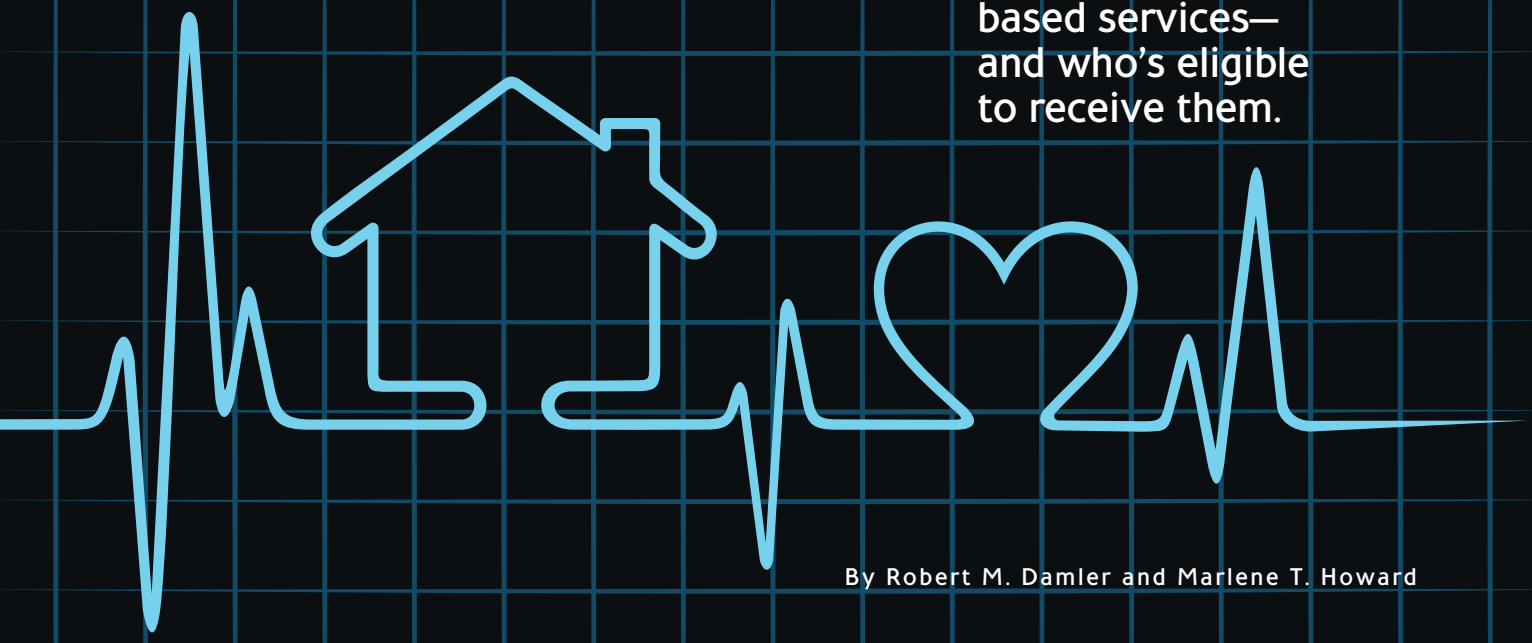
Medicaid and the ACA

The sweeping health care reform means some big changes for home and community-based services—and who's eligible to receive them.



By Robert M. Damler and Marlene T. Howard

THE AFFORDABLE CARE ACT (ACA) has had a significant effect on the way consumers, payers, and providers operate in the health care market. For Medicaid programs in particular, the ACA implemented changes that affected eligibility, funding, and policy related to the Medicaid program. While 28 states are moving forward with the implementation of Medicaid eligibility expansion for individuals between the ages of 18 and 64 and below 138 percent of the federal poverty level (FPL),[1] many other aspects of the 2010 legislation provide additional opportunities for eligibility and benefit changes that would interest key stakeholders and warrant consideration in actuarial budget forecasts.

