1915(i) Home and Community Based Services (HCBS) State Plan Option: Requirements for Needs-Based Criteria and State Option to Target Benefit

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Presentation Objectives:

This webinar will provide:

- A brief overview of the 1915(i) Home and Community-Based Services (HCBS) State Plan Option;
- A detailed discussion of effective approaches for the development of 1915(i) needs-based criteria used to evaluate and reevaluate whether an individual is eligible for State Plan HCBS;
- Discussion of additional needs-based criteria for receipt of specific services;
- Strategies for the state option to target the 1915(i) State Plan benefit to a specific population based on age, disability, diagnosis, and/or eligibility group; and
- An overview of the maintenance of effort (MOE) requirements currently in effect.

1915(i) HCBS State Plan Option

Overview

- The 1915(i) State Plan Option was added to the Social Security Act (the Act) through the Deficit Reduction Act (DRA) of 2005 and was later amended by the Affordable Care Act of 2010.
- 1915(i) provides states with the option to cover HCBS through their Medicaid State Plans rather than through a 1915(c) waiver.
- 1915(i) delinks the receipt of HCBS from the 1915(c) institutional level of care requirement.
- Final regulations for 1915(i) were published on March 17, 2014.
- Since many of the 1915(i) provisions share regulatory and policy guidance with 1915(c) HCBS waivers, the 1915(c) HCBS Technical Guide is a resource for states for both authorities.

What Must Be Included as Part of the Benefit (1 of 3)

Through the use of a 1915(i) State Plan Amendment, states **must:**

- Establish needs-based criteria for benefit eligibility that are less stringent than institutional level of care criteria (42 CFR 441.715(a));
- Establish a process to ensure that assessments of need and evaluations of eligibility are independent and unbiased (42 CFR 441.715(d) and 42 CFR 441.720);
- Ensure that the 1915(i) benefit is available to all eligible individuals within the state (42 CFR 441.745(a));
- Provide adequate and reasonable provider standards to meet the needs of the target population (42 CFR 441.730);

What Must Be Included as Part of the Benefit (2 of 3)

Cont.

- Ensure that the HCBS are provided in accordance with a person-centered service plan and are delivered in home and community-based settings as defined in regulation (42 CFR 441.725);

- Exclude coverage for room and board (42 CFR 440.182(d));

- Establish a quality improvement strategy for the benefit (42 CFR 441.745);

What Must Be Included as Part of the Benefit (3 of 3)

Cont.

- Determine eligibility for the benefit, including application of needs-based criteria and verification of target group eligibility through an independent evaluation of each individual according to the regulatory requirements contained at 42 CFR 441.715(d); and

- For each individual determined eligible, provide for an independent assessment of needs, which may include the results of a standardized functional needs assessment, in order to establish a service plan per 42 CFR 441.720.

What States May Include as Part of the Benefit

Through the use of a 1915(i) State Plan Amendment, states may:

- Cover any service(s) that could be covered under 1915(c) HCBS waivers as described at section 1915(c)(4)(b) of the Act, including state-defined and CMS-approved "other services" applicable to the population (42 CFR 440.182);
- Target the HCBS benefit to one or more specific populations (42 CFR 441.710(e)(2));
- Establish separate additional needs-based criteria for individual HCBS (42 CFR 441.720(a)(5));
- Establish a new Medicaid eligibility group for people who get State Plan HCBS (42 CFR 435.219 and 436.219); and/or
- Allow any or all HCBS to be self-directed. (42 CFR 441.740).

The CMS Approval Process

- The State Medicaid Agency must submit a State Plan Amendment (SPA) to CMS for review and approval to establish a 1915(i) HCBS benefit. All typical SPA submission and review requirements apply.

- State Plan HCBS benefits do not have a time limit after CMS approval except when states choose to target the benefit to a specific population(s).

- When a state targets the benefit, approval periods are for 5 years, with the option to renew with CMS approval for additional 5-year periods.

(42 CFR 441.745(a)(2)(vi))

1915(i): An Overview of Current Status

As of today, nineteen states operate at least one 1915(i) State Plan benefit. The purpose and scope of these SPAs vary and have assisted states in designing tailored benefits to address state-identified objectives including:

- Providing HCBS to individuals with mental health support needs;
- Providing cross-disability supports to individuals seeking to gain and maintain competitive integrated employment; and/or
- Providing habilitation to individuals with intellectual and/or developmental disabilities, including those who do not meet an institutional level of care.

