Deficit Reduction Act
Major Provisions for HCBS

- 1915(i) HCBS State Plan Option
- 1915(j) Self-Directed PAS State Plan Option
- MFP
- PRTF

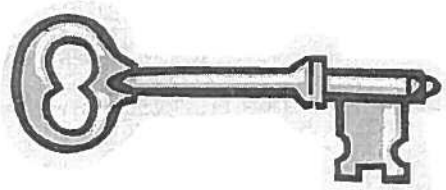
HCBS as a State Plan Option 1915(i) of the Social Security Act

Section 6086 of the Deficit Reduction Act 2005

CMS

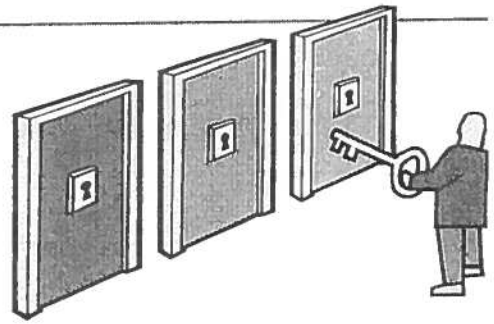
CENTERS for MEDICARE & MEDICAID SERVICES

State Plan HCBS — Key Features



- New section 1915(i) established by DRA of 2005. Effective January 1, 2007
- State option to amend the state plan to offer HCBS as a state plan benefit
- Unique type of State plan benefit with similarities to HCBS waivers
- Breaks the "eligibility link" between HCBS and institutional care now required under 1915(c) HCBS waivers

1915(i) Services

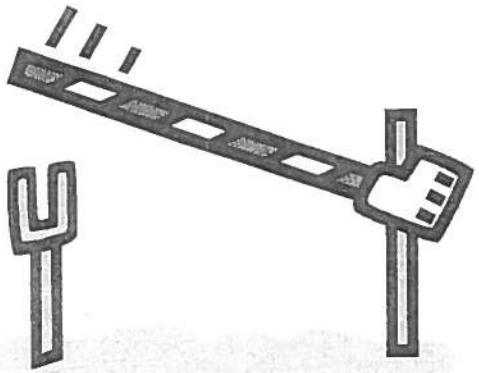


Any of the statutory 1915(c) services:

- Case management
- Homemaker
- Home Health Aide
- Personal Care
- Adult Day Health
- Habilitation
- Respite Care
- For Chronic Mental Illness:
  - Day treatment or Partial Hospitalization
  - Psychosocial Rehab
  - Clinic Services

But NOT the 1915(c) "Other" flexibility to design unique HCBS waiver services

Who May Receive State plan HCBS?



- Must be eligible for medical assistance under the State plan
- Must have income that does not exceed 150% of FPL
- States must provide **needs-based criteria** to establish who can receive the benefit
- Must reside in the community

1915(i) Needs-Based Criteria

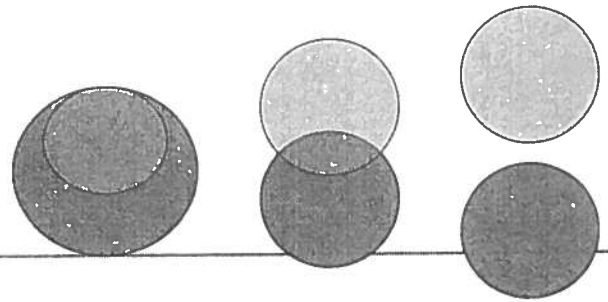
- Determined by an individualized evaluation of need (e.g., individuals with the same condition may differ in ADLs)
- May be functional criteria such as ADLs
- May include State-defined risk factors
- Needs-based criteria are <u>not</u>:
  - descriptive characteristics of the person, or diagnosis
  - population characteristics
  - institutional levels of care

