



Side-By-Side Comparison of Current HCBS Waivers and HCBS  
Provisions of the Improving Long-Term Care Choices Act

July 29, 2005

**Comparison of Medicaid 1915(c) Home and Community-Based Waiver Provisions (Section 1915(c)) and Proposed Medicaid Home and Community-Based State Plan Option; and Provisions Related to Integrated Acute and Long-Term Care Services (as Contained in Version ERN05454.LC)**

Provision	Current Law	Proposal Contained in Version ERN05454.LC of the bill
<b>Title II — Medicaid Home and Community-Based Services Optional Benefit</b>		
<b>Authority</b>	The Secretary of Health and Human Services (HHS) may approve a state's request to provide, as medical assistance, home and community-based services (HCBS) to persons who, but for the provision of such services, would require the level of care provided in a hospital, nursing home, or intermediate care facility for persons with mental retardation (ICF-MR).	States are allowed to cover HCBS, as an optional benefit under their state Medicaid plans. The state may provide this option to individuals <i>without</i> determining that “but for the provision of such services” the person would require the level of care provided in a hospital, nursing home, or ICF-MR.
<b>Waiver provisions</b>	Under a waiver program, states may request approval from the Secretary to waive Medicaid state plan requirements that services provided be available on a statewide basis, and that they be comparable for all groups covered by the state plan.	No provision. Under the HCBS state plan option, states must make HCBS services available on a statewide basis, and the services must be comparable in scope for all beneficiaries.
<b>Approval Process</b>	Under the HCBS waiver program, states may receive approval to operate the waiver for an initial three-year period before requesting a waiver renewal. Subsequent waiver renewals may be approved for a five-year time period.	Under the HCBS state plan option, states would be required to submit a Medicaid state plan amendment to cover this benefit and to describe the services to be covered. (Note: An approved state plan option is not time-limited. States must request an amendment to the state plan to propose a change in the benefit.)

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<b>Eligible groups</b>	Groups eligible are any individuals who are eligible under a state's Medicaid plan <i>and</i> whom the state chooses to cover under the HCBS waiver option. States may cover individuals who meet the income and resource standards for institutional care (e.g., an individual may have <i>countable</i> income up to 300% of the Supplemental Security Income (SSI) federal benefit rate of \$1,737/month).	Groups eligible include individuals eligible under a state's Medicaid plan. In addition, states have the option of extending the HCBS optional benefit to individuals whose income does not exceed 300% of the SSI federal benefit rate of \$1,737/month.
<b>Allowable services</b>	<p>Services that may be provided include case management, homemaker/home health aide services, personal care, adult day health, habilitation, respite care, and other services requested by the state and approved by the Secretary. States may also provide day treatment or other partial hospitalization services, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness.</p> <p>The Secretary is prohibited from restricting the number of hours or days of respite care under a waiver (subject to budget neutrality provisions).</p>	<p>States are authorized to provide those home and community-based services that are specifically referenced in Section 1915(c)(4)(B) and (d)(5)(C)(I) of Medicaid law. These include case management, homemaker/home health aide services, personal care, adult day health, habilitation, respite care, day treatment, partial hospitalization services, psychosocial rehabilitation services, clinic services for individuals with chronic mental illness, and any services requested by the state and approved by the Secretary. Services also include home health services, private duty nursing, and medical and social services that can contribute to the health and well-being of individuals and their ability to reside in a community-based setting.</p> <p>No provision.</p>

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<b>Level of care; needs-based criteria</b>	<p>Persons eligible for waiver services must require the level of care provided in a hospital, nursing home, or ICF-MR.</p> <p>The state may choose (with the Secretary's approval) the specific criteria to be used to determine whether an individual requires the level of care provided in a hospital, nursing home, or ICF-MR.</p>	<p>Applicants are <i>not</i> required to meet the level of care requirements provided in a hospital, nursing home or ICF-MR.</p> <p>States are required to establish <i>needs-based criteria</i> for determining an individual's eligibility for the HCBS option established by the bill, and the specific HCBS the individual will receive. The State must also establish needs-based criteria for determining whether an individual requires the level of care provided in a hospital, nursing home, ICF-MR, or under a waiver of the state plan, that is more stringent than the needs-based criteria for the HCBS option established by the bill.</p>
		<p>The needs-based criteria must be based on an assessment of an individual's support needs and capabilities, and may take into account the inability of the individual to perform one or more activities of daily living (ADLs) as defined in the Internal Revenue Service (IRS) code (i.e., bathing, dressing, transferring, toileting, eating, and continence), or the need for significant assistance to perform these activities, and other risk factors determined to be appropriate by the state.</p>

