



**U.S. Department of Health and Human Services  
Assistant Secretary for Planning and Evaluation  
Office of Disability, Aging and Long-Term Care Policy**

# **THE USE OF 1915(I) MEDICAID PLAN OPTION FOR INDIVIDUALS WITH MENTAL HEALTH AND SUBSTANCE USE DISORDERS**

**November 2016**

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## ACRONYMS

The following acronyms are mentioned in this report.

ABA	Applied Behavioral Analysis
ABI	Applied Behavioral Intervention
ACA	Patient Protection and Affordable Care Act
CMS	HHS Centers for Medicare & Medicaid Services
EHB	Essential Health Benefits
EIBI	Early Intensive Behavioral Intervention
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
FPL	Federal Poverty Level
HCBS	Home and Community-Based Services
HHS	U.S. Department of Health and Human Services
HMA	Health Management Associates
ID/DD	Intellectual or Developmental Disabilities
IMD	Institution for Mental Disease
LTSS	Long-Term Services and Supports
M/SUD	Mental Health or Substance Use Disorder
MRO	Medicaid Rehabilitation Option
NRI	National Association of State Mental Health Program Directors Research Institute
SAMHSA	HHS Substance Abuse and Mental Health Services Administration
SED	Serious Emotional Disturbance
SME	Subject Matter Expert
SMI	Serious Mental Illness
SPA	State Plan Amendment
SSI	Supplemental Security Income
TCM	Targeted Case Management

## EXECUTIVE SUMMARY

Created by the Deficit Reduction Act of 2005 and amended by the Patient Protection and Affordable Care Act, Section 1915(i) of the Social Security Act gives state Medicaid programs the flexibility to cover home and community-based services (HCBS) without the need to seek a federal waiver. Unlike Medicaid HCBS waivers under Social Security Act Section 1915(c):

- 1915(i) does not require states to show that HCBS reduces Medicaid's institutional care costs. As result, non-elderly adults with mental health or substance use disorders (M/SUDs) can receive help, although Medicaid does not typically fund their institutional care.
- People can qualify for HCBS even if their conditions are not severe enough to require institutionalization, and states can target specific populations based on identified risk factors. 1915(i) can thus help people transition out of institutional long-term services and supports. It can also help prevent institutionalization by catching patients at an earlier stage in the development of illness, focus institutional beds on the neediest cases, shorten the length of institutional stays, and provide uncapped funding for state compliance with legal requirements to place beneficiaries in home and community-based settings.
- States cannot cap enrollment, and services must be offered statewide. If caseload growth exceeds projections, states can limit costs by tightening clinical eligibility criteria for new enrollees.

This research project analyzed state implementation of 1915(i), including prospects for innovative and more widespread future use. We began with an environmental scan that encompassed 1915(i) state plan amendments (SPAs) approved by the U.S. Department of Health and Human Services (HHS) Centers for Medicare & Medicaid Services (CMS), peer-reviewed journal articles, and the "grey" literature of reports and presentations available from states, beneficiary advocates, and provider organizations. We then interviewed five national subject matter experts (SME) and brought together ten state officials for a one-day national meeting.

Our environmental scan identified 23 approved 1915(i) SPAs. Four focused on children with mental health disorders; four helped children with other conditions, such as autism; seven targeted non-elderly adults with M/SUDs; and eight focused on adults with other conditions. Specific details varied by state, but most provided a broad range of services and supports to narrowly defined populations.

Our SME interviews and state official meeting identified both advantages and challenges of 1915(i), from the standpoint of state policymakers. In addition to the

program features noted earlier, officials observed that 1915(i) can fill gaps in Medicaid coverage of M/SUDs. The combination of 1915(i), other Medicaid benefits, and funding from non-Medicaid sources (most important, grants from the HHS Substance Abuse and Mental Health Services Administration, or SAMHSA) can go a long way towards providing the full range of services and supports identified by SAMHSA as making up a “Good and Modern Addiction and Mental Health System.” SMEs and state officials identified several promising areas of largely untapped potential under 1915(i), including:

- Coverage targeted to certain populations, such as people involved with or transitioning out of the criminal justice system, people transitioning out of homelessness, patients with first-episode psychosis, and patients receiving mandatory M/SUD treatment outside the hospital.
- Coverage of particular services, including beneficiary self-direction and housing supports.
- Tightening criteria for institutionalization without reducing coverage of HCBS. Since 1915(i) is not limited to those with a need for institutional care, a state can narrow the grounds for institutionalization without thereby reducing eligibility for HCBS under 1915(i).

State officials explained several challenges that limit their use of 1915(i):

- Many (but not all) officials expressed concern about cost exposure, due to 1915(i)’s prohibition of enrollment caps. Efforts under 1915(i) to control caseload by narrowing clinical eligibility criteria were not seen as adequately assuring limited risk. State officials saw enrollment caps as easier to administer and more politically feasible for maintaining stakeholder consensus.
- Officials saw the statewide requirement as precluding geographic phase-ins of 1915(i) coverage. Such phase-ins were characterized as important for fine-tuning new policies before they go statewide and for gradually developing support among policymakers when they see innovation yielding positive results.
- Requirements for independent review, conflict-free case management, and quality review were described as imposing onerous burdens on states, health plans, and providers. Independent review requirements were found helpful in fee-for-service or sole-source contexts, where they prevented excessive services and cost-shifting. However, with competitive managed care plans, officials viewed these requirements as replicating functions already served by other systems and conflicting with the basic nature of risk-bearing managed care.
- Except for populations who need institutional-level care, 1915(i) limits eligibility to beneficiaries with incomes at or below 150 percent of the federal poverty level (FPL). This makes it difficult to serve children, who are covered significantly

above that income level in nearly all states, as well as adults whose recovery involves increasing earnings as they transition to independence.

- CMS has not provided the kind of comprehensive guidance for 1915(i) that is available for 1915(c) HCBS waivers. Such guidance could be particularly useful for 1915(i)'s coverage of adults with M/SUDs, which requires cross-cutting expertise in Medicaid and behavioral health.

To avoid these challenges, a number of states are pursuing alternative vehicles for offering services that could otherwise fall under 1915(i). One vehicle involves 1115 waivers, with managed care plans providing otherwise uncovered services “in lieu of” other Medicaid benefits. Another vehicle involves Early and Periodic Screening, Diagnosis, and Treatment, which covers all federally-reimbursable treatment required by beneficiaries under age 21. Finally, some states include 1915(i) as part of much broader, multi-vehicle approach to covering HCBS or treating M/SUDs. Other components of these coordinated policies may include 1915(b), (c) and (k) as well as 1115 waivers, depending on the state and the applicable policy.

Officials suggested several federal policy options to help states go farther in achieving 1915(i)'s goals:

- To address concerns about the statewideness requirement, CMS could: (1) use Section 1115 to waive statewideness; or (2) clarify the availability of geographic phase-ins for new 1915(i) coverage.
- 1915(i)'s requirements for independent review, conflict-free case management, and quality reporting might be applied differently in competitive managed care settings, letting states perform these functions by using a common approach across multiple coverage vehicles.
- CMS could provide guidance indicating that states have the option to serve beneficiaries with gross incomes above 150 percent of FPL by using eligibility methodologies with less restrictive income disregards than apply in cash assistance programs.
- States would like to see additional guidance about 1915(i), including examples of promising state practices. Such guidance could also explore how states can use 1915(i) together with other Medicaid and non-Medicaid options to develop comprehensive, integrated systems for serving beneficiaries with M/SUDs and for providing HCBS.

