	Comparative Analysis of Medicaid HCBS (1915(c) & 1115) Waivers and State Plan Amendments				
Features	**§1915(c)** **Home and Community-Based Services Waiver**	**§1915(i) SPA** **State Plan Home and Community Based Services**	**§1915(j) SPA** **Self-directed Personal Assistance Services (PAS)**	**§1915(k) SPA** **Community First Choice Option**	**§1115** **Research and Demonstration Project Waiver**
Authority Type	Waiver	State plan option	State plan option	State plan option	Secretarial waiver
Effective Date	1981	Original: January 1, 2007 Revised: October 1, 2010	January 1, 2007	Original: October 1, 2011 Revised: May 7, 2012	1990
Purpose	Provides Home and Community-Based (HCBS) Services to individuals meeting income, resource, and medical (and associated) criteria who would otherwise be eligible to reside in an institution.	Provides HCBS to individuals who require less than institutional level of care and who would therefore not be eligible for HCBS under 1915(c). May also provide services to individuals who meet the institutional level of care.	Provides a new State Plan participant-directed option to individuals otherwise eligible for State Plan Personal Care or §1915(c) services.	Provides a new State plan option to provide consumer controlled home and community-based attendant services and supports Provides a 6% FMAP increase for this option.	Authorizes the DHHS Secretary to consider and approve experimental, pilot or demonstration projects likely to assist in promoting the objectives of the Medicaid statute.
Requirements That May Be Waived	• Statewideness • Comparability • Community income rules for medically needy population	• Comparability • Community income rules for medically needy population	• Statewideness • Comparability	Community income rules for medically needy population	Secretary may waive multiple requirements under §1902 of the Social Security Act if waivers promote the objectives of the Medicaid law and intent of the program.

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Application Process	Application submitted electronically via §1915(c) HCBS waiver application	State plan amendment submitted on pre-print.	State plan amendment submitted on pre-print.	State plan amendment submitted on pre-print.	Standardized application requirements found at: 431.412(a)(1) Requires approval of an Operations Protocol within 90 days of operation. Must be approved by CMS and an External Federal Review Team; CMS readiness review site visit required
Approval Duration	Initial application: 3 years Renewal: 5 years	One-time approval. Changes must be submitted to CMS and approved. If using targeting, renewal every 5 years.	One-time approval. Changes must be submitted to CMS and approved.	One-time approval. Changes must be submitted to CMS and approved.	Initial application: 5 years Renewal: 5 years

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Reporting	Annual reports.	Annual reports.	Annual reports and triennial health and welfare reports required.	Annual reports on expenditures and utilization and quality measures	Monthly progress calls, quarterly and annual progress reports.
Administration & Operation	Administered by the Single State Medicaid Agency (SSMA). May be operated by another state agency under an interagency agreement or memorandum of understanding.	Administered by the Single State Medicaid Agency (SSMA). May be operated by another state agency under an interagency agreement or memorandum of understanding.	Administered by the Single State Medicaid Agency (SSMA).	Administered by the Single State Medicaid Agency (SSMA).	Administered by the Single State Medicaid Agency (SSMA). May be operated by other entities as approved by CMS.

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Provider Agreements	Required between providers and the SSMA. Delegation allowed to a provider agency under the Organized Health Care Delivery System or Provider of Financial Management Services. Requires written specification of delegated activity.	Required between providers and the SSMA. Delegation allowed to a provider agency under the Organized Health Care Delivery System or Provider of Financial Management Services. Requires written specification of delegated activity.	Required between providers and the SSMA. Delegation allowed to a provider agency under the Organized Health Care Delivery System or Provider of Financial Management Services. Requires written specification of delegated activity.	Required between providers and the SSMA.	Not required.

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Medicaid Eligibility	May use institutional income and resource rules for the medically needy (institutional deeming). May include the special income group of individuals with income up to 300% of SSI.	All individuals eligible for Medicaid under the State plan up to 150% of Federal Poverty Level. May include special income group of individuals with income up to 300% SSI. Individuals must be eligible for HCBS under a §1915(c), (d), or (e) waiver or§1115 demonstration program.	Must be Medicaid eligible for and receiving services under either state plan requirements or eligible for and receiving services under a §1915(c) HCBS waiver	Individuals eligible for Medicaid under the State plan up to 150% of Federal Poverty Level. Individuals with income greater than 150% of the FPL may use the institutional deeming rules. .	State defines eligible categories and may expand eligibility. Not intended to add new Medicaid eligibility group(s).
Other Eligibility Criteria	Must meet institutional level of care.	For the 300% of SSI income group, must be eligible for HCBS under a §1915(c),(d),or(e) waiver or §1115 demonstration program.		Individuals must meet institutional level of care May include the special income group and receiving at least one §1915(c) HCBS waiver service per month.	State determines requirements for services.