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		<p><i>Adjustment Authority.</i> A state is allowed to modify the needs-based criteria in the event that enrollment of individuals for the HCBS option exceeds projected enrollment. The state is not required to seek prior approval of the Secretary if the state wishes to modify the needs-based criteria, but must give the Secretary and the public at least 60 days notice of the proposed modification.</p> <p>If a state modifies the needs-based criteria, existing recipients of the HCBS optional state plan services will continue to be eligible to receive those services based on the most recent version of the criteria in effect prior to the modification, as long as they continue to meet the criteria in effect prior to the modification.</p>
<b>Assessment of an individual's needs; protection against conflict of interest</b>	States are required to evaluate the needs of persons who are entitled to medical assistance and who may be eligible for HCBS waiver services, to determine their need for inpatient hospital care, nursing facility care, or care in an ICF-MR.	The state is required to use an independent evaluation for determining an individual's eligibility for HCBS under the state's needs-based criteria and to establish an individualized care plan.
	No requirement for an independent evaluation.	The state must establish standards for the conduct of the independent evaluation to prevent conflicts of interest.

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	<p>No provision in law; however, federal regulation on the HCBS waiver outlines the general steps states must take in evaluating an individual's needs.</p>	<p>The independent evaluation is to include an assessment of the needs of the individual to: (1) determine whether he/she satisfies the criteria for receipt of one or more HCBS; (2) determine a necessary level of services and supports consistent with the individual's physical and mental capacity; and (3) prevent unnecessary or inappropriate care.</p> <p>The assessment must include: (1) an objective evaluation of an individual's ability to engage in major life activities, such as walking, seeing, hearing, breathing, speaking, working, performing manual tasks, learning, thinking, concentrating, interacting with others, and sleeping, and any other appropriate activities; (2) a face-to-face evaluation of the individual by a skilled professional designated by the state and trained in the assessment and evaluation of individuals whose physical or mental conditions trigger a potential need for HCBS; (3) where appropriate, consultation with the individual's family, spouse, guardian, or other responsible individual; (4) consultation with all treating and consulting health and support professionals caring for the individual; (5) an examination of the individual's relevant history and medical records, and care and support needs guided by best practices and research on effective strategies that result in improved health and quality of life outcomes. The assessment must also evaluate the ability of the individual to self-direct the purchase and control of HCBS if he/she elects this option.</p>

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<b>Written individualized plan of care</b>	HCBS waiver services that are approved by the Secretary must be provided according to a written plan of care.	The independent evaluation is to establish a written individualized plan of care. The plan must: (1) be developed in consultation with the individual's treating physician, health care or support professionals, or other appropriate individuals, and the family, caregiver or individual representative if appropriate; (2) take into account the extent, and the need for, any family or other supports for the individual; (3) identify HCBS to be provided (or if the individual elects to self-direct his/her care); (4) meet federal and state guidelines for quality assurance; and (5) be reviewed periodically or as needed when there is a significant change in circumstances.
<b>Option for self-directed services</b>	No legislative provision (although CMS administrative authority allows self-directed services to be carried out under state HCBS waiver programs).	States must allow individuals to elect to self-direct the purchase and control of state plan HCBS. States are required to provide support and oversight in an individual's purchase and receipt of self-directed HCBS to ensure that services are consistent with the individual's independent evaluation and the appropriateness and quality of services.
<b>Definition of individual's representative</b>	No provision.	An individual's representative is defined as a parent, a family member, guardian, advocate, or any other individual who is authorized to represent the individual.
<b>Client choice</b>	Individuals who are determined to need inpatient hospital, nursing facility, or ICF-MR care are to be informed of feasible alternatives to institutional care that may be available under the HCBS waiver.	No provision.

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<b>Provision of room and board</b>	HCBS do not include room and board for a recipient of services. However, room and board expenses of an unrelated personal caregiver residing in the same household with the recipient is an allowable service, if, without the caregiver's assistance, the recipient would require admission to a hospital, nursing facility, or ICF-MR.	No provision.
<b>Limit on persons to be served</b>	Under a HCBS waiver, a state may limit the number of individuals to receive benefits to those for whom there is a reasonable expectation that HCBS will not exceed the amount of medical assistance to such individuals in the absence of a waiver.	No provision.
	When a state limits the number of persons to be served under the waiver, it may add persons to a waiver when individuals die or become ineligible.	No provision.
<b>Budget neutrality</b>	Under a HCBS waiver, the average per capita expenditure for medical assistance for HCBS recipients may not exceed the average per capita expenditures that the state would have spent absent the waivers.	No provision.