# INTRODUCTION AND BACKGROUND

## Report Structure

State and federal Medicaid programs are increasingly focused on providing home and community-based services (HCBS) as an alternative to institutional care. In 2013, the majority of Medicaid spending on long-term services and supports (LTSS) was for HCBS, for the first time in the program's history. The share of LTSS dollars devoted to HCBS grew from 18 percent in 1995 to 51 percent in 2013.<sup>1</sup> Multiple goals animated this shift: improving health outcomes, slowing cost growth, accommodating beneficiary and family desires for community-based care, and helping implement the Supreme Court's *Olmstead* ruling, which requires states to offer people with disabilities HCBS.

Among non-elderly adults, the shift toward HCBS has, until recently, primarily involved populations with intellectual or developmental disabilities (ID/DD), rather than those with behavioral health needs. Social Security Act Section 1915(i), created in 2005 and amended in the Patient Protection and Affordable Care Act (ACA), gave Medicaid programs additional flexibility in approaching HCBS, including through providing services and supports to adults with behavioral health needs. This report analyzes past and current state uses of 1915(i) as well as the broader potential offered by this Medicaid option.

The remainder of this Introduction and Background section discusses the policy context for 1915(i), requirements and options for state implementation of 1915(i), and the project's research questions. The Methodology section then describes our approach to answering the research questions. Finally, the Findings section explains what we learned about state use of 1915(i), opportunities and challenges perceived by state officials and subject matter experts (SMEs), and suggestions from those officials and experts of possible federal options to help states better achieve 1915(i)'s goals.

## Policy Context for 1915(i)

### Patient Protection and Affordable Care Act Implementation

Policy, funding, and delivery of health care services have seen unprecedented changes in the years leading up to and following passage of the ACA. The 1915(i) option was introduced while Medicaid and the broader health policy environment were undergoing a level of flux that has not been experienced since the creation of Medicaid and Medicare in the 1960s. States, the U.S. Department of Health and Human Services (HHS) Centers for Medicare & Medicaid Services (CMS), and the HHS Substance Abuse and Mental Health Services Administration (SAMHSA) maneuvered to keep traditional programs and services operating while developing new approaches, at the

same time dealing with the most significant recession in more than a generation, Medicaid and health systems transformation, and capacity limitations at the federal, state, and private vendor levels. These broader economic forces, coupled with a burgeoning belief that traditional approaches to health services could not sustain, let alone improve health outcomes, had a significant impact on states. The ability and appetite of individual states to develop new programs varied; some states were well-positioned to quickly take advantage of the 1915(i) option while others were immersed in dealing with other issues.

## **Medicaid Coverage of Mental Health and Substance Use Disorders for Adults**

### ***Before the Patient Protection and Affordable Care Act***

Medicaid has long required states to offer certain “mandatory benefits,” including physician services, inpatient and outpatient hospital care, and nursing facility services. In addition, states can pick from a menu of “optional” services. Behavioral health services offered at state option include prescription drugs, clinic services, and a broad range of disability-related services, such as case management, rehabilitative care, and HCBS.<sup>2</sup> The broad definitions of these service categories, both mandatory and optional, enable states to provide many behavioral health benefits. Some of the most important service categories, from a behavioral health perspective, are “optional,” but all states cover them:

- **Clinic option services** follow a medical model. Services are provided in a clinic setting and require direct physician (psychiatrist) oversight of licensed behavioral health practitioners. These psychiatric services include: psychotherapy (counseling), medication management, and psychological testing and diagnosis. This category of behavioral health services under Medicaid most closely mirrors a commercial behavioral health benefit. Note that some clinic services, such as those provided by federally qualified health centers, are mandatory rather than optional Medicaid benefits.
- **Targeted case management (TCM)** can be employed by states to assist a targeted population (e.g., individuals with serious mental illness, or SMI) in gaining access to needed medical, social, educational, and other services. TCM services are generally performed by non-physician, non-nurse staff in linking a Medicaid beneficiary to other needed direct services.
- **The Medicaid rehabilitation option (MRO)** allows states to provide a range of intensive support services to people in home and community settings. In the behavioral health arena, states use the MRO to cover psychosocial rehabilitation services for individuals with SMI. Often this service category includes in-home counseling and therapy, assertive community treatment, crisis services, medication education, and skill building. Frequently used in conjunction with TCM services, the MRO represents the single largest source of behavioral health

expenditures in the Medicaid program. In 2012, all 50 states and the District of Columbia used the MRO to provide behavioral health services.<sup>3</sup>

### ***The Patient Protection and Affordable Care Act***

The ACA created a new Medicaid eligibility category for low-income adults under age 65 with incomes at or below 138 percent of the federal poverty level (FPL), which the U.S. Supreme Court made optional in 2012. The ACA also included features that are likely to expand Medicaid coverage of behavioral health services:

- The ACA applied mental health parity requirements to Medicaid alternative benefits provided to newly eligible adults.
- Essential health benefits (EHBs) covered for newly eligible adults include both rehabilitative and habilitative services. In a state where the “benchmark plan” that defines EHBs does not include coverage of habilitative services, the state has broad authority to define the scope of covered services. In states that do not define habilitative care, a broad federal definition applies: “[H]ealth care services and devices that help a person keep, learn, or improve skills and functioning for daily living (habilitative services). Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.” 45 CFR 156.115(a)(5)(i),
- CMS has ruled that a state can provide different services to different groups of newly eligible adults, within “alternative benefit packages.”<sup>4</sup> Those with particularly great needs for care--such as those with serious mental health or substance use disorders (M/SUDs)--can receive a broader range of Medicaid-covered services than other newly eligible adults.<sup>5</sup>
- The ACA created an option for states to provide “health home” services to chronically ill Medicaid beneficiaries, coordinating all forms of care these individuals receive. Enhanced federal match, at a 90 percent rate, is available for two years to cover such services as care management, care coordination, health promotion, transition management, individual and family support, referral to community and social supports, and the use of health technology to provide linkages. Many states are using this new option to help integrate acute physical health care, behavioral health care, and LTSS for Medicaid beneficiaries with severe mental illness.<sup>6</sup>

These provisions are quite important, given the prevalence of M/SUDs among newly eligible adults in states that expand Medicaid. Before the ACA’s main coverage expansion provisions became effective in 2014, an estimated 4.9 percent of uninsured men with incomes at or below 138 percent of FPL had SMI; 12.3 percent experienced serious psychological distress; and 20.5 percent had substance use disorders. Those

percentages among women were 9.0 percent, 17.6 percent, and 7.7 percent, respectively, according to SAMHSA.<sup>7</sup> Many previously uninsured consumers with M/SUDs are now eligible for Medicaid, for the first time, under provisions that potentially increase the availability of treatment for these conditions.

Within this context, many policymakers have sought to transform systems of care for persons with behavioral health needs, including M/SUDs. At the core of many transformation efforts is the shift from institution-based care to HCBS and supports, with beneficiaries gaining more influence and control over their own care along with encouragement to maintain independence and community engagement. This shift is discussed in the following section.

