Federal Medicaid Waivers

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Federal Authority

- Social Security Act
  - Social Security Amendments of 1965 – The Medicare and Medicaid Act
- States Medicaid programs are subject to requirements in 42 USC 1396a(a) -State Plan, if States chooses to participate in Medicaid
  - Joint Federal/State funded (42 USC 1396a(a)(2)); federal match depends on state's per capita income (Federal Medical Assistance Percentage (FMAP) not less than 50%)
  - Fair hearing rights (42 U.S.C. 1396a(a)(3))
  - Single State agency to administer program (42 U.S.C. 1396a(a)(5))
  - "Reasonable promptness" for applications (42 U.S.C. 1396a(a)(8))
  - Mandatory eligible groups (42 U.S.C. 1396a(a)(10)(A)(i))
  - Optional eligible groups (42 U.S.C. 1396a(a)(10)(A)(ii))
- State Plan is implemented through state statute and administrative regulation

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Medicaid Waivers

- §1115 Medicaid Demonstration Waiver
  - States can develop experimental, pilot, or demonstration projects that are approved by the Health and Human Services Secretary that will likely promote the objective of Medicaid (provide medical assistance to low-income individuals), such as expanding eligibility, delivery system reforms payment experiments
- §1915(b) Waiver
  - Allows use of Managed Care Organizations (MCOs)
- §1915(c) Waiver
  - Home and Community Based Services (HCBS) waivers for states without HCBS in their state plans

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§1115 [42 U.S.C. 1315]

Medicaid Demonstration Waiver

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§1115 [42 U.S.C. 1315] Medicaid Demonstration Waiver

- Waives certain federal requirements (Sec. 1115(a)(1) and 42 U.S.C. 1315(a)(1))
  - Most common waivers seek to waive requirements under
    - Sec. 1902(a)(1) Statewideness
    - Sec. 1902(a)(10)(B) Comparability
    - Sec. 1902(a)(23) Freedom of Choice
  - Cannot waive the federal-state matching system or the right to fair hearing
  - Waivers may be broad or narrow in scope and population
- Generally approved for 5-year period with extensions of 3 – 5 years
  - CMS can withdrawal approval at anytime

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§1115 [42 U.S.C. 1315] Medicaid Demonstration Waiver

- The Secretary may approve the use of federal Medicaid funds on generally impermissible expenditures
  - Sec. 1115(a)(2)
  - 42 U.S.C. 1315(a)(2)
- "Budget Neutral" Required
  - Federal spending would be equal to that without the demonstration project
  - Budget neutrality is not defined under federal statute or regulations but has been in practice for numerous years
  - Budget neutrality is monitored throughout the demonstration period and a final determination is made by CMS at the conclusion of the approval period

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§1115 [42 U.S.C. 1315] Medicaid Demonstration Waiver

- Affordable Health Care Act (Sec. 10201(i)) instituted changes to Section 1115 regarding transparency, public input, and evaluation
  - Sec. 1115(d)
  - 42 U.S.C. 1315(d)
  - 42 C.F.R. pt. 431, subpt. G
- State public notice process (42 C.F.R. §431.408) requires a minimum 30-day public notice and comment period
- Requirements for the contents of the application and extensions
- Federal public notice process (42 C.F.R. §431.416)
- Monitoring, Compliance, and Evaluation

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§1115 [42 U.S.C. 1315] Medicaid Demonstration Waiver

- Waiver Process
  - Draft Application
  - State 30-day public comment period and minimum 2 public hearings
  - Submit application to CMS
  - Federal 30-day public comment period
  - CMS review (Health and Human Services and Office of Management and Budget)
  - Approval
  - Implementation
  - Monitoring/Evaluation
  - Amendments/Renewals

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§1915(b) [42 U.S.C. 1396n(b)]

Medicaid Waivers for Medicaid Managed Care

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§1915(b) [42 U.S.C. 1396n(b)] Medicaid Waivers - MCOs

