):** States can make 1915(i) services available only to people with specific needs and risk factors. For example, states can use this authority to target services to the elderly, technology-dependent children, people with behavioral health conditions, or

people with intellectual disabilities. States might also choose to target services on the basis of disease or condition, such as Acquired Immune Deficiency Syndrome.

- **Income & Resources Rules Applicable in the Community ([Section 1902\(a\)\(10\)\(C\)\(i\)\(III\)](#)):** States can provide Medicaid to people who would otherwise be eligible only in an institutional setting, often due to the income and resources of a spouse or parent.

As of March 2018, approximately a dozen states offer 1915(i) benefits to particular target groups within the state. Many of these 1915(i) programs are aimed at supporting individuals with mental health conditions, a population that has historically been underserved in HCBS waivers due to the Medicaid-funded institutional cost comparison requirements, which do not include institutions for mental disease (IMDs) for individuals ages 22-64. Other states have used the 1915(i) benefit to offer HCBS as a preventive measure to stave off decline to institutional level of care or to meet the needs of individuals who may not meet level of care requirements. In addition, one state, Delaware, has designed a cross-disability 1915(i) benefit to provide employment services to transition-aged young adults.

#### Target Population Requirements/Opportunities

Unlike most other state plan benefits, states can choose to target 1915(i) services to particular populations and have great latitude to define the identified target groups within the 1915(i) benefit. The state must describe the group(s) receiving state plan HCBS, subject to the Secretary's approval. Targeting criteria cannot have the impact of limiting the pool of qualified providers from which an individual would receive services or have the impact of requiring an individual to receive services from the same entity from which they purchase their housing. These groups must be defined on the basis of any combination of the following: (a) age, (b) diagnosis, (c) disability, (d) Medicaid eligibility group.

The state may elect in the state plan amendment to limit the availability of specific services defined—or to vary the amount, duration, or scope of those services—to one or more of the group(s) described above.

#### Clinical Eligibility Parameters/Level of Care Considerations

The state must establish needs-based criteria for determining an individual's eligibility under the state plan for the HCBS benefit and may establish needs-based criteria for each specific service. Needs-based criteria are factors used to determine an individual's requirements for support and may include risk factors. The criteria are not characteristics that describe the individual or the individual's condition. A diagnosis is not a sufficient factor on which to base a determination of need. A criterion can be considered needs-based if it is a factor that can only be ascertained for a given person through an individualized evaluation of need.

The 1915(i) HCBS state plan option is not, as noted above, tied to an institutional level of care. In fact, the requirements for entrance into the 1915(i) must be less stringent

than institutional (and therefore, waiver) level of care. While the criteria must be less stringent for entry, individuals meeting or exceeding institutional care criteria may be served in the 1915(i).

#### Financial Eligibility Parameters

All individuals eligible for Medicaid under the state plan may be eligible for the 1915(i) if they have incomes up to 150% of federal poverty level.

In addition, states may elect to include a special income group for individuals with income up to 300% SSI; to qualify under this group, individuals must be eligible for HCBS under a §1915(c), (d), or (e) waiver or an 1115 demonstration program.

#### Potential Service Array

The services available under the 1915(i) are the same set of services that are available under a 1915(c) HCBS waiver. This includes the statutory services that are listed in the law at 1915(c)(4)(b) as well as the “other” service category that enables states to propose relevant services for the Secretary’s approval.

Services offered under a 1915(i) state plan amendment must comport with settings regulatory requirements.

#### Availability of Self-Direction

States may elect to offer the opportunity for self-direction to individuals enrolled in a 1915(i) benefit. In 1915(i), the term “self-directed” means, with respect to state plan HCBS, services that are planned and purchased under the direction and control of the individual, including the amount, duration, scope, provider, and location of the HCBS.

States may determine the scope of available self-direction opportunities, including whether individuals can exercise authority over the employment of service providers and/or authority over expenditures from the individualized budget.

Financial management services are required if participant direction is offered and may be covered as a service, an administrative function, or performed directly by the State Medicaid Agency (SMA).

#### Geographic Limitations, If Any

1915(i) services must be made available on a statewide basis.

#### Limitation on Number of Individuals Served

States may not limit the number of individuals served on 1915(i). Any individuals meeting the targeting criteria and needs-based criteria for the benefit must be served.

States electing to establish targeting criteria through a 1915(i) may limit the enrollment of individuals or the provision of services to enrolled individuals based upon criteria described in a phase-in plan, subject to CMS approval.



A state that elects to target the state plan HCBS benefit and to phase in enrollment and/or services must submit a phase-in plan for approval by CMS that describes, at a minimum:

- The criteria used to limit enrollment or service delivery
- The rationale for phasing in services and/or eligibility
- Timelines and benchmarks to ensure that the benefit is available

Additionally, the plan may not include a cap on the number of enrollees.

#### Renewal Requirements

In general, as a state plan amendment, there is a one-time approval; no renewals are needed. However, if a state elects to target the benefit to particular populations—which all states have done to date—and establishes targeting criteria, the approval of the state plan amendment will be in effect for a period of five years from the effective date of the amendment. To renew for an additional five-year period, the state must provide a written request for renewal to CMS at least 180 days prior to the end of the approval period. CMS approval of a renewal request is contingent upon state adherence to federal requirements and the state meeting its objectives with respect to quality improvement and beneficiary outcomes.

#### Cost/Financial Tests

There are no specific cost/financial tests for the 1915(i) benefit, though, as a state plan amendment (SPA), the state must provide an estimate of the federal budgetary impact of the SPA.

#### Administrative and Reporting Requirements and Public Notice Requirements

The state will annually provide CMS with the projected number of individuals to be enrolled in the benefit and the actual number of unduplicated individuals enrolled in state plan HCBS in the previous year.

Standard state plan public notice requirements apply.

#### Quality Assurance/Quality Improvement

States must develop and implement an HCBS quality improvement strategy that includes a continuous improvement process and measures of program performance and experience of care. The strategy must be proportionate to the scope of services in the state plan HCBS benefit and the number of individuals to be served. The state will make this information available to CMS at a frequency determined by the Secretary or upon request.

The continuous quality improvement process must include monitoring, remediation, and quality improvement; be evidence-based, and include outcome measures for program performance, quality of care, and individual experience (as determined by the Secretary); provide evidence of the establishment of sufficient infrastructure to implement the program effectively; and measure individual outcomes associated with

the receipt of HCBS, related to the implementation of goals included in the individual service plan.

In practice, the quality sections of the approved 1915(i) state plan amendments have been similar to the 1915(c) waivers in the types of performance measures identified.

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## Section 1915(k) Community First Choice Option

### Authority Overview

The 1915(k) Community First Choice (CFC) Option allows states to provide home and community-based attendant services and supports to eligible Medicaid enrollees under their state plan. This state plan option was established under the Affordable Care Act of 2010. The option became available on October 1, 2011 and provides a 6% increase in federal matching payments to states for service expenditures related to the option.

The purpose of the CFC option is to provide individuals meeting an institutional level of care the opportunity to receive necessary personal attendant services (PAS) and supports in a home and community-based setting. The CFC option expands Medicaid opportunities for the provision of home and community-based long-term services and supports (LTSS) and is an additional tool that states can use to facilitate community integration while receiving enhanced federal match of 6% CFC services and supports.

The CFC option allows services to be available across populations for people who meet the institutional level of care, in accordance with need and regardless of age or the type, nature, or severity of disability.

### Target Population Requirements/Opportunities

The CFC benefit does not permit a disregard of the comparability requirements of Medicaid; therefore, states may not target the benefit to specific populations and must serve all eligible individuals.

### Clinical Eligibility Parameters/Level of Care Considerations

Individuals must meet one of the following institutional levels of care (LOC): a long-term hospital, a nursing facility, an ICF/IDD, an institution providing psychiatric services for individuals under age 21, or an IMD for individuals age 65 or over. If the state does not have long-term hospitals in their state, they will not be required to include that type of institutional level of care.

States must serve individuals of all ages and may not target specific populations to receive the CFC benefit, and therefore, states should assure that they are assessing individuals against the level of care for the setting in which the individuals would have received institutional services.

## Financial Eligibility Parameters

Section 1915(k) of the Act did not create a new eligibility category for the CFC state plan option. Therefore, coverage for 1915(k), like other state plan services, is dependent on an individual meeting all the requirements for a Medicaid eligibility category covered under the state.

In addition to being eligible for Medicaid under the state plan, individuals must meet one of two eligibility requirements specific to the CFC benefit. If an individual is in an eligibility category covered under the Medicaid State Plan to which coverage for nursing facility services is available, no separate income test is applied to determine the individual's eligibility for coverage of CFC (§441.510(b)(1)). However, if an individual is not in such an eligibility category, the individual not only must meet any income test applicable to the Medicaid eligibility group but also must have income that is at or below 150% of the federal poverty level.

## Potential Service Array

States electing CFC are required to cover the following services:

- activities of daily living (ADLs), instrumental activities of daily living (IADLs) and health related tasks, through hands-on assistance, supervision, and/or cueing;
- acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish ADLs and IADLs and health-related tasks;
- back-up systems or mechanism to ensure continuity of services and supports; and
- voluntary training on how to select, manage, and dismiss attendants.

States may additionally opt to cover:

- expenditures for transition costs (such as first month's rent and utilities or bedding, basic kitchen supplies, etc.) necessary for an individual transitioning from an institutional setting to a home and community-based setting; and
- expenditures relating to a need that increases an individual's independence or substitutes for human assistance, to the extent that Medicaid expenditures would otherwise be made for human assistance. States have a degree of flexibility to determine the scope of what to include in transitional costs and items that increase independence or substitute for human assistance. It is not necessary for the state to list every service or support that would be covered for this purpose; however, in accordance with general Medicaid requirements, a state must describe any limitations on the amount, duration or scope of any of the required and optional services.

### Availability of Self-Direction

There are three service delivery models available to states to include in their CFC benefit. While each model will have varying levels of responsibilities afforded to the individual, **all models must offer a consumer-controlled method of selecting and obtaining services that allows the individual the maximum control possible.** Services may be provided through: (a) an agency-provider model, (b) a self-directed model with a service budget (utilizing a financial management entity and/or direct cash payments or vouchers), or (c) a state defined model that is approved by the Secretary. The state determines service delivery model(s) to include in its CFC benefit.

### Geographic Limitations, If Any

CFC benefits must be offered on a statewide basis.

### Limitation on Number of Individuals Served

States may not limit the number of individuals served through the 1915(k).

### Renewal Requirements

There are no renewal requirements for CFC. States gain approval and the benefit stays in effect unless removed from the state plan by the state. The state may make changes to the benefit through the state plan amendment process.

### Cost/Financial Tests

For the first full 12-month period in which the state plan amendment is implemented, the state must maintain or exceed the level of state expenditures for home and community-based attendant services and supports provided under Sections 1115, 1905(a), 1915, or otherwise under the Act, to individuals with disabilities or elderly individuals attributable to the preceding 12-month period.

In addition, the general requirements for state plan services apply, and states must estimate the cost to the federal government in the development of their state plan amendment.

### Administrative and Reporting Requirements and Public Notice Requirements

States with CFC benefits must submit annual reports on expenditures and utilization and quality measures in accordance with CMS guidance.

Prior to submitting a State Plan Amendment (SPA) pre-print to CMS, states must consult and collaborate with a state established Development and Implementation Council when developing and implementing an SPA to provide CFC services and supports. The regulations at 42 CFR 441.575 specifically require the majority of the Development and Implementation Council members be individuals with disabilities, elderly individuals, and their representatives. States may use existing Medicaid advisory committees to serve the purpose of the Development and Implementation Council.

## Quality Assurance/Quality Improvement

The CFC SPA must include a description of a quality assurance system. The system must include a quality improvement strategy that addresses both individual and systemic issues. Among other requirements, the system must also continuously monitor the health and welfare of each CFC recipient, include a process for mandatory reporting, investigation, and resolution of allegations of neglect, abuse, or exploitation in connection with CFC services and supports and a method of measuring individual outcomes associated with an individual's receipt of CFC services. The quality assurance system must include standards for all service delivery models, including how and when an individual can appeal service denials (e.g., type of services requested or the number of assessed service hours), as well as reconsideration procedures for an individual's person-centered service plan.

In addition, the CFC regulations specify certain data elements for which states must collect and report data.

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## Section 1115 Research and Demonstration Waivers

### Authority Overview

Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that are likely to assist in promoting the objectives of the Medicaid program. The purpose of these demonstrations, which give states additional flexibility to design and improve their programs, is to demonstrate and evaluate state-specific policy approaches to better serving Medicaid populations.

The 1115 authority is very broad and enables the Secretary to waive a wide array of otherwise applicable provisions of the Social Security Act. Because of this expansive authority, states can devise unique services (excluding room and board), service delivery methods, eligibility considerations, and other program attributes not otherwise feasible utilizing other statutory authorities.

For each of the authorities discussed above, the following elements as permitted in statute and regulation were described

- Authority Overview
- Target Population
- Requirements/Opportunities
- Clinical Eligibility
- Parameters/Level of Care
- Considerations
- Financial Eligibility Parameters
- Potential Service Array
- Availability of Self-Direction
- Geographic Limitations, If Any
- Limitation on Number of Individuals Served
- Renewal Requirements
- Cost/Financial Tests
- Administrative and Reporting Requirements and Public Notice Requirements
- Quality Assurance/Quality Improvement

In an 1115 demonstration, which is highly tailored to each state’s specific objectives and program design, these elements may differ considerably. With the broad authority of the 1115, states can design programs that target particular populations (including cross-disability/condition approaches), and may include multiple, distinct programs under the auspices of a single 1115. States may leverage existing, or build additional, considerations related to eligibility. These have included strategies to expand eligibility or to apply conditions for eligibility for certain populations. States may design and offer service arrays unique to meet state goals and objectives, including scaling access to certain benefit levels based on levels of need or other considerations. States may also include enrollment caps or targets and may seek a waiver of statewideness requirements if needed. The quality and reporting requirements are robust for 1115 demonstrations, with particular elements designed in response to the demonstration’s overarching aim.

Section 1115 waivers are initially approved for five years. They are renewed for up to three years at a time. In the ACA, Congress authorized the Secretary to approve 1115 waivers, as well as 1915(b) and (c) waivers, for five years if they enroll individuals dually eligible for Medicare and Medicaid. According to guidance released by CMS in the fall of 2017, CMS will consider approving “routine, successful, non-complex” Section 1115 waiver extension requests for up to ten years.

Every 1115 must demonstrate budget neutrality. This is a different—and arguably more rigorous—financial test than cost neutrality tests for the 1915(c) waiver program. Budget neutral means that federal Medicaid expenditures for a state cannot be allowed to exceed what would have occurred without the demonstration. The “without demonstration”—commonly referred to as “without waiver”—budget ceiling is calculated using a CMS and state agreed upon methodology with growth trends that estimate what the cost of Medicaid services would be absent the demonstration. For a demonstration to be budget neutral, actual Medicaid service expenditures, plus the cost of any expenditure authorities authorized under the demonstration, cannot be greater than the projected “without waiver” expenditures. Demonstrations that generate federal savings relative to their without-waiver baselines can spend the savings on costs not otherwise matchable (CNOM), such as delivery system reform incentive payments (DSRIP) to providers or expansions of eligibility to individuals who cannot otherwise be covered under the state plan. However, states cannot spend budget neutrality savings without CMS approval of the CNOM expenditures. Most states demonstrate budget neutrality using a per capita method. Under this method, the state is at risk for the costs of individuals served by the demonstration but not for the number of individuals enrolled. States may also elect to use an aggregate cap method in which the state is at risk for both per capita costs and for the number of enrollees in the demonstration, though this is used far less frequently.