Overview of Requirements for Establishment of Needs-Based Criteria for Benefit Eligibility and Specific Services

Needs-Based Criteria
Statutory and Regulatory Requirements (1 of 3)

- Section 1915(i)(1)(A) of the Act requires the state to establish "needs-based criteria for determining an individual's eligibility under the State plan for medical assistance for such home and community-based services…", and
- Section 1915(i)(1)(B) of the Act requires that the "needs-based criteria for determining whether an individual requires the level of care provided in a hospital, a nursing facility, or an intermediate care facility for the mentally retarded under the State plan or under any waiver of such plan…are more stringent than the needs-based criteria established…for determining eligibility for home and community-based services."

In other words, the minimum needs-based criteria required for receipt of 1915(i) State Plan HCBS must be less stringent than those for determining institutional level of care.

Needs-Based Criteria
Statutory and Regulatory Requirements (2 of 3)

- Section 1915(i)(1)(A) of the Act also provides that a state may include additional needs-based criteria for "the specific home and community-based services that the individual will receive…"
  - Per regulations at 42 CFR 441.715(b), if the state defines needs-based criteria for individual 1915(i) State Plan HCBS, it may not have the effect of limiting who can benefit from the State Plan HCBS in an unreasonable way, as determined by the Secretary.

Needs-Based Criteria
Statutory and Regulatory Requirements (3 of 3)

Per 42 CFR 441.715, needs-based criteria are factors used to determine an individual's requirements for support, and may include risk factors.

- The criteria are not characteristics that describe the individual or the individual's condition.
- A diagnosis is not a sufficient factor on which to base a determination of need.
- A criterion can be considered needs-based if it is a factor that can only be ascertained for a given person through an individualized evaluation of need.

Examples of permissible needs-based criteria will be provided in slides to follow.

Needs-Based Criteria Statutory and Regulatory Requirements – Less Stringent than Institutional Criteria

- In a SPA to implement a 1915(i) benefit, a state must attest and demonstrate that the needs-based criteria for HCBS is less stringent than institutional level of care criteria.
- The state must provide a comparative analysis of the needs-based criteria for HCBS against the level of care criteria for each of the following:
  - Nursing facility (NF);
  - Intermediate care facility for individuals with intellectual disabilities (ICF/IID; and
  - Applicable hospital (long-term care hospitals).

Needs-Based Criteria Considerations

- Needs-based criteria should be developed in careful consideration and alignment with the intended outcomes for the benefit and should align with or complement other design features of the 1915(i) SPA.
  - For example, if the state elects to target the benefit to specific populations, the state may wish to consider needs-based criteria that is compatible with the identified groups and benefits included in the SPA (79 FR 2947).
- Needs-based criteria are not diagnosis or age, which would be attributes describing the target group (discussed later in the presentation).
- Adjustments to the needs-based criteria are governed by specific requirements outlined at 42 CFR 441.715(c), which include notice and submission requirements and conditions under which approval may be granted.

Needs-Based Criteria – State Example #1

Below is an example of needs-based criteria for a State Plan aimed at assisting individuals to gain and maintain employment:

- Individuals who have a desire to work in a competitive work environment and for which the services provided herein are not otherwise available to the individual under either special education and related services as defined in section 602(16) and (17) of the Education of the Handicapped Act (20 USC 1401(16) and (17) or vocational rehabilitation services available to the individual through a program funded under section 110 of the Rehabilitation Act of 1973 (29 USC 730).

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Needs-Based Criteria – State Example #1, cont.

- **Group A: Individuals who are Visually Impaired**
  - Individuals who need ongoing physical or verbal assistance with performing one activity of daily living (ADL) and who are at risk of being unable to obtain or sustain competitive employment without assistance.
- **Group B: Individuals with Physical Disabilities**
  - Individuals whose physical condition affects their ability to live independently, who need ongoing assistance with at least one ADL and who are at risk of being unable to sustain competitive employment without supports.
- **Group C: Individuals with Intellectual Disabilities, Autism Spectrum Disorders or Asperger's Syndrome**
  - Individuals with significant limitations in adaptive function and/or who need assistance with at least one area of ADL, and/or who have difficulty understanding and interpreting social situations and who are unlikely to be able to obtain or sustain competitive employment without supports.

Needs-Based Criteria – State Example #2

- The applicant must require assistance with 1 or 2 critical needs. Critical needs are as follows: bathing, dressing, toileting, eating/feeding, transferring, and medication administration. Assistance includes supervision and cueing as well as direct, hands-on assistance. Individuals receiving services under this 1915(i) benefit for home care for elders must have needs that are less stringent than nursing facility level of care. Those whose needs meet a nursing facility level of care will be served under a 1915(c) waiver.

