THE WAIVER CONSULTING GROUP

THE HCBS OPERATOR'S PLAYBOOK

Launching, sustaining, and scaling a Medicaid waiver program in any state

LAUNCH / COMPLY / EXPAND

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WAIVER CONSULTING GROUP

Start Any Program. In Any State.®

CHAPTER ONE

HOW MEDICAID ACTUALLY PAYS FOR HOME AND COMMUNITY-BASED SERVICES

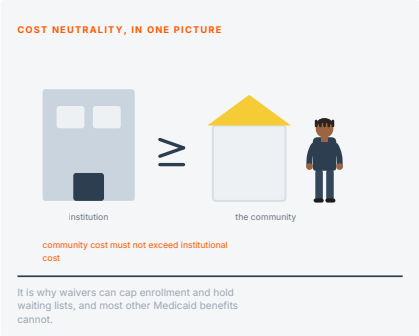
Before you can decide what to build, you have to understand what is paying for it. Six federal authorities fund almost all HCBS in the United States, and each one imposes a different set of constraints on the provider operating under it.

Medicaid was designed in 1965 around institutional care. Nursing facility coverage was mandatory; home-based alternatives were not covered at all. Every mechanism that now funds home and community-based services is, in a legal sense, an exception carved out of that original design — and each exception carries the shape of the carve-out. Understanding those shapes is not academic. The authority under which you enroll determines whether the state can cap your enrollment, whether it must serve everyone who qualifies, whether you must accept a level-of-care determination tied to institutional eligibility, and whether your program can lawfully exist in only part of the state.

The six authorities

Section 1915(c) — the HCBS waiver. This is the workhorse, and probably the authority you will operate under. It permits a state to waive three otherwise-mandatory Medicaid requirements: statewideness, comparability of services, and the community income and resource rules. In exchange, the state must demonstrate that serving people in the community costs no more than serving the same people in an institution — the cost-neutrality requirement.

Three consequences follow directly, and they drive most of what frustrates providers:



- **Participants must meet an institutional level of care.** They must be clinically eligible for a nursing facility, an intermediate care facility for individuals with intellectual disabilities, or a hospital, depending on the waiver. Someone who needs help but does not meet that threshold is not eligible, however obvious their need.
- **Enrollment can be capped.** Because statewideness and comparability are waived, the state may serve a fixed number of people and maintain a waiting list. This is why waiting lists exist in HCBS and not in most other Medicaid benefits. It is also why provider network capacity is sometimes deliberately restricted — the state has no obligation to build capacity beyond its approved slots.
- **Geography can be restricted.** A waiver may operate in some counties and not others.

AUTHORITY

Social Security Act §1915(c); 42 U.S.C. §1396n(c). Implementing regulations at 42 C.F.R. Part 441, Subpart G. Waivers are approved for an initial three-year term and renewed in five-year increments, with amendments filed between renewals.

Section 1915(i) — State Plan HCBS. A newer and structurally different mechanism. Because it is a state plan benefit rather than a waiver, it must be available statewide and it does *not* require an institutional level of care. Eligibility rests on needs-based criteria the state defines, which may be less restrictive than an institutional threshold. The trade-off is that the state has far less ability to control enrollment volume than under a waiver, which is precisely why many states are cautious about using it. For providers, 1915(i) programs often present a more open network and a broader eligible population — frequently including behavioral health populations that fall outside traditional waiver targeting.

Section 1915(k) — Community First Choice. A state plan option for attendant services and supports, carrying a six percentage point increase in federal matching funds as an inducement. It requires an institutional level of care, must be statewide, and cannot maintain a waiting list. States that adopted it typically use it as the foundation layer for personal attendant services, with waivers layered on top for specialized services.

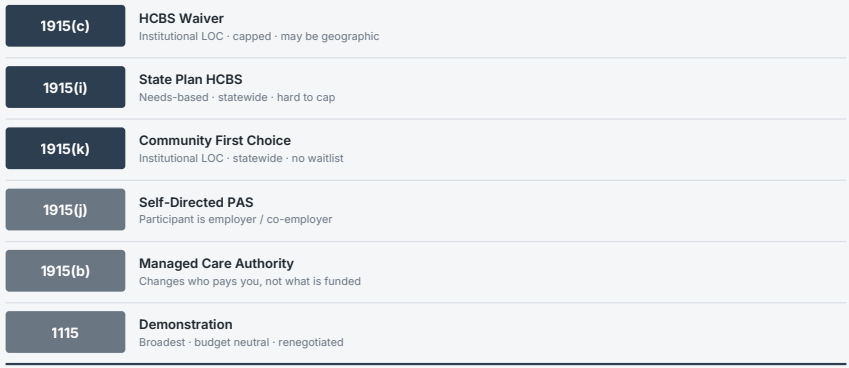
Section 1915(j) — self-directed personal assistance. Authorizes participant-directed models in which the participant functions as the employer of record or co-employer, often with a financial management services entity handling payroll and tax compliance. Providers in this space usually operate as fiscal intermediaries or support brokers rather than as direct service agencies, which is a materially different business.

