



Center for Medicaid, CHIP and Survey & Certification

SMDL# 10-013

ACA # 4

August 6, 2010

Re: Improving Access to Home and Community-Based Services

Dear State Medicaid Director:

The purpose of this letter is to inform you of several changes to Section 1915(i) of the Social Security Act (the Act) made by the Affordable Care Act (ACA)¹. These changes, which become effective October 1, 2010, include revised and new 1915(i) provisions for removal of barriers to offering home and community-based services (HCBS) through the Medicaid State plan. This letter is intended to provide States guidance on those important changes to the law.

Background

Section 6086 of the Deficit Reduction Act of 2005 (DRA) added section 1915(i) to the Act. While this State plan service package includes many similarities to options and services available through 1915(c) HCBS waivers, a significant difference is that 1915(i) does not require individuals to meet an institutional level of care in order to qualify for HCBS. Section 1915(i) provides States an opportunity to offer services and supports before individuals need institutional care, and also provides a mechanism to provide State plan HCBS to individuals with mental health and substance use disorders. As originally enacted, however, States were unable to target 1915(i) services to particular populations within the State, and could only serve individuals whose incomes did not exceed 150 percent of the Federal poverty level (FPL). Additionally, the original service package available under 1915(i) included some, but not all, of the HCBS available through waivers.

The changes to 1915(i) under the ACA enhance an important tool for States in their efforts to serve individuals in the most integrated setting and to meet their obligations under the Americans with Disabilities Act (the ADA) and the *Olmstead* decision. In order to promote State utilization of 1915(i), the ACA includes changes that enable States to target HCBS to particular groups of people, to make HCBS accessible to more individuals, and to ensure the quality of the HCBS.

Improvements to Section 1915(i) in the Affordable Care Act

The following information summarizes major changes and additions to section 1915(i) under the ACA¹.

¹ Section 2402(b) through 2402(f) of the Affordable Care Act (Patient Protection and Affordable Care Act, P.L. 111-148, enacted March 23, 2010, together with the Health Care and Education Reconciliation Act of 2010, P.L. 111-152, enacted March 30, 2010).

Number Served & Statewideness

Under the ACA, States may continue to specify needs-based eligibility criteria but they are no longer permitted to limit the number of eligible individuals who can receive 1915(i) State plan HCBS or establish a waiting list for State plan HCBS. Additionally, States may not limit the availability of 1915(i) services to specific geographic areas or political subdivisions of the State (statewideness). As with other State plan services, 1915(i) State plan HCBS must be offered to all eligible individuals (as defined by the State) on a statewide basis. However, States are afforded new flexibility to target specific 1915(i) services to State-specified populations (see “Targeted Benefits”). States are required to report to the Centers for Medicare & Medicaid Services (CMS) annually, to project the number of individuals who are expected to receive 1915(i) State plan HCBS in a year, and to submit the actual number of individuals served.

If enrollment of eligible individuals exceeds a State’s projected enrollment estimate provided in a CMS-approved 1915(i) State plan amendment (SPA), as included under the DRA, Section 1915(i) continues to permit States to modify the non-financial needs-based eligibility criteria without prior approval by CMS. States need only to notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria. However, the ACA does revise the length of the grandfathering period for individuals under this adjustment authority specified at section 1915(i)(1)(D)(ii)(II). If a State chooses to revise its needs-based eligibility criteria, it must continue offering 1915(i) services in accordance with individual service plans to participants who do not meet the new revised needs-based criteria, but continue to meet the former needs-based criteria, for as long as the State plan HCBS option is authorized.

Financial Eligibility

States continue to have the option to provide State plan HCBS to individuals with incomes up to 150 percent of the FPL who are eligible for Medicaid under an eligibility group covered under the State plan without regard to whether such individuals need an institutional level of care. All individuals served under 1915(i), regardless of their income levels, must meet the non-financial needs-based criteria that the State establishes to access 1915(i) State plan HCBS. As a reminder, each State requesting to add 1915(i) to its State plan is required to demonstrate that the needs-based criteria for 1915(i) services are less stringent than the State’s institutional level of care criteria.

The ACA adds a new section to 1915(i) that allows States the option of providing services to individuals with income up to 300 percent of the Supplemental Security Income (SSI) Federal benefit rate (FBR)². While individuals served in this new eligibility group must be eligible for HCBS under a 1915(c), (d), or (e) waiver or 1115 demonstration program, they do not have to be enrolled and receiving services in either waiver program. For this eligibility group, States are also permitted to use institutional eligibility and post-eligibility rules in the community, in the same manner they would under a 1915(c) waiver. Post eligibility rules determine the amount (if any) for which an individual is liable to pay for the cost of their 1915(i) HCBS.

