



**Removing Barriers:
Allowing 1915(c) Home and Community Based Waivers
to Serve More than One Target Population**

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Introduction

Section 1915(c) of the Social Security Act (the Act) authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may offer home and community based services (HCBS) to state-specified target group(s) of Medicaid beneficiaries who meet a level of institutional care that is provided under the Medicaid State Plan.

This provision was added to the Act by the Omnibus Budget and Reconciliation Act (OBRA) of 1981 (with a number of subsequent amendments). Regulations were promulgated to effectuate this statutory provision, with final regulations issued in the mid-1990s.

There are currently more than 350 Section 1915(c) HCBS waivers operating in 48 States. [Arizona and Vermont also offer HCBS, but do so under Section 1115 demonstration authority.]

This paper will describe areas requiring regulatory change that would enable States to design person-centered, needs-based waiver programs that serve people in settings that are truly home and community based in nature.

Problem Statement

1) *Limited Target Groups Served Per Waiver*

A section 1915(c) waiver may only serve one of the three target populations identified in regulations at 42 CFR 441.301 and further discussed below. States must develop separate 1915(c) waivers in order to serve more than one of these populations.

441.301 . . . (b) If the agency furnishes home and community based services, as defined in Section 440.180 of this subchapter, under a waiver granted under this subpart, the waiver request must –

*. . . (6) Be limited to **one** [emphasis added] of the following target groups or any subgroup thereof that the State may define:*

- (i) Aged or disabled, or both.*
- (ii) Mentally retarded or developmentally disabled, or both.*
- (iii) Mentally Ill.*

This regulatory provision has contributed to States offering waivers with service packages tailored to different groups of individuals based upon *diagnosis*, rather than the individuals' actual need for support.

Because the three target populations are typically associated with a particular institutional level of care (i.e., waiver costs for persons with developmental disabilities are most frequently compared to ICF/MR costs), the necessity to offer multiple separate waivers is often framed as due to a difficulty in combining

levels of care. However, the real issue relates to the division between the target groups required in the regulation.

Historically, in many cases pre-dating the 1915(c) HCBS waiver program, States have utilized a targeted approach to funding and budgeting services for various populations. In most States, certain groups have more mature service delivery systems or have more successful advocacy techniques, resulting in disparate funding with particular groups (variable by state) receiving fewer funds or more limited benefit packages than other groups despite similar or more significant needs.

Either in response to or anticipation of this reality, the States' waiver programs are designed accordingly. In some States, certain populations are offered a complete menu of services that meet the needs identified in the individuals' plans of care, while waivers serving different populations may be less robust.

The regulatory language cited above is a Federal obstacle which, if removed, would allow for remedy of this equity problem at the State level. A Federal regulatory fix allowing combined targeted groups within one waiver, while optional for states and not an instantaneous change in State structures, will remove a real barrier for such change moving forward.

2) Home and Community Based Characteristics

Since the inception of the 1915(c) HCBS waiver program in the 1980s, the Centers for Medicare & Medicaid Services (CMS) (then HCFA – Health Care Finance Administration) has supported State efforts to serve individuals in the least restrictive setting possible. However, some individuals who receive HCBS in a residential setting controlled by a service provider have experienced a very provider-centered and institution-like living arrangement, instead of a person-centered and home-like environment with the freedoms that should be characteristic of any home and community-based setting. For some years CMS has attempted to address this problem indirectly through its review of state service definitions for HCBS, with limited success.

In the recent Notice of Proposed Rulemaking for regulations implementing the Section 1915(i) State plan HCBS benefit¹, CMS affirmatively identified expectations for characteristics of home and community based settings. Section 1915(i), part of the Deficit Reduction Act of 2005, permits States to offer the HCBS specifically identified in Section 1915(c)(4)(b) of the Act as a State plan option instead of a waiver.

A regulatory change articulating CMS requirements for the nature of home and community-based residence under 1915(c) HCBS waivers is necessary to ensure that the expectations for home and community characteristics are consistent across section 1915(c) and section 1915(i) authorities, and to ensure,

¹ 73 FR 18676 <http://edocket.access.gpo.gov/2008/pdf/08-1084.pdf>

most importantly, that individuals receiving HCBS have comparable experience, regardless of the section of the statute authorizing their services.

Solutions

1) Limited Target Groups Served Per Waiver

The solution is to amend the regulation at 42 CFR 441.301(b)(6) to clarify that a State may design a waiver program that includes any combination of the permitted target groups. We would amend the regulation to read:

*Be limited to one **or more** of the following target groups . . .*

While individuals served must still meet a corresponding level of care requirement, and the State must still meet all of the statutory waiver assurances, this regulatory remedy could begin to remove barriers that silo programs at the State level. In addition to this clarification, CMS will specify that 1) the service planning process be person-centered, and 2) the services specified in the plan of care be based upon the needs of the individual, not an average need among a target group. This additional targeting flexibility for states will not effect cost-neutrality. The existing §1915(c) waiver application accommodates multiple levels of care and the corresponding institutional costs.

2) Home and Community Based Characteristics

CMS will amend the regulations concerning eligibility for HCBS waivers, to include requirements for State defined and CMS approved criteria about the home and community nature of any provider-controlled residence. The requirement would provide waiver participants with notice of housing alternatives and increased choice, and a market advantage for person-centered residential settings.

Implementation

The efforts around these solutions begin with an Advance Notice of Proposed Rulemaking (ANPRM), which CMS will undertake at once. Following that step, and taking into consideration comments received in the ANPRM process, CMS will begin the process of making regulatory changes with a Notice of Proposed Rulemaking.

Summary

Benefits of the Solution

The requested regulatory changes will remove real Federal barriers to the States' ability to design needs-based, person-centered HCBS programs, rather than programs based solely upon an individual's diagnosis. This is in keeping with the stated CMS goal of achieving the right care for the right person every time. Some HCBS waiver participants who live in provider-controlled residences will experience increased independence and community living as required by the Supreme Court Olmstead decision.

Potential Negative Consequences

Particular advocacy groups may object to changing the way states may interpret comparability in an HCBS program. States could experience higher costs if services are available across diagnostic target groups, to individuals who share the need for long term supports and services. Some residential service providers who wish to continue with a provider-centered model of care may object to defining home and community characteristics.

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