DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations

SMDL #08-001

Dear State Medicaid Director:

This letter provides guidance on the implementation of section 6086 of the Deficit Reduction Act of 2005 (DRA), Public Law Number 109-171.

Section 6086, Expanded Access to Home and Community-Based Services for the Elderly and Disabled, adds a new section 1915(i) to the Social Security Act (the Act). Under section 1915(i), States have the option to amend their State plans to provide home and community-based services (HCBS) without regard to statewideness or certain other Medicaid requirements. This provision was effective January 1, 2007.

There are certain similarities and differences between HCBS under the new State plan option and the existing section 1915(c) waiver authority. It should be noted that the addition of section 1915(i) of the Act does not alter a State's ability to request or administer waivers under section 1915(c) of the Act. The enclosed chart outlines a comparison of the Medicaid benefits States can offer under these two different authorities.

State Plan HCBS Financial Eligibility
Section 1915(i)(1) of the Act gives States the option of providing HCBS under their State plan to individuals eligible for Medicaid under an eligibility group covered in the State plan, and who have income that does not exceed 150 percent of the Federal poverty level (FPL). This option does not create a new eligibility group. Rather, the 150 percent of poverty income requirement must be met in addition to all of the eligibility requirements applicable to the group under which the individual qualifies for Medicaid. In determining whether the 150 percent of poverty requirement is met, the regular rules for determining income eligibility for the individual's eligibility group apply.

State Plan HCBS Program Eligibility
Section 1915(i)(3) of the Act gives States the option not to apply section 1902(a)(10)(C)(i)(III) of the Act (pertaining to income and resource eligibility rules) for the medically needy living in the community. This election allows States to treat medically needy individuals as if they are living in an institution by not deeming income and resources from an ineligible spouse to an applicant, or from a parent to a child. However, this authority is limited to the medically needy. There is no authority under section 1915(i) of the Act, comparable to the statutory authority under section 1915(c) of the Act, in which a State can treat individuals who are not medically needy as if they are living in an institution for purposes of determining their eligibility for the HCBS State plan option. We note, however, that individuals with incomes up to 150 percent of the FPL who are only eligible for Medicaid because they are receiving 1915(c) waiver services

may also be eligible to receive services under 1915(i) of the Act, provided they meet all other requirements of the 1915(i) State plan option.

Additionally, section 1915(i)(1)(A) of the Act requires States to impose needs-based criteria for eligibility for State plan HCBS. States may also establish additional needs-based criteria for the specific service(s) that an individual could receive under the State plan HCBS. In contrast to HCBS waivers, it is not necessary for States to demonstrate, or for the Centers for Medicare & Medicaid Services (CMS) to conclude, that but for the provision of the services furnished under section 1915(i) of the Act, the individual would require the level of care provided in a hospital, nursing facility, or intermediate care facility for persons with mental retardation. However, States must demonstrate that the institutional level of care criteria they apply are more stringent than the needs-based criteria established for 1915(i) State plan HCBS. States may use the needs-based criteria, as well as requirements of medical necessity, to provide State plan HCBS only to individuals who qualify for the benefit.

Number Served Reporting Requirement

States are required under section 1915(i)(1)(C)(i) of the Act to project the number of individuals served in a year and to submit this information to CMS in the form and upon the frequency specified by the Secretary. CMS will require States to report annually the actual number of individuals served. In the event that a State serves more individuals than the number originally projected, the law provides a mechanism by which the State may modify the needs-based eligibility criteria without prior approval by the Secretary. In addition, States may establish a limit on the total number of individuals served and provide for waiting lists for State plan HCBS.

Services

Section 1915(i) of the Act allows the provision of specific HCBS under the State plan. These services are listed in section 1915(c)(4)(B) of the Act that governs HCBS waivers. The services listed in section 1915(c)(4)(B) of the Act are: case management services, homemaker/home health aide services, personal care services, adult day health services, habilitation services, and respite care. In addition, the following services may be provided for individuals with chronic mental illness: day treatment, other partial hospitalization services, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility). As with other State plan services, States may impose criteria of medical necessity or requirements for prior authorization and utilization control to ensure the appropriate level of services furnished to an eligible individual. In addition, States may establish a maximum utilization level of a particular service furnished under the State plan HCBS option.