Targeted Benefits

With the changes enacted through the ACA, States may design service packages without regard to comparability, as described at 1902(a)(10)(B). States are able to offer HCBS to specific, targeted populations. States will also be permitted to offer services that are different in amount, duration, and scope

² For 2010, 300 percent of SSI is equal to \$2,022 per month.

to specific population groups, including eligibility groups as authorized under 1915(i)(6)(c), either through one 1915(i) service package, or multiple 1915(i) service packages. For example, a State could propose to have one 1915(i) benefit that is targeted and includes specific services for persons with physical and/or developmental disabilities, and another 1915(i) benefit targeted to persons with chronic mental illness. Another State might implement one 1915(i) benefit that is targeted to children with autism and adults with HIV/AIDS, but specify different services to meet the needs for each targeted population group within the same overall benefit package.

If a State chooses to implement this option to provide State plan HCBS to a targeted population(s), the ACA authorizes CMS to approve such a SPA for a 5-year period. States will be able to renew approved 1915(i) services for additional 5-year periods if CMS determines, prior to the beginning of the renewal period, that the State met Federal and State requirements and that the State's monitoring is in accordance with the Quality Improvement Strategy specified in the State's approved SPA.

Services

Section 1915(i) allows States to include any or all of the services that are listed in section 1915(c)(4)(B) of the Act. These services include case management, homemaker/home health aide, personal care, adult day health, habilitation, and respite care services. In addition, the following services may be provided to persons with chronic mental illness: day treatment, other partial hospitalization services, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility). The ACA revised 1915(i) so that States may now offer, "such other services requested by the State as the Secretary may approve." As a result of this change, States will now be permitted to propose "other services" (not including room and board) in a 1915(i) SPA that CMS will evaluate and possibly approve.

States continue to have the option to offer self-direction to individuals receiving State plan HCBS, and CMS urges all States to afford participants the opportunity to direct some or all of their HCBS. Self-direction permits participants to plan and purchase their HCBS under their direction and control or through an authorized representative. As with all 1915(i) services, the provision of these services must be in accordance with an individualized plan of care, which is based upon an independent assessment and a person-centered process driven by what is important to the participant. The services that the participant or his/her representative will self-direct and the methods by which he/she will self-direct and the supports that are available to the participant all must be specified in the plan of care.

Compliance

States will be required to continue to comply with all other provisions of 1915(i) as well as other sections of the Act in the administration of the State plan under this Title.

Submission Procedures

These new and revised provisions will become effective October 1, 2010. Regulations at 42 CFR 430.12(c)(i) require States to amend their State plans to take account of changes in Federal law. Therefore, States with approved 1915(i) services prior to this date that include provisions impacted by the changes under the ACA, should submit a SPA no later than December 31, 2010, that will take effect retroactive to October 1, 2010.

To incorporate a new 1915(i) service package into your State plan, or to revise existing approved 1915(i) services, please submit a SPA electronically to the Associate Regional Administrator for Medicaid in your CMS regional office.

CMS encourages States to submit questions and comments to CMS regarding the statutory changes to 1915(i) made in the ACA through the mailbox at CMCSPPACAQuestions@cms.hhs.gov. If you have any additional questions, please contact Ms. Barbara Edwards, Director of the Disabled and Elderly Health Programs Group, at 410-786-0325.

Sincerely,

/s/

Cindy Mann
Director

Enclosure

cc:

CMS Regional Administrators

CMS Associate Regional Administrators

Ann C. Kohler
NASMD Executive Director
American Public Human Services Association

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Matt Salo
Director of Health Legislation
National Governors Association

Debra Miller
Director for Health Policy
Council of State Governments

Christine Evans, M.P.H.
Director, Government Relations
Association of State and Territorial Health Officials

Alan R. Weil, J.D., M.P.P.
Executive Director
National Academy for State Health Policy

Enclosure

The Affordable Care Act

Section 2402 (b) ADDITIONAL STATE OPTIONS.—Section 1915(i) of the Social Security Act (42 U.S.C. 1396n(i)) is amended by adding at the end the following new paragraphs:

