Introduction to Medicaid, State Plans, and 1915c Waivers

Chapter 7 provides an overview of Medicaid, the Medicaid State Plan, and 1915c Waivers. It will also introduce the core Home and Community Services (HCS) programs that enable individuals to remain in or return to their own communities through the provision of coordinated, comprehensive and economical home and community-based services.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

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BACKGROUND

The purpose of the HCS Division is to promote, plan, develop, and provide long-term care services responsive to the needs of adults with disabilities and the elderly with priority attention to low-income individuals and families. We help people with disabilities and their families obtain appropriate quality services to maximize independence, dignity, and quality of life.

HCS programs are funded by Medicaid and/or state funds and administered by the Home and Community Living Administration (HCLA). To be eligible for all HCLA-funded programs, the applicant must meet the target population, functional, and financial criteria.

MEDICAID

Medicaid, Title XIX of the Social Security Act (SSA), is a needs-based entitlement program that provides medical assistance for certain individuals and families with low incomes and few resources. The Medicaid program became law in 1965 as a jointly funded, cooperative venture between the Federal and State governments to assist states in the provision of adequate medical care to eligible needy persons.

Medicaid is the foundation on which HCS and the Developmental Disabilities Community Services (DDCS) build home and community-based programs. Most of the core programs are funded through either the Medicaid State Plan or a Medicaid 1915(c) waiver. The costs of providing Medicaid services are shared between the Federal and State government.

The portion paid by the Federal government is known as the Federal Medical Assistance Percentage or FMAP. Each state's FMAP is determined annually using a formula that compares the state's average per capita income with the national average. FMAP cannot be lower than 50% or higher than 83%. States with a higher per capita income receive a lower FMAP. Washington State's FMAP is about 50%.

Rules and policies that govern Medicaid are found in the SSA, the Code of Federal Regulations (CFR), and the Centers for Medicare and Medicaid Services (CMS) Medicaid Manual.

Medicaid State Plan

Section 1905 of the SSA requires States that administer the Medicaid program to describe how they will meet the mandatory Medicaid requirements and the optional services they will provide. This is done through the development of a Medicaid State Plan (also known as the State Plan). It is Washington's agreement with CMS that our state will adhere to the requirements of the SSA and the official issuances of the Department of Health and Human Services (DHHS).

The State Plan is "owned" by the Health Care Authority which is Washington's Medicaid State Agency. HCS and DDCS are considered operating agencies for some of the state plan services such as Medicaid Personal Care (MPC) and Community First Choice (CFC).

State Plan Approval

Once approved by CMS, the State Plan deems Washington eligible to receive federal funding or federal matching funds for providing Medicaid services. State Plan services must be offered statewide, and the state cannot set limits on the number of people who will be served or the dollar amount that will be spent. Federal rules require that state plan services should be used before using 1915(c) waiver funds. This is why state plan programs are considered priority programs. By utilizing State Plan services first, Home and Community Based Services (HCBS) waiver capacity is reserved for clients whose amount, duration, or scope of service need is beyond what the state plan programs can provide.

Components

All state plans are different. Each state defines Medicaid eligibility differently and not all states offer some of the optional Medicaid services (like MPC). The State Plan describes:

- Who is eligible;
- What services will be offered including the:
  - amount (how often),
  - duration (for how long), and
  - scope (exact nature of what is provided);
- Who are the qualified providers for each service and what are the specific qualifications for each type of provider;
- How the state sets the rate of payment for services and how payment is made; and
- How the program is administered.

Below is a list of State Plan programs operated by HCS and DDCS:

- Community First Choice (CFC)
- Medicaid Personal Care (MPC)
- Program of All-Inclusive Care for the Elderly (PACE) – HCS Only
- Private Duty Nursing

HCBS 1915c Waiver

Section 1915(c) of the Social Security Act describes the regulations for obtaining and operating a 1915(c) HCBS waiver. These waivers are Medicaid's alternative to providing long-term care in institutional settings. HCBS waiver rules allow states to "waive" Medicaid State Plan rules in order to provide services to individuals in their local communities instead of in an institution such as a nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF/ID).

The state plan rules that can be waived include:

- Income and Resources (the financial eligibility criteria)
- Comparability (targeting a specific population)
- State wideness (targeting a specific geographic are)

States also have more flexibility in adding additional, optional services to a 1915(c) waiver than to a State Plan.

