FOR ATTORNEYS AND ADVOCATES REPRESENTING THE INTERESTS OF PEOPLE EXPERIENCING HOMELESSNESS

The Medicaid Program-Legal Primer

Medicaid is a public health insurance program jointly financed by state and federal governments for low income individuals and is embodied in 42 U.S.C. §1396 et seq. It was first enacted in 1965 as an amendment to the Social Security Act of 1935. Today, Medicaid is a major social welfare program and is administered by the Centers for Medicare and Medicaid Services, formerly known as the Health Care Financing Administration.

Medicaid is the nation’s main public health insurance program for low-income people. It covers tens of millions of Americans. Medicaid beneficiaries include pregnant women, children and families, individuals with disabilities, and very low-income Medicare beneficiaries. Without Medicaid, most enrollees would be uninsured or lack coverage for necessary health services. As a major insurer, Medicaid funding flows to safety-net hospitals, health centers that focus on underserved communities, and long-term care programs including nursing homes and community-based long-term health services.

Medicaid is a joint venture with funding shared between the federal and state governments. The Medicaid program is administered by states guided by broad federal. One of the challenges to extending or increasing coverage is that local governments (states or counties) must find revenue to cover its ‘share’ (match) for the federal funds. The federal government matches state Medicaid spending according to a formula in federal law. The federal match rate varies based on state per capita income.

Under the Affordable Care Act (ACA), Medicaid will expand in 2014 to insure millions more Americans living in poverty or experiencing low-income. This will expand health insurance coverage to uninsured adults—one of the primary goals of the ACA. In fact, the expansion of Medicaid is the foundation of the public-private system of coverage the ACA creates to reach nearly all the uninsured. However, under the Supreme Court decision reviewing the reach of the ACA, the Court ruled that each state will decide whether to implement the Medicaid expansion. The Supreme Court’s decision on the ACA effectively converted the Medicaid expansion policy to a state ‘option.’ However, the ACA offers an incentive to the States. Under new federal law, the federal government will finance 100% of the costs states incur to
cover adults who are newly eligible for Medicaid in the first three years of reform and at least 90% of the costs thereafter.¹

Today, an individual must belong to one of the core eligibility groups under federal Medicaid law: pregnant women, children, adults with dependent children, people with disabilities, and seniors. State are obligated to cover individuals in these groups with Medicaid insurance up to federally defined income threshold. However, many states have expanded Medicaid beyond the minimum requirements, mostly for children.

“Medicaid and the smaller Children’s Health Insurance Program (CHIP) cover 1 in every 3 children. Historically, non-disabled adults without dependent children (“childless adults”) have been excluded from Medicaid by federal law, and states wishing to cover them have had to use state-only dollars or obtain a federal waiver to do so.”²

What are the health services that Medicaid covers?

Medicaid covers a wide range of services to meet the health needs of people. Acute health services, nursing home care, and community-based long-term services:

- inpatient and outpatient hospital services;
- physician and nurse practitioner services;
- laboratory and x-ray services;
- nursing facility and home health care for individuals age 21+;
- early and periodic screening, diagnosis, and treatment (EPSDT) for children under age 21;
- family planning services and supplies; and
- rural health clinic/federally qualified health center services.

Additionally, under federal statues, certain “optional” services may be covered by States. These optional services include: prescription drugs dental care, durable medical equipment, and personal care services.

Generally, the same Medicaid benefits must be covered for all enrollees statewide. However, states have flexibility to provide a different set of benefits for some beneficiaries if the State obtains a waiver (or approval) from the Centers on Medicare and Medicaid (HHS).

Do eligible Medicaid recipients have ease of access to care?

There are limitations to the number of providers/clinics that will accept patients with Medicaid insurance. Often low-income and disabled populations on Medicaid are limited to a set range of clinics, physicians, therapists, or treatment centers that will accept Medicaid.