Section 1915(b) — managed care authority. This one does not fund services; it changes who pays you. It permits a state to restrict freedom of choice and mandate enrollment in managed care. Where a

state has combined 1915(b) with 1915(c) — a concurrent waiver — your relationship shifts from the state to one or more managed care organizations, with all that implies for contracting, credentialing, prior authorization, and claims. Chapter 21 treats this in depth.

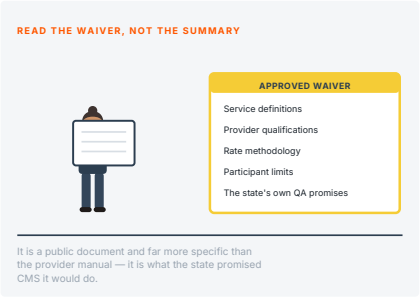
Section 1115 — demonstration waivers. The broadest authority, permitting a state to test approaches that depart substantially from statute, subject to budget neutrality. Many of the largest and most innovative HCBS programs operate under 1115 demonstrations, sometimes bundling housing supports, employment services, or health-related social needs that no other authority would cover. Demonstrations expire and are renegotiated, which introduces a form of risk providers under other authorities do not face: the program you built your organization around may be substantially redesigned at renewal.

FIGURE 1.1 · THE FUNDING AUTHORITIES



Solid navy = services funded directly. Grey = authority shapes delivery or payment.

Why the authority determines your business model



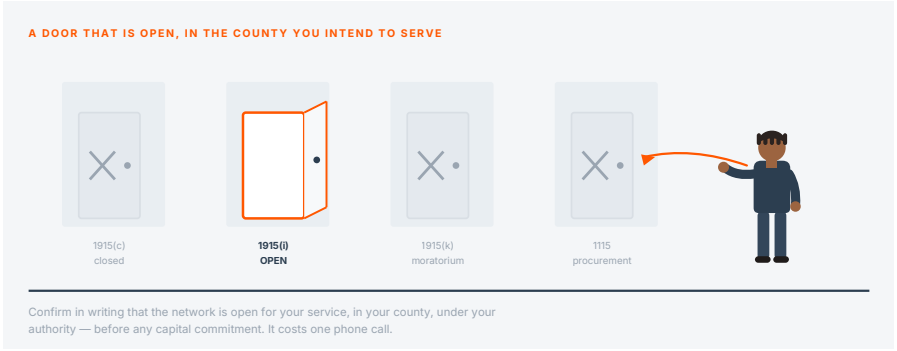
Consider two providers delivering what appears to be an identical service — supported living for adults with intellectual and developmental disabilities.

DIMENSION	UNDER A 1915(C) WAIVER	UNDER 1915(I) STATE PLAN HCBS
Referral volume	Constrained by approved slots; may face a waiting list you cannot influence	Constrained by the eligible population, not by a slot cap
Network entry	State may close or restrict the provider network	Harder for the state to restrict; any qualified provider generally must be admitted
Eligibility gate	Institutional level of care — a real screen that excludes many	Needs-based criteria, typically broader
Geographic reach	May be limited to specified counties	Statewide by requirement
Renewal risk	Amendments and five-year renewals can redefine services	State plan amendments, generally more stable

The service is the same. The business is not. The first provider is competing for access to a rationed resource and should invest heavily in referral relationships with case management entities. The second is competing on capacity and quality in an open market and should invest in recruitment and throughput. A provider who does not know which situation they are in will make the wrong investment.

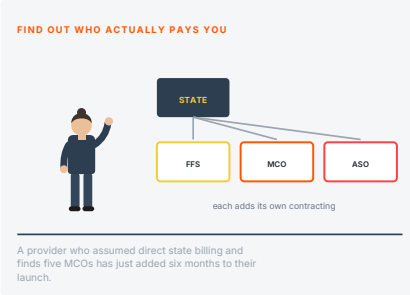
THE MOST EXPENSIVE MISTAKE IN PART ONE

Signing a lease, hiring a director, or committing capital before confirming *in writing* that the state is currently accepting new provider applications for your intended service, in your intended county, under your intended authority. Provider network closures and enrollment moratoria are common, are frequently not announced prominently, and are often communicated only in response to a direct inquiry. Ask the question in writing. Keep the answer.