In sum, the 1115 demonstration is a highly flexible tool with commensurate rigor regarding budget neutrality and quality oversight, evaluation, and reporting. The 1115 provides the potential to design a very state-specific program design with features and attributes meeting the state’s own identified goals.

## Managed care application to the HCBS authorities

Medicaid managed care (MMC) is a tool that provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and managed care plans that accept a set per member per month (capitation) payment for these services. States selecting managed care service delivery must assess their Medicaid policy goals to ensure that this approach is appropriate to meeting the needs of the intended population(s). Early uses of managed care focused primarily on cost control and quality improvement in acute health services. However, for MMC programs that deliver LTSS—known as Managed LTSS programs, or MLTSS—recent goals have included increasing budget predictability, consumer satisfaction, and the ability to tailor services/supports to individual needs, increasing access to HCBS, and system balancing. Each of the HCBS authorities above can be coupled with (or include in the case of an 1115) an authority to implement HCBS in a managed care service delivery system.

MMC programs are not monolithic. Within the Social Security Act (SSA), the law that authorizes the Medicaid program, there are a number of authorities that states can use to implement managed care. These authorities include Sections 1932(a), 1915(a), 1915(b), and 1115. Each of these authorities vary slightly in terms of what they permit with regard to service delivery, enrollment, and eligible populations. Regardless of the statutory authority used, states and managed care plans must meet certain requirements regarding payments, enrollee protections (including choice of managed care plans, information requirements, and appeal and grievance rights), quality, and many other factors.

Similar to the analysis regarding which HCBS authority is best suited to meet a state's overall objectives, if a state seeks to pursue HCBS in a managed care delivery system, there should be concomitant analysis on which managed care authority is most advantageous.

## Potential authority configuration considerations

For a state considering a reconfiguration or streamlining of HCBS, analysis of the opportunities and obligations of each Medicaid authority is critical to ascertain whether a single authority or combination of authorities furthers the state's overarching goals. States have used both a single authority and more than one authority as a means to design a single, seamless service system that provides person-centered approaches while achieving administrative simplification.

To undertake this analysis, guiding principles are important to ensure that any adjustment comports with the state's hopes for the design. These may include elements related to ensuring that any changes:

- further goals of person-centeredness and self-direction;
- improve or maintain sound financial stewardship;

- achieve administrative simplification for both system efficiency and understandability of the service delivery system in the state;
- increase a state's ability to serve individuals in need while utilizing the most cost-effective supports to meet those needs; and
- are aligned with other important overarching goals that should serve as a rudder for any potential change.

Comparing the available authorities against these guiding principles and the state's long-range objectives will reveal the potential best fits for the state. Please see Appendix A for a quick comparison guide of these funding authorities.



## Findings - Review of State Activities

When considering how to successfully deliver LTSS through Medicaid programs, an understanding of end goals is key. Some states seek to unify numerous populations under a single authority while others prefer to gain specificity by creating new waivers geared toward specific populations. Both have merits, and both have been successful strategies for different states.

The table below lists the waiver efforts reviewed for this analysis. Kansas, New Mexico, Tennessee, and Pennsylvania exemplify state efforts to merge Medicaid services of different types and for different populations, with very different outcomes, while New York, and Delaware demonstrate how targeting can be achieved through mindful use of Medicaid funding mechanisms.

Table 1

### Waiver efforts reviewed

STATE	WAIVER EFFORT	FUNDING AUTHORITY
Delaware	Pathways to Employment	1915 (i)
Kansas	Unnamed KanCare expansion	1115
New Mexico	Centennial Care	1115
New Mexico	Mi Via	1915 (c)
New York	Bridges to Health	1915 (c)
Pennsylvania	Community Health Choices	1915 (b/c)
Tennessee	TennCare II	1115

Many states pursue consolidation to simplify their systems and/or decrease limitations or restrictions imposed on service users due to differences in operational practices associated with the multiple waivers that may cover similar populations. Consolidation may achieve uniformity and reduce reliance on specific labels, but it also has the potential to increase overall costs, can be burdensome to get approved, and may create fear among stakeholders of potential funding or service reductions. To be successful, consolidation also requires considerable work to be done in advance to bring the funding mechanisms to be combined into alignment. Pennsylvania provides an excellent example of this through their combination of five 1915(c) waivers into a 1915(b/c) and one remaining 1915(c). Tennessee also provides a useful example in TennCare II, which covers groups previously offered services under five different 1915(c) waivers through a single 1115 split into two groups—CHOICES and ECF CHOICES. It is notable, though, that both Pennsylvania and Tennessee hold out people with I/DD in some way. New Mexico's Medicaid system exemplifies some of the same difficulties of combining populations—as they operate Centennial Care to cover a number of populations and for all acute care services but exclude LTSS

specific to individuals with I/DD. Kansas offers yet another example of consolidation, though the effort was not ultimately achieved.

Others have elected to create targeted waivers that focus on specific populations, or delivery of specific services. New York's Bridges to Health program does this by providing services to a previously underserved population segment. Delaware uses a 1915(i) plan to deliver employment-specific services to teens and young adults with a variety of disability types. New Mexico operates its Mi Via waiver as a standalone self-directed waiver to emphasize and promote self-direction as an option for qualifying service users in the state.

In support of these observations, what follows is a description and discussion of efforts to consolidate HCBS waivers in states, including Delaware, Kansas, New Mexico (two waivers), New York, Pennsylvania, and Tennessee.

## Delaware

Capitalizing on the expanded ability of state plan options to deliver HCBS services, Delaware offers a targeted 1915(i) program to deliver employment services to youth with disabilities.<sup>1</sup> Implemented in 2015, Pathways to Employment provides an innovative array of services to youth ages 14-25 who are visually impaired (Group A), who have physical disabilities (Group B), or who have intellectual disabilities, autism spectrum disorder, or Asperger's Syndrome (Group C). To qualify individuals with different eligibility criteria for this program, Delaware utilized the 1915(i) authority, which carries with it less stringent eligibility criteria than 1915(c) waivers.

The goal of Pathways to Employment, which is aligned with Delaware's overall Employment First vision, is to support low-income youth with disabilities in Delaware to gain the skills they need to find and succeed in work. The program does this by targeting three specific groups, who are offered an innovative array of services that extends beyond a traditional employment service array seen in HCBS offerings. Jointly administered by the Department of Medicaid and Medical Assistance, Division of Developmental Disabilities Services, and Division of Services for Aging and Adults, Pathways to Employment offers traditional employment services such as career exploration and assessment, supported employment, and navigation, in addition to less traditional auxiliary services like benefits coaching, financial coaching, and non-medical transportation. The program aims to not only help participants achieve directly applicable work skills, but also skills like managing the money they make, and understanding the interplay between their Medicaid benefits and work.

Because this program is an addition to an existing program array, there was no major pushback to its development. Eligibility was limited to youth under age 26 due to budgetary restrictions, and program delivery required a new level of coordination across multiple service agencies and other agencies that deliver similar services—which took some effort. On the whole, however, this program fits in line with

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<sup>1</sup> For Delaware's waiver matrix, see Appendix B.

Delaware's statewide Employment First initiative, and had considerable stakeholder support.

Through Pathways to Employment, enrolled individuals may begin receiving employment services at a very young age— age 14— as they begin to consider their transition out of school and their next steps. Targeting youth at this stage may help to drive increases in the number of young people with disabilities who work in competitive employment rather than receive traditional day programming through a Medicaid program as adults. Although currently only available to a small population, this program may help the state to determine innovative ways it might offer employment services to other populations.

## Kansas

While Kansas's effort at waiver consolidation has been suspended indefinitely, it is included here to demonstrate the apprehension toward change that can pose a considerable challenge to states interested in undertaking system redesign.<sup>2</sup> In 2015, Kansas began publicly discussing the idea of waiver integration of seven of its 1915(c) waivers (Autism, HCBS for the Frail Elderly, I/DD, Physical Disability, Serious Emotional Disturbance, Technology Assisted, and Traumatic Brain Injury) into its existing Medicaid managed care program, KanCare. Its goal was to utilize the existing 1115 waiver to serve all these populations under one waiver, thereby reducing limitations or restrictions imposed by having to receive narrowly targeted services.

Concern from stakeholders, including advocacy groups, about the existing managed care program and the true intentions behind the proposed shift, along with worries about cuts to services or budgets and complaints of lack of sufficient information about the proposed change, halted the project. Although officials from the departments overseeing the waivers engaged in a listening tour and attempted to communicate early on in the effort, public concern was considerable enough that the legislature passed a budget proviso to prevent any efforts around waiver consolidation to continue.

Although relatively little information is available to present in this report on Kansas's consolidation effort, and without the ability to know all of the many contributing factors to its postponement, we have included this example to demonstrate several hurdles that states can face in attempting waiver consolidation. Among these are communication and context. Although there is no best or right amount of communication—and, ultimately, it will never be possible to reach every single stakeholder regardless of the number of methods utilized—early, clear, and frequent communication is key. Communication must be responsive to the context of the state, and to stakeholder reactions. If a state wishes to move into a managed LTSS environment, and has not previously utilized any MLTSS, communicating the intentions around doing this and the changes stakeholders can expect (as well as what

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<sup>2</sup> For Kansas' waiver matrix, see Appendix B.

will remain the same) is critical to soothing fears about what this move might mean. Additionally, creating opportunities early on for stakeholders to be a part of any consolidation effort is helpful.

The messaging transmitted through communication is also critical. Stakeholders in Kansas felt suspicious about the administration's assurances that this effort was not about cost-cutting. If curbing costs is a goal of the effort, careful messaging around why this is, why it needs to be done, and how it will impact stakeholders should be undertaken. Further, messaging, like communication, should be responsive to stakeholder feedback.

In addition to communication and messaging, understanding of context and readiness for change is important. Awareness of other happenings in a system or related systems, satisfaction levels with the current system, and other contextual issues are important to understand when selecting the timing of any change effort. Perhaps among other things, Kansas' proposed consolidation involved too many waivers at a single time. Moving strategically to build up MLTSS provision capacity through piloting or moving fewer waivers over may help demonstrate to stakeholders how things will work, which could allay fears. Further, if an existing managed care program is to be used, sufficient time must be allowed to build up infrastructure and MCO capacity to deliver this program and demonstrate to stakeholders that managed care can work. Dissatisfaction among Kansans over the existing KanCare program contributed to considerable doubt that the program would be able to successfully absorb the HCBS programs, resulting in strong pushback against the consolidation effort that ultimately derailed the effort entirely.

## New Mexico

### Centennial Care

Effective beginning in 2014, New Mexico's Centennial Care 1115 managed care waiver unifies physical health, behavioral health, long-term care, and community benefits.<sup>3</sup> Prior to operating this waiver, New Mexico operated a 1915(b) waiver that delivered acute managed care for children and parents, a 1915(b/c) waiver that delivered managed LTSS for dual eligible individuals with a Nursing LOC, a 1915(b) waiver that delivered managed behavioral health services, a 1915(c) waiver that delivered HCBS to people living with HIV/AIDS, and a 1915(c) waiver that delivered HCBS to medically fragile individuals. New Mexico also operates a self-directed waiver, called Mi Via, for individuals with I/DD or who are medically fragile (discussed in the next section) as well as a 1915(c) DD waiver for individuals with I/DD and a 1915(c) waiver for medically fragile individuals, that were not included in this consolidation effort.

As Centennial Care has grown over time, the state's goals for this program have also changed. Originally, goals included streamlining and modernizing, ensuring that services were tailored to individual needs, increased quality, and slowing increasing

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<sup>3</sup> For New Mexico's Centennial Care waiver matrix, see Appendix B.

program costs without cutting services, eligibility, or rates. Now in its fourth year, current goals include continued streamlining, building a care coordination infrastructure, increasing access to LTSS, and demonstrating cost-effectiveness.

Planning for Centennial Care began two years prior to implementation. Originally, New Mexico had intended to roll in its waivers for medically fragile individuals, individuals with I/DD, and the combined self-directed waiver; eventually, however, the state decided to leave them separate due to stakeholder concerns about losing the intensive case management and some other services available on these waivers. There are currently no plans to bring these three waivers into Centennial Care.

The common thread that ties together the many populations offered LTSS through Centennial Care is that they meet a Nursing LOC. Members receiving LTSS may elect to self-direct their services or use traditional service management. Because Centennial Care offers a gamut of Medicaid services to numerous populations, it considers delivery of this program by service type (Medical, Behavioral, or LTSS), rather than by population type. Due to this, it was difficult to learn how New Mexico differentiates or tailors the service experience to different population groups beyond simply focusing on care coordination unique to each individual.

HSRI's key informant noted that the state undertook significant stakeholder engagement efforts to achieve buy-in, including roughly 200 statewide stakeholder input sessions. After MCOs were selected to deliver MLTSS, the MCOs also conducted statewide sessions to get to know future service recipients and answer questions. Service recipients were able to select the MCO they wanted to receive services from, as each operates statewide, so this was both an opportunity to help service recipients learn about MLTSS and determine the MCO that would best meet their needs. The Human Services Department (HSD) also created a call center to assist people with questions as transition occurred.

The state also worked closely with MCOs to ensure appropriate and robust technological solutions were in place to capture necessary data. New Mexico's key informant noted that the technological side of moving into MLTSS was among the most difficult parts of the move, and that the state now has more clear standards and expectations of the kinds of systems MCOs must utilize to manage the information of those in their care. Encounter data, quality monitoring metrics, and other information must be able to be captured and stored securely at the MCO level and must also be able to be received in a usable format by the state. Close work between the state's IT department and those at MCOs was required to achieve a unified data solution that worked for all parties.

In other consolidation efforts analyzed in this report, changes to service offerings have been especially important to the overall effort. Because it became clear early on, due to stakeholder pushback, that the I/DD and medically fragile populations would need to be held out of consolidation due to fears of loss of services, it does not seem that potential changes to service offerings was as much of a factor in this change as elsewhere. New Mexico's key informant did not note any specific pushback from

populations impacted by the consolidation, noting rather that consolidation opened the door to more service recipients because it does not limit the number of beneficiaries who may access these services.

Centennial Care represents an effort that achieved partial consolidation but continues to carve out specific populations. Operating within realistic boundaries like this, the state was able to achieve much of its goal without creating undue agitation. It is notable that these populations are held out, particularly the I/DD population, as many states that offer MLTSS or other sorts of multi-population services have struggled with bringing this population in. There are a variety of reasons for this, including strong advocacy resistance to giving up any hard-won services or budgets. Consolidation which brings some but not all populations under one authority, like Centennial Care, is one option for achieving at least partial streamlining.

#### Mi Via

New Mexico also operates the pioneering, entirely self-directed, Mi Via waiver.<sup>4</sup> Launched in 1999, Mi Via was the first entirely self-directed waiver in the nation. It was created as a separate waiver because at the time of its inception, CMS did not allow multiple target groups to be served under a single waiver, and Mi Via was intended to serve both individuals with I/DD and medically fragile individuals.

At the time of its creation, there were actually two Mi Via Waivers: the I/DD and medically fragile waiver which served the population with an ICF/ID LOC, and another serving older individuals, people with traumatic brain injury, and individuals with HIV/AIDS who met a Nursing LOC. The latter waiver maintained these different populations by writing them in as subgroups to the Aged or Disabled, or both, target group category. The self-directed option for these individuals has since been absorbed into the Centennial Care program. Because of the different needs of these populations, the two Mi Via waivers had rather different service options (but similar overall structures and policies), so the remaining Mi Via waiver has not been incorporated into Centennial Care.