### **Medicaid Coverage of Home and Community-Based Services**

A state's existing HCBS system greatly influences whether and on what terms 1915(i) can complement, expand, or improve on previous coverage. To understand how states have approached 1915(i), it is thus important to consider other Medicaid vehicles for HCBS coverage.

#### ***Before the Patient Protection and Affordable Care Act***

All states must maintain a Medicaid state plan that commits to meeting numerous, specific federal requirements and that specifies the federal options the state has chosen to implement. Such plans address program administration, Medicaid eligibility criteria, service coverage (mandatory and optional), and provider requirements. A state Medicaid plan is a living document that may be amended with approval by CMS. While federal statutory and regulatory requirements broadly govern all states, several sections of the Social Security Act authorize the Secretary of HHS to “waive” otherwise applicable federal Medicaid requirements, such as beneficiary freedom of choice to obtain care from any qualified provider. Several federal laws, collectively called “program authorities,” let states include HCBS within their Medicaid programs. These include Section 1115's very broad demonstration waiver authority, used to test innovative Medicaid policy, and HCBS authority under Section 1915(c).

The original HCBS waiver authority, under 1915(c), was created by Section 2176 of the Omnibus Budget Reconciliation Act of 1981. As an alternative to institutional care, this authority lets states provide a broad array of HCBS (excluding room and board) that may not otherwise be covered. Because this section allows considerable adjustment of policy to address state circumstances, Medicaid HCBS programs vary widely. The resulting need for state-specific analysis and decision-making can prevent the rapid, universal adoption of new HCBS opportunities offered under the Medicaid program.

Section 1915(c) HCBS waivers let states provide LTSS in home and community settings to individuals “at-risk of institutional care.” States can tailor waiver services to meet the needs of a particular target group. They may offer a combination of medical

and non-medical services. Standard services include case management, home health aide services, personal care, adult day health care, and habilitation.

Section 1915(c) requires waivers to be “cost-neutral,” which means that services provided under the waiver cost no more than the care beneficiaries would have received in institutional settings. With seniors, children, people with physical disabilities or ID/DD, Medicaid covers institutional care. This opens the door to 1915(c) waivers providing HCBS that prevent beneficiaries from needing Medicaid-funded institutional care. However, federal law bars Medicaid reimbursement of services for adults between 22 and 64 years of age who live in institutions for mental diseases (IMDs). As a result of this “IMD exclusion,” states are generally unable to meet the 1915(c) cost-neutrality requirement for non-elderly adults with SMI, since Medicaid will not pay for their institutional care in the absence of a waiver.

Of the \$41.4 billion expended nationally on 1915(c) waivers in 2013, only 0.4 percent represented waivers serving adults with SMI or children with serious emotional disturbance (SED). The majority of 1915(c) expenditures are for individuals with developmental disabilities, the elderly, and people with physical disabilities. Although comparatively small in absolute size, the SMI/SED waivers have seen significant year-over-year growth. The average compound rate of growth in expenditures (2005-2010) was 14.4 percent, which is greater than the growth reported for all 1915(c) waivers (11 percent).<sup>8</sup>

Because 1915(c) involves waivers, a state using this authority can avoid certain general requirements of the Medicaid statute. Most important, states need not serve all who qualify. Instead, the state can cap 1915(c) enrollment at a finite number. Once that cap is reached, new applicants can be placed on a waiting list and potentially enrolled later, only after a slot opens up when a previously served beneficiary stops receiving 1915(c) services. Along similar lines, states can be excused from standard Medicaid requirements to provide services on a statewide basis, with beneficiaries receiving “comparable” coverage. Instead, states can limit services to particular geographic areas and beneficiary groups.

### ***The Patient Protection and Affordable Care Act's Changes***

Outside of 1915(i), the ACA made important changes to Medicaid coverage of HCBS:

- A Balancing Incentive Program gave new financial incentives for states to increase the provision of HCBS as an alternative to institutional care.
- A new 1915(k) Community First Choice state plan option offered enhanced federal funding when states furnish certain HCBS to individuals who would otherwise require institutional care. Unlike 1915(c)'s authorization of waivers, 1915(k) is an optional Medicaid eligibility category. As a result, states implementing the 1915(k) option must serve all who qualify on a statewide basis.

- Funding continued and eligibility expanded for “Money Follows the Person” demonstration projects, which help beneficiaries move from institutional to home and community-based settings.
- States and CMS received increased authority to implement demonstration projects that integrate funding and care, including HCBS and other LTSS, for consumers who dually qualify for Medicaid and Medicare.

### **1915(i) State Plan Option**

Section 6086 of the Deficit Reduction Act of 2005 added Section 1915(i) to the Social Security Act, giving states the option to cover HCBs without obtaining a 1915(c) waiver. Unlike 1915(c), the new 1915(i) option let states serve beneficiaries who did not require an institutional level of care. 1915(i) also dispensed with 1915(c)’s cost-neutrality requirement, letting adults with M/SUDs qualify for HCBS, even though the IMD exclusion barred Medicaid from covering their institutional care.

The ACA made a number of important changes to 1915(i):

- Originally, 1915(i) was limited to individuals with incomes below 150 percent FPL. The ACA also allowed 1915(i) to serve consumers with incomes up to three times the eligibility level for the Supplemental Security Income (SSI) program, so long as such consumers qualified for an HCBS waiver.
- In its original form, 1915(i) did not cover all 1915(c) services. The ACA permitted 1915(i) services to include all 1915(c) benefits.
- For the first time, the ACA let states target 1915(i) to particular populations with specific needs or risk factors, varying covered benefits by population.
- Before the ACA, 1915(i) let states cap the number of enrollees. The ACA replaced this state authority with the ability to tighten clinical eligibility criteria if projected enrollment appeared likely to exceed state estimates. Such tightened criteria could apply only to new applicants for 1915(i) services, not beneficiaries who qualified for such services under previous criteria.
- In its original form, 1915(i) dispensed with the standard Medicaid requirement of statewideness. The ACA eliminated state flexibility to implement 1915(i) on less than a statewide basis.

Federal policymakers instituted these changes, in part, to make the 1915(i) option more attractive to states. Before the ACA, five states had implemented 1915(i). As of October 2015, 16 states and the District of Columbia had approved 1915(i) state plan amendments (SPAs) on file with CMS, as discussed later.

## Research Questions

Our research addressed how states have utilized the 1915(i) option, the major advantages and risks facing states that are considering 1915(i), and strategies to further accomplish the core goals of 1915(i). The main questions were as follows:

- How are states using 1915(i)?
- How are states using 1915(i) differently than they have used 1915(c)?
- What aspects of 1915(i) are attractive to states?
- What aspects of 1915(i) are problematic to states?
- What factors have enhanced or hampered states' ability to effectively implement 1915(i)?
- What are states doing to evaluate their progress as it relates to 1915(i)? Are formal or informal evaluations available? Are there other reports or descriptions of results? How is 1915(i) being used to support the development of comprehensive arrays of behavioral health care services?
- What do state officials engaged in 1915(i) implementation and other SMEs envision as the most promising potential uses of 1915(i), including those that have not yet been fully implemented? What do they see as factors facilitating or inhibiting such uses of this Medicaid option? What options do they envision for maximizing the effects of such facilitating factors and overcoming the inhibiting factors?
- How have federal policy developments galvanized state policy shifts?