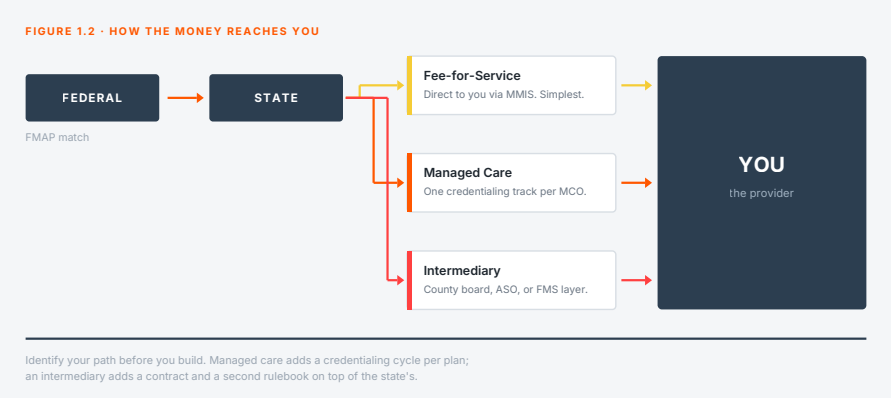
How the money actually reaches you

Federal Medicaid dollars flow to the state as a match against state spending — the Federal Medical Assistance Percentage, which varies by state and by service category. Understanding this matters for one practical reason: **your rate is a state budget line, not a market price.** When you argue for a rate increase, you are not negotiating with a customer; you are asking a legislature to appropriate state matching funds. That is a slower, more political process than provider advocates often expect, and it explains why HCBS rates so often lag wage inflation.



From the state, payment reaches you by one of three paths. Directly, on a fee-for-service basis, through the state's Medicaid Management Information System. Through a managed care organization under capitation, where the MCO bears risk and controls authorization. Or through an intermediary — a regional authority, a county board, an administrative services organization, or a financial management services entity — which is common in developmental disability systems and adds a layer of contracting and rules on top of the state's own.

Identify your payment path before you build anything. A provider who assumed direct state billing and discovers they must contract with five MCOs, each with its own credentialing timeline, portal, authorization process, and claims format, has just added six months and substantial administrative cost to their launch.



The rules that apply regardless of authority

Four federal requirements attach to essentially all HCBS and will shape your operations no matter which authority funds you:

The HCBS settings requirements. Federal regulation defines the qualities a setting must have to be considered home and community-based — integration in the community, choice of setting, privacy, autonomy over daily schedule and activities, and freedom from unnecessary restriction. Settings presumed to be institutional in character, including those in or adjacent to an institution or that isolate participants, face heightened scrutiny. This is not a paperwork requirement; it determines whether your physical setting can be funded at all. Chapter 11 covers it in detail.

Person-centered service planning. Federal regulation prescribes both the process and the content of the service plan, including that it be driven by the individual, developed with people they choose, and reflective of their goals rather than the provider's program. It also establishes conflict-of-interest limits: the entity providing case management generally may not also provide direct services to the same individual, with narrow exceptions where no other qualified entity is available.

Electronic visit verification. Federal law requires states to implement EVV for personal care and home health services, capturing the type of service, the individual receiving it, the individual providing it, the date, the location, and the start and end times. States face reduced federal matching funds for non-compliance, which is why state EVV mandates are enforced firmly. Your service delivery workflow must accommodate this from day one.

The access and payment adequacy requirements. Federal rulemaking has substantially expanded state obligations around HCBS access, including requirements touching incident management systems, grievance processes, payment rate transparency, quality measure reporting, and — consequentially for providers of personal care, homemaker, and home health aide services — a requirement that a specified majority of the Medicaid payment for those services go to direct care worker compensation. The compensation provision phases in over several years and includes accom-

modations for small providers. Its practical effect is to constrain how much of your rate can support administration and profit, which changes the arithmetic in Chapter 8.

> **PRACTITIONER NOTE: READ THE WAIVER ITSELF**
>
> Every approved 1915(c) waiver is a public document, and it is far more specific than the provider manual. It contains the service definitions, the provider qualification standards, the rate methodology, the participant limits, and the state's own quality assurance commitments to CMS. When a state tells you a requirement exists, you can check whether the state actually promised CMS it would do that. Providers who read the waiver argue from a materially stronger position than providers who read the summary.

TAKEAWAYS

1. Identify the specific federal authority funding your intended service before making any capital commitment. It determines your enrollment ceiling, network access, eligible population, and geographic footprint.
2. Confirm in writing that the provider network is open for your service in your county. Network closures are common and rarely advertised.
3. Determine your payment path — state fee-for-service, managed care, or intermediary — because each adds different contracting work to your launch timeline.
4. Obtain and read the approved waiver document, not the provider manual summary. It is the state's binding commitment to CMS and it contains the details.
5. Assume settings requirements, person-centered planning, EVV, and the compensation pass-through apply to you, and design your operations around them from the start rather than retrofitting.

THAT WAS ONE CHAPTER

Twenty-two more cover licensure and enrollment, the policy architecture that survives a survey, unit economics, incident reporting, program integrity, and multi-state expansion.

The full edition runs 23 chapters with 163 figures and five working appendices — a 72-item launch checklist, an annual compliance calendar, and an 80-document survey-readiness inventory.

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