Instructions, Technical Guide and Review Criteria

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Purpose

These instructions provide information to assist states in completing the Version 3.7 Application for a section1915(c) Home and Community-Based Services (HCBS) Waiver, released January 2024.

The instructions include ***technical guidance*** to aid states in designing an HCBS waiver. This guidance is intended to improve understanding of applicable federal policies and their implications for the design and operation of an HCBS waiver. Finally, the instructions incorporate the ***review criteria*** that the Centers for Medicare & Medicaid Services (CMS) uses in order to determine whether a waiver meets applicable statutory, regulatory and other requirements. Publishing these criteria is intended to assist states in clearly understanding CMS expectations concerning the content of HCBS waiver applications.

It is not the purpose of the instructions to prescribe how a state should design its waiver. Instead, the instructions are solely intended to provide information to assist states in the design of waivers and completing the waiver application.

Overview of the Section 1915(c) HCBS Waiver Authority

Operating a program of services under the authority of section 1915(c) of the Social Security Act permits a state to waive certain Medicaid requirements in order to furnish an array of home and community-based services that promote community living for Medicaid beneficiaries and, thereby, avoid institutionalization. Waiver services complement and/or supplement the services that are available through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide to individuals.

States have flexibility in designing waivers, including the latitude to:

- Determine the target group(s) of Medicaid beneficiaries who are served through the waiver;
- Specify the services that are furnished to support waiver participants in the community;
- Incorporate opportunities for participants to direct and manage their waiver services;
- Determine the qualifications of waiver providers;
- Design strategies to assure the health and welfare of waiver participants;
- Manage a waiver to promote the cost-effective delivery of home and community-based services;

- Link the delivery of waiver services to other state and local programs and their associated service delivery systems; and
- Develop and implement a quality improvement strategy to ensure that the waiver meets essential federal statutory assurances and to continuously improve the effectiveness of the waiver in meeting participant needs.

The next section provides a more complete description of the HCBS waiver authority and its principal features.

CMS recognizes that the design and operational features of an HCBS waiver will vary depending on the specific needs of the target population, the resources available to a state, service delivery system structure, state goals and objectives, and other factors.

Version 3.7 HCBS Waiver Application

The Version 3.7 HCBS Waiver Application is available for state use upon release. The revised application reflects current federal policy regarding the operation of HCBS waivers and is designed to ensure that the application includes the full range of information that CMS requires in order to review and take action on a state's request to operate an HCBS waiver. See ***Version 3.7 HCBS Waiver Application Organization*** for additional information concerning the revised application.

Waiver Application Format:

Since November 2006, CMS has offered a web-based version of the application, currently at https://wms-mmdl.cms.gov/WMS/faces/portal.jsp. The web-based application has streamlined the preparation of waiver applications and amendments as well as improved the exchange of information between states and CMS concerning waiver requests.

CMS requires states to employ the web-based application to submit new waivers, waiver renewals, and amendments. The web-based application format contains separate technical directions for its use. In addition, the web-based application is linked to pertinent elements of these instructions. Please see ***Waiver Application Submission Requirements, Process and Procedures*** for more information about the web-based application.

Instructions – Overview

The instructions contain the following major sections:

- ***Description of the Section 1915(c) HCBS Waiver Authority*** provides an overview of the HCBS waiver program, including its statutory basis and principal features and information about where to locate resources that may assist states in designing and operating an HCBS waiver;
- ***Waiver Application Submission Requirements, Processes, and Procedures*** furnishes information and technical guidance concerning the submission of waiver applications and amendments to approved waivers, including use of the web-based format. This section also includes the timelines that CMS must meet in taking action on state waiver submissions, and directions;
- ***Post Approval Activities*** summarizes federal and state activities and processes that are undertaken during the period that a waiver is in effect, including state submission of annual waiver reports and CMS waiver review procedures;

- ***Detailed Instructions for Completing the Version 3.7 Section 1915(c) Waiver Application*** includes detailed item-by-item instructions for completing the application along with technical guidance to assist states in designing and operating a waiver and the criteria that CMS applies when reviewing each element of a waiver application;
- ***Glossary of Terms and Abbreviations*** provides definitions of the key terms and frequently used abbreviations that appear in the application and the instructions; and
- ***Index to Application and Instructions*** cross-references topics between the application and the instructions.

In addition, the following ***Resource Attachments*** accompany the instructions.

- ***Attachment A: Section 1915(c) of the Social Security Act*** contains the full text of the federal law that authorizes the HCBS waiver program;
- ***Attachment B: Federal Regulations Related to the Operation of HCBS Waivers*** compiles selected federal Medicaid regulations that pertain to the operation of HCBS waivers;
- ***Attachment C: Selected State Medicaid Director Letters Concerning HCBS Waivers and Other Materials*** compiles letters issued to State Medicaid Directors by the Center for Medicaid and CHIP Services (CMCS) regarding topics that pertain to the HCBS waiver program. The attachment also includes additional CMS and other reference materials that may prove useful in designing a waiver or completing the waiver application; and
- ***Attachment D: Sampling Guide***

Description of the Section 1915(c) HCBS Waiver Authority

Overview

This section provides a summary description of the HCBS waiver program, including its statutory basis and principal features. It also identifies the CMS organizations and units that are responsible for the administration of the waiver program and web-accessible resources that may assist states in designing and operating HCBS waivers.

Statutory Basis and Legislative History of the HCBS Waiver Authority

Section1915(c) of the Social Security Act ("the Act") authorizes the Secretary of Health and Human Services (HHS) to waive certain specific Medicaid statutory requirements so that a state may offer home and community-based services to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid State plan. This provision was added to the Act by section 2176 of P.L. 97-35 (Omnibus Budget Reconciliation Act (OBRA) of 1981) and subsequently has been amended by P.L. 99-272, (Consolidated Omnibus Reconciliation Act (COBRA) of 1985), P.L. 99-509 (OBRA 1986), P.L. 100-203 (OBRA 1987), P.L. 100-360 (Medicare Catastrophic Coverage Act of 1988), P.L. 100-647 (Technical and Miscellaneous Revenue Act), P.L. 101-508 (OBRA 1990), and section 4743 of P.L. 105-33 (Balanced Budget Act of 1997 – BBA-97). Attachment B to these instructions contains the full text of section 1915(c) of the Act, as amended.

Prior to the enactment of section1915(c) of the Act, the Medicaid program provided for little in the way of coverage for long term services and supports in non-institutional settings but offered full or partial coverage of institutional care. Section 1915(c) was enacted to enable states to

address the needs of individuals who would otherwise receive costly institutional care by furnishing cost-effective services to assist them to remain in their homes and communities.

Section 6086 of the Deficit Reduction Act of 2005 (P.L. 109-171) added §1915(i) to Act. Effective January 1, 2007, states have the option to cover, under the Medicaid State plan, any or all of the home and community-based services that are specifically listed in section 1915(c)(4)(B), not including "other services", to Medicaid eligible individuals who meet certain requirements. This option does not entail applying for a waiver (but it does require submitting a state plan amendment) and it does not include the requirement that beneficiaries require an institutional level of care in order to receive home and community-based services. The section 1915(i) authority provides an additional avenue for states to support individuals in the community. A state may employ both the sections 1915(c) and 1915(i) authorities to fashion a comprehensive approach to the delivery of home and community-based services. The enactment of the section 1915(i) authority did not alter the 1915(c)waiver authority. Further guidance regarding the 1915(i) state plan HCBS authority is available at https://www.medicaid.gov/medicaid/home-community-based-services/home-community-based-services-authorities/home-community-based-services-1915i/index.html.

Principal Features of the HCBS Waiver Authority

Basic Framework

The HCBS waiver authority permits a state to offer home and community-based services to individuals who: (a) are found to require a level of institutional care (hospital, nursing facility, or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)) under the State plan; (b) are members of a target group that is included in the waiver; (c) meet applicable Medicaid financial eligibility criteria; (d) require one or more waiver services in order to function in the community; and, (e) exercise freedom of choice by choosing to enter the waiver in lieu of receiving institutional care. It is entirely a state option to offer waiver services through its Medicaid program.

Waiver Application Process

In order to launch an HCBS waiver, a state must submit an initial waiver application to CMS, pursuant to 42 CFR § 441.301. The application describes the proposed waiver's design and must include sufficient information to permit CMS (acting on behalf of the Secretary of Health and Human Services) to determine that the waiver meets applicable statutory and regulatory requirements, especially the assurances specified in 42 CFR § 441.302. Continuation of a waiver beyond its initial three-year approval period requires that the state submit a five-year waiver renewal application and a determination by CMS that, while the waiver has been in effect, the state has satisfactorily met the waiver assurances and other federal requirements, including the submission of mandatory annual waiver reports (the CMS-372(S) report). Each subsequent renewal of the waiver also requires the submission of a renewal application and a CMS determination that the state has continued to meet federal requirements.

The approved waiver application specifies the operational features of the waiver. A state must implement the waiver as specified in the approved application. If the state wants to change the waiver while it is in effect, it must submit an amendment to CMS for its review and approval. All requests for new waivers, waiver renewals and amendments must be submitted by the state Medicaid agency. There is no limit on the number of HCBS waivers that a state may operate.

Waivers Granted

Section 1915(c) of the Act permits the Secretary of Health and Human Services to grant waivers of three provisions of the Act so that a state may operate an HCBS waiver:

Section 1902(a)(10)(B) (Comparability). Waiver of this provision of the Act permits a state to limit the provision of HCBS waiver services to Medicaid beneficiaries who require the level of care in an institutional setting and are in the target group(s) specified in the waiver, as well as offer services to waiver participants that are not provided to other Medicaid beneficiaries. All HCBS waivers operate under a waiver of this statutory provision;

Section 1902(a)(1) (Statewideness). The Secretary may grant a waiver of this provision of the Act in order to permit a state to limit the operation of a waiver to specified geographic areas of the state; and

Section 1902(a)(10)(C)(i)(III) (Income and Resources for the Medically Needy). A State may request a waiver of this provision in order to apply institutional income and resource "eligibility" rules for medically needy in the community who otherwise qualify for waiver services.

Section 1915(c) does not give the Secretary the authority to waive any other provisions of the Act. Therefore, all other pertinent Medicaid statutory requirements apply to the operation of a waiver. By proposing to operate an HCBS waiver concurrently with another authority such as a section 1915(b) waiver, a state may obtain waivers of certain additional provisions of the Act.

Individuals Served by a Waiver

In its application, a state must specify the group or groups of Medicaid beneficiaries who are served through the HCBS waiver, pursuant to 42 CFR § 441.301. This specification has three dimensions. First, a state must specify the level or levels of institutional care that individuals must need in order to be considered for entrance into the waiver. For example, a waiver may target persons who require the nursing facility level of care. Second, a state must select the specific target group (e.g., the "aged") that the waiver will serve from among the three basic groups that are specified in the waiver regulations. A state may further specify the waiver target group by age, condition and/or other factors. Lastly, a state must identify the Medicaid eligibility groups (e.g., Supplemental Security Income (SSI) recipients) to which waiver services are furnished. These groups may include some or all of the eligibility groups that are included in the Medicaid State plan. Also, a state may elect to apply more generous "institutional eligibility" rules to certain persons in the community to secure Medicaid eligibility on the same footing as persons who elect to receive institutional services.

Waivers target many types of Medicaid beneficiaries, including older persons, individuals who have experienced a brain injury, children with mental illness, children and adults with developmental disabilities, persons with physical and other disabilities, persons living with AIDS, and others.

Services Offered Under a Waiver

A state must specify the services that are furnished through the waiver, pursuant to 42 CFR § 441.301(b)(4). The state may include the services that are specifically enumerated in section 1915(c) of the Act and/or propose to offer other services that assist individuals to remain in the community and avoid institutionalization. Waiver services complement the services that a state offers under its state plan. Waiver participants must have full access to State plan services, including Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services when

children participate in a waiver. Through a waiver, a state may also furnish "extended state plan services" that exceed the limits that apply under the state plan. There is no limit on the number of services that a state may offer in a waiver nor are states required to include specific services in the waiver.
In its application, a state must specify the scope and nature of each waiver service and any limits on amount, frequency and duration that the state elects to apply to a service. Also, the state must specify the qualifications of the individuals or agencies that furnish each waiver service.

Exclusion of Room and Board

Except in limited circumstances, a state may not claim federal financial participation (FFP) for the costs of the room and board expenses of waiver participants. Room and board expenses must be met from participant resources or through other sources.

Number of Waiver Participants

In its application, a state must specify the unduplicated number of individuals that the state intends to serve each year the waiver is in effect, pursuant to 42 CFR § 441.303(f)(6). It is up to the state to determine this number, based on the resources that the state has available to underwrite the costs of waiver services. As state resources permit, this number may be modified by amendment while the waiver is in effect.

Service Plan

The waiver services that an individual will receive must be incorporated into a written person-centered service plan (all references throughout this document to "plan of care" or "service plan" refer to the person-centered service plan described under 42 CFR § 441.301(c)(2)). A state may claim FFP only for the waiver services that have been authorized in the participant's service plan. The service plan must also include the non-waiver services and supports that are used to meet the needs of the participant in the community. In its application, the state must specify how the service plan is developed, including how the plan addresses potential risks to the individual. Effective service plan development processes are essential in order to ensure that waiver participants will receive the services and supports that they need in order to function successfully in the community and to assure their health and welfare. Monitoring the implementation of the service plan is also a critical waiver operational activity.

Participant Direction of Waiver Services

A state may provide that the waiver participant (or the participant's representative) may direct and manage some or all of their waiver services. Participant direction may take a variety of forms, including the participant's employing and directly supervising community support workers and exercising decision-making authority over an amount of waiver funds (the participant-directed budget). When a waiver provides for participant direction, the state is expected to make supports available to the participant as necessary to facilitate participant direction.

Assuring Participant Health and Welfare

A waiver's design must provide for continuously and effectively assuring the health and welfare of waiver participants, pursuant to 42 CFR § 441.302(a). Processes that are important for assuring participant health and welfare include (but are not necessarily limited to):

Specifying the qualifications of waiver providers and verifying that providers continuously meet these qualifications;

Periodically monitoring the implementation of the service plan and participant health and welfare;

Identifying and responding to alleged instances of abuse, neglect and exploitation that involve waiver participants; and

Instituting appropriate safeguards concerning practices that may cause harm to the participant or restrict participant rights.

The renewal of a waiver is contingent on CMS determining that the state has effectively assured the health and welfare of waiver participants during the period that the waiver has been in effect. In its application, the state must specify how it monitors performance in assuring health and welfare and the other waiver assurances by preparing and submitting a quality improvement strategy, discussed in more detail below.

Waiver Administration and Operation

A waiver may be operated directly by the Medicaid agency or by another state agency (termed the "operating agency') under a written agreement with the Medicaid agency, so long as the Medicaid agency retains ultimate authority and responsibility for the waiver in accordance with State Medicaid Agency administrative authority at 42 CFR § 431.10(b)(1). In addition, a state may provide that local or regional non-state organizations (e.g., county human services agencies) or contracted entities perform some waiver administrative and operational tasks, so long as the authority of the Medicaid agency over the waiver is maintained, and any delegation of function performance or authority is expressly identified in writing.

Participant Rights

Pursuant to 42 CFR § 431.220, a state must provide that individuals have the opportunity to request a Medicaid Fair Hearing when they are not given the choice to receive waiver services, are denied the waiver services or providers of their choice, or their waiver services are denied, suspended, reduced or terminated-

Cost Neutrality

In its application and each year during the period that the waiver is in operation, the state must demonstrate that the waiver is cost neutral, pursuant to 42 CFR § 441.303(f). In particular, the average per participant expenditures for the waiver and non-waiver Medicaid services must be no more costly than the average per person costs of furnishing institutional (and other Medicaid state plan) services to persons who require the same level of care.

Quality Improvement Strategy: Overview

For the purpose of the application, the state is expected to have, at the minimum, systems in place to measure and improve its performance in meeting the waiver assurances that are set forth in 42 CFR §§ 441.301 and § 441.302. These assurances address important dimensions of waiver quality, including assuring that service plans are designed to meet the needs of waiver participants and that there are effective systems in place to monitor participant health and welfare. CMS recognizes that the design of the QIS will vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs.

While the QIS must address the waiver assurances as a prerequisite, it can extend to aspects of waiver operations the state deems critical in achieving the waiver's purpose and meeting the expectations of waiver participants and stakeholders. For example, the QIS might include identifying and tracking performance in achieving critical participant outcomes, assessing how effectively the waiver supports participants to direct their services, or improving the capabilities of waiver providers to effectively support participants. In other words, while the QIS as a prerequisite must address compliance with the essential waiver assurances, the state need not limit the scope.

Finally, CMS recognizes that quality improvement is dynamic, and the QIS may change over time. CMS expects that states will have all essential quality improvement components in place at the time the waiver application is submitted.

In March 2014, CMS issued guidance that clarifies sub assurances for each waiver assurance, describes how states may combine quality systems across multiple waivers and discusses some modifications in the IPG process. CMS also issued guidance in July 2022, announcing a standard HCBS measure set that may be used to satisfy some of the assurances outlined in the 2014 guidance (available in Attachment D).

Waiver Assurances and Other Federal Requirements

The waiver assurances (and their component elements)must be included in the QIS pursuant to 42 CFR § 441.302. Also included in parentheses are references to the specific parts of the application that pertain to the respective assurance.

- **Administrative Authority** (*Quality Improvement: Appendix A)*

  Assurance: The Medicaid agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

- **Level of Care (LOC)** *(Quality Improvement: Appendix B)*

  Assurance: The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/re-evaluating and applicant's/waiver participant's level of care consistent with care provided in a hospital, NF, or ICF/IID.

  An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.

  The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.

  The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant LOC.

- **Qualified Providers** (Quality Improvement: *Appendix C)*

  Assurance: The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

  The state verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.

The state monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

The state implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.

- **Service Plan** (*Quality Improvement: Appendix D)*

Assurance: The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for the waiver participants.

Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by waiver services or through other means.

Service plans are updated/revised at least annually, when the individual's circumstances or needs change significantly, or at the request of the individual.

Services are delivered in accordance with the service plan, including the type, scope, amount, duration, and frequency specified in the service plan.

Participants are afforded choice between/among waiver services and providers.

The state monitors service plan development in accordance with its policies and procedures.

- **Health and Welfare** *(Quality Improvement: Appendix G)*

Assurance: The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.

The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.

The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.

State policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.

The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.

- **Financial Accountability** *(Quality Improvement: Appendix I)*

Assurance: The state must demonstrate that it has designed and implemented an adequate system for insuring financial accountability of the waiver program.

The state provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.

The state provides evidence that rates remain consistent with the approved rate methodology throughout the five-year waiver cycle.

Continuous Quality Improvement

CMS expects states to follow a continuous quality improvement (CQI) process in the operation of each waiver program. The process involves a continuous monitoring of the implementation of

each waiver sub-assurance, methods for remediation or addressing identified individual problems and areas of noncompliance, and processes for a) aggregating collected information on discovery and remediation activities, and b) prioritizing and addressing needed systems changes on a regular basis.

Discovery

Discovery consists of monitoring and data collection activities that identify whether and to what extent the State addresses compliance with the assurances. Relevant discovery sources may include record/chart reviews, financial reviews, interviews with participants and providers, observation of program operations; compilation of operations data such as incidents and complaints, claims data, fair hearings and appeals data or the results of licensure/certifications reviews. Discovery activities also might include conducting a structured review targeted to a geographic area or type of service, special studies, or securing the services of an outside entity to perform an oversight/evaluation function.

Discovery activities intended to evaluate how well the state has performed relative to a sub-assurance must be expressed as a performance measure (i.e., a measurable statement reflecting all aspects of the sub-assurance, consisting of a specifically stated numerator and denominator). The numerator must represent the number of items determined to be compliant with the performance measure. The denominator must represent the number of items reviewed, which will usually be the same as the sample size for the performance measure. The state's numerator and denominator must be consistent with the state's sampling methodology. Sampling of less than 100 percent of the universe must be statistically valid. CMS strongly suggests a confidence interval with at least a 95 percent confidence level and +/- 5 percent margin of error. Lower sampling standards will require an explanation by the state. Such an approach provides a clear and concise evidence-based representation of a state's compliance with an assurance. As such, a state is expected to provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and recommendations are formulated.

By way of illustration, the "qualified providers" assurance requires the state to verify on a periodic basis that providers meet approved licensure and/or certification standards and/or adhere to other state standards. In Appendix C-1/C-3, states are expected to include information about each waiver service's provider qualifications, the entity (or entities) responsible for verifying provider qualifications, and how frequently the verification of provider qualifications is performed. One of the state's monitoring activities should describe the source of collected information (for example, record reviews of all waiver program providers or a statistically significant representative sample) and the performance measurement of providers meeting the required qualifications, (that is, from a statistically significant sample, the number meeting approved qualifications (numerator) over the total number reviewed (denominator).

Remediation

It is important to keep in mind that, in each instance, the QIS should specify a similar numerical approach for identified problems or areas of noncompliance, and corrective or remedial actions taken when problems are discovered. The approach is critical in that states must show compliance with the CMS statutory assurances. Therefore, while monitoring data/indicators reveal a level of system performance for discovery activities, when the system performance is less than 100%, a remediation plan is necessary to correct identified areas of noncompliance.

Those individually identified areas require correction in order to support compliance with the assurance, and quality improvement. Specific activities include:

- The remedial action to be taken;
- The timeline for when remediation is effectuated;
- Those responsible for addressing remedial activities; and,
- The frequency with which performance/compliance is measured.

While it is up to the state to identify the types of information used to measure performance related to the assurances, it should be sufficient to conclude compliance with the assurance has been met. Often more than one data source can be tapped to evaluate performance, particularly related to the health and welfare assurance.

Measuring performance against the assurances may occur at different intervals, at different frequency rates, and with varying intensity. The state, however, should be able to verify to its stakeholders and CMS that it has measured its performance against the assurances no less than annually. The approach or frequency of measurement may vary from year to year, particularly when the state finds that it routinely meets the requirements and assurances.

Sampling Approach

The CMS quality requirements are founded on an evidence-based approach. CMS requests from the state evidence that it meets the assurances, and that it applies a continuous quality improvement approach to the assurances. CMS therefore relies on the evidence or data produced by the State to substantiate compliance. For that reason, it is critical that states can assert with a degree of confidence that evidence produced is valid and reliable. Without such certainty, it is difficult at best for the federal government, waiver recipients, or stakeholder groups to have confidence in the state's reported performance. CMS strongly urges state to have a solid sampling approach to the evidence it collects. A reference guide on sampling is available in Attachment D of the waiver application resource manual.

Roles and Responsibilities

States are expected to describe the roles and responsibilities of the parties involved in the quality improvement strategy as they relate to discovery, remediation, and improvement activities. The description should include the roles and responsibilities of the Medicaid agency, operating agency and non-state entities (as applicable), other state agencies, participants, families and advocates, providers, and other contractors (if appropriate) in operationalizing the processes in the quality improvement strategy such as collecting and analyzing individual and system-level information, determining whether the waiver requirements and assurances are met, implementing remediation, and planning system improvement activities.

The focus of this QIS element is on identifying who is involved in appraising performance in meeting the waiver assurances based on the results of discovery processes. The parties involved in performance appraisal may vary by assurance, depending on the nature of the assurance. The state may organize the involvement of individuals and entities in any number of ways including, but not limited to, establishing a quality improvement unit, forming quality improvement councils, and establishing standing committees. It is not necessary that the Medicaid agency directly conduct every aspect of the quality improvement strategy. However, since the QIS focuses on meeting the waiver assurances, it is necessary that the Medicaid agency be the source

of the delegation of activities in the QIS, and the recipient of the monitoring, remediation and system improvement reports that pertain to meeting the assurances. The Medicaid agency must also perform its own monitoring of all delegated activities in accordance with Medicaid administrative authority at 42 CFR § 431.10(b)(1).

CMS urges states to widen the circle of parties involved in waiver performance appraisal to include waiver participants, families (when appropriate), providers and other parties who are directly affected by waiver operations.

Example: Assuring health and welfare requires multiple discovery strategies that generate information about abuse, neglect, exploitation, accidents and injuries, hospitalizations, medication errors, the use of restraints, and self-reports about safety. The QIS might designate one entity or groups of individuals (participants, providers, advocates) to evaluate the utilization of restraints, determine whether improvement strategies are necessary and develop those strategies and specify another entity or groups of individuals to evaluate hospitalizations, accidents and injuries to determine whether there are areas, providers or participants who may warrant special attention.

Example: Monitoring participant service planning and service delivery generates information about implementation of the service plan that might be used by the operating agency alone to evaluate performance, or the operating agency might engage case managers to evaluate information from discovery and to develop improvement strategies. The Medicaid agency may use the same information reports to determine whether the operating agency's oversight system is effective.

The state may create regional or statewide quality councils made up of participants, advocates, providers, clinicians, quality improvement specialists, and government managers to receive recommendations from various committees and determine what strategies should be adopted. However, the creation of quality councils is not required. It is one mechanism that a state may use to appraise performance and secure input regarding quality improvement strategies.

Comprehensive Quality Improvement Strategy –Displaying and Printing in the Web-Based Application

While states are expected to describe components of the quality improvement strategy for the waiver in multiple appendices of the application, there is capability within the web-based application to display and print the quality improvement strategy in its entirety. From the Print Options Menu in the web-based application, simply click on the button entitled "Print/Display Quality Improvement Strategy." This function will extract the information from all relevant areas in the application to assemble the comprehensive quality improvement strategy for the waiver in one consolidated document that can be either saved or printed.

Federal Administration of the HCBS Waiver Authority

The HCBS waiver authority is administered by the Center for Medicaid and CHIP Services (CMCS) at the Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services (HHS). Within CMCS, the Medicaid Benefits and Health Programs Group (MBHPG) Division of Long-Term Services and Supports (DLTSS) has lead responsibility for developing policies concerning the HCBS waiver authority and technical assistance to states in the design and operation of waivers.

The Medicaid and CHIP Operations Group (MCOG) Division of HCBS Operations and Oversight (DHCBSO) is the first point-of-contact for the states concerning the HCBS waiver program. DHCBSO is also tasked with oversight of the waivers and engaging in ongoing dialogue with the state concerning waiver operations and performance. DLTSS and DHCBSO share responsibilities for reviewing waiver applications and requests for amendments and providing technical assistance to states concerning the design and operation of waivers.

HCBS Waiver Services, the ADA and Olmstead

CMS recognizes the important role that Medicaid plays in states' efforts to ensure compliance with the ADA and Olmstead. In the early 2000s, CMS (then the Health Care Financing Administration) issued a series of letters to State Medicaid Directors to identify policies, tools, and expectations for home and community-based services (HCBS) and their role in Olmstead compliance. These letters, collectively known as "the Olmstead letters," identified services that help transition individuals from institutional to community settings and maintain their community living status. The letters also described the obligations of states under federal Medicaid rules to provide services necessary to assure the health and welfare of individuals served under Medicaid section 1915(c) waiver programs. Although this guidance is intended with respect to the Medicaid program, we note that states have obligations pursuant to the Americans with Disabilities Act, section 504 of the Rehabilitation Act, and the Supreme Court's Olmstead decision. Approval of any Medicaid waiver action does not address the state's independent obligations under the Americans with Disabilities Act or the Supreme Court's Olmstead decision.

HCBS Waiver Resources on the Web

In addition to the web-based application for section1915(c) waivers located at https://wms-mmdl.cms.gov/WMS/faces/portal.jsp, CMS makes available assorted information and resources via its website (www.medicaid.gov). General information about the HCBS waiver program along with links to other pertinent information is located at https://www.medicaid.gov/medicaid/hcbs/guidance/index.html.

Version 3.7 HCBS Waiver Application Organization

The Version 3.7 HCBS Waiver Application consists of an application "module" and ten appendices, each of which addresses specific dimensions of waiver operations.

- **Application (Module1)**. The initial section of the application contains the formal state request to operate a section 1915(c) HCBS waiver, including the request for waiver(s) of specific sections of the Act. This module also includes a brief description of the waiver's goals, objectives, organization, and service delivery methods. It also contains the fundamental assurances and additional federal requirements that apply to the operation of a waiver.
- **Appendix A: Waiver Administration and Operations**. This Appendix identifies the state agency that is responsible for the day-to-day operation of the waiver along with other entities that are involved in its operation, including as applicable contracted entities and local/regional non-state entities. The distribution of certain waiver operational responsibilities among these entities also is specified. This Appendix addresses the question: *"What entities are involved in the operation of the waiver?"*

- **Appendix B: Participant Access and Eligibility.** This Appendix is designed to answer the question: *"Who receives waiver services?"* In this Appendix, a state specifies: (a) the waiver's target group(s); (b) the individual cost limit (if any) that applies to individuals entering the waiver; (c) the number of individuals who will be served in the waiver and how this number will be managed during the period that the waiver is in effect; (d) the Medicaid eligibility groups served in the waiver; (e) applicable post-eligibility treatment of income policies; (f) procedures for the evaluation of level of care of prospective entrants to the waiver and the periodic re-evaluation of the level of care of waiver participants; (g) how individuals are afforded freedom of choice in selecting between institutional and home and community-based services; and, (h) how the state provides for meaningful access to the waiver by individuals with Limited English Proficiency (LEP).
- **Appendix C: Participant Services**. This Appendix is designed to answer the question: *"What services does the waiver offer?"* In this Appendix, the state establishes the specifications for each waiver service and any limitations that apply to a service or the overall amount of waiver services. A service specification template (Appendix C-3) consolidates information about each waiver service (including its scope, provider qualifications, and whether the service may be participant-directed).

  Pre-specified service definitions are not embedded in the Version 3.7 waiver application. [N.B., "Core service definitions" that a state may adapt are included as an attachment to the Appendix C instructions.] This Appendix also captures information about state policies concerning criminal history/background and abuse registry checks, payments to legally responsible individuals for the provision of personal care and to relatives/legal guardians for the provision of services, and the 1915(c) home and community-based setting requirements.
- **Appendix D: Participant-Centered Planning and Service Delivery**. In this Appendix, the State describes how the person-centered service plan (plan of care) is developed along with how the state monitors (a) the implementation of the service plan and (b) participant health and welfare. This Appendix is designed to answer two questions: *"How are participant needs identified and addressed during the person-centered service plan development process?"* and *"How does the state monitor the delivery of waiver services?"*
- **Appendix E: Participant Direction of Services**. This Appendix is designed to answer the questions: *"What authority do participants have to direct some or all of their waiver services?"* and *"How are participants supported in directing their services?"* This Appendix permits a state to specify the opportunities afforded to waiver participants to direct and manage their waiver services. This Appendix is completed only when the waiver offers one or both of the participant direction opportunities contained in the Appendix. The new application enables a state to offer participant direction in a waiver in which other service delivery methods also are used or, alternatively, provide that participant direction is the principal service delivery method that is used in the waiver.
- **Appendix F: Participant Rights**. In this Appendix, a state describes how it affords waiver participants the opportunity to request a Fair Hearing as well as any alternate processes that are available to resolve disputes or address participant complaints/ grievances. This Appendix addresses the question: *"How are participant rights protected?"*

- **Appendix G: Participant Safeguards**. This Appendix addresses the question: *"What safeguards has the state established to protect participants from harm?"* In this Appendix, a state describes how it provides for specific safeguards related to assuring participant health and welfare (e.g., response to critical incidents).
- **Appendix H: Systems Improvement.** Here, a state describes the mechanisms it will use to engage in systems improvement activities based upon the information it gathers from the discovery and remediation strategies described throughout the application.
- **Appendix I: Financial Accountability**. In this Appendix, a state specifies how it makes payments for waiver services, ensures the integrity of these payments and complies with applicable requirements concerning payments and federal financial participation. The Appendix is designed to answer the question: *"How does the state maintain financial accountability in the waiver?"*
- **Appendix J: Cost Neutrality Demonstration**. In this Appendix, the State furnishes necessary information to demonstrate the cost neutrality of the waiver. This Appendix is designed to answer the question: *"Does the waiver meet statutory cost-neutrality requirements?"*
- **Appendix K (*not in the waiver management system*): Emergency Preparedness and Response.** Separate from the waiver management system (WMS), states can request to add an Appendix K to an approved 1915(c) HCBS waiver application for temporary use by the state during emergency situations. It includes flexibilities that states can request via a temporary waiver amendment in order to respond to an emergency. CMS created this appendix to reduce the administrative burden during times of emergencies. *The state may only make changes that are permitted under 1915(c) authority.* The state may not make changes that are not allowed under statute, such as the inclusion of room and board costs. Changes that a state may want to make that necessitate authority outside the scope of the 1915(c) authority may be possible with the use of other Medicaid authorities such as section 1115 demonstration waivers or the section 1135 waiver. The state may request a retroactive effective date for an Appendix K amendment. States are not required to apply the 1915(c) public input requirements in an Appendix K amendment; however, the Medicaid Tribal Notice/Consultation requirements do apply. The Appendix K amendment template and technical guidance can be found at: https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/home-community-based-services-public-health-emergencies/emergency-preparedness-and-response-for-home-and-community-based-hcbs-1915c-waivers/index.html

Ongoing CMS Waiver Application Activities

CMS is engaged in several ongoing activities related to the waiver application/review processes and continuing improvement of federal oversight and monitoring of HCBS waivers.

Implementation of the Web-Based Application

With the Version 3.4 application, CMS implemented a web based HCBS waiver application format. Ongoing improvements to the web-based format have further streamlined the application process by eliminating paper copies, enabling states to enter, save, and submit the HCBS waiver application via the Internet, and supports internal CMS processing and review of applications, renewal requests and amendments. The web-based tool stores all waivers and

amendments chronologically so that CMS and the state may at any time view the currently approved waiver, or previously approved versions.

Additional Activities

CMS undertakes the following additional activities:

- **Ongoing Dialogue with State Associations.** CMS is continuing its dialogue with the state associations concerning the HCBS waiver program. This dialogue has proven to be invaluable in continually improving the operation of the program.
- **Continuous Solicitation of State User Feedback**. CMS continuously invites feedback from states that employ the Version 3.7 HCBS Waiver Application about ease of use and the need for additional clarification.
- **Periodic Revisions to the Application and Instructions**. Periodically, CMS will revise and update both the waiver application and these instructions. These revisions will incorporate interim technical clarifications that are issued between revisions. Revisions also may be necessary to reflect new policy developments.

Waiver Application Submission Requirements, Processes and Procedures

Overview

This section addresses the following topics:

- Use of the Version 3.7 HCBS Waiver Application;
- Policies concerning the submission of new and renewal waiver applications;
- Policies concerning the submission and CMS review of waiver amendments; and,
- Related topics

Submission of Applications

A state must submit a new or renewal waiver application using the Version 3.7 application by employing the web-based application.

Making a Submission Using the Web-Based Application

There are several benefits in employing the web-based application to prepare and submit new and renewal applications. These benefits include:

- The web-based application automatically links interrelated parts of the application. Where appropriate, information that is entered in one part of the application is automatically entered in other parts of the application that use the same information. For example, the information about waiver services that is entered in Appendix C is used to populate the Factor D tables in Appendix J. This feature ensures internal consistency within the application. In addition, the web-based application turns off parts of the application that do not apply to a request.
- The web-based application employs validation checks to ensure that selections made in one part of the application are consistent with selections made in other parts. For example, the selection of Medicaid eligibility groups in Appendix B-4 is tightly linked to the selections concerning post-eligibility treatment of income in Appendix B-5. These validation checks ensure that the application has been completed appropriately and

expedite CMS review. In addition, the web-based application prevents the submission of incomplete applications.

- The web-based application also supports internal CMS processing of applications. CMS is notified electronically when an application is submitted and there is tracking of where the application stands in the review/approval process.
- Once an application that has been submitted via the web is approved, states can submit amendments by making changes to the application on the web. Both CMS and states have continuous access to the most up-to-date version of the approved waiver.

Use of the web-based application facilitates both state preparation and CMS review of applications. Separate technical instructions have been issued for using the web-based application.

A new waiver, renewal or amendment is considered submitted when the State Medicaid Director (or designee) submits the application using the submission feature, which is reserved for use only by the Medicaid Director. Submission of the application by the State Medicaid Director is equivalent to signature of the application by the State Medicaid Director. When the application is submitted via the web, the date on which the State Medicaid Director submits the application is considered to be the official submission date for the purpose of starting the 90-day "clock" for CMS review and disposition of the request (see below for further discussion of the 90-day clock). The application is not submitted separately in printed hard copy form when the web-based application is used.

Making Changes to a Submitted Application

Once a waiver application or amendment has been submitted, it may be necessary to make changes. For example, CMS review of a waiver application or amendment may result in CMS suggesting that the state modify the application or amendment. If the state concurs, the state needs to make the change to the application or amendment and resubmit the affected portions of the application to CMS. ***Under no circumstances can CMS personnel modify a waiver application or amendment request.***

Once an application is submitted via the web, the application is "locked" and cannot be modified unless unlocked by CMS. Locking the application preserves the integrity of the original submission. If it is necessary to modify the application, CMS will unlock the application so that the state may make changes. Once the state has made the changes and resubmitted the application to CMS, the application will be locked again.

CMS Waiver Review Process

In general, waiver applications, renewals, and specific amendments are reviewed jointly by CMCS/MBHPG/DLTSS and CMCS/MCOG/DHCBSO . CMS strives to ensure that relevant federal policies are applied consistently across all types of waiver requests. CMS also seeks to work collaboratively with states to resolve issues. In addition, CMS developed the *"Instrument for Reviewing State 1915 (c) HCBS Waiver Applications"* to assist CMS waiver analysts in their review of waiver applications and to build consistency into the application review process.

Requesting Division Review

From time to time, issues may arise where the state believes that the resolution of an issue proposed by the CMCS review team is problematic. When this situation arises, the state may

request that the issue be referred to the DLTSS Director at CMCS/MBHPG for further review. The state should delineate why it regards the proposed resolution to be problematic and the state's preferred resolution of the issue. The DLTSS Director will examine the issue and, as necessary, consult with the state and the CMCS review team to resolve the issue. The Director will transmit the proposed disposition of the issue to the state and the CMCS review team.

Policies Concerning New and Renewal Waiver Applications

This section provides information about the policies that apply to the submission of and CMS action on new and renewal waiver applications.

90-Day Clock

In accordance with 42 CFR § 430.25(f)(3), CMS has no more than 90 calendar days within which to approve or deny an initial waiver application, a waiver renewal or an amendment request or alternatively issue a written request for additional information (RAI). The 90-day period within which CMS must act on a waiver request is known as the "90-day clock." The 90-day clock starts on the day that CMS receives the request. It is extremely important to keep the 90-day clock in mind when preparing new or renewal waiver applications or amendment requests. In particular:

- **In the case of an initial or new waiver application, CMS recommends that the application be submitted at least 90 calendar days in advance of the proposed waiver effective date**. If a request to launch a new waiver is received fewer than 90-days in advance of the proposed effective date, CMS may not be able to complete its review in time to permit the waiver to be implemented when desired by the state. States should consider submitting new waiver applications six-months in advance of the proposed effective date. Submitting a new application well in advance of the proposed effective date increases the likelihood that the waiver can be approved on or before the desired effective date and takes into account the possibility of an RAI. It is important to keep in mind that a new waiver may only be approved with a prospective effective date, in accordance with 42 CFR § 441.304(a). New waivers may not take effect retroactively.
- **In the case of a waiver renewal application, in accordance with 42 CFR § 430.25(h)(3), the application also must be submitted at least 90 calendar days in advance of the approved waiver's expiration date**. If a waiver renewal request is received fewer than 90-days in advance of the expiration date, CMS may not be able to complete its review by the waiver's expiration date. As with new waiver requests, the state should consider submitting a renewal application six months in advance of the waiver's expiration date so that there is time to resolve any questions that might arise during the CMS review of the renewal request.

As a general matter, CMS attempts to resolve problems with a waiver application through informal dialogue with the state. Informal requests for additional information (which might be made by telephone or e-mail) do not stop the 90-day clock. CMS attempts to identify any serious problems in an application within 45-days of its receipt.

If significant problems are identified in the waiver application, the state may take the application "off-the-clock" by notifying CMS that its submission is incomplete. Once the state has addressed the problems, it may resubmit the application, whereupon a new 90-day clock will start. The state also has the option to formally withdraw a request. This option should be

considered when the state determines that it is no longer interested in pursuing the request as submitted.

In the case of either a new waiver application or a renewal request, CMS may issue a formal, written "RAI in the event that CMS identifies issues or problems in the application that are sufficiently serious that CMS may have to disapprove the application unless the problems are resolved satisfactorily.

Only a single RAI will be issued during the waiver review period. When a RAI is issued, the 90-day clock is stopped. The clock remains stopped until the state submits its response to the RAI. Once the response is received, a new 90-day clock starts. In the case of a new waiver application, the issuance of a RAI may make it difficult to complete the review of the application by the state's desired effective date, depending on how far in advance of the proposed effective date the application was submitted and how quickly and satisfactorily the state responds to the RAI. In the case of a renewal application, the issuance of a RAI may pose significant difficulties for completing the review of the renewal application in advance of the expiration date, especially if the application was submitted only 90-days in advance of the expiration date.

The state may wish to stop the clock by notifying CMS that its submission is incomplete if CMS determines that the state's response to a RAI does not satisfactorily resolve the problems in the application. Stopping the clock on an application avoids CMS having to disapprove the application. CMS does not have the authority to suspend its consideration of a waiver request absent a state request to stop the clock.

CMS makes every effort to complete its review of a waiver application on a timely basis and avoid stopping the clock so that new waivers can be implemented when planned by the state and renewals are approved in advance of the waiver's expiration date. Meeting this objective is aided when the state responds promptly to CMS requests to clarify the application. When CMS approves a new waiver, waiver renewal or amendment, it will formally notify the state in writing.

New Waiver Applications

When a state wants to launch a new waiver, it submits an initial waiver application. Under the Act, CMS may approve a new waiver program for a period of three-years or, if the waiver serves individuals who are dually eligible for Medicare and Medicaid, five years at the state's option. The new waiver year period starts on the effective date of the waiver. A new waiver may not go into effect until the effective date proposed by the state or the date that CMS approves the waiver, ***whichever is later***. Again, the state must propose a prospective effective date. A new waiver is never approved retroactively. To account for both the 90 day review period specified in 42 CFR § 430.25(f)(3) and the requirement that new waivers must be prospective in accordance with 42 CFR § 441.304(a), an application for a new waiver must provide for an effective date at least 90-days after the date of submission. If CMS does not approve the waiver request until after the effective date proposed by the state, CMS will ask the state whether it wishes the effective date to be the date that CMS approved the waiver or another date (e.g., the first of the following month to facilitate waiver reporting).

When a new waiver is approved but the state experiences a delay in implementing the waiver on the approved effective date, the state may submit an amendment to move forward the initial effective date (as long as no waiver services have been provided or claimed), in order to start the three or five-year waiver period on the date that the state actually implements the waiver.

Special Considerations: Section 1915(c) Waivers that Operate with Concurrent Managed Care

A state may apply for a section 1915(c) waiver to operate with a concurrent Medicaid managed care authority. Concurrent waivers can be used by a state to combine the delivery of HCBS waiver services with the provision of other state plan services through a managed-care service delivery system. The managed care authority permits a state to waive provisions of the Act beyond the waivers that may be requested under the section 1915(c) waiver authority. For example, a state may request a waiver of section 1902(a)(23) of the Act, the free choice of providers requirement, under authority of section 1915(b)(4) in order to selectively contract with entities that furnish waiver and specified state plan services through a managed care arrangement.

In order to operate managed care/section 1915(c) concurrent waivers, a state must complete and submit separate managed care and section1915(c) waiver applications (or amendments). Each application has different requirements because each waiver authority is governed by distinct provisions of the Act and is subject to different federal regulations. Where appropriate, the Version 3.7 HCBS Waiver Application takes into account the limited number of areas where requirements and features of Medicaid managed care authorities and section 1915(c) waivers intersect.

When a state applies to operate managed care/section1915(c) concurrent waivers, CMS reviews each application or amendment to ensure that it meets the relevant statutory and regulatory requirements that attach to the waiver authority under which they will operate. Both applications are subject to a 90-day clock. CMS internally coordinates the review of both applications.

Since the approval of managed care/section1915(c) concurrent waivers hinge on the approval of both applications, CMS may not approve the section1915(c) application until the managed care authority has been determined to be approvable and/or vice versa. Because significant problems might surface in the review of either application, it is recommended that a state submit a request to operate managed care/section1915(c) concurrent waivers at least six months in advance of the proposed waiver effective date. The two applications may need to be submitted simultaneously so that they can move forward under the same 90-day clock and be effective on the same date.

Special Considerations: Section 1915(a) Authority Concurrently with a 1915(c) Waiver

A state may operate a section1915(c) waiver in conjunction with section1915(a) authority, which permits a state to waive statewideness, comparability, or free choice of provider under certain circumstances. Typically, states have used section1915(a) authority to provide for voluntary managed care for all or some HCBS waiver participants. As the effect on an HCBS waiver varies with the authority sought under section1915(a), and since combination section1915(a)/(c) waivers are not common, these instructions do not discuss options available under section1915(a) throughout. See the Appendix I instructions for a discussion of the section1915(a) authority regarding managed care contracts. Contact CMS to discuss an HCBS application that will include section1915(a) authority.

New Waiver to Replace an Approved Waiver

There are circumstances when a new waiver application is submitted to replace an approved waiver:

- **State Election.** A state may decide to submit a new waiver rather than renew an approved waiver because the state wants to redesign the waiver. The submission of a replacement waiver may be advantageous when the revisions that the state wants to make are substantial and affect many elements of the waiver. When a state decides to replace an existing waiver, the proposed effective date of the new waiver must coincide with the expiration or termination date of the approved waiver (e.g., if the approved waiver expires on June 30, the new waiver should be made effective on July 1 to ensure continuity of participant services). The submission of a new application to replace an existing waiver does not affect the expiration date of the approved waiver. Also, in this circumstance, a state is expected to include in the waiver a transition plan to describe how the transition between the existing and the new waiver will be accomplished (see the detailed instructions for the Application (Module 1) for a discussion of what to include in the transition plan).
- **CMS Directs the Submission of a New Application**. When CMS determines that there are serious problems in the operation of an approved waiver, CMS may direct the state to replace the approved waiver with a new waiver. This circumstance may arise when the CMS review of waiver operations reveals substantial problems in assuring waiver participant health and welfare or when other serious operational deficiencies are identified. In the application for the replacement waiver, the state is expected to propose a waiver redesign that effectively addresses the shortcomings that CMS has identified. In addition, the state may be expected to periodically report its progress in implementing corrective actions to correct waiver operational deficiencies.

Except in the foregoing circumstances, CMS will not generally require that a state submit a new waiver to replace an approved waiver even when significant changes are proposed to the approved waiver either via waiver amendment or in a renewal application. However, if major changes are proposed that might adversely affect current participants (e.g., by altering a waiver's target population or eliminating services that are provided in the approved waiver), CMS may request the state to provide additional justification and/or submit a transition plan that describes the steps that the state will take to address the impact of the changes on current waiver participants. Again, see the instructions for the Application (Module 1) for a more detailed discussion of transition plans.

Renewal Applications

Waivers that have not been formally renewed by the end of the waiver period automatically expire. Section 1915(c) of the Act does not provide for the automatic extension of an approved waiver. In order to ensure the continuous operation of a waiver, a waiver renewal application should be submitted to CMS at least 90 but preferably 180 calendar days prior to the end of the waiver period.

There are two conditions that must be met in order for CMS to consider a waiver renewal application, in accordance with 42 CFR § 441.304(a). These are:

- The state has submitted, and CMS has accepted the required HCBS annual waiver financial and statistical reports (the CMS-372(S) through the end of the next-to-last waiver year. The annual waiver report(s) demonstrates that the waiver has been cost-neutral and also provides information on the quality of services. Cost neutrality and assuring health and welfare are fundamental statutory and regulatory requirements.

Failure to prepare and submit acceptable and timely annual waiver reports can jeopardize continuation of the waiver and/or delay the renewal of the waiver.

- CMS must determine that the waiver has been operated in accordance with the approved waiver, all applicable federal requirements, and the waiver assurances. About one year prior to the waiver expiration date, CMS will issue a report to the state summarizing its findings and conclusions concerning the operation of the waiver. The report may include recommendations concerning the operation of the waiver. If CMS identifies serious problems in the operation of the approved waiver, the state needs to propose remedial steps that are satisfactory to CMS to correct the problems. CMS must be confident that the measures that the state has undertaken or plans to implement will effectively address the problems before CMS can approve the waiver renewal request. It is important to note that CMS is revamping its waiver oversight methods to provide for annual reporting by states concerning performance in meeting the waiver assurances and expects that there will be increased dialogue between the state and CMS throughout the waiver period about performance. The CMS report on state waiver operations in advance of renewal will rely principally on evidence submitted by the state, the annual waiver report that the state submits each year to CMS, and the information obtained through the on-going dialogue between CMS and the state.

If within 90 days of receipt of the renewal request, CMS is unable to conclude that the waiver application satisfactorily addresses each assurance, including problems that may have surfaced during the CMS review of the approved waiver and/or that the waiver is not cost neutral, CMS may either formally request additional information or disapprove the renewal request.

Other Changes to Approved Waivers

There are other types of changes to approved waivers that merit additional discussion. In particular:

- **Splitting a Waiver**. A state may decide that it would be appropriate to divide an approved waiver into two waivers. For example, when a single waiver serves both older persons and individuals with disabilities under the age of 65, the state may determine that dividing the waiver into two waivers may better meet the needs of each target group. When the state proposes to make this change at the time of waiver renewal, the waiver requests will be treated as renewals rather than as new waiver applications. That is, each waiver can be made effective for another five-year period. When the split is accompanied by significant changes in the services that will be provided to one or both of the target groups or other changes that might substantially affect waiver operations, the state is expected to include a transition plan in the waiver.

  When the state wants to create two distinct waiver programs to serve the approved waiver's target population (for example, by dividing a waiver for persons with developmental disabilities into separate waivers based on participant living arrangement), the state should revise the approved waiver to encompass one of the desired configurations and submit a new waiver application to implement the other configuration.

  Splitting an approved waiver prior to its expiration date cannot be accomplished by the submission of a waiver amendment. Instead, a state should discuss with CMS the intended target populations to determine whether two new waivers will be required, or whether an amendment to the existing waiver and one new waiver will be sufficient.

- **Combining Waivers**. Alternatively, a state may determine that it would be more efficient to combine two approved waivers that serve the same or very similar target populations. If both waivers expire on the same date, the combination of the two programs may be accomplished by submitting a renewal application for the waiver that would continue and allowing the other program to expire. The state should alert CMS when it plans to follow this course. In addition, when the two waivers cover different services, CMS may require the state to prepare and submit a transition plan if the effect of combining the waivers would be to reduce the services provided in one or both waivers. If the waivers have different expiration dates, the state should notify CMS that it intends to combine the two programs and seek instructions.
- **Converting a Model Waiver to a Regular Waiver.** A waiver that has been approved as a "model waiver" may be converted to a regular waiver when the state decides to serve more than 200 individuals at any point in time. The conversion of a model waiver to a regular waiver is not considered a request for a new waiver. The conversion may be accomplished at the time of waiver renewal or by the submission of a waiver amendment.
- **Participant Limit Reductions.** When the state submits a request to replace an existing waiver, renew an approved waiver, or amend an approved waiver that would reduce the number of unduplicated individuals who may be served in the waiver, the state is expected to inform CMS whether the reduced participant cap would have an adverse impact on current waiver participants, as provided in CMS State Medicaid Director letter #01-006 Olmstead Update #4 (included in Attachment C). When a request reduces the participant limit, the state may:
  - Provide an assurance that, if the waiver request is approved, there will be sufficient service capacity to serve at least the number of current participants enrolled in the waiver as of the effective date of the new waiver, renewal or amendment. That is, the lower participant limit has the effect of eliminating unassigned "slots."
  - Assure CMS that no current waiver participants will be removed from the program or institutionalized inappropriately due to the lower participant limit. For example, the State may achieve a reduction through attrition rather than terminating current waiver participants.
  - Provide an assurance and methodology demonstrating how individuals currently served by the waiver will not be adversely affected by the lower participant limit. For example, if the waiver is no longer required because the principal service(s) provided through the waiver have been added to the state plan, the state may specify a method to transition waiver participants to the state plan service. Individuals subject to removal from a waiver are entitled to the opportunity to request a fair hearing under Medicaid law.
  - Provide a plan whereby affected individuals will transition to other HCBS waivers without loss of Medicaid eligibility or loss of services. Any loss of services would be subject to notice of Medicaid fair hearing rights.
  - Provide for other means to assure the health and welfare of affected individuals, including arranging for services that may be available under the state plan or through other programs.

Extensions

As described in 42 CFR § 441.304(a)(2)(c),CMS will consider requests for temporary 90-day waiver extensions only in very limited circumstances. A temporary extension permits the state to continue to operate an approved waiver beyond its original expiration date. Extensions are not granted solely for administrative convenience (e.g., to give the state extra time to prepare a waiver renewal request). Extensions may be granted for various reasons:

- The state wants to align the period of the waiver to a state fiscal year.
- The state intends to combine the waiver with another waiver that is under review but has not been approved by CMS.
- The state plans to terminate a waiver and requires additional time to phase out the waiver in an orderly fashion.
- CMS has identified through its review of the waiver renewal application that there are substantial problems in the waiver's design that cannot be rectified by the state prior to the expiration of the waiver; or
- The state requires additional time to satisfactorily resolve quality or financial issues identified by CMS during RO waiver review.

CMS expects states to formally submit a request for an extension in writing to CMS in advance of the approved waiver's expiration date. Extension requests are reviewed by CMS, which makes the determination whether to approve the request. Extensions are considered on a case-by-case basis. When a request for extension arises out of the need to address significant waiver design problems identified by CMS during its review of the waiver renewal application or rectify quality or financial issues, CMS will not approve the temporary extension request unless and until the state submits a satisfactory action plan with specific milestones to resolve the problems. CMS also will request the state to report its progress in implementing the action plan during the extension period. Temporary extensions are only granted for a period of up to 90-days.

All or part of the temporary extension approved by CMS may be subsumed into the period of the waiver renewal. For example, if the waiver was due to expire June 30 but a 90-day temporary extension was approved through September 30, the state may request that the renewal be effective on July 1 or October 1. Please note that in general, a state may not amend a waiver that is on a temporary extension. Instead, the state is required to operate the waiver consistent with the most current CMS-approved waiver. Therefore, while a waiver is on temporary extension, states may not implement any changes made to the waiver through the renewal retroactively. Further, states may not implement any changes to the waiver made through the renewal until the date that CMS approves the renewal.

