



INFORMATION BRIEF

Opportunities and Challenges Presented by Utilizing a Combined 1915 (b)/(c) Waiver

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The major source of public funding for long-term services and supports provided in home and community settings is the Medicaid program. Under this program states have established a range of supports for people with developmental disabilities. A popular means for doing so involves use of a 1915(c) Home and Community-based Services (HCBS) waiver. Specifically, this waiver refers to §1915 (part c) of the Social Security Act. When approved by the Center for Medicare and Medicaid Services, this type of waiver typically allows states to avoid certain requirements of the Social Security Act to target a particular group (e.g., people with developmental disabilities) and/or people living in particular parts of the state. Other types of waivers are possible. The Center for Medicare and Medicaid Services (CMS) explains that a 1915(b) waiver, for example, permits States to make mandatory the enrollment of beneficiaries in Medicaid managed care plans, use local entities to manage services, deliver additional services generated through savings and restrict providers using selective contracting. If the State uses section 1915(b) to deliver services using a managed care delivery system, a managed care contract is required and the State must submit the contract to the appropriate CMS Regional Office for approval.

Recently states have sought to utilize these two authorities together within a combination 1915(b)/(c) waiver.

States may opt to simultaneously utilize section 1915(b) and 1915(c) program authorities to provide a continuum of services to disabled and/or elderly populations. When both authorities are used, the State uses the 1915(b) authority to mandate enrollment in a Medicaid managed care plan and limit freedom of choice and/or selectively contract with providers, and uses the 1915(c) authority to target eligibility for the program and provide home and community-based services. By using both authorities, States can provide long-term services and supports in a managed care environment. Additionally, they could use section 1915(b) authority to use a limited pool of providers.

In addition to providing traditional long-term services and supports available through the State plan (e.g. home health, personal care, and rehabilitative services,) States may include non-State plan home and community-based services (e.g. homemaker services, adult day health services, and respite care) in their managed care programs' capitation rate for individuals eligible for the 1915(c) waivers. States may also include HCBS in their section 1915(b) waivers as Section 1915(b)(3) services.

States can implement 1915(b) and 1915(c) concurrent waivers as long as all Federal requirements for both programs are met. Therefore, when submitting application for

concurrent 1915(b)/(c) programs, states must submit a separate application for each waiver type and satisfy all of the applicable requirements. For example, states must demonstrate cost neutrality in the 1915(c) waiver and cost effectiveness in the 1915(b) waiver.

Meeting these separate requirements can be a potential barrier for States that want to provide home and community based services through a managed care delivery system. However, the ability to develop an innovative, mandatory managed care program that integrates home and community-based services with traditional State plan services is appealing enough to some States to outweigh the potential challenges.

(CMS Regional and Central Office Workgroup on managed HCBS (2009). Providing Long Term Services and Support in a Managed Care Delivery System. Bethesda MD: Centers for Medicare and Medicaid Services.)

Current State Initiatives

There are few examples where states have initiated combination 1915 (b)/(c) waivers:

- In Texas: The STAR+PLUS program, approved in January 1998, was the first concurrent 1915(b)/(c) program to be implemented. This mandatory program serves people with disabilities and elderly beneficiaries in Harris County (Houston). The program integrates acute and long-term care services through a managed care delivery system.

Regarding people with developmental disabilities, there are currently just three examples.

- In Michigan: The Medicaid Prepaid Specialty Services and Supports for Persons with Developmental Disabilities program was approved in June 1998. This program "carves out" specialty mental health, substance abuse, and developmental disabilities services and supports and provides these services under a prepaid shared risk arrangement. The purpose of this program is to provide beneficiaries an opportunity to experience "person-centered" assessment and planning approaches that provide a wider, more flexible, and mutually negotiated set of supports and services. It enables individuals to exercise and experience greater choice and control.
- In Wisconsin: Family Care, authorized by the Governor and Legislature in 1998, serves people with physical disabilities, people with developmental disabilities and frail elders. There are two components: (a) Aging and Disability Resource Centers (ADRCs), designed to be a single entry point where older people and people with disabilities and their families can get information and advice, and (b) Managed Care Organizations (MCOs), which manage and deliver the Family Care benefit, which combines funding and services from a variety of existing programs into one flexible long-term care benefit. To implement Family Care, CMS required that the state establish an alternative to the program. As a result, IRIS (Include, Respect, I Self-Direct) was unveiled in the summer of 2008 as an alternative that features self-direction.
- In North Carolina: The three year old Piedmont Behavioral Health (PBH) Innovations waiver addresses the needs of individuals with developmental disabilities in the five counties of Cabarrus, Davidson, Rowan, Stanley and Union. PBH manages the program. This local entity has designed resource allocation levels for adults and children informed by use of the

Supports Intensity Scale to improve the match between waiver dollars and individual support needs. PHB also manages a local provider network to deliver services to waiver participants.

Tools Used in Combined 1915 (b)/(c) Waivers

A variety of managed care tools are used in combined 1915 (b)/(c) waivers but these techniques can be confusing and increase complexity. Many of these tools, however, are not new to developmental disabilities. Many are already being used around the country, with varying success. What is new is that the combined 1915 (b)/(c) waivers integrate all of these pieces, packaging them into a coherent plan to contain costs while seeking to enhance quality or expanding the population of people with developmental disabilities served. The first group of five tools shown below clearly falls to the payer (the state agency) to define – these are system management issues. The second grouping of five is more relevant to service management.