Statutory Provision	Changes to the Existing 1915(i) Benefit	New Features for the 1915(i) Benefit
(6) STATE OPTION TO PROVIDE HOME AND COMMUNITY-BASED SERVICES TO INDIVIDUALS ELIGIBLE FOR SERVICES UNDER A WAIVER.— (A) IN GENERAL.—A State that provides home and community-based services in accordance with this subsection to individuals who satisfy the needs-based criteria for the receipt of such services established under paragraph (1)(A) may, in addition to continuing to provide such services to such individuals, elect to provide home and community-based services in accordance with the requirements of this paragraph to individuals who are eligible for home and community-based services under a waiver approved for the State under subsection (c), (d), or (e) or under section 1115 to provide such services, but only for those individuals whose income does not exceed 300 percent of the supplemental security income benefit rate established by section 1611(b)(1). AND		Allows States to add a new optional Medicaid eligibility group to provide 1915(i) to individuals who have income that does not exceed 300% of SSI Federal Benefit Rate and are eligible for HCBS under a waiver. To be eligible, the individuals must still also meet 1915(i) needs-based criteria established by the State, as approved in a SPA. This new provision gives States the option to offer HCBS to individuals with higher incomes (up to 300% of SSI FBR) who are eligible for an approved waiver in the State. While individuals must be eligible for a 1915(c) waiver (institutional and any specific waiver targeting criteria) or 1115 demonstration program, they do not have to actually be enrolled and receiving waiver services in either waiver program. AND

2402(d) OPTIONAL ELIGIBILITY CATEGORY TO PROVIDE FULL MEDICAID BENEFITS TO INDIVIDUALS RECEIVING HOME AND COMMUNITY-BASED SERVICES UNDER A STATE PLAN AMENDMENT.— (1) Section 1902(a)(10)(A)(ii) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ii)), as amended by section 2304(a)(1), is amended— (A) in subclause (XX), by striking “or” at the end; (B) in subclause (XXI), by adding “or” at the end; and (C) by inserting after subclause (XXI), the following new subclause: “(XXII) who are eligible for home and community-based services under needs-based criteria established under paragraph (1)(A) of section 1915(i), or who are eligible for home and community-based services under paragraph (6) of such section, and who will receive home and community-based services pursuant to a State plan amendment under such subsection;”. (2) CONFORMING AMENDMENTS.— (A) Section 1903(f)(4) of the Social Security Act (42 U.S.C. 1396b(f)(4)), as amended by section 2304(a)(4)(B), is amended in the matter preceding subparagraph (A), H. R. 3590—186 by inserting “1902(a)(10)(A)(ii)(XXII),” after “1902(a)(10)(A)(ii)(XXI),”. (B) Section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)), as so amended, is amended in the matter preceding paragraph (1)— (i) in clause (xv), by striking “or” at the end; (ii) in clause (xvi), by adding “or” at the end; and (iii) by inserting after clause (xvi) the following new clause:		For this eligibility group, States are also permitted to use institutional eligibility and post-eligibility rules in the community, in the same manner they would under a 1915(c) waiver.
--	--	--

“(xvii) individuals who are eligible for home and community-based services under needs-based criteria established under paragraph (1)(A) of section 1915(i), or who are eligible for home and community-based services under paragraph (6) of such section, and who will receive home and community-based services pursuant to a State plan amendment under such subsection.”.		
(6)(B) APPLICATION OF SAME REQUIREMENTS FOR INDIVIDUALS SATISFYING NEEDS-BASED CRITERIA.— Subject to subparagraph (C), a State shall provide home and community-based services to individuals under this paragraph in the same manner and subject to the same requirements as apply under the other paragraphs of this subsection to the provision of home and community-based services to individuals who satisfy the needs-based criteria established under paragraph (1)(A).		When States choose to serve individuals through the new optional eligibility category, all other requirements continue to apply (ex., needs-based criteria evaluation and assessment, person-centered planning).
(6)(C) AUTHORITY TO OFFER DIFFERENT TYPE, AMOUNT, DURATION, OR SCOPE OF HOME AND COMMUNITY-BASED SERVICES.— A State may offer home and community-based services to individuals under this paragraph that differ in type, amount, duration, or scope from the home and community-based services offered for individuals who satisfy the needs-based criteria established under paragraph (1)(A), so long as such services are within the scope of services described in paragraph (4)(B) of subsection (c) for which the Secretary has the authority to approve a waiver and do not include room or board.		For States that choose to add the new optional eligibility group for individuals with incomes up to 300% SSI FBR, there is an additional flexibility to offer different types, amount, duration, or scope of HCBS to these eligible individuals. All services have to be those allowed under 1915(c)(4)(B), approved by CMS, and not include room and board.
(7) STATE OPTION TO OFFER HOME AND COMMUNITY-BASED SERVICES TO SPECIFIC, TARGETED POPULATIONS.— (A) IN GENERAL.—A State may elect in a State plan amendment under this subsection to target the provision of home and community-based services under this subsection to specific populations and to differ the type, amount, duration, or scope of such services to such specific populations.		Allows States to provide HCBS to specific targeted populations. States are now also allowed the option to have more than one 1915(i) benefit by target group.