One of the additional items relates to Section 1915(i) of the Social Security Act (SSA), which addresses the inclusion of home and community-based services (HCBS) in the state plan. State plan services refer to the scope of benefits that are covered by the Medicaid program and are agreed upon by the state and federal government agencies. While Section 1915(i) predated the enactment of the ACA, the ACA legislation provided some modifications to Section 1915(i) that increased its visibility in the HCBS landscape. The modifications have prompted a number of states to apply for the inclusion of HCBS in their respective state plans through the 1915(i) provision.[2]

The 1915(i) state plan option is viewed as a flexible solution to meeting the HCBS needs of individuals who do not qualify for the more restrictive eligibility criteria under a 1915(c) waiver program. Prior to deciding to implement a 1915(i) state plan option, there are several important implications that must be considered. This article discusses several features and considerations of the 1915(i) state plan option. We will also consider a unique example of a state that overcame Medicaid eligibility challenges by implementing a program using the 1915(i) state plan option.

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Overview of Home and Community-Based Services

"Home and community-based services" refers to a set of benefits that are designed to assist individuals with alternatives to institutional care. The individuals require assistance with activities of daily living (ADLs) and may receive therapies to manage and treat chronic conditions. The required intensity of services will vary depending on the degree of an individual's disability. In the Medicaid program, this service array has traditionally been provided under parameters set forth in Section 1915(c) of the SSA, which requires that an individual satisfy state-established institutional level of care criteria in order to become eligible for the HCBS waiver services. As a result, the majority of historical Medicaid experience for HCBS reflects the cost profile of a long-term care or nursing home population (i.e., those who meet the state-established institutional level of care criteria).

The 1915(i) state plan option offers an alternative method of providing HCBS through the Medicaid program. Recently, many states have been exploring this option and are interested in understanding the fiscal impact of 1915(i) implementation. When using historical experience to project expenditures for a 1915(i) state plan option, actuaries and states need to consider the varying risk profile of the targeted population, particularly for services that may already be provided under a 1915(c) waiver. The cost of services as part of a waiver may not be fully comparable to the cost for a population targeted for the 1915(i) state plan option, given the eligibility requirements that may vary between the 1915(c) waivers and the 1915(i) state plan option.

The table in Figure 1 provides a comparison of the key policy issues between 1915(c) waivers and the 1915(i) state plan option. The sections that follow provide additional detail and describe the evolution of the 1915(i) state plan option, from its roots in the Deficit Reduction Act to modification under the ACA.

Figure 1: High-Level Comparison of 1915(c) Waivers and 1915(i) State Plan Option

	1915(c) Waivers	1915(i) State Plan Option (after ACA revisions)
Service array	Home and community-based services outlined under Section 1915(c)(4)(b) of the SSA. Examples: Case management, homemaker, respite care.	Same requirements as 1915(c). Service offerings are not limited to the services provided through established 1915(c) waivers, provided they are within the parameters outlined in Section 1915(c)(4)(b) of the SSA.
Income eligibility	300 percent of Supplemental Security Income Federal Benefit Rate.	150 percent of FPL.*
Medically needy eligibility requirements	State-established institutional level of care.	Needs-based criteria that are less stringent than 1915(c) requirements**. Example: Assistance with two activities of daily living.
Target populations (waiver of comparability requirements)	Permitted.	Permitted.
Statewide application	Permitted to be waived.	Not permitted to be waived.
Enrollment limits	Permitted.	Not permitted.
Demonstration of cost neutrality	Required.	Not required.

*The income threshold for 1915(i) may vary, as explained later in this article.
**Needs-based criteria will vary with the income threshold for 1915(i).

The Deficit Reduction Act and 1915(i)

Section 1915(i) of the SSA was established under Section 6086 of the Deficit Reduction Act of 2005 (DRA), which discussed "Expanded Access to Home and Community-Based Services for the Elderly and Disabled." Effective Jan. 1, 2007, this version of Section 1915(i) afforded states the flexibility to add certain home and community-based services to the Medicaid state plan.[3] Prior to the DRA, these services had to be included as part of a 1915(c) waiver program and could only be offered to individuals who met institutional level of care criteria.