- Purpose of this waiver is to utilized managed care delivery system to increase cost-effectiveness and efficiency in the delivery of health care
- Typically used by states to waiver requirements for comparability, statewideness, and freedom of choice
- Managed Care
  - Contractual arrangement between state Medicaid agencies and MCOs that accept a set number of enrollees per month payments (capitation) for services
- Capitation "a payment the State makes periodically to a contractor on behalf of each beneficiary enrolled under a contract and based on the actuarially sound capitation rate for the provision of services under the State plan. The State makes the payment regardless of whether the particular beneficiary receives services during the period covered by the payment."
  - 42 C.F.R. 438.2

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§1915(b) [42 U.S.C. 1396n(b)] Medicaid Waivers - MCOs

- Managed care programs may also be implemented under state plan authority §1932(a) and §1115 as a demonstration project waiver.
- May have concurrent §1915(b) and §1915(c) waivers
  - Example: Florida's Statewide Medicaid Managed Care Long-Term Care Waiver (SMMC-LTC)
- State Plan vs. Waiver
  - Under §1915(b) States
    - Able to require dual eligibles, American Indians, and children with special health care needs to enroll in a managed care delivery system
    - State must demonstrate the delivery system is cost-effective, efficient, and consistent with objectives of Medicaid
    - Approval is limited to 2 years
- §1915(a) Waiver
  - Voluntary managed care program by executing contract with MCOs using competitive procurement process. CMS must approve in order to make payment

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§1915(b) [42 U.S.C. 1396n(b)] Medicaid Waivers - MCOs

Cost Effectiveness Required

- Spending is equal to or less than the cost of the same services without the waiver
- Measurement is the projected estimate of the cost of the services provided without the waiver compared to the cost of services under the waiver program
- States must demonstrate that the waiver is cost effective and efficient in the application and quarterly after implementation

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§1915(b) [42 U.S.C. 1396n(b)] Medicaid Waivers - MCOs

Enrollee Rights Guaranteed by State

- Receive information as required in 42 CFR § 438.10
- Be treated with respect and consideration for their dignity and privacy
- Receive information on available treatment options and alternatives
- Participate in health care decision (including refusing treatment)
- Free from restraint or seclusion as a means of coercion, discipline, convenience or retaliation
- Request and receive copy of medical records and request to amened or correct
- Furnished with health care services in accordance with §§ 438.206 through 438.210.

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§1915(b) [42 U.S.C. 1396n(b)] Medicaid Waivers - MCOs

Grievance and Appeals

- Adverse Benefit Determination Notice
  - Notice must include certain information
  - Review 42 CFR for specific time frames of notices
- Timing
  - Grievance may be filed with MCO at anytime
  - File appeal within 60 calendar days of adverse notice
- Resolution of Grievance
- State Fair Hearing
  - Only after receiving notice that an adverse benefit determination was upheld or if MCO failed to adhere to notice and timing requirements
  - No less than 90 calendar days and no more than 120 calendar days to request fair hearing

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§1915(b) [42 U.S.C. 1396n(b)] Medicaid Waivers - MCOs

Continuation of Benefits

- Enrollee may request a continuation of benefits on or before
  - 10 calendar days of notice
  - Effective date of proposed adverse benefit determination
- MCO must continue benefits when certain conditions are met
- Duration of benefits
- MCO can recover cost if under contract, provided solely under continuation, and final decision upheld MCOs decision

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§1915(b) [42 U.S.C. 1396n(b)] Medicaid Waivers - MCOs

Waiver Application

- Preprinted form must be used
- Application
  - Program Overview
  - Access, Provider Capacity, Utilization Standards
  - Quality
  - Program Operations
  - Cost-Effectiveness and Efficiency
- Approval
  - CMS has 90 days to make a decisions unless additional information is requested in writing
  - Two years (five years for programs that include dually eligibility beneficiaries).
- Annual Reporting

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§1915(c) [42 U.S.C. 1396n(c)]

