AN OVERVIEW OF 1915C MEDICAID WAIVERS

PURPOSE OF A WAIVER

- To enable a person to choose to live independently in the community
- Avoid nursing home placement or other institutional care
- Receive a cost effective plan of home and community based services

WHAT IS A 1915C WAIVER

- Authorized under 1915c of the Social Security Act
- The state may request to waive:

  1.Comparability of services as long as the individual meets the waiver level of care requirement and meets target group criteria (offers a broader array of services to the population not otherwise available under Medicaid)

  2. Income and Resources for the Medically Needy

  3. Statewideness

WAIVER REQUIREMENTS

- Waiver specifies institutional level of care that is being targeted
- Includes Nursing Facility, Subacute Nursing Facility, Intermediate Care Facility for Persons with Intellectual Disabilities, Chronic Disease Hospital
- Waiver must be cost neutral to the state
- Purpose of a waiver is to provide a range of services and supports to prevent institutionalization
- Overall, waivers save state dollars

WAIVER ASSURANCES TO CMS

- 6 Assurances
  - Level of Care
  - Service Plan
  - Qualified Providers
  - Health and Welfare
  - Financial Accountability
  - Administrative Authority

WAIVER QUALITY MANAGEMENT

- Each assurance has multiple subassurances
- Assurances and subassurances require a number of performance measures
- State reports once during the 5 year waiver cycle to CMS by submitting a comprehensive evidence package for review and approval

POTENTIAL TARGET GROUPS

1. Aged or Disabled or both

-recognized subgroups-Brain injury, HIV/AIDS,

Medically Fragile or Technology Dependent

2. Intellectual Disability or Developmental Disability or Both

-recognized subgroups-Autism, DD, ID

3. Mental Illness

-Subgroups Mental Illness or Serious Emotional Disturbance

4. CMS rule change effective 3/17/14 now permits the combination of target groups

RELATIONSHIPS WITH OTHER STATE AGENCIES

- Medicaid agency must maintain administrative authority over all waivers including those operated by sister agencies
- Medicaid agency is required to be the lead on all communications with CMS
- DMHAS operates one waiver
- DDS operates 5
- DSS directly administers and operates 5

WAIVER PROCESS

- Initiation of a waiver can come from a state agency or out of legislation
- State agency develops the waiver application
- Sister agencies develop waivers in consultation with DSS
- A fiscal note is required
- Public notice includes tribal notification and a public notice and comment period
- New waivers and substantive changes to existing waivers require legislative approval as specified in section 17b-8 of the CT General Statutes

WAIVER ELIGIBILITY

- Income eligibility is 300% of Supplemental Security Income currently $2205/month
- Spousal assessment rules apply
- 5 year look back for asset transfers is required
- Must meet institutional level of care as specified in the waiver
- Service plan must meet cost cap specified in the waiver

KATIE BECKETT WAIVER

- Maximum of 300 slots
- 100 slots added 7/1/14
- Current enrollment 300
- Waiting list estimated 3 years
- Medicaid waiver for children with severe disabilities
- Renewal effective 1/1/12 caps age at 21
- Only service is case management
- Qualifies children based on their income/assets not the parents

PCA WAIVER

- Approximately 950 participants
- Generally for adults 18-64
- But persons turning 65 are required to transition to the elder waiver
- Income $2,205 same as other waivers, also Medicaid for the Employed Disabled is an eligibility coverage group for this waiver
- Services PCA, Personal Emergency Response System and Assistive Technology

ABI WAIVER

- Current enrollment 446
- Ages 18-64
- With an acquired brain injury after the developmental period
- 4 levels of care: NF, ABI-NF, ICF/MR and Chronic Disease Hospital
- Wide range of services including independent living skills training, vocational and prevocational training, supported employment, mental health services
- Cost cap 200% of the average facility cost
- Closed for intake

ABI Waiver II

- Service package similar to ABI I
- Adds Recovery Assistant and Adult Day Health
- Cost cap is 150% of average facility cost
- Reserves capacity for persons with ABI served by DMHAS and those transitioning from institutions under MFP
- Effective date 12/1/14
- Approximately 150 participants

DDS WAIVERS

- Currently 3 waivers: Comprehensive and Individual and Family Support Waivers, longstanding waivers
- Employment and Day Supports Waiver approved by CMS with a start date of 4/1/11

DDS COMPREHENSIVE WAIVER

- Current enrollment approximately 5,000

- Generally participants have significant physical, behavioral or medical support needs.

- It can also be used to provide services to individuals who live in their own homes or in their family homes and who are in need of a comprehensive level of supports

- Services individuals who live in licensed Community Living Arrangements (CLA), Community Training Homes (CTH) or in Assisted Living Facilities.

DDS INDIVIDUAL AND FAMILY SUPPORTS WAIVER

- Approximately 4,000 participants
- designed to support individuals who live in their own homes or in their family homes
- and need less extensive supports
- typical service plans are less than $50,000 per year.