Independent Evaluation and Assessment & Conflict of Interest Standards

Section 1915(i)(1)(E) of the Act requires an independent evaluation and assessment of each individual who applies for services under this benefit. Additionally, section 1915(i)(1)(H)(ii) of the Act requires States to establish standards for the conduct of the independent evaluation and assessment to safeguard against conflicts of interest. Thus, States should establish standards and procedures to ensure that evaluators and assessors are not:

- related by blood or marriage to the individual, or any paid caregiver of the individual;
- financially responsible for the individual;

- empowered to make financial or health-related decisions on behalf of the individual; and/or
- providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS, except when the only willing and qualified provider in a geographic area also provides HCBS, and States devise conflict of interest protections.

In addition, the law sets forth requirements for the independent assessment. Based on these requirements, the assessment should be based on the following:

- an objective face-to-face evaluation by an independent agent trained in assessment of need for HCBS and supports;
- consultation with the individual and others as appropriate;
- an examination of the individual's relevant history, medical records, care and support needs, and preferences;
- objective evaluation of the inability to perform, or need for significant assistance to perform 2 or more activities of daily living (as defined in section 7702B(c)(2)(B) of the Internal Revenue Code of 1986);
- where applicable, an evaluation of the support needs of the individual (or the individual's representative) to participant-direct; and
- a determination of need (and, if applicable, determination that service-specific additional needs-based criteria are met) for at least one State plan HCBS before an individual is enrolled into the State plan HCBS benefit.

Individualized Care Plans

Section 1915(i) of the Act requires States to provide services according to an individualized care plan for each individual. The law also sets forth requirements for the development and monitoring of the individualized care plan. Based on these requirements, the individualized plan of care should:

- be based on the independent assessment;
- be developed by a person-centered process in consultation with the individual, the individual's treating physician, health care or supporting professional, or other appropriate individuals, as defined by the State, and, where appropriate, the individual's family, caregiver, or representative;
- identify the State plan HCBS necessary for the individual, and furnish (or, fund if the individual elects to participant-direct the purchase of such services) all HCBS which the individual needs and for which the individual meets service-specific additional needs-based criteria (if any);
- take into account the extent of, and need for, any family or other supports for the individual;
- prevent the provision of unnecessary or inappropriate care;
- be guided by best practices and research on effective strategies for improved health and quality of life outcomes; and
- be reviewed at least every 12 months and as needed when there is significant change in the individual's circumstances.

Self-Directed Services
Under the State plan HCBS option, States may offer an individual (or the individual's representative) the option to self-direct HCBS. Self-directed services may be planned and purchased under the direction and control of the individual or the individual's authorized representative, including the amount, duration, scope, provider, and location of such services. The provision of these services must be based upon the individualized plan of care, which specifies the services that the individual or his/her representative will self-direct and the methods by which they will do so. States may also allow individuals who choose to self-direct services to have individualized budgets. With respect to these budgets, the State plan amendment must describe in detail the method for calculating the dollar values (e.g., based on a prospective budget amount uniquely assigned to each participant by level of support). States must also define a process for making adjustments in the budget to reflect changes in the individual assessments and service plans.

Quality
States must ensure that the provision of HCBS meets Federal and State guidelines for quality assurance. As is the case with HCBS waivers, CMS requires States to have a quality improvement strategy that includes methods for ongoing measurement of program performance and mechanisms of intervention to assure quality of care, proportionate to the scope of the HCBS and the number of individuals receiving HCBS.

Effective January 1, 2010, the DRA also requires that the Secretary develop, through the Agency for Health Care Research and Quality, indicators and measures for program performance and quality of care to assess HCBS at the State and national level, and service outcomes, particularly regarding health and welfare of individuals receiving HCBS. Likewise, the measures in the State quality improvement strategy must consist of indicators for program performance and quality of care as approved and prescribed by the Secretary, and applicable to the nature of the State plan HCBS benefit.

Compliance with the Law
States will be required to continue to comply with all other provisions of the Act in the administration of the State plan under this Title.

Submission Procedures
This provision was effective January 1, 2007. To incorporate this new benefit into your State plan, please submit your State Plan Amendment electronically to the Associate Regional Administrator for Medicaid in your servicing regional office.

If you have any additional questions, please contact Ms. Suzanne Bosstick, Director, Division of Community and Institutional Services, Disabled and Elderly Health Programs Group, at 410-786-1301.

Sincerely,

Dennis G. Smith
Director

Enclosure

cc:

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