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Principles for 1915(b)(c) Waivers

1. Section 1915(b)(c) waivers must comply with all federal requirements for each type of waiver. CMS requires this. This includes the waiver application and cost requirements, as well as requirements in federal Medicaid regulations and guidelines for each of these types of waivers. For example, under the (b) waiver, the state must assure an adequate geographic mix of providers, and information about provider networks must be publicly available and up to date. This is more than an "assurance" between the state and CMS and/or the state and its contractors that adequate networks exist.

2. Case managers and care coordinators should be patient-directed and respond to patient needs. Case managers/care coordinators should not be utilization reviewers, i.e. focusing on cost control and cutting services.

   Service planning should be optimal and appropriate. For example, if an individual's standard power wheelchair can be covered through the state plan, then it should be. If the chair is included in the patient's home and community care (c) plan, then she has less money in her waiver budget for other services.

3. Contractors should decide service coverage based on policies and guidelines that are publicly available and consistently applied. Contractors act on behalf of the single state Medicaid agency, and that single state agency remains responsible for assuring that the program operates in a manner consistent with the Medicaid Act, ADA, and Title VI of the Civil Rights Act.

   To give an example: There needs to be transparency in level of care (LOC) standards and how assessment staff is trained on the standards. "Intermediate care" can be defined on paper, but if implementation is being controlled by an activities of daily living (ADL) test, then beneficiaries need to know what those standards are. System design should avoid situations where an assessor can merely testify, "I have a lot of experience reviewing LOC and ADLs. I know LOC when I see it, and this patient's combination of ADLs do not meet the standard."

4. Rates should be sufficient to ensure adequate provider participation, particularly for specialty care and continuous, high quality home care services. Disability advocates have complained that managed care payment rates are insufficient for doctors to join the network. For medically fragile individuals who must change doctors and find new specialists, this search can be challenging. While this scenario may not be new for managed care, it is more acute for home and community care recipients with complex medical conditions.

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5. The state Medicaid agency and its contractors should receive training on the ADA and EPSDT. Advocacy groups should play the important role of monitoring the programs to make sure that state personnel and contractors comply with the ADA and EPSDT laws.

6. The interdisciplinary team should be maintained, and person-centered care should be the norm. Disability advocates from some states have reported that some individuals lost this when the (b)(c) waiver was introduced, causing individuals to lose important support services.

7. Prior authorization should be rarely used, and when used, it should focus on services that are carved out of the (b)(c) waiver. A foundational notion of the (b) waiver is that it is providing beneficiaries a medical home in which the provider knows about and manages the person's care. With the addition of the (c) waiver services, comprehensive, integrated services are being provided through a medical home where the providers are selected based on their high quality and expertise. The high quality of providers in the network is typically stressed by entities that are seeking to receive contracts from the state. If this is indeed to be a key ingredient, then prior authorization almost by definition becomes unnecessary and, instead, adds an unneeded layer of additional costs and barriers.

8. Contractors must understand that specific constitutional and statutory due process requirements apply, and the state must assure that individuals do not lose due process protections. In Texas, for example, problems have been identified with case managers ignoring due process rights: Case managers may reduce the services that a recipient needs/wants included in the plan of care but still must respect the individual's notice and appeal rights.

9. Implementation should be monitored. There should be routine reporting on performance so that the need for the system can be continuously justified. For example, some data show that the Alzheimer's waiver in Florida is costing more, but is not avoiding nursing home placement any better than other waivers. Waivers or contractors which do not produce a real benefit should be terminated.

10. Design and implementation should be subject to on-going public participation. The person-centered innovations developed through states' experimentation and implementation with (c) waivers should be maintained, and the notion that outside involvement does not contribute should be completely rejected.