

Introduction

This is a resource document prepared for a Community of Practice (COP) on using Medicaid funds as a resource to support individual integrated employment. The COP is hosted by the Partnerships in Employment Training and Technical Assistance Center for Partnerships in Employment grantees. The goal of the COP will be to provide opportunities to learn about the ways in which 1915(c) Home and Community Based Waivers and 1915(i) State Plan Home and Community Based Services have been used to support integrated employment in federal statute and in states with PIE grants.

I. Section 1915(c) Home and Community Based Services Waivers

Background

Section 1915(c), the Home and Community Based Services (HCBS) Waiver program, gives states an option to provide services that prevent institutionalization of individuals who would otherwise need care in a nursing home or intermediate care facility. It is the major public funding source for all community-based long-term care (Shirk, 2006) and for vocational and employment services for individuals with intellectual and developmental disabilities (IDD) in particular (Gidugu & Rogers, 2012).

Section 1915(c) authorizes the Secretary of Health and Human Services (HHS) to waive standard Medicaid income and resource rules as well as "statewideness," and "comparability" requirements. With an approved waiver under this section, states can provide specific services solely to targeted populations. States have the option to use more liberal income criteria for determining eligibility, as long as they do not exceed the criteria used for

institutionalized participants. States can limit the provision of services to certain geographic areas, limit the number of people who can be served, allow waiting lists, and cap individual resource allocations or budgets.

States can have multiple 1915(c) waivers. All waiver plans must be "cost neutral." Although the cost of serving some individual participants can exceed the average, for each waiver target group as a whole, the average annual cost per person cannot be higher than the average annual per person cost of institutional care. There is substantial diversity among states' HCBS waiver programs (Centers for Medicare and Medicaid Services, 2013).

1915(c) Waiver Application

States may submit applications for waiver programs to the Centers for Medicare and Medicaid Services (CMS) within HHS. In a standard application format developed by CMS, states provide information on populations to be served, the services to be provided, cost neutrality, and how the waiver will be financed by the state. Proposed plans must define provider standards and ensure that service plans will be individualized and person-centered (CMS, 2013).

States are required to include enrollment limits that can be adjusted at any time with a waiver amendment. Proposals may use or revise standard CMS service definitions. Initial applications are approved for three years, and renewals are approved for five years (CMS, 2013; Cooper et al., 2012; Shirk, 2006).

1915(c) Waiver Services

Allowable services include case management; homemaker/home health aide services; personal care services; and adult day health, habilitation, and respite care. In addition, states may propose for CMS approval any other services that assist

in diverting or transitioning individuals from institutional care (CMS, 2013; Cooper et al., 2012; GAO, 2012).

The habilitation category has been used to provide employment-related services (National Technical Assistance and Research Center, 2011). Habilitative services are defined in the Social Security Act as including “services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community based settings” (Social Security Act Section 1915(a)(5)(A)). States use waivers to provide prevocational supports or non-job specific skills that are needed at work such as attendance, motor skills and workplace safety. Waivers also fund services that assist participants in acquiring or maintaining employment, such as job search activities, training to perform a specific task, on-the-job assistance, and transportation to and from work.

Waivers are used to fund customized employment through which participants undergo extensive planning to identify goals, desires, and support needs, search for employment, and negotiate individualized employment relationships with employers (NTARC, 2011). Waivers are also used for services that help participants to become self-employed or operate small businesses (Sullivan & Katz, 2013). Services must be provided in accordance with a plan of care reflecting participant priorities and self-direction (Cooper, 2013).

Waiver services cannot duplicate those provided under the Medicaid state plan, the Individuals with Disabilities Act (IDEA), or the Rehabilitation Act of 1973. States are required to give participants in their HCBS waiver programs full access to all state plan Medicaid services (CMS, 2013; Cooper et al., 2012). To meet assessed needs, individuals can receive services through more than one Medicaid home and community based services program at the same time (Cooper, 2013).