Policies Concerning Waiver Amendments

Amendments to an approved waiver may be submitted at any time. As is the case with new or renewal waiver applications, CMS has 90 calendar days within which to approve or disapprove the amendment or formally request additional information in order to address problems that have been identified in the amendment request. When a RAI is issued concerning an amendment, the clock is stopped and only restarted (with a full 90-day clock) once the state responds to the RAI.

Whenever there is a change that affects an element of the approved waiver, the state should submit an amendment to the waiver. The approved waiver should be kept in synchronization with state waiver policies, practices, procedures and operations. For example, if a state wants to

alter a limit that it has imposed on the amount, frequency or duration of a waiver service, an amendment should be submitted.

Therefore, all changes in the approved waiver should be made via the submission of a waiver amendment. For example, if a state finds it necessary to reduce the waiver participant cap because state appropriations will not support the number of persons specified in the waiver, the state should submit an amendment to reduce the participant cap specified in Appendix B-3 of the application.

A state may propose that an amendment take effect prospectively on some future date. An amendment also may be made retroactive to the first day of a waiver year (or another date after the first day of the waiver year) in which the amendment is submitted unless the amendment includes changes that are substantive. Per 42 CFR § 441.304(d)(2), waiver amendments that include changes that are substantive may take effect only on or after the date of CMS approval. Per 42 CFR § 441.304(d)(1), substantive changes include but are not limited to: Revisions to services available under the waiver including elimination or reduction of services or reduction in the scope, amount, and duration of any service; A change in the qualifications of service providers (this includes a reduction of providers); Changes in rate methodology, or a constriction in the eligible population (for example, a reduction in the number of persons served, slots available, or adding reserved capacity without also increasing number of persons served/slots). Some additional examples of substantive changes include consolidating waivers, adding services, changes to settings, and changes in the quality improvement system such as adding or deleting sub-assurances or adding or deleting reporting requirements. Please note that typically, in increase in the unduplicated number of participants is not considered to be a substantive change. A retroactive effective date is permissible in a waiver amendment that only includes changes that are not substantive such as for the purpose of increasing the unduplicated number of participants. The state is required to establish a public input process specifically for HCBS waiver changes that are substantive in nature. Substantive changes should be accompanied by information on how the state has assured smooth transitions and minimal adverse impact on individuals impacted by the change. When an amendment would have the effect of reducing the number of waiver participants, the state also should review CMS guidance in State Medicaid Director letter #01-006 Olmstead Update #4 (located in Attachment C).

As a result of its review of the annual waiver report (CMS-372), CMS may instruct the state to submit a waiver amendment when the CMS review reveals that the state is serving a significantly greater number of persons than provided in the approved waiver, actual waiver expenditures substantially diverge from the amounts in the approved waiver, or the state is providing services not included in the approved waiver. When the annual waiver report reveals that the waiver may not be cost-neutral, CMS may instruct the state to take remedial actions to correct the problem (see the next part of the instructions).

Related Topics

CMS Technical Assistance

States are encouraged to confer with CMS when preparing preliminary initial and renewal waiver applications or significant amendments in advance of their formal official submission to CMS. Such informal consultation prior to the formal submission may expedite CMS review of the formal submission. States also may request technical assistance concerning waiver

operations. Technical assistance should be requested through DHCBSO, which will confer with DLTSS as necessary to address questions or technical aspects of the proposed waiver.

Administrative Claiming

Some activities such as case management, supports broker, and financial management services may be provided as a Medicaid administrative activity rather than as a waiver service. In accordance with 45 CFR Subpart E (45 CFR § 95.501 through 45 CFR § 95.519), states must ensure that any such administrative costs, necessary for the efficient administration of the Medicaid State Plan, are consistent with a CMS-approved cost allocation plan. Please note that cost allocation plans are not approved via approval of a 1915(c) HCBS waiver application.

Waiver Termination

There are three potential processes for terminating waivers, depending on the circumstance:

- A state may elect to terminate the operation of an approved waiver before its expiration date:
  - As provided by 42 CFR § 441.307, when the state elects to terminate the waiver prior to its expiration date, the state must notify CMS in writing, in the form of a waiver amendment, at least 30-days in advance before terminating services to waiver participants.
    - Under the 'purpose of the amendment', the state should indicate that the waiver is being terminated and should indicate the termination date.
    - A transition plan should be included in Attachment #1. If phasing into another authority, this transition plan should be accounted for in the accepting authority.
    - If the state is phasing out the waiver, there should be a phase-out schedule, factor c should be adjusted/and or the phase out of slots should be addressed in the transition plan and estimates in Appendix J updated.
  - As provided in 42 CFR § 431.210, the state must notify waiver participants at least 30 days in advance of the change.

- A state may elect to terminate the operation of an approved waiver and allow it to expire at the end of the approved waiver cycle:
  - The state is required to notify CMS at least 30 days in advance via a letter to CMS when individuals are all transitioned at one time. A waiver amendment for closing the waiver is not required.
    - The state must include in their notice to CMS what will happen to current participants when the waiver ends.
    - In most cases, they may have been transitioned to another waiver or authority, or the state may have phased out the waiver.
  - Please note that a waiver amendment is required when individuals are being transitioned over a period of time, when waivers are being combined, subsumed, or participants are being transitioned to other authorities.
  - In transitioning individuals, requirements for notice to participants must be met. The state must notify waiver participants at least 30 days in advance of the change.

- As provided in 42 CFR § 441.304(d), CMS may terminate a waiver when it finds that the state is not meeting one or more waiver requirements (e.g., the state has not assured the

health and welfare of waiver participants or the waiver is not cost neutral). CMS may terminate a waiver for one or more of the following reasons:

- The health and welfare of waiver participants has been jeopardized;
- The waiver is not cost-neutral;
- The state has not submitted required annual waiver reports;
- Accurate financial records have not been maintained to document the cost of waiver services;
- The waiver has not been operated in a manner consistent with the approved waiver; and/or
- The waiver has not been operated in accordance with other applicable federal requirements.

When CMS determines that it is necessary to terminate a waiver, it gives the state notice of its findings and the opportunity for a hearing to rebut these findings. After the notice and hearing, CMS may terminate the waiver. As provided in 42 CFR § 441.308, the procedures specified in Subpart D of 42 CFR § 430 apply to a state's request for a hearing concerning a waiver termination. If CMS terminates the waiver, the state must notify affected waiver participants at least 30-days in advance before terminating their services.

Post Approval Activities

Overview

This section briefly addresses the following topics:

- Preparation and submission of the annual section 1915(c) waiver report;
- On-going dialogue between the state and CMS concerning waiver operations; and
- CMS report to the state prior to waiver renewal.

Annual Waiver Report

As provided in 42 CFR § 441.302(h) (which implements section 1915(c)(2)(E) of the Act):

"annually, [the state] will provide CMS with information on the waiver's impact. The information must be consistent with a data collection plan designed by CMS and must address the waiver's impact on—

(1) The type, amount, and cost of services provided under the state plan; and

(2) The health and welfare of recipients."

The state must assure that it will prepare and submit the annual waiver report as a condition of the approval of the waiver.

Annual Report Form CMS-372(S)

In order to satisfy the annual waiver report assurance, a state must annually prepare and submit the form CMS-372(S) (Simplified) report in the 372 report section of the online waiver management system (WMS). The form CMS-372(S) report, also known as the 372 report, aligns the annual waiver report with the simplified waiver cost-neutrality formula (see instructions for Appendix J).

The CMS-372 report ensures that a state reports for each waiver year financial/statistical and other information about the waiver. This information includes:

- the unduplicated number of persons who participated in the waiver during the waiver year;
- the number of participants who utilized each waiver service;
- the amount expended for each waiver service and for all waiver services in total;
- the average annual per participant expenditures for waiver service;
- the total number of days of waiver coverage for all waiver participants and the average length of stay (ALOS) on the waiver;
- expenditures under the state plan for non-waiver services (including services required under Early and Periodic Screening, Diagnostic and Treatment (EPSDT) requirements when the waiver serves children under the age of 21) that were made on behalf of waiver participants and average per participant expenditures for such services (based on the number of participants who utilized such services); and,
- evidence that demonstrates how the state continues to meet the waiver quality assurances.

The CMS-372(S) reports the actual performance of a waiver against the prospective cost-neutrality demonstration in Appendix J of the revised waiver application. The financial and statistical data reported via the CMS-372(S) also serves as the baseline for the prospective demonstration of cost-neutrality when the state submits a renewal application for an approved waiver.

The quality performance measure evidence includes data for each performance measure and information about how the state monitors performance in each of the waiver quality assurances and sub-assurances, as well as evidence of discovery, remediation and improvement activities for all of the waiver assurances. Additionally, under the health and welfare assurance, the state provides an aggregated report on the individual remediation of substantiated instances of abuse, neglect, and exploitation.

CMS reviews the annual CMS-372(S) report as part of its ongoing oversight of the operation of HCBS waivers. This review is discussed in the Review of the Annual Waiver Form CMS-372(S) Report section. In addition, in accordance with 42 CFR §§ 441.302-305, for CMS consideration of a waiver renewal application, the state must have submitted, and CMS accepted CMS-372(S) reports through the next to last year of the period that the approved waiver is in effect. If the state is unable to prepare timely and acceptable CMS-372(S) reports, the renewal of the waiver may be jeopardized.

Preparation and Submission of the Form CMS-372(S) Report

As noted previously, in accordance with 42 CFR §§ 441.302-305, all state Medicaid agencies administering or supervising the administration of HCBS waivers are required to submit an annual 372 Report in WMS for each approved waiver. The first report for each waiver must have data from the new or renewed waiver effective date (and, for subsequent reports in the waiver cycle, the anniversary of that date) to the end of one full year thereafter. A separate 372 Report is expected for temporary extension (TE) periods granted by CMS while a waiver's renewal is pending if the extension period is not subsumed into the renewal period. A 372 Report is also expected for each extension year, plus a separate report for each additional portion of a year during which the waiver operated on a TE that is not subsumed into the renewal. Similarly, if a waiver only operated for part of a year and was terminated, a 372 Report for that portion of the year in which the waiver was in effect needs to be submitted.

WMS 372 Report Summary Section

States have six months after the end of each waiver year to report on quality assurance requirements and an additional 12 months for financial reporting. As a result, the annual 372 Report includes quality assurance information for the most recent waiver year just ended and financial information for the waiver year prior to the year with the most recent quality information. Therefore, the following information will be different for the data and quality sections of the 372 Report:

- Waiver Year identifies which year in the waiver's three- or five-year cycle is covered by the 372 Report
- Begin Date is the first day of the waiver year covered by the 372 Report
- End Date is the last day of the waiver year covered by the 372 Report
- Report Period Year is the year included in the end date of the 372 Report waiver period

The 372 report types are defined as follows:

- Initial Report – The initial report includes information for the most recent waiver year. This report type typically applies to the quality section and is due six months following the last day of the applicable waiver year.
- Lag Report – The lag report includes information for the year previous to the most recent waiver year. This report type typically applies to the data (financial) section and is due 18 months following the last day of the applicable waiver year.
- Temporary Extension (TE) Report – The TE report includes information for waiver extension periods granted by CMS while a waiver's renewal is pending if the extension period is not subsumed into the renewal period. The waiver year selected must be the final waiver year in the waiver's cycle, e.g. Year 5. A separate report is due for each year and/or each portion of a year during which the waiver operated on a temporary extension.

WMS 372 Report Data Section

The data section of the 372 Report requires data that will be compared to estimates approved in the waiver to determine if the waiver meets the cost neutrality requirement. The following provides an explanation of certain data elements as specified in 42 CFR § 441.303:

- **Unduplicated Participants (Factor C)** – Data on participants is reported based on annual unduplicated individuals, (not cases, slots, or families) also known as Factor C. To be counted as a waiver participant, an individual must have received one or more paid waiver services during the reporting period. For example, if a participant is served under the waiver on multiple occasions during the year with an intervening period of institutionalization, that individual is only counted as one unduplicated participant.
- **Days of Waiver Enrollment** – The number for days of waiver enrollment is the total days of waiver coverage for the unduplicated participants.
- **Average Length of Stay (ALOS)** – The ALOS is computed by dividing the total number of days of enrollment by the number of unduplicated waiver participants. Data should be included all days as follows:
    - Begin with the later of
        - The first day of waiver enrollment, or
        - The first day of the reporting period.
    - End with the earlier of:

- The last day of waiver program enrollment, or
- The last day of the reporting period.

- **Total Waiver Expenditures –** Total waiver expenditures should be reported in whole dollars and represent the total computable expenditures.
- **Average per Capita Waiver Services (Factor D) –** The average per capita annual expenditure for section 1915(c) HCBS provided to the total number of waiver recipients for each level of care in the approved waiver.

  To compute the average per capita expenditures for each level of care in the approved waiver, the sum of the annual expenditures for CMS-approved §1915(c) waiver services for each column is calculated. This sum is divided by the total number of unduplicated participants of these services reported for that level of care. The result is the average per capita expenditures for CMS-approved section 1915(c) waiver services to waiver participants.

- **Average per Capita (APC) for State Plan Services (Factor D')** – The average per capita annual expenditures for all other Medicaid services for which Medicaid payment was made for participants during the time they received section 1915(c) waiver services. This includes state plan services and services above and beyond medically necessary EPSDT services not included in the state plan. Factor D' includes all other Medicaid costs not included in factor D.

  Institutional costs in a waiver year for participants in the institution before they enter the waiver are not included in the computation of factor D'. If an individual is in the waiver and during the waiver year enters an institution and subsequently returns to the waiver in that waiver year, those institutional costs should be included in Factor D'. If an individual is in the waiver and during the same year enters an institution but does not return to the waiver during that waiver year, those institutional costs would not be included in Factor D' because the participant is no longer in the waiver.

- **APC Total (D + D')** – The average per capita total for waiver services is Factor D + Factor D'.
- **Factor G Value** – The estimated annual average per capita Medicaid cost for hospital, NF, or ICF/IID care that would be incurred for participants served in the waiver, were the waiver not granted.
- **Factor G' Value –** The estimated annual average per capita Medicaid costs for all services other than those included in factor G for participants served in the waiver, were the waiver not granted.
- **APC Total if No Waiver (G + G')** – The average per capita total for long-term care participants with no waiver granted is Factor G + Factor G'. The estimated sum of G + G' approved in the waiver, rather than updated actual numbers should be entered. If the state chooses to provide updated numbers, certification on accuracy of the data and a brief explanation as to how the data was derived must be included in the additional information box.
- **Cost Neutrality –** To compute the cost-neutrality formula, the computation to ensure that the sum of D + D' is less than or equal to the estimated sum of G + G' is completed. If after completing the computation the waiver is not cost-neutral, an explanation in the additional information section explaining why the waiver failed to demonstrate cost neutrality should be included. Action needs to be taken to amend the waiver for future

years, and immediately correct the problem or the waiver may be terminated by CMS. (See 42 CFR § 441.304(d).)

- **Annual Number of Section 1915(c) Waiver Participants and Expenditures –** Each service should be specified as it is listed in Appendix J of the approved waiver and the number of unduplicated waiver participants, who received each waiver service by level of care in the approved waiver should be entered.

  The total number of unduplicated waiver services participants is then entered. This number represents, by level of care in the approved waiver, the number of unduplicated participants, who received waiver services.

  The actual annual Medicaid expenditures for each approved home and community-based waiver service received by waiver participants during the reporting period by level of care should be entered.

- **Reporting Managed Care –** The following instructions describe how expenses should be reported when section 1915(c) waiver services are provided via managed care and the state is unable to determine the actual expenses per service because they are included in the capitated payment.
  - The following should be reported in the Additional Information text box:
    - Name of managed care (MC) program;
    - Number of unduplicated MC participants, who received waiver services; and
    - Per member per month (PMPM) cost.
  - The following should be reported in the Annual Number of section 1915(c) Participants and Expenditures Table:
    - Service Name - "Managed Care" should be specified as a service name;
    - Participants – The total number of unduplicated participants, who received managed care through the waiver should be reported; and
    - Expenses are calculated in $ as follows:
      a. The average number of months services were received per participant: ALOS / 30.42 days = months rounded to the nearest hundredth (e.g. ALOS 171 days / 30.42 days = 5.62 months); and
      b. The total expense per year: unduplicated participants x the PMPM cost x average months services received (e.g. 2,000 unduplicated participants x $4,500 PMPM x 5.62 = $50,580,000 Expense in $).
  - The Add Service Line link at the bottom of the page should be used to list the following for each service provided via managed care:
    - Service Name - Name of service provided via managed care;
    - Participants - Number of unduplicated participants, who received the managed care service; and
    - Expenses in Percent - Percentage of the total unduplicated participants, who received the service, e.g. Residential Habilitation. For example, there are 2,000 unduplicated participants, who received section 1915(c) waiver services, but only 500 of them received Residential Habilitation services via managed care. The percent of unduplicated participants who received managed care Residential Habilitation would be calculated by dividing 500 by 2,000 = .25 or 25%.

372 Report Quality Section

States have six months after the end of each waiver year to report on the quality assurance requirements. The prepopulated information in this section is pulled directly from the applicable approved section 1915(c) waiver. States need to provide data for each performance measure as evidence demonstrating that each quality assurance is met. When a deficiency is identified, information about how it will be remediated is expected to be included.

Review of the Annual Waiver CMS-372(S) Report

CMS reviews the financial and statistical information submitted by the state to validate that the section 1915(c) waiver meets regulatory requirements specified in 42 CFR §§ 441.302-305. The review may require the following actions by the state:

- **Waiver Amendment.** If the review of the annual waiver report reveals that the number of waiver participants is significantly greater than the number estimated by the state in the approved waiver and/or waiver expenditures (in total or on an average per participant basis) exceed those estimated in the approved waiver, the state may be required to submit an amendment to the approved waiver to align the demonstration of cost neutrality in the approved waiver to actual experience. States are expected to monitor waiver utilization and expenditures and submit amendments as necessary. It is not necessary to submit an amendment to reflect minor differences in the number of waiver participants or the utilization or costs of specific waiver services. So long as the annual report confirms that the waiver meets the cost-neutrality assurance, these types of amendments will be treated as "technical" in nature.
- **Potential Violations of the Cost-Neutrality Assurance**. When the annual waiver report reveals that the waiver does not meet the cost-neutrality assurance (i.e., the annual average per capita cost of supporting individuals on the waiver exceeds the annual average cost of individuals who receive institutional services at the waiver's level of care), the state may be required to initiate corrective action to bring the waiver into alignment with the cost-neutrality requirement. The implementation of the necessary corrective actions may entail the submission of amendments to the approved waiver. If the state fails to initiate satisfactory corrective actions, CMS may terminate the waiver or disapprove its renewal. It is expected that states monitor waiver expenditures and initiate corrective actions as necessary to assure the cost-neutrality of the waiver.

Ongoing CMS-State Dialogue During the Waiver Period

During the waiver period, DHCBSO has oversight of state waiver operations and making a determination that the waiver has been operated in accordance with the approved application and that the state has met the waiver assurances and related federal requirements. CMS urges that states engage in an on-going dialogue with DHCBSO about the operation of the waiver. This dialogue may include discussions of changes to improve waiver operations, involving DHCBSO in problem solving to address issues that might arise in waiver operations, and keeping DHCBSO apprised of progress in implementing the waiver's quality improvement strategy (QIS).

When appropriate and necessary, DHCBSO will involve DLTSS in this dialogue. CMS can provide assistance to states in designing a QIS or the design of systems to address specific aspects of quality improvement.

CMS Oversight of State Waiver Operations

CMS will utilize the quality information provided in the Form CMS-372(S) Report combined with information obtained by DHCBSO throughout the waiver period to determine the state's quality performance. DHCBSO may also visit states to observe and learn about the operations of the program. CMS may find it necessary, in certain circumstances, including when the health and welfare of waiver participants may be jeopardized or the waiver is not being operated in accordance with other applicable federal requirements, to conduct special or focused on-site or off-site review activities. Prior to launching a special review, DHCBSO will identify to the state the types of information that it requires in order to perform the review. When CMS determines that such a review is necessary, it will notify the state of why the review is being undertaken. The results of this type of review may necessitate the state's preparing and implementing a corrective action plan.

CMS Report to the State Prior to Waiver Renewal

CMS will issue a draft quality review report to the state summarizing its quality performance findings and conclusion. The report may include recommendations. If the draft report concludes that one or more assurances are not demonstrated, DHCBSO will provide the basis for the conclusion In response to the draft report, the state may dispute the CMS findings or propose a course of action to remediate the problem, either immediately or by implementing a corrective action plan with milestones to resolve the problem(s). If the state does not propose a satisfactory course of action, CMS may not approve the state's waiver renewal application. A final report incorporating the state's response will be issued approximately 12 months prior to the waiver's expiration.

Detailed Instructions for the Completion of the Version 3.7 1915(c)HCBS Waiver Application

Overview

The detailed instructions for completing the Version 3.7 1915(c) HCBS Waiver Application are divided into two parts:

- The first part (Using the Application) provides information about completing the web-based application. It discusses the formatting of the application and provides additional information about various elements of the application.
- The second and larger part (Detailed Instructions) contains module-by-module, item-by-item application instructions. These instructions include technical guidance (where applicable) and the review criteria that CMS applies in reviewing waiver applications.

Using the Application

Overview

The web-based application links relevant parts of the application and ensures that the application is complete when it is submitted. The web-based application format includes technical instructions for its use.

Technical instructions for use of the web-based application are available at https://wms-mmdl.cms.gov/WMS/faces/portal.jsp. In addition, each state has a designated systems

administrator (within the Medicaid Agency) who provides state user access and assigns roles related to the use of the application.

Please note that there is no means to load a draft application prepared in word processing software into the web-based application tool. Text may be copied and pasted; selections must be made manually.

Application Format

The application is formatted so that many items in the revised application can be completed by making a selection from a pre-specified list of responses. Other items require text responses. There are two types of response lists where a state responds to an item by selecting from a pre-specified list that contains two or more potential responses. Some application items combine both types of selectable choices. These types of lists are:

- **No more than one selection permitted from among two or more possible choices.** Some items provide for the selection of only one of two or more pre-specified choices. Items of this type appear in the application in the following format and are cued by the instruction "*select one*":

---

a. The state is a *(select one)*:

¡	§1634 State
¡	SSI-Criteria State
¡	209(b) State

For items of this type (where selectable choices are indicated by the "¡" symbol), select one and only one of the pre-specified responses. The web-based application is designed so that it is only possible to make only one selection in items of this type.

- **More than one selection from several choices**. In the case of other items, the application permits selecting more than one of the listed responses. Items of this type appear in the application in the following format and are cued by the instruction "*check each that applies*". An example of this type of item is as follows:

---

a. **Responsibility for Service Plan Development**. Per 42 CFR § 441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals. Given the importance of the role of the person-centered service plan in HCBS provision, the qualifications should include the training or competency requirements for the HCBS settings criteria and person-centered service plan development. *(check each that applies)*:

¨	Registered nurse, licensed to practice in the state
¨	Licensed practical or vocational nurse, acting within the scope of practice under state law
¨	Licensed physician (M.D. or D.O)

¨	Case Manager (qualifications specified in Appendix C-3)
¨	Case Manager (qualifications not specified in Appendix C-3). *Specify qualifications*:
¨	Social Worker. *Specify qualifications:*
¨	Other (*specify the individuals and their qualifications):*

The selectable choices in items of this type are indicated by the "¨" symbol. In the case of these types of items, one, two or more of the choices listed may be selected. The selection of one of the choices does not preclude the selection of the other choices. The web-based application permits multiple choices to be made in items of this type.

In some cases, the selection of a pre-specified response from a list may prompt completing subsequent items or direct skipping the subsequent items and going on to a later item. Linkages among items are programmed into the web-based application. For example, if a response to one item permits skipping another item, the affected subsequent item is not available for completion in the web-based application.

Where the application requires a text response (for example, when the application requires that a policy or practice must be specified), the response is inserted into a ***text field***. Text fields appear in the application as follows:

Text fields sometimes standalone. This is the case when only a narrative response is required to complete an item. In other instances, text fields are associated with choices in an application item (as in the foregoing example). The size of a text field as it visually appears in the web-based application is not to be understood as depicting the expected or desired length of a response. Text fields will accommodate responses that are longer than the text field that appear in the application.

In the web-based application, all text fields are ***character-limited***. That is, they will only accommodate a certain amount of text as measured by a character count (where spaces count as a character). These limits were established during the web-based application design and further

refined during alpha and beta testing of the web-based application. The web-based application provides the user information about the character-limits associated with each text field. A counter above each text box will indicate how many characters have been used and are remaining. The limits that have been established are generous. However, there are some items where the limits have been purposely set to restrict the length of a state's response. In either application format, one page is 6,000 characters regardless of the physical length of the printout.

When using the web-based application, it may prove to be more convenient to prepare lengthier text responses using standard word processing software and then copy and paste the text into the web-based application. It is important to point out that the web-based application only accommodates plain text. Formatted text (e.g., bolding, italics, underlining), graphics (including text converted to graphics) and tabular formats cannot be accommodated. This aspect of the web-based application also means that copying and pasting information from formatted source documents (e.g., copying a form) generally cannot be accommodated unless copied as plain text. Additionally, the width of text boxes in the web-based application is fixed.

Italicized text in the application denotes an instruction or sometimes provides a brief explanation of an item or application component.

The application is designed to be a self-contained document. The web-based application does not accommodate submission of supplementary electronic files or paper documents. Therefore, the Version 3.7 format also does not reference supplementary material.

As necessary and appropriate, a state may cite applicable laws, policies or regulations in its response to an item but should not attach these materials to the application. If, during the course of its review, CMS finds it necessary to examine materials that are referenced in the application, the state will be asked to furnish them. When such materials are provided in response to a CMS informal or formal request, they are not considered to be part of the waiver application.

When materials are referenced or cited in the application, they must be *readily* available through the state Medicaid agency and/or the waiver operating agency (if applicable) should CMS request the materials. It is not necessary that the state Medicaid agency maintain printed copies of all referenced or cited materials. Materials may be maintained in electronic format. **Detailed Instructions, Technical Guidance and Review Criteria**

This part of the instructions is divided into modules which include section-by-section, item-by-item directions for completing the HCBS waiver application. Where appropriate, technical guidance is provided about an item or topic. CMS review criteria associated with an item or items also are included. The instructions are keyed to the application.

Application for a §1915(c) Home and Community-Based Services Waiver

(Module 1)

Overview

This component of the application includes the following sections:

- Basic information about the waiver request;
- A brief description of the waiver;
- A recap of the waiver application components;
- The waiver(s) requested by the state;
- The assurances that the state must make concerning the operation of the waiver;
- Additional requirements associated with the operation of a waiver;
- State contact information; and
- The signature of the State Medicaid Director or designee transmitting the application.

1. Request Information

Overview

This section provides basic information about the waiver.

Item 1-A: State

Instructions

In the web-based application, the state name is entered automatically.

Item 1-B: Waiver Title

Instructions

If the waiver has a title (e.g., "Innovations Waiver"), enter the title. Otherwise, leave blank.

Item 1-C: Type of Request

Instructions

From the choices provided, select the type of request. In the case of a renewal request, a request for a new waiver to replace an existing waiver or an amendment to an approved waiver, enter the CMS waiver control number of the approved waiver. Regular waivers have a four-digit waiver control number assigned by CMS plus extensions (when applicable) that indicate previous renewals (e.g., the number 0999.90 indicates that the waiver has previously been approved once for renewal). In the case of a model waiver, the waiver control number is a five-digit number plus extensions. In the web-based application, this item is pre-filled based on the selection that is made when the state initiates a new request.

Technical Guidance

Refer to the "*Waiver Application Submission Requirements, Processes, and Procedures*" section of the instructions for a discussion of policies and other considerations regarding new waivers, new waivers to replace an approved waiver, and waiver renewals. Also see instructions regarding Attachment #1 for submitting transition plans when a new waiver is to replace an approved waiver, and the other circumstances where a transition plan may be required. Please consult CMS directly to discuss particular situations. Please note that if the state requests a five-year initial waiver per the requirements of Section 2601 of the Affordable Care Act, the state must assure that the waiver provides services to individuals who are eligible for both Medicaid and Medicare.

CMS Review Criteria

- **The type of request (i.e., new waiver, renewal, amendment) has been specified by the state.**
- **For new waivers, the state has indicated the requested approval period (i.e., 3 years or 5 years).**

Item 1-D: Type of Waiver

Instructions

Select the type of waiver that is requested.

Technical Guidance

A “model” waiver is limited to serving no more than 200 individuals at any point in time during the waiver period. A model waiver may serve fewer than 200 persons, depending on the participant limit that a state establishes (as specified in Appendix B-3). Except for assuring that the waiver will serve no more than 200 individuals at any point in time, “model” and “regular” waivers are no different. A regular waiver also may serve a relatively small number of individuals.

A state may subsequently convert a model waiver to a regular waiver in order to serve more than 200 individuals. The conversion may be requested via the submission of a waiver amendment or when the waiver is renewed. Provided that no other major changes are proposed, the conversion of a model to a regular waiver is not considered to be a request for a new waiver. When conversion is requested via the submission of an amendment, the period that the waiver is in effect does not change.

Item 1-E.1: Proposed Effective Date

Instructions

Enter the proposed effective date of the waiver.

Technical Guidance

The effective date is the first day that the waiver will be in operation. In order to facilitate annual waiver reporting, a new waiver should have an effective date that falls on the first day of a month or the beginning of a calendar quarter. Also, in the case of new waivers, the proposed effective date should be at least 90-days from the date of application submission in order to allow sufficient time for CMS review of the application and a subsequent prospective effective date.

In the case of a renewal application or a new waiver that replaces an approved waiver, the proposed effective date should be the day after the approved waiver expires. If a temporary extension has been granted, the effective date may subsume all, part or none of the extension period.

In the case of an amendment, the proposed effective date is the date that the amendment would take effect. Again, keep in mind that any changes included in the amendment must be effective on the same date. See also *Policies Concerning Waiver Amendments* for a discussion of when amendments may be made effective.

Item 1-E.2: Approved Effective Date

Instructions

This item is reserved for CMS use. When the application is approved, CMS will enter the approved effective date. If this date is different from the proposed effective date, the application will be revised to reflect the approved effective date.

Item 1-F. Level(s) of Care

Instructions

Select the level or levels of care that individuals must require in order to be considered for entrance to the waiver. As applicable, specify the specific type of institutional setting or subcategory of a level of care.

Technical Guidance

Waiver services may only be furnished to individuals who are determined to require the level of care furnished in a hospital, nursing facility or ICF/IID when the costs of such institutional care are reimbursable under the state plan. The waiver must specify the level(s) of care that individuals require in order to enter the waiver. More than one level of care may be selected, depending on the target group(s) served in the waiver. For example, if the waiver is designed to support medically fragile children in the community, it may be appropriate to select both the hospital and nursing facility levels of care.

Level of care is one of several application elements that, when taken together, specify the target population of Medicaid beneficiaries who may participate in the waiver. In Appendix B-1, the state further specifies the waiver's target group(s) (i.e., the specific groups or subgroups of individuals who require the level of care that is specified here – for example, older persons – and may receive waiver services). In Appendix B-4, a state also specifies the Medicaid eligibility groups that may be served in the waiver. In Appendix B-6, the process by which the level of care of potential entrants to the waiver is evaluated and re-evaluated is described.

When completing this item, it is important to keep in mind that, per 42 CFR § 441.301(a)(6), a waiver may, at the state's option, serve one or more of the following three groups of Medicaid beneficiaries or subgroups thereof:

- Aged and/or disabled;
- Persons with intellectual disability and/or developmental disabilities; or
- Persons with serious mental illnesses.

These three groups are discussed in more detail in the instructions for Appendix B-1.

Only in limited circumstances may the ICF/IID level of care be combined with another level of care. As provided in CMS State Medicaid Director letter #01-006 Olmstead Update #4 (included in Attachment C), when a waiver serves persons who have experienced a brain injury, the waiver may serve individuals who require ICF/IID level of care (when the brain injury occurred at a young age) and persons who experienced a brain injury at a later age who may require the nursing facility or hospital level of care.

A waiver may not serve individuals between the ages of 22 and 64 who would, but for the waiver, receive services in an Institution for Mental Disease (IMD). The reason is that, under section 1905(a) of the Act, federal financial participation is not available for the costs of services furnished in an IMD to individuals in this age range. However, individuals with serious mental illnesses in this age range who require the nursing facility level of care according to a Preadmission Screening and Resident Review (PASRR) determination may receive waiver services. See the Appendix B-1 instructions for a more detailed discussion of this topic. A waiver may serve persons age 65 and older with serious mental illnesses who would otherwise reside in an IMD when the state plan provides for the reimbursement of IMD services under the provisions of 42 CFR § 440.140. A waiver also may serve children and youth with serious emotional disturbances who require the level of care furnished in inpatient psychiatric facilities for individuals under age 21 when the services furnished in such facilities are included in the state plan as provided in 42 CFR § 440.160 and are provided in a facility licensed as a hospital. Except as provided in Section 6063 of the Deficit Reduction Act of 2005 (P.L. 109-171), a waiver cannot serve as an alternative to services in a Psychiatric Residential Treatment Facility

(PRTFs – as defined in 42 CFR § 483.352) that serve children and youth since section 1915(c) of the Act does not authorize waivers as an alternative to PRTFs.

Some states have established subcategories of the major level of care categories (e.g., skilled and intermediate care nursing facility services). A state may limit the waiver to one or more of these subcategories (e.g., a state may have defined multiple levels of ICF/IID care but decides to limit the waiver to individuals who qualify for one or more of the specific levels). It is permissible for a state to target the waiver in this fashion provided that the level of care subcategories is incorporated into the state plan. If the state wishes to limit the waiver in this fashion, specify the subcategories (e.g., Rehabilitation Hospital under the hospital category). If subcategories are not specified in the state plan or, if they are specified, but the state does not wish to limit the waiver to specified subcategories, insert "not applicable." Keep in mind that in Appendix B-1, the waiver target population may be further specified by age, group, condition, and other factors.

When the waiver serves individuals, who require different levels of care, the demonstration of cost-neutrality in Appendix J is affected. Cost neutrality calculations are based on the Medicaid state plan costs associated with individuals who have the level of care specified for the waiver.

When more than one level of care is selected, in order to meet the requirements at 42 CFR § 441.303(f), cost neutrality calculations must be based on the calculation of a weighted average across the levels of care (see instructions for Appendix J-1).

CMS Review Criteria

- The level(s) of care proposed complies with 42 CFR § 441.301(a)(3).
- The state's proposed level(s) of care aligns with the target group definition contained in Appendix B-1.
- When subcategories of a level of care are specified, the subcategories are contained in the approved state plan.

Item 1-G: Concurrent Operation with Other Programs

Instructions

Indicate whether the waiver is or will be operated concurrently with a program that is operated under one of the other authorities listed. If the waiver will operate concurrently with a section 1915(b) waiver, specify the program and indicate whether a section 1915(b) waiver application has been submitted simultaneously or has been previously approved. Similarly, if the waiver will operate concurrently with a program authorized under section 1115 of the Act, specify the program and indicate whether a section 1115 waiver application has been submitted simultaneously or has been previously approved. In addition, the state should indicate here if the waiver is operating concurrently with a contract approved under section 1915(a) of the Act, a state plan amendment under section 1915(i) of the Act, a state plan amendment under section 1915(j) of the Act, or a state plan amendment under section 1915(k) of the Act. If the waiver does not operate concurrently with another program, select "not applicable."

Technical Guidance

An HCBS waiver may operate concurrently with programs approved under other authorities in the Act. For the purpose of this item, "concurrent operation" means that the operation of the HCBS waiver is directly tied to the use of another authority in the Act. For example, some states operate concurrently section 1915(b)/§1915(c) waivers wherein the section 1915(b) authority is

used to obtain waivers of provisions of the Act in addition to the waivers that may be granted under section 1915(c). Some of these programs employ managed care service delivery methods to furnish HCBS waiver and other state plan services to Medicaid beneficiaries.

This item does not apply when HCBS waiver participants only receive Medicaid state plan health care services through managed care or Primary Care Case Management (PCCM) arrangements that are furnished under another authority. It only applies when the delivery of waiver services is affected by the use of another authority. Please see the Appendix I instructions for a discussion of the section 1915(a) authority.

As discussed in the "*Waiver Application Submission Requirements, Processes, and Procedures*" section of the instructions, when a state wants to launch a concurrent managed care/section 1915(c) waiver, separate managed care and section 1915(c) waiver applications must be submitted because CMS must review each application simultaneously. Once a concurrent section 1915(b)/ §1915(c) waiver is approved, the renewal of each waiver is subject to the timelines under each authority (two or five years for the section 1915(b) waiver and three or five years for the section 1915(c) waiver). Should the section 1915(b) waiver expire or terminate prior to expiration, the state must amend the section 1915(c) accordingly.

CMS Review Criteria

- Both waiver applications have been submitted and have the appropriate proposed effective dates.
- In the case of a new concurrent authority, the section 1915(c) waiver may only be approved when the concurrent authority has been approved and *vice versa*.

Item 1-H: Dual Eligibility for Medicaid and Medicare

Instructions

Check the box if the Waiver provides services for individuals who are eligible for both Medicare and Medicaid.

2. Brief Waiver Description

Instructions

In one page or less (6,000 or fewer characters), briefly describe the purpose of the waiver, including its goals, objectives, organizational structure and service delivery methods.

Technical Guidance

The brief description provides CMS with an overview of the waiver's role in supporting individuals in their homes and communities and, thereby, facilitates CMS review of the application.

There is no pre-specified format for this brief description. However, the description should include: a discussion of the program's purpose (e.g., rebalance resources between institutional and community services or provide community alternatives for children who have complex medical conditions who otherwise would be hospitalized); its goals (e.g., facilitate the community transition of institutionalized persons or implement participant direction in three regions of the state); its objectives (e.g., transition 200 persons to the community each year of the waiver period); organizational structure (e.g., the state agency responsible for operating the waiver and how individuals access services at the local/regional level); and, service delivery

methods (e.g., the use of participant-directed or traditional service delivery methods). The brief description also may address other topics that the state believes will contribute to CMS understanding of what the state is seeking to accomplish through the operation of the waiver.

3. Components of the Waiver Request

Instructions

Select whether the waiver provides for participant direction of services.

Technical Guidance

This part of the application summarizes the remaining components of the application. It is included to inform interested persons about the scope and contents of the application. Item E (Participant Direction of Services) is the only item in this section for which a response is required. It asks whether the waiver provides participants the opportunity to direct some or all of their waiver services. If so, Appendix E must be completed. If not, Appendix E is not completed.

Before responding to this item, review Appendix E and its instructions. Appendix E revolves around two opportunities for participant-direction of waiver services: the participant-employer opportunity and the budget authority opportunity (these opportunities also may be combined). When a state currently does not provide for participant direction, CMS urges that serious consideration be given to affording waiver participants the opportunity to direct some or all of their waiver services. States that already provide one or both of these participant direction opportunities or want to expand the opportunities that are available to individuals must complete Appendix E.

4. Waiver(s) Requested

Overview

Section 1915(c) of the Act permits the Secretary to grant waivers of three specific provisions of the Act. As discussed below, all HCBS waiver programs operate under a waiver of section 1902(a)(10)(B) of the Act (comparability). A state also may request waivers of two other provisions of the Act: statewideness and income/resources. Except for these waivers, HCBS waivers must comply with all other relevant provisions of the Act unless the waiver also operates concurrently with waivers granted under other authorities that permit the waiver of additional provisions of the Act. For example, under the provisions of section 1902(a)(23) of the Act, waiver participants must be able to exercise free choice in selecting any willing and qualified provider of waiver services included in their service plan. Should a state wish to limit the number of providers, it must secure a waiver of section 1902(a)(23) (e.g., by separately requesting a waiver under the provisions of section 1915(b) of the Act).

Item 4-A: Comparability

Technical Guidance

Section 1902(a)(10)(B) of the Act provides that Medicaid services must be available to all categorically eligible individuals on a comparable basis (e.g., services available to adult beneficiaries with disabilities cannot be different in their amount, scope and duration from the services that are available to other adult beneficiaries). HCBS waivers target services only to specified groups of beneficiaries (e.g., persons with developmental disabilities or older persons)

rather than making them available to all beneficiaries. Thus, a waiver of section 1902(a)(10)(B) is an integral and necessary feature of all HCBS waivers. HCBS waivers also include services that are not otherwise available under the state plan and thus not available to beneficiaries who do not participate in the waiver. In order to make those services available, a waiver of comparability also is necessary. The waiver application incorporates the request for a waiver of section 1902(a)(10)(B). Submission of the application constitutes the state's request for this waiver.

Item 4-B: Income and Resources for the Medically Needy

Instructions

Select whether the state requests a waiver of section 1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy.

Technical Guidance

If the state elects to cover the medically needy under the waiver, it may request a waiver of section 1902(a)(10)(C)(i)(III) of the Act so that it may waive the community income and resource rules that apply to the medically needy and, instead, apply institutional income and resource eligibility rules. Institutional income and resource rules usually are more generous than community rules. Application of institutional deeming rules means that income and resources are not deemed to the person from a spouse or parent; thus, making an individual eligible for Medicaid who might not otherwise qualify. This permit covering under a waiver medically needy individuals who may not be eligible for waiver services under community rules but would be eligible under institutional rules. If the waiver serves the medically needy, indicate whether or not this section is waived. If the state does not serve the medically needy under its state plan, check "not applicable." It is important to point out that the waiver of this provision of the Act only applies to the medically needy and that population must be served under the state plan in order for a waiver of section 1902(a)(10)(c)(i)(III) to be requested.

CMS Review Criteria

When a waiver of section 1902(a)(10)(C)(i)(III) is requested:

- The state must cover the medically needy in the state plan.
- The state must include the medically needy in the eligibility groups that may receive waiver services as provided in Appendix B-4 of the application.

Item 4-C: Statewideness

Instructions

Select whether a waiver of statewideness is requested. If a waiver is requested, specify the type or types of waivers of statewideness that are requested and provide the information that is specified.

Technical Guidance

Section 1902(a)(1) of the Act requires that the Medicaid state plan be in effect in all political subdivisions of the state. As provided in section 1915(c)(3) of the Act, a state may request a waiver of section 1902(a)(1) in order to operate a waiver on a less than statewide basis. The Version 3.7 HCBS waiver application provides for requesting two types of waivers of statewideness:

- **Geographic Limitation.** A state may request a waiver of statewideness in order to furnish waiver services only to eligible persons who reside in specific geographic areas (e.g., state planning regions or human services catchment areas) or political subdivisions (e.g., counties or municipalities) of the state. When the waiver is limited to specific political subdivisions, list the subdivisions. When the waiver is limited to another type of geographic area (e.g., state planning region), describe the area and, if applicable, include a reference to the state law or other official document (e.g., governor's executive order) that defines the geographic area. The description needs to be specific enough so that the geographic areas where the waiver is in effect are clearly specified. Absent a waiver of statewideness, the waiver is considered to be in effect in all parts of the state.

  Only request a waiver of statewideness in order to confine the operation of the waiver to specified geographic areas. A waiver of statewideness should not be requested because some waiver services may not be readily accessible in all parts of the state. A waiver of statewideness may not be requested in order to provide different arrays of waiver services or administer the waiver differently in different parts of a state under the same waiver. If the state wants to provide different service arrays or operate differently in different parts of the state, per CMS State Medicaid Director letter #01-006 Olmstead Update #4 (included in Attachment C), the state would need to apply for a separate waiver for each area. In other words, where the waiver is in effect, the waiver must operate consistently in all the areas served by the waiver.

  The request for a waiver of statewideness may also provide for the phase-in of the waiver by geographic area by waiver year. For example, a state may provide that the waiver is in effect in specified counties during its first year of operation but will be in effect statewide during the second and subsequent years of the waiver. If the waiver will be phased-in geographically, request a waiver of statewideness and in the text field specify the geographic area phase-in schedule. If this schedule changes during the period that the waiver is in effect, submit an amendment to reflect the revised phase-in schedule.

- **Limited Implementation of Participant Direction.** A state also may request a waiver of statewideness for the purpose of implementing one or both participant direction opportunities that the state specifies in Appendix E on less than a statewide basis. A waiver of statewideness for this purpose may be requested in conjunction with a waiver that otherwise operates on a statewide basis. This waiver may be useful for states that are interested in affording participants opportunities to direct waiver services but want to phase-in the implementation of participant direction by geographic area. If the waiver operates on a less than statewide basis, this waiver may be requested to offer participant direction opportunities in some but not all the geographic areas where the waiver operates. This waiver does not permit a state to limit the number of individuals who may direct their services within the designated geographic locations.

  This waiver will be granted only when the waiver participants in the geographic areas where participant direction is available also have the choice of receiving waiver services through the service delivery methods that are in effect elsewhere. In other words, this waiver cannot be granted if participant direction would be the only service delivery method available to participants in the geographic areas where participant direction is

made available. Participants who reside in the area subject to this waiver must have access to the same services as participants elsewhere in the state.

Since the implementation of participant direction requires making available additional supports to participants who direct their waiver services (e.g., financial management services), a state may include such supports in the waiver but limit their availability (when covered as a waiver service) to individuals who elect to direct their waiver services. This limitation should be included in the specification of the scope of the support service in Appendix C-3.

In requesting this waiver, the same requirements apply with respect to defining the specific geographic areas where participant direction opportunities will be available as for a geographic limitation. The waiver also may provide for the phase-in of participant direction by geographic area by waiver year.

CMS Review Criteria

- When a waiver of statewideness is requested to limit the operation of the waiver to regions or areas of the state or to implement participant direction of services in some but not all areas where the waiver is in effect, the waiver clearly defines the geographic areas where waiver services and/or participant direction will be available.
- Waiver participants in the geographic areas where participant direction is available also have the choice to receive waiver services through the service delivery methods that are in effect elsewhere.

5. Assurances

Overview/Discussion

In order for CMS to approve a new waiver or the renewal of an approved waiver, a state must make certain assurances concerning the operation of the waiver. These assurances are spelled out in 42 CFR § 441.302 and included in this part of the waiver application. By submitting the waiver application, the state attests that it will abide by these assurances during the period that the waiver is in effect. These assurances may not be altered.

Other components of the application address how the waiver is designed to meet these assurances. For example, Appendix B details how the state will meet the evaluation of need assurance. In addition, the quality improvement strategy contained throughout the application and in Appendix H describes how the state will monitor performance in meeting the assurances on a continuing basis during the period that the waiver is in effect.

6. Additional Requirements

Overview

This section includes additional requirements that apply to the operation of HCBS waivers over and above the assurances contained in 42 CFR § 441.302. States are reminded that waivers must comply with all applicable Medicaid requirements, including requirements that are not listed in this part of the application. Item 6-I (public input) is the only item in this part that requires a state response. The basis of these requirements is discussed below.

Discussion of Additional Requirements

Item 6-A: Service Plan

The services that an individual will receive through the waiver must be spelled out in advance in a written service plan. In the revised application, the terminology "participant-centered service plan" or "service plan" is synonymous with "plan of care." This item spells out federal requirements that pertain to the service plan. Appendix D describes the process that is employed in the waiver to develop the service plan. Service plan development is a critical waiver function. The service plan spells out how the assessed needs of each waiver participant will be met.

The requirements related to the service plan as described under 42 CFR § 441.302(c)(2) are as follows:

- Waiver services must be furnished in accordance with the service plan. Whenever the services that are furnished to a participant change, the service plan must be revised. A state may provide for processes to authorize the provision of waiver services on an emergency basis, provided that the service plan is revised to reflect the additional services.
- The service plan must be inclusive of all the services and supports that are furnished to meet the assessed needs of a participant, including services that are funded from sources other than the waiver (e.g., services that are obtained through the state Medicaid plan, from other public programs and/or through the provision of informal supports). In other words, the service plan should provide a complete picture of how participant needs are met. It is recognized that the waiver operating agency and the state have direct responsibility only for the delivery of waiver services. With respect to other public services and informal supports, responsibilities include linkage, referral and advocacy and monitoring access to and receipt of other services as part of service plan implementation (as described in Appendix D-2).
- With respect to waiver services, the service plan must include the specific waiver services that will be furnished to a participant, their amount, duration and frequency (e.g., daily or weekly), and the *type of provider* that will furnish each service. The service plan need not name the specific provider that will furnish each service, only the type of provider (e.g., home health agency or personal assistant).
- Federal financial participation (FFP) may not be claimed for waiver services that are furnished prior to the development of the service plan or for waiver services that are not included in an individual's service plan. A service plan may not be backdated.
- The service plan must be subject to the approval of the Medicaid agency. Appendix D-1 describes how this is accomplished. This requirement does not necessarily mean that the Medicaid agency must review and approve each and every service plan, either before it goes into effect or on a retrospective basis. Often, this requirement is met by the Medicaid agency's retrospectively reviewing a sample of service plans.

Item 6-B: Individuals Who Are Inpatients

CMS regulations at 42 CFR § 441.301(b)(1)(ii) provides that waiver services may not be furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID. FFP is not available for waiver services while the person is in a hospital, nursing facility or ICF/IID except for temporary short-term respite services delivered in an institution, and personal assistance retainer payments, as described in CMS State Medicaid Director letter Olmstead Update #3

(located in Attachment C). So that waiver participants may continue to receive services in the most integrated setting appropriate to their needs, CMS permits the continued payment to personal assistants under the waiver while a person is hospitalized or absent from his or her home. If a state chooses to make such payments, it must clearly indicate this in the service specifications in Appendix C-3 for the personal assistance service where retainer payments will be made.

States that elect to make personal assistance retainer payments must also specify the limits that will be applied to this service. The personal assistance retainer time limit may not exceed the lesser of 30 consecutive days or the number of days for which the state authorizes a similar payment in nursing facilities.

The institutionalization of a waiver participant does not dictate that the person must be terminated from the waiver. A state may provide for the continuation of the person on the waiver by reserving or holding a waiver opening for the person.
Under certain circumstances, a state may arrange for the provision of some services (e.g., home modifications) in advance of the transition of institutionalized persons to the community in order to ensure the continuity of care for these individuals. These circumstances and the types of services that may be arranged in advance of transition to the community are discussed in more detail in the instructions for Appendix C.

Item 6-C: Room and Board

FFP may not be claimed for the cost of room and board except in certain circumstances. CMS interprets the term "room" to mean shelter type expenses, including all property-related costs such as rental or purchase of real estate and furnishings, maintenance, utilities, and related administrative services. Per 42 CFR § 441.310, the term "board" means three meals a day or any other full nutritional regimen.

As provided in 42 CFR § 441.310(a)(2), room and board may be claimed for temporary short-term respite services that are furnished in settings that are not the participant's own private residences and a state may elect to pay the portion of the rent and food that can be attributed to a live-in caregiver who furnishes services to a participant in the participant's private residence. In Appendix I, a state describes how it excludes the cost of room and board from its claim for federal financial participation in the costs of waiver services. When a state elects to pay for the portion of rent and food that can be attributed to a live-in caregiver, it includes "live-in caregiver" as a covered waiver service in Appendix C and describes how it determines the amount that is paid for the rent and food that is attributable to the live-in caregiver in Appendix I.

A state may claim FFP for the costs of meals that are furnished as part of a program of adult day health or a similar activity conducted outside the participant's living arrangement on a partial day basis. A waiver may also cover "meals on wheels" (or similar) services that provides up to two meals each day and which do not constitute a full nutritional regimen to waiver participants who live in their own private residence.

Item 6-D: Access to Services

Any service that is offered in a waiver must be available to every waiver participant who requires the service as provided in the specifications for each service in Appendix C-3. In Appendix C-3, a state may establish limits on the amount, duration and scope of each service. However, as provided in CMS State Medicaid Director letter #01-006 Olmstead Update #4 (located in

Attachment C), a state may not limit the number of waiver participants who may receive a particular waiver service, nor may a state deny a needed waiver service due to the lack of funds.

In addition, a state may not limit a group of waiver participants to receiving a pre-defined package of waiver benefits by preventing members of the group from accessing other services offered under the waiver. This means that a state may not operate what amounts to a "waiver within a waiver." In short, waiver services must be available on a comparable basis to all waiver participants who have been assessed as needing the services. When a state wishes to offer different benefits to specific groups of individuals, it should apply to operate distinct waivers for each group.

Item 6-E: Free Choice of Provider

HCBS waivers must comply with section1902(a)(23) of the Act and 42 CFR § 431.51, which require that Medicaid beneficiaries must be allowed to obtain services from any willing and qualified provider of a service. A willing provider is a provider who agrees to accept a state's payment as payment in full for rendering a service and to abide by all other Medicaid provider requirements, including executing a provider agreement. A qualified waiver provider means an individual or entity that meets the qualifications that are specified in Appendix C-3 for the service that the provider renders. All qualified providers must be permitted to participate in the waiver program and have a provider agreement with the Medicaid agency if they chose to do so unless a state has secured a waiver of section1902(a)(23) to place restrictions on providers (e.g., by requesting a waiver under the section 1915(b)(4) authority).

Item 6-F: FFP Limitation

In accordance with 42 CFR § 433 Subpart D, FFP may not be claimed for services when another third party (e.g., other third-party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. This requirement applies to all Medicaid services, including waiver services. The Medicaid program functions as the payer of last resort.

Item 6-G: Fair Hearing

Waiver participants (like other Medicaid beneficiaries) must have the opportunity to request a Fair Hearing, pursuant to 42 CFR §§ 431.220-221, to seek a reconsideration of certain types of decisions that affect their eligibility or their services. How this opportunity is provided is described in Appendix F.

Item 6-H: Quality Improvement

This item establishes the expectation that a state have an on-going, continuous system to ensure that the waiver assurances and other requirements are met when the waiver is in effect (see 42 CFR §§ 441.301-302). This system is described in the quality improvement strategy contained throughout the appendices in the document, in Appendix H and in other elements of the application (e.g., Appendix G: Participant Safeguards).

Item 6-I: Public Input

Instructions

In the text field, describe how public input into the development of the new waiver, waiver renewal, or waiver amendment was secured.

Technical Guidance

CMS requires states to obtain public input during the development of a waiver (or a waiver renewal or a waiver amendment with substantive changes) in accordance with 42 CFR § 441.304(f). The public input process must be described fully and be sufficient in light of the scope of the changes proposed, to ensure meaningful opportunities for input for individuals served or eligible to be served in the waiver. For the public input process to be sufficient in light of the scope of the changes proposed, the state is expected to share with the public the entire waiver. In addition, the state's public input process should have included at least two (2) statements of public notice and public input procedures, with at least one being web-based AND at least one being non-electronic to ensure that individuals without computer access have the opportunity to provide input. This state must provide at least a 30-day public notice and comment period and be completed prior to submission of the proposed change to CMS. The state's response to this item in the waiver application should include a summary of the public comments received during the public input process, and if any comments were not adopted, the reasons why. The state should also specify in their summary any modifications to the waiver that they made as a result of the public input process.

