DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Center for Medicaid, CHIP, and Survey & Certification

SMDL# 11-009
ACA# 19

August 5, 2011

Dear State Medicaid Director:

This letter and the accompanying Questions and Answers (Q&As) are part of a series that provide guidance on the "maintenance of effort" (MOE) provisions in the Patient Protection and Affordable Care Act, P.L. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, P.L. 111-152 (together known as the Affordable Care Act). The policies contained in the attached Q&As build upon and clarify the guidance previously issued on the MOE provisions of the American Reinvestment and Recovery Act (the Recovery Act) and their relationship to institutional level of care requirements and home and community-based services (HCBS). We have also included a question and answer regarding ways in which States who have identified a program integrity concern can strengthen program integrity procedures consistent with the MOE provisions.

Many States provide institutional care and HCBS to individuals who are eligible for Medicaid based on their need for those services. HCBS are a vital element of State efforts to build cost-effective, person-centered systems that provide services that enable individuals to remain in or return to their homes and communities and avoid institutional services. In the enclosed Q&As, we address the Affordable Care Act MOE provisions as they relate to institutional care and HCBS, based on questions we have received. We note that States continue to have opportunities to make adjustments to services within their HCBS waivers that are not related to eligibility and thus do not implicate MOE. States also have flexibility to modify their HCBS when a waiver authorizing such services expires.

Medicaid-financed HCBS are frequently the key component of State strategies to deliver services for persons with disabilities that comply with the Americans with Disabilities Act (ADA), the Supreme Court's Olmstead decision and subsequent Federal court opinions interpreting that decision (see our May 20, 2011 State Medicaid Director Letter at http://www.cms.gov/smdl/downloads/SMD10008.pdf). For that reason, we stress that this guidance pertains only to the Medicaid MOE provisions and does not address a State's independent and ongoing obligations under the ADA. States can get further information with respect to ADA compliance by contacting the Department of Health and Human Services (HHS), Office for Civil Rights (OCR) at OCR.Olmstead@hhs.gov or consulting OCR's website at http://www.hhs.gov/ocr. Information about ADA community integration cases and settlements in which the Civil Rights Division of the U.S. Department of Justice is involved may be found at http://www.ada.gov/.

We recommend that States contact CMS for technical assistance with the MOE provisions if they are interested in pursuing any changes to their long-term care policies. We note that other provisions of the Affordable Care Act, such as the Balancing Incentive Program and Community First Choice Option, include maintenance requirements for certain aspects of the Medicaid program in order to

receive new, increased Federal matching payments. This letter does not address a State's requirements under those provisions; however, States may want to review these separate program requirements as they consider actions that affect the provision of HCBS.

Please submit any questions you have about the Affordable Care Act MOE provisions relating to HCBS to Ms. Barbara Edwards at Barbara.Edwards@cms.hhs.gov.

We hope this guidance is informative. We note that previous guidance on the Affordable Care Act MOE provisions—specifically on the topics of 1115 demonstrations, premiums and the non-application provision—was contained in our February 25, 2011 State Medicaid Director letter available at http://www.cms.gov/smdl/downloads/SMD11001.pdf. For general questions about MOE please contact Penny Thompson at Penny.Thompson@cms.hhs.gov.

Sincerely,

/s/

Cindy Mann
Director

Enclosures

cc:

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ENCLOSURE A: THE AFFORDABLE CARE ACT
MAINTENANCE OF EFFORT (MOE)--QUESTIONS & ANSWERS

Q1. Are there flexibilities that a State can utilize to manage their section 1915(c) home and community-based care services (HCBS) waivers?

Answer. Yes. States maintain flexibility to implement mechanisms that simplify administration and control costs in their HCBS waivers. States also can combine waivers of similar target groups for administrative simplicity as long as eligibility criteria remain the same.

While the MOE provisions of the Affordable Care Act require that States maintain eligibility standards, methodologies and procedures, the MOE provisions do not affect a State's ability to manage waiver costs by modifying waiver benefits, rates or introducing new waiver service-specific medical necessity criteria or utilization controls which do not affect individuals' eligibility for Medicaid. For example, a State may change the criteria for receipt of a particular service that would not impact an individual's overall Medicaid eligibility, but would instead impact their ability to receive a specific service. However, States must also carefully consider the implications of such changes on their obligations to ensure the health and welfare of individuals served within the waiver programs, as well as their community integration obligations under the Americans with Disabilities Act (ADA) and the right of individuals to receive public benefits in the most integrated setting appropriate to their needs. That is, irrespective of whether there is an MOE issue, a reduction in benefits could potentially result in individuals losing the ability to have their needs met and live in a home and community-based setting, which could have implications under the ADA, the Olmstead decision, and subsequent Federal court decisions. For example, a reduction in benefits could place individuals with disabilities living in the community at risk of institutionalization or could make it more difficult for individuals who are inappropriately institutionalized to leave the institution and receive services in the most integrated setting.

As detailed in our May 20, 2010 State Medicaid Director Letter at http://www.cms.gov/smdl/downloads/SMD10008.pdf, there are a variety of mechanisms available to States to rebalance their long-term support systems for persons with disabilities to achieve compliance with the ADA.

Q2. How does Institutional Level of Care, which serves as the level of care for HCBS waivers as well, interact with MOE?