## METHODOLOGY

The study included an environmental scan, a series of SME interviews, and an in-person meeting with state officials from across the country.

### Environmental Scan

We began our research with a literature review encompassing both published, peer-reviewed journals and “grey” literature sources. The latter included presentations, issue briefs, newsletters, reports by government agencies and non-governmental organizations, white papers by researchers and advocacy organizations, and other documents. Our compilation of peer-reviewed literature was based on systematic searches within PubMed and Google Scholar. We searched for literature focused on 1915(i), 1915(c), and the intersection of these Medicaid provisions. Additionally, we communicated with contacts at state agencies and organizations representing consumers and providers to identify unpublished materials that would not be located through a traditional literature review. We also examined state Medicaid websites.

We conducted a systematic review of 1915(i) SPAs for each state that had submitted one to CMS by the time of our study. We created an extraction form to enable a consistent identification of information across states. The extraction form included fields for the program name, operating agency, implementation status, effective date, target population, eligibility criteria, income and resource rules, assessment procedures, services offered, service delivery methods, and estimated, projected, or actual number of enrollees. For states that had submitted a 1915(i) SPA, we also analyzed all 1915(c) waivers for that state to identify any that served populations similar those targeted by the 1915(i) SPA. For waivers with eligibility standards that overlapped or resembled the population served by that state’s 1915(i) SPA, we completed a uniform extraction form similar to the form described above.

### Subject Matter Expert Interviews

In July and August 2015, a team comprised of researchers from the Urban Institute, Health Management Associates (HMA) and National Association of State Mental Health Program Directors Research Institute (NRI) conducted five semi-structured telephone interviews with SMEs. SMEs were selected in order to achieve diversity of expertise. We aimed to capture perspectives from former state officials, former CMS officials, providers, and advocacy organizations representing providers and/or consumers. SMEs were well-known experts in Medicaid policy and finance, publicly funded behavioral health systems, HCBS and/or LTSS. Each had unique and

extensive experience with the 1915(i) option. The research team proposed a list of ten SMEs to the project officer, who selected five to be interviewed.

Interviews were conducted over the phone, and each lasted approximately 60 minutes. One or two senior researchers led each interview. A note-taker was also present on each call. Each call was recorded, with permission from interviewees. Interviewees were informed that neither they nor their organization would be named in products that resulted from the interviews, to encourage candor.

Interviews followed semi-structured protocols that were tailored to each interviewee. Generally, these protocols included questions about:

- 1915(i) SPA application and approval process.
- Risks and benefits to the state, providers, and consumers of 1915(i) implementation.
- The relationship between 1915(i) and other Medicaid and non-Medicaid options/waivers/programs available to fund behavioral health services or HCBS.
- Facilitators and barriers to successful 1915(i) implementation.
- How states are using 1915(i) to cover services or populations not included in other programs/waivers.
- The effect of the ACA's changes to 1915(i).
- Promising potential uses of 1915(i), including those not yet fully realized.
- Impact of other federal and state initiatives (e.g., involving managed care regulations, certified community behavioral health clinics, or managed LTSS) on 1915(i).

After each interview, the note-taker created a detailed summary of the call and shared this document with the interviewers to confirm a shared understanding. The team contacted the interviewee for clarification in the few cases where a need for clarification arose after the interview.

## **State Officials Meeting**

On August 3 and 4, 2015, the research team hosted a meeting at the HHS headquarters building in Washington, DC. The meeting was attended by ten current or recent state officials--Medicaid Directors and directors of state Mental Health or Substance Abuse agencies--and representatives from national Medicaid/mental health organizations. As with the SMEs, we convened officials who were deeply

knowledgeable about 1915(i) and who offered a variety of experiences and expertise. We sought diversity in terms of geography, program type (Medicaid, Mental Health Agency, Substance Abuse Treatment Agency), state approach to 1915(i), whether 1915(i) had been implemented before or after the ACA, general state attitudes toward health reform (including both states that expanded and those that did not expand Medicaid, those with and without state-based marketplaces, etc.). Each attendee had comprehensive experience with finance and operational issues related to 1915(i). To achieve these aims, we proposed a list of 15 state officials to our program officer, who chose ten final candidates for the meeting.

Nine state officials joined the meeting in person and one joined by phone. The meeting featured guided, primarily participant-driven discussion sessions, each designed to encourage open discussion about state experiences with 1915(i). The meeting took place during the afternoon of one day and the morning of the next.

Although the meeting was not recorded, researchers from the Urban Institute, HMA and NRI took extensive notes. As with the SME interviews, state officials were informed that neither their name nor their state would be listed in any reports. We believe this encouraged candid discussion. Following the meeting, researchers drafted a five-page memorandum summarizing findings from the meeting. This memorandum was circulated among meeting attendees, who had an opportunity to review findings and propose changes.

## FINDINGS

The environmental scan, SME interviews and state officials meeting together yield a broad and largely consistent picture of current uses of 1915(i), from multiple stakeholder perspectives, and the advantages and challenges of 1915(i), from the perspective of state policymakers. In addition, the SMEs we interviewed and state officials who participated in our national meeting suggested a number of approaches through which federal policymakers could help state officials more effectively pursue the underlying objectives of 1915(i). Each of these topics is discussed in turn, below.

### Characteristics of 1915(i) Programs

Based primarily (though not entirely) on our environmental scan, we describe here the populations and services covered by 1915(i), as embodied in SPAs approved by CMS.

#### Target Populations

At the time of our environmental scan, a total of 23 approved 1915(i) SPAs, from 16 states and the District of Columbia, were available for review. Some SPAs were implemented and others were not. The 23 SPAs fell into four broad categories:

- Four SPAs focused on children with mental health disorders.
- Four SPAs served children with other conditions.
- Seven SPAs targeted adults with M/SUDs.
- Eight SPAs focused on adults with other conditions.

Within each of these categories, we analyzed the populations who were eligible for 1915(i) and the services offered. Nearly all 1915(i) programs cover individuals who are eligible for Medicaid under the existing State Plan and have household incomes at or below 150 percent of the FPL. Some states also offer 1915(i) services to individuals who have incomes up to 300 percent of the SSI benefit amount and who meet all requirements to qualify for HCBS through a waiver under Social Security Act 1915(c), (d) or (e) or through a Section 1115 waiver.

Within the category of states that offer 1915(i) programs for children with M/SUDs, some states target young people diagnosed with a SED, and others offer programs more broadly to those with a diagnosed mental illness. One of the states targeting mental illness more broadly has explicit diagnostic exclusions, and two states targeting

young people with M/SUDs also require a demonstration that the available resources in the community do not meet the treatment needs of the individual. State programs available to children without mental illness generally target two different populations: children with autism spectrum disorders (two states), and children with a broad range of disabilities, including developmental, intellectual, and physical disabilities (two states).