In order for individuals to be eligible for benefits under the 1915(i) state plan option, the Medicaid program had to establish needs-based criteria, which were required to be less stringent than those defined for institutional level of care. The more relaxed needs-based eligibility definition could result in escalating program costs. As a result, states were given the option to limit the number of people receiving the service package and establish waiting lists, to recognize budget constraints that could be present with implementing the 1915(i) state plan option.

Other significant aspects of the 1915(i) state plan option as presented in the DRA include the following:

- States did not have to demonstrate cost neutrality compared with institutional expenditures for the eligible population: This is primarily because there would be no comparable institutional cost for individuals who do not have to meet institutional level of care criteria for 1915(i) eligibility.
- Income eligibility threshold at 150 percent of FPL: In addition to meeting the needs-based criteria with a less restrictive definition than institutional level of care, an individual's income must be no higher than 150 percent of the federal poverty level to be eligible for the 1915(i) service package.
- Comparability requirement had to be met: Any Medicaid-covered individual who met the medical necessity criteria could utilize the HCBS package offered under 1915(i) (comparability requirement).
- Statewide application requirement was waived: States were permitted to limit the geographic scope of the 1915(i) state plan option. Under the ACA, states are no longer permitted to waive the statewide application requirement for services provided through the 1915(i) state plan option.

ACA and New Considerations

Section 2402 of the ACA focused on "Removing Barriers to HCBS" and applied some important revisions to Section 1915(i). The Centers for Medicare and Medicaid Services (CMS) subsequently issued a final rule on Jan. 16, 2014, that provided clarification and additional information related to the revised Section 1915(i).

One of the most significant modifications to Section 1915(i) was the addition of Section 1915(i)(7), which allowed states to define target populations for the delivery of the HCBS benefit package. This section waives the comparability requirement established in the DRA version of Section 1915(i). The CMS final rule proposed that the parameters for the target populations be defined by "diagnosis, disability, Medicaid eligibility groups, and/or age."

The waiver of the comparability requirement allowed states to do the following:

- Define multiple target populations for 1915(i) and tailor multiple HCBS packages that could be individually allocated to each population; and
- Vary the amount, duration, and scope of a single 1915(i) service between various target populations.

If states choose to define target populations, CMS will provide approval for an initial five-year period, and the 1915(i) application will need to be renewed at the end of the period for subsequent five-year approval periods. States are required to use needs-based criteria in defining the target population, and are not permitted to require that an individual be assigned to a specific Medicaid eligibility group. For example, a state cannot require enrollment in a 1915(c) waiver in order to be eligible for the services outlined in the 1915(i) state plan option.

While the ACA allowed the comparability requirement under 1915(i) to be waived, it eliminated the enrollment limit and waiting list provisions of the original 1915(i). Consequently, states need to be vigilant in their definitions of needs-based criteria and/or target populations, in order to manage the cost of the 1915(i) program as a component of state Medicaid budgets.

The ACA also expanded eligibility for the 1915(i) state plan option to individuals with incomes up to 300 percent of the Supplemental Security Income Federal Benefit Rate. If states choose to use this income eligibility definition for a 1915(i) service package, individuals must meet an institutional level of care as well as the needs-based criteria defined by the state. If states maintain the income eligibility threshold of 150 percent of FPL as established by the DRA, individuals do not have to meet an institutional level of care.