HCBS waivers operated by HCS include:

- Community Options Program Entry System (COPES)
- New Freedom
- Residential Support Waiver (RSW)

DDCS operates the following HCBS waivers:

- Basic Plus
- Core
- Community Protection (CP)
- Children with Intensive In-home Behavioral Supports (CIIBS)
- Individual and Family Services (IFS)

PROGRAM DETERMINATION

Before authorizing initial services or reauthorize ongoing services, clients must be determined both financially and functionally eligible for the program that provides the services they need. For information about financial eligibility for services, see Chapter 7a of the LTC manual.

Initial determination for HCS-funded services is made by the HCS Division. Program eligibility for our target population (aged, blind or physically disabled per SSA criteria) is based on a CARE assessment of an individual's functional unmet needs and a Medicaid financial determination. Functional and financial determinations occur at the same time.

Upon completion of a CARE assessment, the case manager determines program eligibility based on functional eligibility for the programs listed in the drop-down menu on the care plan screen in CARE. Program selection is based on the following items:

- Financial and functional program eligibility;
- Program rules; and
- Client's choice of eligible programs and providers.

Hierarchy

Determine the appropriate program selection based on the following general hierarchy:

- Roads To Community Living (RCL); then
  - ↳ Medicaid State Plan programs – CFC or
    – MPC; then
    - ↳ Home and Community-Based Services (HCBS) waivers; then
      - ↳ State-funded Medical Care Services (MCS); then
        - ↳ State-funded LTC for Non-Citizens; then
          - ↳ Washington Roads

Required Form

Clients who are functionally and financially eligible for the waiver programs can choose to receive their care in an institution or in the community. The Acknowledgment of Services form DSHS 14-225 for CFC

and HCS waiver programs is the documentation that all of the program choices have been explained to the client and the client has acknowledged their choice of CFC or waiver services instead of nursing home care. DDCS uses the Voluntary Participation Form DSHS 10-424.

1. This form is a federal requirement.
    a) CFC and waiver services cannot be authorized without the client's signature and signature date on this form.
    b) This document indicates the client's choice of Home & Community-based waiver and CFC services (CFC and/or COPES, New Freedom, or Residential Support Waiver).
2. If the client enters the nursing facility, home and community-based services are terminated on that date.
    a) A new 14-225 is not required if the stay is short-term (e.g. 30 days or less, recipient is attending rehabilitation and will be returning to place of residence.)
    b) If the stay in the nursing home is more than 30 days, a new Acknowledgment of Services form is required if the client wants to return to the community on CFC and/or waiver services. The 14-225 is documentation of the client's choice to receive services outside of the nursing home.
3. Two signed copies are required - one copy is given to the client, and one copy is placed in the client record by sending it to the HCS Imaging Unit.

Excluded Services

Assess and document client goals and services within CARE regardless of funding source. When service planning, you may need to look at funding resources other than HCS and DDCS. Excluded services are found in WAC 388-106-0020. For example, core programs do not cover the following services:

1. For Chore and MPC only:
    - Teaching, including teaching how to perform personal care tasks;
    - Development of social, behavioral, recreational, communication, or other types of community living skills;
    - Nursing care.
- Personal care services provided outside of the client's residence in your place of employment or while accessing community services, that are NOT identified and authorized in your written service plan;
2. Respite (HCS/AAA only);
3. Child care;
4. Animal care, unless for service animals when receiving services through New Freedom;
5. Sterile procedures, administration of medications, or other tasks requiring a licensed health professional, unless authorized as an approved nursing delegation task, client self-directed care task (excludes agency providers), or provided by a family member;
6. Services provided over the telephone;
7. Chore services provided outside the state of Washington;
8. Any services provided outside of the United States;
9. Services to any person who has not been authorized by the department to receive them;
10. Yard care;
11. Assistance with managing finances unless receiving services through New Freedom.

RESOURCES

Related WAC

WAC 388-106-0020 Excluded Services

Acronyms

AAA	Area Agency on Aging
CFC	Community First Choice
CFR	Code of Federal Regulations
CMS	Centers for Medicare and Medicaid Services
COPES	Community Options Program Entry System
DDCS	Developmental Disability Community Services
DHHS	Department of Health and Human Services
FMAP	Federal Medical Assistance Percentage
HCBS	Home and Community Based Services
HCLA	Home and Community Living Administration
HCS	Home and Community Services
MCS	Medical Care Services
MPC	Medicaid Personal Care
SSA	Social Security Act

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
4/2026	Becca Howard	Update contact	
7/2025	Annie Moua	Update ALTSA to HCLA and DDA to DDCS	TBD
10/1/2023	Anne Moua	Update contact	
	Beth Adams	Moved to new template; rearranged content order	