Medicaid Waivers for Home and Community Based Services

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§1915(c) [42 U.S.C. 1396n(c)] Medicaid Waivers for Home and Community Based Services

- Goal of 1915(c) Waivers is to provide services sufficient to avoid or delay institutionalization
  - See Section 1915(c); 42 U.S.C. 1396n(c); and 42 CFR pt. 441 subpt. G
- Waiver of statewideness (§1902(a)(1), comparability (§1902(a)(10)(B)), and income/resources rules (§1902(a)(10)(C)(i)(III))
- Waiver of income and resource rules
  - §1902(a)(10)(C)(i)(III) the single standard to be employed in determining income and resource eligibility
  - States can exclude community spouse's income
  - Allows states to use spousal impoverishment rules to determine eligibility
  - States may establish eligibility for criteria for HCBS (no more restrictive than SSI rules for single applicant)

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§1915(c) [42 U.S.C. 1396n(c)] Medicaid Waivers - HCBS

- Institutional Level of Care
  - hospital, nursing facility (SNF), or intermediate care facility (ICF)
- Enrollment capped and the creation of waitlist for services
  - State provide an estimated number of enrollee
  - Model waivers limited to 200 beneficiaries at a time
- Cost Neutrality Required
  - Average per capita expenditure estimated "does not exceed 100 percent of the average per capita expenditure" for fiscal year under State plan for such individuals
  - Expenditures are reasonable estimated and documented

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§1915(c) [42 U.S.C. 1396n(c)] Medicaid Waivers - HCBS

Services May Include

- Case management
- Homemaker (chores/light housekeeping)
- home health aid
- personal care
- adult day programs
- habilitation services
- respite care
- supported employment
- day treatment or partial hospitalization for individual with chronic mental illness
- educational services
- prevocational services
- other services approved by CMS "as cost effective and necessary to avoid institutionalization."

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§1915(c) [42 U.S.C. 1396n(c)] Medicaid Waivers - HCBS

Person-Centered Service Plan

- Planning process for written person-centered plan
- Services and support that are important to individual and meeting needs (functional needs assessment)
- Written plan must include certain elements outlined in 42 CFR 441.301(c)(2)
  - Goals and desired outcomes
  - Natural Supports
  - Clinical and support needs identified in functional needs assessment
  - Residential setting
  - Finalized and signed
- Reviewed and revised
  - Every 12 months
  - Significant change in needs/circumstances
  - At request

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§1915(c) [42 U.S.C. 1396n(c)] Medicaid Waivers - HCBS

HCBS Settings Rule

- Detailed set of rules adopted to prevent placement of HCBS Waiver enrollees into institutional-like settings.
  - See 42 CF 431.301(c)(4)-(6)
- Setting must be:
  - Integrated in and supports full access to greater community
  - Selected by individual
  - Right to privacy, dignity, respect, and freedom from coercion/restraint
  - Enhances individual initiative, autonomy, and independence in making life choices
  - Facilitates individual choice regarding services and supports, and who provides them
- Provider owned settings have additional requirements under 42 CFR 441.301(c)(4)(vi)

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§1915(c) [42 U.S.C. 1396n(c)] Medicaid Waivers - HCBS

HCBS Settings Rule

- Settings that are not considered HCBS
  - Nursing facility, mental health facility, intermediate care facility (ICF), hospital, and any other locations that have qualities of an institutional setting, as determined by the Secretary
- Compliance with settings rule is part state assurances on initial application
- CMS requires transition plan to bring states into compliance
  - Timeframe based on renewal date and effective date of regulation
  - 30-day public comment period for proposed transition plan

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§1915(c) [42 U.S.C. 1396n(c)] Medicaid Waivers - HCBS

Grievance

- Grievance is defined as an expression of dissatisfaction or complaint related to the State's or a provider's performance of the activities described in paragraphs (c)(1) through (6) of this section, regardless of whether remedial action is requested
  - 42 CFR 441.301(c)(1)-(6).
- May file at any time (oral or written)
- States must have written grievance policies and procedures
- Allow beneficiary an opportunity to present evidence/testimony and make legal/factual arguments
- Provide beneficiary with a copy of their case file free of charge

