Federal Medicaid Authorities for Restructuring Medicaid Health Care Delivery or Payment
3-25-16

Demonstration Waiver

AUTHORITY	DESCRIPTION	KEY FLEXIBILITIES AND/OR LIMITATIONS	CSSB74(FIN)am
Section 1115 Demonstration Program Waivers	Broad waiver authority at the discretion of the Secretary to approve projects that test policy innovations likely to further the objectives of the Medicaid program. Permits states to provide the demonstration population(s) with different health benefits, or have different service limitations than are specified in the state plan. Granted for up to 5 years, and then must be renewed.	• Must further the objectives of the Medicaid program. • Requires some eligibility or benefit expansion, quality improvement, or delivery system restructuring to improve program. • Must have a demonstration hypothesis that will be evaluated with data resulting from the demonstration. • Provides most flexibility of all Medicaid authorities to waive Medicaid requirements. • Comparability of services, freedom of choice, and statewideness are not required. • Must be budget neutral for the federal government. • Managed care enrollment may be voluntary or mandatory.	Section 30 Pg. 29-30 AS 47.07.036(e) & (f)

Health Homes Option

AUTHORITY	DESCRIPTION	KEY FLEXIBILITIES AND/OR LIMITATIONS	CSSB74(FIN)am
Section 1945 Health Home State Plan Option	Provides states with the option to offer enhanced integration and coordination of primary, acute, behavioral health, and long-term services and supports for individuals with chronic illness by adding specific services to the state plan. To be eligible, individuals must have: (1) at least two chronic conditions; (2) one chronic condition and be at risk of another; or (3) a serious and persistent mental health condition. Health home services must include:	• State can select the chronic conditions to be addressed. • Comparability requirements apply; must be available to any categorically eligible individual with the selected conditions. • Must be voluntary and allow choice of provider. • Medicare-Medicaid enrollees must be included. • Comparability of services and statewideness are not required. • Permits a tiered-payment methodology based on the severity of an individual's condition or the capabilities of the designated provider.	Section 30 Pg. 29- AS 47.07.036(d)(3)

	(1) Comprehensive care management; (2) Care coordination and health promotion; (3) Comprehensive transitional care; (4) Individual and family support; (5) Referral to community and social support services; and (6) Use of health information technology.	• Allows alternative payment models. • Requires public notice in line with standard state plan amendment requirements. • Provides a 90% FMAP for the first eight fiscal quarters the state plan amendment is in effect. • Support for planning activities is available. • Health home providers must submit quality measures to the state. • States implementing health homes must take part in an impact assessment (survey and independent evaluation).	

Home & Community-Based Services Waivers & Options

AUTHORITY	DESCRIPTION	KEY FLEXIBILITIES AND/OR LIMITATIONS	CSSB74(FIN)AM
Section 1915(c) "Home and Community-Based Services (HCBS)" Waivers	Renewable waiver authority that allows states to provide long-term care services delivered in community settings as an alternative to institutional settings. The state must select the specific target population and/or sub-population the waiver will serve. 1915(c) waivers are renewable for 5 years after the initial, 3-year approval (or, if applicable, initial 5-year approval).	• Freedom of choice is required absent a concurrent Medicaid authority that permits the state to waive this requirement. • Can implement in limited geographic areas. • Comparability of services with non-waiver enrollees is not required; however, services must be comparable within the waiver population. • Must demonstrate cost neutrality. • Must specify the maximum number of participants for each waiver year, and criteria for selection of entrants. • May include individuals with income up to 300% of the Federal SSI benefit rate.	*Current Medicaid program. Not in CSSB74(FIN)AM.* *Current AK 1915(c) Waivers:* • *Alaskans Living Independently* • *Adults w/Physical and Developmental Disabilities* • *Children w/Complex Medical Conditions* • *People w/Intellectual and Developmental Disabilities*
Section 1915(i) "Home and Community-Based Services"	States can amend their state plans to offer HCBS as a state plan optional benefit statewide. If states choose the option to target the benefit to specific populations, CMS approval would be for a 5-year period and such	• Participants do not have to meet an institutional level of care. • Income eligibility at or below 150% of FPL, but states can opt to also provide HCBS to individuals with incomes up to 300% of the Federal SSI benefit rate if	Section 30 Pg. 29- AS 47.07.036(d)(1)