However, the recent Oregon Health Study, which examined access to care for low-income uninsured adults who gained Medicaid, showed results in increased probability of having a usual source of primary care and the use of preventive care, prescription drugs, and outpatient and hospital care. Further, the study found that Medicaid reduced out-of-pocket costs and medical debt, and adults who were insured through Medicaid had better self-reported physical and mental health than adults who remained uninsured.  

Medicaid enrollees receive their care primarily from private providers. Two-thirds receive all or most of their care in managed care arrangements, predominantly capitated managed care organizations (MCOs), and many others receive at least some services through capitated plans.

**How much does Medicaid cost?**

“In FY 2011, total Medicaid spending excluding administration (5%, data not shown) totaled about $414 billion. Two-thirds of spending was attributable to acute care and one-third went toward long-term care... Roughly two-thirds of Medicaid spending is attributable to elderly disabled beneficiaries although they make up just one-quarter of all Medicaid enrollees. Further, almost 40% of Medicaid spending is attributable to dual eligible beneficiaries; most of their spending is for long-term care.”

**How is Medicaid financed?**

The federal government matches state Medicaid spending according to a formula in federal law. The federal match rate varies based on state per capita income. Under the ACA, the federal government will finance 100% of the costs states incur to cover adults who are newly eligible for Medicaid in the first three years of reform and at least 90% of the costs thereafter.

**What is a State Medicaid Plan?**

Under Title XIX of the Social Security Act, no federal Medicaid funds are available to a state unless it has submitted to the Secretary of HHS, and the Secretary has approved, its state Medicaid plan (and all amendments to the state plan). The state Medicaid plan must meet over 60 federal statutory requirements.

**How is Medicaid related to the State Children’s Health Insurance Program (SCHIP)?**

The State Children’s Health Insurance Program (SCHIP) was established in 1997 to provide funds to states to expand coverage to children who were not eligible for Medicaid under state standards in place in 1997. In essence, SCHIP helped fill a gap between very low-income children who received Medicaid and low-income children who were not eligible for Medicaid and remained uninsured. Under SCHIP, 

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uninsured children under 200% of poverty are the target population. States can use their SCHIP funds either to expand Medicaid coverage for children or create a separate SCHIP program.

**Medicaid and Mental Health Benefits.**

Federal law does not require a state to offer mental health care under Medicaid. Mental health services are considered an “optional” service. Although federal law does not outline the exact types of mental health services that can be provided, all State Medicaid programs provide some mental health services to enrollees. According to HHS,

> "Medicaid reimbursement is available for mental and behavioral health services covered under various service categories: physician’s services, inpatient and outpatient hospital services, licensed practitioner’s services, clinics, rehabilitative services, inpatient psychiatric hospital services for individuals under age 21, as well as, prescription drugs. Examples of Services in these categories include: Counseling, therapy, medication management, psychiatrist’s services, licensed clinical social work services, peer supports, and substance abuse treatment."

Other key services in a mental health continuum such as rehabilitation and case management services are optional under Medicaid, although the majority of states cover them for children. Additionally, prescription drug coverage is another widely utilized benefit under Medicaid programs and it is the fastest growing area of Medicaid spending.

**How Does the Affordable Care Act (Obamacare) affect Medicaid?**

The Patient Protection and Affordable Care Act (Pub. L. 111-148, enacted on March 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152, enacted on March 30, 2010), and together referred to as the Affordable Care Act of 2010 (Affordable Care Act) modifies state’s ability to change eligibility standards for Medicaid. As of 2011, states have the option to expand Medicaid eligibility to include all persons who have income below 133% of poverty regardless of disability status. Therefore, the landscape for state and supportive housing programs has changed