1915(c) Waiver Participant Eligibility

Waiver participants must meet the income eligibility limits specified in state waiver applications, as well as the state’s level of care criteria for institutional

care. Income and resource eligibility limits can match, but cannot exceed, the state’s institutional income and resource limits for the medically needy (Cooper, 2012; Cooper et al., 2012; NCD, 2013; GAO, 2012; NTARC, 2011).

1915(c) Waiver Administration

HCBS waiver programs must be administered by the Single State Medicaid Agency (SSMA), but can be operated by other state agencies under an interagency agreement or memorandum of understanding. Many states administer waivers for people with IDD through specific state agencies for this population, while in other states, the Medicaid authority and IDD agency are one and the same.

Activities delegated to providers require written specification (Cooper et al., 2012). States must collect and analyze data on regulatory compliance and system performance, and must set standards for providers. States must develop and implement quality improvement systems for waiver services that meet CMS requirements. They must continuously monitor the health and welfare of each individual served (Cooper, 2013).

States report annually to CMS on form CMS-372(S) to establish whether the cost neutrality requirement has been met (CMS, 2013). Annual reports on other expenditure and utilization patterns are required as well (Cooper, 2013).

1915(c) Waiver History

The first mechanism for waiving statutory requirements under the Social Security Act was Section 1115, added by the Public Welfare Amendments of 1962. This section authorized the Secretary of the Department of Health, Education, and Welfare to give states waivers to demonstrate new and potentially more effective ways of delivering Social Security Act services (NCD, 2013).

The Medicaid HCBS Waiver program was initially authorized by 1981 amendments to the Social Security Act to correct the institutional bias of Medicaid funding. This occurred in the context of a growing movement to deinstitutionalize individuals with IDD (Cooper, 2012; Gidugu & Rogers, 2012).

The Consolidated Omnibus Reconciliation Act (COBRA) of 1985 authorized expanded habilitation services (prevocational, supported employment, and educational services) within the HCBS Waiver Program, but only to individuals who had been previously institutionalized (Shirk, 2006). It was not until 1987 that the Omnibus Budget Reconciliation Act (OBRA) eliminated the requirement of previous institutional care for the federal funding of habilitation services under HCBS waivers. The Balanced Budget Act of 1997 allowed states to provide supported employment services to participants who had not been previously institutionalized (Gidugu & Rogers, 2012; Shirk, 2006).

Based upon feedback from State Employment Leadership member states, in September 2011, CMS released an information bulletin, “1915(c) Waiver Technical Guidance Revisions,” on waiver program employment services. The bulletin emphasized the importance of integrated employment and person-centered planning, and distinguished between prevocational and supported employment services.

The bulletin also discussed best practices. It split supported employment into two core service definitions: individual and small group (two to eight people) and added a new core service definition for career planning. The bulletin explained that Ticket to Work outcome and milestone payments are not in conflict with payment for Medicaid services (Kennedy-Lizotte & Freeze, 2012).

1915(c) Waiver Successes and Challenges to Individual Integrated Employment

Supported employment grew rapidly with implementation of the 1915(c) waiver program. Many states increased their delivery of supported employment programs when the Balanced Budget Act of 1997 expanded the reach of this service to participants who had not been previously institutionalized (Wehman & Kregel, 1995; Wehman et al., 1997).

The National Council on Disability (NCD) cites Washington State’s program, which makes available “a flexible array of services” through four Medicaid HCBS waiver programs targeted to people with

developmental disabilities, as a model employment program for this population (NCD, 2013).

A recent draft report cites the San Francisco Work-Link program developed by TransCen, Inc. as a model that uses a section 1915(c) waiver and vocational rehabilitation (VR) funding to blend long-term day and integrated employment services for participants with significant disabilities (Mills, 2013).

Although there has been an increase in supported employment services delivered to individuals with IDD, the percentage of waiver participants receiving supported employment has continued to be quite low. West et al. found that only 12% of waiver habilitation funding was used for supported employment, with the remainder paying for segregated options.