Answer. Because the Recovery Act MOE, its extension, and the Affordable Care Act MOE use the same language, we are applying the same basic principle we articulated in the Recovery Act MOE to the Affordable Care Act MOE. As outlined in our August 19, 2009 guidance on Recovery Act MOE (http://www.cms.gov/SMDL/downloads/SMD081909.pdf), implementing more stringent institutional level of care (LOC) criteria affects eligibility for individuals in institutional and section 1915(c) home and community-based settings and therefore are considered

more restrictive eligibility policies. Individuals eligible for Medicaid through their receipt of HCBS waiver services are in an eligibility group defined in regulation at 42 CFR 435.217.

However, States may upwardly adjust institutional LOC criteria in order to promote community-based care and to achieve cost savings in ways that are consistent with the MOE provision. Under these circumstances, the adjustment will not change eligibility, but rather the setting in which services are provided. Below are examples to illustrate this flexibility:

a. A State may upwardly adjust its institutional LOC criteria if it has an alternative vehicle to offer Medicaid eligibility to long-term care services and support in the community to all individuals that would have previously been able to gain eligibility under the original LOC. For example, a State could design a 1915(i) benefit package that is narrowly targeted to individuals who would have been eligible under former LOC levels. In this example, the State, through an eligibility group that provides Medicaid eligibility based on need for 1915(i) services, would ensure continued access to Medicaid eligibility for those who no longer meet LOC levels. The State would then need to ensure that the financial and needs-based criteria for the eligibility group are crafted in a manner that protects Medicaid eligibility for all individuals previously eligible under the former LOC.

b. Another example may be a State that operates an 1115 demonstration offering different levels of care for receipt of HCBS and institutional services, ensuring that the available capacity for Medicaid eligibility remains unchanged.

c. A State may also upwardly adjust its institutional LOC if it does not cover the 42 CFR 435.217 group in its waivers, provided such an adjustment would not result in individuals in institutions losing eligibility for Medicaid. Loss of eligibility, and a resulting MOE issue, could occur if an upward adjustment in institutional LOC means that some individuals eligible under the special income level group would have to leave the institution because they do not meet the new LOC criteria, but could not then maintain eligibility in the community because the State does not cover the 435.217 group for waiver services. To upwardly adjust its institutional LOC while adhering to the MOE, a State that does not cover the 435.217 group for waiver services must be able to make its adjustments without negatively impacting Medicaid eligibility.

Q3. How is the termination or modification of a Medicaid HCBS waiver affected by the Affordable Care Act MOE provisions?

Answer. The requirements for HCBS waivers and the Affordable Care Act MOE are similar to the policies outlined for 1115 demonstrations in our February 25, 2011 State Medicaid Director Letter (http://www.cms.gov/smdl/downloads/SMD11001.pdf). Every HCBS waiver is approved for a time-limited period, after which the waiver continues operation only if a State requests a renewal. The MOE provisions in the Affordable Care Act do not require a State to request that the Secretary continue a HCBS waiver after the date that the waiver would expire under the approval in effect on March 23, 2010. States may discontinue HCBS waivers when the approval period expires. If a State requests a renewal at the end of the approved waiver period in effect as of March 23, 2010, with modifications to the waiver program, it may do so. This would not create an MOE issue. States that do not renew a waiver or that make modifications that have the effect of constricting waiver eligibility must provide to CMS a transition/phase-out plan that describes steps to ensure minimal adverse impact on individuals served. This plan should include, at a minimum: (a) efforts to evaluate individuals who would lose eligibility to see if they may be eligible under another category of Medicaid eligibility, and to link such individuals with continued Medicaid eligibility without a lapse in coverage; and (b) a plan for how the State will phase out treatment services and what alternative services, if any, are available to the impacted individuals. This should be submitted to CMS at least 60 days before waiver expiration.

If a State seeks to modify waiver programs in ways that would restrict eligibility standards, methodologies or procedures before the demonstration approval period has expired, that would not be consistent with the MOE provisions.

We strongly encourage States interested in pursuing these options to contact CMS for technical assistance in order to ensure that any changes made to LOC are consistent with the MOE provisions.

Q4. What program-integrity related changes to eligibility processes are permissible under the MOE provisions?

Ensuring that Medicaid and CHIP cover all eligible people consistent with the highest standards of program integrity is a priority for the Federal government. At the same time, Congress in drafting the Affordable Care Act MOE provision explicitly limited changes not just to eligibility standards, but also to eligibility methods and procedures. There is extensive evidence that eligibility methods and procedures are strong determinants of whether eligible individuals can actually gain and retain coverage. Our experience working with States suggests States can meet their program integrity objectives consistent with the MOE provisions.

Specifically, State administrative activities that address an identified program integrity issue can be designed in ways that do not make the eligibility and renewal process more restrictive and burdensome for eligible individuals. For example, States may:

- Undertake administrative activities, such as conducting data matches to verify eligibility information and pursuing any questions that might arise from these

matches; this would include implementing corrective action procedures of this nature to address specific program integrity issues identified in the payment error rate measurement (PERM) or audit review processes;

- Improve State program integrity implementation efforts, if the policies were in effect, but had not been fully implemented by the State;
- Change transfer of assets requirements to the extent they affect benefits rather than eligibility.

States that have specific program integrity concerns should contact CMS for technical assistance so that we can work with the State in taking any necessary steps to strengthen program integrity while ensuring compliance with the MOE provision.