Needs-Based Criteria – State Example #3

The individual needs assistance demonstrated by meeting at least two of the following criteria on a continuing or intermittent basis for at least twelve months:

- The individual needs assistance to obtain and/or maintain employment.
- The individual needs financial assistance to reside independently in the community.
- The individual needs significant assistance to establish or maintain a personal social support system.
- The individual needs assistance with at least one ADL or instrumental activities of daily living (IADLs) to reside independently in the community.
- The individual needs assistance with management and intervention of maladaptive or antisocial behaviors to ensure the safety of the individual and/or others.

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Needs-Based Criteria – State Example #3, cont.

AND the individual meets at least one of the following risk factors:

- A history of inpatient, partial hospitalization, or emergency psychiatric treatment more than once in the individual's life; or
- The individual has a history of continuous professional psychiatric supportive care other than hospitalization; or
- The individual has a history of involvement with the criminal justice system; or
- Services available in the individual's community have not been able to meet the individual’s needs; or
- The individual has a history of unemployment or employment in a sheltered setting or poor work history; or
- The individual has a history of homelessness or is at risk of homelessness.

Overview of Targeting Opportunities – State Option and Renewal Expectations

1915(i) State Plan HCBS: State Option to Target

- As permitted at section 1915(i)(3) of the Act and 42 CFR 441.710(e)(2), a state may elect in their 1915(i) SPA to not comply with the requirements of section 1902(a)(10)(B) of the Act (relating to comparability).

- This statutory provision gives states the option to target the 1915(i) HCBS benefit to specific groups.

- For states electing this option, these groups must be defined on the basis of any combination of the following:
  - Age
  - Diagnosis
  - Disability
  - Medicaid Eligibility Group

Source: 42 CFR 441.710(d) and (e)

1915(i) State Plan HCBS: State Option to Target, cont.

- Targeting criteria cannot have the impact of limiting the pool of qualified providers from which an individual would receive services or have the impact of requiring an individual to receive services from the same entity from which they purchase their housing.
  - For example, a state may not target the 1915(i) benefit to individuals living in an assisted living facility, as it would have the effect of requiring an individual to receive services from the same entity from which they purchase housing. (However, assisted living could be among the services available within the 1915(i).)
- The state may elect in the SPA to limit the availability of specific services or to vary the amount, duration, or scope of those services, to one or more of the groups targeted.

Source: 42 CFR 441.710(d) and (e)

Targeting 1915(i) Benefits - Considerations

- If a state elects to establish targeting criteria through the approval of a 1915(i) State Plan HCBS Amendment, the 1915(i) benefit will be in effect for a period of 5 years from the effective date of the amendment.

- To renew State Plan HCBS for an additional 5-year period, the state must provide a written request for renewal to CMS at least 180 days prior to the end of the approval period.

- CMS approval of a renewal request is contingent upon state adherence to Federal requirements and the state meeting its objectives with respect to quality improvement and beneficiary outcomes.

Source: 42 CFR 441.745(2)(vi)(A)

Target Groups – State Example #1

Target Groups from one state's 1915(i) benefit that is aimed at supporting individuals to gain and maintain employment:

Target Group A – Individuals who are Visually Impaired

- Individuals age 14 and above determined by a doctor of optometry or ophthalmology to be: totally blind (no light perception), legally blind (20/200 in the better eye with correction, or a field restriction of 20 degrees or less), or severely visually impaired (20/70 to 20/200 in the better eye with correction).

Target Groups – State Example #1, cont.

Target Group B – Individuals with Physical Disabilities

- Individuals age 14 and above with a physical disability; whose physical condition is anticipated to last 12 months or more.

Target Group C – Individuals with Intellectual Disabilities, Autism Spectrum Disorders or Asperger's Syndrome

- Individuals age 14 and above with intellectual developmental disorder attributed to one or more of the following: Intelligence Quotient (IQ) scores of two standard deviations below the mean, autism spectrum disorder, Asperger's disorder, Prader-Willi Syndrome, as defined in the American Psychiatric Association (APA) Diagnostic and Statistical Manual, brain injury, or neurological condition related to IDD that originates before age 22.

Target Groups – State Example #2

Behavioral health 1915(i) target group description from another state's 1915(i) benefit:

Persons Who are Twenty-One Years of Age or Older with a Chronic Mental Illness

- Pursuant to state statute and administrative rules, a person with a chronic mental illness means an individual who is diagnosed by a psychiatrist, a licensed clinical psychologist, a licensed independent practitioner as defined in state statute, or a nonmedical examiner certified by the State Health Authority or the State Department of Human Services as having chronic schizophrenia, a chronic major affective disorder, a chronic paranoid disorder, or another chronic psychotic mental disorder other than those caused by substance abuse.