State Plan Option	states will be able to request CMS renewal for an additional 5-year period if federal and state requirements are met.	eligible for HCBS under 1915(c) or 1115 demonstration. • Must specify needs-based eligibility criteria. • Comparability of services is not required. • No cost neutrality requirement. • No waiting lists or limits on the number of participants. • Cannot waive statewideness.	
Section 1915(k) Community First Choice	Allows states to provide home-and community-based attendant services and supports for beneficiaries on a statewide basis. States must cover assistance and maintenance with activities of daily living, instrumental activities of daily living, and health-related tasks; ensure continuity of services and supports; and provide voluntary training on how to select, manage and dismiss staff. Services can be provided through an agency or a self-directed model. This does not create a new eligibility group; eligible individuals are those who are eligible for Medicaid under the state plan, have incomes up to 150% FPL or over 150% FPL and meet institutional level of care standards.	• States provided a 6 percentage point increase in Federal matching payments for service expenditures under this option. • States have the option to cover transition costs, expenditures related to participant's independence and services, or supports linked to an assessed need or goal. • Financial management services must be available when provided through a self-directed model. • Cannot waive statewideness.	Section 30 Pg. 29- AS 47.07.036(d)(2)

Managed Care Authority, Waivers & Options *not addressed in CSSB 74 (FIN) am*

AUTHORITY	DESCRIPTION	KEY FLEXIBILITIES AND/OR LIMITATIONS
Section 1915(a) Exception to State Plan Requirements for Voluntary Managed Care	Used to authorize voluntary managed care programs on a statewide basis or in limited geographic areas implemented through CMS Regional Office approval of the managed care contract. The state has the ability to use passive enrollment with an opt-out within this authority.	• No waiver or state plan amendment required. • No mandatory enrollment or selective contracting allowed.

Section 1932(a) State Plan Amendment Authority	State plan authority for mandatory and voluntary managed care programs on a statewide basis or in limited geographic areas. States may choose to include dual eligibles as part of a broader managed care program authorized under Section 1932(a).	• Permanent state plan authority. • No cost-effectiveness or budget-neutrality requirement. • Allows selective contracting. • No mandatory enrollment of dual eligibles for Medicaid services; however, dual eligibles may voluntarily enroll. • Comparability of services, freedom of choice and statewideness are not required.
Section 1915(b) Waivers	Two-year (or five-year, if serving dual eligibles) renewable waiver authority for mandatory enrollment in managed care on a statewide basis or in limited geographic areas. 1915(b) waivers must not substantially impair beneficiary access to medically-necessary services of adequate quality.	• Allows for mandatory managed care or PCCM enrollment for dual eligibles for Medicaid services through 1915(b)(1) authority. • Locality may act as a central enrollment broker through 1915(b)(2) authority. • May provide additional, health-related services through 1915(b)(3). • Allows for selective contracting under 1915(b)(4) authority. • Can identify excluded populations. • Comparability of services, freedom of choice and statewideness are not required. • Must be determined to be cost-effective and efficient. Waiver requirements are more administratively burdensome than 1915(a) or 1932(a).
Concurrent 1915(a)/(c) Authority	Used to implement a voluntary managed care program that includes HCBS in the managed care contract. The state may use passive enrollment with an opt-out within this authority.	• No mandatory enrollment allowed. • Cannot selectively contract with managed care providers.
Concurrent 1915(b)/(c) Waivers	Used to implement a mandatory or voluntary managed care program that includes waiver HCBS in the managed care contract. The 1915(c) waiver allows a state to target eligibility and provide HCBS services. The 1915(b) then allows a state to mandate enrollment in managed care plans that provide these HCBS services, and to exercise other 1915(b) options, such as selective contracting with providers. States must apply for each waiver authority concurrently and comply with the individual requirements of each.	• Allows for selective contracting with providers. • Requires administration of two separate concurrent waivers with separate reporting requirements.