There is less variety among 1915(i) programs that serve adults with M/SUDs. In this category, all seven SPAs offer services to individuals who meet Medicaid’s eligibility requirements and have a primary diagnosis of mental illness. Two states further limit eligibility to individuals with a functional need for assistance, either with activities of daily living or community living skills that cannot be met by an outpatient clinic. Most programs that target adults with conditions other than M/SUDs fall into three categories of populations served: individuals with intellectual, functional or developmental disabilities; individuals with chronic or progressive conditions; and those with unmet needs for assistance with activities of daily living. Figure 1 below shows the four categories of SPAs we describe, as well as a list of commonly included services for each. These lists are not exhaustive; each SPA varied in the populations targeted and the services included, but this figure summarizes some of the more frequently covered services for each type of SPA.

<b>FIGURE 1. Approved 1915(i) SPAs by Main Target Group and Commonly Included Services</b>	
<b>Children with M/SUD (n=4)</b>	<b>Children with Other Conditions (n=4)</b>
<ul style="list-style-type: none"> <li>• Therapy for beneficiaries and family (e.g., redirection; crisis intervention)</li> <li>• Family support</li> </ul>	<ul style="list-style-type: none"> <li>• Personal care support</li> <li>• Habilitative services</li> <li>• Community support</li> </ul>
<b>Adults with M/SUD (n=7)</b>	<b>Adults with Other Conditions (n=8)</b>
<ul style="list-style-type: none"> <li>• Care coordination</li> <li>• Habilitative services</li> <li>• Adult day services</li> <li>• Psychosocial rehabilitation</li> <li>• Supported employment</li> </ul>	<ul style="list-style-type: none"> <li>• Habilitative services</li> <li>• Personal care services</li> <li>• Transportation</li> <li>• Case management</li> </ul>
<b>NOTE:</b> SPAs were approved as of May 2015.	

## Services

Common among all types of 1915(i) programs is the development of an individualized care plan. The type of professional responsible for creating these care plans, however, varied across SPAs. Typically, states with a heavier case management emphasis task care coordinators with this responsibility, while other states leave care-plan development to medical or counseling staff. Annual assessments are another common component of 1915(i) programs. These are generally conducted by a care coordinator or social services provider. The purpose of these assessments is to reevaluate the patient’s need for program services.

It is not surprising that these two policy components are present with all types of 1915(i) policies, since they are expressly required by statute. See Social Security Act

1915(i)(1)(E) - (G). The remainder of this section highlights the most common other services in each specific category of 1915(i) programs.

### ***Children with Mental Health or Substance Use Disorders***

1915(i) programs targeting children with M/SUDs include therapy for the participant as a central component, though the therapy categories vary. Common types of therapy include intensive in-home services (also offered to family members), redirection therapy, and crisis intervention; some states also cover group therapy. Crisis intervention and response services are typically available immediately on an on-call basis 24 hours per day, seven days per week. The latter interventions are designed to de-escalate crises and keep the child in his or her current living arrangements by preventing hospitalization and the need for movement to another home.

These programs also generally include some form of family support or education, including family redirection therapy. In addition to the standard individual therapy and family supports provided by all programs that target children with M/SUDs, some programs provide respite services and wraparound facilitation; the latter is an intensive, individualized care planning and management approach designed to support children in their families and communities.

### ***Children with Other Conditions***

As outlined in the “target populations” Section, 1915(i) programs targeting children with other conditions generally fall into two categories: those that focus primarily on children with autism spectrum disorders, and those that target a broader range of disabilities, including developmental, intellectual, and physical disabilities. The three SPAs that target a wider range of disabilities also offer a broader range of services, which are focused on building competence in activities of daily living and capacity for community integration. Specifically, a number of the latter programs offer personal care services, which include training and assistance with self-care activities such as feeding, bathing, dressing, and general mobility.

To promote community integration, programs that target children and youth with disabilities more broadly (i.e., not only those with an autism spectrum disorder) offer habilitative support to help participants expand skills related to activities of daily living, communication, and relationship building. These services are provided in home or community-based settings to reinforce skills taught in school, therapy, or elsewhere. Eligible young people qualify for community support services, which often include emotional support and adaptive skills training as well as transportation. Most of these programs also promote community integration through employment assistance or financial management training, although the intensity of these supports varies. Most states also offer services to help participants and their families track medical expenses as well as manage individual budgets.

In contrast to the programs designed to suit the needs of a broad range of special needs children, the two programs focusing specifically on children with autism spectrum disorders cover more targeted care. Both of the latter states offer Applied Behavioral Analysis (ABA) as the primary service. Like the community support services offered by programs targeting a broader range of disabilities, ABA is intended to reinforce skills taught in school, therapy, or other settings, but it is not intended as a replacement. ABA services are offered at two different levels of intensity: Early Intensive Behavioral Intervention (EIBI) and Applied Behavioral Intervention (ABI). EIBI is a comprehensive service package designed to address skill deficits, behavioral issues, and overall daily functioning. ABI is a less intense, more targeted version of EIBI that is not comprehensive and focuses on specific individual goals.

### ***Adults with Mental Health and Substance Use Disorders***

1915(i) programs that focus on adults with M/SUDs appear to have a stronger care coordination emphasis than most of the programs geared toward children. Many of the adult-centered programs provide care coordination services to help individuals manage the different services they receive, keep track of appointments, and generally navigate the health care system.

To address mental health challenges and improve independence and community integration, most of these programs also provide a broad range of support services, including counseling or therapy, psychosocial rehabilitation, peer and community supports, adult day services, and habilitation and employment assistance. Psychosocial rehabilitation services aim to restore the recipient to his or her highest level of functioning, while peer and community supports help improve and restore integration into the community. Similarly, adult day services and habilitation services help participants improve socialization skills and capacity to live within a community as independently as possible. These services include skills training as well as structured group activities. As is the case in other categories, some 1915(i) programs serving mentally ill adults have further expanded their community integration efforts by offering employment assistance. While some programs are limited to career counseling and skills training, others go further and furnish supported employment to select participants.

### ***Adults with Other Conditions***

Like 1915(i) programs targeting children with other conditions, programs for adults with conditions other than M/SUD cover a wide range of populations. However, these programs cover relatively similar services, offering assistance with and building beneficiaries' capacity for activities of daily living. Such services typically include habilitation, personal care and assisted living, and transportation. A number of programs also offer therapeutic day services, which aim to restore physical and mental function, while others provide case management.

## **Advantages of 1915(i)**

States identified a number of advantages of using 1915(i) to provide beneficiaries with HCBS.

### **Targeting Specific and Underserved Populations**

Under 1915(i), states are not bound by the standard Medicaid requirement for offering comparable services to all beneficiaries within a particular eligibility group. As a result, a state can use 1915(i) to provide different services tailored to meet the needs of different populations.

As explained earlier, the absence of a cost-neutrality requirement in 1915(i) means states can provide HCBS to adults with mental illness to help them avoid or transition out of IMDs. Also unlike 1915(c), 1915(i) does not require that program beneficiaries require an institutional level of care. Instead, it permits states to target beneficiaries based on age, condition, functionality, or other standards. Eligibility need not be defined by diagnosis, and can instead be defined by level of functioning. This flexibility presents an opportunity for states to create highly targeted programs that serve specific high-need or hard-to-serve populations, such as those with SMI. For example, a state can use 1915(i) to provide treatment for individuals with M/SUD who are in or leaving the criminal justice system. Some states have used 1915(i) to maintain coverage for high-need individuals who might otherwise lose Medicaid when the states cut back medically needy eligibility while moving disability-based coverage from Social Security Act Section 209(b) to Social Security Act 1634. Some state officials also characterized 1915(i) as letting states experiment with new services or populations, carefully limiting initial enrollment based on clinical severity.