DDS EMPLOYMENT AND DAY SUPPORTS WAIVER

- Effective 4/1/11
- Approximately 450 participants
- Cost cap $28,000 per year
- Targets young adults transitioning from school to work
- Similar services as other waivers

DDS WAIVER SERVICES

- Adult Day Health
- Health Care Coordination
- Live-in Caregiver
- Residential Habilitation (IFS Waiver)
- Individual Directed Goods and Services
- Individualized Home Supports
- Clinical Behavioral Support Services
- Nutrition
- Independent Support Broker

SERVICES CONTINUED

- Residential Habilitation (Comp Waiver)
- Assisted Living
- Personal Support
- Adult Companion
- Respite
- Supported Employment
- Group and Individualized Day Supports
- Family Training (IFS Waiver)

SERVICES CONTINUED

- Environmental Modifications
- Transportation
- Specialized Medical Equipment
- Personal Emergency Response System
- Interpreter Services

AUTISM WAIVER

- Approved to start 1/1/2013
- Services capped at $60,000
- Serves Individuals on the Spectrum with an IQ > 70
- Services occur in the person's own home or family home
- Currently being renewed
- 93 active participants

EARLY CHILDHOOD AUTISM WAIVER

- Approved 2/1/14
- Serves 3 and 4 year olds with high needs
- Currently has 21 participants enrolled
- Cost limit $30,000/year
- Services are Applied Behavioral Analysis and Life Skills coach
- Will be impacted once a new state plan option is approved
- Waiver being phased out effective 7/1/16

MENTAL HEALTH WAIVER

- Became effective initially 4/1/09, renewed 4/1/17
- Also known as WISE-Working for Integration, Support and Empowerment
- Capped in the current year at 675 participants but increases annually over the course of the waiver
- Nursing Facility Level of Care
- Targets persons with Serious Mental Illness
- Recovery focused
- Waitlist being established

CT HOME CARE PROGRAM FOR ELDERS

- 1 Program, 5 categories of service
- Categories 1 and 2 are State funded
- Currently 3,700 clients statewide
- Category 3 is Medicaid Waiver
- Currently 12,500 clients
- Category 5-1915i State Plan option with 600 enrollees

FUNCTIONAL AND FINANCIAL ELIGIBILITY

- Category 1- 1 or 2 critical needs and not Medicaid active
- Category 2- 3 or more critical needs, not Medicaid eligible
- Category 3- 3 or more critical needs, Medicaid active
- Category 4- 3 or more critical needs, not eligible for community Medicaid (Home Care Program for Adults With Disabilities effective 2007. CT General Statutes 17b-617)
- Category 5- 1or 2 critical needs, Medicaid active, income less than 150% of the FPL
- Critical needs are bathing, dressing, toileting, transferring, eating and medication administration

1915i STATE PLAN OPTION

- Approved by CMS in February of 2012
- Functionally the same as CT Home Care Program Category 1
- Not institutional level of care
- Medicaid active with incomes at or below 150% of the Federal Poverty Level
- All of the same services under CHC
- Services are federally matched

PROGRAM SERVICES

- Homemaker
- Companion
- Personal Emergency Response Systems
- Meals on Wheels
- Adult Day Care
- Chore

SERVICES CONTINUED

- Minor Home Modifications
- Mental Health Counseling
- Assisted Living
- Personal Care Assistant
- Assistive Technology
- Adult Family Living
- Care Management
- And State Plan Services such as Nursing, Home Health Aide, Physical and Occupational Therapies
- Renewal due to CMS no later than 3/31/15 for 7/1 effective date

CMS FINAL RULES EFFECTIVE 3/17/14

- Defines and outlines requirements for person centered planning
- Permits states to combine target groups in a waiver
- Permits states to use a 5 year renewal cycle for waivers
- Provides new standards for assessments
- Moves away from defining home and community based settings by “what they are not” and toward defining them by the nature and quality of the participants’ experiences

HCBS SETTINGS

The rule establishes that any setting:

- Be integrated in and support full access to the community
- Be selected by the individual from a range of options
- Ensure the individual's right of privacy, dignity, respect and freedom from coercion and restraint
- Optimize autonomy and independence in making life choices
- Facilitate choice regarding services and who provides them

PROVIDED OWNED OR CONTROLLED SETTINGS

The rule includes added requirements for provider owned or controlled residential settings and requires that:

- the individual has a lease or other legally enforceable agreement providing similar protections;
- the individual has privacy in their unit including lockable doors, choice of roommates and freedom to furnish or decorate the unit;
- the individual controls his/her own schedule including access to food at any time;
- the individual can have visitors at any time; and
- the setting is physically accessible.

IMPACT OF FINAL RULES ON WAIVERS

- Settings rules apply to both residential and non-residential settings
- Requires states to submit a transition plan outlining assessment and remediation efforts to ensure compliance with the new rules
- State is surveying a range of providers and settings
- Also impacts where services are delivered
- Transition Plan submitted to CMS on 12/19/14

QUESTIONS???

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