Individuals currently served on Mi Via qualify for either the DD or medically fragile waiver. If they choose to self-direct, they are then enrolled into Mi Via. Mi Via serves around 1,000 individuals annually, offering a robust array of services. The services available and the self-directed nature of this waiver are the result of demand from well-organized advocacy groups in New Mexico; in this instance, advocates approached the state with the idea for a self-directed waiver and Mi Via was the result, after considerable negotiations and coordination with multiple groups.

The strong desire for a self-directed option was clearly the driver for the success of Mi Via. A number of the original advocates who pushed for this program still sit on a Mi Via advisory board that meets regularly to monitor the program's progress and to work with the state to make improvements to the program. Additionally, significant collaboration, including joint administration of the program by the Department Of

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<sup>4</sup> For New Mexico's Mi Via waiver, see Appendix B.

Health and the Human Services Department, as well as key operational entities like support brokers and fiscal agents, also contributes to its success through provision of ongoing monitoring and evaluation of the program.

While holding out self-direction in its own waiver structure is no longer necessary to serve multiple target groups, Mi Via does still stand out due to its singular focus. The state's key informant noted that while more individuals are choosing to self-direct with Mi Via, uptake of the self-directed MLTSS option available through Centennial Care is not growing as quickly (only around 1,300 of 30,000 individuals receiving MLTSS in Centennial Care self-direct). Further, Mi Via provides a strong example of working with stakeholders to create the services they need and to deliver them in the way that best fits them.

Mi Via is also included here because it showcases a sort of consolidation that does not involve reducing the number of waivers in operation. Mi Via, as it originated, included two very similar waivers targeted on different populations. Structuring these waivers in the same way created administrative simplification while simultaneously maintaining separate eligibility criteria and targeted services. These original two waivers had enough similarity in their structures, policies, and some number of services that maintenance of both at the same time was not unduly burdensome to the state. Operating each, targeted to a different user group, however, also allowed for service specificity to be achieved, thereby exemplifying both the benefits of coordination across waivers, and of targeting. Although one of these waivers has since been absorbed into Centennial Care, this method of program mirroring across multiple waivers is still of interest and is further showcased in the next section.

## New York

New York's Bridges to Health (B2H) program is operated through three 1915(c) waivers, serving approximately 3,300 youth in New York state care.<sup>5</sup> The program was implemented prior to the 2014 HCBS Final Rule allowing for multiple target groups under a single waiver; notably though, B2H's structures were tantamount to consolidation *before* the regulation change. These three waivers offer the same program and services to three different groups: youth with I/DD, medically fragile youth, and youth with serious emotional disturbance (SED).

The program was born out of the Office for Children and Family Service's observation that other service agencies with whom youth in foster care and in the juvenile justice system were interfacing lacked the specific population knowledge needed to best serve this group. Frustrated with an inability to work with these agencies to improve services, OCFS began in 2005 to design the B2H program to specifically meet the needs of youth in state care so that they could remain in their communities and out of unnecessary hospitalization. Due to budgetary constraints, OCFS had to limit their

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<sup>5</sup> For New York's waiver, see Appendix B.

target populations to only the highest-need groups, focusing specifically on these groups due to their particular needs for support to remain in the community.

B2H began rollout in 2008 with its first Region, consisting of Rochester, the capital region, and New York City. OCFS utilized this strategy of enrolling the major population centers first (the opposite of Pennsylvania's CHC rollout strategy) because of the size (over 70% of foster youth in New York live in New York City) and political sway of these areas. Without buy-in from them, they believed the program would fail. They then utilized the first year of rollout to learn what would work and wouldn't work, and drew on these lessons to make changes in years 2 and 3.

B2H offers an array of supports that cover skill building, healthcare integration, day service, family supports, equipment and modifications, and crisis supports to wrap around service recipients, helping to ensure not only that they can remain in the community but that they can thrive. Services offered through B2H are clearly tailored for these groups, which not only leads to an appropriate fit of services but also to wide satisfaction among families, service users, and providers.

OCFS worked closely with its provider network, forming strong relationships that helped drive the success of the program. The state's key informant noted, in fact, that provider trepidation about losing some of their connection to OCFS in the move to managed care had actually driven lower enrollment because providers feel unsure about their ability to deliver these services in a new funding environment. Until now, the B2H program has had budget limits of \$50,000 per recipient, but these limits were quite soft, and exceptions were readily available. It is not clear what the limits would be under managed care.

Thus far, B2H has been an extremely successful program, with many other states contacting OCFS to learn more about how the program operates. The specificity of its target groups and the services it offers, coupled with a strong rollout strategy in the beginning, have made the B2H program what it is today.

The B2H waivers showcase a state effort to deliver a single program to multiple target groups. In the absence of the ability to target multiple groups under a single waiver, New York elected to create three nearly identical waivers to offer the B2H program to individuals with SED, DD, and who are medically fragile. Within each of the B2H waivers, services and operational protocols were aligned to streamline the waivers in such a way that they can run as a single conceptual program. Coordinating these waivers very closely, while targeting them on three separate groups showcases another example of a state achieving a degree of administrative simplicity while still operating numerous waivers. The similarities of these waivers as they are currently structured will likely be a considerable boon as they are rolled into a managed care framework—highlighting yet another benefit of streamlining waivers.

## Pennsylvania



Pennsylvania operates a 1915(b/c) combination waiver called Community Health Choices (CHC), which it began implementing in January 2018. CHC serves the aged population (65 and older/dual-eligibles), as well as individuals with physical disabilities ages 21 to 64 who require the level of care provided by a Nursing Facility.<sup>6</sup> Overall, CHC consolidates a significant portion of five 1915(c) waivers (Aging Waiver, Attendant Care Waiver, Independence Waiver, CommCare Waiver, and the OBRA Waiver) into a single 1915(b/c). Youth under age 21, individuals with I/DD who do not meet Nursing LOC, and residents of state-operated nursing facilities are not currently included in the CHC program. By the fifth year of this program's implementation, CHC estimates that there will be over 80,000 people to be served.

Planning for CHC began in earnest in 2015 with the issuance of a directive from the governor to move to managed care delivery of long-term services and supports (MLTSS). The move to managed care, however, had been under consideration for some time—due to a desire to align programs and decrease the administrative burden of operating five 1915(c) waivers, some of which served overlapping populations. With the formation of the Office for Long-Term Living (OLTL) in 2007, service definitions, standards, and provider qualifications across eight existing disability waivers were brought into alignment for all common services. Having performed this work in advance of consolidation made the work of bringing waivers together later much simpler. These first streamlining efforts also involved the termination of three waivers. In 2008, upon the renewal period for the Aging and Attendant Waivers, OLTL realized the additional need to standardize rates, which also spurred this work.

To determine the best managed care route for Pennsylvania, work groups were formed within OLTL, including one on CMS authorities. Various managed care options were considered, including the use of an 1115. The group weighed the pros and cons of each authority, analyzing how each would allow them to preserve current services, implement desired initiatives, and coordinate dual-eligibles. Additionally, the group reviewed efforts undertaken by other states. Leadership was presented with the options determined by the group, and the 1915(b/c) authority was selected. The b/c combination allowed the state to utilize its CommCare 1915(c) waiver to receive other populations. This authority was also found to be preferable to the 1115, in part due to the lengthy amount of time that an 1115 can take to get accepted by CMS.

With streamlining their LTSS system as a top goal, OLTL looked at diagnoses, age, service utilization, and other indicators to determine appropriate eligibility criteria for CHC, and to help determine which populations should be served through other programs. OLTL ultimately elected to combine the Attendant Care, Independence, CommCare, and Aging waivers, which all utilized a Nursing LOC eligibility criteria. The OBRA waiver, which targets people with DD, and utilizes an ICF/ID LOC, was excluded from consolidation. Although the uniformity of LOC among the four waivers to be consolidated contributed significantly to the ease of combining these waivers, differing target groups and associated eligibility criteria required much consideration.

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<sup>6</sup> For Pennsylvania's waiver matrix, see Appendix B.

Carving out individuals under age 21 and people with DD<sup>7</sup> into the OBRA waiver assisted with bringing uniformity to the population to be served on CHC. In part because it already served individuals 21 and over, the CommCare waiver was selected as the best option to receive other waivers through consolidation.

In planning implementation, the state elected to engage a three-phase strategy based on geographical area and associated population centers. It was originally intended that each phase would last just six months, with full implementation achieved in a year and a half. This was, however, pushed back to a year for each region, to allow time for observation, analysis, and adjustment between rollout groups. The first geographical region to implement was Southwest Pennsylvania, which encompasses the city of Pittsburgh. The second will be Central Pennsylvania on January 1, 2019. The final will be Southeast Pennsylvania on January 1, 2020, which will include Philadelphia, where the majority of the service population resides. This strategy allows for changes to be made to the waiver before the largest wave of participants are taken in.

As rollout occurs, OLTL has been monitoring what it calls “launch indicators,” which include MCO uptake, number of grievances filed, number and types of critical incidences files, claim payment rates, and abuse and neglect report monitoring. They will continue to monitor relevant indicators throughout rollout of the first region, and for subsequent regions, which will provide them information they will need to make adjustments between phase-in periods.

To ease the transition for individuals moving into CHC, individuals will keep their same service plans for 180 days into implementation, during which time their services and providers cannot be changed by MCOs. This will allow time for MCOs to conduct assessments that will inform new service plans after the continuity of care period ends. Pennsylvania’s key informant for this report notes that while the state was only required to offer a 60-day continuity of care period for physical health services, participants’ requests for a one-year period pushed them to utilize a 180-day period as a compromise. Additionally, individuals in nursing homes served on this waiver can continue their existing care plans in perpetuity. After the 180-day period, and based on MCO assessment, individuals served on the CHC waiver will have all services offered in their previous waiver available to them, plus some that have been moved over from other waivers, such as residential services formerly only available to individuals with brain injury, or home delivered meals, formerly only available to individuals age 65 or older.

One issue that has arisen thus far in implementation is some difficulty surrounding data. In some instances, it has been difficult to match individuals with data due to data coming in from multiple legacy systems. The state’s key informant noted that while case management was using one data system, Medicaid programs were using

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<sup>7</sup> Individuals with DD can be admitted into CHC as long as they meet Nursing LOC. The state’s key informant noted anecdotally that among 500 individuals with DD assessed with Nursing LOC, only 17 did not meet these criteria, suggesting many may be able to be served by CHC.

another, which created mismatches that had to be worked through on a time-consuming case-by-case basis. The state has worked closely with MCOs to clear these issues up and ensure that data gathering is uniform.

Another hurdle associated with this effort has been communication and role clarification. Pennsylvania has a strong county presence, with the role of counties formerly extending as far as operation of the aging waiver, and some design elements of the system. Prior to launching CHC, OLTL began moving this authority away from counties through various mechanisms, which has allowed more total operational control to sit within OLTL alone.

Regarding communication, OLTL has undertaken significant and diverse efforts. These have so far included seeking stakeholder feedback throughout the planning process, including in the design of the RFP for Managed Care Organizations. Feedback received from stakeholders was recorded and compiled into living documents. Ongoing communications with participants are housed online at <http://www.healthchoices.pa.gov/info/about/community/commpart/index.htm>, which also indicates other ways to get information, such as in-person meeting schedules (over 40 in-person meetings were held across region 1 in advance of implementation, and a similar schedule is underway for region 2), a dedicated email address, and a toll-free phone number staffed by OLTL personnel who are available to answer participant questions. An MLTSS advisory committee, of which 51% of members are service users, was formed to provide ongoing feedback during planning and through implementation to date. Additionally, OLTL hosts a “Third Thursday” webinar to update providers and other service departments about planning and progress. OLTL also holds individual meetings with providers and advocacy organizations on a weekly basis. Prior to the January 1 launch of the first region, OLTL hosted an all-day summit for regional stakeholders that was comprised of a morning session describing the overall effort and afternoon breakout sessions relevant to various stakeholder groups.

OLTL invested time into creating and making available a number of informational documents, housed at <http://www.healthchoices.pa.gov/info/resources/publications/community/index.htm>. Brochures explaining covered benefits, general facts about CHC, and a simple and easy-to-follow diagram of the schedule of rollout are available on this site.

As implementation of CHC continues into its second and third years, OLTL will continue to monitor its reception through the many feedback channels it has created and will have opportunities to make mid-course corrections as rollout continues. It will also closely monitor any changes to the population served by the OBRA waiver, which has historically leaned more toward serving those with physical disabilities, to determine if changes will be necessary when it comes up for renewal.

Pennsylvania’s move to MLTSS demonstrates many key lessons for success. Among these include intensive preparation and alignment of waivers to be consolidated, research into funding authorities and an understanding of how each fit with OLTL’s

goals and the context of the state, and early, frequent, and multi-platform communication.

## Tennessee

TennCare<sup>8</sup> is Tennessee's longstanding 1115 Medicaid managed care program, originally implemented in 1990 to deliver healthcare services. Since its inception, TennCare has grown significantly, expanding in 2009 to incorporate LTSS for individuals with physical disabilities and elderly individuals. In 2016, TennCare grew again to include individuals with I/DD. Today, TennCare delivers MLTSS through two programs, each with three subgroups that it serves.

CHOICES, added in 2009, serves individuals with physical disabilities and people over age 65; CHOICES ECF, added in 2016, is for people with I/DD.<sup>9</sup>

The original impetus for adding LTSS through CHOICES was to reduce institutional reliance for older and physically disabled individuals. Moving this population into managed care promoted service delivery in the community through the use of a capitated payment structure. Seeing the success of the CHOICES program at eliminating waitlists while serving people in the community, the I/DD community in Tennessee actually approached TennCare administrators with the request to be added to the demonstration. This was accomplished in 2016; however, the state's three 1915(c) waivers for people with I/DD continue to operate but are not available to new enrollees. These were left in place to allow time to build the MLTSS system, and to strengthen its ability to serve individuals with I/DD.

Both CHOICES and CHOICES ECF were built with tier-type structures. In CHOICES, this acts to divert people who are at-risk of requiring a Nursing level of care by meeting their needs before they reach this stage. In CHOICES ECF, the tier structure roughly mirrors the supports and comprehensive waiver structures that exist in the 1915(c) waivers, and offers a separate group for youth under age 21.

The goal of TennCare has always been to expand access to services for Tennesseans, first through acute and behavioral healthcare and now through the provision of LTSS. Tennessee's key informant notes that since adding people with I/DD, they have begun exploring ways to improve HCBS services to people on the CHOICES program as well, including plans to offer expanded employment services and bolster self-determination mechanisms. By slowly growing its managed care over time, the state has allowed space for learning like this, and for its infrastructure to expand and strengthen. Standing up all of these programs overnight would not have allowed for this to happen, and our key informant notes that this is part of what has made TennCare's MLTSS successful.

In moving over the CHOICES population, the Bureau of TennCare elected to simply pick up the programs as they were and move them into the 1115 demonstration,

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<sup>8</sup> Technically TennCare II, the program is colloquially referred to simply as TennCare.

