



National Association of State Medicaid Directors

an affiliate of the American Public Human Services Association



Center for Workers with Disabilities

a technical assistance center of APHSA and NASMD

Section 6086: Home and Community Based Services

Characteristic	State Plan Option --1915(i)	Waiver Option – 1915(c)
Duration	No set or limited time period, and does not need to be renewed or re-reviewed.	Waivers are approved for a specific time period (3 or 5 years), and need to be renewed (and re-reviewed) when this period is over.
Level of care requirement	No “level of care” requirement for participants.	Includes “level of care” requirements.
Comparability	Can limit the number of participants, and can create waiting lists, but can not waive comparability.	Can waive comparability. States can create waiting lists.
Statewideness	Can waive statewideness.	Can waive statewideness.
Eligibility restrictions	Can not expand eligibility, income of participants can not exceed 150% FPL.	Can waive income limits, eligibility criteria. States must submit eligibility and any applicable post-eligibility criteria.
Needs-based criteria	States must establish needs-based criteria, but needs-based criteria for participants must be less stringent than for institutional-level care.	Does not include this requirement.

Cost neutrality	Does not include requirement of cost-neutrality. The state plan must describe the method used for calculating the budget and define a process for making adjustments and for evaluating expenditures.	Must be cost-neutral.
Required services	States have discretion over what are required services, although they can only choose from a limited list of services authorized by Section 1915 (c)(4)(B) of the Social Security Act. ¹ Under 1915 (i) states may not cover “other” services authorized under 1915(c)(4)(B).	States may provide any or all of the following services: case management, homemaker/home health aide services, personal care services, adult day health, habilitation, and respite care. States can request approval to provide other services that participants may need 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).
Reporting of projected participation	States must submit to CMS the projected number of individuals to receive HCBS under the state plan option.	States must submit the number of participants expected to be served under the waiver.
Data reporting requirements		States are required to provide the federal government with annual data on the impact of the waiver, including the types and amount of services provided and beneficiary information.
Modification of needs-based criteria	States have the authority to modify their needs-based criteria for eligibility without prior approval from CMS if enrollment exceeds projected capacity. In this case, the state must notify the public and	N/A

¹Section 1915 (c)(4)(B) of the Social Security Act gives 1915(c) waiver authority to “provide medical assistance to individuals (to the extent consistent with written plans of care, which are subject to the approval of the State) for case management services, homemaker/home health aide services and personal care services, adult day health services, habilitation services, respite care, and such other services requested by the State as the Secretary may approve and for 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.”

	CMS of the change at least 60 days before it occurs.	
Individual evaluation	States must conduct an evaluation to determine individual eligibility.	States must conduct an evaluation to determine individual eligibility.
Individualized needs assessments	States must conduct individualized needs assessments.	States must conduct individualized needs assessments.
Individualized care plans	States must establish a written individualized care plan. The plan must be developed in consultation with the individual, the individual's physician, and other health care support professionals, and, if appropriate, the individual's family. The plan is to be reviewed annually and as needed based on the individual's circumstances.	States must establish a written individualized care plan.
Self-directed service option	States may provide the option for self-directed services.	Self-direction is not required for the basic 1915(c) waiver, but is an option that states may elect. Self direction is a requirement for the Independence Plus 1915(c) waiver.
Quality assurance	Includes quality assurance provisions based on federal and state guidelines.	Includes quality assurance provisions based on federal and state guidelines; waivers must provide evidence that the statutory and regulatory assurances have been met (i.e., health and welfare, qualified providers, etc).
Redetermination	Redeterminations must be conducted on at least an annual basis. Redeterminations and appeals must be allowed in accordance with the Medicaid state plan.	Redeterminations can be conducted no less than annually.
Presumptive eligibility	States may elect to provide a period of presumptive eligibility for up to 60 days. Payment must be limited to medical assistance associated with the independent, individualized evaluation and assessment.	N/A