

Appendix A: 1915(c) Waivers

The 1915(c) Waiver Option

Medicaid-eligible individuals who meet level of care and other requirements have a federal entitlement to receive long-term care in various institutional settings. However, section 1915(c) of the Social Security Act creates a waiver so that states may provide these individuals services in their homes or in the community instead of in an institution. Since the goal of these waivers is to offer care in the home and/or community, they are frequently referred to as Home and Community-Based Services Waivers. The Centers for Medicare and Medicaid Services (CMS), the federal Medicaid Agency, is responsible for granting these Home and Community-Based Services (HCBS) waivers. The HCBS option has been available to states since the Omnibus Reconciliation Act of 1981 (OBRA 81) amended the Social Security Act to allow these alternative programs.

A 1915(c) waiver must be cost neutral. The average annual per capita cost of serving a group of people under a 1915(c) waiver cannot exceed the cost of serving these people in an institution. The state and the federal government share in the cost of 1915(c) waiver services. The cost share formula is the same as that for other Medicaid services.

Medicaid has several basic requirements, which states may waive for a 1915(c) waiver program. These are:

- Comparability- the same scope of services must be available throughout the state [Section 1902(a)(10)(B) of SSA];
- Eligibility- uniform income and resource rules must be applied throughout the state [Section 1902(a)(10)(C)(i)(III)]; and
- Statewideness- the Medicaid program must operate uniformly throughout the state [Section 1902(a)(1)].

Waiving these requirements gives states the flexibility to target specific, limited groups of people and to offer new and different services under different eligibility rules.

States are allowed under Section 1915(c) to define new provider types with different criteria than those existing in the regular Medicaid program. 1915(c) waivers do not, however, allow states to set arbitrary limits on the number of qualified Medicaid providers participating in the waiver program. States may limit the number of providers under another type of waiver granted by CMS, commonly known as a “freedom of choice” or 1915(b) waiver. 1915(b) waivers are most commonly used by states to selectively contract for services with a limited set of providers or managed care organizations.

Several states operate a specialized subset of very small 1915(c) waivers, commonly known as OBRA waivers because they originated from changes to the Social Security

Act made as a result of the Omnibus Budget Reconciliation Act of 1987. These waivers were granted under Section 1915(c)(7)(B) of the amended Social Security Act. They enabled states to provide community-based alternatives to people with developmental disabilities who were placed in nursing facilities but who did not meet the medical necessity criteria for nursing facility admission without having to demonstrate that a corresponding number of institutional beds existed (“cold bed rule”). Unlike 1915(c) waiver programs, the OBRA waivers were granted on a one-time basis for a specific group of people. States could not increase the size of the eligible population after the waiver was granted. Because of changes in federal policy, these waivers are no longer needed. Most states have merged these “OBRA” waivers into their regular 1915(c) waivers. By 1997, only five of the 21 states that originally operated OBRA waivers continued to maintain separate waivers. Texas combined its OBRA waiver with its HCS waiver in September 2003.

Serving Multiple Populations

A single waiver program may serve individuals with different types of disabilities. Most states serve people with mental retardation (MR) and those with developmental disabilities (DD) in the same waiver program, even though developmental disabilities may be physical as well as cognitive. Some states that operate a combined MR/DD waiver also operate more than one waiver for which individuals with DD are eligible but individuals with MR are not. Other than the Consolidated Waiver Program, Wisconsin’s Family Care is the only waiver program that combines the MR population and the non-DD disabled population. The reasons for the separation between serving these two populations are historical (these populations are often served by different administrative units of state government and have different provider bases) and technical (the costs for ICF-MR and nursing facility care, against which waiver cost effectiveness is measured, are different and must be accounted for separately to obtain federal approval).¹

¹ According to 42 CFR, Chapter IV, subpart G, restricts the combination of groups that may be served in a single waiver.