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8 42 C.F.R. 431, 435, and 457; Federal Register, Vol. 77, Pages 17143-17217; Web. 15 July 2013: [https://www.federalregister.gov/articles/2012/03/23/2012-6560/medicaid-program-eligibility-changes-under-the-affordable-care-act-of-2010](https://www.federalregister.gov/articles/2012/03/23/2012-6560/medicaid-program-eligibility-changes-under-the-affordable-care-act-of-2010); The Department of Health and Human Services, Centers for Medicare & Medicaid Services: "This final rule: (1) Reflects the statutory minimum Medicaid income eligibility level of 133 percent of the Federal Poverty Level (FPL) across the country for most non-disabled adults under age 65; (2) eliminates obsolete eligibility categories and collapses other categories into four primary groups: children, pregnant women, parents, and the new adult group; (3) modernizes eligibility verification rules to rely primarily on electronic data sources; (4) codifies the streamlining of income-based rules and systems for processing Medicaid and CHIP applications and renewals for most individuals; and (5) ensures coordination across Medicaid, CHIP, and the Exchanges."
since prior to the ACA most homeless persons were not ‘categorically eligible’ for Medicaid insurance since they could not show a disability diagnosis.

**Section 1115 Medicaid Waiver Financing.**

While Medicaid benefits are limited by federal law and State Medicaid Plans, Plans can propose special projects to waive specific requirements. This allows advocates for the homeless to devise and propose demonstration projects to offer community-based services to homeless persons as a waiver to the State Medicaid Plan.

Under section 1115 of the Social Security Act, the federal government can allow states to develop comprehensive demonstration, experimental projects that modify (waive) federal Medicaid and State Children’s Health Insurance Program (SCHIP) requirements related to benefits, cost-sharing and eligible populations.

- Any new waivers must be “budget neutral” to the federal government. This means that federal spending can be no higher under the waiver than it would have been without the waiver.
- Several states have combined coverage expansions with a new managed care delivery system and used the anticipated managed care savings to offset the cost of the coverage expansion.

**Home-and Community-Based Services (HCBS) Waiver.**

Also known as the “1915c waiver” after the enabling section in the Social Security Act, this waiver authorizes the Secretary of HHS to allow a state Medicaid program to offer special services to beneficiaries at risk of institutionalization in a nursing facility or facility for the mentally retarded. These home- and community-based services, which otherwise would not be covered with federal matching funds, include case management, homemaker/home health aide services, personal care services, adult day health services, habilitation services, and respite care. They also include, in the case of individuals with chronic mental illness, day treatment and partial hospitalization, psychosocial rehabilitation services, and clinic services.

**Home & Community-Based Services 1915(i).**

Under federal Medicaid law, States can offer a variety of services under a State Plan Home and Community-Based Services (HCBS) benefit package. Health reform gives states the flexibility to offer community-based services not listed in the statute if approved by the HHS and the Centers for Medicare

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and Medicaid Services. Additionally, states can target services to specific populations, an option that was not available under 1915(i) before Health care reform.11

Under Section 1915(i), States have the following options for Home and Community-based Services:

- Target the HCBS benefit to one or more specific populations;
- Establish separate additional needs-based criteria for individual HCBS;
- Establish a new Medicaid eligibility group for people who get State plan HCBS;
- Define the HCBS included in the benefit, including State- defined and CMS-approved “other services” applicable to the population; or
- Option to allow any or all HCBS to be self-directed.

This would allow a state to devise an amendment to their state Plan to target persons experiencing homelessness and chronic illnesses or disabilities. Furthermore, states can develop the HCBS benefit(s) to meet the specific needs of a population(s) within Federal guidelines, including:

- Establish a process to ensure that assessments and evaluations are independent and unbiased;
- Ensure that the benefit is available to all eligible individuals within the State;
- Ensure that measures will be taken to protect the health and welfare of participants;
- Provide adequate and reasonable provider standards to meet the needs of the target population;
- Ensure that services are provided in accordance with a plan of care; or
- Establish a quality assurance, monitoring and improvement strategy for the benefit. See HCBS Quality information.

