



The Children's Waiver Medicaid Eligibility Status Impact on HCBS Eligible Children

This guidance is to provide clarification regarding Medicaid eligibility related to the Children's Waiver and changes due to the approved 1115 Waiver. This guidance explains how the receipt of services are related to waiver and Medicaid eligibility for *"Family of One"* children. Specifically, the guidance explains when either Health Home Care Management or Home and Community Based Services (HCBS) are required for children to obtain eligibility for the Children's Waiver and Medicaid eligibility.

Together, the 1915(c) Children's Waiver and the 1115 MRT waiver authorities provide Medicaid eligibility for children meeting the HCBS eligibility criteria under the Children's Waiver. The 1915(c) Children's Waiver was implemented on April 1, 2019 and consolidated six children's HCBS waivers into one comprehensive waiver. The children's 1115 MRT waiver amendment was approved on August 2, 2019 to allow *"Family of One"* to children meeting the 1915(c) Children's Waiver criteria, who only receive Health Home Care Management services, to retain their Waiver eligibility status. This allows the child to have Medicaid eligibility determined under a *"Family of One"* budget if not otherwise eligible under community budgeting. The two authorities allow all children and youth eligible for the Waiver to have:

- Greater ease of enrollment into Children's Waiver;
- Access to all HCBS (Home and Community Based Services) as needed;
- Greater flexibility for HCBS to be delivered in natural environments for better outcomes;
- Retain eligibility for Medicaid if *"Family of One"* and eligible for the Children's Waiver.

HCBS Care Management:

All children/youth enrolled in the Children's Waiver need care coordination services. Health Home comprehensive care management provides the care coordination service required under the Children's Waiver. If a child/youth is eligible for the Children's Waiver, they automatically receive Health Home care management and a separate Health Home eligibility determination is not needed. As Health Home is an optional benefit, a child/family can opt-out of Health Home services. For a child/youth who opts-out of Health Home services, their care coordination will be provided by the independent entity of Children and Youth Evaluation Services (C-YES) and, if enrolled in Medicaid Managed Care Plan (MMCP), by the MMCP care manager. A child/youth who needs HCBS, but is not enrolled in Medicaid, will be referred to C-YES who will determine HCBS/LOC Eligibility and assist with establishing Medicaid eligibility. Once the child/youth is HCBS and Medicaid eligible, the child/family can choose who they would like to provide care coordination, Health Home or C-YES.

"Family of One" Medicaid Eligibility:

"Family of One" is a phrase used to describe a child that becomes eligible for Medicaid through the use of institutional eligibility rules. If a child is not otherwise eligible for Medicaid when counting parental income (and/or resources, if applicable), these rules allow for the child to have Medicaid eligibility determined as a *"Family of One"*, using only the child's own income (and resources, if applicable). If a child/youth is not currently receiving Medicaid due to parental income (and/or resources, if applicable) and the child/youth is in need of waiver services, when the child/youth is found HCBS/LOC eligible and able to obtain a capacity slot, then based upon waiver eligibility, the child will have Medicaid eligibility determined as a *"Family of One"*.

Note: There is a hierarchy that must be used in determining a child/youth's Medicaid eligibility. This hierarchy requires that parental income information be included in the child's Medicaid



application, even if the income is not ultimately used under a “*Family of One*” budget. If the child is in a medically fragile diagnostic group or certified disabled, parental resource information and any income of non-waiver siblings under age 18 will also need to be included on the Medicaid application. In addition, as part of the Medicaid eligibility determination, children/youth in a medically fragile diagnostic group will have a disability determination made by the State Disability Review Team, if disability status has not already been established by the Social Security Administration. Pending the disability determination, Medicaid coverage will be authorized for such children under an ADC-related “*Family of One*” budget, but the child/family will be required to comply with the disability determination.

Once a child/youth obtains Medicaid under “Family of One” they must be continually enrolled and receiving HCBS or Health Home care management services (as noted below) to continue their “Family of One” eligibility for the Medicaid. Any “*Family of One*” child/youth can also receive other Medicaid services (i.e. State Plan services) such as Private Duty Nursing, CFTSS (Children and Family Treatment and Support Services), pharmacy, hospital, physician, etc. Once a child/youth with “*Family of One*” Medicaid is no longer eligible for the Children’s Waiver and/or doesn’t receive HCBS or Health Home care management, they may lose their Medicaid eligibility all together or they may have to meet a large spenddown each month in order to access Medicaid services.

“Community Eligible Medicaid” is when a child/youth is determined eligible for Medicaid based on a budget that includes family income (and resources when applicable) in the budget calculation (MAGI, ADC-related or SSI-related community budget) and is not tied to Children’s Waiver eligibility.

