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Q & A
Covering HCB Services through the 1915(i) State Plan Option[1]

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Q. My state is considering asking CMS to approve Medicaid coverage of home and community-based (HCB) services through the 1915(i) state plan option. Can you explain what this option is and whether there are any particular issues that advocates should watch for?

A. Section 1915(i) enables to states to offer HCB services through a state plan option. This can be good for P & A clients, because it can increase access to HCB services for individuals who are not eligible for Medicaid waiver programs. At the same time, it can be a way for states to limit coverage of services to particular populations. Therefore, advocates need to closely monitor states' plans to offer 1915(i) services.

Discussion

In 2005, Congress added a new section to the Medicaid Act that authorizes states to provide HCB services to certain individuals through a state plan option.[2] Previously, such home and community-based services could be offered only pursuant to an 1115 or 1915 waiver.[3] The 1915(i) option enables states to serve individuals with incomes under 150% of FPL who need HCB supportive services but whose disabilities are less severe than those served under HCB waivers. Unlike waivers, individuals may qualify for the 1915(i) option

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[2] 42 U.S.C. § 1396n(i), added by the Deficit Reduction Act of 2005, Pub. L. No. 109-362, 120 Stat. 2064 (2006).

[3] 42 U.S.C. § 1315 (authorizing waivers to enable states to run pilot programs to test innovative methods of service delivery); § 1396n(c), (d), (e) (authorizing home and community based waivers to serve individuals who would otherwise need the level of services provided in an institution).

even if they do not need an institutional level of care. According to the Centers for Medicare and Medicaid Services (CMS), the option "provides states with an opportunity to offer services and supports before individuals need institutional care. . ."[4]

To participate, states must establish criteria for determining an individual's need for the supportive services covered under the state plan option.[5] The state must ensure that the criteria for 1915(i) services are less stringent that the state's institutional level of care criteria.[6] Services covered are those that could be covered for 1915(c) waivers: case management, homemaker/home health aide and personal care, adult day health, habilitation, respite care, and other partial hospitalization services, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness.[7] States may also offer self direction of services.[8] States must use an independent evaluation to determine an individual's eligibility and an independent assessment to determine the necessary level of services and supports and to create an individualized care plan.[9]

The federal health reform law, the Affordable Care Act (ACA) makes several significant changes to the 1396n(i) option.[10] First, it enables states to expand eligibility to individuals whose incomes do not exceed 300 percent of the SSI benefit rate and who are eligible for (but not necessarily enrolled in) a 1915(c), (d), (e), or 1115 waiver.[11] It also expands the scope of services that may be covered. One important difference between 1915(c) waivers and the original 1915(i) option was that, under 1915(c) waivers, it was possible for states

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[4] Centers for Medicare and Medicaid Services, *Dear State Medicaid Director,* "Improving Access to Home and Community-Based Services," (Aug. 6, 2010), http://www.hhs.gov/od/topics/community/iathcbssmd8-6-102.pdf.
[5] 42 U.S.C. § 1396n(i)(1)(A).
[6] Id. § 1915(i)(1)(B).
[7] *Id.* § 1396n(i)(1), § 1396n(c)(4)(B).
[8] *Id.* § 1396n(i)(1)(G)(III).
[9] *Id.* § 1396n(i)(E), (F), (G).
[10] For more in-depth discussion of the ACA, *see* National Health Law Program, "Fact Sheet: Federal Health Reform and Affordable Care Act (ACA)," (June 2010) available from NDRN.
[11] *Id.* § 1396n(i)(6).

to cover services not specifically listed in the statute as long as CMS approved.[12] The 1915(i) option as first enacted restricted coverage to those services specifically listed. The new federal law removes this limitation and states may now offer other CMS-approved HCB services under 1915(i).[13]

In addition, the 1915(i) option now allows States to waive Medicaid's comparability requirement, which requires states to cover services in an equal amount, duration, and scope to all beneficiaries who qualify for them.[14] This allows them to offer HCBS to specific, targeted populations and offer different amount, duration, and scope of services to different groups. States are, however, no longer allowed to waive the requirement that services be available statewide nor to place caps on enrollment and maintain waiting lists.[15]