The State Medicaid agency must submit a State plan amendment to CMS for review and approval to establish a 1915(i) HCBS benefit. State plan HCBS benefits don’t have a time limit on 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.12

https://s3.amazonaws.com/public-inspection.federalregister.gov/2012-10385.pdf. "The rule revises Medicaid regulations to define and describe State plan home and community-based services (HCBS) under the Social Security Act (the Act) as added by the Deficit Reduction Act of 2005 and amended by the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act). "This regulation outlines the optional State plan benefit to furnish home and community-based State plan services and draw Federal matching funds. As a result, States will be able to design and tailor Medicaid services to better accommodate individual needs."

MEDICAID – UNITED STATES CODE

42 U.S.C. § 1396 et seq. – FEDERAL MEDICAID PROGRAM

- § 1396. Medicaid and CHIP Payment and Access Commission
- § 1396-1. Appropriations
- § 1396a. State plans for medical assistance
- § 1396b. Payment to States
- § 1396b-1. Payment adjustment for health care-acquired conditions
- § 1396c. Operation of State plans
- § 1396d. Definitions
- § 1396e. Enrollment of individuals under group health plans
- § 1396e-1. Premium assistance option for children
- § 1396f. Observance of religious beliefs
- § 1396g. State programs for licensing of administrators of nursing homes
- § 1396g-1. Required laws relating to medical child support
- § 1396h. State false claims act requirements for increased State share of recoveries
- § 1396i. Certification and approval of rural health clinics and intermediate care facilities for mentally retarded
- § 1396j. Indian Health Service facilities
- § 1396k. Assignment, enforcement, and collection of rights of payments for medical care; establishment of procedures pursuant to State plan; amounts retained by State
- § 1396l. Hospital providers of nursing facility services
- § 1396m. Withholding of Federal share of payments for certain medicare providers
- § 1396n. Compliance with State plan and payment provisions
- § 1396o. Use of enrollment fees, premiums, deductions, cost sharing, and similar charges
- § 1396o-1. State option for alternative premiums and cost sharing
- § 1396p. Liens, adjustments and recoveries, and transfers of assets
- § 1396q. Application of provisions of subchapter II relating to subpoenas
- § 1396r. Requirements for nursing facilities
- § 1396r-1. Presumptive eligibility for pregnant women
- § 1396r-1a. Presumptive eligibility for children
- § 1396r-1b. Presumptive eligibility for certain breast or cervical cancer patients
- § 1396r-1c. Presumptive eligibility for family planning services
- § 1396r-2. Information concerning sanctions taken by State licensing authorities against health care practitioners and providers
- § 1396r-3. Correction and reduction plans for intermediate care facilities for mentally retarded
- § 1396r-4. Adjustment in payment for inpatient hospital services furnished by disproportionate share hospitals
- § 1396r-5. Treatment of income and resources for certain institutionalized spouses
- § 1396r-6. Extension of eligibility for medical assistance
- § 1396r-7. Repealed.
- § 1396r-8. Payment for covered outpatient drugs
- § 1396s. Program for distribution of pediatric vaccines
- § 1396t. Home and community care for functionally disabled elderly individuals
- § 1396u. Community supported living arrangements services
• § 1396u-1. Assuring coverage for certain low-income families
• § 1396u-2. Provisions relating to managed care
• § 1396u-3. State coverage of medicare cost-sharing for additional low-income medicare beneficiaries
• § 1396u-4. Program of all-inclusive care for elderly (PACE)
• § 1396u-5. Special provisions relating to medicare prescription drug benefit
• § 1396u-6. Medicaid Integrity Program
• § 1396u-7. State flexibility in benefit packages
• § 1396u-8. Health opportunity accounts
• § 1396v. References to laws directly affecting medicaid program
• § 1396w. Asset verification through access to information held by financial institutions
• § 1396w-1. Medicaid Improvement Fund
• § 1396w-2. Authorization to receive relevant information
• § 1396w-3. Enrollment simplification and coordination with State health insurance exchanges
• § 1396w-4. State option to provide coordinated care through a health home for individuals with chronic conditions
• § 1396w-5. Addressing health care disparities
Section 1915i of the Social Security Act- State Plan Waivers