Maintenance of Effort (MOE) Considerations

MOE

- As of March 2023, there are two major statutory provisions that impose maintenance of effort requirements on State Medicaid programs.
  - Families First Coronavirus Relief Act (FFCRA), as amended by the Consolidated Appropriations Act, 2023, and
  - American Rescue Plan Act of 2021 (ARP).
- These two statutes have different requirements and states should be aware of both sets of expectations as adjustments are considered to 1915(i) State Plan HCBS.

MOE Section 9817 of the American Rescue Plan Act of 2021 (ARP)

- Section 9817 of the ARP provided states with a temporary 10 percentage point increase to the Federal Medical Assistance Percentage (FMAP) for certain Medicaid HCBS from April 1, 2021 through March 31, 2022 to improve HCBS under the Medicaid program.
- States must comply with specific program requirements to receive the increased FMAP for HCBS expenditures.

MOE Section 9817 of ARP Contd.

- On May 13, 2021, CMS issued a State Medicaid Director Letter that outlines state requirements to meet the statutory obligation to supplement, not supplant resources for HCBS. States must:
  - Not impose stricter eligibility standards, methodologies, or procedures for HCBS programs and services than were in place on April 1, 2021;
  - Preserve covered HCBS, including the services themselves and the amount, duration, and scope of those services, in effect as of April 1, 2021; and
  - Maintain HCBS provider payments at a rate no less than those in place as of April 1, 2021.
- For ARP, these provisions are in effect until the state has fully expended the state funds equivalent to the amount of federal funds attributable to the increased FMAP.

https://www.medicaid.gov/federal-policy-guidance/downloads/smd21003.pdf

Adjustments to Needs-Based Criteria and Targeting of 1915(i) State Plan HCBS and MOE

These MOE provisions are important to keep in mind as states contemplate any adjustments to HCBS programs.

- There are several things that might constitute MOE violations. These may include:
  - Adjustments to increase the stringency of needs-based criteria for either benefit eligibility or receipt of a service;
  - The inclusion of new, more restrictive targeting criteria;
  - Decreasing scope, amount, and/or duration limit for a service; or
  - Other adjustments to the benefits or rates that may be contrary to MOE expectations.

Public Notice Requirements and CMS Engagement

Public Notice Requirements

- The state will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with section 1915(i)(1)(D)(ii) of the Act.
- For 1915(i) SPAs, states must adhere to notice requirements contained at 42 CFR 447.205 pertaining to methods and standards for setting payment rates.
- Per section 1902(a)(73) of the Act, states must also follow state tribal consultation processes prior to submission.

CMS Engagement

- States are encouraged to consult with CMS early in the process on any elements related to 1915(i) State Plan HCBS, but especially those pertaining to needs-based criteria and target group parameters given their potential impact to access to critical HCBS.

- CMS stands ready to provide assistance as states are contemplating developing new or amending existing State Plan benefits.

Summary

- 1915(i) HCBS as a State Plan option allows states to offer home and community-based services, historically only available through a waiver, through the Medicaid State Plan.
- States must include needs-based criteria to determine eligibility for the benefit and these criteria must be based on areas of support necessary and may include risk factors that impact an individual's needs for services.
- States may choose to target the benefit to individuals based on factors such as age, diagnosis, disability, and/or Medicaid eligibility group.
- Targeting and needs-based criteria are not the same, but should be considered carefully to ensure alignment.
- As states contemplate changes to their SPA, they must be cognizant of applicable MOE requirements for FFCRA as amended and ARP. As always, CMS stands ready to provide technical assistance.

Resources

To Submit Questions on Unwinding:
CMSUnwindingSupport@cms.hhs.gov

CMS Baltimore Office Contact—Division of Long-Term Services and Supports:
HCBS@cms.hhs.gov

To request Technical Assistance: http://hcbs-ta.org

Social Security Act:
Statute: https://www.ssa.gov/OP_Home/ssact/title19/1915.htm

Regulations:
https://www.federalregister.gov/documents/2014/01/16/2014-00487/medicaid-program-state-plan-home-and-community-based-services-5-year-period-for-waivers-provider

Resources, cont.

1915(i) Preprint:
https://www.medicaid.gov/sites/default/files/2019-12/1915i-application_0.pdf

HCBS Technical Guide:
https://wms-mmdl.cms.gov/WMS/help/35/Instructions_TechnicalGuide_V3.6.pdf

Guidance and Resources for Unwinding and Returning to Regular Operations after COVID-19:
https://www.medicaid.gov/resources-for-states/coronavirus-disease-2019-covid-19/unwinding-and-returning-regular-operations-after-covid-19/index.html

American Rescue Plan Act of 2021 State Medicaid Director Letter
https://www.medicaid.gov/federal-policy-guidance/downloads/smd21003.pdf

Questions?

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