<sup>9</sup> For Tennessee's TennCare II waiver, see Appendix B.

without changes to rates, limits, or services. This ensured minimal disruption to service recipients. With CHOICES ECF, however, the Bureau wanted to approach the change as an opportunity to improve the program, and so engaged in significant stakeholder communications, both with service recipients and providers. Through this, they learned that people wanted more meaningful day options, including employment and increased opportunities to build meaningful relationships and increase independence—and that the state would also need to focus on services for transitioning youth. The service array offered, therefore, reflects these desires, and places strong emphasis on innovative employment services. The Bureau was able to engage stakeholders to the degree it did because of a deep bench of staff (roughly 75 staff members). Further, it had strong support, much like Pennsylvania, from the governor.

While there is still trepidation statewide about MLTSS, a Tennessee official who was interviewed for this report notes that people have felt they were a part of building the program and so are bought-in to its continued improvement and success. Building up the TennCare program over time has also afforded stakeholders time to see how managed care functions in different environments, and how it can work for different populations.

Nevertheless, there have also been hurdles to delivering LTSS through TennCare. One of the largest of these is that of capacity. The need to move overnight to complete statewide readiness and staffing (despite not moving in all populations at once) is almost impossible to meet. To attract providers, and in acknowledgement of statewide staffing shortages, high rates were built into the program, and the Bureau offered trainings on how to provide new services. Despite these efforts, recruiting and retaining enough providers has remained a challenge. The Bureau is now engaging more targeted efforts toward this end.

Another challenge has been coordinating with the multiple entities and agencies involved in LTSS delivery in Tennessee. Not only does this include undertaking efforts to maintain regular contact with MCOs, it also includes maintaining connection with the IDD agency to ensure they work together as much as possible to achieve overall state aims.

Overall, however, TennCare's expansion into MLTSS has been successful due to the considerable timeframe it has had in terms of planning, rollout, and capacity-building. Demonstrating to the I/DD community the benefits that managed care can bring (such as reducing waitlists for community services) through first bringing in the aging and physically disabled populations, who also benefitted in this way, created significant program buy-in. Working with stakeholders to create a program that works for them has also helped drive success.

Tennessee demonstrates the benefits of slow and careful transition. Although MLTSS has been a success thus far, the state continues to operate 1915(c) waivers, and has no current plans to discontinue this program, likely until it feels the managed care

infrastructure for LTSS is significant and robust enough to deliver the same quality and amount of service currently offered between the two funding structures.



## Conclusions

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The examples in this report illustrate the varied ways that states have utilized Medicaid funding to meet their specific goals. In some cases, this has included creating new waivers or state plans to target specific groups, or to deliver specific services outside of the primary service structures. In others, it has included consolidation efforts to bring multiple populations and waivers under a single authority to achieve greater efficiencies and greater simplicity for service recipients. All of these successful efforts were born out of a desire to better serve individuals, not to utilize a pre-determined route.

New Mexico's Mi Via Waiver, Delaware's Pathways to Employment, and New York's Bridges to Health evidence efforts driven by the desire to achieve very specific goals. New Mexico's Mi Via waiver was brought about due to advocate demands for increased options to self-direct, and through work with the state, this was achieved through a Medicaid waiver. Delaware's and New York's waivers showcase an identification of unmet, target-specific need that was met creatively with the tools available. Delaware utilized the HCBS qualities of the 1915(i) waiver to offer employment services to youth with disabilities, while New York observed that high-needs youth in state care were falling through the cracks, and met those needs with three targeted, but structurally identical, waivers.

Pennsylvania and Tennessee give us strong examples of methods for consolidating waivers and target populations through the use of managed care options, while still operating separate waivers to serve people with I/DD. Of all these efforts, Tennessee has made the greatest strides toward unifying this group with others, but its continued operation of 1915(c) waivers to serve this population demonstrates the difficulty in achieving this goal. Similarly, New Mexico's Centennial Care program was able to unify a number of populations but continues to hold out individuals with I/DD and medically fragile individuals, with no current plans to incorporate them into their demonstration. Kansas, with its effort that did not come to fruition, demonstrates some of the difficulties that accompany attempts to merge populations.

Long-term services and supports are unlike acute care, or even behavioral care, in that they impact every part of a person's life and for many, every hour of their day. The fight that many groups have had to wage to get these services has been long and arduous, and any sense that services or dollars could be lost can easily bring these groups into action against the perceived threat. Many of these efforts showcase strong stakeholder communication efforts that have helped bring stakeholders on board for change by involving them in the conception, design, planning, and implementation of the change. Without this, a reconfiguration's chances of success are limited.

On the technical end, understanding the difficulties that can come with merging populations with different level of care eligibility criteria is important. Pennsylvania's consolidation of four of its waivers was made much easier because they all shared a Nursing LOC. TennCare operates different programs within its 1115 demonstration to

target and offer appropriate services to groups meeting different levels of care. Merging multiple populations with different eligibility criteria within a single 1915(c) can be more difficult. In addition to LOC, states that consolidate waiver groups also need to consider other eligibility criteria. While it may be possible to simply widen the criteria to ensure minimal disruption to current service recipients, such a measure could open the floodgates to new entrants, which could be very costly to the state. Restricting the criteria too tightly, however, could have the effect of rendering some current service users ineligible if they are not grandfathered in, and may create undesired barriers to service for new entrants.

Other key commonalities in the successes of these efforts include lengthy planning and implementation processes. Implementation that utilized a staggered rollout period across regions or population centers was noted by key informants as being especially helpful in standing up these programs successfully, because it allowed for learning and course correction along the way. Further, selecting the right implementation strategy for a particular state context can be helpful to achieving buy-in.

At minimum, most of these efforts each took roughly two years for planning in advance of implementation. Several, however, took significantly longer. Pennsylvania, for example, began work to streamline its waivers more than ten years before it finally implemented a consolidation into managed care. Tennessee moved into MLTSS in segmented steps, allowing time to build up MCO capacity and trust within the state. The work done in advance of any consolidation effort is a critical step to a successful outcome. Streamlining and organizing of services, provider qualifications, operational rules, and policies, in addition to careful planning around implementation strategies can take considerable time but is well worth the effort.

Overall, these efforts demonstrate the many ways that Medicaid funding authorities can be used to pursue a state's goals for delivering services to people with disabilities. The particular funding mechanisms selected are important to, but not the sole factor in determining the success of a particular effort. Clear understanding of the goals being pursued, sufficient time to undertake strong stakeholder engagement, and thorough planning, including determination of an appropriate implementation strategy, and careful consideration to merging different eligibility criteria are all critical to a successful reorganization or addition of a Medicaid LTSS program. In its own pursuit of waiver reconfiguration, Minnesota may draw on many of the lessons learned through these efforts.





# Background and Approach

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## Methods

This report presents research and analysis of available funding authorities and notable state reconfiguration or consolidation efforts. Methods for each task are presented below.

### Analysis of federal funding authorities

The project team focused this review on governing statutes, regulations, and sub-regulatory guidance for the following Medicaid state plan and waiver authorities, selected given their prevalent use for the delivery of HCBS nationally, and the potential alignment with Minnesota's project objectives. Four Medicaid waiver authorities were explored:

- 1915(c) HCBS waivers
- 1915(i) HCBS as a State Plan Option
- 1915(k) Community First Choice Option
- 1115 Research and Demonstration Waivers

When reviewing these authorities, the following operational elements were explored:

- Authority Overview
- Target Population Requirements/Opportunities
- Clinical Eligibility Parameters/Level of Care Considerations
- Financial Eligibility Parameters
- Potential Service Array
- Availability of Self-Direction
- Geographic Limitations, If Any
- Limitation on Number of Individuals Served
- Renewal Requirements
- Cost/Financial Tests
- Administrative and Reporting Requirements and Public Notice Requirements
- Quality Assurance/Quality Improvement

Additional criteria evaluated for each of the funding authorities outlined (as applicable) included:

- Extent to which populations with different diagnostic criteria are addressed;
- Potential for incorporating varying level of care criteria;
- Limitations, or specific regulations, related to services or providers;
- Financial tests, if any;
- Guidance on quality assurance or performance expectations; and
- Administrative or reporting requirements.

## Research into other state activities

To conduct this review, three steps were completed:

1. **A waiver review matrix was compiled.** This matrix (See Table 2), illustrates key informational areas within and related to waivers and waiver reconfiguration efforts that allows for comparison between jurisdictions. The primary resources used to fill in the matrices were the waivers. However, other materials otherwise available online, such as publications made available by the state, or in some cases, news articles, were also used. Some information requested through the matrix, such as the reasons for change, contextual issues, and public reaction, however, was not possible to find through research.

Table 2

### Waiver Review Matrix

#### AREA

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Waiver Authority Converting From

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Waiver Authority Converting To

---

Stated Reason for Change

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Target Groups

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Eligibility

---

Effective Date of Proposed Waiver

---

Change Effort Timeframe

---

Administration and Operation

---

Services—Summary of Services Before and After Change Effort

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Self-Directed (yes/no, & narrative, if applicable)

---

Caps on Individual Resource Allocations or Budgets

---

Limits on Numbers Served

---

Summary of Public Reaction/Change Communication

---

Contextual (Systemic, Political) Hurdles or Opportunities for Change

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Change Complete? If no, state reason

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2. **States were selected for in-depth review.** After developing this matrix, HSRI and NASDDDS jointly discussed which states and efforts would be most beneficial to research for the purposes of this study. Ultimately, six states (Delaware, Kansas, New Mexico [selected for two different efforts], New York, Pennsylvania, and Tennessee) were selected. Kansas, New Mexico, New York, Pennsylvania, and Tennessee all provide examples of waiver consolidation efforts—some completed, some not. New Mexico’s Mi Via waiver also offered an opportunity to look at an entirely self-directed waiver, pertinent to Minnesota’s interest in strengthening the use of their CDCS option. Finally, Delaware was included to provide an example of how alternative funding authorities can be used strategically—in this case to provide employment services.

Table 3

**Waiver efforts reviewed**

STATE	WAIVER EFFORT	FUNDING AUTHORITY
Delaware	Pathways to Employment	1915 (i)
Kansas	Unnamed KanCare expansion	1115
New Mexico	Centennial Care	1115
New Mexico	Mi Via	1915 (c)
New York	Bridges to Health	1915 (c)
Pennsylvania	Community Health Choices	1915 (b/c)
Tennessee	TennCare II	1115

With states selected and the matrix prepared, HSRI conducted online research, in consultation with NASDDDS, on each of the selected efforts. Information that could not be gathered through this method was set aside for key informant interviews. Interview questions differed by state based on the online availability of information needed for the matrix. Information gleaned from these interviews is included, as appropriate, in the matrices presented in Appendix B and also informs the narrative for each effort presented in findings.

3. **Key informants within each state were identified and interviewed.** To obtain information not available through research, we identified key informants from a number of the states for which reconfiguration, or otherwise relevant, efforts were researched. Key informants were selected for the most relevant efforts, and included the following:

- New Mexico: Leadership staff within the Office of Medicaid
- New York: Leadership staff within the Bureau of Waiver Management, Office of Children and Family Services
- Tennessee: Leadership staff within the Bureau of TennCare
- Pennsylvania: Leadership staff within the Office of Long-Term Living

# Appendices

## Appendix A – Funding Authority Comparison Table

### Selected Social Security Act Provisions Authorizing Medicaid Home and Community-Based Services

Provision	Type of Authority:		Description	Enrollment Cap Allowed:		Financing	State Take-Up
	State Plan Option	Waiver		Yes	No		
Section 1915(c)		X	Expands financial eligibility using institutional rules and authorizes HCBS for people who need institutional level of care	X		Requires federal cost neutrality	As of 2012, nearly 300 waivers in 47 states and DC serve 1.5 million beneficiaries
Section 1915(i)	X		Authorizes the same HCBS as available under Section 1915(c) waivers. Requires less than institutional level of care. Services can be targeted to populations.		X*		As of Oct. 2015, 17 states adopted
Section 1915(j)	X		Authorizes self-directed personal care services.		X		As of 2014, 5 states use**
Section 1915(k)	X		Authorizes attendant care services and supports for people who need institutional level of care		X	6% enhanced FMAP	As of Dec. 2015, 5 states adopted
Section 1929	X		Authorizes HCBS (but not full Medicaid state plan benefits) for functionally disabled seniors		X		Used by 1 state (TX)
Section 1930	X		Authorized HCBS for people with I/DD, did not tie eligibility to institutional level of care		X		Provision expired, was used by 8 states for less than 5 years
Section 1115		X	Allows HHS Secretary to approve experimental, pilot or demonstration projects that further purposes of Medicaid program.	X		Must be budget neutral to federal gov.	As of 2014, 12 states use these waivers to deliver HCBS through capitated managed care

Source: Adapted from: 9 Sowers, M., Claypool, H., & Musumeci, M. (2016) *Streamlining Medicaid home and community-based services: Key policy questions*. The Kaiser Commission on Medicaid and the Uninsured.

NOTES: \*Under § 1915(i), states can constrict functional eligibility criteria if their projected number of individuals expected to receive services is exceeded. \*\*Most states offer self-directed HCBS through authorities other than § 1915(j). SOURCES: Kaiser Commission on Medicaid and the Uninsured, [Medicaid Home and Community-based Services Programs: 2012 Data Update](#) (Nov. 2015); State Health Facts, [Section 1915\(i\) Home and Community-based Services State Plan Option](#) (Oct. 2015); State Health Facts [Section 1915\(k\) Community First Choice State Plan Option](#)(Dec. 2015); Kaiser Commission on Medicaid and the Uninsured, [Key Themes in Capitated Managed Long-Term Services and Supports Waivers](#) (Nov. 2014); Jane, K., Traylor, C., Ghahremani, K., Texas Medicaid and CHIP in Perspective. 10th ed. (Feb. 2015); Gettings, Robert M., Forging a Federal-State Partnership: A History of Federal Developmental Disability Policy. AAIDD, NASDDDS (2011).

## Appendix B – State Waivers

### Delaware: Pathways to Employment (1915i)

<b>Funding Authority</b>	Added a 1915i to target youth with disabilities who want to work		
<b>Target Groups:</b>			
<b>Group A</b>	<b>Group B</b>	<b>Group C</b>	
<b>Individuals Who Are Visually Impaired</b> Individuals are unemployed or underemployed or are at risk of losing their job without supports.	<b>Individuals with Physical Disabilities</b> Individuals whose physical condition affects their ability to live independently, who need ongoing assistance with at least 1 ADL and who are at risk of being unable to sustain competitive employment without supports.	<b>Individuals with Intellectual Disabilities, Autism Spectrum Disorders or Asperger’s Syndrome</b> Individuals with significant limitations in adaptive function and/or who need assistance with at least one area of ADL, and/or who have difficulty understanding and interpreting social situations and who are unlikely to be able to obtain or sustain competitive employment without supports.	
<b>Goals</b>	Pathways to Employment is a program designed to support low-income teens and young adults with disabilities in Delaware who want to work. The program helps participants get prepared for work, find jobs, and succeed in the workplace.		
<b>Eligibility:</b>			
<b>State plan HCBS needs-based eligibility criteria</b>	<b>Nursing Facility (NF) (&amp; NF LOC waivers)</b>	<b>ICF/MR (&amp; ICF/MR LOC waivers)</b>	
<b>Group A</b> Individuals who are Visually Impaired Individuals are unemployed or underemployed or are at risk of losing their job without supports.	The individual must have deficits in at least 2 ADLs.	Individual: 1) Has a diagnosis of intellectual or developmental disability and has been deemed eligible for services through the Division of Developmental Disabilities Services (DDDS). 2) Has been recommended for an ICF/IID level of care based on an assessment completed by a Qualified Intellectual Disability Professional, and includes the relevant medical and functional information necessary to evaluate an individual’s need for an ICF/IID level of care. The diagnosis of Intellectual or Developmental Disability is determined based on: 1) The administration of the Adaptive Behavior Assessment System (ABAS) or Vineland Adaptive Behavior Scale (VABS) by a licensed psychologist, certified school psychologist or a licensed physician who practices psychiatry who certifies that the individual/applicant has significantly sub-average intellectual functioning or otherwise meets the following criteria: b. An adaptive behavior composite standard score of 2 or	
<b>Group B</b> Individuals with Physical Disabilities Individuals whose physical condition affects their ability to live independently, who need ongoing assistance with at least 1 ADL and who are at risk of being unable to sustain competitive employment without supports.			