42 U.S.C. § 1396n

(i) State Plan Amendment Option To Provide Home and Community-Based Services for Elderly and Disabled Individuals.—

(1) In general.—Subject to the succeeding provisions of this subsection, a State may provide through a State plan amendment for the provision of medical assistance for home and community-based services (within the scope of services described in paragraph (4)(B) of subsection (c) for which the Secretary has the authority to approve a waiver and not including room and board) for individuals eligible for medical assistance under the State plan whose income does not exceed 150 percent of the poverty line (as defined in section 2110(c)(5)), without determining that but for the provision of such services the individuals would require the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded, but only if the State meets the following requirements:

(A) Needs-based criteria for eligibility for, and receipt of, home and community-based services.—The State establishes needs-based criteria for determining an individual’s eligibility under the State plan for medical assistance for such home and community-based services, and if the individual is eligible for such services, the specific home and community-based services that the individual will receive.

(B) Establishment of more stringent needs-based eligibility criteria for institutionalized care.—The State establishes 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 that are more stringent than the needs-based criteria established under subparagraph (A) for determining eligibility for home and community-based services.

(C) Projection of number of individuals to be provided home and community-based services.—The State submits to the Secretary, in such form and manner, and upon such frequency as the Secretary shall specify, the projected number of individuals to be provided home and community-based services.

(D) Criteria based on individual assessment.—

(i) In general.—The criteria established by the State for purposes of subparagraphs (A) and (B) requires an assessment of an individual’s support needs and capabilities, and may take into account the inability of the individual to perform 2 or more activities of daily living (as defined in section 7702B(c)(2)(B) of the Internal Revenue Code of 1986) or the need for significant assistance to perform such activities, and such other risk factors as the State determines to be appropriate.

(ii) Adjustment authority.—The State plan amendment provides the State with the option to modify the criteria established under subparagraph (A) (without having to obtain prior approval from the Secretary).
in the event that the enrollment of individuals eligible for home and community-based services exceeds the projected enrollment submitted for purposes of subparagraph (C), but only if—

(I) the State provides at least 60 days notice to the Secretary and the public of the proposed modification;

(II) the State deems an individual receiving home and community-based services on the basis of the most recent version of the criteria in effect prior to the effective date of the modification to continue to be eligible for such services after the effective date of the modification and until such time as the individual no longer meets the standard for receipt of such services under such pre-modified criteria; and

(III) after the effective date of such modification, the State, at a minimum, applies the 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 which applied prior to the application of the more stringent criteria developed under subparagraph (B).

(E) Independent evaluation and assessment.—

(i) Eligibility determination.—The State uses an independent evaluation for making the determinations described in subparagraphs (A) and (B).

(ii) Assessment.—In the case of an individual who is determined to be eligible for home and community-based services, the State uses an independent assessment, based on the needs of the individual to—

(I) determine a necessary level of services and supports to be provided, consistent with an individual’s physical and mental capacity;

(II) prevent the provision of unnecessary or inappropriate care; and

(III) establish an individualized care plan for the individual in accordance with subparagraph (G).

(F) Assessment.—The independent assessment required under subparagraph (E)(ii) shall include the following:

(i) An objective evaluation of an individual’s inability to perform 2 or more activities of daily living (as defined in section 7702B(c)(2)(B) of the Internal Revenue Code of 1986) or the need for significant assistance to perform such activities.

(ii) A face-to-face evaluation of the individual by an individual trained in the assessment and evaluation of individuals whose physical or mental conditions trigger a potential need for home and community-based services.
(iii) Where appropriate, consultation with the individual’s family, spouse, guardian, or other responsible individual.

(iv) Consultation with appropriate treating and consulting health and support professionals caring for the individual.

(v) An examination of the individual’s relevant history, medical records, and care and support needs, guided by best practices and research on effective strategies that result in improved health and quality of life outcomes.