CMS Review Criteria

For new waivers, and renewals and amendments with substantive changes:

- Did the state fully describe the public input process?
- Was the public input process at least a 30-day period, and was it completed prior to the waiver submission to CMS?
- Did the state provide at least two (2) statements of public notice and public input procedures? Was one of them web-based?
- Did the state include a summary of the public comments that the state received during the public input process, reasons why any comments were not adopted, and any modifications to the waiver that they made as a result of the public input process?
- Did the state's posting include the entire waiver? For new waivers, was the public input process sufficient?
- For renewals and amendments with substantive changes, was the public input process sufficient in light of the scope of the proposed changes in the waiver submission?

Item 6-J: Notice to Tribal Governments

Instructions

In the text field, describe how federally recognized tribes were consulted.

Technical Guidance

Section 1902(a)(73) of the Act requires states to seek advice from all Indian health providers and urban Indian organizations in the state prior to submitting state plan amendments or waiver requests that may have a direct impact on Indians or Indian health providers. States that have these providers have submitted a SPA outlining the process for seeking advice that they state will follow prior to submitting SPAs or waiver requests, renewals, amendments or extensions. In some cases, the aforementioned SPAs outlined a process for consultation with tribal governments as well as seeking advice from Indian health and Urban Indian organizations. In addition to the requirement to seek advice from Indian health providers and urban Indian

organizations, States must consult with federally recognized Indian Tribes that maintain a primary office and/or majority population within the state of intent to submit a Medicaid waiver request, including a request for a waiver renewal. If a state has outlined the process for consulting with tribal governments in the aforementioned SPA, that process should be followed. If they have not included tribal consultation in the SPA, the notice to tribal governments must be sent at least 60-days in advance of submitting the request, allowing the tribe(s) at least 30 days to respond. Please see State Medicaid Director Letter #01-024 (July 17, 2001), Attachment C, for more information about meeting this requirement. Evidence documenting the process for seeking advice from Indian health providers and urban Indian organizations, as well as documentation that the state fulfilled the tribal government consultation process must be readily available through the state Medicaid agency.

Item 6-K: Limited English Proficient Persons

As in the case of other Medicaid services, a state must provide meaningful access to a waiver by Limited English Proficient persons as described in 42 CFR § 435.905(b). How this access is provided with respect to the waiver is described in Appendix B-8 of the waiver application.

7. Contact Person(s)

Item 7-A: State Medicaid Agency Representative

Instructions

Provide the name and other contact information of the individual at the Medicaid agency with whom CMS should communicate regarding the waiver.

Technical Guidance

The individual identified should be familiar with the waiver and be able to respond to CMS questions concerning the application. A Medicaid agency contact must be identified even though the waiver is operated by another agency. CMS directs its communications regarding a waiver request to the Medicaid agency. The information provided here also is entered into a CMS database that is used to distribute information to states regarding waivers.

Item 7-B: Operating Agency Representative

Instructions

When a waiver is operated by a state agency that is not part of the Medicaid agency (as provided in Appendix A of the application), provide the name and other contact information of an individual at the operating agency who should be included in CMS communications concerning the waiver.

Technical Guidance

While the first line of communication between CMS and a state regarding a waiver application is the through Medicaid agency, CMS recognizes that many waivers are developed and operated by other state agencies in collaboration with the Medicaid agency. Consequently, it is important for the Medicaid agency to also directly involve operating agency representatives in discussions concerning the waiver application.

8. Authorizing Signature

Instructions

When the web-based application is used, the application is signed electronically when the State Medicaid Director or designee submits the application using the submission feature that is reserved only for the use of the Director.

Technical Guidance

All new waiver and waiver renewal applications (as well as amendments) must be submitted to CMS by the Medicaid agency in accordance with 42 CFR § 430.25(e). Therefore, the State Medicaid Director or designee in the Medicaid agency must sign the application.

The State Medicaid Director's signature certifies that the state will abide by all the provisions of the waiver application and that the waiver will be operated to continuously meet the assurances and other requirements that are spelled out in the application.

CMS Review Criteria

The waiver application has been signed by the State Medicaid Director or designee.

Attachments (if applicable)

Attachment #1: Changes from Previous Approved Waiver That May Require a Transition Plan (if applicable)

Instructions: If applicable, check the box next to any of the following changes from the current approved waiver that you are making with this application. Check all of the boxes that apply. If you check any of the boxes, you will be prompted to complete a transition plan.

- ☐ Replacing an approved waiver with this waiver.
- ☐ Combining waivers.
- ☐ Splitting one waiver into two waivers.
- ☐ Eliminating a service.
- ☐ Adding or decreasing an individual cost limit pertaining to eligibility
- ☐ Adding or decreasing limits to a service or a set of services, as specified in Appendix C
- ☐ Reducing the unduplicated count of participants (Factor C).
- ☐ Adding new, or decreasing, a limitation on the number of participants served at any point in time.
- ☐ Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.
- ☐ Making any changes that could result in reduced services to participants.

Technical Guidance

Instructions

When applicable, submit the transition plan for the waiver as Attachment #1.

Technical Guidance

A transition plan should accompany a waiver application whenever individuals who participate in an approved waiver might be adversely affected when a new replacement waiver takes effect, or a renewal or amendment includes certain types of changes in the approved waiver. A transition plan should accompany the waiver application or amendment in the following circumstances:

- A new waiver *replaces* an approved waiver;
- The waiver renewal or amendment would eliminate or limit any of the services that are furnished under the approved waiver;
- The waiver renewal or amendment would result in some participants who are served in the approved waiver losing eligibility or necessitate the transfer of some participants to another waiver;
- The waiver renewal or amendment includes major changes that would affect the amount of services that are furnished to waiver participants under the approved waiver (e.g., the renewal or amendment includes an individual cost limit that is new/lower than the approved waiver or the renewed waiver would impose limits on the overall dollar amount of services that may be authorized in participant service plans;
- Two waivers are being combined; or
- A waiver is being split into two separate waivers.

As applicable, the transition plan should address the following topics:

- Similarities and differences between the services covered in the approved waiver and those that will be covered in the new waiver or the renewed/amended waiver;
- When some services in the approved waiver will not be available through the new or renewed/amended waiver or will be available in lesser amounts, describe how the health and welfare of persons who receive the services that are terminated will be assured;
- When the new or renewed/amended waiver includes limitations on the amount of waiver services that were not included in the approved waiver, how the limitations will be implemented;
- Whether individuals served in the approved waiver also will be eligible to participate in the new or renewed/amended waiver;
- If some persons served in the approved waiver will not be eligible to participate in the new or renewed/amended waiver, describe the steps that the state will take to facilitate the transition of affected individuals to alternate services and supports. Such alternatives may include their timely transition to another HCBS waiver for which they may qualify and assisting them to access other services (including services under the state plan) that may meet their needs;
- The timetable for transitioning individuals to the new waiver (i.e., will participants in the existing waiver transition to the new waiver at the same time or will the transition be phased in (e.g., individuals will transition when their service plan is reviewed or when their level of care is re-evaluated)?); and
- How and when participants will be notified of the changes.

CMS Review Criteria

The transition plan:

- Describes the similarities and differences between the services covered in the approved waiver and those covered in the new or renewed/amended waiver.
- When services in the approved waiver will not be offered in the new or renewed/amended waiver or will be offered in lesser amount, describes how the health and welfare of persons who receive services through the approved waiver will be assured.
- Addresses whether persons served in the existing waiver also are eligible to participate in the new waiver.
- When the new or renewed/amended waiver includes limitations on the amount of waiver services that were not included in the approved waiver, the plan describes how the limitations will be implemented.
- When persons served in the approved waiver will not be eligible to participate in the new or renewed/amended waiver, the plan describes the steps that the state will take to facilitate the transition of affected individuals to alternate services and supports that will enable the individual to remain in the community.
- Includes the timetable for transitioning individuals to the new waiver (i.e., will participants in the existing waiver transition to the new waiver all at the same time or will the transition be phased in?).
- Describes how the participant is notified of the changes and informed of the opportunity to request a Fair Hearing.

Appendix A: Waiver Administration and Operation

Brief Overview

This appendix identifies the state agency that is responsible for the day-to-day waiver administration and operation, other contracted entities that perform waiver operational functions, and, if applicable, local/regional entities that have waiver administrative responsibilities. The Appendix also provides for indicating how specific waiver operational functions and activities are distributed among state, local/regional and other entities and how the state Medicaid agency monitors performance of those functions.

Requirements: Waiver Administration and Operation

The administration and operation of waivers frequently involves the collaboration of the Medicaid agency and other state agencies. In addition, the operation of waivers is often decentralized, and local agencies play important roles in facilitating the access of individuals to the waiver, including performing waiver operational functions. CMS recognizes that it may be efficient and effective for a state to locate the operation of a waiver with an agency other than the Medicaid agency and link the delivery of waiver services to other federal, state and local programs. Appendix A describes the administrative structure under which the waiver is operated. When waiver administrative and operational functions are performed by other entities on behalf of the Medicaid agency, certain requirements must be met.

In accordance with 42 CFR § 431.10, the Medicaid agency is responsible for ensuring that a waiver is operated in accordance with applicable federal regulations and the provisions of the waiver itself. The Medicaid agency may not delegate its authority over a waiver to another entity. When the Medicaid agency delegates to another agency, provided that the other state agency and the Medicaid agency enter into an agreement that specifies the waiver administrative and operational activities and functions that the other agency performs as delegated and under the supervision of the Medicaid agency. In the application, when a waiver is operated by another state agency, the sister agency is referred to as the "operating agency."

The state Medicaid agency may be an umbrella agency with numerous divisions, units or administrations within its domain. When a division, unit or administration within the umbrella state Medicaid agency conducts waiver administrative activities, the state must describe the methods enlisted by the State Medicaid Director to provide oversight and guidance related to those activities. These mechanisms may include performance plans of direct reports, internal delegation documents or other formal mechanisms that impart delegated functions from the State Medicaid Director to a division within the broader Medicaid agency.

The requirement that the Medicaid agency maintain its authority over the waiver means that any rules, regulations and policies that govern how the waiver is operated should be issued by the Medicaid agency rather than by the operating agency. In issuing rules, regulations and policies that affect the waiver, the Medicaid agency may incorporate by reference rules, regulations and policies that have been adopted by the operating agency (or another state agency – e.g., rules and regulations concerning provider qualifications). In short, the operating agency may not independently promulgate rules, regulations and policies that have a material effect on the provision of waiver services and how waiver processes are conducted. Policies and other types of guidance concerning waiver operations may be issued jointly by the Medicaid agency and the operating agency. Alternatively, the Medicaid agency may formally approve policies and guidance developed and issued by the operating agency.

A state also may arrange for the performance of some of the waiver operational and administrative functions by contracted entities. For example, the Medicaid agency or the operating agency (if applicable) may enter into a contract with a private entity to conduct quality improvement functions (e.g., conduct periodic surveys of waiver participants) that are necessary for the proper and efficient administration of the waiver. Such contractual arrangements are subject to the provisions of 42 CFR Part 434 (contracts) or such other federal regulations as may apply.

Finally, a state also may provide that local/regional non-state entities perform waiver operational and administrative functions in order to link the provision of waiver services with other federal, state and local programs that are operated by such entities. Such entities may include public county human services agencies or other types of local human services agencies (e.g., Area Agencies on Aging – AAAs). For example, a state may provide that entrance to a waiver that serves older persons takes place through the state's AAA network in order to link the provision of waiver services to Older Americans Act programs and services. When local/regional non-state entities perform waiver operational and administrative function, there must be contracts or agreements in place that authorize the performance of such functions by local/regional non-state entities, and the state must monitor performance of those functions.

CMS regulations at 42 CFR § 431.10(e) specifies that the Medicaid agency must retain the authority to exercise administrative discretion and issue policies, rules and regulations. If other

state or local agencies or contractors perform waiver administrative and operational functions for the Medicaid agency, such entities must not have the authority to change or disapprove any administrative decision of the Medicaid agency or otherwise substitute their judgment for that of the Medicaid agency with respect to the application of policies, rules, and regulations issued by the Medicaid agency. Provider agreements must be executed between the Medicaid agency and the providers. Note: Medicaid waiver eligibility determinations can only be performed by the State Medicaid Agency (SMA) or a government agency delegated by the SMA in accordance with 42 CFR § 431.10. Thus, eligibility determinations for the group described in 42 CFR § 435.217 (which includes a level-of-care assessment, because meeting a 1915(c) level of care is a factor of determining Medicaid eligibility for the group) must comply with 42 CFR § 431.10. Non-governmental entities can support administrative functions of the eligibility determination process that do not require discretion including, for example, data entry functions, IT support, and implementation of a standardized level-of-care assessment tool. States should ensure that any use of an assessment tool by a non-governmental entity to evaluate/determine an individual's required level-of-care involves no discretion by the non-governmental entity and that the development of the requirements, rules, and policies operationalized by the tool are overseen by the state agency.

With respect to HCBS waivers, a state must provide for the consistent, uniform administration and operation of the waiver across all geographic areas where the waiver is in operation. For example, when local/regional non-state agencies perform waiver administrative and operational functions, the state must ensure that consistent decisions are made about the authorization of waiver services wherever a waiver participant may reside. As previously noted in the instructions for the Application/Module 1, if the state wishes to provide different services or utilize different approaches to service delivery in different parts of the state, the state should consider applying to operate separate waivers in each area of the state. Absent a waiver of statewideness, it is expected that the waiver will be administered and operated in a consistent fashion in all parts of the state and, thereby, ensure that waiver services are provided on a comparable basis to the entire target group of waiver participants in compliance with 42 CFR § 440.240(b) (comparability of services for groups).

When waiver administrative and operational functions are performed by other entities on behalf of the Medicaid agency, the Medicaid agency should have a formal, written document expressly delegating the functions to be performed, and the Medicaid agency must supervise the performance of these functions. Supervision does not mean that the Medicaid agency must review and approve each and every action taken by another entity. It is expected that the Medicaid agency will conduct or arrange for the periodic assessment of the performance of other entities in conducting waiver administrative and operational activities to ensure that the waiver is operated in accordance with the approved waiver and applicable federal requirements. In its quality improvement strategy for the waiver, the state describes how it will assure that the "Medicaid agency retains ultimate authority and responsibility for the operation of the waiver by exercising oversight over the performance of waiver functions by other state and local agencies (if applicable) and contracted entities."

Detailed Instructions for Completing Appendix A

Item A-1: State Line of Authority for Waiver Operation

Instructions

Select whether the waiver is operated by the Medicaid agency or by another state agency. When the waiver is operated by the Medicaid agency, specify whether it is operated by the Medical Assistance Unit or another division/unit within the Medicaid agency. When the waiver is operated by another state agency, specify the state agency and complete Item A-2.

Technical Guidance

This item identifies the state agency that has day-by-day administrative and operational responsibility for the waiver. The waiver may be operated by the Medicaid agency or another state agency under an agreement with the Medicaid agency. The Medicaid agency is the single state agency designated in accordance with 42 CFR § 431.10(b)(1) to administer or supervise the state plan. The medical assistance unit is the unit within the Medicaid agency that is established pursuant to 42 CFR § 431.11(b) and in some states is synonymous with the Medicaid agency. In some states, the Medicaid agency is a state department/agency rather than a division/unit within a state department/agency. When this is the case, the state Medicaid agency may delegate the operation of the waiver to another division/unit within the umbrella Medicaid agency or assign this responsibility to its Medical Assistance Unit. When a division/unit other than the Medical Assistance Unit is responsible for operating the waiver, the waiver is considered to be operated by the Medicaid Agency.

In responding to this item, specify whether the waiver is operated by the Medical Assistance Unit or another Medicaid agency division/unit. The state Medicaid agency may be an umbrella agency with numerous divisions, units or administrations within its domain. When a division, unit or administration within the umbrella state Medicaid agency conducts waiver administrative activities, the state must describe the methods enlisted by the State Medicaid Director to provide oversight and guidance related to those activities. These mechanisms for oversight may include performance plans of direct reports, internal delegation documents or other formal mechanisms that impart delegated functions from the State Medicaid Director to a division within the broader Medicaid agency. If the waiver is operated by a division, unit, or administration within the Medicaid agency that differs from the Medical Assistance Unit, complete Item A-2-a.

Alternatively, a waiver may be operated by another state agency that is not the Medicaid agency. This practice is relatively common. States frequently locate waiver operational responsibility with a state agency that has programmatic and other responsibilities for the full range of services (including services funded by state and/or federal funds other than Medicaid) that are furnished to a target population (e.g., older persons). The other state agency may be located in the same department as the Medicaid agency but is not organizationally a part of the Medicaid agency or located in a different state department.

When the waiver is not operated by a division/unit of the Medicaid agency, in accordance with 42 CFR § 431.10(d), there must be a formal, written agreement between the Medicaid agency and the operating agency that explicitly spells out the waiver activities and functions that the operating agency performs on behalf of the Medicaid agency. This agreement may take the form of an interagency agreement or a memorandum of understanding. Do not submit the agreement as part of the waiver application. If CMS needs to examine the agreement, it will request a copy from the Medicaid agency.

There are no established specifications for these agreements. An agreement, however, must be sufficiently detailed so that it clearly delineates those activities, functions and responsibilities that the Medicaid agency delegates to the operating agency and the responsibilities of the operating agency in carrying out those functions. The agreement need not be confined solely to the operation of the waiver (e.g., it may address additional topics as well) and an agreement may span the operation of more than one waiver so long as operating agency responsibilities for each waiver are clearly delineated. However, the agreement may not undermine the ultimate authority and responsibility of the Medicaid agency for the operation of the waiver, including meeting the waiver assurances. The agreement also may serve as the basis for claiming administrative FFP for the proper and necessary costs that are incurred by the operating agency in administering the waiver. Medicaid administrative claiming, necessary for the efficient administration of the Medicaid state plan, must be in accordance with the state's CMS-approved Medicaid cost allocation plan. Please note that approval of this waiver application does not constitute approval of the state's Medicaid cost allocation plan.

Item A-2: Medicaid Agency Oversight of Waiver Administration

Item A-2-a: Operation by a Division/Unit within the SMA other than the Medical Assistance Unit.

Instructions

This item is only completed when a division/unit (or administration) within the umbrella state Medicaid agency, other than the Medical Assistance Unit operates the waver. In the text field, specify the methods employed by the State Medicaid Director (in some instances, the individual is also the head of the umbrella state agency) to provide oversight and guidance related to those activities. These mechanisms for oversight may include performance plans of direct reports, internal delegation documents or other formal mechanisms that impart delegated functions from the State Medicaid Director to a division within the broader Medicaid agency.

When the waiver is operated by another division/unit/administration within the umbrella Agency designated as the single state Medicaid agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the single state Medicaid agency), (b) the name and most recent execution date of the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director in the oversight of these activities.

Technical Guidance

As noted above, when the waiver is operated by a division/unit/administration of the Medicaid agency that is outside of the Medical Assistance Unit or the division responsible for Medicaid administration, the state must ensure that this division is performing its assigned waiver operational tasks and administrative functions in accordance with waiver requirements. States (and State Medicaid Directors) have discretion to establish these mechanisms, which will vary depending on the umbrella state Medicaid agency (SMA) structure and internal reporting systems. When the waiver is administered by an entity within the SMA other than the Medical Assistance Unit, it is considered for the purpose of this application to be operated by the SMA. However, there should be a clear line of reporting between the Medical Assistance Unit and the operating entity within the SMA, and the Medical Assistance Unit must oversee the operations of the entity in administering the waiver to ensure compliance with federal requirements.

Item A-2-b: Operation by a non-SMA State Entity

Instructions

This item is only completed when a state entity that is NOT the state Medicaid agency operates the waiver. In the text field, specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also, specify the frequency of Medicaid agency assessment of operating agency performance.

Technical Guidance

As noted above, when a waiver is not operated by the Medicaid agency, the Medicaid agency must ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. States have discretion in determining Medicaid agency oversight methods. The methods employed will hinge on the specific scope and nature of the functions and activities that the operating agency performs. These will include the functions and activities indicated in Item A-3 (see next section) and others specified elsewhere in the application. It is important to keep in mind that Medicaid agency oversight need not take the form of the Medicaid agency reviewing and approving each operating agency action (e.g., reviewing all the service plans that the operating agency already has reviewed) or the redundant performance of functions and activities that are carried out by the operating agency (e.g., replicating look-behind type reviews of case manager performance when the operating agency already conducts such reviews). Medicaid agency oversight may be exercised in a variety of ways, including providing that the operating agency track and periodically report to the Medicaid agency its performance in conducting operational functions (e.g., reporting how promptly service plans are developed and implemented once a participant has entered the waiver).

It is important to emphasize that the state Medicaid agency and the operating agency should work together to ensure that the waiver is operated in accordance with Medicaid rules, and that the services delivered are appropriate for the populations served. The knowledge of Medicaid requirements and the requisite program knowledge often contained within the operating agency represent the need for a strong collaborative relationship in the operation of the waiver. The Medicaid agency retains ultimate authority and control over the waiver, but in order to effectuate a strong, Medicaid compliant service delivery mechanism, the state should establish clear and strong lines of communication between the operating agency and the state Medicaid agency.

As noted previously, the state's quality improvement strategy describes how the state assures that the Medicaid agency maintains its authority over the waiver. Oversight of operating agency performance is an element of this assurance. As applicable, the oversight methods described here are to be cited in the QIS section related to the Administrative Authority of the state Medicaid agency.

When the waiver is not operated by the Medicaid agency, the state must specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written documents that and should indicate the frequency of review and update for the document. Please note the MOU or agreement must be in place prior to the implementation of the waiver. In addition, The MOU or agreement must reflect roles and responsibilities of the waiver as it is currently being operated.

CMS Review Criteria

- The Medicaid agency's oversight methods span the full range of operational and administrative responsibilities of the division/unit/administration within the Medicaid agency and the operating agency including its oversight of contracted and local/regional entities' functions as specified in Item A-3 and elsewhere in the application.
- The frequency of oversight is specified.

Waiver Operational and Administrative Functions

Items A-3 and A-4 address whether contracted entities and/or local/regional non-state entities perform waiver operational and administrative functions. Item A-7 lists specific functions that such entities might perform. The response to Items A-3 and A-4 hinges on whether contracted entities or local/regional non-state entities perform one or more of the functions listed in Item A-7. Please note that the Financial Management Service (FMS) may be provided as a Medicaid administrative activity or as a waiver service. When provided as an administrative activity, FMS serves as an example of an entity that could perform a function listed in A-3.

The list in Item A-7 is not inclusive of all waiver operational and administrative functions. The list generally does not include functions that are addressed elsewhere in the application (e.g., the performance of case management activities such as monitoring service plan implementation (addressed in Appendix D-2).

The operational and administrative functions listed in Item A-7 are defined as follows:

- **Participant waiver enrollment**. This function includes performing waiver intake activities, including taking applications to enter the waiver and referring, when necessary, individuals for the determination of Medicaid eligibility and/or disability.
- **Waiver enrollment managed against approved limits**. This function includes ensuring that the waiver's participant limit (as provided in Appendix B-3) is not exceeded and managing entrance to the waiver by applying the state's policies concerning the selection of individuals to enter the waiver (as also provided in Appendix B-3). The function also might include establishing and maintaining a waiting list for entrance to waiver, if necessary. When waiver capacity is allocated by locality or region, local/regional non-state agencies may also be involved in managing enrollment.
- **Waiver expenditures managed against approved levels**. This function includes monitoring waiver expenditures to assure that the waiver is cost neutral and operates within the estimates in the approved waiver (and, as necessary, preparing waiver amendments to modify cost estimates). Usually, this function is performed by a state agency.
- **Level of care evaluation**. Such activities may include compiling the information that is necessary to evaluate potential entrants to the waiver and the continuing need for the level of care that the waiver provides for waiver participants. It may also include the review of such information by the state or a contracted entity in order to determine that an individual meets level of care criteria. Note: If the LOC evaluation results in Title XIX eligibility, the final decision must be a Medicaid agency decision since only the Medicaid Agency can make an eligibility decision. Medicaid eligibility determinations can only be performed by the State Medicaid Agency (SMA) or a government agency delegated by the SMA in accordance with 42 CFR § 431.10. Thus, eligibility determinations for the group described in 42 CFR § 435.217 (which includes a level-of-care assessment,

because meeting a 1915(c) level of care is a factor of determining Medicaid eligibility for the group) must comply with 42 CFR § 431.10. Non-governmental entities can support administrative functions of the eligibility determination process that do not require discretion including, for example, data entry functions, IT support, and implementation of a standardized level-of-care assessment tool. States should ensure that any use of an assessment tool by a non-governmental entity to evaluate/determine an individual's required level-of-care involves no discretion by the non-governmental entity and that the development of the requirements, rules, and policies operationalized by the tool are overseen by the state agency.

- **Review of participant service plans**. This activity may include local/regional entity review of service plans or, if required by the state, the review and approval of service plans by the Medicaid agency or the operating agency (if applicable). The focus is on activities that take place once a service plan has been developed but prior to its implementation. The function does not include the retrospective review of service plans that might be conducted by the Medicaid agency in order to (a) meet the requirement that service plans are subject to the approval of the Medicaid agency (as provided in Appendix D-1) or (b) determine retrospectively whether service plans appropriately address the needs of waiver participants, a quality improvement activity that is addressed in the state's QIS.
- **Prior authorization of waiver services**. This function refers to the review of the necessity of specific waiver services before they are authorized or delivered. It does not refer to review of the overall service plan. For example, a waiver might provide for the provision of crisis stabilization services under certain circumstances but require that the provision of such services be reviewed prior to their authorization. Alternatively, a waiver might provide that additional services may be authorized over and above the limit on the dollar amount established in Appendix C-4 of the waiver but require prior authorization for such services.
- **Utilization management.** Utilization management includes processes to ensure that waiver services have been authorized in conformance to waiver requirements and monitoring service utilization to ensure that the amount of services is within the levels authorized in the service plan or that services utilized have been authorized in the service plan. It also may include identifying instances when individuals are not receiving services authorized in the service plan or the amount of services utilized is substantially less than the amount authorized to identify potential problems in service access.
- **Qualified Provider enrollment**. Qualified provider enrollment refers to the performance of standard provider enrollment processes conducted by the state Medicaid Agency, as well as any delegated functions related to the recruitment and enrollment of providers.
- **Execution of Medicaid provider agreements.** Section 1902(a)(27) of the Act and 42 CFR § 107 require that there be an agreement between the Medicaid agency and each provider that furnishes services under the waiver. In some instances (e.g., when a state contracts with an Organized Health Care Delivery System (OHCDS) to furnish waiver services), the provider agreement is executed with an organization that contracts with other providers to furnish waiver services, but these providers do not have an agreement with the Medicaid agency. Except in these cases (which are discussed where applicable elsewhere in the instructions), there must be a provider agreement between the Medicaid agency and each waiver provider. Such agreements may be multi-party agreements (e.g.,

the agreement may be made by the Medicaid agency, the operating agency and the provider).

The Medicaid agency may assign to another entity (e.g., the operating agency, a county agency, or a financial management services entity that supports waiver participants to direct their own services) the responsibility to execute (sign) the provider agreement on behalf of the Medicaid agency. ***If the Medicaid agency chooses to assign this administrative function to another entity, the Medicaid agency must assign this responsibility in writing to the entity.*** For example, if counties are authorized to execute the state's provider agreement on behalf of the Medicaid agency, the authorization may be included in the agreement between a county and the Medicaid agency to perform waiver operational and administrative functions. *However, the Medicaid agency cannot delegate its statutory responsibilities for oversight and standard setting. In carrying out this administrative responsibility, the entity that executes the provider agreement may not alter or supplement the provisions of the agreement. If the entity to which this administrative function is assigned also provides waiver services to participants, it must execute a provider agreement directly with the Medicaid agency – not itself – for services that the entity provides.*

- **Establishment of Statewide Rate Methodology.** In accordance with section 1902(a)(30)(A) of the Act, a state must have uniform and consistently applied policies concerning the determination of waiver payment amounts or rates. This topic is addressed in more detail in the instructions for Appendix I-2. When this function is performed by entities other than the Medicaid agency, the entity must follow the state's uniform policies.
- **Rules, policies procedures and information development governing the waiver program.** This function includes the development of any rules, policies and procedures that govern administration of the waiver. While other entities may be involved in the development of these items, the state Medicaid agency must retain ultimate approval authority and they must be consistent in all jurisdictions in which the waiver operates. This function may also include making information about the waiver available via the Internet, performing outreach through such organizations as AAAs and consumer support groups, identifying potential enrollees through the operation of a single-point-of-entry or "no wrong door" service access point, and providing individuals with information about the waiver.
- **Quality assurance and quality improvement activities.** This function refers to the activities related to discovery and remediation activities conducted for the waiver, as well as the mechanisms for overall systems improvement.

Item A-3: Use of Contracted Entities

Instructions

Based on the listing of waiver operational and administrative functions in Item A-7 (as described above), indicate whether contracted entities perform one or more of those activities. If so, identify (in the text field) the types of contracted entities and briefly describe the functions that they perform. Also, complete Items A-5 and A-6. When contracted entities do not perform any of the functions listed in Item A-7, select the second choice.

Technical Guidance

Some waiver operational activities and functions may be performed by entities that are under contract with the Medicaid agency or the operating agency (if applicable). For the purpose of this item, contracted entities are third parties that perform functions that are otherwise usually conducted by the state agency. In the context of this item, contracted entities do not include waiver providers or local/regional non-state entities (e.g., counties). In the case of the latter, their role in waiver operations is addressed in items A-4 through A-6 and in item A-7. For example, the evaluation of level of care can be conducted by a professional review organization (PRO) under contract to the Medicaid agency. Note: Medicaid eligibility determinations can only be performed by the State Medicaid Agency (SMA) or a government agency delegated by the SMA in accordance with 42 CFR § 431.10. Thus, eligibility determinations for the group described in 42 CFR § 435.217 (which includes a level-of-care assessment, because meeting a 1915(c) level of care is a factor of determining Medicaid eligibility for the group) must comply with 42 CFR § 431.10. Non-governmental entities can support administrative functions of the eligibility determination process that do not require discretion including, for example, data entry functions, IT support, and implementation of a standardized level-of-care assessment tool. States should ensure that any use of an assessment tool by a non-governmental entity to evaluate/determine an individual's required level-of-care involves no discretion by the non-governmental entity and that the development of the requirements, rules, and policies operationalized by the tool are overseen by the state agency.

Other examples of administrative activities and functions that might be performed by a contracted entity include utilization management, prior authorization of selected services, and the determination of provider rates using the methodology developed by the Medicaid agency. As applicable, contracted entities may include entities that furnish financial management services under an administrative contract to waiver participants who direct their services. When using contracted entities to perform waiver operational activities, the state Medicaid agency should expressly delegate the performance of these activities in writing and oversee the performance of these functions.

Since multiple contractors might perform waiver operational and administrative functions, describe the types of contracted entities that perform these functions (e.g., a PRO, the state's Medicaid fiscal agent, a consumer organization). Do not identify by name the specific entity that performs a function (because if a different contractor is selected to perform a function during the period that the waiver is in effect, an amendment would have to be submitted to modify this item). Also, because multiple contractors might be employed, briefly describe the functions that each type of contractor performs.

Section 1915(c) Waivers that Operate with Concurrent Managed Care

When a section 1915(c) waiver is operated concurrently with a Medicaid managed care authority, managed care entities may perform several waiver operational and administrative functions in conjunction with their delivery of services to beneficiaries. For example, such entities determine payment amounts for providers in their networks and usually have responsibilities concerning enrollment of individuals. For the purpose of the section 1915(c) waiver application, managed care entities that perform the waiver operational and administrative functions listed in Item A-7 are considered to be "contracted entities." Therefore, identify when managed care entities perform these functions and briefly list the functions that these entities perform. Specify the types of entities (e.g., PIHP). Do not list the entities (the specific entities

must be identified in the Medicaid managed care authority application). As appropriate, include entities other than managed care entities that may perform section 1915(c) operational and administrative functions under the provisions of the managed care authority (e.g., an external quality review organization – EQRO). Note: Medicaid eligibility determinations can only be performed by the State Medicaid Agency (SMA) or a government agency delegated by the SMA in accordance with 42 CFR § 431.10. Thus, eligibility determinations for the group described in 42 CFR § 435.217 (which includes a level-of-care assessment, because meeting a 1915(c) level of care is a factor of determining Medicaid eligibility for the group) must comply with 42 CFR § 431.10. Non-governmental entities can support administrative functions of the eligibility determination process that do not require discretion including, for example, data entry functions, IT support, and implementation of a standardized level-of-care assessment tool. States should ensure that any use of an assessment tool by a non-governmental entity to evaluate/determine an individual's required level-of-care involves no discretion by the non-governmental entity and that the development of the requirements, rules, and policies operationalized by the tool are overseen by the state agency.

CMS Review Criteria

When waiver operational and administrative activities are performed by contracted entities, the waiver specifies the types of entities that perform such activities and describes the types of activities that are performed by each type of entity.

Item A-4: Role of Local/Regional Non-State Entities

Instructions

Select whether public and/or non-governmental local/regional non-state entities perform waiver operational and administrative functions. If so, specify the nature of these entities. When such entities perform such functions, complete Items A-5 and A-6.

Technical Guidance

In many states, local/regional non-state entities (e.g., Area Agencies on Aging, county human services agencies, regional mental health/developmental disabilities authorities) play important roles in the provision of services and supports for individuals who need long-term services and supports. These entities often are established under the provisions of state law and have responsibilities for intake, service coordination and resource development. Some states also assign some of the waiver operational and administrative responsibilities to these non-state entities. For the purpose of this item, local/regional non-state entities do not include local/regional offices of the Medicaid agency or the operating agency (if applicable). Such offices are considered to be part of their parent state agency.

Before responding to this item, look over the list of activities and functions in item A-7. If local/regional non-state entities do not perform any of those activities/functions, select the "not applicable" choice and proceed to item A-7. If local/regional non-state entities perform any of the listed functions, then complete this item and proceed to items A-5 and A-6. Note: Medicaid eligibility determinations can only be performed by the State Medicaid Agency (SMA) or a government agency delegated by the SMA in accordance with 42 CFR § 431.10. Thus, eligibility determinations for the group described in 42 CFR § 435.217 (which includes a level-of-care

assessment, because meeting a 1915(c) level of care is a factor of determining Medicaid eligibility for the group) must comply with 42 CFR § 431.10. Non-governmental entities can support administrative functions of the eligibility determination process that do not require discretion including, for example, data entry functions, IT support, and implementation of a standardized level-of-care assessment tool. States should ensure that any use of an assessment tool by a non-governmental entity to evaluate/determine an individual's required level-of-care involves no discretion by the non-governmental entity and that the development of the requirements, rules, and policies operationalized by the tool are overseen by the state agency.

The application identifies two types of local/regional non-state entities:

- **Public agencies**. Public agencies include counties or other governmental entities that are under the control of local elected officials. When public agencies are assigned waiver administrative and operational responsibilities, there must be an interagency agreement, memorandum of understanding or contract in effect that details their responsibilities. The agreement may be between the Medicaid agency and each entity or may be a three-way agreement among the Medicaid agency, the operating agency and each entity. The agreement must preserve the authority of the Medicaid agency over the operation of the waiver.
- **Non-governmental entities**. The second type of local non-state entity is a non-governmental entity. Such entities include non-profit entities established under state and/or federal law to conduct specified human services functions in a specified geographic area. Area Agencies on Aging usually fall under this classification. In some states, there are non-profit, county or multi-county developmental disabilities authorities that serve as the single point of entry for state-funded services and conduct other specified activities. Other states have established non-governmental regional authorities that include elected officials on their governing bodies but are not considered to be governmental entities. When entities of this type perform waiver operational and administrative functions, there must be a *contract* that details the waiver operational functions that these entities perform. When the waiver is not operated by the Medicaid agency, this contract may be structured as a three-party agreement (e.g., the signatories to the contract are the non-governmental entity, the Medicaid agency, and the operating agency).

When waiver operational responsibilities are carried out by these types of entities, select the appropriate response for the type of entity and provide a brief description of the nature of these entities (e.g., "non-profit developmental disabilities authorities that serve one or more counties that are established under the provisions of the following state statutes _____"). This item permits the selection of both types of entities if appropriate (e.g., waiver operational functions and activities are carried out by both public and non-governmental agencies).

When using these types of entities to perform waiver operational activities, the state Medicaid agency should expressly delegate the performance of these activities in writing. Do not include copies of contracts or agreements with local non-state entities when submitting the application. However, such contracts or agreements must be readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Item A-5: Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities

Instructions

This item is only completed when contracted entities (as indicated in Item A-3) and/or local/regional non-state entities (as indicated in Item A-4) perform waiver operational and administrative functions. In the text field, specify the state agency or agencies responsible for assessing the performance of local/regional non-state entities in conducting waiver operational and administrative functions. When more than one state agency is responsible for assessing performance, briefly describe the responsibilities of each agency.

Technical Guidance

When contracted entities and/or local/regional non-state entities perform waiver operational and administrative functions, the performance of such entities must be overseen and assessed by a state agency. Assessment may be performed directly by the Medicaid agency and/or the operating agency (if applicable). If the operating agency assesses the performance of these entities, this responsibility should be reflected in the interagency agreement between the Medicaid agency and the operating agency.

Item A-6: Assessment Methods and Frequency

Instructions

Again, this item is only completed when contracted entities and/or local/regional non-state entities perform waiver operational and administrative functions, as indicated in Items A-3 and/or A-4. In the text field, describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how often performance is assessed.

Technical Guidance

When waiver operational and administrative functions are conducted by contracted entities and/or local/regional non-state entities, there must be oversight of the performance of such entities to ensure that waiver requirements are met. The type and scope of the oversight and performance assessment will hinge on the nature of the functions that are performed by the local/regional non-state entities. Potential methods may include conducting on-site operational reviews or performance audits, periodic review of performance data, participant satisfaction surveys, focus groups, or other methods. Also, specify the frequency with which oversight/performance assessment is conducted. When oversight is performed by the operating agency, there must be procedures for the operating agency to report performance assessment results to the Medicaid agency and the performance of the operating agency in conducting such assessments must be subject to oversight by the Medicaid agency.

In the case of section 1915(c) waivers that operate concurrently with a Medicaid managed care authority, the description of oversight methods may include cross-references to appropriate sections of the Medicaid managed care authority application that address oversight of the performance of managed care entities.

The quality improvement strategy needs to describe how the state assures that the Medicaid agency maintains its authority over the waiver. Oversight of the performance of contracted

and/or local/regional non-state entities is an element of this assurance. As applicable, the oversight methods described here may be cited in the quality improvement strategy rather than repeated.

CMS Review Criteria

When local/regional non-state entities perform waiver operational and administrative functions, the waiver describes:

- The methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements.
- Oversight methods encompass each function that is performed by contracted entities or local/regional non-state entities as specified in Item A-7.
- The frequency with which such assessments are conducted.
- If assessments are performed by the operating agency, the conduct of such assessment is subject to review by the Medicaid agency to ensure that the operating agency is exercising its responsibilities and there are procedures that provide for the reporting of assessment results to the Medicaid agency.

Item A-7: Distribution of Waiver Operational and Administrative Functions

Instructions

In the table, check the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions that are listed. Ensure that Medicaid is checked when the single state Medicaid agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function. Note: More than one box may be checked per item. Note: Medicaid eligibility determinations can only be performed by the State Medicaid Agency (SMA) or a government agency delegated by the SMA in accordance with 42 CFR § 431.10. Thus, eligibility determinations for the group described in 42 CFR § 435.217 (which includes a level-of-care assessment, because meeting a 1915(c) level of care is a factor of determining Medicaid eligibility for the group) must comply with 42 CFR § 431.10. Non-governmental entities can support administrative functions of the eligibility determination process that do not require discretion including, for example, data entry functions, IT support, and implementation of a standardized level-of-care assessment tool. States should ensure that any use of an assessment tool by a non-governmental entity to evaluate/determine an individual's required level-of-care involves no discretion by the non-governmental entity and that the development of the requirements, rules, and policies operationalized by the tool are overseen by the state agency.

Technical Guidance

This table provides CMS with an overview of the distribution of responsibilities for conducting selected waiver operational and administrative functions (as described above) among the entities that have waiver operational and administrative roles. The columns in the table include the four types of entities that may be involved in the operation of a waiver – the Medicaid agency, an operating agency, contracted entities, and local/regional non-state authorities.

For each of the functions listed, indicate the entity or entities that have significant responsibilities in performing or supervising a function. More than one type of entity may be involved in performing a function.

CMS Review Criteria

- The entity or entities that have significant responsibilities in directly performing each of the functions are indicated.
- The SMA is checked when it (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves polices related to the function.

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

Pursuant to 42 CFR § 431.10, the Medicaid agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

Instructions

The QIS describes how the state Medicaid Agency retains ultimate authority for the operation of the waiver program. CMS expects the description to include:

- Activities or processes that are related to *discovery and remediation*, i.e., review, assessment or monitoring processes; who conducts the discovery or remediation activities and with what frequency, along with the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. These monitoring activities provide the foundation for quality improvement by generating information regarding compliance, potential problems and individual corrective actions. The information can be aggregated and analyzed to measure the overall system performance in meeting the waiver assurances. The types of information used to measure performance, should include relevant quality measures/indicators.
- The entity or entities responsible for reviewing the results (data and information) of discovery and remediation activities to determine whether the performance of the system reflects compliance with the assurances; and
- The frequency at which system performance is measured.

Technical Guidance

Performance measures for administrative authority should not be duplicative measures found in other appendices of the waiver application. As necessary and applicable, performance measures should focus on:

- Uniformity of development /execution of provider agreements throughout out all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCBS settings requirements and other new regulatory components

This QIS element focuses on *discovery* and *remediation* activities that is, processes to assess, review, evaluate or otherwise analyze a program, process, operation, or outcome. Specifically,

the evidence produced as a result of discovery and remediation activities should provide a clear picture of the state's compliance in meeting an assurance.

CMS Review Criteria

- The discovery of compliance with this assurance and the remediation of identified problems must address:
  - How the Medicaid agency exercises oversight over the performance of delegated waiver functions by other entities;
  - How frequently oversight is conducted; and
  - The entity (or entities) responsible for the discovery and remediation activities.

Appendix B: Participant Access and Eligibility

Brief Overview

This Appendix specifies the target group(s) of Medicaid beneficiaries that the waiver serves, its scope (i.e., how many persons the waiver serves), and processes associated with entry into the waiver. A state has considerable flexibility in selecting the groups that the waiver serves. When completing this appendix, it is useful to keep in mind that in order for an individual to participate in the waiver, pursuant to 42 CFR § 441.301(b**)** the person must:

- Meet an institutional-equivalent level of care specified for the waiver (in Item 1-F of the Application
  (Module 1));
- Be in the waiver target group specified by the state;
- Be in a state plan Medicaid eligibility group that is included in the waiver; and,
- Choose to receive waiver rather than institutional services under the state plan.

Provided that the state has the capacity to enroll additional participants and the foregoing conditions are met, FFP is available for the waiver services furnished to a person once a service plan has been prepared for the waiver entrant in accordance with 42 CFR § 441.301 (b)(1)(i). No FFP is available for waiver services prior to the date that the service plan is completed. FFP for activities related to the entrance of a person to the waiver that are conducted prior to this date may be eligible for administrative FFP or, if applicable, under a state's coverage of targeted case management services under the state plan.

This Appendix has the following elements:

- The target group(s) served in the waiver (Appendix B-1);
- How entry to the waiver is affected by the expected cost of home and community-based services when compared to the cost of institutional services (termed the "individual cost limit") (Appendix B-2);
- How many individuals will be served each year during the period that the waiver is in effect and how that number is managed (Appendix B-3);

- The Medicaid eligibility groups that may participate in the waiver (Appendix B-4);
- When applicable, the post-eligibility treatment of income policies that apply to individuals who secure Medicaid eligibility by virtue of their participation in the waiver (Appendix B-5);
- How the level of care of individuals is evaluated (Appendix B-6);
- How individuals are afforded the freedom of choice between waiver and institutional services (Appendix B-7); and
- How meaningful access to the waiver is provided to Limited English Proficient (LEP) individuals (Appendix B-8).

Appendix B-1: Specification of the Waiver Target Group(s)

Overview

"Target group" refers to the specific group or groups of individuals who meet an institutional level of care (in Item 1-F of the Application module) which a state determines that it wants to serve in the waiver. A state may provide waiver services to any individual who requires a level of care specified for the waiver or it may instead elect to offer services only to specific subgroups of individuals who meet the level of care requirement (e.g., only children with developmental disabilities who require the ICF/IID level of care).

This Appendix provides for the selection of one or more (at the state's option) of the three broad target groups that may be served in a waiver and specific subgroups within each of the three groups. It also provides for specifying the age range of the individuals who are served in the waiver. Waiver target groups also may be specified in greater detail. When a participant reaches the maximum age specified for a target group, the appendix also provides for describing the transition planning procedures that are followed.

In accordance with final rule CMS 2249-F, states have the option to include multiple target groups within one waiver. This regulatory change will enable states to design programs to meet the needs of Medicaid-eligible individuals and potentially achieve administrative efficiencies. For example, a growing number of Medicaid-eligible individuals with intellectual disabilities reside with aging caregivers who are also eligible for Medicaid. The change will enable the state to design a coordinated section 1915(c) waiver structure that meets the needs of the entire family that, in this example, includes both an aging parent and a person with intellectual disabilities. In this illustration, the family currently would be served in two different waivers, but with the proposed change, both could now be served under the same waiver program.

The revisions to §441.301(b)(6) allow states, but not require them, to combine target groups. Under this rule, states must still determine that without the waiver, participants will require institutional level of care, in accordance with section 1915(c) of the Act. The regulation does not affect the cost neutrality requirement for section 1915(c) waivers, which requires the state to assure that the average per capita expenditure under the waiver for each waiver year not exceed 100 percent of the average per capita expenditures that will have been made during the same year for the level of care provided in a hospital, nursing facility, or ICF/IID under the state plan had the waiver not been granted.

The state must assure CMS that the waiver meets the needs of each individual regardless of target group and that individuals have equal access to all needed services. This means that there may not be different benefit packages for each target group.

Detailed Instructions for Completing Appendix B-1

Item B-1-a: Target Group(s)

Instructions

Select one or more of the three principal target groups. For the target group(s) selected, select one or more of the subgroups listed. For each subgroup that is selected, specify the minimum age at which individuals are considered for enrollment to the waiver (if a child may be enrolled at birth, the minimum age is "0"). If there is a maximum age that applies to entrance to the waiver, specify the maximum age. For example, if individuals are considered for enrollment up to age 22, the maximum age that would be indicated in the table is "21" (through age 21). If there is no maximum age that applies to enrollment, check the final column instead of specifying a maximum age.

Technical Guidance

CMS regulation at 42 CFR § 441.301(b)(6) requires that a waiver be limited to one or more of the following target groups or any subgroup thereof:

- Aged or disabled, or both;
- Individuals with Intellectual Disabilities or a developmental disability, or both;
- Persons with mental illnesses.

CMS regulation at 42 CFR § 441.301(b)(1) requires that HCBS be provided only to recipients who would otherwise require services at the level of care in a Medicaid certified hospital, nursing facility, or ICF/IID.

Individuals who are in the waiver target group and would otherwise require the Medicaid covered level of care specified for the waiver may be considered for entrance to the waiver. Both conditions must be met.

For purposes of this chart, both the minimum and maximum ages refer to the age of an individual on the date of entrance to a waiver. The waiver may provide (in the additional target group criteria) that a person may continue to participate in a waiver beyond the maximum age specified in this chart.

Aged or Disabled Group

This target group usually is composed of individuals who otherwise would require the level of care furnished in a hospital and/or nursing facility.

For convenience, the "aged or disabled" group is further divided into two major subgroups. The first major subgroup includes older persons ("aged") and people with disabilities ("disabled"). A waiver may serve both or only one of these groups. For purposes of the chart, the term "aged" generally has the same meaning as in §1905(a)(iii) of the Act (i.e., persons age 65 and older). However, a state may specify a different minimum age for this group to reflect state practice (e.g., persons age 60 and older). The term disabled generally means individuals with a disability under the age of 64.

The "Specific Recognized Subgroups" section lists specific conditions (e.g., brain injury) within the aged/disabled group that many states have elected to target in waivers. If the waiver is limited to one or more of these specified subgroups, select the specific subgroup(s) under the broader aged or disabled groups. The waiver may be targeted still more discretely than the

groups and subgroups listed in this chart. Additional target group criteria may be specified in the next item.

Intellectual Disability or Developmental Disability Group

This target group (as provided in 42 CFR § 441.301(b)(1)(iii)(C) is composed of individuals who otherwise would require the level of care furnished in an ICF/IID, which is defined in 42 CFR § 440.150(a)(2) as serving persons with "intellectual disability or persons with related conditions." States are advised that the ICF/IID level of care is reserved for persons with intellectual disability or a related condition, as defined in 42 CFR § 435.1009. Participants in a waiver linked to the ICF/IID level of care must meet the "related condition" definition when they are not diagnosed as having an intellectual disability (e.g., persons with autism). Some persons who might qualify as having a "developmental disability" under the Federal Developmental Disabilities Assistance and Bill of Rights Act of 2000 may not meet ICF/IID level of care. While "Developmental Disability" and "Related Conditions" overlap, they are not equivalent. The definition of related conditions is at 42 CFR 435.1009, and is functional, rather than tied to a fixed list of conditions.

Mental Illness Group

The mental illness group (as provided in 42 CFR § 441.301(b)(6)(ii)) is divided into two subgroups. The "serious emotional disturbance" group should be selected when the waiver would serve children and youth with mental illness who require the level of care furnished in an inpatient psychiatric facility that is licensed as hospital for individuals under age 21 (or up to age 22, if provided in the state plan) (as provided in 42 CFR § 440.160).

The "mental illness" subgroup should be selected when the waiver would serve (a) individuals with mental illnesses who require the level of care furnished in a nursing facility or (b) persons with mental illnesses aged 65 and older who would, but for the waiver receive services in an IMD (as provided in 42 CFR § 440.140). With respect to persons with mental illnesses, a waiver may target adults with mental illnesses ages 22-64 when these persons are determined to require the nursing facility level of care. Individuals with serious mental illnesses often have functional limitations that are similar to those of other persons who require the nursing facility level of care. However, a waiver may not target adults with mental illness ages 22-64 who would, but for the waiver, require services furnished in an Institution for Mental Disease (IMD), and regardless of whether the IMD is a hospital or a nursing facility. Medicaid payment is not available for persons in this age range who are served in an IMD and, consequently, an HCBS waiver cannot target such individuals.

CMS Review Criteria

- The target groups align with the levels of care specified in Item 1-F of the Application (Module 1).

Item B-1-b: Additional Criteria

Instructions

In the text field, specify any additional criteria that further specify the target group(s) served by the waiver.

Technical Guidance

More discrete targeting criteria may be specified *over and above* the target group/subgroup and age-ranges selected in the previous item. When additional criteria are not specified, it is presumed that the waiver is available to all persons who need the level(s) of care specified in the Application (Module 1) and are in the groups/subgroups selected in Item B-1-a. The additional criteria may be specified in terms of nature or degree or type of disability, or other reasonable and definable characteristics that distinguish the target group from other persons who may need the level(s) of care specified for the waiver. Such additional targeting criteria may include but are not limited to:

- Nature or type of disability;
- Specific diseases or conditions; and
- Functional limitations (e.g., extent of assistance required in activities of daily (ADLs) and/or instrumental activities of daily living (IADLs).

Additional criteria also may be specified in order to align the waiver to service population eligibility criteria that are specified in state law (for example, when a state's definition of developmental disability specifies that the disability must have been experienced before age 18 rather than age 22). ***In specifying additional targeting criteria, clearly define the terms that are used to specify membership in the target groups.***

When the waiver limits the age range of the target population (e.g., to adults with physical disabilities through age 64), a state may provide that persons who enter the waiver may continue to participate in the waiver after they reach the maximum age that applies to entrance to the waiver. If the state provides for continuing individuals on a waiver past the specified maximum age, specify the continuation policies that apply.

A waiver may target exclusively individuals who want to direct at least some or all of their waiver services by employing the participant direction opportunities that are specified in Appendix E. This targeting criterion should be reflected here.

CMS Review Criteria

The waiver target group or groups are sufficiently well defined to permit the determination that an individual meets the target group criteria.

Item B-1-c: Transition of Individuals Affected by Maximum Age Limit

Instructions

When there is a maximum age limitation on individuals who may be served in the waiver, describe the transition planning procedures for participants affected by the age limit in the text field. Otherwise, select "not applicable."

Technical Guidance

When an individual's participation in the waiver is subject to an upper age limit, there should be transition planning procedures that are followed to assist participants who "age out" of the waiver (i.e., the participant no longer will be eligible once the person reaches the waiver's age limit). As noted previously, in its additional targeting criteria, a state may provide for the continuation of services to participants whose age exceeds the maximum age limit that applies to entrance to the waiver. For example, if a waiver serves the "disabled" under age 65, a state may

provide that individuals may continue to participate in the waiver once they reach age 65. If the waiver does not provide for continuation of individuals beyond the age limit that is applied to entrants to the waiver or continuation is not feasible (due to level of care considerations), transition planning is appropriate. Transition planning is most effective when it is initiated sufficiently in advance of the date that the participant will be terminated from the waiver in order to provide continuity of services to the extent feasible.

Transition planning may include identifying other public programs for which the participant may qualify, informing the person of such programs and linking the person to them. A state also may provide that participants affected by an age limit are referred to and/or enrolled in another HCBS waiver for which the individual may be eligible. A state may provide that such individuals receive priority consideration for entrance into another waiver. A state is not obligated to ensure that individuals adversely affected by a maximum age limit receive services after termination from the waiver.

CMS Review Criteria

When the waiver does not provide for the continuation of services to waiver participants beyond the age limit specified in the waiver, there are transition planning procedures that link affected participants to another waiver or other services and supports that provide continuity of services in the community to the extent feasible.