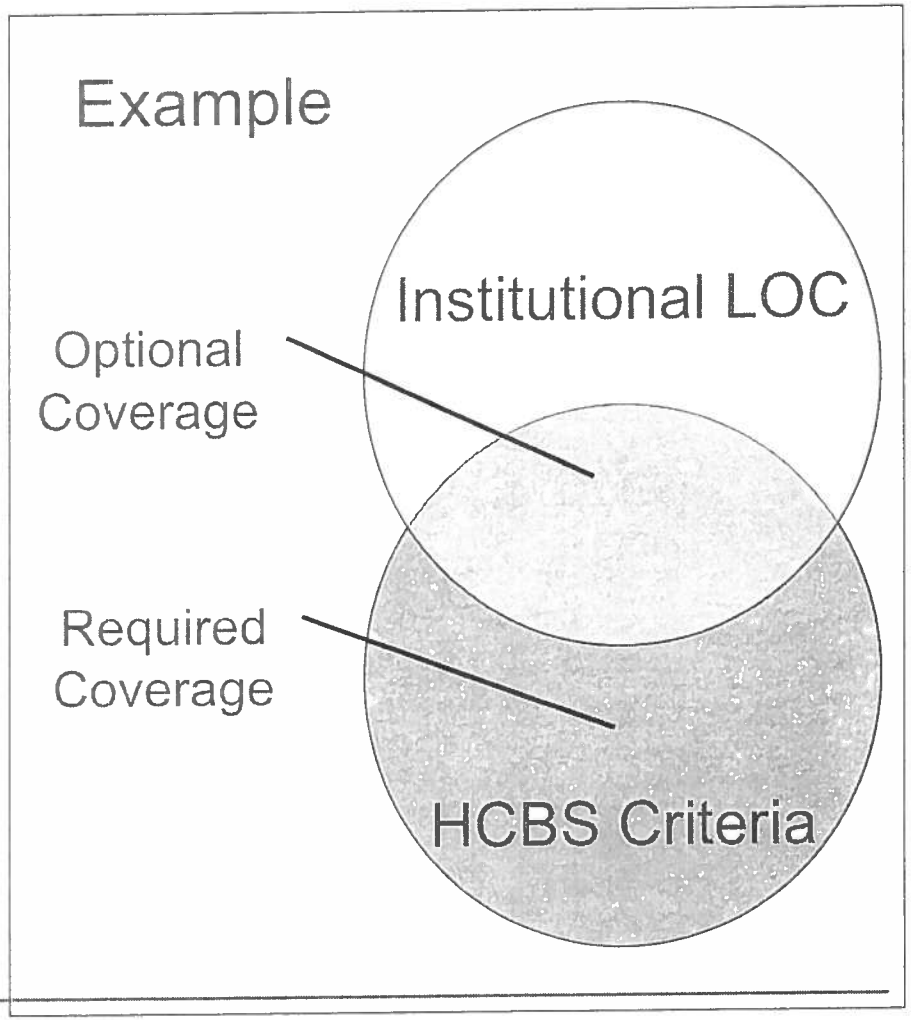
Needs-Based Criteria — Who the benefit may cover

- The lower threshold of needs-based eligibility criteria must be "less stringent" than institutional and HCBS waiver LOC.
- But there is no implied upper threshold of need. Therefore the universe of individuals served:
  - Must include some individuals with less need than institutional LOC
  - and May include individuals at institutional LOC, (but not in an institution)

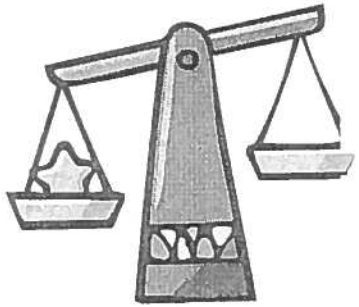
Needs-Based Criteria — Universe

- Eligibility criteria for HCBS benefit may be narrow or broad
- HCBS eligibility criteria may overlap all, part, or none, of the institutional LOC:





State Options



- Option to not apply income and resource rules for the medically needy
- States can limit number of participants who may receive benefit
- States can limit services to specified State areas (option to not apply statewideness)
- Self-Direction

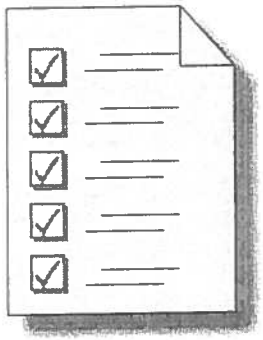
Self-Direction in 1915(i)

- State Option
- Modeled on 1915(c) application
- May apply to some or all 1915(i) services
- May offer budget and/or employer authority
- Specific requirements for the service plan

Quality Improvement in 1915(i)

- As a State plan service, no review & 3-5 year renewal needed as in waivers
- But unlike other State plan services, there is a QI requirement: States must ensure that HCBS meets Federal and State guidelines
- State quality improvement strategy

Under 1915(i)
States are to provide:



- Independent Evaluation to determine program eligibility
- Individual Assessment of need for services
- Individualized Plan of Care
- Projection of number of individuals who will receive State plan HCBS
- Payment methodology for each service
- Quality Improvement

Similarities: HCBS Under 1915(i) State plan & 1915(c) Waivers

- Evaluation to determine program eligibility
- Assessment of need for services
- Plan of care
- Option to limit number of participants
- Quality Improvement requirements
- Self Direction option
- Ability to not apply state-wideness
- Option to not apply income and resource rules for the medically needy

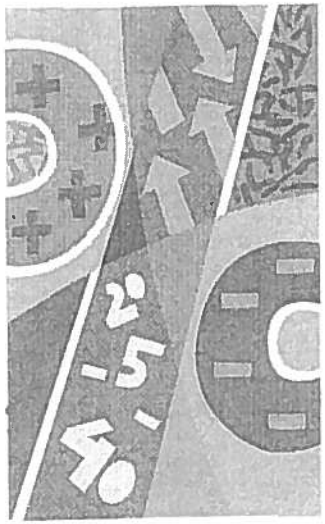
Differences: HCBS Under 1915(i) State plan & 1915(c) Waivers

- ≠ Financial Eligibility Criteria
- ≠ Comparability/Targeting
- ≠ Program eligibility
- ≠ Institutional care requirements
- ≠ Length of time for operation
- ≠ Financial estimates
- ≠ Services

Financial Eligibility Criteria

1915(c)

- Eligibility group must be in State plan
- Option to use institutional deeming eligibility rules (special income level group)



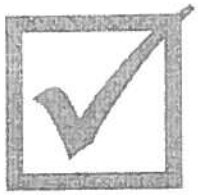
1915(i)

- Must be eligible under State Plan
- 150% of FPL
- Uses community deeming rules
- Option for medically needy only to use institutional deeming rules

Waiver of Comparability (Targeting)

1915(c)

- May waive comparability



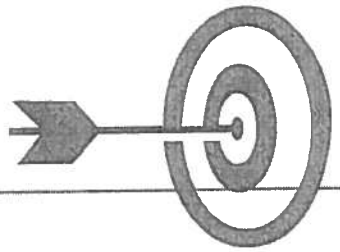
1915(i)

- May not waive comparability

Program Eligibility

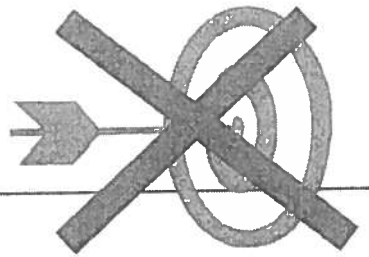
1915(c)

- Must target by institutional LOC
- May additionally target by population characteristics
  - Disease or condition
  - Age



1915(i)

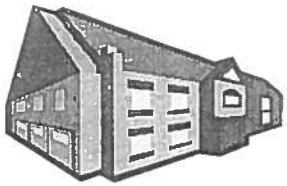
- May not target by population characteristic
- Must establish needs-based eligibility criteria
- May have needs-based criteria for each HCBS



Level of Care

1915(c)

=



- Participants must meet institutional Level Of Care ("but for waiver services")
- Waiver Level of Care must:

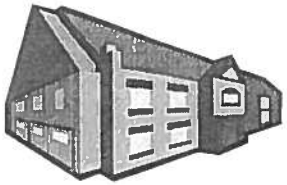
  = Institution LOC

  (Within LOC, may also be targeted at a subgroup)

Needs-Based Criteria

1915(i)

<



- Eligibility is needs based, not tied to institutional LOC
- But, institutional criteria must be more stringent
- Needs-based minimum eligibility criteria must be:
- "less stringent" than Institution LOC

Length of Time for Operation

1915(c)

- 3 years initial
- 5 years upon renewal

1915(i)

- Indefinite

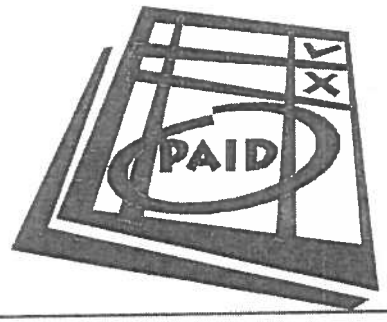
Financial Estimates

1915(c)

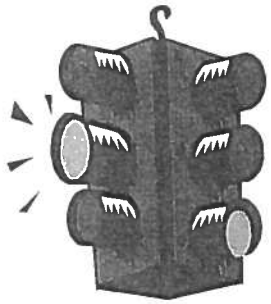
- Reasonable estimates of cost and utilization.
- Program must be cost neutral compared to institutional care

1915(i)

- Reveal payment methodology on Attachment 4.19-B of the State Plan.