At the same time, there were large waiting lists for supported employment in many states (West et al., 2002). A recent analysis of 88 Medicaid HCBS Section 1915(c) waiver applications for services for individuals with IDD submitted by 41 states from May 2010 through January 2012 found that only 3% of the proposed service dollars were allocated to supported employment. The bulk of applications sought residential habilitation dollars (53%), day habilitation (19%), and companion, homemaker, chore, personal assistance and supported living funding (11%) (Rizzolo, 2013).

West et al. (2002) cited several barriers to increasing the delivery of supported employment through the waiver program. These included the requirement for prior service from VR, being found ineligible for VR services, and a shortage of providers. Providers, they found, have been disincentivized by limits on the number of individuals who could be served, the number of service hours individuals could receive, and total reimbursement amounts (West et al., 2002).

Concern also exists that obstacles to blending and braiding waiver funding with other funding sources interfere with the collaboration of schools, VR and waiver funded services on behalf of youth with IDD transitioning from high school. Federal statute and regulation require that Medicaid be the payer of last resort, and CMS reiterates this principle in waiver

application materials.

When a state covers prevocational and/or supported employment services in a waiver, the waiver service definition of each service must specifically provide that the services do not include services that are available under the Rehabilitation Act (or, in the case of youth, under the provisions of the IDEA) as well as describe how the state will determine that such services are not available to the participant before authorizing their provision as a waiver service. (CMS, 2008, pp. 131-132, as quoted in Mills, 2013)

Barriers to delivering supported employment services to individuals with IDD through the waiver program occur in a context in which there are many other contributing systemic deterrents to the integrated employment of this population. These obstacles include inconsistent policy around the relative importance of integrated employment, other payment systems that do not support the achievement of integrated employment outcomes, a history and culture of low expectation and segregation, inadequate preK-12 and postsecondary educational resources and programs, unmet need for professional development of direct service professionals, and insufficient collaboration and coordination among agencies affecting the ability of this population to access education and employment (Butterworth, 2012; Kiernan, 2011).

II. Section 1915 (i) State Plan Option for Home and Community Based Services

1915(i) State Plan Background

Section 1915(i), the state plan option for HCBS, gives states the option of providing home and community based services through Medicaid *without* requiring participants to meet an institutional level of care requirement or states to demonstrate cost neutrality with institutional care (Cooper et al., 2012; NTARC, 2011; Kennedy-Lizotte & Freeze, 2012). States can waive the Medicaid comparability requirement in administering Section 1915(i) by limiting the provision of particular HCBS benefits to specific

populations, defined, by example, by diagnosis, age, disease, or condition (Cooper et al., 2012; Cooper, 2013). However states providing HCBS under 1915(i) cannot cap the number of people served and must provide the service on a statewide, entitlement basis without waiting lists (Cooper et al., 2012; Cooper, 2013; Families USA, 2013).

1915(i) State Plan Application

To establish a 1915(i) HCBS benefit, states submit a state plan amendment to CMS for review. If the state chooses to target a benefit to a specific population, approval of the plan must be sought and obtained every five years and is to be based on a CMS review of quality outcomes and state plan requirements (CMS, 2013; Cooper et al., 2012; Families USA, 2013; GAO, 2012).

1915(i) State Plan Services

The services that may be provided under 1915(i) are identical to those that may be provided under 1915(c). States can provide services not listed in the statute with CMS approval. Services must be provided in accordance with an individualized plan of care reflecting participant priorities and self-direction. Participants can receive services under 1915(i), 1915(c), and 1915(j) as long as the service plan ensures that there is not a duplication of service. As with 1915(c), 1915(i) funding cannot be used to pay for services that can be provided under IDEA or the Rehabilitation Act of 1973. Unlike 1915(c), the 1915(i) state plan must ensure that benefits are available to all eligible individuals within the state (CMS, 2013; Cooper et al., 2012; GAO, 2012; NTARC, 2011).

