Appendix 4: SPA and Waiver Options to Enhance Concurrent Care Programs

Medicaid State Plan Options

Each state describes its Medicaid program in the Medicaid State Plan. The State Plan specifies how the state administers its Medicaid program, and what the requirements are for eligibility, covered services, providers, reimbursement and oversight. The State Plan is subject to federal requirements including which services and eligibility groups a state must cover (mandatory services and eligibility groups) and those that are optional. Mandatory and optional services are listed in Appendix 1. Mandatory and optional eligibility groups are listed in Appendix 2. Services authorized using the state's Medicaid State Plan are referred to as "state plan services."An important state plan service for children is Early and Periodic Screening, Diagnosis and Treatment (EPSDT).

SPA Option 1: Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

States can provide additional services to children including those with a terminal illness under the authority of the EPSDT provisions, subject to CMS approval. CMS has previously approved not only additional services but the removal of requirements that limit the services to children with a terminal illness and life expectancy of six months or less. For example, Washington State includes expanded PPC services for children who have a life-limiting condition as an EPSDT service. Life-limiting condition is defined as a medical condition in children that most often results in death before adulthood.

Washington EPSDT SPA Example

The State of Washington provides PPC under the authority of EPSDT using an SPA. The SPA states specifically that hospice care "also includes PPC services that are provided for approved clients 20 years old and younger who have a life-limiting diagnosis."

The state also requires that managed care plans provide this benefit for eligible children enrolled in the plan.

The PPC benefit consists of up to six PPC contacts per client per calendar month. A contact may consist of any of the following:

- One visit with a registered nurse, social worker, or therapist (licensed physical therapist, occupational therapist, or speech/language therapist) with the client in the client's residence to address

  - Pain and symptom management;
  - Psychosocial counseling; or
  - Education/training;

- Two hours or more per month of case management or coordination services to include any combination of the following:
  - Psychosocial counseling services (includes grief support provided to the client, client's family member(s), or client's caregiver prior to the client's death);
  - Establishing or implementing care conferences;
  - Arranging, planning, coordinating, and evaluating community resources to meet the child's needs; and
  - Visits lasting 20 minutes or less (for example: visits to give injections, drop off supplies, or make appointments for other PPC-related services); and
  - Visits not provided in the client's home.

Approved SPAs with an approval date of June 1, 2007 or after are now available on the CMS website at: *www.cms.gov/MedicaidGenInfo/StatePlan/list.asp*.

SPA Option 2: 1915(i) Home and Community-Based Services (HCBS)

The state option to offer HCBS as state plan services became available in 2005 and was amended by the ACA effective April 1, 2010. This option now permits states to make an array of HCBS available to recipients who have functional deficits below the level of institutional care or who would otherwise be eligible for an HCBS waiver.

Section 1915(i) provides an opportunity for a state to develop a specialized package of services for children receiving hospice care in much the same manner as has been implemented under 1915(c) waivers (see below). The 1915(i) option differs from 1915(c) waivers in several important ways. The 1915(i) option permits states to:

- Provide HCBS to persons who have functional deficits but who do not meet institutional level of care as well as persons who meet institutional level of care;
- Provide the same array of HCBS as may be authorized under a Section 1915(c) HCBS waiver;

- Include the higher income group (persons with incomes up to 300 percent of the Supplemental Security Income (SSI, Federal Benefit Rate (FBR [1]), which is equivalent to about 224% of federal poverty level (FPL)) but this only applies to persons who would otherwise be eligible for an HCBS waiver;
- Provide the services on a statewide basis; and
- Not utilize a waiting list (although there is a phase-in provision for new 1915(i) programs).

Therefore, a state can use a 1915(i) SPA in a manner similar to a 1915(c) waiver, but this option is more flexible than a 1915(c) waiver in terms of eligibility (i.e., not limited to children who meet institutional level of care) but less flexible in terms of enrollment (i.e., without the ability to cap enrollment). Consequently, for a state to use this option, the state must be willing to provide the service to all eligible beneficiaries. For a complete description of 1915(i) HCBS requirements see: Improving Access to Home and Community-Based Services. State Medicaid Director Letter 10-013. August 2010.

SPA Process

States amend their state plans by submitting a SPA to CMS.

Most state plan options have an existing template the state may complete requesting authorization for the change to the state plan. When a new state plan option becomes available, like the amended 1915(i) option, states are not required to wait for CMS to issue a template (which may take some time following the effective date of the option). States may instead develop their own document.

The state completes an SPA submission document (template or state-generated document) along with any supplemental information the state believes is needed to explain or justify the request as well as a required cover form (Form HCFA-179). The SPA submission must be authorized by the state's Medicaid agency director. The state submits the SPA to its regional CMS office and requests an effective date, which may not be retroactive. The CMS office documents the date received.