(vi) If the State offers individuals the option to self-direct the purchase of, or control the receipt of, home and community-based service, an evaluation of the ability of the individual or the individual’s representative to self-direct the purchase of, or control the receipt of, such services if the individual so elects.

(G) Individualized care plan.—

(i) In general.—In the case of an individual who is determined to be eligible for home and community-based services, the State uses the independent assessment required under subparagraph (E)(ii) to establish a written individualized care plan for the individual.

(ii) Plan requirements.—The State ensures that the individualized care plan for an individual—

(I) is developed—

(aa) in consultation with the individual, the individual’s treating physician, health care or support professional, or other appropriate individuals, as defined by the State, and, where appropriate the individual’s family, caregiver, or representative; and

(bb) taking into account the extent of, and need for, any family or other supports for the individual;

(II) identifies the necessary home and community-based services to be furnished to the individual (or, if the individual elects to self-direct the purchase of, or control the receipt of, such services, funded for the individual); and

(III) is reviewed at least annually and as needed when there is a significant change in the individual’s circumstances.

(iii) State option to offer election for self-directed services.—

(I) Individual choice.—At the option of the State, the State may allow an individual or the individual’s representative to elect to receive self-directed home and community-based services in a manner which
gives them the most control over such services consistent with the individual’s abilities and the requirements of subclauses (II) and (III).

(II) Self-directed services.—The term “self-directed” means, with respect to the home and community-based services offered under the State plan amendment, such services for the individual which are planned and purchased under the direction and control of such individual or the individual’s authorized representative, including the amount, duration, scope, provider, and location of such services, under the State plan consistent with the following requirements:

(aa) Assessment.—There is an assessment of the needs, capabilities, and preferences of the individual with respect to such services.

(bb) Service plan.—Based on such assessment, there is developed jointly with such individual or the individual’s authorized representative a plan for such services for such individual that is approved by the State and that satisfies the requirements of subclause (III).

(III) Plan requirements.—For purposes of subclause (II)(bb), the requirements of this subclause are that the plan—

(aa) specifies those services which the individual or the individual’s authorized representative would be responsible for directing;

(bb) identifies the methods by which the individual or the individual’s authorized representative will select, manage, and dismiss providers of such services;

(cc) specifies the role of family members and others whose participation is sought by the individual or the individual’s authorized representative with respect to such services;

(dd) is developed through a person-centered process that is directed by the individual or the individual’s authorized representative, builds upon the individual’s capacity to engage in activities that promote community life and that respects the individual’s preferences, choices, and abilities, and involves families, friends, and professionals as desired or required by the individual or the individual’s authorized representative;

(ee) includes appropriate risk management techniques that recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assure the appropriateness of such plan based upon the resources and capabilities of the individual or the individual’s authorized representative; and

(ff) may include an individualized budget which identifies the dollar value of the services and supports under the control and direction of the individual or the individual’s authorized representative.
(IV) Budget process.—With respect to individualized budgets described in subclause (III)(ff), the State plan amendment—

(aa) describes the method for calculating the dollar values in such budgets based on reliable costs and service utilization;

(bb) defines a process for making adjustments in such dollar values to reflect changes in individual assessments and service plans; and

(cc) provides a procedure to evaluate expenditures under such budgets.

(H) Quality assurance; conflict of interest standards.—

(i) Quality assurance.—The State ensures that the provision of home and community-based services meets Federal and State guidelines for quality assurance.

(ii) Conflict of interest standards.—The State establishes standards for the conduct of the independent evaluation and the independent assessment to safeguard against conflicts of interest.

(I) Redeterminations and appeals.—The State allows for at least annual redeterminations of eligibility, and appeals in accordance with the frequency of, and manner in which, redeterminations and appeals of eligibility are made under the State plan.

(J) Presumptive eligibility for assessment.—The State, at its option, elects to provide for a period of presumptive eligibility (not to exceed a period of 60 days) only for those individuals that the State has reason to believe may be eligible for home and community-based services. Such presumptive eligibility shall be limited to medical assistance for carrying out the independent evaluation and assessment under subparagraph (E) to determine an individual’s eligibility for such services and if the individual is so eligible, the specific home and community-based services that the individual will receive.