1915(i) State Plan Participant Eligibility

States set needs-based and income criteria for eligibility for 1915(i) funding of services. The state's need-based criteria must be less stringent than its criteria for determining eligibility for institutional care. The needs-based criteria must relate to individuals' functional needs for support. This eligibility must be established through an independent evaluation that is free of conflict of interest in accordance with CMS standards (Cooper, 2013). The state plan must establish a process

to ensure that evaluations and assessments are independent and unbiased.

Income eligibility criteria cannot be more restrictive than those of the Supplemental Security Income (SSI) program, and can include individuals up to 150% of the federal poverty level. States can also choose to serve the medically needy and can use institutional deeming rules for individuals with incomes up to 300% of the federal poverty level if they meet institutional level of care criteria. Under section 1915(i), states have the option of creating a new Medicaid eligibility category for full Medicaid benefits (CMS, 2013; Cooper et al., 2012; Cooper, 2013; Families USA, 2013).

1915(i) State Plan Administration

Section 1915(i) must be administered by the Single State Medicaid Agency, but can be operated by other state agencies under an interagency agreement or memorandum of understanding. Many states administer waivers for people with IDD through specific state agencies for this population, while in other states, the Medicaid authority and IDD agency are one and the same. Activities delegated to providers require written specification (Cooper et al., 2012).

State plans must provide adequate and reasonable provider standards and must establish quality assurance, monitoring and improvement strategies for each benefit (CMS, 2013). States must continuously monitor the health and welfare of each individual served (Cooper, 2013).

States submit annual reports on expenditure, utilization, regulatory compliance, and system performance to CMS (Cooper, 2013). Reports include information on the numbers of individuals receiving and projected to receive the 1915(i) state plan services. Proposed rules require states to report, as requested by the Secretary of Health and Human Services, on program performance and quality of care measures designated in state plan amendments (Department of Health and Human Services, 2012).

1915(i) State Plan History

Section 1915(i) was initially created by the Deficit Reduction Act of 2005 and became effective in

2006 (NTARC, 2011). It was then amended in 2010 by the Patient Protection and Affordable Care Act with several significant changes (Families USA, 2013; GAO, 2012; NTARC, 2011). These included:

- » Expanding the range of services from those explicitly identified in the statute to also include those requested by a state and approved by CMS
- » Creating a state option to limit services or service packages in type, amount, duration, or scope to specific, targeted populations
- » Expanding income eligibility by allowing states to offer benefits to participants with incomes up to 150% of the federal poverty level if they are programmatically eligible for the 1915(i) service, and up to 300% of the SSI benefit if the participant is also eligible for HCBS under specified waivers
- » Eliminating state options to limit the number of people who can receive services and to limit the provision of services to certain geographic areas
- » Adding a requirement for developing and implementing a quality improvement strategy

1915(i) State Plan Successes and Challenges to Individual Integrated Employment

Section 1915(i) has removed barriers blocking Medicaid funding for HCBS for individuals with mental illness (NTARC, 2011). Section 1915(c) institutional level of care eligibility and state cost neutrality requirements prevented the provision of HCBS to individuals with mental illness because Medicaid does not cover institutional care for mental illness for people between the ages of 21 and 65 (GAO, 2012).

A 2012 U.S. General Accounting Office (GAO) report found that state Medicaid agencies were slow to respond to 2010 amendments to 1915(i) as a result of the need to address the many other changes brought about by the Affordable Care Act. Also of note was state official's description to the GAO of the "complexity of layering new HCBS options on top of the state's existing HCBS system." State officials asked for guidance from CMS on combining the various options for providing HCBS within a

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ThinkWork!



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FOR MORE INFORMATION, CONTACT:

John Butterworth, PhD | john.butterworth@umb.edu
Institute for Community Inclusion/UMass Boston | 100 Morrissey Blvd. | Boston, MA 02125

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