DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

SMDL #08-001

TO	DATE
Myers	4-14-08

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 000531	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR _____ cc: Ms. Forkner, Deps, Jacobs	[ ] Prepare reply for appropriate signature DATE DUE _____ [ ] FOIA DATE DUE _____ [X] Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
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2.			to CMS Bulletins Folder -
3.			SMDL 08-001 - Log-0005
4.			

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and State Operations

APR -4 2008

SMDL #08-001

Dear State Medicaid Director:

This letter provides guidance on the implementation of section 6086 of the Deficit Reduction Act of 2005 (DRA), Public Law Number 109-171.

Section 6086, Expanded Access to Home and Community-Based Services for the Elderly and Disabled, adds a new section 1915(i) to the Social Security Act (the Act). Under section 1915(i), States have the option to amend their State plans to provide home and community-based services (HCBS) without regard to statewideness or certain other Medicaid requirements. This provision was effective January 1, 2007.

There are certain similarities and differences between HCBS under the new State plan option and the existing section 1915(c) waiver authority. It should be noted that the addition of section 1915(i) of the Act does not alter a State's ability to request or administer waivers under section 1915(c) of the Act. The enclosed chart outlines a comparison of the Medicaid benefits States can offer under these two different authorities.

State Plan HCBS Financial Eligibility

Section 1915(i)(1) of the Act gives States the option of providing HCBS under their State plan to individuals eligible for Medicaid under an eligibility group covered in the State plan, and who have income that does not exceed 150 percent of the Federal poverty level (FPL). This option does not create a new eligibility group. Rather, the 150 percent of poverty income requirement must be met in addition to all of the eligibility requirements applicable to the group under which the individual qualifies for Medicaid. In determining whether the 150 percent of poverty requirement is met, the regular rules for determining income eligibility for the individual's eligibility group apply.

State Plan HCBS Program Eligibility

Section 1915(i)(3) of the Act gives States the option not to apply section 1902(a)(10)(C)(i)(III) of the Act (pertaining to income and resource eligibility rules) for the medically needy living in the community. This election allows States to treat medically needy individuals as if they are living in an institution by not deeming income and resources from an ineligible spouse to an applicant, or from a parent to a child. However, this authority is limited to the medically needy. There is no authority under section 1915(i) of the Act, comparable to the statutory authority under section 1915(c) of the Act, in which a State can treat individuals who are not medically needy as if they are living in an institution for purposes of determining their eligibility for the HCBS State plan option. We note, however, that individuals with incomes up to 150 percent of the FPL who are only eligible for Medicaid because they are receiving 1915(c) waiver services

- empowered to make financial or health-related decisions on behalf of the individual; and/or
- providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS, except when the only willing and qualified provider in a geographic area also provides HCBS, and States devise conflict of interest protections.

In addition, the law sets forth requirements for the independent assessment. Based on these requirements, the assessment should be based on the following:

- an objective face-to-face evaluation by an independent agent trained in assessment of need for HCBS and supports;
- consultation with the individual and others as appropriate;
- an examination of the individual's relevant history, medical records, care and support needs, and preferences;
- objective evaluation of the inability to perform, or need for significant assistance to perform 2 or more activities of daily living (as defined in section 7702B(c)(2)(B) of the Internal Revenue Code of 1986);
- where applicable, an evaluation of the support needs of the individual (or the individual's representative) to participant-direct; and
- a determination of need (and, if applicable, determination that service-specific additional needs-based criteria are met) for at least one State plan HCBS before an individual is enrolled into the State plan HCBS benefit.

Individualized Care Plans

Section 1915(i) of the Act requires States to provide services according to an individualized care plan for each individual. The law also sets forth requirements for the development and monitoring of the individualized care plan. Based on these requirements, the individualized plan of care should:

- be based on the independent assessment;
- be developed by a person-centered process in consultation with the individual, the individual's treating physician, health care or supporting professional, or other appropriate individuals, as defined by the State, and, where appropriate, the individual's family, caregiver, or representative;
- identify the State plan HCBS necessary for the individual, and furnish (or, fund if the individual elects to participant-direct the purchase of such services) all HCBS which the individual needs and for which the individual meets service-specific additional needs-based criteria (if any);
- take into account the extent of, and need for, any family or other supports for the individual;
- prevent the provision of unnecessary or inappropriate care;
- be guided by best practices and research on effective strategies for improved health and quality of life outcomes; and
- be reviewed at least every 12 months and as needed when there is significant change in the individual's circumstances.

If you have any additional questions, please contact Ms. Suzanne Bosstick, Director, Division of Community and Institutional Services, Disabled and Elderly Health Programs Group, at 410-786-1301.

Sincerely,

Dennis G. Smith
Director

Enclosure

cc:

CMS Regional Administrators

CMS Associate Regional Administrators
Division of Medicaid and Children's Health

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