<p><b>Group C</b></p> <p>Individuals with Intellectual Disabilities, Autism Spectrum Disorders or Asperger’s Syndrome.</p> <p>Individuals with significant limitations in adaptive function and/or who need assistance with at least one area of ADL, and/or who have difficulty understanding and interpreting social situations and who are unlikely to be able to obtain or sustain competitive employment without supports.</p>		<p>more standard deviations below the mean; or a standard score of two or more standard deviations below the mean in one or more component functioning areas (ABAS: Conceptual, Social; Practical: VABS: Communication; Daily living Skills, Social).</p>
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Group A	Group B	Group C
<p><b>Individuals Who Are Visually Impaired:</b></p> <p>Individuals age 14 to 25 determined by a doctor of optometry or ophthalmology to be: totally blind (no light perception), legally blind (20/200 in the better eye with correction, or a field restriction of 20 degrees or less) or severely visually impaired (20/70 to 20/200 in the better eye with correction).</p>	<p><b>Individuals with Physical Disabilities:</b></p> <p>Individuals age 14 to 25 with a physical disability; whose physical condition is anticipated to last 12 months or more.</p>	<p><b>Individuals with Intellectual Disabilities, Autism Spectrum Disorders or Asperger’s Syndrome:</b></p> <p>Individuals age 14 to 25 with intellectual developmental disorder attributed to one or more of the following: IQ scores of 2 standard deviations below the mean, autism spectrum disorder, Asperger’s disorder, Prader-Willi Syndrome, as defined in the APA Diagnostic and Statistical Manual, brain injury or neurological condition related to IDD that originates before age 22.</p>

<b>Effective Date of Funding Authority</b>	1/1/2015	
<b>Effort Timeframe</b>	Efforts began roughly 18 months prior to implementation	
<b>Administration and Operation</b>	DMMA, DDDS, DSAAPD and DVI partnered in the design of the authority, and DMMA, DDDS and DSAAPD play key functions in administering the benefit.	
<b>Services</b>	<p>Employment Navigator</p> <p>Career Exploration and Assessment</p> <p>Supported Employment - Individual</p> <p>Supported Employment - Small Group</p> <p>Benefits Counseling</p>	<p>Financial Coaching</p> <p>Non-Medical Transportation</p> <p>Personal Care (including a self-directed component)</p> <p>Orientation, Mobility, Assistive Technology</p>

<b>Self-Directed (yes/no, &amp; narrative, if applicable)</b>	<p>Yes, under the Personal Care service.</p> <p>Personal care is the only service offered under the 1915(j) for which there are self-direction opportunities. All participants in Pathways who receive personal care services are offered the opportunity for employer authority to self-direct these personal care services. Individuals are informed of the opportunity for self-direction during the person-centered planning process.</p> <p>The Employment Navigator provides information, both verbally and in writing, about: the benefit, available supports (such as assistance from the fiscal management entity, what assistance is provided and how to contact the vendor/fiscal employer agent) and information regarding their responsibilities when they elect to self-direct personal care services.</p> <p>Individuals (or parents in the case of minor children) may elect to serve as the employer of record for these services. Individuals receive information and assistance in support of participant direction and vendor/fiscal employer agent support from an entity(ies) contracted with the state for the provision of these services.</p> <p>The vendor/fiscal employer agent function is performed as a Medicaid administrative activity.</p>
<b>Caps on Individual Resource Allocations or Budgets</b>	No
<b>Limits on Numbers Served</b>	Cannot cap enrollment
<b>Summary of Public Reaction</b>	This program has gotten DE good press and has led to it being seen as a national leader in career development for young people with disabilities.
<b>Contextual (Systemic, Political, etc) Hurdles or</b>	While there were not political hurdles (this program had the support of Governor and legislature), there were logistical challenges in coordinating across three distinct agencies (DDDS, DMMA and DSAAPD) along with Education and vocational rehabilitation to ensure a seamless transition for youths ages 14-26. In addition, the state did have to limit eligibility to age 26 for budgetary reasons
<b>CMS Approval?</b>	Yes.
<b>Additional Source Materials</b>	<p>Delaware Pathways to Employment available at: <a href="https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=30488">https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=30488</a></p> <p><a href="http://dhss.delaware.gov/dsaapd/pathways.html">http://dhss.delaware.gov/dsaapd/pathways.html</a></p>

## Kansas: Unnamed Consolidation Effort (1115)

<b>Waiver Authority Converting From</b>	Autism 1915(c) HCBS for the Frail Elderly 1915(c) I/DD 1915(c) Physical Disability 1915(c) Serious Emotional Disturbance 1915(c) Technology Assisted 1915(c) TBI 1915(c)
<b>Waiver Authority Converting To</b>	1115
<b>Target Groups</b>	People with autism, frail elderly, I/DD, physical disability, serious emotional disturbance, technology assisted, and TBI, who would have been separated into two groups: one for children, and one for adults.
<b>Stated Reason for Change</b>	<p>“What we want to be able to do with waiver integration ... is really look at always providing services around the individual and the individual’s needs and not be specifically tied to limitations or restricted by limitations that may be in the individual waivers”</p> <p>Administration officials said that this consolidation would allow all Kansans to receive a broader array of services more efficiently, rather than being constrained by labels. Additionally, it had hoped to reduce waitlists through creation of efficiencies gained by moving to managed LTSS.</p>
<b>Eligibility</b>	Eligibility criteria were not proposed to change between the 1915(c) waivers and the 1115.
<b>Effective Date of Proposed Waiver</b>	N/A
<b>Change Effort Timeframe</b>	Public discussion of this effort dates back to at least 2015, but consideration of moving the 1915(c) waivers into the KanCare 1115 began as early as 2011.
<b>Administration and Operation (movement)</b>	Kansas Department of Health and Environment and Kansas Department of Aging and Disability Services would have jointly overseen this program.
<b>Services—Summary of Services Before and Changes</b>	A final service array was not created; however, Kansas intended to combine and make adjustments to services available across all of the waivers to be consolidated.
<b>Self-Directed (y/n) &amp; narrative-if applicable</b>	N/A



<b>Caps on Individual Resource Allocations or Budgets</b>	N/A
<b>Limits on numbers served</b>	N/A
<b>Summary of Public Reaction/Change Communication</b>	This effort was ultimately postponed indefinitely, in part due to public belief that it was really about cutting costs, and that it was happening too quickly with too little information available about what the changes would be. This was in spite of a statewide listening tour, numerous communications, and public discussion of the goal to provide better care and outcomes, and to reduce limitations imposed on individuals by nature of having to access individual waivers.
<b>Contextual Hurdles of Change</b>	Contextual hurdles were significant. Although this consolidation was proposed to remove limitations that may be present within the different waivers, to provide better care and outcomes, and it would have streamlined waivers that have overlapping services available to people based on their disability label, stakeholder objections were considerable. Although the state engaged in several methods of communication, trepidation about the reasons behind moving to managed LTSS, and claims of insufficient planning caused the state to postpone pursuit of this endeavor. Additionally, wide dissatisfaction with the KanCare managed healthcare program contributed to stakeholder trepidation, with numerous public comments to the proposed 1115 noting myriad issues with the exiting KanCare program that would be compounded by adding additional services to the program.
<b>Change Complete? If no, state reason</b>	Postponed, TBD
<b>Additional Source Materials</b>	<p>Public Information Sessions Q&amp;A: <a href="https://www.kdads.ks.gov/docs/default-source/CSP/HCBS/Waiver-Integration/waiver-integration-public-information-tour-revised-final-q-amp-a-9-28-15.pdf?sfvrsn=4">https://www.kdads.ks.gov/docs/default-source/CSP/HCBS/Waiver-Integration/waiver-integration-public-information-tour-revised-final-q-amp-a-9-28-15.pdf?sfvrsn=4</a></p> <p>Public Comments: <a href="https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ks/KanCare/ks-kancare-pblc-cmmnts.pdf">https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ks/KanCare/ks-kancare-pblc-cmmnts.pdf</a></p> <p>News Articles:</p> <p><a href="http://www.khi.org/news/article/state-officials-combining-medicaid-waivers-not-about-money">http://www.khi.org/news/article/state-officials-combining-medicaid-waivers-not-about-money</a></p> <p><a href="http://kcur.org/post/disability-group-kdads-contract-would-combine-medicaid-waivers#stream/0">http://kcur.org/post/disability-group-kdads-contract-would-combine-medicaid-waivers#stream/0</a></p> <p><a href="http://kcur.org/post/brownback-administration-suspends-medicaid-waiver-integration">http://kcur.org/post/brownback-administration-suspends-medicaid-waiver-integration</a></p> <p><a href="https://www.drckansas.org/about-us/news/your-input-is-needed-this-week-on-proposed-global-hcbs-waiver">https://www.drckansas.org/about-us/news/your-input-is-needed-this-week-on-proposed-global-hcbs-waiver</a></p> <p><a href="https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ks/KanCare/ks-kancare-pblc-cmmnts.pdf">https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ks/KanCare/ks-kancare-pblc-cmmnts.pdf</a></p>

## New Mexico: Centennial Care (1115)

<b>Funding Authority</b>	<b>Converted from:</b> <ul style="list-style-type: none"><li>• Salud! 1915(b) waiver: Acute managed care for children and parents;</li><li>• CoLTS 1915(b)(c) waiver: MLTSS for dual eligible and individuals with a nursing facility level of care;</li><li>• Behavioral health 1915(b) waiver: Managed behavioral health services through a statewide behavioral health organization;</li><li>• AIDS 1915(c) waiver: Home and community-based services for people living with HIV/AIDS; and</li><li>• Medically Fragile 1915(c) waiver: HCBS for individuals who are determined to be medically fragile (initially included, but is currently left out of the 1115 renewal)</li></ul>	<b>Converted to:</b> 1115 Centennial Care MLTSS
<b>Target Groups</b>	The demonstration enrolled most New Mexico Medicaid beneficiaries and New Mexico Medicaid expansion Children's Health Insurance Program (CHIP) beneficiaries in managed care for a full range of services, including physical health, behavioral health and long-term services and supports (home and community-based services and institutional care). The demonstration consolidated the existing delivery system waivers into a single comprehensive managed care product.	
<b>Goals</b>	Prior to initial approval, goals included: <ul style="list-style-type: none"><li>• Assuring Medicaid recipients receive the right amount of care at the right time, in the most cost-effective settings</li><li>• Assuring the care is measured for quality, not quantity</li><li>• Slowing the rate of growth of program costs (bending the cost curve) without cutting services, eligibility or provider rates</li><li>• Streamlining and modernizing the program in preparation for January 2014</li></ul> The state's goals in implementing the demonstration (2014) were to: <ul style="list-style-type: none"><li>• Assure that Medicaid beneficiaries in the program received the right amount of care, delivered at the right time, cost effectively in the right setting;</li><li>• Ensure that the expenditures for care and services being provided were measured in terms of quality and not solely by its quantity;</li><li>• Slow the growth rate of costs or "bend the cost curve" over time without cutting benefits or services, changing eligibility or reducing provider rates; and</li><li>• Streamline and modernize the Medicaid program in the State.</li></ul>	

Now that the program has been implemented, goals around renewal include:

- Streamlining administration of the program
- Building a care coordination infrastructure
- Increasing access to LTSS
- Continuing to lead the nation in spending more money on community settings than institutional
- Demonstrating cost-effectiveness and improved utilization of health care services

**Level of Care**

To receive the LTSS benefit, members must meet a Nursing LOC.

**Eligibility**

Eligibility Groups **Covered** in Centennial Care

Population Group	Populations
TANF and Related	Newborns, Infants, and Children Children’s Health Insurance Program (CHIP) Foster children Adopted children Pregnant women Low income parent(s)/caretaker(s) and families Breast and Cervical Cancer Refugees Transitional Medical Assistance
SSI Medicaid	Aged, blind and disabled Working disabled
SSI Dual Eligible	Aged, blind and disabled Working disabled
Medicaid Expansion	Adults between 19-64 years old up to 133% of MAGI

The following populations are excluded from Centennial Care:

- Qualified Medicare Beneficiaries;
- Specified Low Income Medicare Beneficiaries;
- Qualified Individuals;
- Qualified Disabled Working Individuals;
- Non-citizens only eligible for emergency medical services;
- Program for All-Inclusive Care for the Elderly;
- Individuals residing in ICF/IIDs;

- Medically Fragile 1915 (c) waiver participants for HCBS;
- Developmentally Disabled 1915 (c) participants for HCBS;
- Individuals eligible for family planning services only; and
- Mi Via 1915 (c) waiver participants for HCBS

**Effective Date of Funding Authority** First approved 1/1/14. Renewal pending, seemingly since 2017.

**Effort Timeframe** Planning began two years prior to implementation of Centennial Care in 2014.

**Administration and Operation** 4 MCOs administer all services. Operated by Human Services Department (HSD).

**Services** Home and Community-Based Services. Under Centennial Care, enrollees who meet the nursing facility level of care criteria will be eligible for the Community Benefit in Centennial Care. Enrollees who are otherwise Medicaid eligible will be able to access the Community Benefit without the need for slots. Enrollees who are made eligible for the demonstration as a result of their nursing facility level of care (the 217-like group) will be subject to the enrollment limits.

The Community Benefit service categories are listed below. The table also indicates which services are available through either the agency-based benefit or the self-direction benefit and which services are available in both.