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<b>Quality of care requirements</b>	<p>States must provide assurances and documentation to the Secretary that necessary safeguards (including adequate standards for provider participation) have been taken to protect the health and welfare of waiver recipients.</p> <p>CMS under its administrative authority has developed several tools for states operating home and community-based waivers including for example, a participant experience survey for waiver enrollees.</p>	<p>A state must ensure that an individual's plan of care meets federal and state guidelines for quality assurance.</p> <p>The bill requires the Secretary acting through the Director of the Agency for Healthcare Research and Quality, to consult with consumers and health and social service providers and other professionals knowledgeable about long-term care services and supports to develop program performance indicators, client function indicators, and measures of client satisfaction regarding HCBS. The indicators would be applied to HCBS offered under Sections 1115 and 1915, and under the HCBS option created by the bill.</p> <p>The Secretary is required to use the indicators and measures to assess HCBS and outcomes, particularly with respect to a recipient's health and welfare, and the overall system for HCBS under Medicaid. The Secretary is also required to make best practices and comparative analyses of system features available to the public.</p>
<b>Financial accountability</b>	The state is required to assure that necessary safeguards have been taken to assure financial accountability for waiver funds.	States choosing to implement the HCBS option would be subject to the general financial requirements of the Medicaid state plan including documentation of actual expenditures and periodic reviews.

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<b>Presumptive eligibility</b>	No provision.	States may elect to provide for a period of presumptive eligibility during the independent evaluation to determine the individual's eligibility and the HCBS he/she will receive.
<b>Definition of habilitation</b>	Habilitation is defined as services to assist individuals in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to reside successfully in HCBS settings, and includes prevocational, educational, and supported employment services. Excludes special education and related services as defined in the Education of the Handicapped Act that are available through a local educational agency. Excludes vocational rehabilitation services available through Section 110 of the Rehabilitation Act of 1973.	No specific provision in the bill defining "habilitation." (Note: the reference to the services in the bill could be interpreted to include the definition used in current law.)
<b>Reporting</b>	The statute requires the state to report to the Secretary information on the impact of the waiver on the amount of medical assistance and on the health and welfare of recipients.	Under general Medicaid rules, states must submit a copy of all HCBS claims to CMS through the Medicaid Statistical Information System (MSIS). (Note: states may not be required to report the specific sub-services (e.g., respite) under the HCBS option.)
<b>Redetermination and appeals</b>	No statutory provision; however, federal regulations require states to periodically reevaluate (no less than annually) the individual's level of need for the waiver.	States must allow for redeterminations and appeals of an individual's eligibility for HCBS and the services he/she will receive, and whether he/she requires the level of care in hospital care, nursing facility care, or care in an ICF-MR, or under a waiver of the state plan.

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<b>Estimates of expenditures for HCBS waivers</b>	The law contains a number of provisions regarding calculation of waiver expenditure estimates.	Under general Medicaid rules, states are required to submit an estimate of projected expenditures by type of service on Form 37. (Note: If HCBS were added as a state plan benefit, the form may be revised to include projected expenditures.)

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<b>Cooperative arrangements regarding children with special health needs</b>	The state Medicaid agency may enter into cooperative arrangements with the state agency administering programs for children under Title V of the Social Security Act whenever appropriate.	No provision.

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<b>Title III — Integrated Acute and Long-Term Care Services for Dually Eligible Individuals</b>		
<p><b>Regulations to remove barriers to integrated acute and long-term care services for dually eligible individuals (those eligible for both Medicare and Medicaid)</b></p>	<p>No provision.</p>	<p>The Secretary of HHS is required to issue regulations removing administrative barriers under Medicare and Medicaid that impede delivery of integrated acute and long-term care services for dual eligibles. The Secretary is to consult with state Medicaid programs, health care insurers, managed care entities, Medicare Advantage plans, PACE providers, and representatives of dual eligibles. Services are defined to include acute, HCBS, nursing facility, mental health services, and prescription drugs under part D of Medicare (if the individual is eligible for such services).</p> <p>The regulations must address conflicting requirements for Medicaid managed care entities, Medicare Advantage Plans including those for special needs individuals, and PACE providers. Issues to be addressed are identification cards, marketing requirements, timelines for submission of documentation, and other issues identified by the Secretary.</p> <p>Regulations must be issued by January 1, 2007.</p> <p>The Secretary is required to submit recommendations regarding removal of legislative barriers to integrated services to Congress. The Medicare Payment Advisory Commission (MedPAC) is required to submit to Congress comments on the recommendations made by the Secretary by February 1, 2007.</p>