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§1915(c) [42 U.S.C. 1396n(c)] Medicaid Waivers - HCBS

Grievance

- Resolution of Grievance
  - Not to exceed 90 calendar days
  - May be extended 14 calendar days
  - Expeditious resolution
  - Notice must be provided to beneficiary
- Recordkeeping
  - States must maintain records of all grievances
    - general description of the reason; date received; date of each review/review meeting/resolution; resolution; and name of beneficiary

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§1915(c) [42 U.S.C. 1396n(c)] Medicaid Waivers - HCBS

Waiver Application

- CMS forms recommended but not required
- Applications are extensive and detailed
  - State assurances
  - Supporting documents
  - Specific waiver requests
  - Cost neutrality
  - Services
  - Eligibility
  - Number of enrollees
  - Service areas
- Approval
  - CMS has 90 days to make a decisions unless additional information is requested in writing
  - Three years (five years for programs that include dually eligibility beneficiaries).

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§1915(c) [42 U.S.C. 1396n(c)] Medicaid Waivers - HCBS

Reporting

- Compliance Reporting
  - Incident management systems
  - Critical incidents see 42 CFR 441.302(a)(6)(i)(A)
  - Person-Centered Planning annual report
  - Annual report on impact on services (type, amount, cost)
- HCBS Quality Measure Set
  - To promote public transparency related to the administration of Medicaid-covered HCBS
- Annual Access Reporting
  - Waiting Lists
  - Access to homemaker, home health aide, personal care, and habilitation services
- Annual Payment Adequacy Reporting

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Enrollee Rights

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Medicaid Enrollee Rights

- Constitutional Due Process
  - Goldberg v. Kelly, 397 U.S. 254 (1970) - Procedural due process applies to welfare benefits
- Notice
  - Must contain:
    - Statement of what action the is being taken and effective date
    - Specific reason supporting action
    - Regulations support or chang in law requiring action
    - Explanation of rights
    - Continuation of benefits
  - State or local agency must send notice at least 10 days before date of action except as permitted under 42 CFR 431.213 (death, voluntary withdrawal, etc) and 431.214 (probable fraud).

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Medicaid Enrollee Rights

- Fair Hearing
  - Required as outlined in 42 CFR 431.220
  - Request for Fair Hearing
    - Procedures
    - Agency cannot interfere or limit in the request for hearing
    - Agency may assist in submitting and processing request
    - Must allow reasonable time to request hearing (not to exceed 90 days from date of notice)
  - Continuation of benefits
    - Agency may recover costs of continued services if agency action is upheld by hearing decisions
  - Decisions
    - recommendations or decisions must be based exclusively on evidence introduced at the hearing.
  - Corrective action if favorable decision for beneficiary

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Medicaid Enrollee Rights

- Federal Rights
  - Provisions of the Medicaid Act have been determined to be enforceable as individual civil rights under 42 U.S.C. §1983 (Civil Action for Deprivation of Rights).
    - See Gonzaga Univ. v. Doe, 536 U.S. 273 (2002) and Blessing v. Freestone, 520 U.S. 329 (1997).
    - Enrollees be provided medical assistance with reasonable promptness. 42 USC 1396a(a)(8); 42 CFR 435.930(a).
    - Enrollees be provided a fair hearing. 42 USC 1396a(a)(3);
    - That services to children meet the requirements of Early & Periodic Screening, Diagnosis and Treatment (EPSDT). 42 USC 1396a(a)(43)
  - Americans with Disabilities Act 42 USC 12132
    - Olmstead v. LC, 527 U.S. 582 (1999), Supreme Court decision found that unnecessary institutionalization of persons with disabilities was a violation of the Americans with Disabilities Act of 1990.
      - States must provide services in the "most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 CFR 35.130(d)

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Questions?

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