Community Benefit Services Included Under Centennial Care		
	Agency-Based Benefit	Self-Direction Benefit
Adult Day Health	X	
Assisted Living	X	
Behavior Support Consultation	X	X
Community Transition Services	X	
Customized Community Supports		X
Emergency Response	X	X
Employment Supports	X	X
Environmental Modifications	X	X
Home Health Aide	X	X
Homemaker/ Personal Care		X
Nutrition Counseling		X
Personal Care Services*	X	
Private Duty Nursing for Adults	X	X
Related Goods		X
Respite	X	X
Skilled Maintenance Therapy Services	X	X
Specialized Therapies		X
Transportation (non-medical)		X

<b>Self-Directed (yes/no, &amp; narrative, if applicable)</b>	Yes. Option for Participant Direction of certain HCBS. Centennial Care participants who elect the self-direction opportunity must have the option to self-direct the HCBS. Participant direction must afford Centennial Care participants the opportunity to have choice and control over how services are provided and who provides the service. Member participation in participant direction is voluntary, and members may participate in or withdraw from participant direction at any time.
<b>Caps on Individual Resource Allocations or Budgets</b>	\$60,000 annual
<b>Limits on Numbers Served</b>	No limits on numbers served.
<b>Summary of Public Reaction</b>	There was apprehension among stakeholders about this substantial change to the LTSS system. The Department convened approximately 200 listening sessions across the state in an effort to create open dialogue in preparation for the change. It was not well received in the Native American community due to the mandatory enrollment policy that was initially included. This clause was later amended to provide the choice for Native Americans to opt-in. Advocates from the Medically Fragile population expressed concerns about changes to support coordination and benefit packages. In response to these concerns, the state chose to continue to operate the Medically Fragile 1915 (c) waiver, and not include that population under Centennial Care at this time.
<b>Contextual (Systemic, Political, etc) Hurdles or Opportunities</b>	Directly after implementation, service recipients experienced issues related to disruptions in their pharmacy benefits that had to be addressed. The state set up a call center to assist with a smooth transition and monitor potential issues with implementation.
<b>CMS Approval?</b>	Yes, implemented 2014-2018. Centennial Care Version 2.0 Waiver Pending.
<b>Additional Source Materials</b>	<p>Centennial Care 1115 waiver. Available at: <a href="https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=8029">https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=8029</a></p> <p>Centennial Care overview. Available at: <a href="http://www.hsd.state.nm.us/centennial-care-2-0.aspx">http://www.hsd.state.nm.us/centennial-care-2-0.aspx</a></p> <p>Centennial Care Evaluation Design. Available at: <a href="http://www.hsd.state.nm.us/LookingForInformation/nm-centennial-care-evaluation-design-05-18-17-.pdf">http://www.hsd.state.nm.us/LookingForInformation/nm-centennial-care-evaluation-design-05-18-17-.pdf</a></p> <p>Centennial Care FAQ. Available at: <a href="http://www.hsd.state.nm.us/uploads/files/Looking%20For%20Information/Information%20for%20Recipients/Centennial%20Care%20Information/Centennial%20Care%20Overview/FAQ.pdf">http://www.hsd.state.nm.us/uploads/files/Looking%20For%20Information/Information%20for%20Recipients/Centennial%20Care%20Information/Centennial%20Care%20Overview/FAQ.pdf</a></p> <p>Quality Strategy for the New Mexico State Medicaid Managed Care Program. Available at: <a href="http://www.hsd.state.nm.us/providers/2013-nm-quality-strategy-final.pdf">http://www.hsd.state.nm.us/providers/2013-nm-quality-strategy-final.pdf</a></p> <p>Key Informant Interview conducted with Angela Medrano on 4/2/2018.</p>

## New Mexico: Mi Via (1915c)

<b>Funding Authority</b>	1915 (c)
<b>Target Groups</b>	<p>Previously, New Mexico operated two Mi Via waivers - one for individuals with IDD and medically fragile conditions (Mi Via ICF/IID), and one for elderly and disabled, individuals with brain injury or HIV/AIDS (Mi Via NF). Each group had slightly different service needs but both waivers offered a wide range of services to enable individuals to self-direct their care and increase their ability to live independently.</p> <p>As part of the reconfiguration, the Mi Via NF waiver was terminated, and participants were included with the option to self-direct under Centennial Care. New Mexico continues to operate the Mi Via ICF/IID waiver.</p> <p>Current Mi Via ICF/IDD indicates two Target Groups:</p> <ul style="list-style-type: none"><li>• Aged or disabled or both (Medically fragile)</li><li>• Intellectual disability or developmental disability or both (autism, DD, ID)</li></ul> <p>Prior to the updated rule in 2014 allowing for identification of multiple target populations, Mi Via ICF/IID specified: To be eligible for the Mi Vi waiver program, participants must meet both the ICF/IID LOC criteria and either the medically fragile criteria or the developmental disabilities criteria, as applicable to the participant's waiver allocation.</p>
<b>Goals</b>	Mi Via is intended to provide a community-based alternative to institutional care that facilitates greater participant choice, direction and control over services and supports. Mi Via was implemented in 2006 as the first self-directed waiver.
<b>Level of Care</b>	<p>Mi Via ICF/IID requires an ICF/IDD Level of Care</p> <p>Mi Via NF(terminated) required a Nursing Facility Level of Care</p>
<b>Eligibility</b>	<p>The waiver is limited to persons who want to direct their services.</p> <p>Mi Via participants receiving waiver services access acute and ancillary services through a Centennial Care Managed Care Organization (MCO).</p> <p>The most basic responsibility of a Mi Via participant is to maintain his/her financial and medical eligibility to be in the program. This includes completing the required HSD documentation and participating in the annual comprehensive in-home assessment (IHA) of the Level of Care (LOC) conducted by the Third Party Assessor (TPA). The Mi Via consultant is available to assist with the Medicaid application and recertification process as needed.</p> <p>Developmental Disabilities Waiver Services are intended for individuals who have developmental disabilities limited to Mental Retardation (MR) or a Specific Related Condition as determined by the Department of Health/Developmental Disabilities Supports Division. The developmental disability must reflect the person's need for a combination and sequence of special interdisciplinary or generic treatment or other supports and services that are lifelong or of extended duration and are individually planned and coordinated.</p>

The definition for Mental Retardation is as follows:

Mental Retardation refers to significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period.

- a. General intellectual functioning is defined as the results obtained by assessment with one or more of the individually administered general intelligence tests developed for the purpose of assessing intellectual functioning.
- b. Significantly sub-average is defined as approximately IQ of 70 or below.
- c. Adaptive behavior is defined as the effectiveness or degree with which individuals meet the standards of personal independence and social responsibility expected for age and cultural group.
- d. The developmental period is defined as the period of time between birth and the 18th birthday.

The definition for Specific Related Condition is as follows:

An individual is considered to have a Specific Related Condition if he/she has a severe chronic disability, other than mental illness, that meets all of the following conditions:

- a. Is attributable to Cerebral Palsy, Seizure Disorder, Autistic Disorder (as described in the Fourth Edition of the Diagnostic and Statistical Manual of Mental Disorders), Chromosomal Disorders (e.g. Down's), Syndrome Disorders, Inborn Errors of Metabolism, or Developmental Disorders of the Brain Formation;
- b. Results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with mental retardation and requires treatment or services similar to people with mental retardation;
- c. Is manifested before the person reaches age twenty-two (22) years;
- d. Is likely to continue indefinitely; and
- e. Results in substantial functional limitations in three (3) or more of the following areas of major life activity:
  - i. Self-care;
  - ii. Receptive and expressive language;
  - iii. Learning;
  - iv. Mobility;
  - v. Self-direction;
  - vi. Capacity for independent living; and
  - vii. Economic self-sufficiency.

In addition to the Mental Retardation (Intellectual Disability) or Developmental Disability target groups indicated above, the waiver will also include the Medically Fragile subgroup as follows: Medically Fragile (minimum age 0; no maximum age limit).

The definition for Medically Fragile is as follows:

Medically Fragile individuals who have been diagnosed with a medically fragile condition before reaching age 22; and individuals who have a development disability or developmental delay, or who are at risk for developmental delay; and a medically fragile condition defined as a chronic physical condition, which results in a prolonged dependency on medical care for which daily skilled (nursing) intervention is medically necessary and is characterized by one or more of the following: a life-threatening condition, characterized by reasonably frequent periods of acute exacerbation, which require frequent medical supervision and/or physician consultation, and which, in the absence of such supervision or consultation, would require hospitalization; frequent, time-consuming administration of specialized treatments which are medically necessary; or dependence on medical technology such that without the technology a reasonable level of health could not be maintained. Examples include, but are not limited to, ventilators, dialysis machines, enteral or parenteral nutrition support and continuous oxygen.

The scoring for the Long Term Care Assessment Abstract (LTCAA) is on a Likert scale for each question. Levels of care are determined by the totaling the scores.

After the level of care is determined with the Long Term Care Assessment Abstract, other documents are used to further substantiate the level of care. The Client Individual Assessment (for DD) or Comprehensive Individual Assessment & Family Centered Review (for MF) further delineates medical, functional, social and developmental information; the Vineland, a norm referenced, age-appropriate assessment for DD participants; and History and Physical are reviewed for any inaccuracies that may dispel the level of care determined in the Long Term Care Assessment Abstract.

The rule criteria for LOC are set forth at 8.314.3 and 8.314.5 NMAC.

**Effective Date of Funding Authority**

First approved in 2006. Current approval date 10/01/15.

**Effort Timeframe**

Mi Via is the result of the efforts of many individuals and groups state-wide, starting in 1999, to realize the inclusion of self-direction as an option in New Mexico's HCBS waivers.

**Administration and Operation**

The program is administered through a partnership between the Department of Health (DOH) and Human Services Department (HSD).

**Services**

Consultant/Support Guide	Supports for Participant Direction	In-Home Living Supports
Customized Community Group Supports	Personal Plan Facilitation	Individual Directed Goods and Services
Employment Supports	Behavior Support Consultation	Nutritional Counseling
Home Health Aide Services	Community Direct Support	Private Duty Nursing for Adults
Homemaker/Direct Support Services	Emergency Response Services	Specialized Therapies
Respite	Environmental Modifications	Transportation
Skilled Therapy for Adults		



<b>Self-Directed (yes/no, &amp; narrative, if applicable)</b>	Yes. Within the context of Mi Via, self-direction means participants choose which services, supports and goods they need. Participants also decide when, where and how those services and supports will be provided and who they want to provide them. Participants decide who they want to assist them with planning and managing their services and supports. Self-direction means that participants have more choice, control, flexibility, freedom and responsibility.
<b>Caps on Individual Resource Allocations or Budgets</b>	The budget is developed one goal at a time. Each goal includes a clear and complete explanation of the requested service(s) or good(s), how they are related to the participant's condition and why they are appropriate for the participant.
<b>Limits on Numbers Served</b>	The State does not limit the number of participants that it serves at any point in time during a waiver year. The state does not reserve capacity for any groups.
<b>Summary of Public Reaction</b>	Overall the reaction to the implementation of Mi Via was positive. The effort grew out of a need expressed by the disability community. The Mi Via program was developed through strong collaboration between the Department and a variety of stakeholders. The original advisory group that was initiated during the planning for Mi Via continues to meet regularly and be an influential group.
<b>Contextual Hurdles of Change</b>	At times, contentious issues would arise within the stakeholder community and the Department worked to share information and respond in a timely manner.
<b>CMS Approval?</b>	Yes. Established 2006
<b>Additional Source Materials</b>	<p>Mi Via ICF/IID 1915 (c) waiver. Available at: <a href="https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=8034">https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=8034</a></p> <p>Mi Via Service Standards. Available at: <a href="https://nmhealth.org/publication/view/regulation/3380/">https://nmhealth.org/publication/view/regulation/3380/</a></p> <p>Mi Via HCBS Transition Plan. Available at: <a href="http://www.hsd.state.nm.us/uploads/files/Looking%20For%20Information/Information%20for%20Recipients/Special%20Programs%20and%20Waivers/Home%20and%20Community%20Based%20Waiver/Mi%20Via/NM%20Mi%20Via%20HCBS%20Settings%20Transition%20Plan.pdf">http://www.hsd.state.nm.us/uploads/files/Looking%20For%20Information/Information%20for%20Recipients/Special%20Programs%20and%20Waivers/Home%20and%20Community%20Based%20Waiver/Mi%20Via/NM%20Mi%20Via%20HCBS%20Settings%20Transition%20Plan.pdf</a></p> <p>Key Informant Interview conducted with Angela Medrano on 4/2/2018.</p>

## New York: Bridges to Health (1915c)

<b>Funding Authority</b>	Three 1915(c) Waivers: <ol style="list-style-type: none"><li>1. NY Bridges to Health for Children w/SED</li><li>2. NY Bridges to Health for Children w/DD</li><li>3. NY Bridges to Health for Children who are Medically Fragile</li></ol>
<b>Target Groups</b>	<p>Children in the care and custody of Local Departments of Social Services (counties and New York City), and children in the custody of OCFS Division of Juvenile Justice and Opportunities for Youth with DD, SED, or who are Medically Fragile, ages 0-20 (services discontinued upon 21<sup>st</sup> birthday).</p> <p><b>Intellectual Disability</b> (Autism, DD, ID, ages 0-20)</p> <p><b>Mental Illness</b> (Mental Illness ages 19-20, Serious Emotional Disturbance (SED) ages 0-18)</p> <p><b>Aged or Disabled or Both - General</b> (Physical Disability ages 0-20, Other disability ages 0-20)</p> <p><b>Aged or Disabled - Specific Recognized Subgroups</b> (Brain Injury ages 0-20, HIV/AIDS ages 0-20, Medically Fragile ages 0-20, Technology Dependent ages 0-20)</p> <p>Because these waivers were established before CMS allowed for multiple target groups within a single waiver, OCFS created three nearly identical waivers to serve these different groups.</p>
<b>Goals</b>	<p>Based on an observation that other service agencies for youth in state care lacked the specific population knowledge needed to best serve youth in foster and juvenile justice care, OCFS elected to itself create three waivers to target services specific to this population. Due to budgetary limitations, and intolerance for broad, systemic change, OCFS focused these waivers just on the highest-needs youth in their care, offering services specifically to youth with intellectual disability, serious emotional disturbance, or who are Medically Fragile. Its goal is to help young people in their service to remain in the community through providing them the services and supports they need.</p>
<b>Level of Care</b>	<p><b>SED LOC</b>= Inpatient psych facility for individuals age 21 and under</p> <p><b>MF LOC</b>= Nursing facility</p> <p><b>DD LOC</b>= ICF/ID</p>
<b>Eligibility</b>	<p>Children in the care and custody of Local Departments of Social Services (counties and New York City) (LDSS) and children in the custody of OCFS Division of Juvenile Justice and Opportunities for Youth (DJJOY) are the target population for children initially entering the waiver. Once enrolled, eligibility can continue after the child is discharged from LDSS and OCFS DJJOY custody.</p> <p>A child can qualify for waiver entry only while in foster care. However, once in the waiver, they can generally retain the services until age 21, as long as they meet waiver eligibility. To enhance their opportunities for successful reunifications and placements, the services can follow the participant home, into adoption, to lower levels of foster care and to adulthood.</p>

	<p>The child must be Medicaid eligible.</p> <p>The child must have a qualifying diagnosis.</p> <p>The child must be able to benefit from the services.</p> <p>The number of B2H waiver "slots" statewide is limited. Applications are accepted on a first come, first served basis, and a child may be placed on a waiting list for waivers.</p>		
<b>Effective Date of Funding Authority</b>	12/8/17 for all through current amendment. Began enrollment of first phase-in group in 2008.		
<b>Effort Timeframe</b>	2005-2010. The program is due to be rolled into an 1115 managed care waiver within the coming year.		
<b>Administration and Operation</b>	<p>Operated by the NY State Office of Children and Family Services (OCFS). Contracted Health Care Integration Agencies identify Waiver Service Providers who assist applicants with the waiver enrollment package, information dissemination, etc.</p> <p>The Office of Children and Family Services issues policy direction and program guidance to LDSS (Local Departments of Social Services).</p> <p>Child care agencies with demonstrated experience in provided supplemental services for children in out-of-home care, known as Health Care Integration Agencies (HCIAs), provide B2H services. HCIAs must have experience in serving people with disabilities. Local Departments of Social Services (LDSSs) make the eligibility determinations, enrollment decisions and referrals to HCIAs. HCIAs employ Health Care Integrators (HCIs) and Waiver Service Providers (WSPs) who are responsible for coordinating and administering the services.</p>		
<b>Services</b>	<p>Health care integration</p> <p>Family and caregiver supports and services</p> <p>Skill building</p> <p>Day habilitation</p> <p>Special needs community advocacy and support</p>	<p>Pre-vocational services</p> <p>Supported employment</p> <p>Planned respite</p> <p>Crisis avoidance, management, and training</p> <p>Immediate crisis response services</p>	<p>Intensive in-home supports</p> <p>Crisis respite</p> <p>Adaptive and assistive equipment</p> <p>Accessibility modifications</p>
<b>Self-Directed (yes/no, &amp; narrative, if applicable)</b>	No		
<b>Caps on Individual Resource Allocations or Budgets</b>	Somewhat. Each waiver slot technically has a \$50,000 limit, but there is an exceptions process for individuals who need more. Additionally, there are caps on each service, but they are generally higher than any individual has been able to use up.		
<b>Limits on Numbers Served</b>	<p>DD- 541</p> <p>MF- 145</p> <p>SED- 2619</p> <p>No reserved capacity</p>		