States may authorize these programs for a period of five years. States may also phase in eligible individuals and covered services, so long as all are enrolled and all services provided by the end of that five year period. States may renew for an additional five year term if the Secretary determines that the state had complied with the requirements of the subsection and meet quality and outcome improvement goals.[16]

Though States no longer have the ability to cap enrollment, they may still limit enrollment indirectly. They are required to project and report to CMS the number of individuals that they expect to receive services under 1915(i). If enrollment exceeds a state's estimate, they may modify the needs-based eligibility criteria to restrict further enrollment without getting advance permission from CMS. But, they must give CMS and the public at least 60 days notice of such modification and any individuals who are eligible for services will remain so until they no longer meet the original eligibility criteria.[17]

The ACA also adds an optional category of eligibility that includes individuals who would be eligible for home and community-based services

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[12] *Id.*. § 1396n(c)(4)(B) (allowing coverage for "such other services requested by the State as the Secretary may approve.)
[13] ACA § 2402(c), amending 42 U.S.C. § 1396n(i)(1).
[14] 42 U.S.C. § 1396a(a)(10)(B).
[15] ACA § 2402(e), (f), amending 42 U.S.C. § 1396n(i)(1)(C), (3).
[16] 42 U.S.C. § 1396n(j)(B).
[17] *Id.* § 1396n(i)(1)(D)(ii)(I).

through § 1396n(i). This would allow states to cover the full scope of Medicaid benefits, such as physician services, hospital care, and home health, rather than only covering HCBS.[18]

Implications of the 1915(i) Option

A number of states are already offering this option, including Colorado, Iowa, Nevada, Washington, and Wisconsin. Other states, including California, Oregon, North Carolina, and Texas, have applications pending.

There is good reason to welcome the 1915(i) option as it offers an additional way for states to expand coverage of HCB services. In particular, it improves states' ability to cover services for people with mental illnesses.[19] And, the fact that it is a state plan option, rather than a waiver, is an incremental step toward making these services available to all Medicaid beneficiaries who need them. It is particularly helpful that states may no longer have wait lists for 1915(i) services. But, there are significant limitations to the benefits that this option confers of which advocates should be aware.

First, the law allows states to waive comparability and target services in order to offer different benefit packages to different categories of individuals. CMS issued a letter in August 2010 explaining how states might do this:

> 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.[20]

While this flexibility may encourage states to offer benefits that they otherwise would not, it also defeats part of the purpose of having a benefit

[18] *Id.* § 1396a(a)(10)(A)(ii)(XXII).
[19] For further discussion of this topic, *see* Judge David L. Bazelon Center for Mental Health, "Webinar: Adding Support Services to Medicaid: Now You Can," (broadcast Oct. 12, 2010), available at www.bazelon.org.
[20] Centers for Medicare and Medicaid Services, "Improving Access to Home and Community-Based Services," *id.*

offered as part of a state plan, i.e. that states must cover benefits in an equal amount, duration, and scope for all eligible individuals. So, the fact that states may also waive comparability when offering the 1915(i) option means that it is not as significant an expansion as it could be.

Moreover, states may attempt to use this option as a method to limit services in ways they otherwise could not. One example is a proposal from North Carolina. North Carolina has proposed a number of state plan amendments that would limit coverage of personal care services (PCS) for those living in their own homes, while offering much broader coverage to those living in adult care homes. It has proposed limitations on the number of hours of coverage of PCS in the home and tightened the needs-based eligibility criteria. Advocates estimate that this would result in the elimination or significant reduction of PCS for more than 20,000 residents living in their homes. At the same time, the State has proposed a 1915(i) state option to cover PCS that has much less stringent eligibility criteria but only is available to individuals in adult care homes. This would result in a significant shift away from covering care in the home to covering it in much less integrated settings – a result contrary to the intent of the provision. Advocates are deeply concerned about this plan and have raised concerns about it with CMS and the Department of Justice[21]

Conclusion

Advocates should encourage their states to offer 1915(i) benefits and, at the same time, monitor all such plans closely to ensure that they in fact expand services in the community. The statute's requirement of 60 days notice of any plan proposal gives advocates an opportunity to review proposed 1915(i) plan amendments and highlight problematic issues for state and federal officials. The U.S. Department of Justice has been receptive to complaints about the manner in which states are using this option, so advocates should not hesitate to raise concerns about implementation of 1915(i).

[21] For further information, contact Sarah Somers at NHeLP.