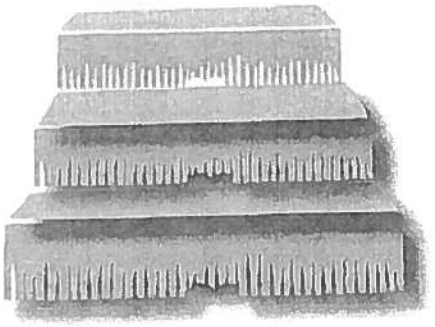


Experience 2007 - 2008



- More inquiries than submissions
  - Technical Assistance
- Iowa State plan HCBS
  - First to add State Plan HCBS benefit
  - Approved April 5, 2007
- Pending State plan amendments

Possible Challenges for States using 1915(i)



- Regulation not yet final
- Eligibility determined by needs-based criteria
- Only 1 HCBS Benefit available per State
  - Deciding how to best use the option; competing priorities
- Cross–agency collaboration

State plan HCBS: Resources

- Regulation published as NPRM April 4, 2008 (comment period ended June 3, 2008).
  Complete proposed rule (CMS2249P) at

  http://www.cms.hhs.gov/MedicaidGenInfo/08_Medicaidregulations.asp

- State Medicaid Directors Letter released April 4, 2008

- Draft State plan HCBS application available through CMS regional offices

State plan HCBS: Contact Information

- CMS Regional Office Representative

- CMS Central Office:

Kathy Poisal Kathryn.Poisal@cms.hhs.gov

Self-Directed Personal Assistance Services 1915(j) of the Social Security Act

Section 6087 of the
Deficit Reduction Act 2005

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Section 1915(j) Key Features

- Section 6087 of the Deficit Reduction Act of 2005
- Amends §1915 of SSA – new 1915 (j)
- Effective 1/1/07
- States may elect to provide self-directed personal assistance services (PAS) in the State Plan so demonstrations and waivers would not be necessary

Key Features

- Can target populations, limit numbers and limit by geographic areas
- Requires assurances:
  - Safeguards to protect health and welfare & ensure financial accountability
  - Individuals are evaluated by the State for their need for personal care
  - Participation is voluntary and individuals are informed of feasible alternatives to the PAS program
  - Support system is available prior to and throughout enrollment
  - Annual report
  - Triennial evaluation of impact on health & welfare

Key Features

- Individuals have both employer and budget authority:
  - can hire, fire, supervise and manage workers capable of providing the assigned tasks
  - can purchase personal assistance and related services

- At State's election:
  - Can permit hiring of legally liable relatives
  - Can permit individuals to purchase items that increase independence or substitute for human assistance, to the extent that expenditures would otherwise be made for the human assistance

- Services may not be provided to individuals residing in property owned, operated or controlled by a provider of services not related by blood or marriage

Key Features

- Individuals have an approved self-directed service plan and budget
  - Individuals exercise choice and control over budget, planning and purchase of PAS
  - Individuals' needs, strengths, preferences for PAS are assessed
  - The plan for services and supports is developed using person-centered planning process

Key Features

- The budget is developed based on the assessment and plan, and a methodology that uses valid, reliable cost data
  - Amount is expected cost of services if not self-directed
  - May not restrict access to other medically necessary care & services not included in budget

Key Features

- Quality assurance and risk management techniques are in place

- State may employ a financial management entity to make payments to providers, track costs, make reports; payment at the 50% admin rate

State Medicaid Director Letter and Preprint

- SMD Letter, with preprint, issued September 13, 2007

- Provides guidance to States
  - Assurances
  - Prospective cash disbursements at State's option
  - Voluntary and Involuntary Disenrollment
  - Quality Assurance and Improvement Plan to be described
  - Risk Management System to be described

Current Status

- Final Regulation expected to be published in late September
- Five States have approved 1915(j)
  - Alabama
  - Oregon
  - Arkansas
  - Florida
  - New Jersey

Further Information

- Carrie Smith, Technical Director, Disabled & Elderly Health Programs Group, CMS Central Office, 410-786-4485.