<b>Summary of Public Reaction</b>	B2H is very well liked by service recipients, families, and providers. There is a lot of concern about moving it into managed care, as people have gotten familiar and comfortable with the program as it is.
<b>Contextual (Systemic, Political, etc) Hurdles or Opportunities for Change</b>	Budgetary limits forced the original idea of the program to be scaled back just to the highest-need individuals at the inception of the program. Its impending move to managed care has also hit somewhat of a roadblock due to funding, which has delayed the timeframe of the move.
<b>CMS Approval?</b>	Yes
<b>Additional Source Materials</b>	<p>New York Bridges to Health 1915(c) Waivers available at:</p> <p><a href="https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=8219">https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=8219</a></p> <p><a href="https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=8221">https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=8221</a></p> <p><a href="https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=8223">https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=8223</a></p> <p>Bridges to Health main website: <a href="https://ocfs.ny.gov/main/b2h/">https://ocfs.ny.gov/main/b2h/</a></p> <p>Key Informant Interview conducted with Mimi Weber on 4/5/2018.</p>

## Pennsylvania: Community Health Choices (1915b/c)

<b>Funding Authority</b>	<b>Converted from:</b> Five 1915(c) Waivers: <ol style="list-style-type: none"> <li>1) Aging Waiver</li> <li>2) Attendant Care Waiver</li> <li>3) Independence Waiver</li> <li>4) CommCare Waiver</li> <li>5) OBRA Waiver</li> </ol>	<b>Converted to:</b> Pursued waiver streamlining. Considered an 1115 among these, ultimately selecting a 1915 b/c. Used CommCare (changed to Community Health Choices) as a receiving waiver to blend in the Aging, Attendant Care, and Independence waivers. The OBRA waiver will remain in operation and serve individuals with disabilities ages 21 and younger and people with developmental disabilities.
<b>Target Groups</b>	Aged or Disabled - General: Aged 65 or older, or Physically disabled ages 21-64. Includes individuals on all waivers being folded in. (Dual eligible and people with physical disabilities).	
<b>Goals</b>	The overall intent of this effort was to incorporate targeted populations with long-term support needs under a managed care delivery model. In addition, the aims of the reconfiguration include: <ol style="list-style-type: none"> <li>1. Enhance opportunities for community-based living</li> <li>2. Strengthen coordination of LTSS and other types of health care, including all Medicare and Medicaid services for dual eligible</li> <li>3. Enhance quality and accountability</li> <li>4. Advance program innovation</li> <li>5. Increase efficiency and effectiveness</li> </ol>	
<b>Level of Care</b>	The four 1915 (c) waivers identified for consolidation under CHC require a Nursing Facility Level of Care. The OBRA waiver requires an ICF/IID Level of Care and is not included in consolidation.	
<b>Eligibility</b>	In addition to NF LOC, each of the 1915 (c) waivers had additional eligibility criteria that had to be reconciled. Resulting in the following: <ul style="list-style-type: none"> <li>• Individuals ages 21 and older who are dually eligible for Medicare and Medicaid</li> <li>• Individuals ages 21 and older who need the level of care provided by a nursing facility</li> <li>• Individuals with intellectual or developmental disabilities who are eligible for services through the Office of Developmental Programs and residents of a state-operated nursing facility (including state veterans' homes) are not part of CHC</li> </ul>	
<b>Effective Date of Funding Authority</b>	1/1/18 (for the CHC 1915c)	
<b>Effort Timeframe</b>	Pennsylvania began to bring services, service definitions, and provider qualifications from different waivers into alignment as early as 2007, when they shifted to administration through the Office of Long-Term Living. Planning in earnest for the move to managed care began in 2015.	

**Administration and Operation**

State Medicaid Agency, Office of Long-Term Living. MCOs deliver services.

Managed Care Organizations: OLTL has entered into agreements with fully capitated risk based managed care organizations to conduct operational, administrative, and case management functions within five regions of the commonwealth for the waiver. CHC-MCOs are also responsible for the following functions: referring individuals to the Independent Enrollment Broker for enrollment; certifying and training direct service providers participating in their provider networks, but for consumer directed services; collecting the documentation and information necessary for completing the annual level of care redetermination and forwarding this information to the independent assessment entity (see above); ensuring that assessments are completed within the required timeframes as set forth in the agreement; ensuring each participant's Person-Centered Service Plan (PCSP) reflects waiver services in the amount, scope, and duration necessary to meet the participant's assessed needs; conducting prior authorization and utilization management of waiver services; and performing quality assurance and quality improvement activities.

**Services**

- |  |  |
|--|--|
| Adult Daily Living                         | Speech and Language Therapy Services                                 |
| Employment Skills Development              | Therapeutic and Counseling Services                                  |
| Job Coaching                               | Assistive Technology   |
| Personal Assistance Services               | Benefits Counseling  |
| Residential Habilitation                   | Career Assessment  |
| Respite                                    | Cognitive Rehabilitation Therapy Services                            |
| Service Coordination                       | Community Integration Community Transition Services Home Adaptations |
| Structured Day Habilitation Services       | Home Delivered Meals   |
| Supported Employment                       | Job Finding  |
| Behavior Therapy                           | Non-Medical Transportation Nutritional Consultation                  |
| Counseling Services                        | Participant-Directed Community Supports                              |
| Home Health Aide Services                  | Participant-Directed Goods and Services                              |
| Home Health Services                       | Personal Emergency Response System (PERS)                            |
| Nursing Services                           | Pest Eradication   |
| Occupational Therapy Services              | Prevocational Services   |
| Physical Therapy Services                  | TeleCare   |
| Specialized Medical Equipment and Supplies | Vehicle Modifications  |

**Self-Directed (yes/no, & narrative, if applicable)**

Yes;  
 All participants have the option to make decisions about and self-direct their own waiver services as identified in Section E-1. g., of the waiver. Participants in the CHC Waiver may choose to hire and manage staff using Employer Authority or manage an individual budget using Budget Authority. In addition, participants may choose a combination of service models to meet their individual needs. Participants are encouraged to self-direct their services to the highest degree possible. During the actual provision of services, the participant is responsible for directing the activities of their support worker.

Under Employer Authority, the participant serves as the common-law employer and is responsible for hiring, firing, training, supervising, and scheduling their support worker. Budget Authority, known in Pennsylvania as Services My Way, provides participants with a broader range of opportunities for participant-direction. Services My Way provides participants with greater flexibility, choice and control over their services, by giving participants the opportunity to: 1) select and manage staff that performs personal assistance type services under the Participant- Directed Community Supports service definition; 2) manage a flexible Spending plan; and 3) purchase allowable goods and services through their Spending plan.

How Participants May Take Advantage of Self-Directed Opportunities: Participants may choose to self-direct certain services during the development of the person-centered service plan (PCSP), at reassessment, or at any time. The participant's Service Coordinator is responsible for presenting all available service options and ensuring that each participant understands the full range of self-directed opportunities within the waiver. The CHC-MCO will provide all waiver participants with information about self-direction as part of the member handbook and orientation materials. Materials must be written at a level that is easily understood using everyday common language to ensure accessibility, and in alternate formats as needed by the participant.

As stated previously, the participant may utilize a combination of any model(s) to personalize their PCSP. The PCSP is developed in conjunction with the Service Coordinator and the waiver participant, as described in Appendix D, to ensure that the participant's service needs are met, and reflects the participant's choice of model of service. Service Coordinators shall offer provider-managed services to all participants who have chosen to self-direct their services until the individual's support workers are hired. Participants may elect to change their service model at any time by notifying their Service Coordinator. Service Coordinators must work with participants to ensure they do not experience a disruption in services when participants choose to change service models.

#### Entities That Support Individuals:

Participants will receive a full-range of supports, ensuring that they are successful with the participant-directed experience. Individuals choosing Employer or Budget Authority will receive support from certified Vendor Fiscal/Employer Agents (F/EA), Support Brokers and Service Coordinators to assist them in their role as the common-law employer of their workers. The F/EA will:

- Enroll participants in Financial Management Service (FMS) and apply for and receive approval from the IRS to act as an agent on behalf of the participant;
- Provide orientation and skills training to participants or their representative on required documentation for all directly hired support workers, including the completion of federal and state forms; the completion of timesheets; effective management of workplace injuries; and workers compensation;
- Establish, maintain and process records for all participants and support workers with confidentiality, accuracy and appropriate safeguards;
- Establish and maintain a separate bank account for the purposes of managing participant-directed funds and provide a full accounting of the use of these funds;

- Conduct criminal background checks and when applicable, child abuse clearances, on potential employees;
- Assist participants in verifying support workers citizenship or alien status;
- Distribute, collect and process support worker timesheets as verified and approved by the participant;
- Prepare and issue support workers' payroll checks, as approved in the participant's PCSP;
- Withhold, file and deposit federal, state and local income taxes in accordance with federal IRS and state Department of Revenue rules and regulations;
- Broker workers' compensation for all support workers through an appropriate agency;
- Process all judgments, garnishments, tax levies, or any related holds on workers' pay as may be required by federal, state or local laws;
- Prepare and disburse IRS Forms W-2's and/or 1099's, wage and tax statements and related documentation annually;
- Assist in implementing the state's quality management strategy related to FMS;
- Establish an accessible customer service system for the participant and the Service Coordinator;
- Receive, verify and process all invoices for Participant Goods and Services as approved in the Participant's Spending Plan (Budget Authority only);
- Procure participant employer related functions training for common-law employers through a Supports Broker(s); and
- Provide written financial reports to the participant, the Service Coordinator and the CHC-MCO on a monthly and quarterly basis, and as requested by the participant, Service Coordinator, and the CHC-MCO (Budget Authority only).

Participants may receive assistance and training from Support Brokers on their roles and responsibilities as a common-law employer. Support Broker services are designed to provide assistance as needed with employer-related functions and maintenance in order to support the participant's ability to self-direct their services. Support Broker services are optional services and may supplement, but do not replace, the supports provided by either the F/EA or Service Coordinator. To support a participant to self-direct, duties performed by a Support Broker may include assistance with:

- Understanding and/or fulfilling the responsibilities outlined in the Common Law Employer Agreement form and the Managing Employer Agreement form;
- Understanding and completing employer-or managing employer related paperwork;
- Effective hiring techniques including creating job descriptions, ads for hiring, strategies for evaluating candidates and informing candidate on selection or non-selection;
- Techniques for interviewing and conducting reference checks;
- Effective management and supervision techniques such as conflict resolution;
- Proper procedures for termination of workers or communication with the Service Coordination Entity regarding the desire for termination of workers;
- Review of workplace safety issues and strategies for effective management of workplace injury prevention;
- Techniques on scheduling paid and unpaid supports;
- Developing systems or finding help to manage finances and resources;
- Techniques related to problem-solving, decision-making, and achieving desired outcomes within self-directed services;



- Developing, modifying and negotiating an individualized Spending Plan; and
- Assisting an individual to be a successful employer of self-directed services.

Support Brokers must work collaboratively with the participant’s Service Coordinator. The Support Broker assists individuals and representatives with being able to self-direct the individual's services and supports. Support Brokers may not replace the role or perform the functions of a Service Coordinator. No duplicate payments will be made.

In addition, individuals choosing to self-direct their services will receive assistance from their Service Coordinator to develop their person-centered service plan. Once the PCSP is developed, approved, and authorized, the Participant is responsible for arranging and directing the services outlined in their plan, with, as appropriate, information and support from the Service Coordinator. During the implementation and management of the PCSP, the Service Coordinator will:

- Assist the Participant to gain information and access to necessary services, regardless of the funding source of the services;
- Advise, train, and support the participant as needed and necessary;
- Assist the Participant to develop an individualized back-up plan;
- Assist the Participant to identify risks or potential risks and develop a plan to manage those risks;
- Recommend or arrange training on the topics of abuse, neglect, exploitation and abandonment as defined by protective services statues;
- Monitor the provision of services to ensure the Participant’s health and welfare; and
- Assist the Participant to secure training of support workers who deliver services that would require a degree of technical skill and would require the guidance and instruction from a health care professional such as a Registered Nurse.

Participants who choose to manage an individual budget will receive assistance from Service Coordinators to implement and manage the Spending Plan. The Service Coordinator will review and approve the participant’s Spending Plan. Once the Spending Plan is developed, approved and authorized, the participant is responsible for arranging and directing the services outlined in their plan. During the implementation and management of the Spending Plan, the Service Coordinator will assist the participant with the execution and development of the Spending Plan and monitor spending of the Spending Plan.

**Caps on Individual Resource Allocations or Budgets**

There are caps on participant-directed goods and services, which are purchased out of the participant’s Individual Spending Plan.

**Limits on Numbers Served** The state limits the number of participants that it serves at any point in time during a waiver year. The limit that applies to each year of the waiver period is specified in the following table:

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	899
Year 2	935
Year 3	13305
Year 4	75871
Year 5	81580

Some capacity reserved

**Summary of Public Reaction**

PA has undertaken numerous different efforts to ensure stakeholder engagement with the move to managed care. OLTL hosts a “Third Thursday” webinar for providers to ask questions and receive progress updates. OLTL also engaged in numerous informational outreach measures for all stakeholders, which it makes available on its website (<http://www.healthchoices.pa.gov/info/about/community/commpart/index.htm>). There are additional weekly phone calls with various advocacy organizations. A 1-day summit was also held for relevant stakeholders in advance of implementation. Additionally, an MLTSS advisory committee was formed, with a majority on the committee identifying as service users. This committee meets monthly. Prior to implementation, over 40 participant education events were held at libraries, service coordination agencies, CBOs, and other locations, to explain the change to managed care. A significant number of steps in the process were put out to receive public comment, including the RFP for MCOs. Comments were incorporated as appropriate. Feedback from these efforts is also incorporated into living documents that continue in circulation. Nevertheless, complaints were waged from the advocacy community about minimal information and education efforts for stakeholders (<http://www.post-gazette.com/aging-edge/gary-rotstein-s-what-s-new-in-aging/2017/10/20/Community-HealthChoices-consumer-advocates-Pennsylvania-managed-care-long-term-care/stories/201710200061>). Through a key informant interview with Virginia Brown, Director of the Bureau of Policy and Regulatory Management within OLTL, Ms. Brown indicated that she felt the implementation thus far was going well, and that the numerous stakeholder engagement measures had been a key part of that.

**Contextual (Systemic, Political, etc) Hurdles or Opportunities**

Pennsylvania had been considering moving to managed care for many years. The formation of OLTL provided an initial catalyst to being aligning and consolidating waivers. Implementation of CHC is viewed as the final step that that. Ultimately, it was a directive from the governor’s office to move to managed care that spurred earnest work on determining a best-fit funding authority, and mapping the move to CHC. The pre-work that had been done through aligning and consolidating waivers laid much of the groundwork to make the move to a b/c authority easier, and CMS approval quicker.

Additionally, having the same LOC across 4 of the 5 waivers involved in consolidation created a natural opportunity for merger, although careful consideration had to be made for how to incorporate the varying target groups served by each waiver without overly broadening eligibility criteria for CHC.