Appendix B-2: Individual Cost Limit

Overview

In order to comport with waiver cost neutrality requirements at 42 CFR § 441.303(f), a state may restrict enrollment into, and ongoing participation in, a waiver based on the expected cost of the home and community-based services that would be furnished to a person. In Appendix B-2, the ***individual cost limit*** (if any) under which the waiver operates is specified. The individual cost limit is specified in relationship to the costs of the institutional services at the level of care that a person requires. The cost comparison is based on the expected costs of home and community-based waiver services plus the costs of other state plan services that the person likely will require to the average cost of institutional services at the level of care the person requires plus the costs of state plan services that would be furnished to the person in an institutional setting. When an individual cost limit is specified, CMS expects the state to specify the state's safeguards to address the needs of waiver participants whose continuation on the waiver may be subsequently affected by the individual cost limit.

A waiver's design may include reasonable methods to control overall spending, including the specification of an individual cost limit. In combination, the individual cost limit, the waiver's service array, the availability of other services under the state plan and from other sources, and any other limits on the amount and scope of services must be sufficient to assure the health and welfare of the waiver's target population.

When completing this Appendix, it is important to keep in mind that the individual cost limit functions as a criterion against which the determination is made about whether to offer entrance to a waiver to an individual and the person's continued participation in the waiver post-entrance. The individual cost limit does not specify an amount of waiver services to which an individual is entitled. The amount of waiver services that a person receives is determined through the

participant-centered service plan development process and is subject to any other limitations that a state may impose on the amount, duration and frequency of specific waiver services as provided in Appendix C-3 or the overall amount of groups of services or the total amount of services in the service plan, as specified in Appendix C-4. The individual cost limit (if imposed) governs entrance to the waiver (e.g., if the expected costs of the services that a person requires exceed the cost limit, the person will be denied entrance) and continued stay on the waiver. Given that the individual cost limit is a criterion for entrance and continued stay on a waiver, the state may elect only one individual cost limit, applied fairly and uniformly to all potentially eligible individuals.

Detailed Instructions for Completing Appendix B-2

Item B-2-a: Individual Cost Limit

Instructions

Select one of the four choices presented. As applicable, provide the additional information as specified.

Technical Guidance

This item presents four choices concerning the individual cost limit. One of these choices must be selected:

- **No Cost Limit**. When an individual cost limit is not imposed, this means that no otherwise eligible individual will be denied entrance to the waiver solely based on the anticipated costs of the home and community-based services that the person may require. Again, this does not mean that the person is entitled to unlimited home and community-based services once enrolled in the waiver program. The amount of services that will be furnished to an individual is determined based on assessed needs and as specified during the development of the service plan and is subject to any other limitations specified in Appendix C. This selection allows the entrance to the waiver of individuals who may require an amount of home and community-based services that exceeds the average cost of the institutional services for the level of care that the person requires. When this choice is selected, it is not necessary to complete the remaining two items (Items B-2-b and B-2-c) in this Appendix. When any of the other choices are selected, the next two items need to be completed.

  The selection of this choice (or any of the other three choices) does not permit a state to implement practices that *de facto* amount to the imposition of a cost limit (for example, by limiting or managing entrance to the waiver by selecting individuals who are expected to have relatively low costs or requiring that the costs of individuals who require intensive services must be offset by only permitting the entrance of persons with off-setting lower costs). An individual cost limit must be applied uniformly to all potential waiver entrants. While a waiver may be managed in the "aggregate" to assure cost-neutrality or achieve a targeted level of expenditures per waiver participant, entrance determinations must be made on an individual basis.
- **Cost Limit in Excess of Institutional Costs**. A state may elect to offer entrance to the waiver to persons when the costs of their home and community-based services are expected to be greater than the average cost of the institutional services, as specified as Factor G in Appendix J of the waiver, for the level of care that the person requires but set

an upper limit on how much expected costs may exceed institutional costs. For example, a state may provide for the entrance of persons whose costs are not expected to exceed 125% of institutional costs. If this choice is selected, the cost limit needs to be specified. In addition, the state still must demonstrate cost-neutrality in the aggregate.

- **Institutional Cost Limit**. A state may elect to limit entrance to the waiver to only those individuals for whom the costs of home and community-based services are not expected to *exceed* the average costs of the institutional services for the level of care that the person requires. When this choice is selected, entrance to the waiver will be denied when a person's expected costs of home and community-based services exceed the average cost of institutional services.
- **Cost Limit Lower Than Institutional Services**. Finally, a state may elect to impose an individual cost limit that is lower than the cost of the institutional services for the level of care that the person requires. The selection of this limit generally is only appropriate in the case of waivers that target individuals who can be expected to have available services and supports from other sources (e.g., family caregivers or other public programs) that, in combination with waiver services, will be sufficient to assure their health and welfare. When a state elects this choice, it needs to specify the basis of the limit that it imposes (i.e., the information analyzed and the rationale to support the assertion that the limit selected ensures that individuals who enter the waiver will have sufficient services and supports to assure their health and welfare). This evidence may be based on:
    - An analysis of service utilization in a waiver that serves a similar target group;
    - An analysis of service utilization in a state program that serves a similar target group;
    - The experience of a waiver that serves a similar target group in another state; and/or
    - An assessment of the service needs of individuals in the target group.

  For example, if a waiver targets children with disabilities, information about the amount of state plan services (including enhanced EPSDT services) that are typically utilized by children with disabilities might be combined with estimates of the expected utilization of waiver services to serve as the basis for the cost limit.

  The limit that is applied also needs to be specified. This limit may be expressed as an absolute dollar amount, a percentage (less than 100%) of the costs of the institutional services for the level of care that the person requires or another type of limit that the state specifies. If the limit is expressed as an absolute dollar limit, specify how the limit will be adjusted during the period in which the waiver is in effect to account for changes in the cost of providing services.

CMS Review Criteria

- When the waiver imposes a cost limit that is lower than the cost of institutional services, the limit is based on sound analysis and rationale that, within the amount of the limit, the health and welfare of the waiver target population will be assured post entrance to the waiver.
- When the limit is expressed as an absolute dollar limit, the waiver describes how the limit will be adjusted during the period in which the waiver is in effect to account for changes in the cost of providing services.
- When a waiver imposes an individual cost limit, it is applied uniformly and fairly to all potentially eligible individuals.

Item B-2-b: Method of Implementation of the Individual Cost Limit

Instructions

This item should be completed unless the "no cost limit" selection is made in Item B-2-a. In the text field, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit.

Technical Guidance

When an individual cost limit is established, there are procedures that are conducted during entrance to the waiver to determine that the individual's health and welfare can be assured within the amount of the cost limit. Such procedures may include conducting an assessment to identify the services that the person may require or initiating the development of a service plan in order to ascertain the amount of waiver services that the person may require (in addition to state plan and the other services and supports available to the person) to meet the person's needs. When the application of an individual cost limit results in the denial of entrance to the waiver, the affected individual must be offered the opportunity to request a Fair Hearing, as provided in Appendix F.

CMS Review Criteria

The procedures that are specified take into account the full range of supports that the person requires in the community and includes notification of the opportunity to request a Fair Hearing if entrance is denied.

Item B-2-c: Participant Safeguards

Instructions

When an individual cost limit is specified, indicate the safeguards that are in effect when post-entrance, a waiver participant requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare. Check each choice that applies and provide the specified information.

Technical Guidance

After a person enters the waiver, the individual may experience a change in condition or circumstances (e.g., a family caregiver no longer is available or is temporarily unavailable to support the individual) that might necessitate the provision of additional waiver services in order to assure the waiver participant's health and welfare. When there is an individual cost limit, the need for such additional services may result in the person no longer being eligible for the waiver.

In this item, specify the safeguards that have been established in the event that the person requires services that would cause the cost limit to be exceeded. The item specifies three types of safeguards; these safeguards may be used in combination. These safeguards are:

- **The person is referred for enrollment in another waiver**. This selection may be appropriate when there is another waiver that operates under a higher individual cost limit or no cost limit for which affected individuals might qualify. A state may provide the continuation of waiver services until the person can be transitioned to the other waiver. Depending on a state's policies, referral to another waiver may or may not ensure that the person can actually be enrolled in the other waiver;
- **There is provision to authorize services in excess of the individual cost limit in order to avoid disruption to the participant**. The waiver may provide for the authorization of additional services to address time-limited or other needs for additional services in order to support an individual until alternative arrangements are made. If this choice is selected, describe the procedures that are followed in authorizing additional services over the amount of the individual cost limit, including whether there is a limit on the amount of the additional services that may be authorized or the length of time the additional services will be provided; and
- **Other**. A state may provide for other alternatives to address the needs of waiver participants affected by the individual cost limit. Describe these alternatives. These alternatives may include informing the participant of other options and making referrals to other services in the community. Referral to other services does not necessarily ensure that the person will be furnished such services. If need be, such alternatives may include referral for institutional services as a last resort.

CMS Review Criteria

- The waiver specifies one or more safeguards to facilitate the continuity of services for affected individuals in the community.
- The waiver provides for informing the participant of, and referral to, other options.

Appendix B-3: Number of Individuals Served

Overview

In this Appendix, a state specifies the maximum number of unduplicated participants who will be served during each year that the waiver is in effect. In addition, this Appendix provides for the selection of options that may be employed to manage the number of persons served by the waiver. Also, the Appendix specifies (when applicable) how waiver openings are distributed across areas of the state and policies that affect the selection of individuals for entrance to the waiver.

By way of reference, an unduplicated participant means a unique individual who participates in the waiver during a waiver year, regardless of when the individual entered the waiver and length of stay on the waiver. A person who enters, exits, and re-enters the waiver during a waiver year counts as one unduplicated waiver participant.

Detailed Instructions for Completing Appendix B-3

Item B-3-a: Unduplicated Number of Participants

Instructions

In Table B-3-a, enter the maximum number of unduplicated participants who may be served during each waiver year that the waiver is in effect. In the case of a new waiver (including a new waiver to replace an approved waiver), enter figures for waiver years 1-3, or years 1-5 if applicable. For a waiver renewal, enter figures for waiver years 1-5. The numbers entered in this table are also entered into Table J-2-a in Appendix J (Cost-Neutrality Demonstration). The web-based application automatically displays the correct number of rows based on whether the state is submitting a new or renewal waiver. In addition, the web-based application links this table to Table J-2-a.

Technical Guidance

The number specified for each waiver year constitutes the maximum limit on the unduplicated number of participants that the waiver will serve (also known as Factor C). It is up to the state to specify this maximum. Until the maximum number of unduplicated participants in the approved waiver is reached, a state may not deny entry to the waiver of otherwise eligible individuals unless the state elects to establish a point-in-time enrollment limit, adopts a phase-in or phase-out schedule, or reserves capacity for specified purposes (see following items).As a consequence, the number of persons who will be served should be based on a careful appraisal of the resources that the state has available to underwrite the costs of waiver services.

Post-approval, the maximum number of unduplicated participants may be modified by submitting a waiver amendment to CMS to increase or decrease the maximum. An amendment to increase the maximum may be made effective to the beginning of the current waiver year. When more individuals are served in the waiver than the maximum, the state should submit an amendment to align the waiver with the number of individuals served. Note: An amendment to reduce the maximum number of waiver participants below the number currently being served may only be made effective on the date that CMS approves the amendment. Consequently, when a reduction is necessary, an amendment should be submitted as soon as the need for a change to the participant limit is identified. When a reduction in the maximum number of participants is requested, the amendment request needs to include information concerning the impact of the reduction on existing waiver participants (see *Waiver Application, Submission Requirements, Processes, and Procedures – Other Changes to Approved Waivers* for additional information).

A state may find it necessary to reduce the maximum number of participants because legislative appropriations are insufficient to support the number of persons specified in the approved waiver. In order to affect such a reduction, a state needs to submit a waiver amendment and the amendment must be formally approved by CMS. If a state finds it necessary to freeze waiver enrollment or place a moratorium on new entrants to the waiver, the state also needs to submit an amendment to CMS to revise the unduplicated participant cap for the affected waiver year.

Item B-3-b: Limitation on the Number of Participants Served at any Point in Time

Instructions

Select whether there is a limit on the number of individuals who may participate in the waiver at any point in time during a waiver year. If there is a limit, complete Table B-3-b by specifying the limit for each waiver year.

Technical Guidance

In addition to specifying the maximum number of unduplicated participants, a state also may specify the maximum number of participants who are served at any point in time during the waiver year. Specifying such a maximum may assist in managing waiver expenditures and taking into account participant turnover during the course of a waiver year.

For example, a waiver may provide for the enrollment of no more than 1,000 unduplicated participants during a waiver year. Taking turnover into account, a state might establish a point-in-time enrollment limit of 950 individuals. Establishing such a limit may avoid a state's having to freeze entrance to the waiver before the end of the waiver year.

The decision to establish such a limit is up to the state. If the state does not wish to establish such a limit, select the first choice. If a limit is established, select the second choice and specify the limit for each year to which a limit will be applied. A limit may be applied to each waiver year or only selected years. For example, when a waiver is being phased in, a state might limit participation in the waiver by adopting a phase-in schedule as provided in Item B-3-d during the initial period that the waiver is in effect but provide for a point-in-time limit for subsequent waiver years. The limit that is established will be lower than the maximum unduplicated waiver participant limit specified in Item B-3-a and should be reasonably related to the expected rate of turnover of waiver participants.

In the case of a model waiver, the second choice should be selected when the number of participants specified in Item B-3-a is equal to or greater than 200 and the maximum number of participants served at any point in time may not exceed 200 persons.

CMS Review Criteria

When the waiver provides for a point-in-time limit, the limit for each waiver year is consistent with the implied turnover rate in the average length of stay estimates in Appendix J-2-b. (Turnover rate = Total # unduplicated persons per year / # of persons served at any point in time.)

Item B-3-c: Reserved Waiver Capacity

Instructions

Specify whether waiver capacity is reserved for purposes specified by the state. If no capacity is reserved, select the first choice. When capacity is reserved, complete Table B-3-c for each purpose a state has to reserve capacity. For each purpose, provide a brief title or name for the purpose of reserve capacity, specify the purpose for which capacity is reserved, how the amount of reserved capacity was determined, and specify the amount of capacity reserved for each Waiver Year.

Technical Guidance

A state may reserve a portion of a waiver's capacity for specified purposes. Reserving waiver capacity means that some waiver openings (a.k.a., "slots") are set aside for persons who will be admitted to the waiver on a priority basis for the purpose(s) identified by the state. If capacity is not reserved, then all waiver openings are considered available to all target group members who apply for waiver services and are eligible to receive them. Reserved capacity is not available to persons who are not in the state-specified priority population. Examples of appropriate purposes for which capacity may be reserved include (but are not limited to):

- Setting aside capacity to accommodate the community transition of institutionalized persons (e.g., through a "Money Follows the Person" initiative). In this case, reserving capacity ensures that there is waiver capacity available when individuals are ready to transition to the community transition;
- Reserving capacity to accommodate the transition of individuals from other waivers;
- Reserving capacity to accommodate individuals who may require services due to a crisis or emergency; and
- Providing for the transition of individuals who age out of another waiver or other services (e.g., youth who age out of child welfare services) in order to ensure the continuity of their services.

Capacity may be reserved for more than one purpose. It is not appropriate to reserve capacity to reflect uncertainties about future legislative appropriations for the waiver. Reserving capacity is only a means to hold waiver openings for the entrance of specific sets of individuals to the waiver. In accordance with State Medicaid Director Letter #01-006 (Olmstead Update #4), a state may not reserve capacity in a fashion that would have the effect of limiting the number of waiver participants who may access certain types of waiver services and, thereby, result in creating a "waiver within a waiver." All individuals who enter the waiver must have comparable access to the services offered under the waiver. For example, a state may not reserve capacity in order to limit the number of persons who receive assisted living services in a waiver. Additionally, a state may not use this feature to control access by certain Medicaid eligibility groups (e.g., by limiting access by the special home and community-based eligibility group (217 group) to 10% of waiver participants). Similarly, capacity may not be reserved to limit the number of waiver participants who may direct some or all of their waiver services.

CMS Review Criteria

When capacity is reserved, it is reserved only for the purpose of holding waiver capacity for one or more specific sets of individuals and does not violate the requirement that all waiver participants enrolled in the waiver have comparable access to all services offered in the waiver.

Item B-3-d: Scheduled Phase-In or Phase-Out

Instructions

When entrance to the waiver is subject to a phase-in schedule or the waiver is being phased-out, select the second choice and complete Attachment #1 to Appendix B-3. If the waiver is not subject to a phase-in or phase-out schedule, select the first choice.

Technical Guidance

A state may phase-in or phase-out a waiver over the course of a waiver year or multiple waiver years. For example, a state may provide for the entrance of 100 persons per month to the waiver during the first year of a waiver's operation. Alternatively, a state may decide to phase out a waiver by transitioning individuals to another waiver over an extended period of time. A state may limit waiver capacity month-by-month during a waiver year by tying the maximum number of waiver participants who may be served each month to a phase-in or a phase-out schedule. Absent such a limit, a state is obligated to allow individuals to enter the waiver up to the participant limit for the waiver year as specified in Item B-3-a or B-3-b. When a waiver is being phased-in or phased out, the average length of stay of individuals on the waiver is affected. Item J-2-a in Appendix J (Cost Neutrality Demonstration) provides for describing the basis of the

estimate of the average length of stay on the waiver. In the description, reference may be made to this item when the waiver is being phased-in or phased-out.

Attachment #1 to Appendix B-3: Waiver Phase-In or Phase-Out Schedule

Instructions

As previously noted, this attachment is completed only when a waiver is being phased in or phased-out.

Item a: Select whether the waiver is being phased-in or phased out.

Item b: Waiver Years Subject to Phase-In or Phase-Out Schedule

Indicate the waiver years during which phase in or phase out will take place. Phase-in or phase-out may extend over multiple waiver years.

Item c: Phase-In or Phase-Out Time Period

In the table, specify the first calendar month of each waiver year. For example, if a waiver is effective on October 1, enter October. In the next row, enter the month and the waiver year when phase-in or phase-out will begin. In the final row, enter the month and the waiver year when the phase-in or phase-out will be completed.

Item d: Phase-In or Phase Out Schedule

This table should be completed for each waiver year during which phase-in or phase-out is taking place. If phase-in or phase-out will take place over more than one waiver year, add another page to the application (by inserting a page break) and copy this table onto to the new page. An example of a completed table is provided below.

Example: Phase-In or Phase-Out Schedule			
Waiver Year:		One	
Month	Base Number of Participants	Change in Number of Participants	Participant Limit
October	3,500	0	3,500
November	3,500	0	3,500
December	3,500	0	3,500
January	3,500	150	3,650
February	3,650	150	3,800
March	3,800	150	3,950
April	3,950	150	4,100
May	4,100	150	4,250
June	4,250	150	4,400
July	4.400	0	4,400

August	4,400	0	4,400
September	4.400	0	4,400

Waiver Year: In the table, indicate the waiver year for which the phase-in or phase-out schedule applies. Complete the remainder of the table as follows:

Month Column: Enter the first month of the waiver year and fill the remainder of the column with the names of the subsequent months through the end of the waiver year.

Base Number of Participants: In this column, enter the number of participants who will be served during the month, not counting the number who will be added to or leave the waiver during the same month.

Change in Number of Participants: Enter the number of participants who will be added to the waiver or leave the waiver during the month.

Participant Limit: The participant limit for a month is the sum of the base number of participants plus the number who will enter the waiver or less the number who will leave the waiver. This participant limit becomes the base number of participants for the next subsequent month.

Item B-3-e: Allocation of Waiver Capacity

Instructions

Select whether waiver capacity is allocated/managed on a statewide basis or, instead, is allocated based on local/regional geographic area. In the latter case, specify: (a) the entities or areas upon which waiver capacity is allocated; (b) the methodology that is employed to allocate capacity; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities or geographic areas.

Technical Guidance

"Allocation of waiver capacity" refers to the practice in some states (especially states where waivers are operated through local/regional non-state entities) of allocating waiver openings (a.k.a., "slots") by geographic area. This contrasts to managing entrance to the waiver on a statewide basis (or less than statewide basis when there is a waiver of statewideness, but the state manages entrance across all areas served by the waiver) where entrance to the waiver is not based on geographic area. The practice of allocating waiver capacity by geographic area is permissible so long as the methods to allocate waiver capacity result in similar access to the waiver among the geographic areas where the waiver operates. When waiver capacity is allocated in a fashion that results in substantially unequal access among geographic areas, the waiver may not meet statewideness requirements.

The allocation of waiver capacity by geographic area may not impede the free movement of waiver participants from area to area in a state. That is, waiver "slots" must be portable across areas of the state.

Appropriate methods of allocating waiver capacity by geographic area may include taking into account the population of each area, other demographic factors, assessed need for waiver

services by area or a combination of such factors. A state may find it necessary to implement strategies to adjust allocations of waiver capacity on a multi-year basis in order to achieve similar access to waiver services across geographic areas. For example, a state may reserve some waiver capacity to increase allocations in underserved areas.

When waiver capacity is allocated by geographic area, there also should be methods to reallocate unused capacity to areas where additional capacity may be needed (e.g., where there are waiver waiting lists). States cannot operate a waiver in a fashion that results in individuals waiting for services in some geographic areas when there is unused capacity in other areas. When a state intends to limit the number of persons served by geographic area, it needs to submit a waiver application and an accompanying waiver of statewideness in order to confine the operation of the waiver to the geographic area.

CMS Review Criteria

When waiver capacity is allocated to local/regional non-state entities or geographic areas:

- The waiver describes the methodology that is employed to allocate capacity.
- The methodology is based on objective factors/criteria.
- The waiver specifies the entities to which capacity is allocated, if applicable.
- There are policies to reallocate unused capacity among local/regional non-state entities or geographic areas.
- The state's practices do not violate the requirement that individuals have comparable access to waiver services across the geographic areas served by the waiver or impede the movement of participants across geographic areas.

Item B-3-f: Selection of Entrants to the Waiver

Instructions

In the text field, specify the policies that apply to the selection of individuals for entrance to the waiver.

Technical Guidance

The state's limit on the number of individuals who participate in a waiver may result in a waiting list for waiver services (e.g., entrance to the waiver of otherwise eligible applicants must be deferred until capacity becomes available as a result of turnover or the appropriation of additional funding by the legislature). Entrance to the waiver may not be deferred when there is unused waiver capacity (except when a state has established a point-in-time limit, reserved capacity or made entrance subject to a phase-in schedule). If it is necessary to defer the entrance of individuals to the waiver, the state should have policies that govern the selection of individuals for entrance to the waiver when capacity becomes available. These policies should be based on objective criteria and applied consistently in all geographic areas served by the waiver. Examples of appropriate policies may include (but are not necessarily limited to):

- Entry to the waiver is offered to individuals based on the date of their application for the waiver; or,
- Entry to the waiver is prioritized based on the imminent need for services that is determined through an assessment process.

When the state operates the waiver in a fashion that does not entail deferring the entrance of otherwise eligible persons, simply state that the waiver provides for the entrance of all eligible persons.

The state should not base policies for the selection of otherwise eligible individuals on factors such as the expected costs of waiver services or the types of services that an individual might require post-entrance. A state may not delegate the authority to establish policies for the selection of individuals to enter the waiver to local/regional non-state entities or other types of entities.

CMS Review Criteria

- There are state-established policies governing the selection of individuals for entrance to the waiver.
- Policies are based on objective criteria and do not violate the requirement that otherwise eligible individuals have comparable access to all services offered in the waiver.

Appendix B-4: Medicaid Eligibility Groups Served in the Waiver

Overview

In this Appendix, the state specifies the Medicaid eligibility groups that are served in the waiver. In order for an eligibility group to be included in the waiver, it must already have been included in the state plan.

Detailed Instructions for Completing Appendix B-4

Item B-4-a: State Classification

B-4-a-1 State Classification

Instructions

Select whether the state is: (a) a section1634 state; (b) an SSI-criteria state; or, (c) a 209(b) state as described below. In the web-based application, the selection made for this item links to Appendix B-5 and calls up the appropriate post eligibility treatment of income sections for section 1634, SSI Criteria, or 209(b) states.

Technical Guidance

With respect to Supplemental Security Income (SSI) beneficiaries, a state may be:

- **A section 1634 State**. Under the provisions of section 1634(a) of the Act, a state may enter into a contract with the Social Security Administration (SSA) under which SSA determines Medicaid eligibility at the same time that eligibility for SSI benefits and/or federally-administered state supplementary payments is determined. In §1634 states, SSI recipients do not make a separate application for Medicaid and are automatically enrolled in Medicaid;
- An "**SSI-Criteria State**." In these states, SSI beneficiaries are categorically eligible for Medicaid but must make a separate application for Medicaid; or,
- **A section 209(b) State**. The state applies rules that are more restrictive than SSI, but no more restrictive than the rules used by the state's Medicaid program on January 1, 1972, in determining the Medicaid eligibility of SSI beneficiaries.

These are mutually exclusive categories. State officials who are familiar with Medicaid eligibility policies under the state plan should be consulted when completing this item. The response to this item determines which post-eligibility treatment of income rules apply when Appendix B-5 is completed.

B-4-a-2 Miller Trust State

Instructions

Indicate whether the state is a Miller Trust State.

Technical Guidance

Refer to guidance contained in Appendix B-5 of these instructions regarding Miller Trusts.

CMS Review Criteria

The selection comports with the state plan.

Item B-4-b: Medicaid Eligibility Groups Served in the Waiver

Instructions

Specify each Medicaid eligibility group that is included in the waiver. Where indicated, furnish the additional information about a group.

Technical Guidance

In order to participate in a waiver, a person not only must require the level of care specified for the waiver and meet the waiver's target group criteria but also be a member of a Medicaid eligibility group (e.g., SSI beneficiaries) that a state has decided to include in the waiver. A state may include a Medicaid eligibility group in the waiver only when it includes the same group in its state plan. In other words, operating an HCBS waiver does not permit a state to expand Medicaid eligibility beyond what already is provided in the state plan. If a group is not included in the state plan, it may not be included in the waiver.

If a group is included in the Medicaid state plan, a state has the option to include the group in the waiver. The impact of a waiver in assisting individuals to remain in the home and community is enhanced when the waiver includes all applicable Medicaid eligibility groups.

In the context of the HCBS waiver program, Medicaid eligibility groups fall into two broad categories: (a) eligibility groups that include individuals who are eligible for Medicaid without regard to whether they are institutionalized (e.g., SSI beneficiaries) and (b) eligibility groups that include individuals who would not be eligible for Medicaid except in an institutional setting (e.g., the special income level group). When the second group is included in the waiver (as provided by section 1902(a)(10)(A)(ii)(VI) of the Act), institutional eligibility rules (which are usually more generous than the "community rules" that apply to the first category) may be used in the community. This second group is referred to as the "special home and community-based services waiver eligibility group" as provided in 42 CFR § 435.217 (see below).

Appendix B-4 provides for checking off specified Medicaid eligibility groups that are included in the waiver. The listed community groups often are included in waivers. Since many states have added the Medicaid "Buy-In" eligibility groups to their state plans, checkoffs have been included for both the BBA-97 and TWWIA buy-in groups. However, this list is not exhaustive. There are over 50 distinct groups that a state may include in its state plan. If there are additional groups

that a state includes in the waiver over and above those listed, they should be specified (by citing the appropriate statute or regulation) in the text box provided at the end of the list. When completing this part of the application, personnel at the Medicaid agency who are well versed concerning the eligibility groups included in the state plan should be consulted to ensure that the appropriate selections are made.

Note: While not affecting any of a state's choices or elections in Appendix B-4, states should be aware, for eligibility-related purposes, that they may target less restrictive financial methodologies at individuals in need of HCBS authorized under section 1915(c) of the Act (among other HCBS-related authorities), which may include (but is not limited to) partially or totally disregarding spousal resources. This authority is described in State Medicaid Director Letter #21-004 (December 7, 2021). A state that wishes to adopt less restrictive methodologies for individuals in need of section 1915(c) waiver services may do so by submitting a state plan amendment (SPA) pursuant to 42 CFR § 435.601(f)(2).

There are additional requirements with respect to covering medically needy eligibility groups under home and community-based services waivers. States that limit coverage of medically needy by eligibility group can only cover those medically needy groups covered in the state plan. For example, if a state only covers the mandatory medically needy group in its state plan, it may only cover those individuals on the waiver. If a state does not cover medically needy individuals in an institution, it cannot cover them in the waiver. For example, if a state does not cover nursing facility services for medically needy, it cannot provide HCBS waiver services to medically needy individuals who require the nursing facility level of care.

There are check offs for including the "special home and community-based services waiver eligibility group" under 42 CFR § 435.217. All individuals in this group may be included or the state may elect to include only specified groups (the second response). An individual is eligible under the § 435.217 group, if the individual (1) is otherwise eligible for the HCBS waiver but would not be eligible for Medicaid while he or she is living in the community; (2) is eligible (or would be eligible) under the state Medicaid plan without spending down income if he or she were in a hospital, nursing facility or ICF/IID; and (3) receives waiver services. Check off whether the § 435.217 group is included and then indicate the specific groups that are included and, if necessary, identify any other groups that are included but not listed. The web-based application links the selection of the § 435.217 group to completing Appendix B-5 (Post Eligibility Treatment of Income).

The interplay between medically needy eligibility and eligibility under the § 435.217 group is as follows:

- **For section 1634 and SSI criteria states**, the individual would be eligible only in an institution as categorically needy and medically needy without spending down income. The HCBS waiver and the § 435.217 group permit the special income level group to be covered in the community. Individuals with income under the special income level are categorically needy. Therefore, the basis for qualifying for the waiver changes from medically needy to the special income level group for individuals with income under the special income level group without a spenddown. However, a medically needy individual with income over the special income level cannot spend down to the special income level and be eligible under the § 435.217 group.

- **For 209(b) states**, the individual would be eligible for Medicaid in the institution without a categorically needy or medically needy spenddown. Mandatory categorically needy individuals eligible under 42 CFR § 435.121 are not eligible under the § 435.217 group (e.g., SSI recipients). However, optional categorically needy individuals can be eligible under the §435.217 group. The HCBS waiver and the § 435.217 group permit the special income level group to be covered in the community. Individuals with income under the special income level are categorically needy. Therefore, individuals who are both medically needy and optional categorically needy and have income below the special income level would be eligible under the special income level group without a spenddown. However, individuals with income over the special income level cannot spenddown to the special income level and be eligible under the § 435.217 group.

When the § 435.217 group is included in the waiver, Appendix B-5 (Post-Eligibility Treatment of Income) also needs to be completed.

CMS Review Criteria

The eligibility groups served in the waiver are included in the state plan.

Appendix B-5: Post-Eligibility Treatment of Income

Overview

In this Appendix, state policies are detailed concerning the post-eligibility treatment of income of waiver participants who are eligible under 42 CFR § 435.217.

As of January 1, 2014, and extending through September 30, 2027 (or other date as required by law), states must apply the eligibility and post-eligibility methodologies described in section 1924 of the Act (the spousal impoverishment statute) to all married individuals seeking eligibility under the category described at 42 CFR § 435.217. This requirement applies to all new 1915(c) waivers. As part of any renewal or amendment to a state's 1915(c) waiver, a state should, if necessary, modify the terms of its waiver (specifically, in Appendix B-5) to conform its provisions to section 1924 if the § 435.217 category is covered under the waiver. See instructions for Appendices B-5-a, B-5-e, B-5-f, and B-5-g.

Post-Eligibility Treatment of Income: Overview

All waiver participants who are eligible under 42 CFR § 435.217 (the special home and community-based services waiver eligibility group) (as described in the instructions for Appendix B-4) are subject to post-eligibility calculations. Eligibility and post-eligibility are two separate and distinct processes with two separate calculations. Eligibility determines whether a person may be served in the waiver and is conducted in conjunction with entrance to the waiver. Post-eligibility determines the amount (if any) by which Medicaid reduces its payment for services that are furnished to an individual in the § 435.217 group. By doing so, post-eligibility determines the amount (if any) for which an individual is liable to pay for the cost of waiver services. Post-eligibility is conducted ONLY for waiver participants in the § 435.217 group. Waiver participants who are eligible for Medicaid under "community rules" (e.g., SSI beneficiaries) are not subject to post-eligibility.

Post-eligibility calculations are affected as specified in Appendix B-4 by federal regulations depending on whether the state is a Section 1634 State or an SSI-Criteria State (42 CFR §

435.726), or a section 209(b) state (42 CFR § 435.735). These regulations are included in Attachment C to the instructions. The post-eligibility calculations also may be affected by whether "spousal impoverishment rules" are used to determine the eligibility of a waiver participant with a community spouse. For the period beginning January 1, 2014, and extending through September 30, 2027 (or other date as required by law), states must use spousal impoverishment rules.

Allowances

Post-eligibility calculations arrive at the amount that the waiver participant is liable to pay for the cost of waiver services by deducting from the person's income four types of allowances:

- **Allowance for the needs of the waiver participant**. This allowance also is referred to as the "maintenance needs" allowance. This is the amount of income from which the participant will provide for her/his everyday living expenses (e.g., rent, food, and other living expenses). As provided in 42 CFR § 435.726(c)(1)(i) and § 735(c)(1)(i), the state must provide for a maintenance allowance that is based on a reasonable assessment of the individual's needs in the community. As provided in section 1915(c)(3), a state may establish the maintenance allowance for the participant at any level the state chooses so long as it is based on a reasonable assessment of individual needs. Different maintenance allowances may be established for individuals or for groups of individuals, based on an assessment of the individual's or the group's particular needs. The amount(s) established must be sufficient to provide for a participant's shelter, food and other routine expenses. In the case of waiver participants with a community spouse whose eligibility is determined using spousal impoverishment rules (under section 1924 of the Act), the state may provide for a different maintenance allowance than participants who do not have a community spouse (see Item B-5-d). However, if this amount is different from the amount protected for the individual's maintenance allowance under 42 CFR § 435.726 or §435.735, the state must explain why it believes the amount is reasonable to meet the individual's maintenance needs in the community.
- **Allowance for a Spouse.** Under regular post-eligibility rules, if the individual lives with his or her spouse or if the individual is living in the community and the spouse is living at the individual's home, the state must protect an additional amount for the spouse's maintenance. This allowance cannot exceed the highest of the SSI standard, the Optional State Supplement standard or the Medically Needy Income standard. The state may choose which standard to apply. If the individual's spouse is not living in the individual's home, no maintenance amount is protected for the spouse's needs. Under spousal impoverishment post-eligibility, a community spouse is defined as a spouse who is not living in a medical institution or nursing facility. For the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law), states must use spousal impoverishment rules.
- **Allowance for a Family:** Under regular post-eligibility rules, if other family members live with the individual, an additional amount is protected for their needs. This amount is limited by the AFDC need standard for a family of the same size or by the appropriate medically needy income standard for a family of the same size. The state may choose which standard to apply.
- **Medical and Remedial Care Expenses:** Medical and remedial care expenses are specified

in 42 CFR § 435.726, § 435.735 and section 1924 of the Act. Under the post eligibility process, which is specified at section 1902(r)(1) of the Social Security Act, states must deduct from an individual's income: (a) health insurance premiums, deductibles and co-insurance charges (including Medicaid co-payments) and (b) amounts incurred for necessary medical and remedial care expenses that are not subject to payment by a third party and which are recognized under state law but not covered under the state plan. With respect to the deduction of incurred remedial and medical care expenses not covered by Medicaid, a state may elect to deduct all such expenses or, at its option, establish reasonable limits on amounts for incurred remedial and medical care expenses not covered by Medicaid. The individual must currently be liable for the payment for these services in order for them to be deductible.

For post eligibility purposes, services not covered under a state's plan are any services not paid for by Medicaid for that particular individual. These include services listed as covered services in the state plan, as well as services the plan does not cover. They also include services the individual received prior to becoming eligible for Medicaid, as well as services received after becoming eligible.

Medical and remedial care expenses incurred prior to a period of Medicaid eligibility would be deductible under the post eligibility process, since these expenses were incurred when the person was ineligible for Medicaid and thus Medicaid did not pay for them. However, in order for these old expenses to be deducted under the post eligibility process the individual must be currently obligated to pay for these costs. As noted previously, these and other incurred medical and remedial expenses are subject to reasonable limits which may be established by the state Medicaid program. However, those reasonable limits must ensure that waiver participants are able to use their own funds to purchase necessary medical or remedial care not covered; i.e., not paid for, by the state plan.

For example, it would be reasonable for a state to provide that only uncovered services prescribed by a physician may be deducted. It would also be reasonable for states to impose specific dollar limits for specific services or items, provided that these limits reflect annual increases in the cost of medical care services and supplies. However, it would not be reasonable for states to set an overall dollar limit, such as $50 per month, for all non-covered services. Similarly, it would not be reasonable for states to impose a limit on the total number of medically necessary services or items that an individual could deduct in any month.

The amount of a person's income that remains after providing for the foregoing allowances is the amount for which the individual is liable for the cost of waiver services.

Miller Trusts

Miller Trusts (also known as Qualifying Income trusts) are exempt from being treated under the normal Medicaid Trust rules. The exemption allows individuals with excess income to exclude that income from being counted for eligibility purposes by placing it in a Miller Trust. Miller Trusts apply only in certain states; i.e., those states that provide Medicaid nursing facility services to individuals eligible under the special income limit group, but do not pay for such services for the medically needy. However, the use of Miller Trusts is not limited to individuals needing Medicaid for nursing facility services. Miller Trusts also apply to individuals receiving HCBS waiver services.

While income placed in a Miller Trust is not counted in determining an individual's Medicaid eligibility, it still meets the SSI definition of "income". Therefore, the income placed in the Trust is included when determining the amount of an individual's total income for post eligibility calculation purposes. Specifically, the state calculates the amount of the individual's total income, including income placed in the Miller trust, and then makes the required deductions (maintenance allowance for the waiver participant, spouse and family allowance, and an allowance for medical and remedial care services) under the post eligibility process. Any income remaining after the required deductions is applied to the cost of HCBS waiver services.

Many states have set their maintenance allowance for the waiver participant at 300 percent of the SSI Federal Benefit Rate (FBR), effectively protecting all of the individual's income for his or her own use. However, if the individual has a Miller trust the income placed in the trust, when combined with his or her other income, may result in total income that exceeds a state's maintenance allowance. In that case, the individual's income up to 300 percent of the SSI FBR would still be protected. But any income in excess of 300 percent would be used in determining the patient liability under post eligibility.

To calculate the amount of the patient liability, the state would start with the amount of income that exceeds the state's maintenance allowance for the waiver participant, and then make the required deductions for a spouse and family members, and for medical and remedial care services. Any remaining income is applied to the cost of waiver services.

States may also increase the maintenance needs allowance for waiver participants above 300 percent of the SSI/FBR and protect all of the individual's income (including the income that is placed in the Miller trust). In this case, we suggest the state use the following language when specifying the maintenance needs allowance for individuals in the special home and community-based waiver eligibility group, "The maintenance needs allowance is equal to the individual's total income as determined under the post eligibility process which includes income that is placed in a Miller trust.

In summary, if the state recognizes Miller trusts, under the post-eligibility process for individuals in the special home and community-based waiver group, the state has two options:

- Protect amounts of income for the waiver participant's maintenance needs and allowances for his/her spouse, family members, and remedial and medical care not covered by Medicaid, as described above; or
- Increase the amount of the waiver participant's maintenance allowance, as described above."

General Guidance Concerning Completing Appendix B-5

Whenever a waiver covers the § 435.217 group, Item B-5-a must be completed. The web-based application has been designed so that only the items a state must complete will appear, based on the selection made in Item B-4-a (whether a state is a section 1634, SSI Criteria or 209(b) state) and Item B-5-a (whether a state uses spousal eligibility rules and applies spousal post eligibility rules).

Items B-5-b, B-5-c, and B-5-d apply for time periods after September 30, 2027 (or other date as required by law).

Section 1634 and SSI criteria states must complete Item B-5-b; Section 209(b) states must complete Item B-5-c if regular post-eligibility rules are applied. Item B-5-d is completed when a

state employs spousal impoverishment rules under section 1924 of the Act to determine the eligibility of individuals with a community spouse and also elects to use spousal post-eligibility rules as provided in section 1924. When a state elects to use spousal post-eligibility rules, the allowance for the personal needs of the individual that is provided in Item B-5-d takes the place of the allowance for the individual under Item B-5-b or B-5-c when the individual has a community spouse. Item B-5-d does not apply when a state does not elect to use spousal impoverishment rules to determine the eligibility of individuals with a community spouse or when a state elects to use spousal impoverishment rules to determine eligibility but decides not to use spousal impoverishment post-eligibility rules. If this is the case, then Item B-5-d does not apply. Once a state elects to use spousal impoverishment post-eligibility rules, it must apply these rules to all waiver participants who have a community spouse. The state applies regular post-eligibility rules to waiver participants who do not have a community spouse.

Items B-5-e, B-5-f, and B-5-g apply for the period beginning January 1, 2014, and extending through September 30, 2027 (or other date as required by law), when states must use spousal impoverishment rules whenever a waiver covers the §435.217 group. If the state indicates in Item B-5-a that it uses spousal impoverishment rules when they are not required, entry of B-5-e, B-5-f, and B-5-g is not required. The entries in Item B-5-b-2 or B-5-c and in Item B-5-d will apply. Otherwise, section 1634 and SSI criteria states must complete Item B-5-e and section 209(b) states must complete Item B-5-f. All states must complete Item B-5-g whenever a waiver covers the § 435.217 group for the period beginning January 1, 2014, and extending through September 30, 2027 (or other date as required by law).

Detailed Instructions for Completing Appendix B-5

Item B-5-a: Use of Spousal Impoverishment Rules

Instructions

If the waiver is effective during the period beginning January 1, 2014, and extending through September 30, 2027 (or other date as required by law), the state must check the first box in this section. This box indicates that spousal impoverishment rules under section 924 of the Act are used to determine the eligibility of individuals with a community spouse for the § 435.217 group.

If the waiver is effective during a time period before January 1, 2014, or after September 30, 2027 (or other date as required by law), select whether spousal impoverishment rules are used to determine eligibility. If such rules are employed, also select whether the state elects to apply spousal post-eligibility rules. When spousal impoverishment eligibility rules are not used to determine eligibility or when spousal eligibility rules are used to determine eligibility but the state does not elect to apply spousal post-eligibility rules, complete Item B-5-b-1 or B-5-c-1 in the next section of the Appendix. When spousal impoverishment eligibility rules are used to determine eligibility and spousal post-eligibility rules are applied, proceed to the second section of the Appendix and complete Item B-5-b or B-5-c and Item B-5-d.

Technical Guidance

This item requires specifying whether spousal impoverishment rules are used to determine the eligibility of individuals in the § 435.217 group. When a person who is eligible as a member of a § 435.217 group and has a community spouse, the state treats the individual as if he or she is institutionalized. This permit applying the spousal impoverishment post eligibility rules of

section 1924 of the Act (protection against spousal impoverishment) instead of the regular post-eligibility rules under 42 CFR § 435.726 and § 435.735 to waiver participants with a community spouse. The section 1924 post-eligibility rules provide for a more generous community spouse and family allowance than the rules under 42 CFR § 435.726 and §435.735. Spousal impoverishment post-eligibility rules can only be used if the state uses spousal impoverishment eligibility rules. The response to this item affects whether a state completes Items B-5-d, B-5-e, B-5-f, and B-5-g.

CMS Review Criteria

The state has specified that it uses spousal impoverishment rules under section 1924 of the Act if the waiver is effective at any time between January 1, 2014, and September 30, 2027 (or other date as required by law) and the state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR § 435.217.

Item B-5-b: Regular Post-Eligibility Treatment of Income: Section 1634 and SSI Criteria State

Instructions

This item pertains to section 1634 and SSI Criteria States. Based on the response to Item B-5-a, complete Item B-5-b.

Technical Guidance

The entries in this item apply only for the time periods after September 30, 2027 (or other date as required by law). However, this item must be completed for all waivers in section 1634 or SSI Criteria States, as indicated in Item B-4-a in Appendix B-4. The rules governing post-eligibility treatment of income in section 1634 and SSI criteria states are located at 42 CFR § 435.726 (see Attachment C). All parts of the item must be completed. Under each part of the item (i-iii), select only one of the pre-specified choices. In the case of the allowance for the needs of an individual, the allowance may be based on a standard contained in the state plan (e.g., SSI standard) or spelling out another basis for the allowance. There is no ceiling on the amount of this allowance. States have latitude in establishing the maintenance allowance for the individual. As discussed previously, the amount of the allowance may vary depending on the needs of the individual or groups of individuals.

With respect to the allowances for the community spouse and the participant's family, the choices available are defined under the provisions of 42 CFR § 435.726. Select one of the choices specified for the community spouse and the family. With respect to incurred medical and remedial care expenses, indicate whether the state deducts all such expenses or imposes a reasonable limit on the amount that may be deducted and specify the nature of the limit.

If the amount protected for the individual's maintenance allowance is equal to or greater than the amount calculated as the individual's total income under the post eligibility process, select the "not applicable" choice under the allowance for a spouse and a family. If the state is a Miller Trust State, see the preceding discussion of Miller Trusts.

When a state uses spousal impoverishment rules to determine eligibility and elects to use spousal post-eligibility rules, the state still must address post-eligibility treatment of income in the case of waiver participants who do not have a spouse by completing Item B-5-b-2. Item B-5-b-2 provides for specifying an allowance for a spouse who does not meet the definition of a

community spouse under the provisions of section 1924 of the Act. As a general matter, such an allowance is not provided because spousal post-eligibility rules will apply and the "not applicable" choice should be selected. If, however, the state provides for such an allowance, it must specify the circumstances when an allowance for a spouse will be made under regular post-eligibility rules. CMS will review these circumstances to determine whether such an allowance may be made. Spousal post-eligibility rules must be used in all instances to which they apply. A state may not provide for the use of alternative rules to its spousal post-eligibility rules.

Item B-5-c: Regular Post-Eligibility Treatment of Income: Section 209(b) State

Instructions

This item pertain to section 209(b) states. Based on the response to Item B-5-a, complete Item B-5-c.

Technical Guidance

The entries in this item apply only for the time periods after September 30, 2027 (or other date as required by law). However, this item must be completed for all waivers in §209(b) states. Each item parallels the corresponding item for section 1634 and SSI criteria states, but some of the choices differ, based on the requirements in 42 CFR § 435.735 which govern post-eligibility in section 209(b) states. See the technical guidance for Item B-5-b.

Item B-5-d: Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

Instructions

This item must be completed whenever a state uses spousal impoverishment rules to determine eligibility **and** elects to apply spousal post-eligibility rules.

Technical Guidance

In this item, the state establishes the post-eligibility rules that it will apply to waiver participants for whom eligibility has been determined using spousal impoverishment rules, provided that the state also has elected to apply spousal post-eligibility rules. In the case of individuals who do not have a community spouse as defined in section 1924 of the Act, regular post-eligibility rules (as specified in Item B-5-b or Item B-5-c) apply.

The spousal impoverishment post-eligibility rules provide for a more generous community spouse and family allowance than the rules under 42 CFR § 435.726 and 42 CFR § 435.735. The spousal protection rules also provide for a personal needs allowance (PNA) described in section 1902(q)(1) of the Act for the needs of the institutionalized individual. This allowance is a "reasonable amount for clothes and other personal needs of the individual...while in an institution." For an institutionalized individual, this may be as low as $30 per month. However, unlike the institutionalized individual whose room and board are covered under Medicaid, the personal needs of a waiver participant must include a reasonable amount for food, shelter, clothing and other customary living expenses. The minimum monthly PNA is not sufficient to meet these needs when the individual lives in the community.

Therefore, states that elect to serve HCBS waiver participants with community spouses under the section 1924 spousal rules must use as the personal needs allowance either the maintenance amount which the state has elected under 42 CFR § 435.726 or 42 CFR § 435.735 (as appropriate), or an amount that the state can demonstrate is a reasonable amount to cover the individual's maintenance needs in the community. If the PNA amount differs from the amount

specified for the individual under regular post-eligibility rules, explain in Item B-5-d-ii why this amount is reasonable to meet the needs of the participant. Also, specify the state's policies with respect to the deduction of incurred expenses for necessary medical and remedial care not covered under the state plan.

Item B-5-e: Regular Post-Eligibility Treatment of Income: Section 1634 and SSI Criteria State

Instructions

Complete the item if required based on Item B-4-a and Item B-5-a. See *General Guidance Concerning Completing Appendix B-5*.

Technical Guidance

The entries in this item apply only for the period starting January 1, 2014 and extending through September 30, 2027 (or other date as required by law). This item applies to waivers in section 1634 or SSI Criteria States, as indicated in Item B-4-a in Appendix B-4. The rules governing post-eligibility treatment of income in section 1634 and SSI criteria states are located at 42 CFR § 435.726 (see Attachment C). All parts of the item must be completed. Under each part of the item (i-iii), select only one of the pre-specified choices. In the case of the allowance for the needs of an individual, the allowance may be based on a standard contained in the state plan (e.g., SSI standard) or spelling out another basis for the allowance. There is no ceiling on the amount of this allowance. States have latitude in establishing the maintenance allowance for the individual. As discussed previously, the amount of the allowance may vary depending on the needs of the individual or groups of individuals.

With respect to the allowances for the community spouse and the participant's family, the choices available are defined under the provisions of 42 CFR § 435.726. Select one of the choices specified for the community spouse and the family. With respect to incurred medical and remedial care expenses, indicate whether the state deducts all such expenses or imposes a reasonable limit on the amount that may be deducted and specify the nature of the limit.

If the amount protected for the individual's maintenance allowance is equal to or greater than the amount calculated as the individual's total income under the post eligibility process, select the "not applicable" choice under the allowance for a spouse and a family. If the state is a Miller Trust State, see the preceding discussion of Miller Trusts.

Even though the state must use spousal impoverishment rules to determine eligibility and must use spousal post-eligibility rules, the state still must address post-eligibility treatment of income in the case of waiver participants who do not have a spouse. Item B-5-e provides for specifying an allowance for a spouse who does not meet the definition of a community spouse under the provisions of section 1924 of the Act. As a general matter, such an allowance is not provided because spousal post-eligibility rules will apply and the "not applicable" choice should be selected. If, however, the state provides for such an allowance, it must specify the circumstances when an allowance for a spouse will be made under regular post-eligibility rules. CMS will review these circumstances to determine whether such an allowance may be made. Spousal post-eligibility rules must be used in all instances to which they apply. A state may not provide for the use of alternative rules to its spousal post-eligibility rules.

Item B-5-f: Regular Post-Eligibility Treatment of Income: Section 209(b) State

Instructions

Complete the item if required based on Item B-4-a and Item B-5-a. See *General Guidance Concerning Completing Appendix B-5*.

Technical Guidance

The entries in this item apply only for the period starting January 1, 2014, and extending through September 30, 2027 (or other date as required by law). This item applies to waivers in section 209(b) states, as indicated in Item B-4-a in Appendix B-4. Each item parallels the corresponding item for §section 1634 and SSI criteria states, but some of the choices differ, based on the requirements in 42 CFR § 435.735 which govern post-eligibility in section 209(b) states. See the technical guidance for Item B-5-e.

Item B-5-g: Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

Instructions

Complete the item if required based on Item B-4-a and Item B-5-a. See *General Guidance Concerning Completing Appendix B-5*.

Technical Guidance

The entries in this item apply only for the period starting January 1, 2014, and extending through September 30, 2027 (or other date as required by law). In this item, the state establishes the post-eligibility rules that it will apply to waiver participants for whom eligibility has been determined using spousal impoverishment rules. In the case of individuals who do not have a community spouse as defined in section 1924 of the Act, regular post-eligibility rules (as specified in Item B-5-e or Item B-5-f) apply.

The spousal impoverishment post-eligibility rules provide for a more generous community spouse and family allowance than the rules under 42 CFR § 435.726 and 42 CFR § 435.735. The spousal protection rules also provide for a personal needs allowance (PNA) described in §1902(q)(1) of the Act for the needs of the institutionalized individual. This allowance is a "reasonable amount for clothes and other personal needs of the individual...while in an institution." For an institutionalized individual, this may be as low as $30 per month. However, unlike the institutionalized individual whose room and board are covered under Medicaid, the personal needs of a waiver participant must include a reasonable amount for food, shelter, clothing and other customary living expenses. The minimum monthly PNA is not sufficient to meet these needs when the individual lives in the community.

Therefore, states that elect to serve HCBS waiver participants with community spouses under the section 1924 spousal rules must use as the personal needs allowance either the maintenance amount which the state has elected under 42 CFR § 435.726 or 42 CFR § 435.735 (as appropriate), or an amount that the state can demonstrate is a reasonable amount to cover the individual's maintenance needs in the community. If the PNA amount differs from the amount specified for the individual under regular post-eligibility rules, explain in Item B-5-g-ii why this amount is reasonable to meet the needs of the participant. Also, specify the state's policies with respect to the deduction of incurred expenses for necessary medical and remedial care not covered under the state plan.

Post Eligibility Treatment of Income Under Concurrent Waivers

Technical Guidance

Under the post-eligibility process, the income remaining after the required deductions are taken can only be applied to the cost of home and community-based waiver services. Excess income cannot be applied to the cost of regular Medicaid state plan services. This poses a problem in a capitated system because it is difficult to identify and separate 1915(c) waiver services for each individual.

Since excess income can only be applied to the cost of 1915(c) waiver services, the state may elect to use one of the following options regarding the application of excess income under a capitated system:

- The state could increase the amount of the waiver participant's maintenance needs allowance to an amount equal to or greater than the amount of income an individual can have and be eligible under 42 CFR § 435.217 (for Miller Trust States this includes income that is placed in a Miller trust);
- The state could develop a method to carve out/identify the cost of home and community-based waiver services from the cost of other Medicaid services so that the individual's patient liability is applied only to the cost of home and community-based waiver services; or
- The state could use the portion of the capitated payment rate that is attributable to home and community-based waiver services as the "dollar" amount of waiver services that the individual is liable for since the capitated portion of the rate that is attributable to home and community based waiver services is the actual amount that the state pays to the managed care organization/entity for these services.

If the state elects to increase the maintenance needs allowance for the waiver participant, the state would provide this information in Appendix B-5, Post Eligibility Treatment of Income under the allowance for the maintenance needs of the waiver participant under the following formula, electing the appropriate sections based on the state classification and whether or not the state is using the spousal impoverishment post eligibility rules.

If the state develops a method to carve out/identify the cost of home and community-based waiver services from the cost of other Medicaid services so that the individual's patient liability is applied only to the cost of home and community-based waiver services, this methodology should be specified in Appendix B-5 under the allowance for the needs of the waiver participant.

If the state uses capitated payment rate that is attributable to home and community-based waiver services as the "dollar" amount of waiver services that the individual is liable it must provide an explanation in Appendix B-5 under the allowance for the needs of the waiver participant that takes into account the following: Under a capitated system, the "benefit" becomes the amount the state is expending on behalf of the beneficiary, or the capitated payment and not necessarily the actual services that the individual receives. Therefore, states can isolate the amount of the capitation rate that applies to waiver services. When a state develops a capitation rate, factors that are used may include geographic area, age, target group, level or intensity of services. Thus, a state may have more than one capitation payment rate for the cost of home and community-based waiver services. If a state uses these factors in developing its rate, these amounts could be

used for the amount of the waiver services that an individual uses in determining his/her patient liability.