“Family of One” and Care Management:

Children/youth who meet HCBS/LOC eligibility (target, risk and functional) and obtain a capacity slot, must be connected and in receipt of at least one HCBS on a monthly basis. Under the new Children’s Waiver/1115 Waiver authorities, any “*Family of One*” (with a KK code) child/youth meeting the eligibility criteria for the 1915(c) Children’s Waiver must receive Health Home care management services or HCBS.

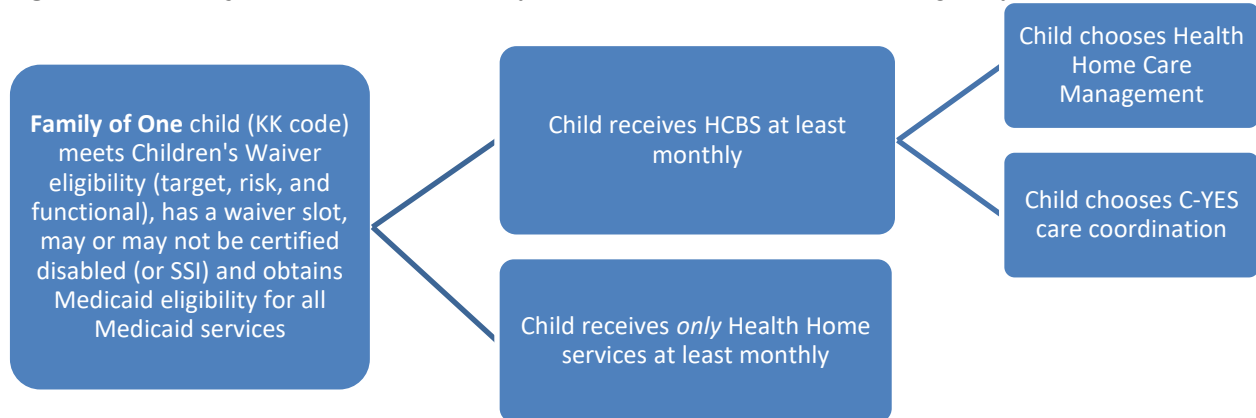
For all children/youth whether Community Eligible or “*Family of One*” Medicaid, a determination of services necessary must be supported by an assessment of needs and strengths with the child/family and their identified care team as developed in the person-centered plan of care (POC). The Children’s Waiver offers an expanded array of service options for children and families. Based on the needs and priorities of the family, the Health Home Care Manager can link the family with the appropriate services to best support their needs, including Private Duty Nursing under the Medicaid State Plan. HCBS found necessary to maintain the child/youth in their home should be supportive and appropriate for the child/youth’s needs. The child/youth’s care record must reflect the needs and necessary services through appropriate documentation.

If an HCBS/LOC eligible child/youth has no need for an HCB Service, **and** is only eligible for Medicaid under a “*Family of One*” budget, then similar to the previous HCBS Waivers, if the child/youth receives Health Home Care Management in order to be maintained in the home, the child/youth qualifies for the Children’s Waiver. Health Home care management may be the sole service for a “*Family of One*” child/youth to continue waiver eligibility and have access to other needed Medicaid services. In these cases, **only** Health Home comprehensive care management with monthly face-to-face monitoring, regardless of acuity level, is allowable. C-YES/MMCP care coordination will not meet this requirement; this restriction must be explained

to the child/family. In contrast, a community Medicaid eligible child must receive an HCBS waiver service monthly to continue waiver eligibility. See the separate document for more details regarding this policy: [The Children’s Waiver - HCBS Waiver Eligibility Service Requirements](#) guidance document.

Health Home care management for an HCBS/LOC and “Family of One” eligible child/youth, in absence of any other HCBS waiver service, requires that the POC outline frequency, scope and duration for the Health Home care management services.

Figure 1: “Family of One” children may obtain waiver and Medicaid eligibility in two ways

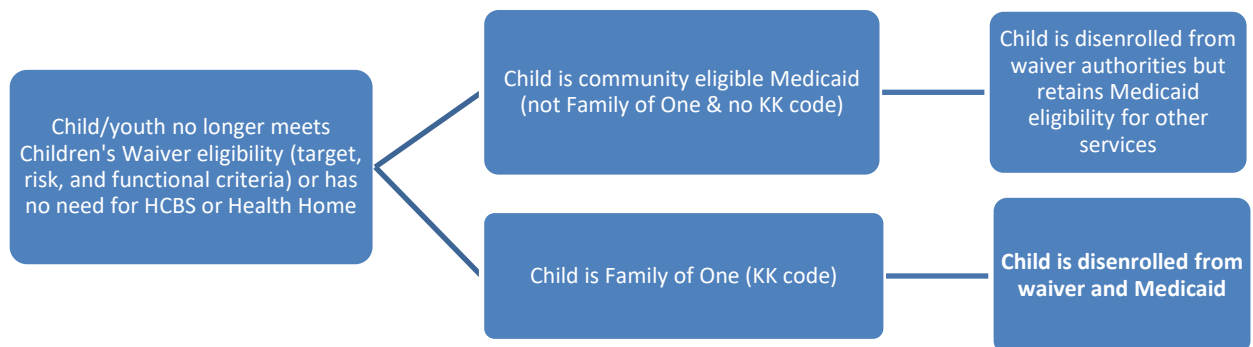


As noted in the figure above, children and youth meeting the Children’s Waiver eligibility criteria, assigned to a capacity slot, and receiving HCBS, may receive care management either through Health Home or C-YES/MMCP based upon child/family choice. The difference between Health Home comprehensive care management and C-YES HCBS care coordination, with MMCP care management as applicable. must be explained to the child/family so an informed choice can be made.

