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Fact Sheet

Community Living Exchange

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Comparision of Waiver Options

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The Community Living Exchange at Rutgers/NASHP provides technical assistance to the Real Choice Systems Change grantees funded by the Centers for Medicare & Medicaid Services.

We collaborate with multiple technical assistance partners, including ILRU, Muskie School of Public Service, National Disability Institute, Auerbach Consulting Inc., and many others around the nation.

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Technical Assistance Exchange conference call Conducted by: Robert Mollica Rutgers Center for State Health Policy/National Academy for State Health Policy	
Purpose	To discuss options for combining Medicaid long term care funding and expanding the scope of long term care services. The call was organized in response to a need identify by a grantee and included states that were available and had relevant experience with the questions being raised.
Date	April 19, 2002
Background	Under a Real Choice Grant, one state is interested in combining Medicaid long term care funding. Among the state's goals are to: Eliminate the Medicaid nursing home bias Expand financial eligibility Cover beneficiaries who do not meet the nursing home level of care criteria Pay spouses for caring for family members.
Options	The primary option under consideration is a §1115 waiver. Other options include concurrent §1915 (b) and (c) waivers in a prepaid health plan and a §1915 (a) state plan amendment with a §1915 (c) waiver.
1915 (a) state plan amendment	§1915 (a) allows states "to enter into a contract with an organization which has agreed to provide care and services in addition to those offered under the State plan to individuals eligible for medical assistance who reside in the geographic area served by such organization and who elect to obtain such care and services from such organization, or by reason of the fact that the plan provides for payment for rural health clinic services only if those services are provided by a rural health clinic." This section also allows restriction to network providers. The contract and capitation can cover services provided by the organization. Services that are not provided by the organization must be available fee for service or through another MCO. This section allows you to provide all the services available under a 1915 (c) waiver through the capitation. However, the §1915 (c) waiver has been used to cover people under 300% of SSI. This option cannot be used to require enrollment of beneficiaries.
Prepaid health plan	Prepaid health plans receive capitation for at least two of the following Medicaid services: outpatient, rural health services, FQHCs, lab and x-ray, nursing facility, EPDST, family planning, physician services and home health services. Dual eligibles can be required to enroll under a §1915 (b) waiver for Medicaid services only. Community based, non-MCO or hospital organizations can qualify.
Discussion	New Mexico has developed a concept paper for a §1115 waiver that would cap spending for nursing facility and home and community based waiver services. Personal care services under the state plan would not be capped. A concept paper was prepared and submitted to CMS for comment. The state suggests starting a discussion with the CMS regional office about the goals of the program and options/requirements from the CMS perspective. Wisconsin has two programs that combine Medicaid funding. The Wisconsin Partnership Program uses §1115 and §222 waivers to combine all Medicaid and Medicare services. The Family Care Pilot uses prepaid health plan authority, §1915 (b) and (c) to capitate long term care services (nursing facility, home health, mental health, therapies, durable medical equipment, disposable supplies, home and community based services, and services in residential settings). Family Care funds two organizations: Resource Centers and Care Management Organizations, one to provide information and assistance and the other to authorize and coordinate

	services. Wisconsin is considering converting the WI Partnership Program's §1115 waiver to a concurrent §1915 (a), (c) program. Utah added a §1915 (c) waiver to its §1915 (a) state plan amendment managed care program. The program serves current nursing home residents or beneficiaries that hospital discharge planners determine will have to enter a nursing home. The program provides a capitation payment to an MCO for acute and long term care services. The flexibility of the capitation allows the MCO to pay for non-traditional items such as room and board in an assisted living facility.
Diverting admissions	States are using centralized intake or comprehensive entry points to control placements from hospitals in nursing homes. States may use Medicare nursing home stays as a transition period to initiate community services or allow access to a limited amount of HCBS to establish a service plan immediately upon discharge. Coordination with the discharge planner and a service provider are needed to facilitate access on discharge. The functional and financial eligibility process can also impede placement in the community. Presumptive eligibility (at state cost for denials) is another option to facilitate diversion.
Access	Care management organizations in Wisconsin are responsible for recruiting an adequate network of providers. It's been easier in the more urban demonstration counties than it might be when the program expands to rural areas.
Questions	Need to explore and clarify the difference between a prepaid health plan and a §1915(a) contractor to see which avenue more closely fits the goals of the project. There are many similarities among §1915 (a), §1915 (b) and the prepaid health plan options that must be compared to the goals of the program and the §1115 requirements. Need to examine impact of BBA regulations that become final in October, 2002. Need to determine the number of people who would not qualify under the 300% and spend down options to weight merits of §1115. Are Miller Trusts being used?

Options		
Authority	**Advantages**	**Barriers**
§1915 (a) state plan amendment with §1915 (c)	Allows use of capitation to create flexible benefit package. The extent of the services covered are determined by the capacity of the contracting organization. Depending on state rules, licensure as an HMO may not be required for organizations that serve only Medicaid beneficiaries. Easier approval process compared to the §1115 waiver process. §1915 (c) waiver covers 300% group. Program waivers can be renewed at the State's discretion.	Would cover all Medicaid state plan service which is beyond the scope of the proposal. Absence of existing organizations that receive and manage a capitation payment. Possible organizations could be certified home health agencies, area agencies on aging, or a new entity formed through a collaboration of the two. Cannot require mandatory enrollment under §1915 (a) amendments. Financial eligibility could not be expanded beyond 300% of SSI.
§1915 (b) (c) in a PHP	Simpler approval process. Allows flexible use of capitation for two or fewer state plan services eg., nursing facility, home health. Can limit capitation to long term care state plan and home and community based waiver services. Allows mandatory enrollment for dual eligibles for Medicaid covered services only. Allows services to non-nursing home eligible.	Absence of existing organizations that receive and manage a capitation payment. Possible organizations could be certified home health agencies, area agencies on aging, or a new entity formed through a collaboration of the two. Financial eligibility could not be expanded.
§1115 waiver	Contains the flexibility to address each of the state's goals. Serves non-nursing home eligible. Allows expansion of the income standard to people likely to spend down in an institution. Allows mandatory enrollment of dual eligibles for Medicaid services only.	Medical inflation rate has been higher than the used in the neutrality formula making it harder to stay within cost projections. Budget neutrality requirement may be difficult to meet as applied by the Office of Management and Budget Requires factoring in the costs of all eligible beneficiaries rather than just the beneficiaries that enroll in the program. Program is time-limited.