CMS Review Criteria (Items B-5-b – B-5-g)

- The state has completed the appropriate Regular Post Eligibility item, based on the selections made in Item B-5-a and Item B-4-a in Appendix B-4.
- For Regular Post Eligibility, the protected amounts comply with 42 CFR § 435.726 or 42 CFR § 435.735 as applicable.
- When the state imposes a limit on the amount of incurred medical or remedial care expenses that may be deducted, the limit is specified and is reasonable.
- For Spousal Impoverishment Post Eligibility, if the personal needs amount differs from the amount protected under regular post-eligibility rules, there is an explanation as to why the amount is reasonable to meet the maintenance needs of the waiver participant.

Appendix B-6: Evaluation/Reevaluation of Level of Care

Overview

In Appendix B-6, waiver level of care evaluation and reevaluation processes are specified. Only individuals who are determined to require an institutional level of care specified for the waiver may be enrolled in the waiver. The process that is used to make this determination for new waiver entrants is termed "evaluation." In accordance with 42 CFR § 441.302(c), the evaluation must find that there is a reasonable indication that the individual would need services in the appropriate level of care within the near future (one month or less). The periodic review of a waiver participant's condition to verify that the individual continues to require the level of care is termed "reevaluation."

In accordance with 42 CFR § 441.302(c), waiver level of care determinations must be consistent with those made for the appropriate institutional level of care under the state plan. Level of care is typically assessed using a standardized instrument or form that evaluates and re-evaluates an individual's need for the level of care. Most commonly, states utilize the same level of care evaluation instrument and procedures for the waiver as are used for hospital, NF, or ICF/IID services, as applicable. When an individual is determined not to require a level of care specified in the waiver, the person must be afforded the opportunity to request a Fair Hearing as provided in Appendix F-1.

Detailed Instructions for Completing Appendix B-6

Item B-6-a: Reasonable Indication of Need for Services

Instructions

Specify: (a) the minimum number of services (at least one) that an individual must require in order to be determined to need waiver services and (b) the minimum frequency services must be needed - at least monthly or require monthly monitoring when services are furnished on less than a monthly basis. The state may establish a minimum frequency, other than monthly, that a participant must require services in order to be determined to need waiver services or require monthly monitoring when services are furnished on less than a monthly basis.

Technical Guidance

In order for an individual to be considered to require a level of care specified for the waiver, the person should: (a) require at least one waiver service (as evidenced by the service plan) and (b) require the provision of waiver services at least monthly or, if less frequently, requires monthly monitoring (as documented in the service plan) to assure health and welfare. Individuals may not be enrolled in a waiver for the sole purpose of enabling them to secure Medicaid eligibility as members of the § 435.217 group. Entrance to the waiver is contingent on a person's requiring one or more of the services offered in the waiver in order to avoid institutionalization.

The need for the level of care specified for the waiver is demonstrated by the individual's needing one or more of the services offered by the waiver and the need to receive such services at least monthly. When services are not required on at least a monthly basis, the need for the level of care may instead be based on the need for at least monthly monitoring of the person's health and welfare and include periodic "face-to-face" monitoring of the health and welfare of the participant. This monitoring needs to be consistent with the monitoring procedures as specified in Appendix D-2 of the application. Such monitoring may be conducted through the waiver or through another means (e.g., targeted case management). The need for monitoring must be specified in the person's service plan and its performance recorded in the waiver record.

Post-entrance to the waiver, when a waiver participant is found not to be utilizing any waiver services for an extended period, the state should conduct a re-evaluation of level-of-care to reassess the need for waiver services.

CMS Review Criteria

The waiver specifies that:

- An individual must require at least one waiver service.
- An individual must require the provision of waiver services monthly or other minimum frequency as established by the state or, if less frequently than monthly, require monthly monitoring to assure health and welfare.

Item B-6-b: Responsibility for Performing Evaluations and Reevaluations

Instructions

Select the agency that performs evaluations and reevaluations of level of care (i.e., the agency that makes the level of care determination).

Technical Guidance

The determination that an individual requires a level of care specified in the waiver may be made directly by the Medicaid agency or another entity that has been designated by the Medicaid agency. In the case of the latter, the Medicaid agency must oversee the performance of the other entity, including ensuring that applicable level of care criteria have been properly applied, and should describe this in Appendix A of the waiver application.

When a different agency performs the initial evaluation of level of care and reevaluations, select the "other" choice and specify the agency that performs the initial evaluation and the agency that performs the reevaluation.

This item focuses on the agency that makes the level of care determination. Other entities (e.g., case management providers) may be responsible for performing assessments, gathering the

information that is necessary to make this determination and submitting this information to the state for the level of care waiver eligibility determination. Do not include such entities in the response to this item. The role that such entities play in the level of care process may be described in Item B-6-f. Pre-entrance activities associated with the initial evaluation of level of care may not be claimed as a waiver service since federal financial participation (FFP) for waiver services may only be claimed once a person has entered the waiver. The expenses for conducting such activities may be claimed as an administrative expense or, if provided in the state plan, under the coverage of targeted case management services. Please note that administrative costs, necessary for the efficient administration of the Medicaid state Plan, must be in accordance with the CMS approved Medicaid cost allocation plan. Cost allocation plans are not approved via approval of the HCBS waiver application.

CMS Review Criteria

The agency that performs evaluations and reevaluations of level of care is described sufficiently in the waiver application.

Item B-6-c: Qualifications of Individuals Performing Initial Evaluation

Instructions

In the text field, specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants.

Technical Guidance

42 CFR § 441.303(c)(1) requires that the waiver specify the credentials (minimum qualifications) of level of care evaluators. The state has latitude in determining these credentials. However, the qualifications should be appropriate for the waiver's target population. Examples might include a physician, registered nurse, licensed social worker, or qualified developmental disability professional. The qualifications of individuals who perform re-evaluations are specified in Item B-6-h.

CMS Review Criteria

The specified qualifications of evaluators are appropriate to the target groups specified in the waiver.

Item B-6-d: Level of Care Criteria

Instructions

In the text field, fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the state's level of care instrument/tool. Specify the level of care instrument/tool that is employed.

Technical Guidance

In this item specify the criteria that are used to evaluate/re-evaluate level of care. The description of the criteria should identify the factors that are assessed in evaluating level of care and the scoring system (if applicable) that is employed to determine level of care. Do not "paste" an instrument/tool or applicable protocols or regulations into the "text field" (when the web-based application is used, any material that is pasted into a text field will lose its underlying formatting). In addition to the full level of care criteria, the response may also include citations

of applicable state laws, regulations, and policies. When such citations are made, CMS expects that the documents will be made available through the Medicaid agency or the operating agency (if applicable) to CMS upon request. Also specify the instruments/tools that are used (e.g., by referencing the name of the instrument or form or the name of the automated system).

States should keep in mind that the ICF/IID level of care instrument for waiver or institution should not limit participation to those with certain conditions but instead should encompass persons with intellectual disability and related conditions, as provided in 42 CFR § 435.1009. (See discussion in section B-1-a). Waiver participation may be limited to individuals with certain conditions (e.g., autism), but those conditions must be explicitly specified in Appendix B-1-b, not embedded in a level of care evaluation.

When ICF/IID level of care is evaluated, it is not required that a physician recommend, certify, or verify that the individual should receive the level of care furnished through the waiver. Similarly, a physician certification or recommendation is not required for nursing facility level of care.

CMS Review Criteria

- The factors used to evaluate and re-evaluate level of care are consistent with and relevant to the level(s) of care specified for the waiver.
- ICF IID level of care is consistent with 42 CFR § 435.1009, persons with IID or related conditions. The level of care evaluation tool is functional and does not limit participation to individuals with certain conditions.

Item B-6-e: Level of Care Instrument(s)

Instructions

Select whether the instrument/tool that is used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care. If the tools are different, furnish the information specified.

Technical Guidance

When the waiver level of care instrument/tool differs from the instrument/tool used to determine institutional level-of-care, 42 CFR § 441.303(c)(1) requires the state to describe how and why they differ and explain how the outcome of the level of care determination under the waiver is reliable, valid, and fully comparable to the outcome for institutional evaluation. In particular, the state must be able to demonstrate that individuals who meet level of care via the application of the waiver instrument also would meet level of care when the institutional instrument is employed. Usually, states employ the same instrument/tool to evaluate level of care for the waiver and institutional services.

CMS Review Criteria

The waiver documents and provides evidence that when a different level of care instrument/tool is used for the waiver and institutional services, the outcomes of the evaluations are equivalent.

Item B-6-f: Process for Level of Care Evaluation/ Reevaluation

Instructions

In the text field, describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences.

Technical Guidance

The description of the process to evaluate/reevaluate the need for a level of care specified in the waiver should include a description of the assessments that are performed and the information that is gathered as part of the process and who is responsible for performing or arranging for these assessments or obtaining the necessary additional information. The process used for the re-evaluation of level of care does need not exactly match the process used for the initial evaluation of level of care, although the level of care criteria that are applied must be the same. For example, it may be necessary to obtain a psychological assessment to determine that a person who has applied for services in a developmental disabilities waiver program has intellectual disability. However, a state need not require that such an assessment be performed as part of re-evaluation once the person's diagnosis of intellectual disability has been confirmed. For re-evaluation, a state's criteria may take into consideration the needs of the individual without the support provided through the waiver. When the re-evaluation process differs from the initial evaluation process, it must be sufficient to confirm that the person continues to require the level of care specified in the waiver, including the continuing need for the provision of waiver services. A state may not provide for the presumptive continuation of an individual on the waiver. The re-evaluation process must provide for an affirmative finding that the individual continues to require the level of care.

CMS Review Criteria

- The waiver describes the types of assessments and information that is used in support of the determination of level of care and who is responsible for ensuring that this information is obtained.
- When the re-evaluation process differs from the evaluation process, appropriate information is gathered to confirm that the waiver participant continues to require a level of care specified in the waiver.

Item B-6-g: Re-evaluation Schedule

Instructions

Select the minimum frequency for the performance of level of care re-evaluation.

Technical Guidance

42 CFR §441.303(c)(4) requires that the state specify how often level of care re-evaluations are performed. In response to this item, specify the minimum frequency for the performance of level of care re-evaluations. Level of care must be re-evaluated no less frequently than annually. Re-evaluation of level of care may be performed at any time due to a change in a person's condition or service needs.

CMS Review Criteria

The waiver specifies that level of care will be re-evaluated at least annually.

Item B-6-h: Qualifications of Individuals Who Perform Re-evaluations

Instructions

Select whether the qualifications of individuals who perform level of care re-evaluations are the same as the qualifications of the persons who perform initial evaluations. If the qualifications are different, specify the qualifications of individuals who perform re-evaluations in the text field.

Technical Guidance

Individuals who may perform re-evaluations need not have the same qualifications as persons who perform initial evaluations. For example, a state may require that a physician perform the initial evaluation but permit a nurse to perform the re-evaluation. The qualifications should be appropriate for the waiver's target population.

CMS Review Criteria

The qualifications of individuals who perform re-evaluations are appropriate for the target groups specified in the waiver.

Item B-6-i: Procedures to Ensure Timely Re-Evaluations

Instructions

In the text field, specify the procedures that are used to ensure timely re-evaluations of level of care.

Technical Guidance

The regulation at 42 CFR § 441.303(c)(4) requires that the state specify its procedures to ensure that the level of care re-evaluations is performed on a timely basis. Timely re-evaluation means that the re-evaluation is completed prior to the end date of the previous evaluation to prevent a break in the continuity of a participant's services. Eligibility for waiver services hinges on the determination of the need for a level of care specified in the waiver. If a re-evaluation is not performed timely, it may have an adverse impact on the participant. In addition, the state will not be able to claim FFP for the services furnished to the participant until waiver eligibility is restored and may not claim FFP for services delivered during the period in which level of care has lapsed. Examples of possible procedures include the use of tickler files, edits in computer systems, or components parts of case management.

CMS Review Criteria

The procedures specified ensure that re-evaluations will be performed on a timely basis.

Item B-6-j: Maintenance of Evaluation/Reevaluation Records

Instructions

In the text field, specify the location(s) where records of evaluations and reevaluations of level of care are maintained.

Technical Guidance

Records of waiver participant evaluations and re-evaluations must be kept in written (printed) or electronically retrievable form for a minimum period of three years after the end of the waiver year when the evaluation or re-evaluation was performed. State law may dictate that these

records be kept for a longer period. These records must be readily retrievable, including when requested by CMS. As provided in 42 CFR § 441.303(c)(3), the location(s) where records of evaluations and reevaluations of level of care are maintained must be specified in the waiver. Records may be maintained at the Medicaid agency, the operating agency (if applicable), in case manager records, and/or in other locations (e.g., waiver provider offices). It is advisable that a set of records be maintained by a state agency (or, if applicable, by a state contractor) rather than only locally in order to ensure that the records are retrievable.

Quality Improvement: Level of Care

Level of Care (LOC) Determination

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/re-evaluating and applicant's/waiver participant's level of care consistent with care provided in a hospital, NF, or ICF/IID.

An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.

The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant LOC.

Instructions

The QIS must describe how the state Medicaid Agency will determine that each waiver assurance (and its associated component elements) is met. The waiver assurance and component elements are listed above. For each component element, this description must include:

- Activities or processes that are related to discovery and remediation, i.e., review, assessment or monitoring processes; who conducts the discovery or remediation activities and with what frequency, along with the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. These monitoring activities provide the foundation for quality improvement by generating information regarding compliance, potential problems and individual corrective actions. The information can be aggregated and analyzed to measure the overall system performance in meeting the waiver assurances. The types of information used to measure performance, should include relevant quality measures/indicators.
- The entity or entities responsible for reviewing the results (data and information) of discovery and remediation activities to determine whether the performance of the system reflects compliance with the assurances; and,
- The frequency at which system performance is measured.

Technical Guidance

This QIS element focuses on *discovery* and *remediation* activities, that is, processes to assess, review, evaluate or otherwise analyze a program, process, operation, or outcome. Specifically, the evidence produced as a result of discovery and remediation activities should provide a clear picture of the state's compliance in meeting an assurance.

CMS Review Criteria

The discovery of compliance with this assurance and the remediation of identified problems must address how the Medicaid agency assures compliance with the following level of care sub-assurances:

- An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.
- The LOC of enrolled participants are reevaluated at least annually or as specified in the approved waiver**.**
- The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant LOC;
- How frequently oversight is conducted; and
- The entity (or entities) responsible for the discovery and remediation activities.

Appendix B-7: Freedom of Choice

Overview

As provided in section 1915(c)(2)(C) of the Act and 42 CFR § 441.302(d), individuals have freedom of choice in the selection of home and community-based services or institutional services. The individual's choice must be documented during entrance into the waiver program. When an individual is not given freedom of choice of institutional or home and community-based services, the person must be afforded the opportunity to request a Fair Hearing as provided in Appendix F-1.

A state must inform the person of the feasible alternatives under the waiver so that the individual (or the person's legal representative) can make an informed choice. Feasible alternatives may only be determined after the assessment of an individual's needs and an evaluation of level of care. Feasible alternatives mean the types of waiver services that would be available to the individual to address the person's assessed needs, subject to the development of the person's service plan. It is not expected that an individual will be offered entrance to the waiver unless the assessment indicates that person's needs (including assuring the person's health and welfare) can be met through the provision of waiver services in combination with state plan, other formal and informal supports, and appropriate safeguards. Appropriate safeguards may include ensuring that the individual is informed of alternatives and risks and responsibilities, as evidenced, for example, by the execution of a risk agreement (see Appendix D-1). In this Appendix, the process by which individuals are afforded freedom of choice is specified.

Detailed Instructions for Completing Appendix B-7

Item B-7-a: Procedures

Instructions

In the text field, describe the procedures that are followed to inform the individual (or the person's legal representative) of the feasible alternatives under the waiver and to document the individual's choice of home and community-based services or institutional services.

Technical Guidance

The regulation at 42 CFR § 441.303(d) requires that the waiver describe how eligible individuals are informed of the feasible alternatives available under the waiver and how such individuals are

permitted to choose either institutional services or home and community-based services. In addition to describing the procedures for how these activities are performed, the description also should identify the entity or individual responsible for performing these activities. The procedures should include ensuring that the individual (or the individual's legal representative) exercises an informed choice. This may entail orally explaining the feasible alternatives and the right to exercise freedom of choice or communicating with the individual through alternative means. A record must be established that documents the individual's choice. Include in the description the name of the form/document that is used to document that the person has been informed of feasible alternatives and has been permitted to choose between waiver and institutional services.

CMS Review Criteria

- The procedures described ensure that individuals are provided information about the services that are available under the waiver and that they have the choice of institutional or home and community-based services prior to the enrollment into the waiver program.
- The waiver identifies the entity or individual responsible for providing information about feasible alternatives and informing the individual, or their legal representative, about their freedom of choice between waiver and institutional services.

Item B-7-b: Maintenance of Forms

Instructions

In the text field, specify the locations where copies of the forms that document that the participant has been informed of feasible alternatives and has exercised choice in the selection of waiver or institutional services are maintained.

Technical Guidance

States are not required to submit copies of the form that documents that an individual has been informed of the feasible alternatives under the waiver and has exercised freedom of choice in the selection of waiver or institutional services. However, the form (or forms) identified in Item B-7-c must be available from the Medicaid agency or the operating agency (if applicable) to CMS upon request.

The requirements for maintaining records concerning freedom of choice are the same as those that apply to the maintenance of documentation of level of care evaluations and re-evaluations.

Appendix B-8: Access to Services by Limited English Proficient Persons

Overview

Recipients of federal assistance (including Medicaid) are required to provide oral and written assistance to persons who are limited English proficient (LEP) to aid them to access and use services in accordance with 42 CFR § 435.905(b).

Detailed Instructions for Completing Appendix B-8

Instructions

In text field, describe the accommodations that are made for LEP persons who seek waiver services and post-entrance for LEP waiver participants.

Technical Guidance

Oral and written assistance to LEP persons may take various forms, including hiring bilingual staff, arranging for interpreters (interpreter services may be offered as a waiver service), and translating written materials when a significant number or percentage of program beneficiaries require information in a language other than English.

CMS Review Criteria

A variety of accommodations are described, both in conjunction with the waiver entrance process and for communicating with LEP persons on an ongoing basis (e.g., by providing for bilingual case managers).

Appendix C: Participant Services

Brief Overview

Appendix C specifies the services that are provided in the waiver. The Appendix has four components:

- Appendix C-1 is a summary listing of the services covered in the waiver;
- Appendix C-2 contains general service specifications;
- In Appendix C-3, the specifications of each waiver service are detailed; and,
- In Appendix C-4, the limitations (if any) that apply to the overall amount of waiver services are specified.

CMS policies and guidance concerning the coverage of waiver services are discussed in detail in the instructions for Appendix C-3.

Web-Based Application

The web-based waiver application combines Appendix C-1 and Appendix C-3 into a single module. In the web-based application, services are added one-by-one and a master list of services is created that is the equivalent of Appendix C-1. In addition, the web-based application uses the master list of services to populate the tables in Appendix J-2 that must be completed in order to calculate Factor D in the cost-neutrality demonstration. In addition, there also are linkages between the Appendix C-1/C-3 module and Appendix E with respect to waiver services that may be participant-directed.

Appendix C-1: Summary of Services Covered

Overview

In Appendix C-1, the services offered under the waiver are listed. Waiver services are categorized into four types. Each of these services is further specified in Appendix C-3. When case management is not provided as a waiver service, information also must be provided about how case management is furnished to waiver participants.

Detailed Instructions for Completing Appendix C-1

Item C-1-a: Waiver Services Summary

Instructions

In the table, indicate whether the waiver includes one or more of the listed statutory services. If a statutory service has an alternate title, insert the title. Also list the titles of other waiver services, extended state plan services, and supports for participant direction that are covered in the waiver (as applicable). See the technical guidance for a discussion of the classification of waiver services by type. In the web-based application, drop-down menus are used to select and classify services.

Technical Guidance

This table serves as a master summary list of the services covered in the waiver. A service specification template (Appendix C-3) must be completed for each service listed in the summary. In addition, this table serves as the basis for the list of waiver services that are included in the estimate of the average per capita cost of waiver services in Appendix J-2 of the application.

The table is divided into four parts: (a) services that are specifically authorized or otherwise included in section 1915(c) of the Act ("statutory services"); (b) "other services" not specified in the statute for which the state requests the authority to provide under the provisions of 42 CFR § 440.180(b)(9); (c) extended state plan services; and (d) supports for participant direction. Each of these classifications is described as follows:

1. Statutory Services

This table lists each of the services that are specifically authorized or otherwise included in section 1915(c) of the Act. The core definitions of these services (included in the attachment to this Appendix) describe the commonly understood scope and nature of each of these services. Indicate whether the waiver includes these services. The scope of the service (as specified in Appendix C-3) does not have to exactly match the core service definition. So long as the specified scope of the service aligns with the core service definition, the service is considered a statutory service. Similarly, it is not necessary that the title for the service be the same as statutory title. For example, if the scope of case management services aligns with the core definition, the waiver is considered to include this service, even though the state may use "care management" or "support coordination" as its title. When an alternative title is used, enter it in the text field provided. Also use the alternative title in the service specification template in Appendix C-3 and in the cost neutrality calculation table in Appendix J.

When case management services are not included as a waiver service, complete Items C-1-b and C-1-c (if applicable) (see below). Please note that when case management is provided as an administrative function, administrative costs must be in accordance with the approved cost allocation plan. Cost allocation plans are not approved via this waiver application.

2. Other Services

CMS regulation at 42 CFR § 440.180(b)(9) permits a state to request the authority to offer "other" services that are not expressly authorized in the statute as long as it can be demonstrated that the service will be necessary to assist a waiver participant to avoid institutionalization and function in the community. In this part of the table, list the services that are offered in the waiver that are not statutory services. However, in this list, do not include "extended state plan" or

"supports for participant direction" services, even though they are considered to be types of "other services." These services are listed in the next two parts of the table. Some non-statutory services are included in the core service definitions (e.g., assisted living, personal emergency response system). However, the core service definitions are by no means inclusive of all the types of services and supports that states may offer in waivers. Again, if necessary, insert additional rows into this part of the table to accommodate all the other services offered through the waiver.

3. Extended State Plan Services

The services included in a waiver must not duplicate services that are provided under the state plan. However, through a waiver, a state may augment the services that it provides under the state plan. When a state wants to enhance the amount, duration or frequency of a state plan service but otherwise the scope of the service is the same as the state plan service, the service is considered an "extended state plan" service. For example, under a waiver, the number of home health aide visits that are allowed under the state plan can be augmented. The amount chargeable as waiver services is the amount incurred after any limits in state plan services are exhausted. In this part of the table, list any other extended state plan services that are included in the waiver. In the service specifications for these services, note that the service is covered under the state plan and describe how the amount, duration or frequency of the service differs from the state plan. While a waiver service may be similar in scope to a state plan service, it would be considered an "other" service rather than an extended state Plan service if the service delivery modality (i.e., availability of participant direction) is different under the waiver.

Services that a state chooses not to cover under their state plan (optional state plan services) but are included under a waiver, are considered "other" services or statutory services (e.g., personal care) as the case may be, not extended state plan services. When a service is covered under the waiver that is similar to but has a different scope and/or uses different types of providers than the service covered under the state plan, it is considered an "other" service, not an extended state plan service. A service is not considered to be an extended state plan service if it cannot be reimbursed in whole or in part under the state plan.

If an extended state plan coverage is proposed in order to provide a service in an amount greater than permitted under the state plan, the coverage may only apply to adults (individuals age 21 and older). When children are served in a waiver, the services that are included in the waiver must take into account the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit requirements. Federal requirements concerning EPSDT mandate that Medicaid eligible children receive all medically necessary services coverable under section 1905(a) of the Act regardless of whether such services are specifically included in the state plan. The waiver may not provide for the coverage of services that could be furnished to children under EPSDT. If a waiver targets children exclusively, it may not provide for the coverage of any service that can be offered through the state plan.

4. Supports for Participant Direction

As discussed in more detail in the instructions for Appendix E, when a state provides the opportunity for participants to direct some or all of their waiver services, the state must make available certain supports to waiver participants who do so. These supports include "financial management services" and "information and assistance" to support waiver participants in

directing and managing their services. The core service definitions include "financial management services" and "information and assistance in support of participant direction."

When the waiver provides opportunities for participants to direct some or all of their waiver services, indicate in this part of the table whether either of these supports (along with any other supports for participant direction as defined by the state) are covered as waiver services. Please note that these supports for participant direction do not necessarily have to be provided as a distinct waiver service (for example, supports for participant direction may be offered in conjunction with the provision of waiver case management services. Both types of supports also may be furnished as administrative activities rather than as waiver services. When these supports are not covered as waiver services, their provision is described in Appendix E.

Section 1915(b)/1915(c) Concurrent Waivers: Section 1915(b)(3) Services

When the HCBS waiver operates concurrently with a section 1915(b) waiver, the state may have received CMS approval to offer additional services under the provisions of section 1915(b)(3) of the Act. Because the provision of such services is authorized under the section 1915(b) waiver authority rather than the section 1915(c) waiver authority, do not include the additional section 1915(b)(3) services in the listing of HCBS waiver services. Such services are specified in the section 1915(b) waiver application and subject to separate CMS review and approval. Similarly, when the section 1915(b) waiver permits managed care entities to use savings in order to provide alternative services to beneficiaries, do not include such services in the listing of HCBS waiver services. Also note that any additional services provided to section 1915(c) waiver participants as part of a capitated arrangement under section 1915(b), are provided without additional cost to the section 1915(c) waiver — the cost to the section 1915(c) waiver is the capitated rate, whether or not additional services are provided.

CMS Review Criteria

- Services have been properly classified.
- There is no duplication of state Medicaid plan services.
- Non-statutory ("other") services are necessary for assisting waiver participants to avoid institutionalization and function in the community.

Item C-1-b. Alternate Provision of Case Management Services to Waiver Participants

Instructions

Select the payment authority or authorities under which case management functions are conducted and complete Item C-1-c as applicable, including an indication as to whether case management is provided as a waiver service. Given that case managers are critical for ensuring that regulatory requirements for both person-centered planning and HCBS settings are met, states should describe the training required of case managers on both topics.

Technical Guidance

In the context of an HCBS waiver, case management usually entails (but is not limited to) conducting the following functions:

- Evaluation and/or re-evaluation of level of care;
- Assessment and/or reassessment of the need for waiver services;
- Development and/or review of the service plan;
- Coordination of multiple services and/or among multiple providers;

- Linking waiver participants to other federal, state and local programs;
- Monitoring the implementation of the service plan and participant health and welfare,
- Addressing problems in service provision;
- Monitoring compliance with HCBS settings criteria;
- Reporting and following-up on critical incidents;
- Responding to participant crises; and
- For waivers with cost or service duration limits, monitoring to detect and resolve situations when the needs of an individual might exceed the limit(s) to ensure health and welfare of waiver participants.

Case management may be covered as a waiver service. When case management is covered as a waiver service, functions that are performed prior to the entrance of an individual to the waiver (e.g., initial evaluation of level of care) may not be billed as a waiver service (however, they potentially may be claimed as an administrative expense or billed to 1915(g) state plan Targeted Case Management or another Medicaid authority).

Case management also may be covered as a state plan service (Targeted Case Management) under section 1915(g)(1) of the Act, or another Medicaid authority. When case management is covered as a waiver service, its scope and other information about the service is described in Appendix C-3. When case management is not covered as a waiver service, select the payment authority under which waiver case management functions are provided and complete Item C-1-c. This information assists CMS in understanding the overall structure of the waiver. In rare instances (e.g., small, highly specialized waiver programs), case management may not be furnished as a distinct activity but instead is furnished as a component of other waiver services. If this is the case, select "not applicable." When case management is provided as a Medicaid administrative activity, states must ensure that the costs are in accordance with the approved cost allocation plan. CMS does not approve cost allocation plans via the waiver application.

Item C-1-c: Delivery of Case Management Services

Instructions

In the text field, specify the entity or entities that conduct case management functions on behalf of waiver participants and the requirements for their training on the HCBS settings and person-centered planning regulatory requirements. Do not complete if case management is a service covered through the waiver and defined in C-1/C-3.

Item C-1-d: Remote/Telehealth Delivery of Waiver Services

Instructions

Specify in the chart whether each waiver service that is specified in Appendix C-1/C-3 can be delivered remotely/via telehealth. If any waiver services can be delivered remotely/via telehealth, add a response for the items below the chart.

Technical Guidance

"Telehealth" refers to a general service modality, and states may use other terms to reflect the use of telehealth in their HCBS waivers.

If the state is planning to allow for any waiver services to be delivered remotely/via telehealth, include the following information in the waiver application:

- How the remote service will be delivered in a way that respects the privacy of the individual especially in instances of toileting, dressing, etc.
- How the telehealth service delivery will facilitate community integration.
- How the telehealth will ensure the successful delivery of services for individuals who need hands on assistance/physical assistance, including whether the service may be rendered without someone who is physically present or is separated from the individual.
- How the state will support individuals who need assistance with using the technology required for telehealth delivery of the service.
- How the telehealth will ensure the health and safety of an individual.

Appendix C-2: General Service Specifications

Overview

Appendix C-2 addresses topics that typically cut-across several waiver services rather than applying only to specific, individual services. In part, this appendix is designed to relieve states of having to repeat information multiple times in each service's specification (e.g., a requirement that a direct service worker must undergo a criminal background investigation). Additional topics that are addressed include the provision of services in facilities that are subject to the requirements of the Keys Amendment (section 1616(e) of the Act) and whether a state pays legally responsible individuals, relatives and/or legal guardians for the provision of waiver services.

Detailed Instructions for Completing Appendix C-2

Item C-2-a: Criminal History/Background Investigations

Instructions

When individuals who provide waiver services must undergo a criminal history/background investigation, select the "yes" response and specify in the text field the types of positions (e.g., personal assistants) for which such investigations are required, the scope of the required investigation (e.g., state or national background check), and the process that is employed to ensure that mandatory investigations have been conducted, including the entity responsible for conducting the investigation. If the state does not require that such investigations be conducted for any type of position that furnishes waiver services, select the "no" response.

Technical Guidance

As a safeguard, most states require that individuals who provide direct support and/or other services to waiver participants undergo a pre-employment criminal history check and/or background investigation. Here, identify the types of positions for which such checks or investigations are required, the entity that is responsible for conducting checks or investigations (e.g., provider agency), and the nature of such investigations. When investigations or checks are required, explain how the state ensures that they have been conducted in accordance with the state's policies (e.g., as part of the certification of workers or as part of the periodic review of provider agencies). The response may cite applicable state laws, regulations, or policies that pertain to this topic. The material cited must be readily available through the Medicaid agency or the operating agency (if applicable) upon request by CMS. When criminal history and/or

background investigations are required, this information need not be repeated in the provider qualifications section of the applicable service specifications in Appendix C-3.

CMS Review Criteria

When criminal history/background investigations are required, the waiver specifies:

- The types of positions that must undergo such investigations;
- The entity responsible for conducting the checks or investigations;
- The scope of the required investigation; and
- The state's process to ensure that mandatory investigations have been conducted

Item C-2-b: Abuse Registry Screening

Instructions

If abuse registry screening is required, select the "yes" response and specify in the text field: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the type of positions (e.g., personal assistants, case managers) for whom abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted, including the entity responsible for conducting the screening against the registry, and (d) the process for ensuring continuity of care for a waiver participant whose service provider was added to the abuse registry. If abuse registry screening is not conducted, select the "no" response.

Technical Guidance

As an additional safeguard, many states maintain abuse registries and require that workers who furnish direct services to waiver participants and other positions to undergo pre-employment screening through such a registry. This item asks whether such screening is required and, if so, requests that the state provide information about such screening. State laws, regulations, or policies cited in the response to this item must be readily available through the Medicaid agency or the operating agency (if applicable) when requested by CMS. When abuse registry screening is required, this information need not be repeated in the provider qualifications section of the applicable service specifications in Appendix C-3.

CMS Review Criteria

When abuse registry screening is required, the waiver specifies:

- The entity (entities) responsible for maintaining the abuse registry;
- The type of staff for whom abuse registry screenings must be conducted;
- The entity or entities responsible for conducting the screening against the registry;
- The state process for ensuring that mandatory screenings have been conducted; and,
- The process for ensuring continuity of care for a waiver participant whose service provider was added to the abuse registry.

Item C-2-c: Facilities Subject to Section 1616(e) of the Social Security Act

With publication of final regulations in 2014 and the addition of the section Appendix C-5 regarding home and community-based settings requirements, this section of the waiver application is no longer needed. Therefore, this section was removed from the waiver application in 2022 and all instructions and technical guidance for this section of the waiver application were removed from the Technical Guide. States need to complete Appendix C-5upon renewal .

Discussion: Items C-2-d and C-2-e

Items C-2-d and C-2-e address similar topics but are distinct. Both concern state policies regarding payment for the provision of waiver services by individuals who are related to the participant (and, in the case of Item C-2-e, a legal guardian of a participant). However, the scope of Item C-2-d is narrow. It solely concerns payment for the provision of *personal care or similar services by legally responsible individuals* (e.g., a parent of minor child). The instructions for Item C-2-d below define "personal care or similar services."

Item C-2-e addresses state policies regarding the payment for the provision of *any type of waiver service* by a relative or legal guardian, and the provision of services other than personal care by legally responsible individuals (keeping in mind that the provision of personal care or similar services by such persons has been addressed in Item C-2-d). In this item, a state specifies whether it permits payments to relatives or legal guardians for waiver services and, if so, any conditions or limitations that the state places on such payments. For example, a state may decide to make payments to relatives or legal guardians only in certain circumstances, for limited periods of time, or permit payment to be made only to specified types of relatives (e.g., relatives who do not reside in the same household as the participant).

States are required to ensure individuals have access to needed services, and when necessary, states should strongly consider the authorization of legally responsible individuals to meet the requirement of ensuring the delivery of needed services. It is up to the state to decide whether to provide for either type of payment and, when such payments are made, to specify the circumstances when they are permitted. In the Appendix C-3 service specification template, there are check-offs as to whether the state allows for the provision of a service by a legally responsible individual and/or a relative/legal guardian. The conditions on payment specified in Items C-2-d and C-2-e apply to these check-offs. For example, if a state provides in Item C-2-e that a relative may furnish waiver transportation services only when there is no other provider available, then that that condition applies when "relative/legal guardian" is checked as a potential provider of the transportation service in Appendix C-3.

Whenever a legally responsible individual or relative/legal guardian is paid for the provision of a waiver service, the individual must meet the provider qualifications that apply to a service in accordance with 42 CFR §§ 441.302(a)(1) and (2) and there must be a properly executed provider agreement, in accordance with 42 CFR § 431.107(b). In addition, other requirements such as the proper documentation and monitoring of the provision of services also apply.

Lastly, other regulatory provisions such as 42 CFR §§ 441.301(c)(1) and (c)(4) regarding the person-centered planning process and HCBS settings criteria continue to apply, including the requirements at 42 CFR § 441.301(c)(1)(vii): "The person-centered planning process: offers informed choices to the individual regarding the services and supports they receive and from whom."

Item C-2-d: Provision of Personal Care or Similar Services by Legally Responsible Individuals

Instructions

Select whether the waiver provides for *extraordinary care* payments to legally responsible individuals for the provision of personal care or similar services. If so, specify: (a) the types of

legally responsible individual(s) who may be paid to furnish such services and the services they may provide; (b) the method for determining that the amount of personal care or similar services provided by a legally responsible individual is "extraordinary care**"** , exceeding the ordinary care that would be provided to a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant and avoid institutionalization; (c)the state policies to determine that the provision of services by a legally responsible individual is in the best interest of the waiver participant; (d) the state processes to ensure that legally responsible individuals who have decision-making authority over the selection of waiver service providers use substituted judgement on behalf of the individual; (e) any limitations on the circumstances under which payment will be authorized or the amount of personal care or similar services for which payment may be made; (f) any additional safeguards the state implements when legally responsible individuals provide personal care or similar services; and, (g) the procedures that are used to ensure that payments are made only for services rendered.

Technical Guidance

Through an HCBS waiver, a state may elect to make payment for personal care or similar services that are rendered by legally responsible individuals (as defined in state law or regulations, such as a parent (biological or adoptive) or guardian of a minor child) when such services are deemed extraordinary care so long as the state specifies satisfactory criteria for authorizing such payments. The criteria must include how the state will distinguish extraordinary from ordinary care. By extraordinary, CMS simply means care exceeding the range of activities that a legally responsible individual would ordinarily perform in the household on behalf of a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant and avoid institutionalization. For example, support for activities of daily living such as bathing and dressing by a legally responsible individual to a teenage child enrolled in a waiver could constitute extraordinary care, as teenage children without a disability or chronic illness do not typically require such support.

In the context of this item, personal care or similar services mean: (a) personal care (assistance with ADLs or IADLs) whether furnished in the home or the community and however titled by the state in the waiver (e.g., personal assistance, attendant care, etc.) and (b) closely related services such as home health aide, homemaker, chore, and companion services.When a state provides for the payment to legally responsible individuals for extraordinary care, the service must meet all the waiver criteria required when delivered by a customary provider. The legally responsible individual must meet the provider qualifications (as specified in Appendix C-3) that the state has established for the personal care or similar services for which payment may be made. The state must also ensure waiver participants have informed consent of providers of such services in accordance with Appendix D-1-f and must monitor the delivery of those services as provided in Appendix D-2, including the required documentation and assurance that the services are delivered in accordance with the service plan. In addition, as with all providers, such arrangements require the proper execution of a provider agreement, and, as with all services, states are to implement payment review procedures to ensure that the services for which payment is made have been rendered in accordance with the service plan and the conditions that the state has placed on the provision of such services.

For waiver services that states permit to be provided by legally responsible individuals, state policies should include determining that the provision of personal care or similar services by a legally responsible individual is in the best interests of the waiver participant and, in instances when the legally responsible individual has decision-making authority over the selection of providers of waiver services, ensuring that the legally responsible individual uses substituted judgement on behalf of the individual (i.e., makes decisions based on an understanding of what the individual would want).

States may choose to specify limitations on the utilization of legally responsible individuals, such as specific circumstances under which legally responsible individuals may be paid providers, ~~additional safeguards~~ such as:

- Limiting the amount of services that a legally responsible individual may furnish. For example, a state may decide to limit the amount to no more than 40 hours in a week and thereby take into account the amount of care that a legally responsible individual ordinarily would provide. When there is such a limitation, it should be reflected in the limitations section of the service specification in Appendix C-3. Note that states may need to revisit such limitations if they are unable to meet the waiver assurance that services are delivered in accordance with the service plan, including in the type, scope, amount, duration, and frequency specified in the service plan.
- Addressing other foreseeable risks that might attend the provision of services by legally responsible individuals. States should describe these risks and mitigation strategies.

When legally responsible individuals are used to deliver services, all required statutory and regulatory components of 1915(c) waivers must continue to be met, including, but not limited to, an individual's free choice of providers, adherence to person-centered service planning, health and welfare oversight, and ensuring community integration consistent with the home and community-based settings regulations.

In addition, states should be aware that unless the waiver uses institutional eligibility rules that disregard the family income of a child waiver participant, paying a legally responsible relative may affect the child's eligibility for Medicaid.

To summarize, when a state provides for payment to legally responsible individuals for the provision of personal care or similar services, the services will be equivalent to services supplied by other types of providers. The waiver must also specify:

- The types of legally responsible individual (as defined in state law or regulations) to whom payment may be made;
- The waiver personal care or similar services for which payment will be made;
- How the state distinguishes extraordinary care from ordinary care;
- The state policies to determine that the provision of personal care or similar services by a legally responsible individual is in the best interests of the participant;
- When the legally responsible individual has decision-making authority over the selection of providers of waiver services, the state's process for ensuring that the legally responsible individual uses substituted judgement on behalf of the individual;
- Any limitations of the circumstances under which payment will be authorized;

- Any limitations on the amount of services for which payment will be made;
- Any additional safeguards not specified above the state implements when legally responsible individuals provide personal care or similar services;
- How the state implements required oversight, such as determining that payments are made only for services rendered.

CMS Review Criteria

When the waiver provides for the payment for personal care or similar services to legally responsible individuals for extraordinary care, the waiver specifies:

- The types of legally responsible individuals to whom payment may be made;
- The waiver personal care or similar services for which payment may be made;
- The method for determining that the amount of personal care or similar services provided by legally responsible individual is "extraordinary care," exceeding the ordinary care that would be provided to a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant and avoid institutionalization;
- The state policies to determine that the provision of personal care or similar services by a legally responsible individual is in the best interests of the participant;
- When the legally responsible individual has decision-making authority over the selection of providers of waiver services, the state's process for ensuring that the legally responsible individual uses substituted judgement on behalf of the individual;
- Any limitations on the circumstances under which payment will be authorized or the amount of personal care or similar services for which payment may be made;
- Any additional safeguards the state implements when legally responsible individuals provide personal care or similar services; and
- The procedures that are used to implement required state oversight, such as ensuring that payments are made only for services rendered.

Item C-2-e: State Policies Concerning Payment for Waiver Services Furnished by Relatives/ Legal Guardians

Instructions

This item concerns state policies regarding payment for waiver services rendered by relatives and/or legal guardians that do not fall within the scope of Item C-2-d. Select whether the state makes payments to relatives or legal guardians for any waiver service (besides personal care or a similar service furnished by a legally responsible individual as described in C-2-d). If the state makes payments to relatives and/or legal guardians for waiver services, select one of the next three choices and provide the additional information under the selected choice.

Technical Guidance

At the option of the state, waiver services may be provided by a relative and/or legal guardian of the participant. When responding to this item, keep in mind that Item C-2-d addresses extraordinary care payments to legally responsible individuals who furnish personal care or similar services to a waiver participant. **For the purposes of this item, legally responsible individuals are considered to be a type of "relative" with respect to payments for the provision of waiver services other than personal care or similar services.** When a relative or

legal guardian may be paid to provide waiver services, the relative or legal guardian must meet the provider qualifications that have been specified for the service. Services must be monitored as provided in Appendix D-2 and there must be a properly executed provider agreement.

This item presents four response choices as follows:

- **No Payments**. A state may elect not to make payments to relatives or legal guardians for the provision of any waiver services.
- **Specific Circumstances**. A state may elect to pay relatives or legal guardians for the provision of specified waiver services only in *specific circumstances*. Such circumstances must be specified by the state. Specific circumstances might include: (a) the lack of a qualified provider in remote areas of the state; (b) the lack of a qualified provider who can furnish services at necessary times and places; (c) the unique ability of a relative or legal guardian to meet the needs of a person; and/or, (d) other circumstances specified by the state.

  When this choice is selected, the waiver must specify the following:

  - The types of relatives or legal guardians that may be paid to furnish waiver services. For example, a state may specify that relatives may be paid to furnish services but not legal guardians. The state may specify that only relatives who do not live in the same household as the participant may be paid to furnish services. A state may specify that certain types of relatives may be paid to furnish services (e.g., grandparents of the participant) but others may not (e.g., legally responsible individuals). A state may provide that legally responsible individuals may be paid to furnish services (other than personal care or similar services, which have been addressed in Item C-2-d) that require specialized skills (e.g., nursing or physical therapy), provided that the legally responsible individual is not legally obligated to furnish such services.
  - The types of waiver services, and any limitations on the amount of waiver services, for which payment may be made to a relative or legal guardian. Non-legally responsible individuals may be permitted to furnish personal care or similar services.
  - The specific circumstances when payment may be made to a relative or legal guardian. The waiver also must describe the method for determining when these circumstances apply.
  - When payment may be made to a relative/legal guardian, the waiver should include the state policies for determining that the provision of waiver services by a legal guardian is in the best interests of the waiver participant.
  - When the relative/legal guardian has decision-making authority over the selection of providers of waiver services, the state's process for ensuring that the legally responsible individual uses substituted judgement on behalf of the individual;
  - Any additional safeguards the state implements when relatives/legal guardians provide waiver services; and
  - The procedures that are followed to ensure that payment is made only for services rendered.

  In Appendix C-3, there is the opportunity to select whether a waiver service may be provided by a legally responsible individual or a relative/legal guardian. When this choice has been

selected, the selection in Appendix C-3 is qualified by the response to this item (i.e., "relative/legal guardian" means the types that are specified in this item). It is not necessary to repeat the information provided in response to this item in the service specifications.

- **Specific Circumstances Do Not Apply**. A state may provide that relatives or legal guardians are permitted to be paid for rendering waiver services but not limit payment for such services to specific circumstances. That is, provided that the relative otherwise meets the qualifications to provide a service, the state will make payment to the relative or legal guardian. When this selection is made:
    - Specify any limitations on the types of relatives or legal guardians who may furnish services (e.g., whether legally responsible individuals are excluded).
    - In Appendix C-3, for each waiver service that a relative or legal guardian may furnish, check off relative/legal guardian as a provider type. When relative/legal guardian is not checked off in Appendix C-3, the state does not allow relatives or legal guardians to be paid to furnish the service. For example, if this selection has been made in Item C-2-e and transportation is the only service that has been checked off in Appendix C-3, then only the relatives or legal guardians specified here may be paid to furnish transportation and they may not be paid to provide any other waiver services.
    - Specify the state policies to determine that the provision of waiver services by a relative/legal guardian is in the best interests of the participant.
    - When the relative/legal guardian has decision-making authority over the selection of providers of waiver services, the state's process for ensuring that the legally responsible individual uses substituted judgement on behalf of the individual.
    - Specify the procedures that have been established to ensure that payment is made only for services rendered.
- **Other Policy**. Select this choice when either of the foregoing two choices does not accommodate the state's policies. For example, the state may restrict payment for waiver services to specific circumstances in the case of some services or certain types of relatives or legal guardians but not in the case of other services or other types of relatives or legal guardians. When this choice is selected, the information provided in the text field should parallel that required in the foregoing choices, depending on whether specific or extraordinary circumstance are involved.

CMS Review Criteria

When the waiver provides for the payment of services furnished by relatives or legal guardians:

- The types of relatives or legal guardians to whom payment may be made are specified.
- The waiver services for which payment may be made to relatives or legal guardians are specified.
- When relatives or legal guardians may be paid to furnish waiver services only in specific circumstances, the waiver specifies the circumstances and the method of determining that such circumstances apply.
- Limitations on the amount of services that may be furnished by a relative or legal guardian are specified.
- The state policies to determine that the provision of waiver services by a relative/legal guardian is in the best interests of the participant are specified.
- When the relative/legal guardian has decision-making authority over the selection of providers of waiver services, the state has a process in place for ensuring that the relative/legal guardian uses substituted judgement on behalf of the individual.
- Any additional safeguards the state implements when relatives/legal guardians provide waiver services are specified.
- The waiver specifies the procedures that are employed to ensure that payment is made only for services rendered.

Item C-2-f: Open Enrollment of Providers

Instructions

In the text field, specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers.

Technical Guidance

Except when a section 1915(c) waiver operates concurrently with a waiver granted under section 1915(b) of the Act waiving section 1902(a)(23) with respect to Medicaid beneficiary free choice of provider, any willing and qualified provider must be afforded the opportunity to enroll as a Medicaid provider. A willing provider is an individual or entity that executes a Medicaid provider agreement and accepts the state's payment for services rendered as payment in full. A qualified provider is a provider that meets the provider qualifications set forth in the approved waiver. In accordance with 42 CFR § 431.51. the state must provide for the ***continuous, open enrollment*** of waiver service providers.

A state may not place obstacles in the way of open provider enrollment (e.g., by selecting only a limited number of providers to furnish a waiver service through an RFP process, requiring that a provider be capable of furnishing services on a statewide basis or requiring that a provider contract with a governmental entity (other than the Medicaid agency) or affiliate with an Organized Health Care Delivery System). States have latitude in establishing qualifications to ensure that providers possess the requisite skills and competencies to meet the needs of the waiver target population. However, a state may not specify qualifications that are unnecessary to ensure that services are performed in a safe and effective manner. When CMS reviews the qualifications associated with each waiver service, it examines whether the proposed qualifications create obstacles to the enrollment of all willing and qualified providers.

In response to this item, describe the processes that are employed in conjunction with the operation of the waiver to assure that all willing and qualified providers have the opportunity to enroll as waiver providers. Potential providers should have ready access to information regarding the requirements and procedures to enroll as waiver providers. Effective processes might include making provider enrollment information and forms continuously available via the internet and/or periodically soliciting open provider enrollment in which times any provider that met the waiver provider qualifications would be enrolled by the state.

Section 1915(c) Waivers that Operate with Concurrent Managed Care

In the case of section 1915(b)/1915(c) concurrent waivers or other managed care authorities running concurrently with a 1915(c) waiver, it may be possible for a state to limit the providers of services by requesting a waiver of section 1902(a)(23) of the Act. In general, this waiver (most frequently granted under the provisions of section 1915(b)(4) of the Act) is employed to permit a state to contract with a limited number of managed care entities through which Medicaid beneficiaries obtain waiver and other services. Under a concurrent waiver, beneficiaries may be required to enroll with a managed care entity to receive services (when a waiver is granted under the provisions of section 1915(b)(1) of the Act) or may elect to voluntarily receive services through a managed care entity rather than through the regular Medicaid program (i.e., a state does not request a waiver under the provisions of section 1915(b)(1)).

In any case, a state must assure compliance with the provisions of 42 CFR § 438.207 which provides that each managed care entity "maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area." This requirement extends to providers of home and community-based waiver services that are furnished under the concurrent waivers.

In the case of section 1915(b)/1915(c) concurrent waivers, a state should respond to this item by briefly describing how it will assure compliance with 42 CFR § 438.207 with respect to the delivery of home and community-based waiver services, including describing any applicable provisions of its contracts with managed care entities.

The state should similarly respond here if the 1915(c) waiver is operating concurrently with another managed care authority, including sections 1932(a), 1915(a), or 1115 demonstrations.

CMS Review Criteria

- The provider enrollment processes described assure that all willing and qualified providers have the opportunity to enroll.
- Providers have ready access to information regarding requirements and procedures to qualify, and the timeframes established for qualifying and enrolling in the program.

Item C-2-g: State Option to Provide HCBS in Acute Care Hospitals

Instructions

Specify whether the state chooses the option to provide waiver HCBS in acute care hospitals. If the state chooses this option, specify: the services in this waiver can be provided by the 1915(c) HCBS provider when they are not duplicative of services available in the acute care hospital setting; how the 1915(c) HCBS will assist the individual in returning to the community; and

whether there is any difference from the typically billed rate for these HCBS provided during an acute care hospitalization (which is specified in the rate methodology in Appendix I-2-a).

Technical Guidance

Under section 3715 of the Coronavirus Aid, Relief, and Economic Security (CARES) Act, Congress added to the Social Security Act under section 1902(h)(1) a new provision that allows states to provide HCBS in acute care hospitals under certain conditions. In accordance with section 1902(h)(1) of the Act, the services must be:

- identified in an individual's person-centered service plan (or comparable plan of care);
- provided to meet the needs of the individual that are not met through the provision of hospital services;
- not a substitute for services that the hospital is obligated to provide through its conditions of participation, under federal or state law, or under another applicable requirement; and
- designed to ensure smooth transitions between acute care settings and home and community-based settings, and to preserve the individual's functional abilities.

CMS Review Criteria

If the state selected yes to this option:

- The waiver services that can be provided in acute care hospitals are specified.
- How the HCBS provided in acute care hospitals will assist individuals in returning to the community is described.
- Any difference from the typically billed rate for the HCBS when provided during acute care hospitalization is described.
- If there is a difference in the typically billed rate, this is included in the rate methodology in Appendix I-2-a.

Quality Improvement: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

The state verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.

The state monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

The state implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.

Instructions

The QIS must describe how the state Medicaid agency will determine that each waiver assurance (and its associated component elements) is met. The waiver assurance and component elements are listed above. For each component element, this description must include:

- Activities or processes that are related to *discovery and remediation*, i.e., review, assessment or monitoring processes; who conducts the discovery or remediation activities and with what frequency, along with the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. These monitoring activities provide the foundation for quality improvement by generating information regarding compliance, potential problems and individual corrective actions. The information can be aggregated and analyzed to measure the overall system performance in meeting the waiver assurances. The types of information used to measure performance, should include relevant quality measures/indicators.
- The entity or entities responsible for reviewing the results (data and information) of discovery and remediation activities to determine whether the performance of the system reflects compliance with the assurances; and
- The frequency at which system performance is measured.

Technical Guidance

This QIS element focuses on *discovery* and *remediation* activities, that is, processes to assess, review, evaluate or otherwise analyze a program, process, operation, or outcome. Specifically, the evidence produced as a result of discovery and remediation activities should provide a clear picture of the state's compliance in meeting an assurance.

CMS Review Criteria

The discovery of compliance with this assurance and the remediation of identified problems must address how the Medicaid agency assures compliance with the following provider qualification sub assurances:

- The state verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services;
- The state monitors non-licensed/non-certified providers to assure adherence to waiver requirements;
- The state implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.
- How frequently oversight is conducted; and
- The entity (or entities) responsible for the discovery and remediation activities.

Appendix C-3: Waiver Services Specifications

Overview

In Appendix C-3, the specifications of each service that is offered under the waiver (and listed in Appendix C-1) are detailed. The next section provides technical guidance concerning the coverage of services under a waiver and detailed instructions for completing the application's waiver service specifications template.

Technical Guidance Concerning Service Coverage

Introduction

States have considerable latitude in selecting and specifying the services that are offered through a waiver. Section 1915(c) of the Act specifically authorizes the provision of several types of home and community-based services. A state may propose to offer other services that are not listed in the statute, subject to CMS approval. Waiver services complement and supplement services that are furnished under the state plan. Waiver services may not duplicate the services that are provided under the state plan, but a waiver may expand upon the amount, duration, and frequency of services provided under the state plan except for EPSDT services. The selection of services to meet the needs of the waiver's target population clearly is a critical consideration in designing an effective waiver program.

While states have flexibility in selecting and specifying a waiver's services, there are certain requirements that must be met in specifying service coverage and additional considerations that states should take into account in designing their waiver programs and services. These topics are discussed in the following sections. There also is a brief overview discussion of waiver and Medicaid requirements as they pertain to providers of waiver services.