System Management Issues	Service Management Issues
Eligible population	Network management
Capitation	Care Coordination
Risk management	Utilization review
Care criteria	Service substitution
Flow of money	Quality assurance

- **System Management Issues.** The bottom line in managed care is cost containment, whether that takes the form of holding to current expenditure levels and continuing to serve the current population in a higher quality way, or holding funding and quality constant while expanding the population served. Five elements have the greatest effect on the total amount of money that is spent in combined (b)/(c) waivers; who gets the services (eligible population), how much is paid per person (capitation), who covers cost overruns (risk), what services are provided (care criteria), and who controls the flow of the funds. If the payer is to contain costs, it must have decision making power over how these five components are structured.
- **Service Management Issues.** If the managed care intermediary, specifically a Managed Care Organization (MCO), Management Services Organization (MSO) or Local Management Entity (LME), is willing to shoulder much of the risk that comes in guaranteeing to provide all needed services for a fixed price, it will want to provide all needed services for a fixed price, it will want substantial flexibility and control over how it operates the service delivery network. The key arenas in which intermediaries can exert control are network management, utilization review, care coordination, service substitution, and quality assurance. These are the second group of five tools of managed care used in combined 1915 (b)/(c) waivers.

Opportunities Associated with Combined 1915 (b)/(c) Waivers

Developmental disability services have evolved into a complex and expensive system, one that is not uniformly effective in assisting people to become self-directed participants in ordinary community life. The primary opportunity associated with combined 1915 (b)/(c) waivers concerns increased capabilities for managing the service system. These new capabilities are

shared between the funder (i.e., state agency) and a local managing organization that is chosen by the state. Within this context, three related opportunities include:

- Using resources more efficiently. A key policy goal associated with combination HCBS 1915(b)/(c) waivers is cost containment. This goal may be achieved, for example, by altering the price paid for services, inserting economic incentives for providers to hold down their costs, influencing service utilization patterns in terms of both choice of providers and the amount of services used, and by better coordinating the services needed, both within the developmental disabilities system and across other human services systems. More specifically:
 - Categorical funding streams may be merged to become a single, flexible funding source.
 - A provider network may be established and services offered primarily from those in the network.
 - Providers may be given incentives to be innovative in supporting people.
 - Providers can be encouraged to form networks.
 - System payments can be made on a per capita basis, rather than a fee-for-service basis.
 - Utilization and quality can be controlled directly.
- Improving service quality. When establishing a managed care system specific policy goals may be tied to desired outcomes for individuals. For instance, the state funder may require that the managing entity emphasize employment among service recipients, seeking an increase in the percent enjoying integrated employment. Or they may emphasize community residences housing fewer than four people or an increase in the number of people owning their own home. In essence, performance goals may be set to assure the health and well being of individuals, while nudging the system strongly toward more progressive practices. Necessarily, service providers will need to adjust to these expectations – at the price the managing entity is willing to pay – or risk being removed from the approved provider network.
- Promoting self-directed approaches. In Michigan and Wisconsin specific attention is being given to approaches that encourage self-direction. That is, participants are encouraged to take a strong leadership role in developing a plan of support, choosing providers and managing their supports. In particular, in Wisconsin the “Self-Directed Option” rests within the mainstay Family Care managed care program. In this instance, managed care entities are seeking to embed emerging best practice into their management protocols.

Mainly, the (b)/(c) waiver system should allow a capitation rate and management practices that contain costs, but also offer service recipients opportunity to design a plan of support so that they can get the services they need.

Challenges Associated with Combined 1915 (b)/(c) Waivers

Just as there are opportunities associated with combined 1915 (b)/(c) waivers, there are challenges. In essence, a primary policy maker – the state agency – is ceding significant authority to an organization that is asked to manage a system for a set amount of money (i.e., a

capitated amount). In turn, this organization will indeed make decisions to contain costs (and so make a profit) and deliver services to some standard. As a result, tensions will inevitably arise due to a variety of concerns:

- Key to success is an organized and well conceived approach coupled with ample capacity within collaborating state agencies to: (a) set direction for the effort, and (b) oversee, monitor and manage the local managed care organization(s). There can be no confusion at the state level regarding what state authority is leading the effort. Policy goals and expectations must be well defined. And, the state must have the capacity to track events locally (e.g., number served, expenditures, service use) and press local managing organizations to achieve performance expectations.

Likewise, local managed care organizations must have the expertise and organizational acumen to succeed. This includes skills sets among staff pertaining to administering managed care systems, as well as related infrastructure (e.g., information management).

- The developmental disabilities field has no agreed upon standards of practice or care criteria. As a result, some will be critical of whatever decisions are made by the managed care organization as it establishes its provider network, sets service reimbursement rates, approves individual plans of support, restricts or channels service use or assesses quality.
- State developmental disabilities service agencies lack a reliable data base on service usage to have as a basis for capitation. Key to the initiative is the capitation rate that the managing entity is granted. This is the flat amount the organization has to serve the individuals it agrees to accommodate.
- All long-term services and supports are not clinical in nature. In fact, emerging best practice encourages use of informal or unpaid supports that integrate individuals more effectively into their communities. Managed care companies, dedicated to utilizing approved service providers, may have difficulty integrating informal supports into an “approved service array.”
- Establishing an approved provider network may upset some providers who are left out of the network. It may disturb service recipients, as well, who may feel their choices are overly restricted and pushed to accept services and providers that they do not want.
- The provider network established by the managed care organization may not be able to support those with severe or unique needs, or those who live in rural areas.
- The design of self-directed approaches may be difficult for managed care companies to embrace and implement. After all, these approaches accord individual service recipients significant authority over their plans of support and the providers they employ.

Summary

There are no guaranteed benefits or failings associated with combined HCBS 1915(b)/(c) waivers. The angels and devils are in the details. The state and service recipients may realize several benefits associated with improved system efficiency and performance to yield enhanced quality of life for participants. Yet, lacking ample and capable management, a managed care system may inevitably fail to match the expectations policy makers set for it.