Did You Know?

Home and Community Based Waivers and AT

Children and adults can benefit from a wide range of assistive technology (AT) devices that would be difficult, if not impossible to obtain from the traditional Medicaid program. These include home modifications, computer software, vehicle modifications, adapted kitchen appliances, and a Personal Emergency Response System, to name a few. Although states are not required to implement waiver programs, all states have one or more Home and Community Based Services (HCBS) waivers. These otherwise difficult-to-obtain items may be available through an HCBS waiver program in your state.

Medicaid is a program that is subject to very extensive federal mandates. An HCBS waiver, approved by the federal Centers for Medicare and Medicaid Services (CMS), allows a state to operate outside the confines of specified federal mandates, often to test innovative approaches to delivery of services or to extend or expand coverage for a targeted population.

There are three basic requirements to qualify for any HCBS waiver: the individuals served must be at risk of institutional care (waivers are intended to serve as a community alternative to institutional care); the average per capita cost of providing waiver services must not exceed the average cost of institutional care; and the individual must meet the income criteria for the Medicaid program (although the income of legally responsible spouses and parents may be ignored if that is part of the approved waiver).

The HCBS waiver can be used to waive three key federal Medicaid requirements:

- Statewideness: Ordinarily, the state's Medicaid plan must offer comparable coverage in all regions of a state. A waiver could be approved that would offer a level of coverage in one or more sections of the state that is not available statewide.

- Comparability: Ordinarily, the state's Medicaid plan must treat all similarly situated recipients equally. A waiver could select a targeted group, such as individuals with traumatic brain injury, and offer them a scope of services not available to other recipients.

- Certain income and resource rules: A waiver can be implemented which exempts certain populations from the general income and resource requirements. For example, many states operate waiver programs that make certain children with very severe disabilities eligible for Medicaid without regard to parental income and resources.

Under federal HCBS waiver regulations, a very wide range of services can be provided, including case management, homemaker, home health aide, personal care, adult day health, habilitation, respite care, day treatment or other partial hospitalization, and other services requested by the agency and approved by CMS as cost effective and necessary to avoid institutionalization. See 42 CFR 440.180. States have apparently used this "other services" category to approve things like home and vehicle modifications and AT.

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Importantly, services provided under a HCBS waiver are those not otherwise funded under the state's Medicaid plan. Some states' waiver programs may require that other funding sources, including the state Medicaid program, be explored before seeking an item through the waiver.

There may be spending limits for certain waiver services. For example, Alabama has an HCBS Living at Home Waiver for Persons with ID [intellectual disabilities]. This waiver includes environmental accessibility adaptations, specialized medical equipment, and specialized medical supplies. The yearly spending limits per individual for environmental accessibility adaptations and specialized medical equipment are $5,000 each, while the limit for specialized medical supplies per individual per year is $1,800. In contrast, one of North Dakota's HCBS waivers, the Traditional MR DD HCBS waiver, limits spending for "environmental supports/modifications" and "equipment and supplies" service categories to $20,000 each for the duration of the waiver. The New York HCBS Waiver for Individuals with Traumatic Brain Injury has a $15,000 per year limit on AT, but that limit can be exceeded with approval from the waiver management staff.

Waiver applicants and recipients do not leave their due process rights behind when they enter a waiver program. States are required to provide the opportunity to request a fair hearing to individuals: who are not given the choice of home and community-based services as an alternative to institutional care; who are denied the services of their choice or the providers of their choice; or whose services are denied, suspended, reduced, or terminated. The waiver application submitted to CMS and available on the CMS website lists the procedures the state will use in providing the opportunity to request a hearing. Of course, due process requires proper notice of action. Notice requirements as specified in 42 CFR 431.210 apply to waivers.

Access to each state's HCBS waivers is available from the CMS website: www.cms.gov/MedicaidStWaivProgDemoPGI/MWDL/list.asp. Waivers vary greatly from each other, even within the same state, and advocates and attorneys are encouraged to check their states' waiver applications for details about the services available to various population groups within their state. Advocates and attorneys are invited to share any significant fair hearing or court decisions involving waivers with the National AT resource library by forwarding copies to Diana Straube.

A more extensive article on HCBS waivers appears in the Summer-Fall 2007 issue of our *AT Advocate* newsletter. It is available at www.nls.org/av/fall07.pdf.

Those who are reading this post as a list serve posting are encouraged to use "reply all" to share comments or questions that they want to reach all participants on the list serve. Use "reply" to communicate only with the person who did the posting.

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