Requirements Concerning the Specification of the Scope of Services

As provided in 42 CFR § 441.301(b)(4), a state is required to: "describe the services to be furnished so that each service is separately defined." The definition of each waiver service must describe in concrete terms the goods and services that will be provided to waiver participants, including any conditions that apply to the provision of the service. The definition of the service (including any conditions that apply to its provision) is termed the "scope" of the service. When specifying the scope of a service do not use terms such as "including but not limited to . . .," "for example . . .," "e.g.,", "including . . .," "etc." CMS will not approve vague, open-ended or overly broad service definitions. The scope of a service must be readily ascertainable from the state's service definition – that is, the nature of what is provided to a waiver participant is expressed in understandable terms. It is important to keep in mind that FFP is only available for the performance of activities or the provision of goods that fall within the scope of the approved waiver service.

The scope of a service may be defined in one of two ways. An exhaustive service definition may be employed. An exhaustive definition specifies in detail the types of activities that are undertaken on behalf of a waiver participant or the goods that may be provided to a participant. For example, if a waiver includes the coverage of medical equipment, the service definition could include a detailed list of each item of medical equipment that may be provided. Items not included in the list will not be provided or reimbursed. If a state wishes to alter an exhaustive service definition, it must submit an amendment request to CMS.

In the alternative, a service may be defined as to its purpose. For example, a state may elect to cover "only those medical supplies needed for the respirator-related needs of a respirator-dependent patient" without listing the specific supplies that might be furnished. When a service is defined as to its purpose, it is not necessary to submit a waiver amendment to reflect changes in the exact nature of the service that might occur post-approval. At the same time, when a service is defined as to its purpose, the service definition may not be expressed in open-ended terms. In addition, when a service is defined as to purpose, the service definition should specify at least the component elements of the service. Many of the core service definitions included as

an attachment to the instructions for this Appendix are examples of how services may be defined as to their purpose.

As previously noted, states have the option of using the suggested core service definitions that are included in the attachment, modifying those definitions to meet their needs or developing their own service definitions. If a new service is proposed, its definition should use commonly accepted terms and may not be open ended in scope. When new services are proposed, CMS reviews the proposed service to ascertain whether the service:

- Contributes to the community functioning of waiver participants and thereby avoids institutionalization;
- Is reasonably related to addressing waiver participant needs that arise as a result of their functional limitations and/or conditions; and/or
- Falls within the scope of §1915(c) of the Act and is not at odds with other provisions of the Act.

Services that are diversional/recreational in nature fall outside the scope of section 1915(c) of the Act. In addition, with some exceptions, waiver funds may not be employed to pay for room and board expenses due to the general prohibition on coverage of room and board under section 1915(c) of the Act or to acquire goods and services that a household that does not include a person with a disability would be expected to pay for as household expenses (e.g., subscription to a cable television service).

The scope of the individual services included in a waiver may overlap. For example, the provision of personal assistance often is a common element in the delivery of many waiver services. It would be unreasonable and inefficient for CMS to require that services be defined in a fashion to eliminate overlapping activities by requiring that all forms of personal assistance be furnished under a single personal assistance service. At the same time, there must be mechanisms to prevent duplicate billing of services in accordance with the Improper Payments Elimination and Recovery Act of 2010. When, for instance, a state provides for the "free-standing" coverage of personal assistance but includes the provision of personal assistance as an integral element of the delivery of a residential or day service, the state must prohibit the billing of the free-standing coverage for personal assistance activities that are performed during periods when the waiver participant receives the residential or day service that already includes the provision of personal assistance and payment for personal assistance activities have been included in the payment for the residential or day service.

In a similar vein, the situation may arise when a waiver participant may be concurrently receiving two services that are nominally duplicative or overlapping. For example, when a participant is directing waiver services, the participant may be concurrently receiving both case management and information and assistance in support of participant direction (a.k.a., support brokerage). The performance of both services may entail performing similar functions (e.g., assisting the participant to locate service providers). CMS does not require that service definitions be fashioned to eliminate all potential overlap (e.g., by only permitting support brokers or case managers to provide assistance in locating providers but not both). However, service definitions should be structured so that they prevent the duplicative performance of and billing for the same activity undertaken on behalf of a waiver participant by multiple providers. For example, it is permissible for a case manager to bill for the time that the case manager spends in developing a service plan and for a support broker to bill for the time spent advising the participant during the service plan development process. It would not be permissible for both

the case manager and the support broker to bill for the preparation of the service plan. When there is the potential for duplicative billing for the performance of overlapping functions, states are advised to specify clearly in the relevant service definitions how the underlying activities are distinct and/or how duplicative billing will be prevented.

The regulation at 42 CFR § 441.301(b)(4) also provides that "multiple services that are generally considered to be separate services may not be consolidated under a single definition." The chief reasons why services may not be "bundled" are to: (a) ensure that waiver participants can exercise free choice of provider for each service and (b) ensure that participants have access to the full range of waiver services. Bundling means the combining of disparate services with distinct purposes (e.g., personal care and environmental modifications) under a single definition and providing that the combined services will be furnished by a single provider entity (e.g., one provider would furnish both personal care and environmental modifications) that is paid one rate for the provision of the combined services. CMS will consider a combined or bundled service definition only when it is established that the bundling of services will result in more efficient delivery of services but not compromise an individual's access to services or free choice of providers. When a bundled service definition is proposed, the costs of each component service must be separately identified in the estimate of Factor D in Appendix J-2 and utilization/costs must be tracked during the period that the waiver is in effect (i.e., encounter-type data must be compiled).

A service usually is not deemed to be a "bundled" service in the following circumstances:

- When the tasks/activities that are conducted on behalf of a participant are closely related or require similar provider skills (e.g., the provision of homemaker, chore and personal care services by an "in-home supports" service worker);
- The state groups related services under a single broad service title (e.g., "employment-related services") but clearly provides that: (a) each component service (e.g., prevocational, supported employment and supports for self-employment) is separately authorized in the service plan; (b) the participant may exercise free choice of providers for each component service; and (c) each component service is separately billed. When services are grouped under a broad service title, the costs and expected utilization of each component service must be separately identified in the estimate of Factor D in Appendix J-2 and utilization/costs of each component service must be tracked during the period that the waiver is in effect; and
- The service normally involves the co-provision of several services through a single provider in order to achieve the purpose of the service. Residential services typically fall into this category because of their round-the-clock nature.

Additional Considerations Concerning Service Coverage

There are several additional considerations that states should keep in mind when fashioning the coverage of services under a waiver. These include:

A. Relationship of Waiver Services to State Plan Services

Waiver services may *complement* the services that a state furnishes to Medicaid beneficiaries under the state plan by including services that are not covered under the state plan or *supplement* state plan services by providing for the coverage of services offered under the state plan in an amount, frequency or duration greater than allowed under the state plan) the services that a state furnishes to Medicaid beneficiaries under the state plan.

When *reviewing* proposed waiver service coverage, CMS will determine whether the service already is covered under the state plan. If so, the service will be approved when the state is proposing to exceed the limits imposed under the state plan (e.g., an extended state plan coverage is proposed). When a service coverage is proposed that appears to duplicate a state plan coverage, CMS will probe more deeply to determine whether the proposed waiver coverage is sufficiently distinct from the state plan coverage to warrant approval. The coverage generally will be considered distinct when: (a) the scope of the waiver coverage is materially different from the state plan service (b) the providers of the waiver service are different from the providers of the state plan service; and/or, (c) the method of service delivery is different (this difference may entail the availability of participant direction options under the waiver which are not available under the state plan). Coverage of services is not considered to be distinct when the sole difference lies in the amount of or the method of payment for the service. When proposing to cover a service that potentially overlaps the state plan coverage of a similar service, the state should include information in the service definition that clearly delineates how the two coverages differ.

In the case of certain services (e.g., specialized medical supplies and equipment), CMS recognizes that it would be overly burdensome to require states to spell out in detail how the waiver coverage does not duplicate coverage under the state plan. In such cases, it is acceptable for a state to specify that the authorization of such services will include making a determination that the state plan does not cover the item in question (either by determining that the state plan does not cover the item or requiring that an item be subject to a coverage determination under the state plan before it is authorized as a waiver service).

In addition, a state may not impair the access of waiver participants to services under the state plan. A state may not provide that the receipt of a waiver service is grounds for the denial of a state plan service for which the waiver participant may otherwise be eligible. For example, the receipt of personal assistance services under a waiver may not serve as the basis for denying the provision of home health services under the state plan. Similarly, a state may not require a waiver participant to terminate the receipt of a state plan service as a condition for receiving a waiver service. However, when authorizing waiver services, a state may take into account the services that a waiver participant receives through the state plan. The overarching objectives of this analysis are (1) to ensure that individuals have unfettered access to services to which they are entitled; and, (2) to ensure that there is no duplication (or potential duplication) of payment for services.

B. Pharmacy Services

Under the provisions of the Medicare Prescription Drug Benefit (Part D) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, states may not claim federal financial participation in the costs of most drugs that are furnished to dual-eligible Medicare/Medicaid beneficiaries on or after January 1, 2006. These beneficiaries will receive prescribed drugs through the Medicare Part D benefit. As a consequence, when a state covers pharmacy benefits under a waiver (usually as an extended state plan service in order to furnish prescribed drugs in an amount greater than permitted under the state plan), the service specification must exclude the provision of prescribed drugs available under Part D to dual eligible beneficiaries except when a drug is not covered under Part D.

State Medicaid Director letter #05-002 (included in Attachment C) provides further information on drugs that are excluded from Part D coverage. When a state does not cover these excluded

drugs for dual-eligible beneficiaries under its state plan, the excluded drugs may be covered under the waiver.

C. Relationship of Waiver Services to EPSDT Services

When a waiver serves children, the services that a state proposes to offer in the waiver must take into account the expanded benefits that must be provided to Medicaid child beneficiaries (individuals under the age of 21 who are eligible for Medicaid) under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) provisions contained in section 1905(r) of the Act. These provisions apply to children who are served in waivers, including children who would not be eligible for Medicaid except by virtue of their enrollment in a waiver. The intersection of HCBS waivers and EPSDT services is discussed in more detail in CMS State Medicaid Director letter #01-006 Olmstead Update #4 (included in Attachment C).

Among its other provisions, section 1905(r) requires that Medicaid-eligible children receive coverage of all services necessary to diagnose, treat, or ameliorate defects identified by an EPSDT screen, as long as the service is within the scope of section 1905(a) of the Act. irrespective of whether the state explicitly includes such benefits in its state plan.

In the case of waivers that serve children, the waiver still may be employed to provide services that supplement the services available under the state plan, beyond those EPSDT benefits, required under section 1905(r). Services that may be provided under a waiver to children could include respite care, supported employment (in the case of older youth), and other services approved by CMS that are cost neutral and necessary to prevent institutionalization.

If a service is available to a child under the state plan or could be furnished as service required under the EPSDT benefit under the provisions of section 1905(r), it may not be covered as a waiver service for child waiver participants. Thus, in a waiver that serves children, services such as rehabilitative services (as defined in 42 CFR § 440.130), private duty nursing (as defined in 42 CFR § 440.80), physical and occupational therapy (as defined in 42 CFR § 440.110), and nurse practitioner services (as defined in 42 CFR § 440.166) may not be furnished as waiver services to children unless the waiver authorizes these services beyond what is considered medically necessary under EPSDT.

When a waiver serves both children and adults, any waiver services that could be furnished in accordance with the provisions of EPSDT requirements at section 1905(r) must be limited to adult waiver participants since those services for waiver participants under the age of 21 are provided as part of the EPSDT benefit. For example, if an extended state plan coverage is proposed in order to provide a service in an amount greater than permitted under the state plan, the coverage may only apply to adults, unless the waiver authorizes these services beyond what is considered medically necessary under EPSDT.

States have an affirmative responsibility to ensure that all child waiver participants (including children who become eligible for Medicaid by virtue of their enrollment in an HCBS waiver) receive the medically necessary services that they require, including Medicaid coverable services available under EPSDT. Because the HCBS waiver can provide services not otherwise covered under Medicaid and can also be used to expand coverage to children with special health care needs, EPSDT and HCBS waivers can work well in tandem. However, a child's enrollment in an HCBS waiver cannot be used to deny, delay, or limit access to medically necessary services that are required to be available to all Medicaid-eligible children under federal EPSDT rules. While states may limit the number of participants under an HCBS waiver, they may *not* limit the

number of eligible children who may receive EPSDT services. Thus, children cannot be put on waiting lists for Medicaid coverable EPSDT services (those coverable under section 1905(a)). Children who are enrolled in the HCBS waiver must also be afforded access to the full array of EPSDT services. Moreover, under EPSDT, there is an explicit obligation to "make available a variety of individual and group providers qualified and willing to provide EPSDT services".

D. Children's Education Services

Section 1915(c)(5)(C) of the Act indicates that habilitative services may not include special education and related services under the provisions of Individuals with Disabilities Education Improvement Act of 2004 (IDEA). The funding of such services is the responsibility of state and local education agencies.

The IDEA requires the provision of comprehensive education and related services to children and youth with disabilities who are enrolled in special education programs. As a consequence, when a state proposes to include habilitation services and/or expanded habilitation such as educational services in its waiver, CMS will review the proposed waiver coverage to ensure that it does not provide for the payment of services that are mandated under IDEA.

If a state chooses to include habilitation services and/or expanded habilitation such as educational services in schools as a service in a 1915(c) waiver:

- If transportation between the participant's place of residence and the school site is provided as a component of the services and the cost of this transportation is included in the rate paid to providers of these services, include a statement to that effect in the service definition.
- Specify the service elements/activities that are furnished under the waiver.
- Specify the process by which it will be determined that these services do not fall within the requirements of the IDEA.

Section 1903(c)(3) of the Act provides that FFP is available for Medicaid services included in an IEP.

As indicated in the December 15, 2014 letter to State Medicaid Directors, Medicaid-covered services furnished in schools are eligible for reimbursement when Medicaid program requirements are met. Aside from the habilitative services prohibition described above, this includes 1915(c) waiver services.

E. Children's Foster Care Services

Waiver services may be furnished to children in foster care living arrangements but only to the extent that waiver services supplement maintenance and supervision services furnished in such living arrangements and waiver services are necessary to meet the identified needs of children. Pursuant to 42 CFR §433 Subpart D, waiver funds are not available to pay for maintenance (including room and board) and supervision of children who are under the state's custody, regardless of whether the child is eligible for funding under Title IV-E of the Act. The costs associated with maintenance and supervision of these children are considered a state obligation. The costs associated with the treatment of these children may be Medicaid reimbursable. Depending on the nature of the treatment (i.e., habilitation), the costs of treatment may be eligible for FFP under a waiver.

When waiver case management services are furnished to children in foster care who are eligible for Title IV-E funding, the state must ensure that the claim for FFP does not include costs that are properly charged as Title IV-E administrative expenses.

F. Rehabilitative Services

Waivers are not limited to the provision of habilitation services that are designed to teach individual skills. A state also may cover ***rehabilitative services*** where the purpose is to restore functioning. Rehabilitative services may be covered in a waiver as "other waiver services" since rehabilitative services are not explicitly mentioned in section 1915(c) of the Act. When the state plan covers rehabilitative services, they also may be offered in a waiver on an extended state plan service basis. The receipt of rehabilitative services does not preclude the provision of enhanced habilitation services to a waiver participant.

G. Prevocational and Supported Employment Services

Prevocational and supported employment services may be furnished as expanded habilitation services under the provisions of section 1915(c)(5)(C) of the Act. They may be offered to any target group for whom the provision of these services is appropriate and beneficial. As provided in CMS State Medicaid Director letter Olmstead Update #3 (included in Attachment C), the provision of these services is not limited to waiver participants with developmental disabilities.

However, such services may only be furnished to a waiver participant to the extent that they are not available as vocational rehabilitation services funded under the Rehabilitation Act of 1973. When a state covers prevocational and/or supported employment services in a waiver, the waiver service definition of each service must specifically provide that the services do not include services that are available under the Rehabilitation Act (or, in the case of youth, under the provisions of the IDEA) as well as describe how the state will determine that such services are not available to the participant before authorizing their provision as a waiver service.

Waiver funding is not available for the provision of vocational services (e.g., sheltered work performed in a facility) where individuals are supervised in producing goods or performing services under contract to third parties. Employment related waiver services must be provided in accordance with CMCS Informational Bulletin dated September 16, 2011 (located in Attachment D).

H. Services to Facilitate the Transition of Institutionalized Persons to the Community

In various State Medicaid Director letters issued since 2000 (located in Attachment C), CMS has issued policy guidance concerning the provision of services for persons who transition from an institutional setting to the community. This guidance provides that certain services may be furnished in advance of the discharge of the person from the institutional setting and claimed for federal financial participation once the individual enters the waiver. The basis of this policy guidance is to assure the continuity of services for individuals who are returning to the community. Community transition services may be furnished to facilitate the transition of persons from any congregate setting (both institutional and non-institutional) to a more independent/less restrictive living arrangement.

All transition services must be reasonable and necessary, not available to the participant through other means, and clearly specified in the waiver participant's service plan. States may not claim FFP for services that are furnished or activities that are performed in advance of the individual's entrance to the waiver but may claim FFP once the person is enrolled in the waiver. If the

individual should not enroll in the waiver due to unforeseen circumstances such as death or change in eligibility status, the state may be able to claim for some or all of the transition activities as administrative costs in accordance with an approved Medicaid cost allocation plan.

States have the flexibility to cover transition case management activities as either an HCBS waiver service or as targeted case management under the state plan. States are encouraged to include these transition services in their waiver programs. The relevant service specification should indicate when a service is furnished on transition basis.

I. Participant Direction of Services

When the waiver provides for participant direction of services (as specified in Appendix E), it is permissible to limit the availability of Financial Management Services and Information and Assistance in Support of Participant Direction (when covered as a waiver service) to waiver participants who have elected to direct some or all of their services. It also is permissible to limit the availability of other waiver services to participants who have elected to direct their waiver services when the delivery of the waiver service is tied to the use of the Employer or Budget Authorities.

J. Provision of Waiver Services Out-of-State

Waiver services may be furnished in another state to a waiver participant. For example, it may be more convenient for waiver participants to obtain services in a bordering state. In addition, services such as personal assistance may be furnished to waiver participants who travel to another state to visit family members or for other purposes.

Applicable policies and considerations regarding the provision of waiver services out-of-state are delineated in CMS State Medicaid Director letter Olmstead Update #3 (included in Attachment C). In brief, waiver services that are furnished out-of-state must meet the state of residence waiver standards and requirements in all respects. That is, the out-of-state provider that furnishes the services need to meet the same qualifications as in-state providers and there must be a provider agreement in effect. In addition, when services are furnished out-of-state, they are subject to the same monitoring requirements as if they were furnished in-state. This includes assuring the health and welfare of the waiver participant and monitoring compliance with HCBS settings criteria. As discussed in Olmstead State Medicaid Directors Letter #3, a state may enter into agreements with other states to facilitate the provision of services out-of-state.

K. Provider Requirements

The waiver assurances at 42 CFR § 441.302(a) require that: (a) there are adequate standards for all types of providers that provide services under the waiver and (b) that the standards must be met when services are furnished. In other words, waiver services may only be furnished by providers who have been found to meet all applicable qualifications. In Appendix C-3, the standards that apply to each waiver service are specified along with the qualifications that providers must meet. Considerations that apply to the specification of provider qualifications are discussed below. In addition, the waiver's quality improvement strategy related to providers in Appendix C and in the systems improvement, strategies described in Appendix H must address how the state will verify that providers meet applicable standards during the period that the waiver is in effect.

In addition, it is important to keep in mind that section 1902(a)(27) of the Act (as further specified in 42 CFR § 431.107(b)) requires that each provider of a Medicaid service have a

provider agreement in effect with the Medicaid agency. This requirement applies to the provision of waiver services and assures accountability in the provision of Medicaid services. The Medicaid agency may authorize in writing that another entity (e.g., the operating agency) may perform the administrative task of executing and holding the provider agreement on its behalf. In the case of participant direction, a financial management services entity may be authorized to execute the provider agreement on behalf of the Medicaid agency. There are two exceptions to this requirement. When section 1915(c) waiver services are delivered through managed care entities under a concurrent waiver, only the managed care entity has an agreement with the Medicaid agency; network providers contract with the managed care entity rather than the Medicaid agency. The other exception is when waiver services are delivered through an Organized Health Care Delivery System (OHCDS) arrangement. Such arrangements are discussed in more detail in the instructions for Appendix I.

L. Electronic/Remote Monitoring HCBS

States have the option to include services in the HCBS waiver that includes remote monitoring and remote monitoring equipment to enhance/increase individuals' independence. When remote monitoring is permitted under an HCBS waiver service, safeguards must be in place to protect individual rights and privacy and to ensure that the remote monitoring is not being used to substitute for on-site staff unless it has been agreed upon by the individual and documented in the individual's person-centered service plan prior to use.

Remote (electronic) monitoring can include devices under an assistive technology and/or environmental modifications waiver service. States may also propose to cover the costs of the remote monitoring under a stand-alone service, which may or may not also include the remote monitoring device/technology with a separate service cost component in the Factor D charts in Appendix J of the waiver application. In the waiver service definition, the state needs to demonstrate that the remote monitoring and/or device/technology will significantly enable the individual to live, work or meaningfully participate in the community with less reliance on paid staff supervision or assistance.

CMS will evaluate any request for electronic monitoring on a case-by-case basis and take into consideration the need for the individual's safety. Electronic monitoring should not take place of staff monitoring as described in the individual's person-centered service plan and should enable the person to avoid possible institutional placement or placement in a more restrictive living environment.

If the state includes electronic/remote monitoring inside of a waiver service, the state needs to explain in the service definition:

- Who will be responsible for the remote monitoring activity, including whether they are on-site or on-call.
- How the remote monitoring will facilitate community integration.
- How the state will ensure that the individual's right to privacy is being met, as well as that of others in the home and what safeguards will be in place to protect individual rights and privacy.
- How the state will ensure that the waiver participant, involved family members and/or guardian has agreed to the use of remote monitoring and that this is documented in the individual's person-centered service plan prior to use.

- How the remote monitoring will ensure the individual's needs are being met and that health and welfare needs are being addressed.
- The back-up plan in the event of equipment/technology failure (e.g., evaluation of the existence or availability of back-up power sources, alarms, additional person(s) to assist, etc.).
- For remote monitoring devices/equipment/technology the state needs to describe:
    - Where devices/monitors will be placed, including whether the state will permit placement of video cameras/monitors in bedrooms and bathrooms. If the state will permit video cameras/monitors to be placed in bedrooms and bathrooms, how the state will ensure that this is determined to be necessary on an individual basis and justified in the person-centered service plan.
    - The control that the waiver participant will have over the equipment, including whether the waiver participant can turn off the remote monitoring device/equipment, if they choose to do so, and how they are informed of this option and how to do it.

Detailed Instructions for Completing Appendix C-3

Appendix C-3 is a template that is designed to consolidate pertinent information about the specifications for each waiver service (e.g., its definition, pertinent limitations, and provider qualifications). In the web-based application, the required information is entered by completing webpages that are linked to each service. Each element of the template is discussed below.

Service Specifications

Service Title

Instructions

Complete the text field with the title of the service. In the case of statutory services, select a service from the drop-down list and enter an alternate title if one has been assigned.

Also, select the HCBS Taxonomy category and sub-category from the drop-down list. To add a Taxonomy Category, select the category from the drop-down list under the Category heading.

To add a Taxonomy Sub-category, select the subcategory from the drop-down list under the Sub-category heading.

Technical Guidance

An important characteristic of 1915(c) waivers is state flexibility to identify new services and supports. One challenge with this flexibility is that it is difficult to know what is happening in HCBS at a national level. Measuring what occurs is a necessary step to demonstrating the effectiveness of HCBS.

The HCBS Taxonomy, a standard categorization structure for Medicaid HCBS, was added to the 1915(c) application on March 1, 2014. A table with definition of the categories and subcategories in the HCBS Taxonomy, titled the "Medicaid Home and Community-Based Services (HCBS) Taxonomy Category and Subcategory Definitions," is available on the WMS website. The HCBS taxonomy provides an orderly classification of services so CMS can aggregate data. CMS intends to use the taxonomy to provide national data regarding availability,

utilization, and expenditures of categories of HCBS. It also will enable states or CMS to compare utilization and expenditures across states for categories of HCBS.

The HCBS Taxonomy does not change state flexibility to identify and define services and supports. States will be able to use the taxonomy to identify other states that provide a certain type of service, even if the states use different names.

A combination of Taxonomy Category and Taxonomy Sub-Category is a single match of a service to the HCBS Taxonomy. The Taxonomy Category includes a drop-down field with 17 categories of service that indicate distinct types of services. The category field must be entered first.

The Taxonomy Sub-Category is a subset of a category to provide more specific information. A few categories have only one sub-category. The drop-down options for the Sub-Category vary based on the entry for the Taxonomy Category.

A service may include more than one Taxonomy Category and Sub-Category combination. A state can enter up to four sets of Taxonomy Category and Taxonomy Sub-Category for a single service. Multiple combinations of Taxonomy Category and Sub-Category are likely only for the following:

- Round-the-Clock Services: for example, some waivers have a service with more than one type of residential habilitation;
- Supported Employment: some waivers have a service that includes both job development and ongoing supported employment;
- Day Services: some waivers have a service that includes two types of day support, such as adult day health and adult day care (social model); or day habilitation and prevocational services;
- Nursing: some waivers combine private duty nursing and skilled nursing in a single service;
- Caregiver Support: some waivers combine in-home and out-of-home respite in a single service;
- Caregiver Support and Participant Training: some waivers combine caregiver and participant training in a single service;
- Services Supporting for Self-Direction: some waivers combine financial management services and information and assistance in a single service; and
- Equipment, Technology, and Modifications: some waivers combine equipment and supplies in a single service.

The service might have the same name as the Taxonomy Sub-Category, or the service might have one of the common names listed in the taxonomy table document.

The state should check the definition to ensure the terms are used in the same manner, and if a match is not obvious, look at the taxonomy document from top to bottom.

It is possible that two or more services from the same waiver could have the same Taxonomy Category and Sub-Category. For example, a state may have separate services for case management and transition case management.

States should consider the service as a whole, and not as discrete tasks. For example, many states have an assisted living service that provides personal care, homemaker, and other supports.

In such instances, the service should be considered as a whole (e.g., Group Living, other), rather than mapped separately to personal care, homemaker, etc.

Some states define some services in part by what is NOT provided. For example, homemaker does not include assistance with activities of daily living (ADLs). Therefore, the Taxonomy Sub-Categories within the home-based services category are presented approximately in a continuum from more to less assistance.

In addition, personal care might include homemaking tasks as well as ADL assistance, and home health aide and personal care might include similar assistance. If home health aide services include supervision by a registered nurse or licensed therapist AND services provided by a licensed home health agency, these services would fall under the HCBS Taxonomy category of personal care.

Carry Over Services

Instructions

This section of the template is reserved for renewal waivers, new waivers that replace an approved waiver and amendments that convert an approved waiver to the new application format. In the case of each waiver service, indicate whether the coverage of a service included in the approved waiver is being continued without modification, is carried over with modifications, or is a new service that was not previously covered. This information will facilitate CMS review.

Service Definition

Instructions

Describe the service definition in the text field.

Technical Guidance

The service definition specifies the scope of the service. The scope of a service describes the purpose of the service, the types of activities that comprise the service, including, as applicable, any goods that will be furnished to a waiver participant who receives the service. As appropriate, the service definition may include additional parameters that apply to or affect the provision of the service. Such parameters may include:

- Conditions under which the service is considered necessary and thereby will be authorized. For example, a state may limit the provision of skilled nursing services to waiver participants who have specified needs that require the performance of certain tasks by licensed nurses.
- Requirements that a service be subject to additional review before it is furnished. For example, a state may make the provision of behavioral support services subject to the review and approval of a behavioral services clinician. Alternatively, the provision of home accessibility modifications may require that a physical or occupational therapist review their appropriateness.
- Requirements that a service is subject to prior authorization by the Medicaid agency or the operating agency (if applicable).
- Other conditions that must be present in order for a service to be furnished. For example, the provision of respite care may be restricted only to participants who reside with unpaid

caregivers. Alternatively, the waiver may provide that a service only will be furnished when it is not available through the state plan.

- Specifications concerning when a service may not be furnished to a participant who is the recipient of another service. For example, a state may provide that individuals who receive residential services may not also receive freestanding personal assistance services concurrently when such services are furnished as part of a residential service.
- As previously noted, a state may limit the provision of certain services to persons who have elected to direct their waiver services.

The parameters included in a service definition specify the circumstances when a service will or will not be furnished. However, do not include in the service definition limitations on the amount, frequency or duration of service. Such limitations are addressed in the next part of the template.

When a service may be participant-directed, the participant usually has the authority to establish additional parameters on the provision of the service (e.g., decide when the service will be furnished and how the service will be furnished). Additional participant-specified parameters are permissible as long as they comport with the underlying definition of the service.

Applicable Limits on Amount, Frequency, or Duration

Instructions

In the text field, specify applicable limits (if any) on the amount, frequency or duration of the service (e.g., maximum allowable units, maximum allowable expenditure).

Technical Guidance

A limit on the amount of a service may take the form of a maximum allowable expenditure for the service or the maximum number of units of the service that will be furnished during the period of the service plan. A limit on frequency is a limit that restricts the number of units of service that will be furnished during a shorter period of time (e.g., per week or per month). A limit on duration is the maximum period of time over which a service will be provided or authorized unless the necessity of the service is re-established.

When limits on amount, frequency or duration are applied, they should not pose obstacles to the service achieving its stated purpose. A state may include a dollar limit on the amount of a specific service per individual (for example home modifications may be limited to $10,000 in a year) so long as the state continues to assure the health and welfare of the waiver participant once the limit is reached. If the state establishes a dollar or other limit on a service, the state must explain the steps that it will take to ensure that the individual's needs can be met within the dollar limit, what alternatives are available once the dollar limit is reached, and how the state will continue to assure the waiver participants' health and welfare.

A state may exempt waiver participants who exercise Budget Authority as provided in Appendix E-2-b from a limitation on the amount, frequency, or duration of a service provided that: (a) the service is included in the participant-directed budget; (b) the exemption does not result in a change in the overall amount of the participant-directed budget; and, (c) the additional services are authorized in the service plan. If participants who exercise Budget Authority are exempt from the application of the limitation, include a statement to that effect in the text field.

When a state imposes limits on sets of services (e.g., a dollar limit applies to two or more services in combination) or limits on the overall amount of waiver services that may be furnished to a participant, such limits are specified in Appendix C-4.

Provider Specifications

This part of the template consolidates information about the providers of the service, including their qualifications. Provider means an individual or agency that performs the service on behalf of the waiver participant, holds a Medicaid provider agreement to furnish the service, and receives payment for services rendered. Each component of this part of the template is discussed below. Preceding this discussion is a brief discussion of the nature and role of the Medicaid provider agreement.

Provider Category(s)

Instructions

Indicate whether the service is provided by individual providers, agencies or both. For each category of provider, list the types of providers who furnish the service.

Technical Guidance

An individual provider is defined as a person who is in independent practice and not employed by a provider agency. Workers who are employed by a participant are considered to be individual providers. List the type of individual provider (e.g., personal assistant, psychologist, physical therapist).

An agency provider is an entity whose employees furnish the service or from which goods are purchased. When a service is provided by an agency, also list the types of agencies that furnish the service (e.g., home health agency, medical supply company, certified case management agency). Additional information about each type of provider listed in this part of the template is captured in the next two sections (provider qualifications and verification of provider qualifications).

The situation frequently arises that a state elects to specify that a service is furnished by an agency but requires that the agency employees who render the service meet specific qualifications. For example, a state may decide to purchase skilled nursing services only from home health agencies but require that the service may only be provided by licensed nurses who are employed by the home health agency. In this instance, home health agency is listed as the only provider type (because the agency holds the provider agreement and receives payment for the services furnished by its nurse employees). The nurse employee is not considered to be the provider even though the nurse renders the direct service. In the provider qualifications section of the template (discussed below), the state may indicate that only licensed nurses may perform the service).

The selection of the categories of providers who may furnish a service has implications for waiver participant exercise of free choice of provider and access to waiver services. As a general matter, free choice of provider and access to waiver services are enhanced when waiver participants are able to select from among a wide variety of providers, including both individual and agency providers. CMS will review the application to assess whether the types of providers specified is overly narrow and thereby poses obstacles to waiver participants obtaining waiver services from otherwise willing and qualified providers of services. This assessment will also include reviewing the proposed provider qualifications to ensure that they are reasonable and

appropriate in light of the nature of the service and do not contain elements that would unnecessarily constrict participant free choice of provider. When only agency providers may provide a service, CMS may request that the state furnish additional justification for not permitting individual providers to furnish the service.

Provision by Legally Responsible Persons or Relatives/Legal Guardians

Instructions

Select whether the service may be furnished by a legally responsible person, relative and/or legal guardian.

Technical Guidance

Items C-2-d and C-2-e detail the state's policies with respect to permitting: (a) legally responsible persons to furnish personal care or similar services and (b) relatives and/or legal guardians to furnish waiver services. The checkboxes provided in this part of the template link those policies to each waiver service. For example, if in Item C-2-e, the state provides that only certain types of relatives but not legal guardians may provide a service, then the checkboxes for relatives and legal guardians in this part of the template are interpreted in light of the policies expressed in Item C-2-e.

Remote/Telehealth Delivery of Services

Instructions

Select whether the state will allow for providers to deliver the waiver service remotely/via telehealth.

Technical Guidance

Item C-1-c specifies the state's policies with respect to permitting waiver services to be delivered remotely/via telehealth. "Telehealth" refers to a general service modality, and states may use other terms to reflect the use of telehealth in their HCBS waivers.

Provider Qualifications

Instructions

For each type of individual or agency provider identified under the provider category section of the template, specify the provider qualifications. Add as many providers as necessary in order to accommodate all types of providers.

Technical Guidance

Provider standards or qualifications are the criteria that a provider must meet in order to provide the waiver service. The template provides for three types of provider qualifications:

- A license issued under the authority of state law. In this instance, provide the legal citation of the applicable state law governing the issuance of the license. Do not include the text of the state law;
- A certificate issued by a state agency or other recognized body. For example, a certificate may be issued as a result of a quality review of the provider or by a recognized accreditation organization. In this instance, cite the applicable state regulations or policies that serve as the basis of the certification; and
- Other standards specified by the state. These other standards may be in addition to a required license or certificate and must be specified.

One or more of these types of qualifications must be specified for each service.

CMS has not promulgated minimum provider qualifications for waiver services. States have latitude in establishing appropriate qualifications. Like other Medicaid services, waiver services are subject to any relevant requirements contained in state law. However, provider qualifications need to be reasonable and appropriate in light of the nature of the service. They need to reflect sufficient training, experience, and education to ensure that individuals will receive services from qualified persons in a safe and effective manner. Provider qualifications and standards should not contain provisions that have the effect of limiting the number of providers by the inclusion of requirements unrelated to quality and effectiveness.

Training is particularly important for person care service (PCS) providers, such as personal care attendants (PCAs). While CMS has not established specific standards that states must meet, the state should provide **detailed** information to demonstrate that PCAs are sufficiently trained and educated to provide applicable waiver services. Details of the training can include but are not limited to; the hours of training required for PCAs prior to starting their work with individuals, any continuing educational opportunities available for PCAs, any state-sponsored training programs, a detailed description of the delivery method and frequency of available training, and the number of hours required for PCAs to maintain certification or licensure. Finally, the state should document whether they maintain and make available to individuals and families a provider listing or database for both qualified individual PCAs and PCS providers. For self-directed services the individual and/or representative must identify the specific training needed to meet the individual's needs for assistance as part of the person-centered service plan.

As previously noted, there may be instances when a state elects to limit the providers of a service to specific types of agencies, but the state should also describe the qualifications of the agency employees who furnish the service directly. Such requirements may be reflected in the template in various ways, depending on the nature of the requirement. In the example of skilled nursing services previously discussed, the requirement that such services be provided by home health agency employees who are licensed nurses can be reflected in the license column by citing the license that the home health agency must possess and adding an "employee" section to cite the license that the employee nurse must possess. Another alternative is to reflect employee qualifications in the "other standard" column.

It is important to keep in mind that FFP is only available for waiver services that are furnished by providers who have been determined to be qualified in accordance with 42 CFR § 441.302(a)(1) and (2) when the service is furnished. Consequently, when a provider must meet certain experience and training qualifications, the services that the provider renders may only be claimed for FFP if the provider has completed all necessary training.

A state may provide that additional qualifications may be incorporated into the service plan in order to meet the unique or specific needs of the participant. In addition, participants who exercise the Employer Authority may require that the workers whom they hire to have skills or characteristics that the participant judges are important to meeting the participant's particular needs. However, a state may not provide that provider qualifications will be solely specified in the service plan or by the participant. In other words, a state must establish the essential minimum qualifications that a provider must meet in order to be deemed a qualified provider and the state must ensure that those requirements are met when the service is provided.

Verification of Provider Qualifications

Instructions

For each type of provider (individual or agency), explain the entity or entities that are responsible for verifying that the provider possesses the qualifications specified for the service prior to delivery of the service and how often the qualifications are re-verified.

Technical Guidance

The verification of provider qualifications may be conducted by entities other than the Medicaid agency or the operating agency (if applicable) as specified in Appendix A. In the case of participant-directed services, the waiver may provide that the participant is responsible for the verification of some or all provider qualifications. Financial management services entities also may be tasked with verifying some or all provider qualifications.

There is no federally-required schedule for the re-verification of provider qualifications. In the case of some types of providers (e.g., personal assistants), a state may provide that provider qualifications are only re-verified as necessary. Irrespective of the schedule that is employed to re-verify provider qualifications, the state has the responsibility to ensure that providers meet the qualifications for each service on an on-going basis. Often, this may include specific program documentation and visit verification methods. For PCS providers, states must describe supervision and monitoring requirements that ensure only qualified providers are providing personal care services.

Service Delivery Method

Instructions

Select whether the service is participant-directed, provider-managed or both. If the waiver does not provide for participant direction of services, select only the provider-managed service delivery method.

Technical Guidance

Provider-managed means that the service provider is responsible for managing all elements of service provision in accordance with the participant's service plan, including taking into account any directives contained within the service plan regarding how and when the service is to be furnished and the expressed preferences of the participant.

Participant-directed means that the participant has the authority to manage some or all aspects of service provision as provided in Appendix E (Participant Direction of Services). A service may only be specified as participant-directed when the waiver makes available the participant direction opportunities that are specified in Appendix E. When a service may be participant-directed, it also must be listed in the table in Item E-1-g in Appendix E where the type of participant direction opportunity (or opportunities) that is employed in conjunction with the service is indicated. In the web-based application, each service that is specified as participant-directed is automatically listed in Item E-1-g. There is no limitation on the number of waiver services that may be participant directed. When a service may be either provider-managed or participant-directed, the participant may decide which service delivery method to employ.

CMS Review Criteria

CMS applies the following criteria when reviewing each service in Appendix C-3:

CMS Review Criteria

- Each service is separately defined.
- The service does not duplicate coverage under the state plan.
- When the waiver serves individuals under age 21, the service does not duplicate a service that can be provided under the state plan as services required under EPSDT.
- The service definition clearly delineates the purpose and the scope of the service.
- The scope of the service does not span multiple, unrelated services, although similar or related services may be combined.
- When the scope of a service potentially overlaps with the scope of another service, there are mechanisms that prevent duplicate billing.
- In the case of non-statutory services, the service is necessary to avoid institutionalization and address functional impairments or other participant needs that, if left unaddressed, would prevent the person from engaging in everyday community activities.
- Any limits on the amount, duration and frequency for the service are consistent with assuring health and welfare for the target population.
- Provider qualifications are specified for each service and are appropriate to the nature and type of the service.
- Provider qualifications include requirements for training, experience and education that are sufficient to ensure that waiver participants will receive services in a safe and effective manner.
- Provider qualifications do not include requirements that would unnecessarily restrict the number of providers, including unnecessarily restricting the provision of a service to agency providers.
- For personal care services, the following details must be provided:
    - Requirements regarding training hours and availability of continuing education, and whether such training is state sponsored, are highlighted for PCAs and other PCS providers.
    - States should maintain a listing of qualified PCA/PCS staff and make the list available to individuals and families.
    - PCS providers must be regularly monitored and supervised by the agency and/or waiver participant in accordance with state policies.

Appendix C-4: Additional Limits on Amount of Waiver Services

Overview

In Appendix C-3, a state specifies the limits (if any) on the amount, frequency and duration that apply to each specific waiver service, including a dollar limit. In this Appendix, a state may specify dollar limits that apply to a set (or sets) of waiver services (two or more services in combination). A state also may establish limits on the maximum dollar amount of waiver goods and services that is authorized in a participant's service plan. Sometimes such limits are termed "budget allocations." Dollar limits on the overall amount of services that apply after entrance to the waiver are distinguished from the *individual cost limit* (specified in Appendix B-2) that a state may apply in determining whether to enroll or maintain an individual in the waiver. For example, when a state does not impose an individual cost limit, it still may subject service plans

to overall dollar limits post-entrance to the waiver. Since limits on sets of services or dollar limits on the overall dollar amount of a service plan constitute limits on the amount of services, the state must specify in the waiver any such limits that apply. If the limit is only applicable to one service, that limit should be identified in the limitation section of the service specification in Appendix C-3.

Types of Limits

The appendix pre-identifies three types of limits that a state might employ:

- **Limits on Sets of Services**. This type of dollar limit is applied to two or more waiver services, usually services that are closely related or might serve as substitutes for one another (e.g., personal care and chore services). A state may define several sets or groupings of services to which dollar limits apply.
- **Prospective Individual Budget Amount**. Some states have developed and implemented methodologies that determine a specific budget amount that is uniquely assigned to each individual waiver participant. The assigned budget amount constitutes a limit on the overall amount of services that may be authorized in the service plan. This method is termed "prospective" because the amount that is assigned is determined in advance of the development of the participant's service plan.
- **Budget Limit by Level of Support**. Other states have developed and implemented methodologies that group waiver participants who share similar characteristics or support needs. States assign budget limits to each of these levels or participant groupings. These limits specify the maximum dollar amount of waiver goods and services that may be included in the service plans of participants who fall into each level or grouping.

Other approaches also have been implemented by states. For example, some states have established "baseline" budget allocations that apply to all waiver participants but provide for stepping-up the baseline allocation in certain pre-defined circumstances.

When a state also provides for the participant direction budget authority opportunity (in Appendix E), there may be a relationship between the participant-directed waiver budget and the budget allocation methods described here. This appendix addresses limits that apply to all waiver participants, regardless of whether the waiver provides for participant direction. If the waiver only provides for the use of individual budgets when participants have budget authority as provided in Appendix E, then this appendix does not apply. The methods for how self-directed budgets are developed would be described only in Appendix E.

Applicability

This Appendix needs to be completed whenever a state imposes a dollar limit on the amount of waiver services that may be authorized in a service plan over and above any limits on amount, duration and frequency that apply to individual waiver services. The "not applicable" selection should be made only when no such dollar limits are applied. If one of the pre-identified selections does not appropriately describe the dollar limits that the state applies, select "other" and describe the dollar limit that is imposed.

Basic Information Requirements

Regardless of the type of limit that is applied to waiver services, certain basic information needs to be provided, including:

(a) The waiver services to which the limit applies. A budget limit, for example, might be applied to all waiver services or, alternatively, some services (e.g., crisis services) may be excluded from the limit and furnished in amounts necessary outside the budget.

(b) The basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject. When dollar limits are imposed, CMS expects that the amount of the limit will be based on evidence that the limit is a realistic estimate of the expected amount of services that waiver participants are likely to require. Limits may not be arbitrary or lack foundation in observed experience. The methodology that is employed to determine the amount of the limit must be fully described. When the amount of the limit is based on assessment information or other factors, how such information is used to determine the limit should be fully explained.

(c) How the limit will be adjusted over the course of the waiver period. Describe whether the limit will be adjusted to take into account cost increases and/or whether the methodology will be periodically re-evaluated in light of changes in utilization patterns or other factors.

(d) Provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state. Especially in the case of limits on the overall amount of waiver services that may be authorized in a service plan, describe the conditions under which the limit may be adjusted to assure participant health and welfare.

(e) The safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs. Such safeguards may include referring the participant for enrollment in another waiver program where more resources may be available.

(f) How participants are notified of the amount of the dollar limit. Because a dollar limit constitutes a limitation on the amount of waiver services that a participant may receive, it is important that the participant be made aware of the limit.

In the case of some types of limits, additional information is required, as discussed below.

Whenever dollar limits of the types addressed in this Appendix are employed, the state must afford participants the opportunity to request a Fair Hearing in the event that they are denied waiver services as a result of a dollar limit.

Additional Information Requirements

As previously noted, certain additional information requirements attach to specific types of limits. In particular:

Limit(s) on Set(s) of Waiver Services

In addition to the basic information specified above, explain the basis for the grouping of services in each set. As a general matter, the services in a set should address participant needs that are reasonably related. For example, clinical services might be grouped separately from daily support services such as chore and homemaker services.

Prospective Individual Budget Amount

In addition to the basic information specified above:

- Specify the entity that determines the budget amount;

- Include a complete description of the participant-related factors that are taken into account when determining the budget amount and how these factors affect the individual budget amount. If assessment results are used in determining the budget amount, specify the types of assessments that are employed;
- If the budget amount varies geographically, explain the basis for adjusting the budget based on participant location; and
- Describe how the methodology that is employed is open for public inspection. When a formula is employed to determine the individual budget amount, the numeric values that are inserted into the formula need not be disclosed as part of public inspection.

Budget Limits by Level of Support

In addition to the basic information specified above, describe:

- The levels of support or groupings that have been established and the basis for these groupings;
- The procedures that are followed to assign participants to a level of support or participant grouping, including the entity or entities responsible for determining the assignment of individuals. If assessment results are used to assign individuals to groupings, specify the types of assessments that are employed;
- Whether the budget limit varies geographically and, if applicable, the factors that are used to adjust budget amounts based on geographic considerations; and
- How the state makes its methodology for determining budget limits by level of support open for public inspection. When a formula is employed to determine the budget amount, the numeric values that are inserted into the formula need not be disclosed as part of public inspection.

Other Type of Limit

In addition to the basic information specified above:

- Fully describe the limit and its basis; and
- To the extent that the limit combines elements of the other types of limits addressed in this Appendix, include the additional information associated with those types of limits. For example, if the limit is structured by sets of services but also includes limits based on level of support within each set, include information about how individuals are assigned to each level of support.

CMS Review Criteria

When reviewing this Appendix, CMS applies the following review criteria:

CMS Review Criteria

General Criteria:

- The waiver specifies the services to which the limit applies.
- The method of determining the limit is objective and evidence based (e.g., the method of determining the individual budget amount is based on the analysis of historical costs and utilization and other factors that are likely to affect costs).
- The waiver specifies the processes that are used to determine the amount of the limit to which a participant's services are subject.
- The waiver specifies how the amount of the limit is adjusted during the period that the waiver is in effect.
- The waiver contains provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state. Any criteria that are applied to adjust the budget are clear and explicit.
- The waiver specifies safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs.
- The waiver provides for notifying participants of the amount of the limit to which their waiver services are subject.

Criteria Applicable to Specific Types of Limits

Limit(s) on Set(s) of Waiver Services

The services in the set to which the limit applies are reasonably related to one another.

Prospective Individual Budget Amount

- The waiver specifies the assessment and other participant information upon which the individual budget amount is based.
- The waiver explains how assessment and other participant information is employed in determining he individual budget amount.
- The entity responsible for determining the individual budget amount is identified.
- If geographic factors affect the budget amount, the waiver explains how such adjustments are made.
- The waiver specifies how the methodology for determining the individual budget amount is open for public inspection.

Budget Limits by Level of Support

- The waiver specifies the levels of support or participant groupings that have been established and the basis for such groupings.
- The waiver specifies the procedures that are followed to assign participants to a level of support or participant grouping.
- The waiver specifies the entities responsible for determining the assignment of individuals by level of support.
- When assessment results are used to assign individuals to groupings, the waiver specifies the types of assessments that are employed.
- If geographic factors affect the budget amount, the waiver explains how such adjustments are made.
- The waiver specifies how the methodology for determining the budget limit based on level of support amount is open for public inspection.

Other Type of Limit

Based on the nature of the other type of limit that is used, any of the foregoing criteria may apply.

Appendix C-5: Home and Community-Based Settings Requirements

Overview

Since April 2008, CMS has engaged in ongoing discussions with stakeholders, states and federal partners about the qualities of community-based settings that distinguish them from institutional settings. As part of this stakeholder engagement, CMS issued a 1915(c) Waiver Advanced Notice of Proposed Rule Making (ANPRM) and various proposed rules relating to home and community-based services authorized by different sections of the Medicaid law, including 1915(c) HCBS waivers, 1915(i) State Plan HCBS and 1915(k) Community First Choice State Plans. CMS' definition of home and community-based settings has benefited from and evolved as a result of this stakeholder engagement.

In final rules published on January 16, 2014, CMS moved away from defining home and community-based settings by "what they are not," and toward defining them by the nature and quality of individuals' experiences. The home and community-based setting provisions in the final rules established a more outcome-oriented definition of home and community-based settings, rather than one based solely on a setting's location, geography, or physical characteristics. The purpose of the home and community-based settings requirements under 42 CFR § 441.301(c)(4) is to maximize the opportunities for participants in HCBS programs to have access to the benefits of community living and to receive services in the most integrated setting. The requirements effectuate the law's intention for Medicaid HCBS to provide alternatives to services provided in institutions. States' implementation of these requirements will contribute significantly to the quality and experience of participants in Medicaid HCBS waiver programs and will further expand their opportunities for meaningful community integration in support of the goals of the Americans with Disabilities Act and the Supreme Court's decision in *Olmstead v. L.C.*

Instructions

In this section of the waiver application, states are to document state compliance with the final regulations published on January 16, 2014, regarding the (HCBS settings requirements at 42 CFR § 441.301(c)(4)-(5). In this section, states are to specify and describe the types of settings in which waiver services are received. Only the types of settings are required to be included in the description, and not the title/name for each specific setting. Also include in the description the process that the state will use to assess each setting (each individual setting and not each setting type) to ensure that each setting meets the federal HCBS settings requirements at 42 CFR § 441.301(c)(4)-(5) at the time of submission to CMS, as well as how the state will ensure that all settings will continue to meet the HCBS settings requirements as a part of ongoing monitoring. Please include a detailed explanation of how the state will perform ongoing monitoring across residential and non-residential settings in which individuals receive HCBS.

Technical Guidance

The HCBS settings requirements support home and community-based settings that serve as an alternative to institutional care and that take into account the quality of individuals' experiences. They require that all home and community-based settings meet certain qualifications in accordance with 42 CFR § 441.301(c)(4)(i)-(v), including, at a minimum:

- Is integrated in and supports full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage

in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS;

- Is selected by the individual from among setting options, including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board;

- Ensures individual rights of privacy, dignity and respect, and freedom from coercion and restraint;

- Optimizes, but does not regiment, individual initiative, autonomy and independence in making life choices; including but not limited to, daily activities, physical environment, and with whom to interact;

- Facilitates choice regarding services and who provides them.

The regulation at 42 CFR § 441.301(c)(4)(vi)(A)-(E) also includes additional requirements for provider-owned or controlled home and community-based residential settings. A provider-owned or controlled setting is a setting that is owned, co-owned, operated and/or controlled by a provider of home and community-based services. A setting is provider-owned or controlled if the selection of a setting limits an individual's selection of a waiver service provider in that setting or if a waiver service provider plays a role in an individual's ability to select a particular setting in which to receive services. A setting is provider-controlled when a provider has influence over whether an individual is accepted for residency as well as when the landlord has influence over which service providers the individual in the setting uses. These requirements include ensuring:

- The individual has a lease or other legally enforceable agreement providing similar protections. The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the state, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the state must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.
- The individual has privacy in their sleeping or living unit including:
  - Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.
  - Individuals sharing units have a choice of roommates in that setting.
  - Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.
- The individual has the freedom and support to control his/her own schedule and activities, including access to food at any time;
- The individual can have visitors of their choosing at any time; and

- The setting is physically accessible to the individual.

In accordance with 42 CFR § 441.301(c)(4)(vi)(F), any modification to these additional requirements for provider-owned home and community-based residential settings must be supported by a specific assessed need and justified with documentation in the person-centered service plan including the following:

- Identify a specific and individualized assessed need.
- Document the positive interventions and supports used prior to any modifications to the person-centered service plan.
- Document less intrusive methods of meeting the need that have been tried but did not work.
- Include a clear description of the condition that is directly proportionate to the specific assessed need.
- Include regular collection and review of data to measure the ongoing effectiveness of the modification.
- Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
- Include the informed consent of the individual.
- Include an assurance that interventions and supports will cause no harm to the individual.

The regulations at 42 CFR § 441.301(c)(5) excludes certain settings as permissible settings for the provision of Medicaid home and community-based services. These excluded settings include nursing facilities, institutions for mental disease, intermediate care facilities for individuals with intellectual disabilities, and hospitals. Other Medicaid funding authorities support services provided in these institutional settings.

The regulations at 42 CFR § 441.301(c)(5)(v) also identify other settings that are presumed to have institutional qualities, and do not meet the threshold for Medicaid HCBS. These settings include:

- any setting that is located in a building that is also a publicly or privately-operated facility that provides inpatient institutional treatment,
- any setting that is located in a building on the grounds of, or immediately adjacent to, a public institution, or
- any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS.

If states seek to include such settings in a 1915(c) waiver, CMS will make a determination through heightened scrutiny, based on information presented by the state demonstrating that the setting is home and community-based and does not have the qualities of an institution. This process is intended to be transparent and therefore, must include input and information from the public.

Settings that Isolate

Some settings have the effect of isolating individuals receiving HCBS from the broader community. As described in the State Medicaid Director's Letter #19-001 issued on March 22, 2019 (in Attachment C), CMS intends to take the following factors into account in determining whether a setting may have the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving HCBS:

- Due to the design or model of service provision in the setting, individuals have limited, if any, opportunities* for interaction in and with the broader community, including with individuals not receiving Medicaid-funded HCBS;
- The setting restricts beneficiary choice to receive services or to engage in activities outside of the setting; or
- The setting is physically located separate and apart from the broader community and does not facilitate beneficiary opportunity to access the broader community and participate in community services, consistent with a beneficiary's person-centered service plan.