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Target Groups	• Aged or disabled • Intellectually disabled or developmentally disabled • Mentally ill (ages 22-64) • Any subgroup of the above	May define and limit the target group(s) served.	May define and limit the target group(s) served.	No targeting. Services must be provided on a statewide basis, in a manner that provides such services and supports in the most integrated setting appropriate to the individual's needs, and without regard to the individual's age, type or nature of disability, severity of disability, or the form of home and community-based attendant services and supports that the individual requires in order to lead an independent life.	State determines target groups and defines eligibility criteria.

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Other Unique Requirements	None. **Cannot cover:** Room & board costs except for allowable transition services. Special education and related services provided under IDEA that are education related only & vocational services provided under Rehab Act of 1973.	Multiple State plan amendments covering different target groups permitted. **Cannot cover:** Room & board costs except for allowable transition services. Special education and related services provided under IDEA that are education related only & vocational services provided under Rehab Act of 1973.	Must either operate a HCBS waiver covering PAS or have an approved state plan amendment for "traditional" PAS.	MOE requirement for 1st fiscal year for services provided under §1115, §1905(a), and §1915, of the Act. Must establish & consult with a Development & Implementation Council with majority representation from consumers. **Cannot cover:** Certain assistive devices & assistive technology services; medical supplies & equipment, home modifications. Room & board costs except for allowable transition services. Special education and related services provided under IDEA that are	State must operate under an approved Operations Protocol. Requires public input.

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				education related only & vocational services provided under Rehab Act of 1973. **Increased FMAP** §1915(k)(2) of the Act provides that States offering this option to eligible individuals during a fiscal year quarter occurring on or after October 1, 2011 will be eligible for a 6 percentage point increase in the Federal medical assistance percentage (FMAP).	
Limits on Numbers Served	Allowed.	Not allowed.	Allowed.	Not allowed.	State estimates numbers served. Operates as an entitlement to all who are eligible.

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Waiting Lists	Allowed.	Not allowed.	Allowed.	Not allowed.	Not applicable.
Combining Service Populations	Combining service populations is limited to: 1) Aged/Disabled 2) Intellectually Disabled or Developmentally Disabled 3) Mentally Ill 4) Any subgroup of the above	States may combine service populations.	States may combine service populations.	States may combine service populations.	States may combine service populations.
Caps on Individual Resource Allocations or Budgets	Allowed.	May determine process for setting individual budgets for participant-directed services.	May determine process for setting individual budgets for participant-directed services.	May determine process for setting individual budgets for participant-directed services.	Budget neutrality must be maintained. Caps or benefit limits may apply.
Allowable Services	• Case management services • Homemaker/home health aide services &	Includes both §1915(c) statutory services and "other" category of services.	• Personal care or related services. • Home and community-based	**MUST COVER**: • Assistance w/ ADLs, IADLs, & health related	State decides what services are covered, subject to CMS approval.

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	personal care services • Adult day health services • Habilitation services • Respite care • "Other services requested by State as Secretary may approve" • Day treatment or other partial hospitalization services* • Psychosocial rehabilitation services* • Clinic services* • For individuals with chronic mental illness		services otherwise available to the participant under the state plan or an approved 1915(c) waiver. • At state's discretion, items that increase an individual's independence or substitute for human assistance.	tasks. • Acquisition, maintenance & enhancement of skills necessary for individual to accomplish ADLs, IADLs, & health-related tasks. • Back-up systems or mechanisms to ensure continuity of services & supports. • Voluntary training on how to select, manage and dismiss staff. • **MAY COVER:** • Fiscal Management Services • Transition costs such as rent and utility deposits, 1st	

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				month's rental and utilities, bedding, basic, kitchen supplies, and other necessities linked to an assessed need for an individual to transition from a NF, institution for mental diseases, or ICF-ID to a home & community-based setting where individual resides. • Expenditures relating to a need identified in an individual's person-centered plan that increases his/her independence or substitutes for human assistance to the extent the expenditures would otherwise be made for the human assistance.	