The waiver of the comparability requirement and the expanded income eligibility definition result in the following options in the design of a 1915(i) service package for a population that meets an institutional level of care:

- **Offer home and community-based services that are not currently covered under the 1915(c) waiver:** In this scenario, the 1915(i) state plan option reduces the administrative burden required to amend the current waiver and demonstrate cost neutrality in order to provide additional HCBS. It is important to note, however, that because 1915(i) eligibility is determined by needs-based criteria and cannot be restricted to waiver enrollees, any individual who qualifies for this 1915(i) plan design can utilize these services without enrolling in an HCBS waiver.
- **Design 1915(i) service packages that mirror one or more of the current 1915(c) benefit packages:** This benefit design would allow a state to extend the scope of the HCBS to individuals who are eligible for the 1915(c) waiver but are unable to enroll because of enrollment limits presented by the waiver. An approved 1915(i) application of this type would allow states to offer the waiver service package to additional eligible individuals without having to amend the current waiver to increase enrollment slots, and would resolve any waiver waitlist issues. This strategy can also lead to a smooth phase-out of the current 1915(c) waivers if the state elects not to renew the 1915(c) waiver at the end of the demonstration period.

A final key component of the ACA as it relates to Section 1915(i) was the allowance for states to introduce an optional medically needy eligibility group that could qualify for full Medicaid coverage upon meeting the needs-based criteria for 1915(i) services. Using the 1915(i) state plan option as a vehicle for comprehensive Medicaid coverage can assist states in targeting certain groups that would not otherwise be eligible for Medicaid benefits.

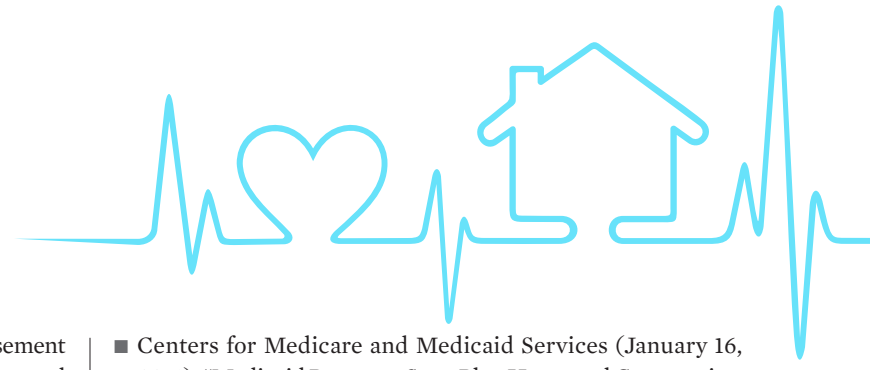
The following example highlights the method one state used in applying this provision to ensure continued Medicaid coverage to one such specialized group.

Indiana Medicaid: 1915(i) for Behavioral and Primary Health Care Coordination

On June 1, 2014, the state of Indiana converted from Section 209(b) status to Section 1634 status. (In summary, a state operating under Section 209(b) status establishes state-specific eligibility criteria for Medicaid disability status rather than accepting the Supplemental Security Income (SSI) disability determination. Under Section 1634 status, Medicaid eligibility determinations for disabled individuals would be based on SSI eligibility determinations.)

The Office of Medicaid Policy and Planning (OMPP) raised the income eligibility limit to 100 percent of FPL for disabled individuals. This change enabled many beneficiaries affected by the transition to maintain full Medicaid coverage. Individuals with incomes exceeding this threshold would generally be eligible to purchase insurance through the exchange marketplace and to receive premium subsidies. Unfortunately, a number of individuals were at risk of losing Medicaid coverage who were classified with serious mental illness, not meeting institutional levels of care, and with income levels exceeding 100 percent of FPL. Prior to the Section 1634 transition, these individuals qualified for a set of mental health services through the Medicaid Rehabilitation Option. With the conversion to Section 1634 status

The goal of the 1915(i) service was to provide a pathway to full Medicaid coverage and the specific mental health services that would be required by the eligible individuals.



in the state, it was uncertain whether third-party reimbursement would be available to these individuals for the level of mental health services needed to function safely in the community.[4]

To allow for continuation of Medicaid coverage for this population, therefore, OMPP applied for a behavioral and primary health care coordination (BPHC) service under the 1915(i) state plan option, which is a care management benefit targeted to adults age 19 or older with a qualifying mental health condition and income up to 300 percent of FPL.