** "Opportunities", as well as identified supports to provide access to and participation in the broader community, should be reflected in both individuals' person-centered service plans and the policies and practices of the setting in accordance with 42 CFR §§ 441.301(c)(1)-(3) and (4)(vi)(F), 42 CFR §§ 441.530(a)(1)(vi)(F) and 441.540, and 42 CFR §§ 441.710(a)(1)(vi)(F) and 441.725.*

With the March 17, 2023 expiration of the transition period for states to comply with the HCBS settings criteria, the waiver application becomes the documentation of a state's ongoing monitoring procedures to ensure continued provider compliance. States should include a detailed explanation of how they will perform ongoing monitoring across residential and non-residential settings in which individuals receive HCBS.

More information regarding the home and community-based setting requirements is available on the CMS website at:

https://www.medicaid.gov/medicaid/hcbs/guidance/index.html

CMS Review Criteria

The state's description of settings in which HCBS are received demonstrates how the state will ensure that all HCBS settings requirements at 42 CFR § 441.301(c)(4)-(5) will be met and includes:

- A list of the setting types in which waiver services are received;
- The process that the state Medicaid agency used to assess and determine that all settings meet the HCBS settings requirements at the time of submission; and
- The process that the state Medicaid agency will use to ensure that all settings will continue to meet the HCBS settings requirements as part of on-going monitoring.

Attachment: Core Service Definitions

Overview

This attachment contains core waiver service definitions that states may adapt when completing Appendix C-3 (waiver service specification template) in the waiver application. Many of these definitions are based on the service definitions contained in the 1995 standard waiver application format. Definitions of additional services also are included. The definitions are listed in the following order: (a) statutory services; (b) other services; (c) extended state plan services; and (d)

services in support of participant direction. The "core definitions" specify the essential scope of each service. States may modify or supplement the core definition in order to more precisely reflect the nature and scope of each service included in a waiver. For example, if a core service definition includes an activity that a state does not wish to provide, the activity may be removed. The definitions are accompanied by **instructions** that specify coverage parameters that should be addressed in the service definition. Also, as appropriate, **guidance** is included concerning service coverage.

As noted in the instructions, states are not required to use these core service definitions. A state may propose an alternate definition. However, each service must be fully described and not described in open-ended terms. Alternate definitions will be reviewed by CMS to determine whether the scope and nature of the service as defined is consistent with regulatory definitions, as applicable, and waiver service coverage policy.

In addition, a state may propose to cover services beyond those that are included here. When coverage of another service is proposed, CMS will review the proposed coverage to ensure that the service is necessary in order to avoid institutionalization and addresses participant needs that stem from their disability or condition.

In Appendix C-3 of the waiver application, separate provision has been made for specifying limitations on the amount, frequency and duration of waiver services (e.g., limiting respire care to no more than 720 hours in a year). Such limitations should not be incorporated in the service definition itself but instead specified in the appropriate location in the waiver service specification template. However, limitations on the scope of the service should be included in the definition. For example, if a service (e.g., personal assistance) is available only to participants who reside in their own private residence, the limitation should be reflected in the service definition. Similarly, any additional criteria that apply to the provision of a service also should be incorporated into the definition (e.g., the provision of a service requires the determination by a professional that the service is necessary to address specific participant needs). Also, do not include provider qualifications in the service definition. Provider qualifications are specified separately in the Appendix C-3 waiver service specification template.

A. Statutory Services

Statutory services are services specifically identified in section 1915(c) of the Act and 42 CFR § 440.180. They also are listed in the Appendix C1/C3 Service Specification section of the web-based application. Core service definitions are provided for each of these services. Where the definition is based in regulation, a citation is included. Otherwise, the definition represents a suggestion. As discussed in the instructions for Appendix C-1, a waiver is considered to cover an identified statutory service as long as the state's definition aligns with the core service definition included here, even though an alternate title is used (e.g., support coordination instead of case management or attendant care instead of personal care).

1. Case Management

Background

Case management services are an optional benefit that a state may furnish under its state plan, as provided in 42 CFR § 440.169. Case management services are also identified as 1915(c) waiver home and community-based services at 42 CFR § 440.180(b)(1).

Core Service Definition

Services that assist participants in gaining access to needed waiver and other state plan services, as well as medical, social, educational, and other services, regardless of the funding source for the services to which access is gained.

Instructions

- When case managers perform other activities/functions (e.g., crisis response) that are not included in the core definition, specify the additional activities/functions.
- When case managers are responsible for the ongoing monitoring of the provision of services included in the participant's service plan and/or participant health and welfare, include a statement to that effect in the service definition.
- When case managers are responsible for initiating the process to evaluate and/or re-evaluate the individual's level of care and/or the development of service plans as specified in Appendices B & D of the application, include a statement to that effect in the service definition.
- When the state claims the cost of case management furnished to institutionalized individuals prior to their transition to the waiver (as provided in State Medicaid Director letter Olmstead Update No.3 (see Attachment C), include a statement to that effect in the service definition. Specify the period that such services may be furnished. Providers may not bill for this service until the date of the person's entry into the waiver program.
- When case management includes providing supports to assist participants to direct their services, specify the types of supports that case managers furnish. For example, a case manager may have responsibility for monitoring the expenditure of funds included in the participant-directed budget when the Budget Authority opportunity is provided under the waiver.
- In the provider qualifications section, include requirements for training on the HCBS settings regulation and person-centered service planning requirements.

Guidance

- When case management is furnished as a waiver service, a state may not limit the providers of case management to specific classes of entities (e.g., county human services agencies). All willing and qualified providers must be offered a provider agreement in accordance with 42 CFR § 431.107. Participants must be able to select from among all qualified providers in accordance with section 1902(a)(23) of the Act.
- When activities related to the assessment of level of care and service plan development are furnished as waiver case management activities, payment for such services may not be made until the individually is actually enrolled in the waiver.
- The scope of case management services may not include activities/services that constitute the provision of direct services to the participant that normally are covered as distinct services.
- Case management must comport with conflict of interest requirements at 42 CFR § 441.301(1)(vi) and in accordance with Appendix D-1-b.

2. Homemaker Services

Background

Homemaker services are identified as 1915(c) waiver home and community-based services at 42 CFR § 440.180(b)(2). There is no specific regulatory definition of homemaker services.

Core Service Definition

Services that generally consist of the performance of household tasks (e.g., meal preparation and routine household care) provided by a qualified homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home.

Instructions

- If homemaker services include other activities/functions that are not reflected in the core definition, modify the core definition to specify the activities/ functions.
- If homemaker services are limited to the performance of a specific household task(s), list the specific task(s) in the definition.

Guidance

- Homemaker services are generally distinguished from personal care services. Personal care services include assistance in activities of daily living whereas homemaker services usually are confined solely to the performance of household tasks.
- The core service definition may be modified to include the performance of "chore-type" services by a homemaker.

3. Home Health Aide Services

Background

Home health services are a mandatory state plan service defined at 42 CFR § 440.70, within which home health aide services are a component of the state plan coverage. Home health aide services are also identified as 1915(c) waiver home and community-based services at 42 CFR § 440.180(b)(3). In a waiver, a state may elect to furnish home health aide services that are different in their scope and nature than the services offered under the state plan. Alternatively, if there are limitations on the amount, frequency and duration of the provision of home health aide services in the state plan, a state may elect to provide additional services over and above those permitted under the state plan. Two alternative core service definitions are provided depending on how the state elects to cover home health aide services under the waiver:

Core Service Definition *(Services differ in scope and nature from the state plan):*

Services defined in 42 CFR § 440.70 that are provided in addition to home health aide services furnished under the approved state plan. Home health aide services under the waiver that are different in nature, scope, supervision arrangements, or provider type (including provider training and qualifications) from home health aide services in the state plan. The differences from the state plan are as follows:

Core Service Definition *(Extended State Plan Service):*

Services defined in 42 CFR § 440.70 that are provided when home health aide services

furnished under the approved state plan limits are exhausted. The scope and nature of these services do not differ from home health aide services furnished under the state plan. Services are defined in the same manner as provided in the approved state plan. The provider qualifications specified in the state plan apply. The additional amount of services that may be provided through the waiver is as follows:(specify)

Instructions

- If the only difference between the coverage of home health aide services under the state plan and the waiver is that waiver services supplement state plan services over and above state plan limitations on amount, duration and frequency, use the home health aide services "extended state plan service" definition above. For example, if the state plan limits home health aide services to no more than ten visits per month but the state wishes to provide for additional visits for waiver participants, use the extended state plan service definition. Specify the additional services that are provided when the state plan benefit is exhausted.
- When the scope and nature of home health aide services under the waiver differ from the coverage under the state plan, use the first core definition and specify how the scope and nature of services differs from the state plan, including the other activities/functions that home health aides perform in addition to those specified under the state plan.

Guidance

- If home health aide services may be furnished outside the participant's home, include a statement to that effect in the service definition.
- One source of difference between the coverage of home health aide services under the state plan and the waiver may arise from provider qualifications. Home health services (including home health aide services) under the state plan may only be furnished by home health agencies that meet the requirements for participation in Medicare, as. provided in 42 CFR § 489.28.
- The coverage of home health aide services under a waiver does not permit a state to restrict access by waiver participants to home health services that are offered under the state plan. Waiver participants are entitled to receive all benefits for which they are eligible under the state plan.
- Home health aide services that can be covered under the state plan should be furnished to waiver participants under age 21 as services required under EPSDT rather than through the waiver.

4. Personal Care

Background

Personal care services are an optional benefit that a state may furnish under its state plan, as provided in 42 CFR § 440.167. Personal Care Services are also identified as 1915(c) waiver home and community-based services at 42 CFR § 440.180(b)(4). A state may offer personal care under a waiver when: (a) it does not offer personal care under its state plan; (b) its coverage under the waiver differs in scope and nature from the coverage under the state plan; or (c) the state wishes to furnish personal care services in an amount, duration or frequency that exceed the limits in the state plan. Two core service definitions are provided:

Core Service Definition *(Services differ in scope and nature from personal care under the state plan or personal care is not provided under the state plan)*:

A range of assistance to enable waiver participants to accomplish tasks that they would normally do for themselves if they did not have a disability. This assistance may take the form of hands-on assistance (actually performing a task for the person) or cuing to prompt the participant to perform a task. Personal care services may be provided on an episodic or on a continuing basis. Health-related services that are provided may include skilled or nursing care and medication administration to the extent permitted by state law.

Core Service Definition *(Extended State Plan Service)*:

Services that are provided when personal care services furnished under the approved state plan limits are exhausted. The scope and nature of these services do not differ from personal care services furnished under the state plan. The provider qualifications specified in the state plan apply. The additional amount of services that may be provided through the waiver is as follows: (specify)**Instructions**

- If personal care under the waiver is furnished to supplement personal care under the state plan but otherwise the scope of the coverage and who may provide the service is the same as under the state plan, use the "extended state plan service" core definition. Specify the additional amount of services that may be provided under the waiver.
- When personal care services are not provided under the state plan, use the first core definition.
- When personal care is covered under the state plan but the scope and nature of personal care furnished to waiver participants differs from the state plan, also use the first core definition and include the following statement: *"Personal care under the waiver differs in scope, nature, supervision arrangements, and/or provider type (including provider training and qualifications) from personal care services in the state plan."* Also, briefly describe the differences between the waiver coverage and the state plan coverage.
- When the first core definition is used, as appropriate, supplement the core definition by specifying the types of assistance furnished. Such assistance may include assistance in performing ADLs (bathing, dressing, toileting, transferring, maintaining continence) and IADLs (more complex life activities, e.g., personal hygiene, light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, medication and money management). Such assistance also may include the supervision of participants as provided in the service plan.

- If personal care is furnished outside the participant's home, include a statement to that effect in the first core definition.
- A state may elect to make retainer payments to personal assistants when the waiver participant is hospitalized or absent from his/her home for a period of no more than 30-days. See CMS State Medicaid Director letter Olmstead Update #3 (July 25, 2000) in Attachment C for additional information. If the state elects to make such payments, describe the circumstances under which such payments are authorized and applicable limits on their duration. For waivers offering participant direction, states may permit the use of the retainer to afford direct support workers time off from providing services to their employer.
- Also, with respect to the first core definition, when individuals who are not employed by a provider agency may provide personal care, the service definition must specify who oversees and supervises these individual providers (e.g., a registered nurse, case manager, and/or the participant), and the frequency of supervision.
- When personal care may be participant-directed, specify in the service definition the responsibilities and authority of the participant to direct the delivery of personal care.
- Personal care may be furnished to escort participants to participate in community activities or access other services in the community if the state explains how it is incidental to the personal care service in the service definition, and the costs for the transportation are specified as a subcomponent of the personal care service in the Appendix J Factor D charts. However, any transportation costs that are not associated with the provision of personal care are not personal care services and thus, would have to be billed separately and may not be included in the scope of personal care. Personal care aides may furnish and bill separately for transportation provided that they meet the state's provider qualifications for transportation services, whether medical transportation under the state plan or non-medical transportation under the waiver.

Guidance

- Alternate service titles may be employed for personal care, including personal assistance and attendant care.
- It is not necessary to reflect in the service definition pertinent policies that apply to the provision of personal care by legally responsible individuals or other family members/legal guardians. These topics are addressed in the responses to Items C-2-d and C-2-e in Appendix C-2 of the application.
- The scope of personal care may include performing incidental homemaker and chore services tasks. However, such activities may not comprise the entirety of the service. When personal care services includes incidental homemaker and chore tasks, the state must have mechanisms in place to ensure against duplication of payment if homemaker/chore services are also a separate or component of another Medicaid service.
- When personal care is included in the scope of another covered service (e.g., residential habilitation or assisted living), a state may prohibit concurrent provision of personal care as a distinct additional service when the participant receives the other service that includes personal care.

- Personal care may be furnished in order to assist a person to function in the workplace or as an adjunct to the provision of employment services.
- When personal care services are offered under the state plan, a state may not restrict the access of waiver participants to such services.
- Personal care services that can be covered under the state plan should be furnished to waiver participants under the age of 21 as services required under EPSDT.

5. Adult Day Health

Background

Adult day health services are identified as home and community-based services at 42 CFR § 440.180(b)(5). There is no specific regulatory definition of adult day health services. Pursuant to the general prohibition on coverage of room and board outlined at section 1915(c) of the Act, meals provided as part of adult day health services may not constitute a "full nutritional regimen" (i.e., up to 2 meals per day and which do not constitute a full nutritional regimen is permitted).

Core Service Definition

Services generally furnished 4 or more hours per day on a regularly scheduled basis, for one or more days per week, or as specified in the service plan, in a non-institutional, community-based setting, encompassing both health and social services needed to ensure the optimal functioning of the participant. Meals provided as part of these services may not constitute a "full nutritional regimen" (i.e., up to 2 meals per day and which do not constitute a full nutritional regimen is permitted).

Instructions

- Supplement or modify the core definition as appropriate to encompass specific service elements/activities furnished as adult day health under the waiver.
- If physical, occupational and/or speech/language therapies included in the participant's service plan are furnished as components of this service, include a statement to that effect in the definition.
- If transportation between the participant's place of residence and the adult day health site is provided as a component of adult day health services and the cost of this transportation is included in the rate paid to adult day health providers, include a statement to that effect in the definition.
- While adult day health services generally are provided for four or more hours per day, they may be furnished for fewer hours. It also is not required that participants receive adult day health services each day.

Habilitation Services

General Guidance

Habilitation services are identified as home and community-based services at 42 CFR § 440.180(b)(6). Habilitation may be covered as a distinct waiver service. Usually, coverage of habilitation takes the form of the coverage of day and residential habilitation as separate services.

In addition, states may cover enhanced habilitation services (supported employment, education, and prevocational services) as described in regulation at 42 CFR § 440.180(c). In general, when enhanced habilitation services are covered, they need to be covered as distinct services rather than combined as a single service. Core definitions are provided for habilitation, residential habilitation, day habilitation, prevocational, supported employment, and education.

While habilitation is frequently identified with the provision of services to persons with intellectual disability and other related conditions, habilitation services (including enhanced habilitation services) may be furnished to other target groups (e.g., persons who have experienced a brain injury) who may benefit from them.

6. Habilitation

Background

Habilitation services are defined in section 1915(c)(5) of the Act as services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community based settings.

Core Service Definition

Services designed to assist participants in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings.

Instructions

- Supplement or modify the core definition as appropriate to specify the specific service elements/activities that are furnished as habilitation under the waiver.
- Specify the settings in which habilitation is furnished.

Guidance

- Habilitation may be furnished in a home or other community setting.
- When habilitation is provided as a single service (rather than broken down into component parts), in accordance with section 1902(a)(23) of the Act, the provider qualifications specified must not have the effect of unnecessarily limiting the providers of the service.
- Retainer payments may be made to providers of habilitation while the waiver participant is hospitalized or absent from his/her home for a period of no more than 30-days. See CMS State Medicaid Director letter Olmstead Update #3 (July 25, 2000) in Attachment C for additional information. If the state elects to make such payments, describe the circumstances under which such payments are authorized and applicable limits on their duration. Such payments are not permissible when the state has included a cost-center in the rate paid to providers to address absences.

7. Residential Habilitation

Background

There is no specific regulatory definition for residential habilitation, but generally it involves individually tailored supports available in a provider-owned or controlled residential setting or a participant's own home that assist with the acquisition, retention, or improvement in skills related to living in the community. Pursuant to the general prohibition on coverage of room and board outlined at section 1915(c) of the Act, payment may not be made for residential habilitation for the cost of room and board, including the cost of building maintenance, upkeep and improvement. The method by which the costs of room and board are excluded from payment for residential habilitation is specified in Appendix I-5.

Core Service Definition

Individually tailored supports that assist with the acquisition, retention, or improvement in skills related to living in the community. These supports include adaptive skill development, assistance with activities of daily living, community inclusion, transportation, adult educational supports, social and leisure skill development, that assist the participant to reside in the most integrated setting appropriate to his/her needs. Residential habilitation also includes personal care and protective oversight and supervision.

Payment may not be made for the cost of room and board, including the cost of building maintenance, upkeep and improvement. Payment is not made, directly or indirectly, to members of the individual's immediate family, except as provided in Appendix C-2.

Instructions

- Supplement or modify the core definition as appropriate to encompass the specific service elements/activities furnished as residential habilitation.
- Residential habilitation may be furnished in the following living arrangements: participant's own home, the home of a relative, a semi-independent or supported apartment or living arrangement, or a group home. Supplement the core definition by specifying the types of settings where residential habilitation is furnished.

Guidance

- Residential habilitation services may be provided in the participant's living arrangement or in the surrounding community, provided that such services do not duplicate services furnished to a participant as other types of habilitation.
- Provider owned or leased facilities where residential habilitation services are furnished must be compliant with the Americans with Disabilities Act of 1990, 42 U.S.C. § 12101 et seq. (1990).
- Home accessibility modifications when covered as a distinct service under the waiver may not be furnished to individuals who receive residential habilitation services except when such services are furnished in the participant's own home. Compensation for the costs of life safety code modifications and other necessary accessibility modifications that a provider makes may be included in provider rate (as amortized costs) so long as they are necessary to meet the needs of residents and are not basic housing costs.
- Residential habilitation services may include the provision of medical and health care services that are integral to meeting the daily needs of residents (e.g., routine administration of medications by nurses or tending to the needs of residents who are ill or require attention to their medical needs on an ongoing basis). The provision of such

routine health services and the inclusion of the payment for such services in the payment for residential habilitation services is not considered to violate the requirement at 42 CFR § 440.180 that a waiver may not cover services that are available through the state plan. Medical and health care services such as physician services that are not routinely provided to meet the daily needs of residents may not be included.

- Personal care/assistance or other similar services may be a component part of residential habilitation services but may not comprise the entirety of the service. When personal care or another similar service is covered as a distinct waiver service but also is furnished as a component of residential habilitation, in accordance with the Improper Payments Elimination and Recovery Act of 2010, there must be mechanisms that prevent the duplicative billing of the provision of personal care services.
- If transportation between the participant's place of residence and other service sites or places in the community is provided as a component of residential habilitation services and the cost of this transportation is included in the rate paid to providers of residential habilitation services, include a statement to that effect in the service definition.
- Respite care may be made available to persons who receive residential habilitation or other types of residential services under the waiver (e.g., adult foster care) for the relief of a primary caregiver, provided that there is no duplication of payment. When respite is furnished for the relief of a foster care provider, foster care services may not be billed during the period that respite is furnished. Respite care may not be furnished for the purpose of compensating relief or substitute staff for a waiver residential service. The costs of such staff are met from payments for the waiver residential service.
- Retainer payments may be made to providers of residential habilitation while the waiver participant is hospitalized or absent from his/her home for a period of no more than 30-days. See State Medicaid Director letter Olmstead Update #3 (July 25, 2000) in Attachment C for additional information. If the state elects to make such payments, describe the circumstances under which such payments are authorized and applicable limits on their duration.

8. Day Habilitation

Background

There is no specific regulatory definition of day habilitation but generally the service involves the provision of regularly scheduled activities in a non-residential setting, separate from the participant’s private residence or other residential living arrangement, such as assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills that enhance social development and develop skills in performing activities of daily living and community living. As noted previously, coverage of room and board is not permitted under 1915(c) of the Act.

Core Service Definition

Provision of regularly scheduled activities in a non-residential setting, separate from the participant's private residence or other residential living arrangement, such as assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills that enhance social development and develop skills in performing activities of daily living and community living.

Activities and environments are designed to foster the acquisition of skills, building positive social behavior and interpersonal competence, greater independence and personal choice. Services are furnished consistent with the participant's person-centered service plan. Meals provided as part of these services shall not constitute a "full nutritional regimen" (i.e., up to 2 meals per day and which do not constitute a full nutritional regimen is permitted).).

Day habilitation services focus on enabling the participant to attain or maintain his or her maximum potential and are coordinated with any needed therapies in the individual's person-centered service plan, such as physical, occupational, or speech therapy.

Instructions

- Supplement or modify the core definition as appropriate to specify service elements/activities furnished as day habilitation under the waiver.
- Day habilitation may be furnished in any of a variety of settings in the community other than the person's private residence. Day habilitation services are not limited to fixed-site facilities. Supplement the core definition by specifying where day habilitation is furnished.
- If transportation between the participant's place of residence and the day habilitation site, or other community settings in which the service is delivered, is provided as a component part of day habilitation services and the cost of this transportation is included in the rate paid to providers of day habilitation services, the service definition needs to include a statement to that effect in the definition.

Guidance

- Day habilitation may not provide for the payment of services that are vocational in nature (i.e., for the primary purpose of produces goods or performing services) per 42 CFR § 440.180(c)(3)(ii).
- Personal care/assistance may be a component part of day habilitation services as necessary to meet the needs of a participant but may not comprise the entirety of the service.
- Participants who receive day habilitation services may also receive educational, supported employment and prevocational services. A participant's person-centered service plan may include two or more types of non-residential habilitation services. However, different types of non-residential habilitation services should not be billed during the same period of the day.
- Day habilitation services may be furnished to any individual who requires them and chooses them through a person-centered planning process. Such services are not limited to persons with intellectual or. developmental disabilities.
- For individuals with degenerative conditions, day habilitation may include training and

supports designed to maintain skills and functioning and to prevent or slow regression rather than acquiring new skills or improving existing skills.

- Day habilitation services may also be used to provide supported retirement activities. As some people get older, they may no longer desire to work and may need supports to assist them in meaningful retirement activities in their communities. This might involve altering schedules to allow for more rest time throughout the day, support to participate in hobbies, clubs and/ or other senior related activities in their communities.
- If states wish to cover "career planning" activities, they may choose to include it as a component part of day habilitation services, or it may be broken out as a separate standalone service definition.

9. Education

Core Service Definition

Educational services consist of special education and related services as defined in the Individuals with Disabilities Education Improvement Act (IDEA) of 2004, 34 CFR § 300.5 (20 U.S.C. 1401 et seq.), to the extent to which they are not available under a program funded by IDEA. Documentation is maintained in the file of each individual receiving this service that the service is not otherwise available under section 110 of the Rehabilitation Act of 1973 or the IDEA.

Instructions

- If transportation between the participant's place of residence and the educational services site is provided as a component of education services and the cost of this transportation is included in the rate paid to providers of education services, include a statement to that effect in the service definition.
- Supplement or modify the core definition as appropriate to specify the service elements/activities that are furnished under the waiver and where education services are furnished.
- Supplement the core definition to specify the process by which it will be determined that education services do not fall within the requirements of the IDEA.

Guidance

- The IDEA requires the provision of comprehensive education and related services to children and youth with disabilities who are enrolled in special education programs. As a consequence, when a state proposes to include education services in its waiver, CMS will review the proposed waiver coverage to ensure that it does not provide for the payment of services that are mandated under IDEA.

10. Prevocational Services

Background

Prevocational services are described in 42 CFR § 440.180(c)(2)(i). To ensure compliance with 42 CFR § 440.180(c)(3), documentation is expected to be maintained in the file of each

individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

Core Service Definition

Services that provide learning and work experiences, including volunteer work, where the individual can develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated community settings. Services are expected to occur over a defined period of time and with specific outcomes to be achieved, as determined by the individual and his/her service and supports planning team through an ongoing person-centered planning process, to be reviewed not less than annually or more frequently as requested by the individual. Individuals receiving prevocational services are expected to have employment-related goals in their person-centered service plan; the general habilitation activities may be designed to support such employment goals. Competitive, integrated employment in the community for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities is considered to be the successful outcome of prevocational services.

Prevocational services should enable each individual to attain the highest level of work in the most integrated setting and with the job matched to the individual's interests, strengths, priorities, abilities, and capabilities, while following applicable federal wage guidelines. Services are intended to develop and teach general skills that lead to competitive and integrated employment including, but not limited to ability to communicate effectively with supervisors, co-workers and customers; generally accepted community workplace conduct and dress; ability to follow directions; ability to attend to tasks; workplace problem solving skills and strategies; general workplace safety and mobility training.

Participation in prevocational services is not a required pre-requisite for individual or small group supported employment services provided under the waiver. Many individuals, particularly those transitioning from school to adult activities, are likely to choose to go directly into supported employment. Similarly, the evidence-based Individual Placement and Support (IPS) model of supported employment for individuals with behavioral health conditions emphasizes rapid job placement in lieu of prevocational services.

Documentation is maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

Instructions

- Supplement or modify the core definition as appropriate to incorporate the specific service elements furnished under the waiver.
- Prevocational services may be furnished in a variety of locations in the community and are not limited to fixed-site facilities. Specify in the service definition where these services are furnished.
- If transportation between the participant's place of residence and the prevocational services site/s is provided as a component part of prevocational services and the cost of this transportation is included in the rate paid to providers of prevocational services, the service definition includes a statement to that effect.

- Specify in the definition how the determination is made that the services furnished to the participant are prevocational rather than vocational in nature in accordance with 42 CFR § 440.180(c)(2)(i).

Guidance

- Per 42 CFR §440.180(c)(2)(i), pre-vocational services include activities that are not primarily directed at teaching skills to perform a particular job, but at underlying habilitative goals (e.g., attention span, motor skills, interpersonal relations with co-workers and supervisors) that are associated with building skills necessary to perform compensated work in community integrated employment. Vocational services, which are not covered through waivers, are services that teach job task specific skills required by a participant for the primary purpose of completing those tasks for a specific facility-based job and are not delivered in an integrated work setting through supported employment. The distinction between vocational and pre-vocational services is that pre-vocational services, regardless of setting, are delivered for the purpose of furthering habilitation goals that will lead to greater opportunities for competitive and integrated employment and career advancement at or above minimum wage. These goals are described in the individual's person-centered services and supports plan and are designed to teach skills that will lead to integrated competitive employment.
- A person receiving pre-vocational services may pursue employment opportunities at any time to enter the general work force. Pre-vocational services are intended to assist individuals to enter the general workforce.
- Individuals participating in prevocational services may be compensated in accordance with applicable federal laws and regulations and the provision of prevocational services is always delivered with the intention of leading to permanent integrated employment at or above the minimum wage in the community.
- All prevocational and supported employment service options should be reviewed and considered as a component of an individual's person-centered services and supports plan no less than annually, more frequently as necessary or as requested by the individual. These services and supports should be designed to support successful employment outcomes consistent with the individual's goals.
- Personal care/assistance may be a component of prevocational services but may not comprise the entirety of the service.
- Individuals who receive prevocational services may also receive educational, supported employment and/or day habilitation services. A participant's person-centered service plan may include two or more types of non-residential habilitation services. However, different types of non-residential habilitation services may not be billed during the same period of the day.
- If states wish to cover "career planning" activities, they may choose to include it as a component part of pre-vocational services, or it may be broken out as a separate stand-alone service definition.
- Prevocational services may include volunteer work, such as volunteer learning and training activities that prepare a person for entry into the paid workforce.

- Prevocational services are not limited to persons with intellectual or developmental disabilities.

11-a Supported Employment - Individual Supported Employment

Background

Supported employment services are described at 42 CFR § 440.180(c)(2)(iii) and defined in the CMCS Informational Bulletin dated September 16, 2011 (available in Attachment D). To ensure compliance with 42 CFR § 440.180(c)(3), documentation should be maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.). Federal financial participation may not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment; or

2. Payments that are passed through to users of supported employment services.

Core Service Definition

Ongoing supports to participants who, because of their disabilities, need intensive on-going support to obtain and maintain an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce at or above the state's minimum wage, at or above the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals.

Supported employment services can be provided through many different service models. Some of these models can include evidence-based supported employment for individuals with mental illness, or customized employment for individuals with significant disabilities. States may define other models of individualized supported employment that promote community inclusion and integrated employment.

Supported employment individual employment supports may also include support to establish or maintain self-employment, including home-based self-employment. Supported employment services are individualized and may include any combination of the following services: vocational/job-related discovery or assessment, person-centered employment planning, job placement, job development, negotiation with prospective employers, job analysis, job carving, training and systematic instruction, job coaching, benefits and work-incentives planning and management, transportation, asset development and career advancement services. Other workplace support services including services not specifically related to job skill training that enable the waiver participant to be successful in integrating into the job setting.

Services do not include incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment; or payments that are passed through to users of supported employment services.

Documentation is maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

Instructions

- Supplement or modify the core definition as appropriate to incorporate the specific service elements furnished in the waiver.
- Supported employment individual employment supports is not intended for people working in mobile work crews of small groups of people with disabilities in the community. That type of work support is addressed in the core service definition for Supported Employment Small Group employment support.
- If transportation between the participant's place of residence and the employment site is a component part of supported employment individual employment services and the cost of this transportation is included in the rate paid to providers of supported employment individual employment supports services, as permitted under 42 CFR § 440.180(c)(2)(iii)(C), the service definition must include a statement to that effect.

Guidance

- Statewide rate setting methodologies, which are further described in I-2-a of the waiver application may be used to embrace new models of support that help a person obtain and maintain integrated employment in the community. These may include co-worker support models, payments for work milestones, such as length of time on the job, number of hours the participant works, etc. Payments for work milestones are not incentive payments that are made to an employer to encourage or subsidize the employer's hiring an individual with disabilities, which is not permissible.
- Supported employment individual employment supports does not include facility based, or other similar types of vocational services furnished in specialized facilities that are not a part of the general workplace.
- In addition to the need for an appropriate job match that meets the individual's skills and interests, individuals with the most significant disabilities may also need long term employment support to successfully maintain a job due to the ongoing nature of the waiver participant's support needs, changes in life situations, or evolving and changing job responsibilities.
- All prevocational and supported employment service options should be reviewed and considered as a component of an individual's person-centered services and supports plan no less than annually, more frequently as necessary or as requested by the individual. These services and supports should be designed to support successful employment outcomes consistent with the individual's goals.
- Supported employment individual employment supports do not include volunteer work. Such volunteer learning and training activities that prepare a person for entry into the paid workforce are addressed through pre-vocational services.
- Supported employment individual employment supports do not include payment for supervision, training, support and adaptations typically available to other workers without disabilities filling similar positions in the business.
- Supported employment individual employment supports may be provided by a co-worker or other job site personnel provided that the services that are furnished are not

part of the normal duties of the co-worker, supervisor or other personnel and these individuals meet the pertinent qualifications for the providers of service.

- Personal care/assistance may be a component part of supported employment individual employment supports but may not comprise the entirety of the service.
- Supported employment individual employment supports may include services and supports that assist the participant in achieving self-employment through the operation of a business; however, Medicaid funds may not be used to defray the expenses associated with starting up or operating a business. Assistance for self-employment may include: (a) aid to the participant in identifying potential business opportunities; (b) assistance in the development of a business plan, including potential sources of business financing and other assistance in including potential sources of business financing and other assistance in developing and launching a business; (c) identification of the supports that are necessary in order for the participant to operate the business; and (d) ongoing assistance, counseling and guidance once the business has been launched.
- Individuals receiving supported employment individual employment supports services may also receive educational, pre-vocational and/or day habilitation services and career planning services. A participant's person-centered services and supports plan may include two or more types of non-residential habilitation services. However, different types of non-residential habilitation services may not be billed during the same period of time.
- If states wish to cover "career planning" they may choose to include it as a component part of supported employment individualized employment support services, or it may be broken out as a separate standalone service definition.
- Supported employment individual employment supports may be furnished to any individual who requires and chooses them through a person-centered planning process. They are not limited to persons with intellectual or developmental disabilities.

11-b Supported Employment – Small Group Employment Support

Background

Supported Employment – Small Group Employment Support are services defined in the CMCS Informational Bulletin dated September 16, 2011 (available in Attachment D).

To ensure compliance with 42 CFR § 440.180(c)(3), documentation should be maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

Federal financial participation may not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment services; or

2. Payments that are passed through to users of supported employment services.

Core Service Definition

Services and training activities provided in regular business and industry settings for groups of two (2) to eight (8) workers with disabilities. Small group employment support does not include services provided in facility-based work settings. Examples include mobile crews and other business-based workgroups employing small groups of workers with disabilities in integrated employment in the community. The outcome of this service should lead to sustained paid employment and work experience leading to further career development and individual integrated community-based employment for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

Supports may include any combination of the following services: vocational/job-related discovery or assessment, person-centered employment planning, job placement, job development, negotiation with prospective employers, job analysis, training and systematic instruction, job coaching, benefits management, transportation and career advancement services. Other workplace support services may include services not specifically related to job skill training that enable the waiver participant to be successful in integrating into the job setting. Supported employment small group employment support should be provided in a manner that promotes integration into the workplace and interaction between participants and people without disabilities in those workplaces.

Services do not include incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment services; or payments that are passed through to users of supported employment services.

Documentation is maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

Instructions

- Supplement or modify the core definition as appropriate to incorporate the specific service elements furnished in the waiver.
- If transportation between the participant's place of residence and the employment site is a component part of supported employment services small group employment support and the cost of this transportation is included in the rate paid to providers of supported employment small group employment supports services as permitted under 42 CFR § 440.180(c)(2)(iii)(C), the service definition must include a statement to that effect.

Technical Guidance

- Supported employment small group employment support does not include facility-based work settings or other similar types of vocational services furnished in specialized facilities that are not a part of general community workplaces.
- Supported employment small group employment supports do not include volunteer work. Such volunteer learning and training activities that prepare a person for entry into the paid workforce are addressed through pre-vocational services.

- Supported employment small group employment support does not include payment for supervision, training, support and adaptations typically available to other workers without disabilities filling similar positions in the business.
- Supported employment small group employment support services may be provided by a co-worker or other job site personnel provided that the services that are furnished are not part of the normal duties of the co-worker, supervisor or other personnel and these individuals meet the pertinent qualifications for the providers of service.
- Personal care/assistance may be a component part of supported employment small group employment support services but may not comprise the entirety of the service.
- All prevocational and supported employment service options should be reviewed and considered as a component of an individual's person-centered services and supports plan no less than annually, more frequently as necessary or as requested by the individual. These services and supports should be designed to support successful employment outcomes consistent with the individual's goals.
- Individuals receiving supported employment small group employment support services may also receive educational, prevocational and/or day habilitation services and career planning services. A participant's person-centered services and supports plan may include two or more types of non-residential habilitation services. However, different types of non-residential habilitation services may not be billed during the same period of time.
- If states wish to cover "career planning" they may choose to include it as a component part of supported employment small group employment support services, or it may be broken out as a separate standalone service definition.
- Supported employment small group employment support services may be furnished to any individual who requires and chooses them. They are not limited to persons with intellectual or developmental disabilities.

12. Respite Care

Background

Respite services are identified as home and community-based services at 42 CFR § 440.180(b)(7). There is no specific regulatory definition of respite. Federal financial participation may not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the state that is not a private residence per 42 CFR § 441.360(b).

Core Service Definition

Services provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the participant. Services do not include room and board except when provided as part of respite care furnished in a facility approved by the state that is not a private residence.

Instructions

- Supplement or modify the core definition as appropriate to incorporate specific service elements under the waiver.
- The service definition specifies the location(s) where respite care is provided. These locations may include (but are not limited to):

- Participant's home or private place of residence
- The private residence of a respite care provider
- Foster home
- Medicaid certified Hospital
- Medicaid certified Nursing Facility
- Medicaid certified ICF/IID
- Group home
- Licensed respite care facility
- Other community care residential facility approved by the state that is not a private residence. Specify the types of these facilities where respite is provided.

- The service definition specifies the location(s) (if any) where FFP is claimed for the cost of room and board. FFP may not be claimed for room and board when respite is provided in the participant's home or place of residence pursuant to 42 CFR § 441.360(b).

Guidance

- Receipt of respite care does not necessarily preclude a participant from receiving other services on the same day. For example, a participant may receive day services (such as supported employment, adult day care, personal care, nursing care, etc.) on the same day as they receive respite care. Payment may not be made for respite furnished at the same time when other services that include care and supervision are provided per the Improper Payments Elimination and Recovery Act of 2010.
- Respite care may be made available to persons who receive residential habilitation or other types of residential services under the waiver (e.g., adult foster care) for the relief of a primary caregiver, provided that there is no duplication of payment. When respite is furnished for the relief of a foster care provider, foster care services may not be billed during the period that respite is furnished. Respite care may not be furnished for the purpose of compensating relief or substitute staff for a waiver residential service. The costs of such staff are met from payments for the waiver residential service.

Mental Health Services

Day treatment or partial hospitalization, psychosocial rehabilitation, and clinic services may be covered under the state plan. Under 42 CFR § 440.180(b)(8), a state may also furnish these services under a 1915(c) home and community-based services waiver to individuals with chronic mental illness. A state may also offer other types of mental health services in addition to these as "other" waiver services.

The provision of mental health services under a waiver is not limited to persons who have a primary diagnosis of chronic mental illness. They may be furnished to any participant who requires them regardless of waiver target group. As is the case with other services, mental health services under a waiver may be furnished on an "extended state plan services" coverage basis or may provide for the coverage of services furnished that differ from state plan services.

Mental health services offered under the state plan sometimes are limited to Medicaid beneficiaries who have been diagnosed as having serious (severe or persistent) mental illnesses.

Under a waiver, a state may offer mental health services to persons who would benefit from them but who do not meet state plan criteria.

When a state proposes to cover mental health services under a waiver, CMS will review the state plan to ensure that the proposed coverage does not duplicate the coverage under the state plan. In the case of waivers that serve individuals under age 21, this review also will encompass the extent to which the proposed mental health services can be provided under the state plan and, therefore, should be furnished as services required under EPSDT.

13. Day Treatment

Background

Day treatment for persons with chronic mental illness can be included under a 1915(c) waiver in accordance with 42 CFR § 440.180(b)(8). There is no specific regulatory definition of day treatment. There are two core service definitions provided.

When day treatment or partial hospitalization services are covered under the waiver on an "extended state plan service" basis (e.g., the services furnished differ from the state plan coverage only in amount, duration and frequency but not scope or type of provider), employ the alternate service core service definition provided below.

Core Service Definition

Services that are necessary for the diagnosis or treatment of the individual's mental illness. The purpose of this service is to maintain the individual's condition and functional level and to prevent relapse or hospitalization. These services often consist of the following elements:

- *individual and group therapy with physicians or psychologists (or other mental health professionals to the extent authorized under state law);*
- *occupational therapy, requiring the skills of a qualified occupational therapist;*
- *services of social workers, trained psychiatric nurses, and other staff trained to work with individuals with psychiatric illness;*
- *drugs and biologicals furnished for therapeutic purposes, provided that the medication is not otherwise available under the state plan or as a Medicare benefit to a participant;*
- *individual activity therapies that are not primarily recreational or diversionary,*
- *family counseling (the primary purpose of which is treatment of the individual's condition);*
- *training and education of the individual (to the extent that training and educational activities are closely and clearly related to the individual's care and treatment); and,*
- *diagnostic services.*

Meals provided as part of these services may not constitute a "full nutritional regimen" i.e., up to 2 meals per day and which do not constitute a full nutritional regimen per day is permitted).

Core Service Definition *(Extended State Plan Service):*

Services that are provided when day treatment services furnished under the approved state plan limits are exhausted. The scope and nature of these services do not differ from day treatment services furnished under the state plan. The provider qualifications specified in the state plan

apply. The additional amount of services that may be provided through the waiver is as follows: (specify)

Instructions

- Supplement or modify the core definition's list of service elements as appropriate to reflect the specific service elements covered under the waiver.
- If transportation between the participant's place of residence and the day treatment is provided as a component part of day treatment/partial hospitalization services and the cost of this transportation is included in the rate paid to providers of these services, include a statement to that effect in the service definition.
- In the definition, specify whether these services are only furnished to individuals with chronic mental illness or whether they are available to all individuals served on this waiver who may require them, whether or not they have a formal diagnosis of chronic (serious) mental illness.

If day treatment services are covered under the state plan but the waiver coverage is different, include the following statement in the service definition: *"Day treatment (partial hospitalization) services under the waiver differ in nature, scope, supervision arrangements, or provider type (including provider training and qualifications) from day treatment (partial hospitalization) services in the state plan."* Also, specify the differences between the waiver and the state plan coverage. If day treatment or partial hospitalization is not covered under the state plan, do not include this statement.

14. Psychosocial Rehabilitation Services

Background

Psychosocial rehabilitation services generally encompass various types of mental health services that may be covered as rehabilitative services in the state plan under 42 CFR § 440.130. Psychosocial rehabilitation services for persons with chronic mental illness can also be included under a 1915(c) waiver in accordance with 42 CFR § 440.180(b)(8). There are two core service definitions provided.

When psychosocial rehabilitation services are covered under the waiver solely on an "extended state plan service" basis (e.g., the services furnished differ from the state plan coverage only in amount, duration and frequency but not scope or type of provider), use the alternate service core service definition provided below.

Core Service Definition

Services may include the following:

- *restoration and maintenance of daily living skills (grooming, personal hygiene, cooking, nutrition, health and mental health education, medication management, money management and maintenance of the living environment);*
- *social skills training in appropriate use of community services;*
- *development of appropriate personal support networks, therapeutic recreational services (which are focused on therapeutic intervention rather than diversion); and,*
- *telephone monitoring and counseling services.*

The following are specifically excluded from payment for psychosocial rehabilitation services:

- *vocational services,*
- *prevocational services,*
- *supported employment services, and*
- *room and board.*

Core Service Definition *(Extended State Plan Service):*

Services that are provided when psychosocial rehabilitation services furnished under the approved state plan limits are exhausted. The scope and nature of these services do not differ from psychosocial services furnished under the state plan. The provider qualifications specified in the state plan apply. The additional amount of services that may be provided through the waiver is as follows: (specify)

Instructions

- Supplement or modify the core definition list of service elements as appropriate to reflect the specific service elements covered under the waiver.
- In the definition, specify whether these services are only furnished to individuals with chronic mental illness or whether they are made available to all waiver participants who need the service, whether or not they have a formal diagnosis of chronic (serious) mental illness.
- Psychosocial rehabilitation services may be furnished in any of a variety of locations in the community, including the participant's own home, provider-operated living arrangements and other community settings. In the service definition, specify where these services will be furnished. When services are furnished in a residence, federal financial participation may not be claimed for the cost of room and board.
- If psychosocial rehabilitation services (mental health rehabilitation services) are covered under the state plan but the waiver coverage is different, include the following in the service definition: "*Psychosocial rehabilitation services under the waiver differ in nature, scope, supervision arrangements, or provider type (including provider training and qualifications) from psychosocial rehabilitation services in the state plan.*" Also, specify the differences between the waiver coverage and the state plan coverage. If psychosocial rehabilitation services are not covered under the state plan, do not include this statement.

Guidance

- The term "psychosocial rehabilitation services" subsumes the various types of mental health services that may be covered as rehabilitative services in the state plan under 42 CFR § 440.130.
- Participants who are furnished psychosocial rehabilitation services may be provided prevocational and/or supported employment services when such services are included in the waiver as enhanced habilitation services. However, these services may not be combined with psychosocial rehabilitation services.

15. Clinic Services

Background

Clinic services under the state plan are defined in 42 CFR §440.90 as preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. Clinic services (whether or not furnished in a facility) for individuals with chronic mental illness are also permitted under 1915(c) waivers in accordance with 42 CFR § 440.180. There are two core service definitions provided below.

Core Service Definition

Services (whether or not furnished in a facility, that include preventive, diagnostic, therapeutic, rehabilitative, or palliative services provided to individuals with chronic mental illness.

Core Service Definition *(Extended State Plan Service):*

Services that are provided when clinic services (as defined in 42 CFR § 440.90) furnished under the approved state plan limits are exhausted. The scope and nature of these services do not otherwise differ from clinic services furnished under the state plan. The provider qualifications specified in the state plan apply. The additional amount of services that may be provided through the waiver is as follows: (specify)

Instructions

- In the definition, specify whether these services are only furnished to individuals with chronic mental illness or whether they are made available to all individuals served on this waiver, whether or not they have a formal diagnosis of chronic (serious) mental illness.
- Supplement or modify the core definition list of service elements as appropriate to reflect the specific service elements covered under the waiver.
- In the definition, specify whether clinic services may only be furnished on the premises of a clinic or may be furnished outside the clinic facility. If services may be furnished offsite, specify the locations where they may be furnished.
- If clinic services are covered under the state plan for individuals with a chronic mental illness but the waiver coverage is different, include the following statement in the service definition: *"Clinic services under the waiver differ in nature, scope, supervision arrangements, or provider type (including provider training and qualifications) from clinic services in the state plan."* Also, specify the differences between the waiver coverage and the state plan coverage. One way that the coverage of clinic services under the waiver may differ from coverage under the state plan is when services are furnished off-site from the clinic. Describe the difference between the waiver and the state plan coverage.
- When mental health clinic services are covered under the waiver only on an "extended state plan service" basis (e.g., the services furnished differ from the state plan coverage only in amount, duration and frequency but not scope), employ the following alternate service core service definition:

16. Live-in Caregiver

Background

There is no regulatory definition of this service; however, section 1915(c)(1) limits payment for the service to the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant.

Core Service Definition

Services include the payment for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. Payment will not be made when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

Instructions

- Live-in caregiver is treated as a service that needs to be included in the listing of services in Appendix C-1.
- Method of determining the amount paid is specified in Appendix I-6.
- The expected costs and utilization of live-in care giver payments must be accounted for as a distinct item in the computation of Factor D in Appendix J-2.

B. Other Services

Other services are services that are not: (a) statutory services; (b) extended state plan services; or (c) services in support of participant direction. Provided below are services that may be covered under a waiver as home and community-based services consistent with 42 CFR § 440.180(b)(9).

1. Home Accessibility Adaptations (a.k.a., environmental accessibility adaptations)**Background**

There is no regulatory definition for home accessibility adaptations; however, they generally entail physical modifications to a private residence to enable the participant to function independently in their own home.

Core Service Definition

Those physical adaptations to the private residence of the participant or the participant's family, required by the participant's service plan, that are necessary to ensure the health, welfare and safety of the participant or that enable the participant to function with greater independence in the home. Such adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the participant.

Excluded are those adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the participant. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).

Instructions

- Supplement or modify the core definition list of service elements as appropriate to reflect the specific service elements covered under the waiver.
- An exhaustive listing of the specific adaptations may be included in the definition rather than the more general types of adaptations contained in the definition. In the core definition, the sentence beginning "Such adaptations …" may be deleted and the sentence "Adaptations include:" substituted, followed by the exhaustive listing of the specific home adaptations included in the coverage.
- The scope of home accessibility modifications may include the performance of necessary assessments to determine the types of modifications that are necessary. The cost estimates and claiming for this activity would need to be itemized separately in Appendix J as a cost component of the service.

Guidance

- Home accessibility adaptations may not be furnished to adapt living arrangements that are owned or leased by providers of waiver services.
- When, as provided in CMS State Medicaid Director letter Olmstead Update No. #3 (see Attachment C), the state authorizes home accessibility modifications up to 180 consecutive days of admission in advance of the community transition of an institutionalized person, the definition should reflect that provision has been made for such modifications. In such cases, the home modification begun while the person was institutionalized is not considered complete, and may not be billed until, the date the individual leaves the institution and enters the waiver.

2. Vehicle Modifications

Background

There is no regulatory definition for vehicle modifications; however, they generally entail adaptations or alterations to an automobile or van that is the waiver participant's primary means of transportation in order to safely facilitate the participant's integration into the community.

Core Service Definition

Adaptations or alterations to an automobile or van that is the waiver participant's primary means of transportation in order to accommodate the special needs of the participant. Vehicle adaptations are specified by the service plan as necessary to enable the participant to integrate more fully into the community and to ensure the health, welfare and safety of the participant. The following are specifically excluded:

1. *Adaptations or improvements to the vehicle that are of general utility, and are not of direct medical or remedial benefit to the individual;*
2. *Purchase or lease of a vehicle; and*
3. *Regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modifications.*

Instructions

- Modify or supplement the core definition to reflect the scope of vehicle modifications

furnished under the waiver. If such modifications are limited to specific modifications, list the modifications for which payment will be made.

- The scope of vehicle modifications may include the performance of necessary assessments to determine the types of modifications that are necessary. The cost estimates and claiming for this activity would need to be itemized separately in Appendix J as a cost component of the service.

Guidance

- The vehicle that is adapted may be owned by the individual, a family member with whom the individual lives or has consistent and on-going contact, or a non-relative who provides primary long-term support to the individual and is not a paid provider of such services.
- Payment may not be made to adapt the vehicles that are owned or leased by paid providers of waiver services. The costs of necessary adaptations to provider vehicles may be compensated in the payment rate for transportation or other services (e.g., day habilitation) that include the cost of transportation.

3. Non-Medical Transportation

Background

Under the Medicaid program, states must assure coverage of both emergency transportation and non-emergency medical transportation (NEMT) when necessary to enable the beneficiary to access a covered service. Under a home and community-based waiver, states have the option to include non-medical transportation to supplement state plan medical transportation.

Core Service Definition

Service offered in order to enable waiver participants to gain access to waiver and other community services, activities and resources, as specified by the service plan. This service is offered in addition to medical transportation required under 42 CFR § 431.53 and transportation services under the state plan, defined at 42 CFR § 440.170(a) (if applicable), and does not replace them. Transportation services under the waiver are offered in accordance with the participant's service plan. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge are utilized.

Instructions

- Modify or supplement the core definition to reflect the scope of non-medical transportation furnished under the waiver.
- If transportation services are limited to specific situations, specify when transportation services are furnished in the definition.

Guidance

- Waiver transportation services may not be substituted for the transportation services that a state is obligated to furnish under the requirements of 42 CFR § 431.53. For example, transportation of a waiver participant to receive medical care that is provided under the state plan must be billed as a state plan transportation service or charged as an administrative expense, not as a waiver service. Payment for transportation under the waiver is limited to the costs of transportation needed to access a waiver service included

in the participant's service plan or access other activities and resources identified in the service plan.

- When the costs of transportation are included in the provider rate for another waiver service (e.g., adult day health), there must be mechanisms to prevent the duplicative billing of non-medical transportation services in accordance with the Improper Payments Elimination and Recovery Act of 2010.
- Non-medical transportation services may be furnished to waiver participants under age 21.
- If some providers have capacity to transport and it is incidental to the service the provider is delivering, then the state would need to incorporate the cost of transportation into the rate or add a cost component to cover it. If there are also providers that don't have the capacity to transport, then the state should reflect the different reimbursement methodologies in Appendix I, and the range of cost estimates in Appendix J.

4. Specialized Medical Equipment and Supplies

Background

Coverage of medical supplies and equipment is available under the state plan pursuant to 42 CFR § 440.70(b)(3) and may also be covered under a 1915(c) HCBS waiver to supplement state plan coverage.

Core Service Definition

Specialized medical equipment and supplies include: (a) devices, controls, or appliances, specified in the plan of care, that enable participants to increase their ability to perform activities of daily living; (b) devices, controls, or appliances that enable the participant to perceive, control, or communicate with the environment in which they live; (c) items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items; (d) such other durable and non-durable medical equipment not available under the state plan that is necessary to address participant functional limitations; and, (e) necessary medical supplies not available under the state plan. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the state plan and exclude those items that are not of direct medical or remedial benefit to the participant. All items have to meet applicable standards of manufacture, design and installation.

Instructions

- Modify or supplement the core definition to reflect the scope of medical equipment and supplies furnished under the waiver.
- When coverage is limited to specific supplies or equipment, include a listing in the definition.
- If the coverage includes the costs of maintenance and upkeep of equipment, include a statement to that effect in the definition.
- When the coverage includes training the participant or caregivers in the operation and/or maintenance of the equipment or the use of a supply, include a statement to that effect in the definition.

- If the coverage includes the performance of assessments to identify the type of equipment needed by the participant, include a statement to that effect in the definition. The cost estimates and claiming for this activity would need to be itemized separately in Appendix J as a cost component of the service.
- When necessary equipment is purchased in advance of the community placement of an institutionalized person and claimed as a waiver cost post-entrance of the person to the waiver, include a statement to that effect.

Guidance

- This coverage may be used to supplement medical supplies and equipment under the state plan, items that the state makes available, or items that Medicare covers under Durable Medical Equipment.
- States have employed this coverage to furnish a wide variety of adaptive positioning devices, mobility aids, and adaptive equipment.
- The coverage also may include augmentative communication devices and services, or such services may be covered as a distinct service.
- Medical equipment and supplies that can be covered under the state plan should be furnished as services required under EPSDT to waiver participants under age 21.

5. Assistive Technology

Background

There is no regulatory definition for assistive technology; however, generally it includes equipment, service animals, or product systems that address a specific need and enables the waiver participant to function safely in their home or community.