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1. In 2010, the FBR is $674 for a qualified individual and $1,011 for a qualified couple. The 2011 rate is unchanged from 2010.

CMS has a 90-day timeframe from the date received within which to approve the amendment, disapprove the amendment, or request additional information (RAI).

- If CMS sends an RAI to the state, the state has 90 days to respond to the RAI. If the state does not respond to the RAI by the end of the 90-day period, CMS initiates disapproval of the SPA.
- If CMS does not approve the SPA within 90 days of receipt but also does not issue an RAI, the SPA is deemed approved at the end of the 90-day review period.
- The effective date of the SPA is the date authorized by CMS and generally will be the date requested by the state that was specified in the SPA document.

Medicaid Waiver Options

States seek authorization from CMS to deviate from federal Medicaid requirements through the use of a Medicaid waiver. Different types of Medicaid waivers permit states to "waive" specific federal requirements. Federal requirements for the Medicaid program are contained in Title XIX of the Social Security Act (SSA). Examples of requirements commonly waived using different types of waivers are provided below. Note that only a Section 1115 waiver may be used to waive all of the examples listed:

- **Section 1902(a)(1) State-wideness/Uniformity:** A waiver of this requirement permits a state to operate a program on less than a statewide basis.
- **Section 1902(a)(10)(B) Amount, Duration and Scope/Comparability of Services:** A waiver of this requirement allows a state to provide services to recipients enrolled in the waiver program that are not available to other recipients not enrolled in the waiver program.
- **Section 1902(a)(10)C)(1) Income and Resource Rules:** A waiver of this requirement allows a state to include higher income individuals who would not otherwise be covered by the waiver program because they do not meet existing "regular" Medicaid eligibility requirements in a specific state.
- **Section 1902(a)(14) Cost-Sharing:** A waiver of this requirement is used to impose cost-sharing requirements that are greater than normally permitted.
- **Section 1902(a)(23) Freedom of Choice:** A waiver of this requirement permits states to limit a recipient's choice of providers.

- **Section 1902(a)(32) Direct Payment:** A waiver of this requirement allows someone other than the provider of a service to receive Medicaid payment for that services. Often this is a managed care organization (MCO) that then reimburses the provider.

There are three major types of Medicaid program waivers. Each waiver is referred to by the Section of the Social Security Act that authorizes its provisions and by a primary feature of the waiver:

- **Waiver Option 1:** Section 1915(b) waivers: - Most commonly referred to as Freedom of Choice waivers;
- **Waiver Option 2:** Section 1915(c) waivers - Most commonly referred to as Home and Community-Based Services (HCBS) waivers;
- **Waiver Option 3:** Section 1915(b) and 1915(c) combination waivers: - Most commonly used to implement managed long-term care programs that include HCBS waiver services.
- **Waiver Option 4:** Section 1115 waivers: Most commonly referred to for their two primary uses - as Coverage Expansion waivers or Research and Design waivers.

Medicaid Waiver Option One: 1915(b) Waivers

Section 1915(b) waivers, commonly called Freedom of Choice waivers, are used primarily to require Medicaid recipients to enroll in managed care arrangements, limiting their choice of providers. States may also use a 1915(b) waiver to contract with a limited number of providers of a specific service (referred to as selective contracting). Selective contracting is sometimes used for dental services and hospital services.

States may include some or all Medicaid services in a 1915(b) waiver. The most common arrangements are for managed care organizations (MCOs) that provide physical health services; MCOs that provide behavioral health services; and MCOs that provide both physical and behavioral health services.

1915(b) waivers include the following requirements and options:

- The program authorized by the waiver may be less than statewide;
- The program must be identified as either a Prepaid Ambulatory Health Plan (which does not include inpatient hospital services) or a Prepaid Inpatient Health

Plan, which includes inpatient hospital services. Different federal requirements apply to each of these arrangements;

- The MCO may choose to offer additional services to recipients who enroll into their health plan. These are services the MCO chooses to offer, rather than services the state identifies that MCOs may provide in addition to required services. Examples of additional services may be dental services or over the counter medications;
- The MCO may choose to offer enrollees alternative services that are more cost-effective if the service can reasonably be expected to achieve a similar outcome and the enrollee agrees to this service. This is referred to as downward substitution;
- The state may include "supplemental services." (Supplemental services are authorized under Section 1915(b)(3) of the SSA and are services provided to enrollees that are paid for out of cost savings resulting from the use of more cost-effective medical care. The savings must be expended for the benefit of the enrollee and must be services that are not covered under the state plan but that are for allowable medical or health-related care or other services. They are different from additional services because they are services authorized by the state and are included in the cost-effectiveness calculations for the waiver);
- This waiver does not provide for expanded eligibility;
- Payment is typically made on a capitated, pre-paid basis to the MCO (the MCO receives a per member per month (PMPM) amount for each enrollee to cover the cost of all services included in the program);
- The state may not limit enrollment to the program based on a specific number of enrollees or have a waiting list for this type of program, although MCOs may limit enrollment into their health plan based on their provider capacity;
- The state must offer a choice of at least two MCOs or an MCO and another option such as primary care case management (PCCM) to enrollees, except under special circumstances authorized by CMS.