The goal of the 1915(i) service was to provide a pathway to full Medicaid coverage and the specific mental health services that would be required by the eligible individuals. This result was achieved through the optional eligibility group provisions and the income disregards for medically needy individuals outlined in Section 1902 of the SSA.[5] Due to the 1915(i) program changes under the ACA, Indiana was able to maintain access to critical mental health services for more than 4,500 individuals.

Summary

In the period between the January 2007 effective date of 1915(i) as set forth by the DRA and the revisions introduced by the ACA in 2010, only five states had incorporated HCBS into their state plans. By August 2014, 12 states were participating in the 1915(i) state plan option and four more states were planning to participate in federal fiscal year 2014. The growing popularity of the 1915(i) state plan option can be attributed to its flexibility, which allows states to do the following:

- Provide a vehicle for full Medicaid coverage to medically needy individuals who would not otherwise qualify for Medicaid;
- Add HCBS and/or expand coverage of individuals who meet institutional levels of care without having to amend current 1915(c) waivers; and
- Meet the HCBS needs of Medicaid enrollees who have a degree of physical and intellectual disability that does not qualify them for institutional levels of care.

A key consideration in the implementation of a 1915(i) service package is that the delivery of HCBS through the state plan may assist in managing eligible individuals' chronic conditions, and may lead to savings by delaying or avoiding more costly care in a hospital or other institutional setting. As a result, both the program cost and potential offsets in other service categories should be presented in discussions of the financial implications of providing the 1915(i) state plan option.

Useful Resources

The following resources were instrumental in the writing of this article, and are also very good references for additional information related to the 1915(i) state plan option:

- Centers for Medicare and Medicaid Services (January 16, 2014). "Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Home and Community-Based Setting Requirements for Community First Choice and Home and Community-Based Services (HCBS) Waivers; Final Rule." *Federal Register*. See http://www.gpo.gov/fdsys/pkg/FR-2014-01-16/pdf/2014-00487.pdf.
- U.S. Government Accountability Office Report to Congressional Requesters (June 2012). "Medicaid: States' Plans to Pursue New and Revised Options for Home- and Community-Based Services." See http://www.gao.gov/assets/600/591560.pdf.
- Letter from Centers for Medicare and Medicaid Services to State Medicaid Directors (August 6, 2010). "Re: Improving Access to Home and Community-Based Services." See http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD10015.pdf.
- Letter from Center for Medicaid and State Operations to State Medicaid Directors (April 4, 2008). "Guidance on Implementation of Section 6086 of Deficit Reduction Act of 2005." See http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD040408.pdf.
- O'Keeffe, J., Saucier, P., et al. (October 29, 2010). "Understanding Medicaid Home and Community Services: A Primer, 2010 Edition." See http://aspe.hhs.gov/daltcp/reports/2010/primer10.htm. □

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Endnotes

1 Kaiser Family Foundation (August 28, 2014). Status of State Action of the Medicaid Expansion Decision. State Health Facts. Retrieved October 27, 2014, from http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/.

2 According to the Kaiser Family Foundation, 12 states were participating in the 1915(i) state plan option and four more states were planning to participate in fiscal year 2014, as of August 2014. See http://kff.org/medicaid/state-indicator/section-1915i-home-and-community-based-services-state-plan-option/.

3 In an April 4, 2008, letter from CMS to state Medicaid directors, the service offerings were limited to any or all of the following: "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 or other partial hospitalization services, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility)."

4 Indiana Family and Social Services Administration. Behavioral and Primary Healthcare Coordination (BPHC) 1915(i) Home and Community Based Service (HCBS). Retrieved October 27, 2014, from http://www.in.gov/fssa/files/BPHC_Overview_Presentation_for_Providers.pdf.

5 More information related to the BPHC program is available on the Indiana Medicaid website at http://www.in.gov/fssa/ddrs/4862.htm.