Another use of 1915(i) involves states that participated in a CMS demonstration program. The Community Alternatives to Psychiatric Residential Treatment Facilities Demonstration Grant program provided \$218 million to nine states. These states worked with CMS to develop programs to provide wraparound HCBS to children as alternatives to facility-based care. As the grant period ended on September 30, 2012, those states that had been successful (Indiana, Michigan, Kansas, Georgia) in developing strong programs worked with CMS to develop either 1915(i) SPAs or 1915(c) waivers to continue and strengthen these initiatives.

### **Providing a Full Continuum of Care**

SAMHSA has described the components of a “Good and Modern Addiction and Mental Health System.” This framework is based on a public health model that emphasizes prevention, primary care, and high quality, evidence-based, patient-centered care. Furthermore, it encompasses non-medical components including housing and employment supports. Elements of the “Good and Modern” system fall into nine categories: health care home and physical health care; prevention and wellness; engagement services; outpatient and medication services; community and recovery

support (rehabilitative); other supports (habilitative); intensive support services; out-of-home residential services; and acute intensive services.

States can use 1915(i) to provide many of these components, filling previous gaps in Medicaid coverage. For example, 1915(i) can cover habilitation services and recovery supports not previously within the scope of many states' Medicaid-covered rehabilitation services. Because Medicaid programs vary greatly in their coverage of M/SUD services, the precise gap-filling role played by 1915(i) will also differ by state.

## Meeting *Olmstead* Requirements

In *Olmstead v. L.C.*, the U.S. Supreme Court ruled that states must provide integrated, community-based services to individuals with disabilities if the individual desires the services, such services are appropriate, and the services can be “reasonably accommodated,” given the state’s resources.<sup>9</sup> In other words, *Olmstead* requires states to offer people with disabilities treatment in the most integrated setting that is appropriate for their level of need.

Some states use 1915(i) to finance and support the array of HCBS that must be offered under *Olmstead*. 1915(i) services can help people with disabilities remain integrated in community settings and prevent unnecessary institutionalization. While 1915(c) waivers can also help meet *Olmstead* requirements, these waiver programs tend to be smaller-scale. Moreover, 1915(c) programs have enrollment caps, as noted earlier. 1915(i), by contrast, can fund *Olmstead* services without limitation to a specific number of covered beneficiaries.

## Unrealized Opportunities

State officials and SMEs outlined several opportunities for using 1915(i) that have yet to be fully realized. Some involve eligibility. States have not yet used 1915(i) to target certain populations:

- **Justice-involved populations.** States can use 1915(i) to cover intensive M/SUD services for individuals who are involved with the criminal justice system or reentering the community from that system.
- **People transitioning out of homelessness** can qualify for help under 1915(i).
- **People with first-episode psychosis** can receive 1915(i) services to prevent longer-term illness.
- **Patients receiving mandatory services outside the hospital.** When people experiencing acute episodes of M/SUD pose a danger to themselves or others, courts may approve involuntary treatment. 1915(i) offers the opportunity to furnish these services outside the hospital, with potential cost savings to the state and reduced intrusion on consumers.

SMEs and state officials noted several promising uses of 1915(i) to expand covered services that have not been widely used:

- **Beneficiary self-direction** was flagged as offering unrealized promise with 1915(i).
- **Housing supports**, covered through 1915(i), could combine with subsidized housing programs to help vulnerable populations move home or remain living at home. Examples of relevant housing subsidies include the Housing Choice Voucher program and project-based rental assistance.
- **Tightening criteria for institutionalization without reducing coverage of HCBS.** Under 1915(c), people cannot qualify for HCBS unless they require an institutional level of care. If a state tightens its criteria for institutionalization, such a step, by definition, takes away 1915(c) HCBS from those who meet the old but not the new test for institutionalization. By contrast, 1915(i) is not limited to those with a need for institutional care. A state that limits criteria for institutionalization can continue covering 1915(i) HCBS, without any limitation to reflect the state's new institutionalization standards.

## Challenges of 1915(i)

Despite the opportunities presented by 1915(i), states also identified a number of challenges. In some cases, challenges described below were significant enough that a state decide to stop developing a 1915(i) proposal, to withdraw a SPA application, or to abandon 1915(i) after SPA approval or initial implementation.

### Cost Exposure

As articulated by many state officials, one of the primary challenges presented by 1915(i) is states' cost exposure. Because of the inability to cap enrollment, many officials worry that enrollment could exceed projections, placing an unsustainable financial burden on the state. To limit costs, as noted earlier, states have an alternative to an enrollment cap. If enrollment is projected to exceed state expectations, the state can modify the criteria for eligibility, effectively preventing or slowing future growth. However, this can only occur after a 60-day notice period (which complicates monitoring and administration), and the change cannot affect beneficiaries who enrolled under the prior criteria. Many state officials believe that making a policy change to tighten eligibility criteria could generate more opposition (including potential litigation) than would be present with a pre-defined and unchanging numerical enrollment cap.

While some states identified cost exposure as their biggest concern related to 1915(i), others suggested it was manageable. This was partially because of the mitigation option described above, and partially because of natural limitations on

caseload; one such constraint results from limited provider participation. Similarly, programs that provide housing supports to beneficiaries who receive housing subsidies are limited by the availability of such subsidies.

As a related challenge, many state officials believed that the ACA's statewideness requirement for 1915(i) prevents states from phasing in the program geographically. Phase-ins let a state identify and solve problems before a full statewide rollout, potentially saving time and money. A phase-in can also build constituency over time and win support from policymakers for smaller-scale changes that can later be scaled up to the statewide level, according to officials.

Moreover, states that rely on county or other local governments to help pay the required state Medicaid match indicated that the statewideness requirement prevented them from offering counties the *option* to provide 1915(i) services. In those states, some but not all counties were willing to fund the state share of implementing 1915(i), and officials did not plan to go forward on a statewide basis.

### **Independent Review and Conflict-Free Case Management**

According to state officials, 1915(i) has independent review and conflict-free case management requirements that can be burdensome or duplicative in some settings. Some state officials found that, in a fee-for-service or "sole-source provider" environment, such requirements helped detect and prevent over-service and cost-shifting. However, in competitive, managed care environments, such requirements cause extra work for plans, providers, and states, imposing burdens that many state officials found inconsistent with the basic structure of risk-bearing, capitated plans that are responsible for managing care.

In addition, SMEs reported that CMS's interpretation of "conflict-free case management" has barred beneficiaries from receiving case management services and advice from providers with whom beneficiaries have longstanding relationships.

Moreover, the requirements for independent review and conflict-free case management mean that limited provider resources must be used for these non-clinical purposes, potentially undermining access to care. This was described as especially problematic in rural areas, where qualified providers are in short supply. Provider shortages and long wait times are exacerbated by these non-clinical demands.

Finally, officials reported that the conflict-free case management and independent review requirements associated with 1915(i) can differ from other HCBS programs that exist within a given state. The required 1915(i) procedures can thus be seen as redundant by providers, health plans, and state staff.

