A Quick Guide to Medicaid Waivers and State Plan Amendments

Medicaid is public health insurance. It pays for medically-necessary healthcare services. States provide Medicaid through a contract with the Centers for Medicare and Medicaid Services (CMS) called a Medicaid State Plan. There are specific federal guidelines that every state plan must include; however states may apply to CMS to create new benefits and serve specific populations under specific authorities called waivers and plan amendments.

Many states are seeking waivers and/or plan amendments in order to pay for pre-tenancy and tenancy-sustaining services in supportive housing. This Quick Guide provides an overview of the Medicaid authorities most suitable for creating Medicaid Supportive Housing Services Benefits.

Note: CSH tracks the progress of states that are pursuing and implementing Supportive Housing Services Benefits. Check out the federal and state policy section of csh.org/health for the latest updates.

1115 Research and Demonstration Waiver- 1115 waivers offer the flexibility to pilot and evaluate new Medicaid program components that are not covered under traditional Medicaid requirements under the condition of budget neutrality.

Opportunities:

- High level of flexibility
- States can target specific populations
- Opportunity to innovate in different program design areas
- Ability to pay for certain critical tenancy supports that people access and remain in housing

Limitations:

- Extensive flexibility requires greater decision
- Must evaluate the success of the waiver, demonstrate outcomes and re-apply for a waiver to maintain program

1915 (c) Home and Community Based Services Waivers- 1915(c) waivers allow for states to provide services to beneficiaries in their homes and communities instead of in an institutional setting. Unlike other Medicaid waivers, this waiver has a designated cap and can be used to target specific populations.

***Opportunities*:**

- Creates services packages for people who are institutionalized or at risk or institutionalization such
  - Example: Extremely high-cost, frequent hospital users
- Potential to include services that are not typically Medicaid reimbursable
  - Example: Pre-tenancy outreach and engagement, tenancy supports
- States concerned with increased cost can limit implementation to specific geographic areas and/or establish a cap on the number of eligible beneficiaries

***Limitations*:**

- Supportive housing services are limited to people in institutions and those who, without the services of this waiver, would require the level of care provided in a hospital, nursing facility, or intermediate care facility.
- Can limit the amount of people experiencing homelessness that receive services because most people experiencing homelessness do not require this level of care.
- Must be cost neutral[1]

1915(i) HCBS State Plan Optional Benefit- Through the 1915(i), states can provide Home and Community Based Services (HCBS) for individuals who meet a set of criteria outlined by the state based on need. This waiver is similar to the 1915(c) waiver as it focuses on HCBS for people who would otherwise receive services in an institutional setting; however, the 1915(i) requires the state serve all eligible individuals and cannot cap enrollment but can restrict enrollment criteria if the number of individual expected to receive services exceeds the state's projections[2].

Opportunities:

- Requires state to serve people with disbilities as defined by the state
- Broad population target
- Connects individuals to community-based housing and services
- No cost-neutrality requirements

Limitations:

- Requires a established criteria for eligibility based on medical necessity/ risk
- Criteria does not include descriptive characteristics of the person, diagnosis, or general population characteristics (homelessness)
- Eligibility criteria relates to behavior, cognitive abilities, medical risk factors, and functional level
- Must be cost neutral

[1] Cost Neutrality- per participant expenditures for the waiver and non-waiver services are no more than the average per-person cost of providing institutional care (and other plan services) to persons who require the same level of care.

[2] http://kff.org/report-section/streamlining-medicaid-home-and-community-based-services-key-policy-questions-issue-brief/