(7)(B) 5-YEAR TERM.— (i) IN GENERAL.—An election by a State under this paragraph shall be for a period of 5 years. (ii) PHASE-IN OF SERVICES AND ELIGIBILITY PERMITTED DURING INITIAL 5-YEAR PERIOD.— A State making an election under this paragraph may, during the first 5-year period for which the election is made, phase-in the enrollment of eligible individuals, or the provision of services to such individuals, or both, so long as all eligible individuals in the State for such services are enrolled, and all such services are provided, before the end of the initial 5-year period.		(i) If States choose to target populations, the SPA will be approved for a 5-year period.
(7)(C) RENEWAL.—An election by a State under this paragraph may be renewed for additional 5-year terms if the Secretary determines, prior to beginning of each such renewal period, that the State has— (i) adhered to the requirements of this subsection and paragraph in providing services under such an election; and “(ii) met the State’s objectives with respect to quality improvement and beneficiary outcomes.”.		States may renew for additional 5-year periods if CMS determines prior to beginning of renewal period that the State met all quality and programmatic requirements.
1915(i)(c) REMOVAL OF LIMITATION ON SCOPE OF SERVICES.—Paragraph (1) of section 1915(i) of the Social Security Act (42 U.S.C. 1396n(i)), as amended by subsection (a), is amended by striking “or such other services requested by the State as the Secretary may approve”.	This change allows States to provide “other services” as permitted under 1915(c) waivers. States must continue to identify and define services (including provider qualifications) in a CMS-approved 1915(i) SPA.	

(e) ELIMINATION OF OPTION TO LIMIT NUMBER OF ELIGIBLE INDIVIDUALS OR LENGTH OF PERIOD FOR GRANDFATHERED INDIVIDUALS IF ELIGIBILITY CRITERIA IS MODIFIED.—Paragraph (1) of section 1915(i) of such Act (42 U.S.C. 1396n(i)) is amended— (1) by striking subparagraph (C) and inserting the following: “(C) PROJECTION OF NUMBER OF INDIVIDUALS TO BE PROVIDED HOME AND COMMUNITY-BASED SERVICES.—The State submits to the Secretary, in such form and manner, and upon such frequency as the Secretary shall specify, the projected number of individuals to be provided home and community-based services.”; and	This provision removes the option for a State to limit number of eligible individuals who can receive 1915(i) services. As a result, States may no longer establish a wait list for receipt of State plan HCBS.	
(2) in subclause (II) of subparagraph (D)(ii), by striking “to be eligible for such services for a period of at least 12 months beginning on the date the individual first received medical assistance for such services” and inserting “to continue to be eligible for such services after the effective date of the modification and until such time as the individual no longer meets the standard for receipt of such services under such pre-modified criteria”.	This provision removes the 12-month limit from the grandfathering period. If a State decides to tighten its needs-based criteria, it must continue offering 1915(i) services to individuals who were eligible and being served under the former standards.	

(f) ELIMINATION OF OPTION TO WAIVE STATEWIDENESS; ADDITION OF OPTION TO WAIVE COMPARABILITY.—Paragraph (3) of section 1915(i) of such Act (42 U.S.C. 1396n(3)) is amended by striking “1902(a)(1) (relating to statewideness)” and inserting “1902(a)(10)(B) (relating to comparability)”.	This provision removes the ability for States to limit the availability of the 1915(i) benefit to specific geographic areas or political subdivisions of the State (statewideness). As with other State plan services, 1915(i) State plan HCBS must be offered to all eligible individuals on a statewide basis.	This provision also adds a new provision to allow States to waive comparability. States can now target 1915(i) to specific populations. States are now also allowed the option to have more than one 1915(i) benefit by target group. As with new Section 1915(i)(7), States that choose to target populations will be able to renew the approved 1915(i) benefit for additional 5-year periods if CMS determines, prior to the beginning of the renewal period, that States met Federal and State requirements and the State’s monitoring is in accordance with the Quality Improvement Strategy (QIS) specified in the State’s approved 1915(i) State plan service benefit.
---	---	--