**CMS Approval**

Yes. Implementation began January 2018 and will be complete within three years.

**Additional Source Materials**

PA Community Health Choices 1915(c) waiver. Available at: <https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=8367>

Section 1915(b) Waiver Proposal For MCO, PIHP Programs And FFS Selective Contracting Programs. Available at: [http://www.healthchoices.pa.gov/cs/groups/webcontent/documents/document/c\\_264257.pdf](http://www.healthchoices.pa.gov/cs/groups/webcontent/documents/document/c_264257.pdf)

CHC Concept Paper. Available at: [http://www.dhs.pa.gov/cs/groups/webcontent/documents/document/c\\_209847.pdf](http://www.dhs.pa.gov/cs/groups/webcontent/documents/document/c_209847.pdf)

CHC Fact Sheet. Available at:

[http://www.healthchoices.pa.gov/cs/groups/webcontent/documents/document/c\\_237795.pdf](http://www.healthchoices.pa.gov/cs/groups/webcontent/documents/document/c_237795.pdf)

CHC Implementation Timeline. Available at:

[http://www.healthchoices.pa.gov/cs/groups/webcontent/documents/document/c\\_227013.pdf](http://www.healthchoices.pa.gov/cs/groups/webcontent/documents/document/c_227013.pdf)

CHC Waiver Transitions Flowchart. Available at:

[http://www.healthchoices.pa.gov/cs/groups/webcontent/documents/document/c\\_260104.pdf](http://www.healthchoices.pa.gov/cs/groups/webcontent/documents/document/c_260104.pdf)

Key Informant Interview conducted with Virginia Brown on 3/23/2018.

## Tennessee: TennCare II (1115)

<b>Funding Authority</b>	<b>Converted from:</b> Elderly and Disabled HCBS Waiver 1915 (c) Self-Determination Waiver 1915 (c) Comprehensive Aggregate Cap (CAC) 1915 (c) Statewide HCBS Waiver 1915 (c)	<b>Converted to:</b> TennCare II MLTSS 1115 <ul style="list-style-type: none"><li>• Elderly and Disabled waiver became CHOICES</li><li>• Employment and Community First (ECF) CHOICES was developed to serve individuals with I/DD</li></ul>
<b>Target Groups</b>	Aged or Disabled, or Both CHOICES <ul style="list-style-type: none"><li>• HCBS for elderly (65 and older) and physical disabilities</li></ul> ECF CHOICES <ul style="list-style-type: none"><li>• HCBS for people with I/DD</li></ul>	
<b>Goals</b>	<p>The decision to add CHOICES to TennCare was driven by a desire to deinstitutionalize and to eliminate waitlists for services. Moving these populations into TennCare, while keeping the same rates and services under a capitation structure drove increased service provision in the community. By bringing those served under the elderly and physically disabled waiver, Tennessee was able to move thousands of people off of waitlists, out of institutions, and into community services.</p> <p>Adding ECF CHOICES to TennCare was the result of requests from the I/DD community to be brought into the demonstration waiver. Tennessee operated (and still does operate, though enrollment is closed to new entrants) 3 1915(c) waivers for people with I/DD, that were expensive to operate, and which had significant waitlists. Creating the option for individuals with I/DD to be served through TennCare opened up services to individuals who had been waiting.</p> <p>Adding both these programs into TennCare expanded services to more individuals, drove increased service provision in the community, and created greater coordination of services for people served by TennCare, while still allowing the state to remain budget neutral with this program.</p> <p>Because it is a demonstration waiver, TennCare has also been able to try innovative services like expanded employment services, which have become national exemplars.</p> <p>Current goals of the TennCare program include:</p> <ul style="list-style-type: none"><li>• Provide high-quality care to enrollees</li><li>• Ensure enrollees' satisfaction with services</li><li>• Improve health outcomes for enrollees</li><li>• Support access to care at safety net health care providers in the Medicaid delivery system through targeted support of such providers</li></ul>	

- Provide enrollees with appropriate and cost-effective HCBS within acceptable budgetary parameters
- Manage expenditures at a stable and predictable level, and at a cost that does not exceed what would have been spent in a Medicaid fee-for-service program

**Level of Care** The previous Elderly and Disabled waiver required Nursing Facility (LOC), and the existing 1915 (c) for individuals with I/DD require an ICF/IID (LOC).

Group designations under CHOICES and ECF CHOICES specify a Nursing Facility or At Risk of Nursing Facility placement.

**Eligibility** CHOICES  
 Additional Eligibility Criteria:  
**CHOICES Group 1** is for people of all ages who receive nursing home care.  
**CHOICES Group 2** is for adults (age 21 and older) with a physical disability and seniors (age 65 and older) who qualify to receive nursing home care but choose to receive home care services instead.  
**CHOICES Group 3** is for adults (age 21 and older) with a disability and seniors (age 65 and older) who don't qualify for nursing home care but need a more moderate package of home care services to delay or prevent the need for nursing home care.  
 ECF CHOICES  
 Additional Eligibility Criteria:  
**ECF CHOICES 4** (Essential Family Supports) is for children under age 21 with I/DD living at home with family who meet NF LOC, or are "at risk" of NF placement, or those who meet NF or are "at risk" and elect to be in this benefit group.  
**ECF CHOICES 5** (Essential Supports for Employment and Independent Living) is for adults 21 and older with I/DD who do not meet NF LOC but who in the absence of HCBS are "at risk" of NF placement  
**ECF CHOICES 6** (Comprehensive Supports for Employment and Community Living) is for adults age 21 or older with I/DD who meet NF LOC and need specialized services for I/DD

**Effective Date of Funding Authority** 1/31/18 (Amendment #33 in process, anticipated effective date July 1, 2018)

**Effort Timeframe** Tennessee established its first TennCare demonstration on January 1, 1994, becoming the first state to mandate enrollment for Medicaid beneficiaries. In 2002, launched TennCare II, which introduced numerous stabilization measures meant to address MCO instability that was introduced with the abrupt shift to managed care in 1994 (a shift that occurred literally overnight, catapulting the state from a 3% penetration of managed care enrollment by Medicaid beneficiaries to 100% overnight). In 2005, Tennessee was approved for a series of amendments that allowed them to disenroll individuals already found eligible for service, who were then absorbed into a demonstration expansion approved in 2006. In 2009, the CHOICES program was implemented to provide long-term care and HCBS to older individuals and individuals with disabilities.

One of the critical first steps toward creating CHOICES [of the Long-term Care Community Choices Act of 2008, which became CHOICES] occurred in September 2008 when the federal government granted the state approval for 2,300 additional openings in the existing HCBS waiver program. Since that time, all of these slots have been filled by Tennesseans who prefer to be cared for in their own homes instead of a nursing facility.

The HCBS waiver for elderly and disabled was formally terminated August 2010.

Tennessee continues to work to bring LTSS for people with IDD into greater alignment with its overall Medicaid strategy and began ECF Choices in 2016.

**Administration and Operation**

TennCare Managed Care

**Services (CHOICES only)**

Benefit	CHOICES 1	CHOICES 2	CHOICES 3
Nursing facility care	X	Short-term only	Short-term only
Community-based residential alternatives (CBRAs)		X	X
Personal care visits (up to 2 visits per day)		X	X
Attendant care (up to 1080 hours per calendar year); up to 1400 hours per calendar year ONLY when Homemaker services are needed in addition to hands-on care		X	X
Home-delivered meals (up to 1 meal per day)		X	X
Personal Emergency Response Systems		X	X
Adult day care (up to 2080 hours per calendar year)		X	X
In-home respite care (up to 216 hours per calendar year)		X	X
In-patient respite care (up to 9 days per calendar year)		X	X
Assistive technology (up to \$900 per calendar year)		X	X
Minor home modifications (up to \$6,000 per project; \$10,000 per calendar year; and \$20,000 per lifetime)		X	X
Pest control (up to 9 units per calendar year)		X	X

Services (ECF CHOICES only)

Benefit	Essential Family Supports	Essential Supports for Employment & Independent Living	Comprehensive Supports for Employment & Community Living
Respite (up to 30 days per calendar year <b>or</b> up to 216 hours per calendar year only for persons living with unpaid family caregivers)	X	X	X
Supportive home care (SHC)	X		
Family caregiver stipend in lieu of SHC (up to \$500 per month for children under age 18; up to \$1,000 per month for adults age 18 and older)	X		
Community integration support services (subject to limitations specified in Attachment G)	X	X	X
Community transportation	X	X	X
Independent living skills training (subject to limitations specified in Attachment G)	X	X	X
Assistive technology, adaptive equipment and supplies (up to \$5,000 per calendar year)	X	X	X
Minor home modifications (up to \$6,000 per project; \$10,000 per calendar year; and \$20,000 per lifetime)	X	X	X
Community support development, organization and navigation	X		
Family caregiver education and training (up to \$500 per calendar year)	X		
Family-to-family support	X		
Conservatorship and alternatives to conservatorship counseling and assistance (up to \$500 per lifetime)	X	X	X
Health insurance counseling/forms assistance (up to 15 hours per calendar year)	X		
Personal assistance (up to 215 hours per month)			X
Community living supports (CLS)		X	X
Community living supports—family model (CLS-FM)		X	X
Individual education and training (up to \$500 per calendar year)		X	X
Peer-to-peer person-centered planning, self-direction, employment and community support and navigation (up to \$1,500 per lifetime)		X	X
Specialized consultation and training (up to \$5,000 per calendar year)		X	X
Adult dental services (up to \$5,000 per calendar year; up to \$7,500 across three consecutive calendar years)	X	X	X

**Self-Directed (yes/no, & narrative, if applicable)**

**Companion care.** A consumer-directed residential model in which a CHOICES member may choose to select, employ, supervise and pay, utilizing the services of a fiscal intermediary, on a daily, weekly, or monthly basis, as applicable, a live-in companion who will be present in the member's home and provide frequent intermittent assistance or continuous supervision and monitoring throughout the entire period of service duration. Such a model will be available only for a CHOICES member who requires and does not have available through family or other caregiving supports frequent intermittent assistance with activities of daily living or supervision and monitoring for extended periods of time that cannot be met more cost-effectively with other nonresidential services. A CHOICES member who requires assistance in order to direct his or her companion care may designate a representative to assume consumer direction of companion care services on his/her behalf, pursuant to requirements for representatives otherwise applicable to consumer direction.

**Consumer direction of eligible CHOICES HCBS.** The opportunity for a member assessed to need specified types of HCBS including attendant care, personal care visits, homemaker services (provided only as part of attendant care or personal care visits), in-home respite care, companion care and/or any other service specified in TennCare rules and regulations as available for consumer direction to elect to direct and manage (or to have a representative direct and manage) certain aspects of the provision of such services—primarily the hiring, firing, and day-to-day supervision of consumer-directed workers delivering the needed service(s).

**Caps on Individual Resource Allocations or Budgets**

The cost of medical assistance provided to an eligible participant in CHOICES 2 is limited to the amount calculated in the individual cost neutrality test used in Section 1915(c) waivers as set forth in Section 1915(c)(4)(A). The state may delegate implementation of the cost neutrality test to the MCOs. For purposes of determining capitation rates, the cost of room and board is not included in non-institutional care costs. For persons in CHOICES 3 or Interim CHOICES 3, in addition to the service limits, the total cost of the HCBS identified in shall not exceed \$15,000 per calendar year, excluding the cost of minor home modifications.

ECF CHOICES benefits will be subject to an annual per member expenditure cap. Specifically: (A) Individuals receiving Essential Family Supports benefits will be subject to a \$15,000 cap (on benefits), not counting the cost of minor home modifications; (B) Individuals receiving Essential Supports for Employment and Independent Living benefits will be subject to a \$30,000 cap on benefits. The State may grant an exception for emergency needs up to \$6,000 in additional services per year, but shall not permit expenditures to exceed a hard cap of \$36,000 per year; and (C) Individuals receiving Comprehensive Supports for Employment and Community Living benefits will be subject to an annual expenditure cap as follows: i. Individuals with low-to-moderate need as determined by the State, in accordance with the published criteria, will be subject to a \$45,000 expenditure cap ii. Individuals with high need as determined by the State, in accordance with the published criteria, will be subject to a \$60,000 expenditure cap. iii. The State may grant an exception as follows: For individuals with developmental disabilities (DD) and exceptional medical/behavioral needs as determined by the State in accordance with published criteria, up to the average cost of NF plus specialized services that would be needed for persons with such needs determined appropriate for NF placement; or for individuals with intellectual disabilities (ID) and exceptional medical/behavioral needs as determined by the State in accordance with published criteria, up to the average cost of private ICF/IID services.



**Limits on Numbers Served**

The CHOICES targets will include both upper limits and lower limits, with the actual target number to be published in state rules. The upper limit will serve as a ceiling on the enrollment target; TennCare will not set the target above the upper limit. The lower limit will serve as an enrollment floor; TennCare will not set the target below the lower limit. To help ensure continuity of eligibility and benefits, the target for each benefit group will not be less than enrollment in that group at the time the target is established.

The ECF CHOICES targets will include both upper limits and lower limits; with the actual target number to be published in state rules. The upper limit will serve as a ceiling on the enrollment target; TennCare will not set the target above the upper limit. The lower limit will serve as an enrollment floor; TennCare will not set the target below the lower limit. To help ensure continuity of eligibility and benefits, the target for each benefit group will not be less than enrollment in that group at the time the target is established. Persons transitioning into ECF CHOICES from a Section 1915(c) waiver or from CHOICES Groups 2 or 3 shall not count against the enrollment target for the ECF CHOICES Group in which they are enrolled.

Effective July 1, 2016, the Enrollment Target for ECF CHOICES shall be five hundred (500) for Group 4, one thousand (1,000) for Group 5, and two hundred (200) for Group 6.

**Summary of Public Reaction**

The overall reaction to the transition to managed long-term services and supports was mostly positive, particularly from the I/DD population, as it offered opportunities for those waiting for services to receive supports. However, some local news sources did report stories of individuals who were at risk of losing supports due to changes in eligibility criteria with the implementation of CHOICES.

**Contextual (Systemic, Political, etc.) Hurdles or Opportunities**

The long-standing experience with managed care in Tennessee provided a good foundation for inclusion of LTSS populations under the umbrella of managed care. It was also beneficial that representatives in the highest levels of state government had an understanding of health care and managed care and supported the level of staffing necessary to achieve the aims.

It was challenging to prepare to administer a statewide program that would begin with zero enrollment. The administrative structures and staffing had to be in place around the state to be ready to serve on day one.

The impacts of the provider workforce shortage became apparent. While reimbursement rates for certain services were intentionally higher in the ECF program to promote employment opportunities and community inclusion, due to the small population, agencies did not immediately benefit. These workforce issues led to more discussions to develop a comprehensive strategy for recruitment and retention.

**CMS Approved**

Yes. On August 1, 2010, the statewide implementation of CHOICES was completed, and ECF CHOICES was approved in 2016.

**Additional Source Materials**

TennCare II 1115 waiver. Available at: <https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=8387>

TennCare Eligibility Description. Available at: <https://www.tn.gov/tenncare/long-term-services-supports/choices/to-qualify-for-choices.html>

ECF Overview. Available at: [https://providers.amerigroup.com/Public%20Documents/TNTN\\_CAID\\_ECFForumPresentation.pdf](https://providers.amerigroup.com/Public%20Documents/TNTN_CAID_ECFForumPresentation.pdf)

Key Informant Interview conducted with Patti Killingsworth on 3/28/2018.