Home and Community-Based Services 1915(c) Waivers

1. Medicaid home and community-based service (HCBS) waivers afford States the flexibility to develop and implement creative alternatives to placing Medicaid-eligible individuals in hospitals, nursing facilities or intermediate care facilities for persons with mental retardation. The HCBS waiver program recognizes that many individuals at risk of being placed in these facilities can be cared for in their homes and communities, preserving their independence and ties to family and friends at a cost no higher than that of institutional care.

2. Under section 1915 (c) of the Social Security Act (the Act), States may request waivers of certain Federal requirements in order to develop of Medicaid-financed community-based treatment alternatives. The three requirements that may be waived are in section 1902 of the Act and deal with statewideness, comparability of services and community income and resource rules for the medically needy.

3. The Act specifically lists seven services which may be provided in HCBS waiver programs: case management, homemaker/home health aide services, personal care services, adult day health, habilitation, and respite care. Other services, requested by the State because they are needed by waiver participants to avoid being placed in a medical facility (such as non-medical transportation, in-home support services, special communication services, minor home modifications, and adult day care) may also be provided, subject to HCFA approval. The law further permits 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. Room and board is excluded from coverage except for certain limited circumstances.

4. States have the flexibility to design each waiver program and select the mix of waiver services that best meets the needs of the population they wish to serve. HCBS waiver service may be provided statewide or may be limited to specific geographic subdivisions.

5. Federal regulations permit HCBS waiver programs to serve the elderly, persons with physical disabilities, developmental disabilities, mental retardation or mental illness. States may also target 1915(c) waiver programs by specific illness or condition, such as technology-dependent children or individuals with AIDS. States can make home and community-based services available to individuals who would otherwise qualify for Medicaid only if they were in an institutional setting.

6. To receive approval to implement HCBS waiver programs, State Medicaid agencies must assure HCFA that, on an average per capita basis, the cost of providing home- and community-based services will not exceed the cost of care for the identical population in an institution. The Medicaid agency must also document that there are safeguards in place to protect the health and welfare of beneficiaries.

7. HCBS waiver programs are initially approved for 3 years and may be renewed at 5- year intervals.

8. HCFA's first home and community-based waiver program was established in 1981. There are

currently 240 HCBS waiver programs in effect. All States except Arizona have at least one such program. Arizona is a technical exception, though, because it runs the equivalent of an HCBS waiver program under section 1115 demonstration waiver authority.

From this site, you can download the latest summary report of all regular and model approved home and community-based services waivers.

(The summary report, [hcbwapp.exe], is in self-extracting zipped "rich text format" which is readable by most word processing software packages. To download, click on the link above, save the file to a disk or your hard drive, then extract the zipped files using your file manager by running [double-clicking] the file. The extracted files, [regular.rtf and modelwa.rtf], can then be viewed using your word processing software.)

For more information, please go to our list of State Medicaid contacts for States' home and community-based services waiver program.

For Information on Federal Requirements Contact One of the Following:

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proposed to provide home health aide services which were defined more broadly than those available under the State plan, these could be included as waiver services.

4. Define each specific service separately. Multiple services commonly considered separate services (e.g., personal care and habilitation services) generally may not be packaged as a single "comprehensive" service to which one expansive definition is applicable. Further, each definition must be reasonably related to the common meaning(s) of the service defined. A combined service definition (bundling) will be considered if you establish that the bundling of services will permit more efficient delivery of services and not compromise either an individual's access to services or free choice of providers. (See §4442.8C.2.d.)

5. Assure HCFA that each "other" service, independent of any others, is essential to prevent institutionalization, and provide a reasonable explanation as to why it is essential.

6. Cost out each "other" service, documenting the estimated costs and utilization with actual cost data (e.g., from studies or current price lists), and demonstrate the cost effectiveness of each. This documentation must be separate from that provided in your overall cost demonstration using the formula prescribed in 42 CFR 441.303(f).

B. Considerations Related to Specific Services.--

1. FFP is not available for personal care services or any waiver services when provided to recipients by legally responsible relatives, i.e., spouses or parents of minor children, when the services are those that these persons are already legally obligated to provide.

2. Services provided by relatives or friends, except as noted in item B.1., may be covered only if the relatives or friends meet the qualifications for providers of care, there are strict controls to assure that payment is made to the relative or friend as providers only in return for specific services rendered, and there is adequate justification as to why the relative or friend is the provider of care, e.g., lack of other qualified provider in remote areas. Medicaid payment may be made to qualified parents of minor children or to spouses for extraordinary services requiring specialized skills (e.g., skilled nursing, physical therapy) which such people are not already legally obligated to provide.

3. Prevocational, educational or supported employment services may not be provided under the waiver other than as part of habilitation services as defined below.

