Comparison of Federal Medicaid Authorities

States have broad flexibility to design Medicaid programs to meet state-specific goals. This flexibility is tempered by Medicaid statute that is part of the Social Security Act. The Medicaid statute includes basic requirements[1] outlined in 1902(a) of the Social Security Act that govern program development. States may choose to meet goals by amending the State Plan and/or developing a waiver from the basic requirements. The chart below provides features of various federal authorities that are used to support delivery of home and community based services (HCBS). These authorities build on what is available through the state's plan for Medical Assistance. The comparison of select features of the 1115 Demonstration, 1915(b) and 1915(c) waivers and the 1915(i) and 1915(k) State Plan Options were pulled from key online resources available from the Home and Community Based Services Technical Assistance Center[2] and the Medicaid State Resource Center.[3]

	1115 Demonstration	1915(b) Waiver	1915(c) Waiver	1915(i) State Plan Option	1915(k) State Plan Option
Purpose and Applicable CFR Section	Authorizes the DHHS Secretary to consider and approve experimental, pilot or demonstration projects likely to assist in promoting the objectives of the Medicaid statute. 42 CFR §431.412	Two-year (or five-year, if serving dual eligibles), renewable waiver authority for mandatory enrollment in managed care on a statewide basis or in limited geographic areas. 42 CFR §438	Provides HCBS to individuals meeting income, resource, and medical (and associated) criteria who otherwise would be eligible to reside in an institution. 42 CFR §441.300 to 310	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. 42 CFR §441.700-745	Provides a State plan option to provide individual controlled home and community-based attendant services and supports Provides a 6% FMAP increase for this option. 42 CFR §441.530-590
Medicaid Requirements That May Be Waived	DHHS Secretary may waive multiple requirements under §1902 of the Social Security Act if waivers promote the objectives of Medicaid law and intent of the program.	• Comparability of services • Freedom of Choice • Statewideness	• Statewideness • Comparability • Community income rules for medically needy population	• Comparability • Community income rules for medically needy population	• Community income rules for medically needy population
Medicaid Eligibility	State defines eligible categories and may expand eligibility. Not intended to add new Medicaid eligibility group(s).	Follows State Plan for Medical Assistance Requirements. Allows for mandatory managed care or primary care case management (PCCM) enrollment for dual	May use institutional income and resource rules for the medically needy (institutional deeming). May include the special income group of individuals	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 eligible for Medicaid under the State plan up to 150% of Federal Poverty Level. Individuals with income greater than 150% of the

[1] See: https://www.macpac.gov/subtopic/waivers/ for the definition of basic requirements that a State may waive under specific federal authorities to meet program goals.
[2] See: http://www.hcbs-ta.org/authority-comparison-chart
[3] See: https://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/At-a-glance-medicaid-Authorities.pdf

		eligibles for Medicaid services through 1915(b)(1) authority.	with income up to 300% of SSI.	Individuals must be eligible for HCBS under a §1915(c), (d), or (e) waiver or §1115 demonstration program.	FPL may use the institutional deeming rules.
Other Eligibility Criteria	State determines requirements for services.	Not applicable.	Must meet institutional level of care. Individuals receiving any waiver services must reside in CMS approved allowable HCBS settings as per 42 CFR §441.301	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 receiving any 1915(i) State Plan optional services must reside in CMS-approved allowable HCBS settings as per 42 CFR §441.710	Must meet institutional level of care. May include the special income group and receiving at least one §1915(c) HCBS waiver service per month. Individuals receiving any CFC services must reside in CMS-approved allowable HCBS settings as per 42 CFR §441.530
Case Management Requirements related to Conflict of Interest and Person Centered Planning Directly Included in the Authority	Conflict of interest requirements may apply in terms and conditions.	No applicable rule. However, conflict of interest requirements do apply in some circumstances if a managed care plan owns/operates direct LTSS services.	Conflict of interest requirements apply under 42 CFR §441.301(b)(vi) Person-centered planning requirements apply under 42 CFR §441.301(c)(1)	Conflict of interest requirements apply under 42 CFR §441.730(b) Person-centered planning requirements apply under 42 CFR §441.725	Conflict of interest requirements apply under 42 CFR §441.555 Person-centered planning requirements apply under 42 CFR §441.540
Limits on Numbers Served	State estimates numbers served. Operates as an entitlement to all who are eligible.	No applicable rule. However, limits may be specified in managed care contracts.	Allowed.	Not allowed.	Not allowed.
Allowable Services/Participant-Directed Services	State decides what services are covered, subject to CMS approval. Participant-directed services are allowed.	May provide additional, health-related services through 1915(b)(3). Allows for selective contracting under 1915(b)(4) authority.	Statutory Services: • Case management services • Homemaker/home health aide services & personal care services • Adult day health services • Habilitation services • Respite care • "Other services requested by State as	See §1915(c) services. Includes both §1915(c) statutory services and "other" category of services. Participant-directed services are allowed.	**MUST COVER**: • Assistance w/ ADLs, IADLs, & health related tasks. • Acquisition, maintenance & enhancement of skills necessary for individual to accomplish ADLs, IADLs, & health-related tasks.

			Secretary may approve" • Day treatment or other partial hospitalization services* • Psychosocial rehabilitation services* • Clinic services* *For individuals with chronic mental illness Participant-directed services are allowed.		• 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 linked to an assessed need for an individual to transition from an institution for mental disease to the community. • Expenditures relating to an identified need that increases his/her independence or substitutes for human assistance. Participant-directed services are required.
Cost Requirements	Budget-neutrality. Services cannot in aggregate cost more than without the §1115 waiver.	Must be determined to be cost-effective and efficient.	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. 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.

Interaction with State Plan Services, Waivers & Amendments	State defines relationship to State Plan, waivers, and amendments, subject to CMS approval.	May be combined with other waivers such as 1915(c), 1915(i), and 1915(k)	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), §1915(j)/§1915(k) services simultaneously. May be combined with other waivers such as §1915(a) or (b).	Individuals may be eligible for and receive State Plan services, §1915(c), §1915(i), §1915(j)/§1915(k) services simultaneously, so long as the service plan (plan of care) ensures duplication of services is not occurring. May be combined with other waivers such as §1915(a) or (b).	Individuals may be eligible for and receive State Plan, §1915(c), §1915(i) and §1915(j)/§1915(k) services simultaneously. May be combined with other waivers such as §1915(a) or (b).