(2) Definition of individual’s representative.—In this section, the term “individual’s representative” means, with respect to an individual, a parent, a family member, or a guardian of the individual, an advocate for the individual, or any other individual who is authorized to represent the individual.

(3) Nonapplication.—A State may elect in the State plan amendment approved under this section to not comply with the requirements of section 1902(a)(10)(B) (relating to comparability) and section 1902(a)(10)(C)(i)(III) (relating to income and resource rules applicable in the community), but only for purposes of provided home and community-based services in accordance with such amendment. Any such election shall not be construed to apply to the provision of services to an individual receiving medical assistance in an institutionalized setting as a result of a determination that the individual requires the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded.
(4) No effect on other waiver authority.—Nothing in this subsection shall be construed as affecting the option of a State to offer home and community-based services under a waiver under subsections (c) or (d) of this section or under section 1115.

(5) Continuation of federal financial participation for medical assistance provided to individuals as of effective date of state plan amendment.—Notwithstanding paragraph (1)(B), Federal financial participation shall continue to be available for an individual who is receiving medical assistance in an institutionalized setting, or home and community-based services provided under a waiver under this section or section 1115 that is in effect as of the effective date of the State plan amendment submitted under this subsection, as a result of a determination that the individual requires the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded, without regard to whether such individuals satisfy the more stringent eligibility criteria established under that paragraph, until such time as the individual is discharged from the institution or waiver program or no longer requires such level of care.

(6) State option to provide home and community-based services to individuals eligible for services under a waiver.—

(A) In general.—A State that provides home and community-based services in accordance with this subsection to individuals who satisfy the needs-based criteria for the receipt of such services established under paragraph (1)(A) may, in addition to continuing to provide such services to such individuals, elect to provide home and community-based services in accordance with the requirements of this paragraph to individuals who are eligible for home and community-based services under a waiver approved for the State under subsection (c), (d), or (e) or under section 1115 to provide such services, but only for those individuals whose income does not exceed 300 percent of the supplemental security income benefit rate established by section 1611(b)(1).

(B) Application of same requirements for individuals satisfying needs-based criteria.—Subject to subparagraph (C), a State shall provide home and community-based services to individuals under this paragraph in the same manner and subject to the same requirements as apply under the other paragraphs of this subsection to the provision of home and community-based services to individuals who satisfy the needs-based criteria established under paragraph (1)(A).

(C) Authority to offer different type, amount, duration, or scope of home and community-based services.—A State may offer home and community-based services to individuals under this paragraph that differ in type, amount, duration, or scope from the home and community-based services offered for individuals who satisfy the needs-based criteria established under paragraph (1)(A), so long as such services are within the scope of services described in paragraph (4)(B) of subsection (c) for which the Secretary has the authority to approve a waiver and do not include room or board.

(7) State option to offer home and community-based services to specific, targeted populations.—
(A) In general.—A State may elect in a State plan amendment under this subsection to target the provision of home and community-based services under this subsection to specific populations and to differ the type, amount, duration, or scope of such services to such specific populations.

(B) 5-year term.—

(i) In general.—An election by a State under this paragraph shall be for a period of 5 years.

(ii) Phase-in of services and eligibility permitted during initial 5-year period.—A State making an election under this paragraph may, during the first 5-year period for which the election is made, phase-in the enrollment of eligible individuals, or the provision of services to such individuals, or both, so long as all eligible individuals in the State for such services are enrolled, and all such services are provided, before the end of the initial 5-year period.

(C) Renewal.—An election by a State under this paragraph may be renewed for additional 5-year terms if the Secretary determines, prior to beginning of each such renewal period, that the State has—

(i) adhered to the requirements of this subsection and paragraph in providing services under such an election; and

(ii) met the State’s objectives with respect to quality improvement and beneficiary outcomes.

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