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Provider Qualifications	Determined by state, subject to CMS approval.	Determined by state, subject to CMS approval.	No statement required as to provider qualifications in the 1915(j) preprint.	Determined by state, subject to CMS approval.	Determined by state, subject to CMS approval.
Participant-directed Services	Allowed.	Allowed.	Required.	Required.	Allowed.
Hiring of Legally Responsible Individuals	Allowed at the State's discretion.	Allowed at the State's discretion.	Allowed at the State's discretion.	Allowed at the State's discretion.	Allowed at State's discretion.
Cash Payments to Participants	Direct cash payments not permitted.	Direct cash payment not permitted.	Direct cash payments are permitted.	Direct cash payments are permitted.	Direct cash payments are permitted.

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Financial Management Services	Required if participant direction is offered. May be a waiver service, an administrative function, or performed directly by the SSMA.	Required if participant direction is offered. May be performed directly by the SSMA or as an administrative function. Service reimbursement is not available.	Required. May be directly by the SSMA or as an administrative function. Service reimbursement is not available.	Required depending on model of participant direction. SSMAs and vendors allowed to provide FMS.	Required if participant direction is offered. May be a demonstration service or an administrative function.
Goods and Services	Permitted as a wavier service.	***Permitted as a service.***	Permitted as a service.	Permitted as a service.	Permitted as a service.
Direct Payment of Providers	Required (state has options to meet this requirement).	Required.	Required.	Required.	Not required.
Provider Payments	Payment item must be listed in the service plan (plan of care), provided by an enrolled provider, and provided prior to reimbursement.	Payment item must be listed in the service plan (plan of care), provided by an enrolled provider, and provided prior to reimbursement.	Payment item must be listed in the service plan (plan of care), provided by an enrolled provider, and provided prior to reimbursement.	Payment item must be listed in the service plan (plan of care), provided by an enrolled provider, and provided prior to reimbursement.	Payments for allowable services may be paid prospectively (before the service is provided).

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Cost Requirements	Must be cost-effective. Average annual cost per person served under §1915(c) cannot exceed average annual cost of institutional care for each target group served.	None. Benefit limits may apply.	None. Benefit limits may apply.	None. Benefit limits may apply. For the first full fiscal year in which the State Plan amendment is implemented, a State must maintain, or exceed, the level of expenditures for services provided under §1115, §1905(a), and §1915, of the Act, or otherwise to individuals with disabilities or elderly individuals attributable to the preceding fiscal year.	Budget-neutrality. Services cannot in aggregate cost more than without the §1115 waiver.

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Quality Management	Extensive quality management and quality improvement activities required per HCBS Waiver Application, including how state will comply with all multiple waiver assurances and how state will conduct quality oversight, monitoring and discovery, remediation and improvement of issues relating to quality.	Pre-print requires a quality assurance and improvement plan including how state conducts discovery, remediation and quality improvement.	Requires a quality assurance and improvement plan including how state conducts discovery, remediation and quality improvement. State must provide system performance measures, outcome measures, and satisfaction measures that will be monitored and evaluated.	Requires a quality assurance and improvement plan including how state conducts discovery, remediation and quality improvement. State must provide system of performance measures, outcome measures, and satisfaction measures that will be monitored and evaluated.	Extensive data collection and evaluation plans to assess the effectiveness of the project or demonstration.

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Interaction with State Plan Services, Waivers, & Amendments	Participants have access to and must utilize state plan services before using identical extended state plan services under the waiver. Waiver services may not duplicate state plan services. Individuals may be eligible for and receive State plan, §1915(c), §1915(i) and §1915(j) services simultaneously.	Individuals may be eligible for and receive State plan services, §1915(c), §1915(i) and §1915(j) services simultaneously, so long as the service plan (plan of care) ensures duplication of services is not occurring.	State must either operate a HCBS waiver covering PAS or have an approved state plan amendment for "traditional" PAS. Individuals voluntarily or involuntarily dis-enrolled from §1915(j) must have access to other PAS services under the state plan or 1915(c). Individuals may be eligible for and receive State plan, §1915(c), §1915(i) and §1915(j) services simultaneously.	Individuals may be eligible for and receive State plan, §1915(c), §1915(i) and §1915(j) services simultaneously.	State defines relationship to state plan, waivers, and amendments, subject to CMS approval.