However, effective on or after April 7, 1986, you may include in your definition of habilitation services furnished to individuals who have been discharged from a NF or ICF/MR prevocational, educational, and supported employment services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully outside an institution. This expanded definition of habilitation applies to individuals who have been discharged from a Medicaid certified NF or ICF/MR, regardless of when the discharge occurred.

(b) *Requirements for certified pediatric nurse practitioner.* The practitioner must be a registered professional nurse who meets the requirements specified in either paragraphs (b)(1) or (b)(2) of this section.

(1) If the State specifies qualifications for pediatric nurse practitioners, the practitioner must—

(i) Be currently licensed to practice in the State as a registered professional nurse; and

(ii) Meet the State requirements for qualification of pediatric nurse practitioners in the State in which he or she furnishes the services.

(2) If the State does not specify, by specialty, qualifications for pediatric nurse practitioners, but the State does define qualifications for nurses in advanced practice or general nurse practitioners, the practitioner must—

(i) Meet qualifications for nurses in advanced practice or general nurse practitioners as defined by the State; and

(ii) Have a pediatric nurse practice limited to providing primary health care to persons less than 21 years of age.

(c) *Requirements for certified family nurse practitioner.* The practitioner must be a registered professional nurse who meets the requirements specified in either paragraph (c)(1) or (c)(2) of this section.

(1) If the State specifies qualifications for family nurse practitioners, the practitioner must—

(i) Be currently licensed to practice in the State as a registered professional nurse; and

(ii) Meet the State requirements for qualification of family nurse practitioners in the State in which he or she furnishes the services.

(2) If the State does not specify, by specialty, qualifications for family nurse practitioners, but the State does define qualifications for nurses in advanced practice or general nurse practitioners, the practitioner must—

(i) Meet qualifications for nurses in advanced practice or general nurse practitioners as defined by the State; and

(ii) Have a family nurse practice limited to providing primary health care to individuals and families.

(d) *Payment for nurse practitioner services.* The Medicaid agency must reimburse nurse practitioners for their services in accordance with § 441.22(c) of this subchapter.

[60 FR 19661, Apr. 21, 1995]

§ 440.167 Personal care services.

Unless defined differently by a State agency for purposes of a waiver granted under part 441, subpart G of this chapter—

(a) *Personal care services* means services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that—

(1) Authorized for the individual by a physician in accordance with a plan of treatment or (at the option of the State) otherwise authorized for the individual in accordance with a service plan approved by the State;

(2) Provided by an individual who is qualified to provide such services and who is not a member of the individual's family; and

(3) Furnished in a home, and at the State's option, in another location.

(b) For purposes of this section, *family member* means a legally responsible relative.

[62 FR 47902, Sept. 11, 1997]

§ 440.170 Any other medical care or remedial care recognized under State law and specified by the Secretary.

(a) *Transportation.* (1) "Transportation" includes expenses for transportation and other related travel expenses determined to be necessary by the agency to secure medical examinations and treatment for a recipient.

(2) Transportation, as defined in this section, is furnished only by a provider to whom a direct vendor payment can appropriately be made by the agency. If other arrangements are made to assure transportation under § 431.53 of this subchapter, FFP is available as an administrative cost.

(3) "Travel expenses" include—

(i) The cost of transportation for the recipient by ambulance, taxicab, common carrier, or other appropriate means;

(ii) The cost of meals and lodging en route to and from medical care, and while receiving medical care; and

(iii) The cost of an attendant to accompany the recipient, if necessary, and the cost of the attendant's transportation, meals, lodging, and, if the attendant is not a member of the recipient's family, salary.

(b) *Services of Christian Science nurses.* "Services of Christian Science nurses" mean services provided by nurses who are listed and certified by the First Church of Christ, Scientist, Boston, Mass., if—

(1) The services have been requested by the recipient; and

(2) The services are provided—

(i) By or under the supervision of a Christian Science visiting nurse organization listed and certified by the First Church of Christ, Scientist, Boston, Mass.; or

(ii) As private duty services to a recipient in his own home or in a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Mass., if the recipient requires individual and continuous care beyond that available from a visiting nurse or that routinely provided by the nursing staff of the sanatorium.

(c) *Services in Christian Science sanatoriums.* "Services in Christian Science sanatoriums" means services provided in Christian Science sanatoriums that are operated by, or listed and certified by, the First Church of Christ, Scientist, Boston, Mass.

(d) *Skilled nursing facility services for individuals under age 21.* "Skilled nursing facility services for individuals under 21" means those services specified in § 440.40 that are provided to recipients under 21 years of age.

(e) *Emergency hospital services.* "Emergency hospital services" means services that—

(1) Are necessary to prevent the death or serious impairment of the health of a recipient; and

(2) Because of the threat to the life or health of the recipient necessitate the use of the most accessible hospital available that is equipped to furnish the services, even if the hospital does not currently meet—