## Quality Measurement

Quality measurement requirements associated with 1915(i) can be burdensome for providers, health plans, and state staff, according to officials. Different programs (e.g., other Medicaid HCBS programs, SAMHSA grants) often have quality measurement and reporting requirements that differ from those under 1915(i). States that already have HCBS programs in place may elect not to pursue 1915(i) if its quality measurement and reporting requirements vary significantly from what the state is already doing for existing programs. In some cases, states must establish a completely different system to address 1915(i) quality measurement requirements, with extra burdens on plans and providers that can discourage program participation.

## Income Restrictions

Although the ACA expanded financial eligibility for 1915(i), individuals who do not require an institutional level of care cannot qualify for 1915(i) if their incomes exceed 150 percent of FPL. This presents potential problems for children eligible for Medicaid or the Children's Health Insurance Program (CHIP) whose family incomes exceed 150 percent of FPL.

Additionally, adults who initially have incomes under 150 percent of FPL may lose 1915(i) coverage when they leave an institutional setting and start a job. Officials noted that job placement assistance provided through 1915(i) may disqualify the recipients of those services from further coverage. More broadly, this income limitation can interfere with beneficiaries' efforts to become self-supporting, which can be an important part of the recovery process for many of 1915(i)'s core target populations.

## Development and Review Process for State Plan Amendments

A number of states reported that, when rapid action was needed to prevent consumers from losing coverage or to help states comply with *Olmstead* requirements, CMS acted quickly to work intensively with states and expeditiously approve SPAs. However, in other cases, a number of states described the SPA development, application, review, and approval process as time-consuming and difficult. Several states have experienced confusion and uncertainty about 1915(i)'s requirements and options. Materials provide extensive technical guidance for 1915(c) waivers, but not 1915(i) SPAs.

Some state officials also pointed to structural challenges. A 1915(i) SPA targeting adults with M/SUDs can entail a level of issue overlap between Medicaid and adult behavioral health care that has rarely been required for past Medicaid initiatives. The necessary cross-cutting expertise is in short supply, at both the state and federal levels. Past experience with 1915(c) waivers, often involving the ID/DD populations, does not always translate effectively to the adult M/SUD context, according to state officials.

As described below, some states are using 1915(i) as part of a suite of HCBS programs that may also include 1915(b), (c), (k), and 1115 waivers. These multi-vehicle initiatives can trigger involvement of federal experts in each affected program area. While that expertise is important and can improve the resulting policy, state officials observed that such multi-faceted engagement can slow the review process.

## **Interagency Coordination**

In addition to Medicaid funding and SAMHSA grants, additional public dollars support behavioral health and social support services. These resources, which sometimes flow through state agencies outside mental health authorities and Medicaid, are important for states to consider in developing M/SUD programs under 1915(i).

SMEs and state officials report that effective interagency coordination and financing of comprehensive services and supports for behavioral health consumers has sometimes been difficult to establish and maintain. State agencies that are usually successful at interagency coordination may experience barriers within a state's finance and budget system, which may include multiple streams of federal, state, and local dollars, each with accompanying requirements and options. Even the highly technical terminology used in different programs can pose a barrier to clear communication and effective joint action.

However, recent years' budget crises in many states as well as new opportunities under the ACA have spurred some officials to minimize duplication of services, as well as to address other inefficiencies in purchasing necessary services. Many state policymakers are now taking a system-wide approach to developing state mental health policy, with strong encouragement from federal agencies. State officials suggest that 1915(i), combined with other payment streams and Medicaid options, can help states develop comprehensive and modernized arrays of sustainably funded services while moving towards coordinated, integrated, patient-directed systems of behavioral and physical health care.

## **Alternative Vehicles for States to Achieve 1915(i) Goals**

To sidestep the above-described challenges while still attaining the objectives of 1915(i), states are increasingly using other vehicles to provide services that are potentially coverable under 1915(i).

This first alternative approach uses waivers under Section 1115 to cover populations and services that might otherwise require a 1915(i) SPA. Managed care organizations (MCOs) operating under such waivers can provide otherwise uncovered services "in lieu of" other services. As CMS explained in its proposed regulations for Medicaid managed care:

*"[W]e propose to clarify that managed care plans have had flexibility under risk contracts to provide alternative services or services in alternative settings in lieu of covered services or settings if cost-effective, on an optional basis, and to the*

*extent the managed care plan and the enrollee agree that such setting or service would provide medically appropriate care.”<sup>10</sup>*

Combining an 1115 waiver with MCO provision of otherwise uncovered HCBS “in lieu of” more traditional Medicaid benefits lets a state achieve many of 1915(i)’s goals. State officials indicated that this alternative offers important advantages over a 1915(i) SPA:

- A state can limit costs by capping its caseload.
- A state can use a geographic phase-in to bring new populations and services on line.
- Eligibility can extend above 150 percent FPL.
- Requirements for independent review, conflict-free case management, and quality reporting can be aligned across coverage vehicles and structured to fit competitive, managed care settings.

On the other hand, the “in lieu” approach does not provide certainty that 1915(i)-covered services will be furnished. Under current policy, such coverage depends on choices made by the MCO and beneficiary. Moreover, CMS’s current policy is part of a proposed rule that has not yet been finalized. Risks of policy change are greater than with the 1915(i) statute, which continues in effect, barring new legislation.

A second alternative focuses on beneficiaries less than 21 years of age, all of whom qualify for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). EPSDT covers any service potentially reimbursable under federal law when that service is needed by a particular child or young person. It thus furnishes a vehicle for providing 1915(i)-coverable services from birth through age 20.

Finally, many states see 1915(i) coverage as part of an integrated, multi-vehicle approach to covering HCBS and/or treatment of M/SUDs. Other components of such a coordinated approach might include 1915(b), (c) and (k) as well as 1115 waivers. When deployed within a broad suite of HCBS coverage vehicles, 1915(i) is likely to perform a much narrower gap-filling role than if it is a leading source of HCBS coverage.

## **Options for Further Accomplishing the Goals of 1915(i)**

CMS and states have already made significant progress achieving the objectives underlying 1915(i), both through 1915(i) SPAs and alternative approaches. To build on that progress, SMEs and state officials have suggested federal policy approaches that do not require legislation. Some of these approaches are specific to 1915(i), but others sweep more broadly.

## **Options Specific to 1915(i)**

Experts and state officials noted several steps that federal policymakers could take to overcome the above-described challenges to 1915(i) SPAs.

### ***Statewideness***

State officials discussed several possible approaches to this issue. First, waivers under 1115 could let states implement 1915(i) without the statewideness requirements. Waivers of statewideness have been a common feature of 1115 waivers for decades.

Second, CMS could provide more information about the option, in 1915(i)(7)(B)(ii), to phase-in 1915(i) coverage. State 1915(i) policies are approved for five-year periods, and a phase-in can last throughout the initial five-year approval period. See 42 CFR 441.677(a)(2)(ii). CMS could consider clarifying that such phase-ins can allow a new policy approach to be tested in one geographic area, after which the state can: (1) assess the policy's effects (including an analysis of infrastructure adequacy); and (2) potentially modify the policy before implementing it statewide.<sup>11</sup> However, even if this clarification were made, states would still need to assume the administrative burden of preparing a phase-in plan and gaining federal approval; and mid-course adjustments that narrow eligibility criteria could not apply retroactively to beneficiaries who enrolled during the first part of the phase-in.