Disenrollment from Waiver:

A child/youth who does not meet the Children’s Waiver eligibility criteria and who has no need for HCBS or Health Home care management, should be disenrolled from the Children’s Waiver. In addition, once a child/youth has been successful in reaching the goal of the HCBS (i.e. Environmental Modification) and no other HCBS is needed, possible discharge from the waiver authorities should be reviewed and determined if other HCBS goals are not appropriate.

Figure 2: Disenrollment from Waiver if child/youth does not meet Children’s Waiver criteria or need HCBS/Health Home services





“Family of One” children/youth (with a KK code) who do not require at least one HCBS monthly but continues to meet the eligibility criteria for the Children’s Waiver must receive Health Home Care Management and have HCBS in their plan of care for health and welfare monitoring to maintain their Medicaid eligibility.

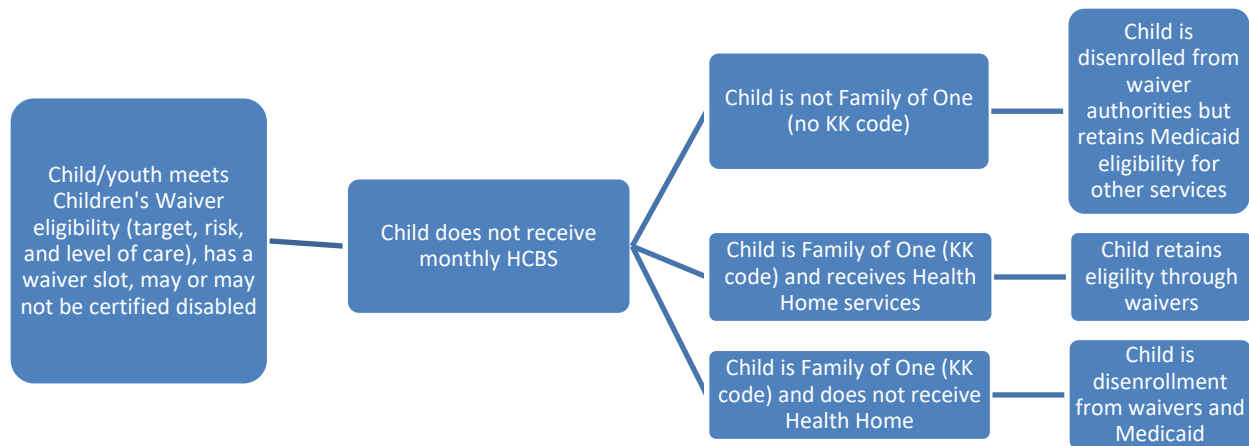
If a child/youth has community Medicaid (without a KK code) and does not need HCBS monthly but needs State Plan services or other supports to be safe and supported at home and in their community, will be disenrolled from the Children’s Waiver. The child/youth will retain Medicaid eligibility to receive all other medically necessary Medicaid services.

Receipt of HCBS or Health Home Care Management Services

If State Plan Services such as Children and Family Treatment and Support Services (CFTSS) or Community First Choice Options (CFCO) can meet a child/youth’s needs, then these services must be accessed prior to HCB Services. This does not prohibit a child/youth from receiving both State Plan services and HCBS at the same time, as long as it is reflective of the child/youth’s needs in the person-centered POC and does not result in duplicative services. The child/youth’s needs should be continually monitored and reviewed with the family and treating service providers. If it is determined that the child/youth’s needs are met via non-HCBS programs and/or services, HCBS discharge should be explored.

If State Plan or CFCO services alone meet the needs of the child/youth, then the child/youth should **not be** enrolled in the Children’s Waiver unless the child/youth is only eligible for Medicaid under “Family of One” (KK code). A “Family of One” child/youth who meets the Children’s Waiver eligibility criteria and receives HCBS and/or Health Home Care Management, can access other State Plan services such as Private Duty Nursing, and will continue to meet waiver and Medicaid eligibility requirements.

Figure 3: Disenrollment from waiver if child/youth doesn’t receive monthly HCBS but continues to meet Children’s Waiver criteria



This guidance document compliments [The Children’s Waiver - HCBS Waiver Eligibility Service Requirements](#) guidance document and both documents should be reviewed together.