1915(b) waivers are approved for two years and renewed every two years. However, as a result of the ACA and at CMS discretion, waivers that include dual eligibles (patients who are eligible for both Medicare and Medicaid benefits) may be approved and renewed for five-year periods.

1915(b) Waiver Example: Florida's Program For All-Inclusive Care for Children

Florida operates a PPC program (Partners in Care – Together for Kids (PIC:TFK)), under its 1915(b) managed care waiver. The intent of the PIC:TFK model is to provide pediatric palliative support care services to children with life-limiting conditions from the time of diagnosis and throughout the treatment phase of their illness.

It provides pain and symptom management, counseling, expressive therapies for young children, respite and hospice nursing and personal care services to children enrolled in the CMS Network.

The waiver includes a waiver of state-wideness (operating in limited areas of the state) and uses Section 1915(b)(4) authority to selectively contract with PIC:TFK providers who are hospices and who meet specified criteria for the program.

The supplemental services are provided under the authority of 1915(b)(3), which means they are funded from savings attributable to the 1915(b) waiver.

More information about Florida's PACC program is available in the report "Program For All-Inclusive Care For Children – 2009 Partners In Care Annual Evaluation Report (Evaluation Year 3), which may be downloaded at: *http://ahca.myflorida.com/Medicaid/quality_management/mrp/contracts/med052/final_annual_pic_report_february_2009.pdf*.

Medicaid Waiver Option Two: 1915(c) Waivers

1915(c) or Home and Community-Based Services (HCBS) waivers, are used to provide HCBS such as personal care, respite care and specialized medical equipment, to persons who would otherwise require institutional care. Institutional care is nursing home care, hospital care or care in an Intermediate Care Facility for persons with Mental Retardation (ICFs/MR)[2] that is covered by Medicaid.[3] HCBS waivers generally serve persons at one level of care, although they can serve persons at more than one level of care.

HCBS waivers also include the following features:

- HCBS waivers may be implemented on less than a statewide basis;
- HCBS waivers may include persons with higher incomes, up to 300 percent of the SSI FBR and may also include the medically needy (persons with higher incomes who have very high medical expenses);

2. The Social Security Act and Code of Federal Regulations continue to use the term "mental retardation" although many states now use the term "developmental disabilities (DD)" or "intellectual and developmental disabilities (IDD)".

3. HCBS waivers cannot be used for groups that would receive non-covered institutional services. For example, a waiver cannot serve persons who would otherwise be residing in an Institution for Mental Diseases (IMD), the cost of which cannot be covered under Medicaid for non-elderly adults.

- The state may limit enrollment to a specified number of persons or slots;
- The state may limit enrollment to persons whose cost of care exceeds a specified amount; and
- The state may include consumer-directed care, but cannot include the option where consumers receive cash to pay for their care.

Colorado operates a 1915(c) waiver that provides services such as expressive therapies and family counseling to children with a life-limiting illness. The waiver, Pediatric Hospice Waiver (HOPEFUL Program), does not require that children have a life expectancy of six months or less. Because it is a 1915(c) waiver, the child must be at risk of hospitalization. The state also limits enrollment to 200 slots, an option not available in most instances for state plan services.

HCBS waivers must be cost-neutral. The cost to serve a person enrolled in the waiver must be no greater than the cost to serve a person in the institutional setting appropriate to the waiver program, on average. The cost calculation includes the cost of all Medicaid services. The calculation is based on the average cost per person – some persons will have higher costs and others lower.

HCBS waivers are submitted electronically to CMS using an electronic application maintained on a portal. Once the application is received, CMS has 90 days to review and approve the waiver, disapprove the waiver or issue a Request for Additional Information (RAI). If the state issues an RAI, the state has 90 days to respond to CMS. CMS sometimes works with states on an informal basis providing comments on the application without issuing a formal RAI in order to keep the review process moving.

HCBS waivers are approved initially for three years and renewed for 5-year periods. However, as a result of the ACA and at CMS discretion, waivers that include dual eligibles (individuals who are eligible for both Medicare and Medicaid) may be approved and renewed for five-year periods.

1915(c) PPC Waiver Examples

California, Colorado and North Dakota each operate PPC programs under a Section 1915(c) waiver. The waivers provide supplemental services to children with a life-limiting condition. The waivers also use a diagnosis of "life-limiting condition" rather than a terminal illness with a life expectancy of six months. Finally, in all three states even prior to the passage of the ACA, CMS approved concurrent care for the children enrolled in these 1915(c) waivers.