### ***Income Limits***

A longstanding principle of Medicaid eligibility determination could potentially be used to address the limitation of 1915(i) eligibility to people with incomes at or below 150 percent of FPL, when such people do not require institutional-level care. This authority was long used to cover children and pregnant women with nominal income levels above the FPL percentages specified in the Medicaid statute. Using "less restrictive methodologies" for determining income than are applied by cash assistance programs, states applied income disregards that reduced gross incomes to FPL described in the Medicaid statute. Similar disregards of assets are sometimes used to extend eligibility for Medicare Savings Programs.

In this case, states might be authorized to determine a beneficiary's eligibility for 1915(i) services by using a less restrictive methodology than that used for cash assistance programs. For example, if a state wanted to cover certain individuals with gross incomes up to 200 percent FPL, such a methodology could apply an income disregard equal to 50 percent FPL; that disregard would reduce gross incomes at or below 200 percent FPL to a final, net amount at or below 150 percent FPL.

In its original form, 1915(i) specifically authorized states to use different income methodologies for 1915(i) purposes than with standard Medicaid eligibility.<sup>12</sup> The ACA preserved this language. More broadly, however, the ACA limited states' previous methodological flexibility, generally forbidding income disregards under Social Security

Act 1902(e)(14)(A) - (C), added by ACA 2002. However, this prohibition does not apply to long-term care, according to 1902(e)(14)(D)(iv):

*“Subparagraphs (A), (B), and (C) shall not apply to any determinations of eligibility of individuals for purposes of medical assistance for nursing facility services, a level of care in any institution equivalent to that of nursing facility services, home or community-based services furnished under a waiver or State plan amendment under Section 1915 or a waiver under Section 1115, and services described in Section 1917(c)(1)(C)(ii).”*

The Medicaid statute may thus permit income disregards as a less restrictive methodology that determines eligibility for “home and community-based services ... under Section 1915”--including 1915(i).

### ***Conflict-Free Case Management***

Experts and officials noted that the requirement of conflict-free case management is imposed administratively, not required by statute. CMS thus may have flexibility to reinterpret the requirement.

Our informants explained that any such reinterpretations would need to retain safeguards against undue influence exerted by those who have financial interests at stake. At the same time, a revised approach to conflict-free case management could let beneficiaries obtain advice from providers with whom they have longstanding relationships of trust. State officials suggested the example of limiting conflicts when a provider furnishes advice by determining case management reimbursement without regard to volume of services provided. Advice could also be required to include full disclosure, in plain language, of the provider’s financial interests. As a final example, when a state administers 1915(i) together with other coverage vehicles for HCBS, states might be allowed to use common conflict avoidance rules for all vehicles.

### ***Independent Review***

Unlike conflict-free case management, independent review is explicitly required by the 1915(i) statute. While the statute specifies the duties to be performed by the independent reviewer, it does not define independence. SMEs and state officials have suggested that, in the context of competitive, risk-bearing MCOs, independence could be assured within an MCO. For example, internal firewalls could be required to separate an MCO’s independent reviewer from MCO staff with fiscal duties or utilization review responsibilities. To meet independence requirements, payments to the reviewer would need to be unaffected by the results of the review. Medicaid external quality review organizations could also be tasked with auditing the performance of MCO independent reviewers. These are just a few suggestions from state officials of how federal policymakers might ensure that, when 1915(i) is implemented in a competitive MCO environment, independent review requirements are adjusted to fit that environment.

## Broader Options

State officials suggested several broader administrative actions that would improve their ability to achieve 1915(i)'s underlying goals:

- **Permit a common approach to key administrative functions** when states propose integrated systems that use multiple vehicles for covering HCBS or M/SUD services. States could be empowered to propose and use a single approach to quality measures, reporting requirements, independent review, and conflict-free case management. When SAMHSA funding supports part of such an integrated system, states could be authorized to use such common approaches with both Medicaid and SAMHSA programs. Using one approach to achieving these shared administrative goals could reduce burdens on states, plans, and providers. Among other gains, fewer burdens could improve provider participation.
- **Encourage collaboration at HHS regional offices** between Medicaid specialists and experts in behavioral health. It could lay the groundwork for more efficient and better informed regional office review of state proposals that involve Medicaid coverage of M/SUDs, including through 1915(i).
- **Create materials to help states achieve the goals of 1915(i)**. Such materials could take many different forms:
  - A summary document could provide examples of state policies that have been approved, along with an explanation of the key features of the state proposal and the policy context that facilitated approval.
  - Guidance could provide examples of permitted state policies, using both Medicaid and SAMHSA funding, to provide Medicaid beneficiaries with each element of a “good and modern” behavioral health system, as itemized by SAMHSA.
  - Guidance could provide examples of how states can integrate multiple HCBS coverage vehicles, including 1915(b), (c), (i), and (k) as well as 1115 waivers.
  - A frequently asked questions document could provide examples of how states can move forward with 1915(i)-covered services and populations using either 1915(i) SPAs or other approaches.

## CONCLUSION

1915(i) gives states new opportunities to furnish HCBS to Medicaid beneficiaries, including non-elderly adults with behavioral health needs. The number of states proposing 1915(i) SPAs grew following the amendments made by the ACA, but the number of implementing states remains modest, as does the scope of most states' 1915(i) coverage. State officials report that 1915(i) offers significant advantages, compared to other vehicles for covering HCBS, but also challenges. To achieve those advantages while avoiding the challenges, a number of states are using alternative policies for providing services that otherwise might be covered through 1915(i). State officials have identified several policy options that federal agencies could consider to help states more effectively achieve the goals of 1915(i), which include helping vulnerable populations access the full range of services needed to treat M/SUDs.

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8. Steve Eiken, Brian Burwell, Lisa Gold, Kate Sredl, and Paul Saucier. "Medicaid Expenditures for Section 1915(c) Waiver Programs in FY 2013". Truven Health Analytics. <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/downloads/1915-expenditures-2013.pdf>.
9. *Olmstead v. L.C.*, 527 U.S. 581. 1998.

10. Centers for Medicare & Medicaid Services. “Medicaid and Children’s Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability.” June 1, 2015. 80 Fed. Reg. 31098 (to be codified at 42 C.F.R. pts. 431, 433, 438, 440, 457, & 495).
11. In promulgating the final regulation, CMS explained: “A state may choose to phase-in the benefit or the provision of specific services based on the assessed needs of individuals, the availability of infrastructure to provide services, or both. Infrastructure is defined as the availability of qualified providers or of physical structures and information technology necessary to provide any service or set of services.” Centers for Medicare & Medicaid Services. “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.” January 16, 2014. 79 Fed. Reg. 2948, 2998. <https://www.gpo.gov/fdsys/pkg/FR-2014-01-16/pdf/2014-00487.pdf>. A geographic phase-in would let a state establish and test infrastructure in one part of the state. After that test, the state could analyze infrastructure and other issues and make necessary mid-course adjustments before the 1915(i) policy is taken statewide.
12. Section 1915(i)(3) specifically authorizes state 1915(i) programs “to not comply with the requirements of ... 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” a 1915(i) SPA.

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