Table 1: 1915(c) PPC Waiver Services Examples

California Waiver Services	Colorado Waiver Services	North Dakota Waiver Services
Care coordination	Expressive therapies	Case Management
Home respite care	Client/Family/Caregiver Respite Care	Home Health Aide
Expressive Therapy	Palliative/Supportive Care services provided concurrently with curative care services	Hospice
Family counseling		Skilled Nursing
Family training		Bereavement counseling
Out-of-home respite care		Expressive therapy
		Palliative Care

1915(c) Waivers for Medically Fragile Children

Some states include palliative care under 1915(c) waivers targeting children who are medically fragile including New York (Care At Home I/II) and North Carolina Community Alternatives Program for Children.

As an example, New York's Care at Home Waiver serves children who are determined physically disabled based on Supplemental Security Income (SSI) criteria, ages birth through 17, and who would otherwise require hospital or nursing home care. The waiver appears to serve a broader group of children than those who have a terminal illness or a life-limiting condition. The services covered through the waiver are:

- Case Management
- Bereavement Services
- Expressive Therapies
- Family Palliative Care Education (Training)
- Home and Vehicle Modification
- Massage Therapy
- Pain and Symptom Management
- Respite

Authorized providers include certified home health agencies or hospices.

Medicaid Waiver Option Three: Combination Waivers

States may also use 1915(b) waivers combined with 1915(c) waivers (a "combination waiver") to implement managed long-term care programs that include HCBS waiver services. Combination waivers may include all Medicaid services or just LTC services. The state may choose to limit the HCBS waiver services to a specific number of slots. Therefore, a recipient could be enrolled into the program and be on a waiting list for the HCBS waiver services included in the program.

Table 2: Examples of Combination 1915(b)/(c) Waivers

State	1915(b)/(c)
Texas	STAR+PLUS: Mandated enrollment into MCOs that provide physical health and LTC services, including HCBS waiver services.
Wisconsin	Family Care: Mandated enrollment into MCOs that provide physical health and LTC services, including HCBS waiver services.
Michigan	Michigan Medicaid Managed Specialty Supports and Services Program: Mandated enrollment into MCOs that provide state plan HCBS (such as personal care and home health services), behavioral health services, nursing home services, ICF/MR services and HCBS waiver services.

If the managed care program is voluntary, the state may use the authority under Section 1915(a) combined with Section 1915(c) to implement a program. Florida's Nursing Home Diversion program is an example of this type of combination program. The Nursing Home Diversion Program voluntarily enrolls dual eligibles into MCOs that provide all Medicaid state plan services (although most physical health and some behavioral health services are received through the Medicare program), nursing home and HCBS waiver services.

Appendix 3 provides a table comparing the major features of Medicaid waivers.

Medicaid Waiver Option 4: 1115 Waivers

Section 1115 waivers may be used to waive most Medicaid requirements in order to test new, innovative program designs. Because of the broad authority available under this waiver, states may use them for very different purposes. There are no PPC programs implemented as 1115 waivers at this time. However, hospice care for adults is included under 1115 waivers in some states (Arizona and Tennessee for example).

Examples illustrate typical uses of the 1115 waiver program.

- Consumer-directed care or "cash and counseling" – prior to the state plan option to permit consumers to receive cash payments for the purchase of HCBS and other services, states needed a Section 1115 Research and Demonstration waiver to implement these programs.
- State Medicaid reform – a number of states have made fundamental changes to their Medicaid program, restructuring how services are provided. Examples include Vermont's use of this waiver to make the Medicaid agency the MCO that contracts with CMS, and California's waiver that includes special financing for hospitals and that will soon enroll seniors and persons with disabilities into MCOs.
- Medicaid expansion programs – states use 1115 waivers when they want to cover persons who were previously uninsured and provide them with a different benefit package from the existing Medicaid program. Recent examples include Indiana's Healthy Indiana Plan (HIP) and Wisconsin's Badger Care Plus Program.
- Specialty programs – states also may use these waivers for specialty programs like Family Planning and HIV/AIDS waivers.

There is no template for an 1115 waiver and no timelines within which it must be approved by CMS. These waivers must also be budget neutral, and states are limited to a total amount of federal funding for a five-year period for the waiver. These waivers, when approved, include a long list of special terms and conditions imposed by CMS. States may be reluctant to develop 1115 waivers for small programs because of the amount of the associated workload for the state.

1115 waivers are approved for a five-year period. Technically, they cannot be reauthorized, although CMS continues to renew these waivers for three-year periods. As a result of the ACA and at CMS discretion, waivers that include dual eligibles may be approved and renewed for five-year periods.