Core Service Definition

Assistive technology means an item, piece of equipment, service animal or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of participants. Assistive technology service means a service that directly assists a participant in the selection, acquisition, or use of an assistive technology device. Assistive technology includes--

- *the evaluation of the assistive technology needs of a participant, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the participant;*
- *services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for participants;*
- *services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;*
- *coordination and use of necessary therapies, interventions, or services with assistive technology devices, such as therapies, interventions, or services associated with other services in the service plan;*
- *training or technical assistance for the participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the*

participant; and

- *training or technical assistance for professionals or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of participants.*

Instructions

- Modify or supplement the core definition to reflect the scope of assistive technology services and devices furnished under the waiver. If such devices, items and/or services are limited to specific types, list the types for which payment will be made.
- If the coverage includes the performance of assessments to identify the type of equipment needed by the participant, include a statement to that effect in the definition. The cost estimates and claiming for this activity would need to be itemized separately in Appendix J as a cost component of the service.

6. Personal Emergency Response System (PERS)

Background

There is no regulatory citation for PERS; however, it is a common service that enables waiver participants to request help in an emergency.

Core Service Definition

Coverage of PERS under a waiver refers to an electronic device that enables waiver participants to secure help in an emergency. The participant may also wear a portable "help" button to allow for mobility. The system is connected to the participant's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals, as specified herein.

Instructions

- Supplement or modify the core definition as appropriate to reflect the specific covered devices and services under the waiver.
- If installation, upkeep and maintenance of devices/systems are provided, include a statement to that effect in the definition. The cost estimates and claiming for this activity would need to be itemized separately in Appendix J as a cost component of the service.

7. Community Transition Services

Background

There is no regulatory citation for community transition services. The core service definition below is instead derived from guidance included in State Medicaid Director letter #02-008 (available in Attachment C), which stipulates that states may secure federal matching funds under HCBS waivers on behalf of waiver participants who make the transition from an institution to their own home or apartment in the community, such as security deposits, that do not constitute payment for housing rent. The service is also available for participants transitioning from a provider-operated/controlled living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses.

Core Service Definition

Non-recurring set-up expenses for individuals who are transitioning from a Medicaid-funded institution or another provider-operated/controlled living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include: (a) security deposits that are required to obtain a lease on an apartment or home; (b) essential household furnishings and moving expense required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens; (c) set-up fees or deposits for utility or service access, including telephone, electricity, heating and water; (d) services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy; (e) moving expenses; (f) necessary home accessibility adaptations; and, (g) activities to assess need, arrange for and procure need resources.

Community Transition Services are furnished only to the extent that they are reasonable and necessary as determining through the service plan development process, clearly identified in the service plan and the person is unable to meet such expense or when the services cannot be obtained from other sources. Community Transition Services do not include monthly rental or mortgage expense; food, regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes.

Instructions

- Supplement or modify the core definition as appropriate to reflect the specific community transition services that are included under the waiver.
- The service definition may be modified as necessary to reflect specific items and services that are included or excluded.
- Community Transition Services may not include payment for room and board. The payment of a security deposit is not considered rent.

Guidance

- See State Medicaid Director letter #02-008 (Attachment C) for further information. Also, see State Health Official letter # 21-001 (in Appendix C).
- When Community Transition Services are furnished to individuals returning to the community from a Medicaid-funded institutional setting or a provider-operated/controlled living arrangement before entrance to the waiver, the costs of such services are considered to be incurred and billable when the person leaves the institutional setting and enters the waiver. The individual must be reasonably expected to be eligible for and to enroll in the waiver. If for any unseen reason, the individual does not enroll in the waiver (e.g., due to death or a significant change in condition), transitional services may be billed to Medicaid as an administrative cost in accordance with a CMS-approved cost allocation plan.
- At the state's option, Community Transition Services may be furnished as a waiver service to individuals who transition from provider-operated settings other than Medicaid reimbursable institutions to their own private residence in the community.
- Community Transition Services may not be used to pay for furnishing living

arrangements that are owned or leased by a waiver provider where the provision of these items and services are inherent to the service they are already providing.

8. Skilled Nursing

Background

As defined in 42 CFR §440.70, "skilled nursing" is a component of the Medicaid state plan home health benefit and refers to the provision of nursing services on a periodic or intermittent basis. Coverage of skilled nursing services under a 1915(c) waiver may supplement state plan coverage. There are two core service definitions provided.

Core Service Definition

Services listed in the service plan that are within the scope of the state's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the state.

Core Service Definition *(Extended State Plan Service)*

Services that are provided when nursing services furnished under the approved state plan limits are exhausted. The scope and nature of these services do not otherwise differ from nursing services furnished under the state plan. The provider qualifications specified in the state plan apply. The additional amount of services that may be provided through the waiver is as follows: (specify)

Instructions

- If skilled nursing services are limited to specific types of nursing services, specify the types of services in the definition.
- If skilled nursing services are covered under the state plan but the waiver coverage is different, include the following statement in the service definition: *"Skilled nursing services under the waiver differ in nature, scope, supervision arrangements, or provider type (including provider training and qualifications) from skilled nursing services in the state plan."* Also, specify the differences between the waiver coverage and the state plan coverage. If skilled nursing services are not covered under the state plan, do not include this statement. Describe the difference between the waiver coverage and the state plan coverage.
- If skilled nursing services are covered under the waiver only on an "extended state plan service" basis (e.g., the services furnished differ from the state plan coverage only in amount, duration and frequency but not scope), employ the alternate service core service definition.

Guidance

- Skilled nursing is the provision of nursing services on an intermittent or part-time basis. "Private duty nursing" (see below) entails the provision of nursing services on a continuous or full-time basis.
- Skilled nursing services that can be furnished under the state plan should be furnished as services required under EPSDT to waiver participants under age 21.

9. Private Duty Nursing

Background

Private duty nursing is the provision of nursing services on a continuous or full-time basis as defined in 42 CFR § 440.80. Coverage of private duty nursing services under a waiver may supplement state plan coverage. There are two core service definitions provided.

Core Service Definition

Individual and continuous care (in contrast to part time or intermittent care) provided by licensed nurses within the scope of state law. These services are provided to a participant at home.

Core Service Definition *(Extended State Plan Service):*

Services that are provided when the limits of private duty nursing furnished under the approved state plan are exhausted. The scope and nature of these services do not otherwise differ from private duty nursing services furnished under the state plan. The provider qualifications specified in the state plan apply. The additional amount of services that may be provided through the waiver is as follows: (specify)

Instructions

- If private duty nursing services are limited to specific types of nursing services, specify the types of services in the definition.
- When private duty nursing services are covered under the state plan but the waiver coverage is different, include the following statement in the service definition: *"Private duty nursing services under the waiver differ in nature, scope, supervision arrangements, or provider type (including provider training and qualifications) from private duty nursing services in the state plan."* Also, specify the differences between the waiver coverage and the state plan coverage. If private duty nursing services are not covered under the state plan, do not include this statement. Describe the difference in waiver coverage and state plan coverage.

If private duty nursing services are covered under the waiver only on an "extended state plan service" basis (e.g., the services furnished differ from the state plan coverage only in amount, duration and frequency but not otherwise), employ the alternate service core service definition.Guidance

- As defined in 42 CFR §440.80, private duty nursing is the provision of nursing services on a continuous or full-time basis. "Skilled nursing" is the provision of nursing services on a periodic or intermittent basis.
- Private duty nursing services that can be provided under the state plan should be furnished to waiver participants under age 21 as services required under EPSDT.

10. Adult Foster Care

Background

There is no regulatory definition for adult foster care; however, the service generally entails the provision of personal care and related supports to a waiver participant in a licensed private home by a principal care provider who lives in the home. Pursuant to the general prohibition on coverage of room and board outlined at section 1915(c) of the Act, payment may not be made for

the cost of room and board, including the cost of building maintenance, upkeep and improvement. The method by which the costs of room and board are excluded from payment for adult foster care is specified in Appendix I-5.

Core Service Definition

Personal care and supportive services (e.g., homemaker, chore, attendant care, companion, medication oversight (to the extent permitted under state law)) provided in a licensed (where applicable) private home by a principal care provider who lives in the home. Adult foster care is furnished to adults who receive these services in conjunction with residing in the home. The total number of individuals (including participants served in the waiver) living in the home, who are unrelated to the principal care provider, cannot exceed [insert number]. Separate payment is not made for homemaker or chore services furnished to a participant receiving adult foster care services, since these services are integral to and inherent in the provision of adult foster care services.

Payments for adult foster care services are not made for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement. Payment for adult foster care services does not include payments made, directly or indirectly, to members of the participant's immediate family.

Instructions

- Modify or supplement the core definition to reflect the scope of adult foster care furnished under the waiver.
- In the core definition, insert the total maximum number of individuals not related to the caregiver who may reside in the home.

Guidance

- Adult foster care is a residential service that is furnished in the primary caregiver's own private home. In some states, these services are entitled "host home services."
- A state may contract with each primary caregiver for the provision of adult foster care services and/or contract with agencies that, in turn, contract with and supervise individual caregivers.
- Adult foster care is considered a residential habilitation service only when habilitation is included in the defined scope of the adult foster care service. Adult foster care is not considered a residential habilitation service when habilitation services are furnished in the adult foster care setting by a different provider and billed separately.

11. Assisted Living Services

Background

There is no regulatory definition for assisted living services; however, they generally entail the provision of personal care and related supports to waiver participants who reside in a 24-hour provider-owned and operated setting. Pursuant to the general prohibition on coverage of room and board outlined at section 1915(c) of the Act, payment may not be made for the cost of room and board, including the cost of building maintenance, upkeep and improvement. The method by which the costs of room and board are excluded from payment for assisted living services is specified in Appendix I-5.

Core Service Definition

Personal care and supportive services (homemaker, chore, attendant services, meal preparation) that are furnished to waiver participants who reside in a setting that meets the HCBS setting requirements and includes 24-hour on-site response capability to meet scheduled or unpredictable resident needs and to provide supervision, safety and security. Services also include social and recreational programming, and medication assistance (to the extent permitted under state law). Services that are provided by third parties must be coordinated with the assisted living provider.

Nursing and skilled therapy services are incidental rather than integral to the provision of assisted living services. Payment may not be made for 24-hour skilled care. Federal financial participation is not available for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement.

Instructions

- Modify or supplement the core definition to reflect the scope of assisted living services furnished under the waiver.
- Indicate whether payment for assisted living services includes any of the following:
    - Home health care
    - Physical therapy
    - Occupational therapy
    - Speech therapy
    - Medication administration
    - Intermittent skilled nursing services
    - Transportation specified in the service plan
    - Periodic nursing evaluations
    - Other specified services

Guidance

- Note: While this version of the waiver application continues to list "assisted living" as a service definition, CMS encourages states to use a more accurate name for the service. The term assisted living describes a setting, not a service. In accordance with 42 CFR § 441.360(b), Medicaid never pays for "assisted living" in the ordinary sense of the monthly fee to the facility for room, board and services. Medicaid may cover, as a waiver service, some of the supportive services provided to assisted living residents. These services may be appropriately titled to reflect their nature and scope.
- Payment for assisted living services may encompass a comprehensive array of services and supports that are normally furnished on an integrated basis by an assisted living provider to residents.
- When the scope of assisted living services includes services (e.g., personal care or chore services) that are also covered as distinct services under the waiver, there must be mechanisms that ensure, when such services are included in the comprehensive rate that

is paid to the assisted living provider, the services may not also be billed separately.

- When a comprehensive payment is made to a provider for assisted living services, the provider's own employees must directly furnish some or all services to residents. The provider may arrange for the provision of some services on a contractual basis.
- The scope of assisted living services may include services that may be offered through the state plan to the extent such services are normally furnished as part of a comprehensive array of on-site assisted living services. However, there must be mechanisms to ensure that, when such services are included in the comprehensive rate that is paid to the assisted living provider, the services may not also be billed separately as state plan services pursuant to the Improper Payments Elimination and Recovery Act of 2010.

12. Chore Services

Background

There is no regulatory definition for chore services; however, they generally involve the completion of household tasks necessary to ensure the health and safety of a waiver participant's home environment.

Core Service Definition

Services needed to maintain the home in a clean, sanitary and safe environment. This service includes heavy household chores such as washing floors, windows and walls, tacking down loose rugs and tiles, moving heavy items of furniture in order to provide safe access and egress. These services are provided only when neither the participant nor anyone else in the household is capable of performing or financially providing for them, and where no other relative, caregiver, landlord, community/volunteer agency, or third-party payor is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, is examined prior to any authorization of service.

Instructions

Supplement or modify the core definition as appropriate to reflect covered service elements/ tasks under the waiver.

13. Adult Companion Services

Background

There is no regulatory definition for adult companion services. They typically entail the provision of non-medical care, supervision and socialization supports on behalf of an individual with functional needs.

Core Service Definition

Non-medical care, supervision and socialization, provided to a functionally impaired adult. Companions may assist or supervise the participant with such tasks as meal preparation, laundry and shopping. The provision of companion services does not entail hands-on nursing care. Providers may also perform light housekeeping tasks that are incidental to the care and supervision of the participant. This service is provided in accordance with a therapeutic goal in the service plan.

Instructions

- Supplement or modify the core definition as appropriate to reflect the specific covered service elements under the waiver.
- When the waiver also covers personal care, chore and/or homemaker services, the definition must describe how the provision of adult companion services does not duplicate the provision of such services.

14. Training and Counseling Services for Unpaid Caregivers

Background

There is no regulatory definition for training and counseling services for unpaid caregivers. The intent of these services is to provide instruction or support to unpaid caregivers on meeting specific needs or service goals identified in the waiver participant's person-centered service plan.

Core Service Definition

Training and counseling services for individuals who provide unpaid support, training, companionship or supervision to participants. For purposes of this service, individual is defined as any person, family member, neighbor, friend, companion, or co-worker who provides uncompensated care, training, guidance, companionship or support to a person served on the waiver. This service may not be provided in order to train paid caregivers. Training includes instruction about treatment regimens and other services included in the service plan, use of equipment specified in the service plan, and includes updates as necessary to safely maintain the participant at home. Counseling must be aimed at assisting the unpaid caregiver in meeting the needs of the participant. All training for individuals who provide unpaid support to the participant must be included in the participant's service plan.

Instructions

Modify or supplement the core definition to reflect the specific types of training furnished that is furnished to unpaid persons who support the participant.

Guidance

- Training furnished to persons who provide uncompensated care and support to the participant must be directly related to their role in supporting the participant in areas specified in the service plan.
- Counseling similarly must be aimed at assisting unpaid individuals who support the participant to understand and address participant needs.

- FFP is available for the costs of registration and training fees associated with formal instruction in areas relevant to participant needs identified in the service plan. FFP is not available for the costs of travel, meals and overnight lodging to attend a training event or conference.

15. Consultative Clinical and Therapeutic Services

Background

There is no regulatory definition for consultative clinical and therapeutic services. These services are intended support unpaid caregivers and/or paid support staff in implementing treatment plans or goals specified in the waiver participant's person-centered service plan.

Core Service Definition

Services that assist unpaid caregivers and/or paid support staff in carrying out individual treatment/support plans, and that are not covered by the Medicaid state plan and are necessary to improve the individual's independence and inclusion in their community. Consultation activities are provided by professionals in psychology, nutrition, counseling and behavior management. The service may include assessment, the development of a home treatment/ support plan, training and technical assistance to carry out the plan and monitoring of the individual and the provider in the implementation of the plan. This service may be delivered in the individual's home or in the community as described in the service plan.

Instructions

Modify or supplement the core definition to reflect the specific types of consultative services that are furnished.

Guidance

The purpose of consultative services is to improve the ability of unpaid caregivers and paid direct support staff to carry out therapeutic interventions.

16. Individual Directed Goods and Services

Background

There is no regulatory definition for individual directed goods and services. They generally include services, equipment, or supplies that are not otherwise available to the waiver participant in order to facilitate community integration and/or ensure the waiver participant's health and safety. The coverage of this service is limited to waivers that incorporate the budget authority participant direction opportunity.

Core Service Definition

Services, equipment or supplies not otherwise provided through the Medicaid state plan that address an identified need in the service plan (including improving and maintaining the participant's opportunities for full membership in the community) and meet the following requirements: the item or service would decrease the need for other Medicaid services; AND/OR promote inclusion in the community; AND/OR increase the participant's safety in the home environment; AND, the participant does not have the funds to purchase the item or

service or the item or service is not available through another source. Individual Directed Goods and Services are purchased from the participant-directed budget. Experimental or prohibited treatments are excluded. Individual Directed Goods and Services must be documented in the service plan.

Instructions

Modify or supplement the core definition to reflect the scope of individual directed goods and services in the waiver.

Guidance

- The coverage of this service permits a state to authorize the purchase of goods and services that are not otherwise offered in the waiver or the state plan.
- The coverage of this service is limited to waivers that incorporate the budget authority participant direction opportunity.
- Goods and services purchased under this coverage may not circumvent other restrictions on the claiming of FFP for waiver services, including the prohibition against claiming for the costs of room and board.
- The specific goods and services that are purchased under this coverage must be documented in the service plan in accordance with 42 CFR § 441.301 (b)(1)(i).
- The goods and services that are purchased under this coverage must be clearly linked to an assessed participant need established in the service plan in accordance with 42 CFR § 441.301 (b)(1)(i).

17. Bereavement Counseling

Background

There is no regulatory definition for bereavement counseling. This service is available to the waiver participant and/or their family members to help them manage the stress associated with caring for a child with a life-threatening condition.

Core Service Definition

Services provided to the participant and/or family members in order to guide and help them cope with the participant's illness and the related stress that accompanies the continuous, daily care required by a terminally ill child. Enabling the participant and family members to manage this stress improves the likelihood that the child with a life-threatening condition will continue to be cared for at home, thereby preventing premature and otherwise unnecessary institutionalization. Bereavement activities and opportunities for dialogue offer the family a mechanism for expressing emotion and asking questions about death and grieving in a safe environment thereby potentially decreasing complications for the family after the child dies. Bereavement counseling is initiated and billed while the child is on the waiver but may continue after the death of the child for a period of up to six months.

Instructions

Modify or supplement the core definition to reflect the scope of bereavement counseling in the waiver.

Guidance

- Bereavement counseling services are associated with waivers that target children with terminal illnesses.
- Payment for bereavement counseling services may be provided for on-going counseling to family members after the child's death so long as such services were initiated prior to the child's death. The expected costs of such counseling must be billed in advance.

18. Career Planning

Background

There is no regulatory definition for career planning. The service is intended to assist a waiver participant in identifying and achieving employment objectives.

Core Service Definition

A person-centered, comprehensive employment planning and support service that provides assistance for waiver program participants to obtain, maintain or advance in competitive employment or self-employment. It is a focused, time limited service engaging a participant in identifying a career direction and developing a plan for achieving competitive, integrated employment at or above the state's minimum wage. The outcome of this service is documentation of the participant's stated career objective and a career plan used to guide individual employment support.

Instructions:

- Supplement or modify the core definition as appropriate to incorporate the specific service elements furnished in the waiver.
- Supplement the core service definition by specifying where in the community career planning may be furnished.
- If transportation between the participant's place of residence and the site where career planning is delivered is provided as a component part of career planning services and the cost of this transportation is included in the rate paid to providers of career planning services, the service definition must include a statement to that effect in the definition.

Guidance:

- For young people with disabilities transitioning out of high school or college into adult services, it is important to have the opportunity to plan for sufficient time and experiential learning opportunities for the appropriate exploration, assessment and discovery processes to learn about career options as one first enters the general workforce.
- Individuals who receive career planning services may also receive educational, supported employment, pre-vocational and/or day habilitation services. A participant's person-centered services and supports plan may include two or more types of non-residential habilitation services. However, different types of non-residential habilitation services may not be billed during the same period of the day.
- If a waiver participant is receiving prevocational services or day habilitation services, career planning may be used to develop experiential learning opportunities and career options consistent with the person's skills and interests.

- If a waiver participant is employed and receiving either individual or small group supported employment services, career planning may be used to find other competitive employment more consistent with the person's skills and interests or to explore advancement opportunities in his or her chosen career.
- All prevocational and supported employment service options, including career planning, should be reviewed and considered as a component of an individual's person-centered services and supports plan no less than annually, more frequently as necessary or as requested by the individual. These services and supports should be designed to support successful employment outcomes consistent with the individual's goals.
- Career planning furnished under the waiver may not include services available under a program funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17) pursuant to section 1915(c)(5)(C) of the Act and 42 CFR § 440.180(c)(3).
- Career planning may include benefits support, training and planning, as well as assessment for use of assistive technology to increase independence in the workplace.
- If a state wishes to cover "career planning" it may choose to include it as a component part of day habilitation, pre-vocational services or supported employment small group or individual employment support services or it may be broken out as a separate standalone service definition.
- Career planning services may be furnished to any individual who requires and chooses them. They are not limited to persons with intellectual or developmental disabilities.

19. Assistance in Community Integration – Housing Supports: Background

There is no regulatory definition for Assistance in Community Integration – Housing Supports; however, related guidance regarding community integration can be found in SHO letter # 21-001, Opportunities in Medicaid and CHIP to Address Social Determinants of Health (located in Attachment C).

Core Service Definition

Services that enable participants to maintain their own housing as set forth in the participant's approved person-centered service plan. Services must be provided in the home or a community setting. ***When not otherwise available,*** *the service may include the following components:*

- *Conducting a community integration assessment identifying the participant's preferences related to housing (type, location, living alone or with someone else, identifying a roommate, accommodations needed, or other important preferences) and needs for support to maintain community integration (including what type of setting works best for the individual, assistance in budgeting for housing/living expenses, assistance in obtaining/accessing sources of income necessary for community living, assistance in establishing credit and in understanding and meeting obligations of tenancy).*
- *Assisting participant with finding and securing housing as needed. This may include arranging for or providing transportation.*
- *Assisting participant in securing supporting documents/records, completing/submitting applications, securing deposits, and locating furnishings.*

- *Developing an individualized community integration plan based upon the assessment as part of the overall person-centered service plan. Identify and establish short and long-term measurable goal(s) and establish how goals will be achieved and how concerns will be addressed.*
- *Participating in person-centered service plan meetings at re-determination and/or revision plan meetings as needed.*
- *Providing supports and interventions per the person-centered service plan (individualized community integration portion). Identify any additional supports or services needed outside the scope of this service and address among the team.*
- *Supports to assist the individual in communicating with the landlord and/or property manager regarding the participant's disability (if authorized and appropriate), detailing accommodations needed, and addressing components of emergency procedures involving the landlord and/or property manager.*
- *This service will provide supports to preserve the most independent living arrangement and/or assist the individual in locating the most integrated option appropriate to the individual.*

Instructions:

Supplement or modify the core definition as appropriate to reflect the specific covered service elements under the waiver.

C. Extended State Plan Services

Discussion

When a service is included as an extended state plan service, the coverage parameters (e.g., nature of the service and provider qualifications) contained in the state plan apply. The coverage of a state plan service on an extended basis means providing the service in an amount over and above that permitted under the state plan (e.g., if the plan limits physician visits to three per month, extended coverage may permit additional visits). When a service is defined in a fashion that is different from the coverage under the state plan, it is considered an "other service" that is separately defined in the application. Services that could be covered under the state plan, but which are not are considered "other services" for the purpose of the waiver application. Extended state plan services may not supplant medically necessary section 1905(a) Medicaid state plan services required for eligible individuals under the age of 21 under EPSDT.

Core Service Definition

The following core service definition may be employed for each extended state plan service included in the waiver:

Extended state plan services under a waiver are provided when the limits of [state plan service] under the approved state plan are exhausted. The scope and nature of these services do not otherwise differ from [state plan service] services furnished under the state plan. The provider qualifications specified in the state plan apply. The additional amount of services that may be provided through the waiver is as follows: (specify)

Instructions

- Insert the name of the specific state plan service that is offered on an extended basis under the waiver. Extended state plan services may include but are not limited to:
    - Physician services
    - Home health care services
    - Physical therapy
    - Occupational therapy
    - Speech, hearing and language services
    - Prescribed drugs, except drugs furnished to participants who are eligible for Medicare Part D benefits
    - Dental services
    - Other services specified by the state

  For each extended state plan service, specify the extent of the extended coverage (e.g., the provision of additional therapeutic treatments over and above the amount allowed in the state plan).

D. Services in Support of Participant Direction

Discussion

Services in support of participant direction are offered whenever a waiver affords participants the opportunity to direct some or all of their waiver services. Two core service definitions are provided: (a) information and assistance in support of participant direction and (b) financial management services. States may propose additional types of supportive services.

1. Information and Assistance in Support of Participant Direction (Supports Brokerage)

Background

There is no regulatory definition for information and assistance in support of participant direction. In general, this service is used to assist the waiver participant in developing the skills necessary to independently direct and manage their waiver services and providers.

Core Service Definition

Service/function that assists the participant (or the participant's family or representative, as appropriate) in arranging for, directing and managing services. Serving as the agent of the participant or family, the service is available to assist in identifying immediate and long-term needs, developing options to meet those needs and accessing identified supports and services. Practical skills training is offered to enable families and participants to independently direct and manage waiver services. Examples of skills training include providing information on recruiting and hiring personal care workers, managing workers and providing information on effective communication and problem-solving. The service/function includes providing information to ensure that participants understand the responsibilities involved with directing their services. The extent of the assistance furnished

to the participant or family is specified in the service plan. This service does not duplicate other waiver services, including case management.

Instructions

Modify or supplement the core definition to accurately reflect the scope and nature of supports for participant direction furnished under the waiver.

Guidance

- This service is limited to participants who direct some or all of their waiver services.
- As discussed in the instructions for Appendix E (Participant Direction of Services), the scope and nature of this service hinges on the type and nature of the opportunities for participant direct afforded by the waiver.
- Through this service, information may be provided to participant about:
    - person centered planning and how it is applied;
    - the range and scope of individual choices and options;
    - the process for changing the plan of care and individual budget;
    - the grievance process;
    - risks and responsibilities of self-direction;
    - free of choice of providers;
    - individual rights;
    - the reassessment and review schedules; and
    - such other subjects pertinent to the participant and/or family in managing and directing services.

  Assistance may be provided to the participant with:
    - defining goals, needs and preferences, identifying and accessing services, supports and resources;
    - practical skills training (e.g., hiring, managing and terminating workers, problem solving, conflict resolution)
    - development of risk management agreements;
    - development of an emergency backup plan;
    - recognizing and reporting critical events;
    - independent advocacy, to assist in filing grievances and complaints when necessary; and
    - other areas related to managing services and supports.
- This service may include the performance of activities that nominally overlap the provision of case management services. In general, such overlap does not constitute duplicate provision of services. For example, a “support broker” may assist a participant during the development of a person-centered plan to ensure that the participant’s needs and preferences are clearly understood even though a case manager is responsible for the

development of the service plan. Duplicate provision of services generally only arises when exactly the same activity is performed and billed on behalf of a waiver participant. Where the possibility of duplicate provision of services exists, the participant's service plan should clearly delineate responsibilities for the performance of activities.

2. Financial Management Services

Background

There is no regulatory definition for financial management services offered through a 1915(c) waiver. Generally, this service is available to participants who direct their waivers to facilitate disbursements of funds available in the participant-directed budget, manage the employment of staff, and conduct fiscal accounting on behalf of the waiver participant.

Core Service Definition

Service/function that assists the family or participant to: (a) manage and direct the disbursement of funds contained in the participant-directed budget; (b) facilitate the employment of staff by the family or participant, by performing as the participant's agent such employer responsibilities as processing payroll, withholding federal, state, and local tax and making tax payments to appropriate tax authorities; and, (c) performing fiscal accounting and making expenditure reports to the participant or family and state authorities.

Instructions

Supplement or modify the core definition to accurately reflect the scope and nature of financial management services furnished under the waiver.

Guidance

- This service is limited to participants who direct some or all of their waiver services.
- As discussed in the instructions for Appendix E (Participant Direction of Services), the scope and nature of this service hinges on the type and nature of the opportunities for participant direct afforded by the waiver. In general, the functions that may be performed in conjunction with the provision of financial management services include (but are not necessarily limited to):

Employer Authority

- Assist the participant to verify worker citizenship status
- Collect and process timesheets of support workers
- Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance

Budget Authority

- Maintain a separate account for each participant's participant-directed budget
- Track and report participant funds, disbursements and the balance of participant funds
- Process and pay invoices for goods and services approved in the service plan

- Provide participant with periodic reports of expenditures and the status of the participant-directed budget

Additional functions/activities

- Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency
- Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency
- Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget

- When financial management services are provided as a waiver service, entities that perform these services may be deemed by the state to function as an Organized Health Care Delivery System.
- When entities are not deemed to be an Organized Health Care Delivery System, such entities should have a written agreement with the Medicaid agency in order to execute and hold Medicaid provider agreements and receive and disburse funds.
- When financial management services are furnished as a waiver service, the number of providers may not be limited.
- The waiver may provide that entities which furnish financial management services undergo a readiness review as part of the determination that such entities are qualified to furnish these services.

Appendix D: Participant-Centered Planning and Service Delivery

Brief Overview

This Appendix addresses the following:

- Service plan development (Appendix D-1)
- Service plan implementation and monitoring (Appendix D-2)

Appendix D-1: Service Plan Development

Background

A well-designed process for developing and implementing waiver participant service plans is perhaps the most critical component of the waiver program. Service planning is the process through which each waiver participant's needs, goals and preferences are identified, and strategies are developed to address those needs, goals and preferences. It is the process through which the participant exercises choice and control over services and supports and through which risks are assessed and planned for. A well-designed process incorporates and maximizes the resources and supports present in the person's life and community. It is important that the planning process also enables and supports each participant (and/or family or legal representative, as appropriate) to fully engage in and direct the planning process to the extent

they choose. It is through the planning process that roles and responsibilities are clarified for participants who direct their own services.

The service plan (plan of care) identifies the waiver services as well as other services and supports that a person needs in order to live successfully in the community and, therefore, avoid institutionalization. In accordance with 42 CFR § 441.301 (b)(1)(i), all waiver services must be furnished pursuant to a written person-centered service plan that is developed for each waiver participant. The service plan must reflect the full range of a participant's service needs and include both the Medicaid and non-Medicaid services along with informal supports that are necessary to address those needs. The service plan commits the state to provide the Medicaid services and supports that are specified in the plan.

FFP may be claimed only for those waiver services that are included in the service plan and may not be claimed for services furnished prior to the development of the service or for services not included in the service plan.

When *non-waiver services and supports* are included in the service plan, the waiver administering agency is not responsible for ensuring their availability or actual delivery. As necessary and appropriate, activities should be undertaken to link, refer or advocate for such services. When non-waiver services and supports are needed to meet the needs of the participant, their provision must be monitored during the implementation of the service plan.

CMS regulations at 42 CFR § 441.301(c)(1) require the use of person-centered planning methods in service plan development. Such methods actively engage and empower the participant and individuals selected by the participant in leading and directing the design of the service plan and, thereby, ensure that the plan reflects the needs and preferences of the participant (and/or family, if applicable).

The person-centered service plan must contain, at a minimum, the elements included at 42 CFR § 441.301(c)(2), including: the services that are furnished, the amount and frequency of each service, and the type of provider to furnish each service. It is not necessary to submit a copy of the form or forms used to document the service plan along with the application. However, the form or forms employed must be readily available to CMS upon request through the Medicaid agency or operating agency (if applicable). The form or forms employed in conjunction with the waiver must meet the minimum standards just described. Meeting these standards is a condition of claiming federal financial participation in the cost of waiver services furnished to a waiver participant.

The service plan must be revised as necessary to add or delete services or modify the amount and frequency of services. Service plans must be reviewed at least annually or whenever necessary due to a change in the participant's needs.

How the waiver assures that service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means is one of the six waiver assurances and other requirements that must be addressed in the quality improvement strategy described throughout the application.

Detailed Instructions for Completing Appendix D-1

Service Plan Title

Instructions

Specify the title that the state has adopted for the service plan and, if applicable, its abbreviation (e.g., Individual Service Plan (ISP)).

Item D-1-a: Responsibility for Service Plan Development

Instructions

From the choices listed, select who is responsible for service plan development. As applicable, specify the qualifications of these individuals. Given the importance of the role of the person-centered service plan in HCBS provision, should include for these individuals the training or competency requirements for the HCBS settings criteria and person-centered plan development.

Technical Guidance

Responsibility for the development of the service plan means ensuring that all applicable policies and procedures associated with service plan development are carried out. These policies and procedures include but are not limited to the following: (1) the participant has the opportunity to engage and/or direct the process to the extent they wish; (2) those whom the participant wishes to attend and participate in developing the service plan are provided adequate notice; (3) the planning process is timely; (4) needs are assessed and services meet the needs and, (5) the responsibilities are identified. It does not mean that the individual who is responsible for service plan development has decision-making authority over the services included in the plan. The qualifications of individuals who are responsible for service plan development should be reflective of the nature of the waiver's target population. It is not a federal requirement that medical professionals (e.g., physicians, nurses) must be responsible for service plan development.

CMS Review Criteria

The state has specified qualifications of the individuals responsible for service plan development that reflect the nature of the waiver's target groups.

Item D-1-b: Service Plan Development Safeguards

Instructions

Indicate whether the entities and/or individuals responsible for the development of the person-centered service plan are permitted to provide other direct (non-case management) services to the waiver participant, or whether they have an interest in or are employed by a provider of HCBS. If such entities are permitted to furnish other services, explain how and why they are the only willing and qualified entity to be responsible for the person-centered service plan, and describe the safeguards that the state has established to mitigate the potential for conflict of interest in person-centered service plan development .

Technical Guidance

CMS regulation at 42 CFR § 441.301(c)(1)(vi) requires that providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual must not provide case management or develop the person-centered service plan,

except when the state demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS. In these cases, the state must devise conflict of interest protections including separation of entity and provider functions within provider entities, which must be approved by CMS. Individuals must be provided with a clear and accessible alternative dispute resolution process.

The safeguards to mitigate and addresses the potential problems that may arise when the individual's HCBS provider, or an entity with an interest in or employed by a provider of HCBS, performs service plan development (ex. self-referral) need to include, at a minimum:

- Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;
- An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;
- Direct oversight of the process or periodic evaluation by a state agency;
- Restricting the entity that develops the person-centered service plan from providing services without the direct approval of the state; and
- Requiring the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.

CMS Review Criteria

When a state allows for an entity that is responsible for person-centered service plan development to also provide other direct waiver services, the state has:

- Demonstrated that the entity is the only willing and qualified provider to develop the person-centered service plan; and
- Described safeguards that mitigate and addresses the potential problems that may arise, with the service providers' influence on the person-centered planning process (exercising free choice of providers, controlling the content of the plan, including assessment of risk, services, frequency and duration, and informing the participant of their rights) including:
    - Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;
    - An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;
    - Direct oversight of the process or periodic evaluation by a state agency;
    - Restricting the entity that develops the person-centered service plan from providing services without the direct approval of the state; and
    - Requiring the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.

Item D-1-c: Supporting the Participant in Service Plan Development

Instructions

In the text field, specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

Technical Guidance

An effective person-centered service plan development process provides the waiver participant the opportunity to actively lead and engage in the development of the plan, including identifying individuals who will be involved in the process. The participant should be furnished supports that are necessary to enable the participant to actively engage in the planning process, including providing information about the range of services and supports offered through the waiver in advance of service plan development and engaging individuals (e.g., a support broker) to assist the participant or facilitate a person-centered planning process. Participants also may be offered other education/training opportunities initially and on an ongoing basis.

CMS Review Criteria

- The participant's authority to include individuals of his/her choice to participate in the service plan development process is specified.
- The description identifies the meaningful information and supports that are available to the participant (or others designated by the participant) to actively engage in and direct the process.

Item D-1-d-i. Service Plan Development Process

Instructions

In four pages or less (no more than 24,000 characters), provide a comprehensive description of the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support service plan development, including securing information about participant needs, preferences and goals, and health status, including who conducts the assessments; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated and by whom; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change; and, (h) how the participant engages in and/or directs the planning process.

Technical Guidance

This item requires furnishing a comprehensive description of the dimensions of the person-centered service plan development process, including the sequence of activities, the integration of assessment information into service planning, and the distribution of roles and responsibilities. The next item separately addresses how the service plan development process identifies potential risks to the participant and how strategies to mitigate risk are incorporated into the service plan. State laws, regulations, and policies cited in response to this item that affect the service plan development process must be available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

When the service plan development process results in an individual being denied the services of their choice or the providers of their choice, the state must afford the individual the opportunity to request a fair hearing in accordance with 42 CFR § 431, Subpart E. The fair hearing process is addressed in Appendix F-1.

When the waiver provides for participant direction opportunities, the response to this item should identify any activities that are undertaken during the service plan development process that are specific to participant direction (e.g., furnishing information and assistance in setting up the participant-directed budget).

When provision is made to develop a temporary interim or provisional service plan in order to initiate services in advance of the finalization of a full-service plan, describe the procedures used to develop the interim/provisional plan and the duration of the interim plan (not to exceed 60 days).

D-1-d-ii. HCBS Settings Requirements for the Service Plan.

Instructions

By checking the boxes below in the waiver application, the state is assuring that the following will be included in the service plan:

- The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.
- For provider-owned or controlled settings, any modification of the additional conditions under 42 CFR § 441.301(c)(4)(vi)(A) through (D) must be supported by a specific assessed need and justified in the person-centered service plan and the following will be documented in the person-centered service plan:
    - A specific and individualized assessed need.
    - The positive interventions and supports used prior to any modifications to the person-centered service plan.
    - Less intrusive methods of meeting the need that have been tried but did not work.
    - A clear description of the condition that is directly proportionate to the specific assessed need.
    - Regular collection and review of data to measure the ongoing effectiveness of the modification.
    - Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
    - Informed consent of the individual.
    - An assurance that interventions and supports will cause no harm to the individual.

CMS Review Criteria

The description of the service plan development process addresses:

- Who develops the plan and who participates in the process;
- The timing of the plan and how and when it is updated, including in response to changing circumstances and needs (including how the planning meetings are scheduled at times and locations convenient to the individual and the person(s) they want to participate);
- The types of assessments that are conducted as part of the service plan development process, including securing information about participant strengths, capacities, needs, preferences, and desired outcomes, health status, and risk factors;
- How participant is informed of services available under the waiver;
- How the process ensures that the service plan addresses participant desired outcomes, needs and preferences;
- How responsibilities are assigned for implementing the plan;
- How the process addresses participants' health care needs;
- How waiver and other services (i.e., state Plan services and services furnished through other state and federal programs) are coordinated;
- The assignment of responsibility to monitor and oversee the implementation of the service plan;
- How and when the service plan is updated;
- How the participant engages in and/or directs the planning process;
- If the state uses temporary, interim/provisional service plans to get services initiated until a more detailed service plan can be finalized, the state has described the procedures for developing interim/provisional plans and the duration of not more than 60 days for such plans;
- The state has assured that person-centered service plans include the setting options that are based on the individual's needs, preferences, and, for residential settings, resources available for room and board;
- The state assured that person-centered service plans include, for provider owned or controlled settings, any modification of the additional conditions under 42 CFR § 441.301(c)(4)(vi)(A) through (D) that are supported by a specific assessed need and justified in the person-centered service plan; and
- How the state documents consent of the person-centered service plan from the waiver participant or their legal representative.

Item D-1-e. Risk Assessment and Mitigation

Instructions

In the text field, specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Technical Guidance

The presence of risks does not mean that an individual should not be offered waiver services, or that they should not have decision making authority over their services. The identification of potential risks to waiver participants and the development of strategies to mitigate such risks are integral to enabling participants to live as they choose in the community while assuring their

health and welfare. Critical risks should be addressed during the service plan development process by incorporating strategies into the plan to mitigate whatever risks may be present. Methods to identify potential risks may include the use of risk assessment tools/instruments to systematically identify risks.

Strategies to mitigate risk should be designed to respect the needs and preferences of the waiver participant. Such strategies might include supports other than waiver services and the use of individual risk agreements that permit the participant to acknowledge and accept the responsibility for addressing certain types of risks. When individuals are supported in their own private residence or other settings where staff might not be continuously available, the service plan should include a backup plan to address contingencies such as emergencies, including the failure of a support worker to appear when scheduled to provide necessary services when the absence of the service presents a risk to the participant's health and welfare. An effective back-up plan is one that is crafted to meet the unique needs and circumstances of each waiver participant. The response to this item should also describe the types of back-up arrangements that are employed. Such arrangements may include arranging for designated provider agencies to furnish staff support on an on-call basis as necessary.

CMS Review Criteria

The waiver describes:

- How risks are assessed.
- How strategies to mitigate risk are incorporated into the service plan in a manner sensitive to the person's preferences, including responsibilities and measures for reducing risks.
- The types of back-up arrangements that are used**.**
- How back-up plans are developed and incorporated into the service plan.

Item D-1-f: Informed Choice of Providers

Instructions

Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

Technical Guidance

Waiver participants have the right to freely select from among any willing and qualified provider of waiver services (except when an HCBS waiver operates concurrently with a managed care authority that waives free choice of provider). In order to effectively exercise this right, participants should have ready access to accessible information about the qualified waiver providers that are available to furnish the services included in the plan. Such information may be furnished as part of the service plan development process or by other means (e.g., making available resource directories in printed form or via the Internet).

CMS Review Criteria

- Participants are initially provided with, and on an ongoing basis have ready access to accessible information (in a manner consistent with their needs) about choice of qualified providers and available service providers.
- Participants are supported in selecting providers.

Item D-1-g: Process for Making Service Plan Subject to the Approval of the Medicaid Agency

Instructions

In the text field, describe the process by which the service plan is made subject to the approval of the Medicaid agency.

Technical Guidance

Regulation at 42 CFR § 441.301(b)(1)(i) requires that waiver service plans must be subject to the approval of the Medicaid agency. This requirement does not mean that the Medicaid agency must review and approve each and every service plan. While the waiver operating agency or other entities (e.g., counties) may approve service plans as part of day-to-day waiver operations when authorized by the Medicaid agency, the Medicaid agency must retain responsibility for service plan approval and at a minimum must review at least a sample of service plans retrospectively or employ other methods that ensure that plans have been developed in accordance with applicable policies and procedures and plans ensure the health and welfare of waiver participants. This oversight activity is a critical element of the Medicaid agency's responsibility to actively oversee the operation of the waiver and ensure health and welfare of recipients.

When this oversight is conducted through an in-depth review of a sample of service plans, specify the basis for the size of the sample, how frequently retrospective review is conducted, the methods for conducting the review, and the persons or entities who conduct the review. The state sample of service plans must be representative of the demographic makeup of the waiver population. Reviews may be conducted jointly by the Medicaid agency and the operating agency as part of the operating agency's routine oversight. When other methods are employed to satisfy this requirement, describe the methods that are used and how they ensure that service plans meet applicable requirements.

CMS Review Criteria

- The process described to review plans indicates that the Medicaid agency exercises oversight of service plans on a routine and periodic basis. The waiver includes a review process to ensure a practice of person-centered service planning in accordance with § 441.301(c).
- If an in-depth review of a sample of service plans is conducted, the state has specified the basis for the sample size, the frequency of these retroactive reviews, review methodology, and persons/entities who conduct the review. The state ensures that the sample of service plans is representative of the demographic makeup of the waiver population.

Item D-1-h: Service Plan Review and Update

Instructions

From the choices provided, specify the minimum schedule for the review and update of the service plan.

Technical Guidance

The service plan is the fundamental tool for assuring the participant's health and welfare. As such, it must be subject to periodic review and update. Such reviews determine the ongoing appropriateness and adequacy of the services and supports identified in the plan and ensure that

the services furnished are consistent with the nature and severity of the individual's disability and continue to be responsive to the individual's needs and preferences. *In accordance with 42 CFR § 441.301(c)(3), a service plan must be reviewed and updated no less than annually, when the individual's circumstances or needs change significantly, or at the request of the individual*. Specify the minimum frequency for reviewing and updating service plans, so long as the frequency is at least annual. If the frequency is other than the selections offered, specify the frequency in the "other" selection. A state may provide that the service plans of specific types of participants are reviewed and updated on different schedules (e.g., the service plan of a person who has significant medical issues might be reviewed more frequently than the plans of other participants). A state may not provide for the automatic continuation of service plans. The plan must be reviewed and updated as necessary.

CMS Review Criteria

The waiver service plan review schedule provides for conducting reviews no less than annually.

Item D-1-i: Maintenance of Service Plan Forms

Instructions

In the text field, specify the location or locations where copies of the services plan are maintained.

Technical Guidance

As provided in **45 CFR § 92.42**, copies of service plans must be maintained in written or electronic facsimile form for a period of three years from their ending date (or longer when required by state law).

CMS Review Criteria

The waiver specifies where copies of service plans are maintained for a period of at least three years.

Appendix D-2: Service Plan Implementation and Monitoring

Background

In order to assure participant health and welfare and the effective delivery of waiver services, active, continuous monitoring of the implementation of the service plan is an essential component of the waiver. The purpose of monitoring is to ensure that waiver services are furnished in accordance with the service plan, meet the participant's needs and achieve their intended outcomes. Monitoring also is conducted to identify any problems related to the participant's health and welfare that may require action. In addition to the on-going monitoring of service plan implementation that most typically is conducted by case management agencies, a state may specify that other entities perform this monitoring. In addition, states may supplement service plan monitoring. For example, a state may perform additional monitoring of health and welfare, satisfaction with services, and the use of behavioral interventions. The state may specify a minimum monitoring schedule and/or provide that the monitoring schedule and methods of monitoring are incorporated into each participant's service plan. The frequency with which monitoring is performed may vary based on participant risk factors.

In its quality improvement strategy, the state must describe the discovery, remediation and improvement processes that it employs to ensure that there is continuous monitoring of the health and welfare of waiver participants and remediation actions are initiated when appropriate.

Detailed Instructions for Completing Appendix D-2

Item D-2-a: Service Plan Implementation and Monitoring

Instructions

In the text field, specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and (c) the frequency with which monitoring is performed.

Technical Guidance

At a minimum, the description of monitoring methods and processes needs to address the following:

- The entity or entities responsible for monitoring service plan implementation and participant health and welfare, and adherence to the HCBS settings criteria under 42 CFR § 441.301(c)(4);
- The minimum frequency of monitoring, including the frequency of direct, in-person contact with the participant;
- How monitoring methods determine whether:
    - Services are furnished in accordance with the service plan;
    - Participants have access to waiver services identified in the service plan (e.g., has the participant encountered problems in securing services authorized in the service plan?);
    - Services meet the needs of the participant;
    - Back-up plans are effective;
    - Participant health and welfare is assured;
    - Participants exercise free choice of providers; and
    - Participants have access to non-waiver services identified in the service plan, including access to health service**s.**
- Methods to ensure prompt follow up of identified problems, including problems identified by participants, service providers and others; and
- How information derived from monitoring is compiled and reported to the state.

CMS Review Criteria

The waiver specifies:

- The entity(ies) responsible for monitoring;
- Monitoring methods and frequency to the target population, e.g., including the frequency of direct, in-person contact with the participant.
- How monitoring methods address:
  - Services furnished in accordance with the service plan;
  - Participant access to waiver services identified in service plan;
  - Participants exercise free choice of provider;
  - Services meet participants' needs;
  - Effectiveness of back-up plans;
  - Participant health and welfare; and
  - Participant access to non-waiver services in service plan, including health services.
- Methods for prompt follow-up and remediation of identified problems.
- Methods for systematic collection of information about monitoring results is compiled, including how problems identified during monitoring, are reported to the state.

Item D-2-b: Monitoring Safeguards

Instructions

Indicate whether entities and/or individuals that are responsible for monitoring service plan implementation and participant health and welfare are permitted to provide other direct (non-case management) services to the same waiver participant because they are the only willing and qualified entity in a geographic area who can monitor service plan implementation. If such entities and/or individuals are permitted to furnish other direct waiver services to the same waiver participant, explain that the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can monitor service plan implementation for the same waiver participant and specify the safeguards to mitigate potential conflict of interest in monitoring of service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements.

Technical Guidance

As described in 42 CFR § 441.301(c)(1)(vi), providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS, are not permitted to have responsibility for monitoring the implementation of the service plan for the same waiver participant except, at the option of the state, when providers are given this responsibility because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections/safeguards. Safeguards must be established when entities that furnish direct waiver services have responsibility for service plan monitoring to avoid problems (e.g., self-monitoring) that may arise in this circumstance. At a minimum, the safeguards must include:

- Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the monitoring of person-centered service plan implementation;
- An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to monitor the person-centered

service plan implementation through a clear and accessible alternative dispute resolution process;

- Direct oversight of the process or periodic evaluation by a state agency;
- Restriction of the entity that monitors the implementation of the person-centered service plan from providing services without the direct approval of the state; and
- Requirement for the agency that monitors the implementation of the person-centered service plan to administratively separate the monitoring of service plan implementation function from the direct service provider functions.

CMS Review Criteria

When service plan monitoring is performed by entities/individuals that furnish direct waiver services for the same participant because they are the only willing and qualified entity in a geographic area who can monitor service plan implementation, the safeguards to mitigate potential conflict of interest in monitoring of service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements are described.

Quality Improvement: Service Plan

Service Plan

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for the waiver participants.

Service plans address all participants' assessed needs (including health and safety risk factors) and personal and community integration goals, either by waiver services or through other means.

Service plans are updated/revised at least annually, when the individual's circumstances or needs change significantly, or at the request of the individual.

Services are delivered in accordance with the service plan, including in the type, scope, amount, duration, and frequency specified in the service plan.

Participants are afforded choice between/among waiver services and providers.

The state monitors service plan development in accordance with its policies and procedures.

Instructions

The QIS must describe how the state Medicaid Agency will determine that each waiver assurance (and its associated component elements) is met. The waiver assurance and component elements are listed above. For each component element, this description must include:

- Activities or processes that are related to *discovery and remediation*, i.e., review, assessment or monitoring processes; who conducts the discovery or remediation activities and with what frequency. These monitoring activities provide the foundation for quality improvement by generating information regarding compliance, potential problems and individual corrective actions. The information can be aggregated and analyzed to measure the overall system performance in meeting the waiver assurances. The types of

information used to measure performance, should include relevant quality measures/indicators.

- The entity or entities responsible for reviewing the results (data and information) of discovery and remediation activities to determine whether the performance of the system reflects compliance with the assurances; and,
- The frequency at which system performance is measured.

Technical Guidance

This QIS element focuses on *discovery* and *remediation* activities, that is, processes to assess, review, evaluate or otherwise analyze a program, process, operation, or outcome. Specifically, the evidence produced as a result of discovery and remediation activities should provide a clear picture of the state's compliance in meeting an assurance.

CMS Review Criteria

- The discovery of compliance with this assurance and the remediation of identified problems must address how the Medicaid agency assures compliance with the following service plan sub assurances:
    - Service plans address all participants' assessed needs (including health and safety risk factors) and personal and community integration goals, either by waiver services or through other means.
    - Service plans are updated/revised at least annually or when the individual's circumstances or needs change significantly, or at the request of the individual.
    - Services are delivered in accordance with the service plan, including in the type, scope, amount, duration, and frequency specified in the service plan.
    - Participants are afforded choice:
        - Between waiver services and institutional care; and
        - Between/among waiver services and providers**.**
    - The state monitors service plan development in accordance with its policies and procedures.
    - How frequently oversight is conducted; and
    - The entity (or entities) responsible for the discovery and remediation activities, the state's method for addressing individual problems as they are discovered, identifying systemic deficiencies, and implementing remediation actions.

Appendix E: Participant Direction of Services

Brief Overview

Appendix E addresses how the waiver affords participants the opportunity to direct some or all of their waiver services. The addition of Appendix E to the waiver application recognizes that participant direction is an increasingly common feature of waivers. Appendix E facilitates the

incorporation of participant direction opportunities into any waiver, including waivers where participants may elect to receive traditional provider-managed services.

There are two parts to this Appendix:

- Appendix E-1 describes the waiver's overall approach to participant direction.
- In Appendix E-2, more detailed information is provided about the specific participant direction opportunities that are available under the waiver.

Both parts of the Appendix should be completed whenever a waiver incorporates one or both of the participant direction opportunities (i.e., the Employer Authority and/or Budget Authority) that are described in more detail below.

CMS urges that all states afford waiver participants the opportunity to direct some or all of their waiver services. Participant direction of services has been demonstrated to promote positive outcomes for individuals and families, improve participant satisfaction and be a cost-effective service delivery method.

Overview: Participant Direction of Waiver Services

Participant direction of waiver services means that the waiver participant has the authority to exercise decision making authority over some or all of her/his waiver services and accepts the responsibility for taking a direct role in managing them. Participant direction is an alternative to provider management of services wherein a service provider has the responsibility for managing all aspects of service delivery in accordance with the participant-centered service plan. Participant direction promotes personal choice and control over the delivery of waiver services, including who provides services and how they are delivered. For example, the participant may be afforded the opportunity and be supported to recruit, hire, and supervise individuals who furnish daily supports as well as to terminate an employee who is not performing in a satisfactory manner. When a waiver service is provider-managed, a provider selected by the participant carries out these responsibilities.

Incorporating participant direction into a waiver involves several interrelated dimensions. The following is an overview of the main dimensions of participant direction under a waiver:

Participant Choice

A waiver may be designed to exclusively serve individuals who want to direct some or all of their waiver services. When this is the case, there needs to be another program that is available to individuals who do not wish to direct their services. Alternatively, a waiver may permit participants to direct some or all of their services or opt instead to receive provider-managed services exclusively. The waiver application supports both basic waiver designs. When a waiver exclusively serves persons who want to direct some or all of their waiver services, this design needs to be reflected in Appendix B-1 (Item B-1-b – additional targeting criteria) and in Appendix E-1. In Appendix E-1, the waiver may further specify that participant direction opportunities are limited to individuals who reside in designated types of living arrangements.

Whenever the application refers to the election of participant direction or the exercise of decision making authority, references to the participant mean: (a) the participant acting independently on her/his own; (b) the parent(s) of a minor child who is a waiver participant acting on behalf of the child; (c) a legal representative when the representative has the authority to make pertinent decisions on behalf of the participant; and, (d) when permitted by the state, a non-legal

representative who has been freely chosen by the participant to make decisions on the participant's behalf.

Geographic Limitation

As discussed in the instructions for Item 4-c (statewideness) in the Application Module (statewideness), the waiver may make participant direction opportunities available in some but not all the geographic regions where the waiver is in effect.

Service Specifications

In Appendix C-3, each service offered under the waiver may be specified as provider-managed, participant-directed, or both. The instructions for Appendix C-3 discuss the considerations associated with the specification of service delivery method. In general, the exercise of the participant direction opportunities (authorities) that are discussed below applies only to the waiver services that have been designated as participant-directed.

Participant Direction Opportunities

Appendix E-1 provides for the selection of two basic participant direction opportunities that may be made available through a waiver. These opportunities may be and often are used in combination and are not mutually exclusive. The opportunities are:

- **Participant Employer Authority**. Under the Employer Authority, the participant is supported to recruit, hire, supervise and direct the workers who furnish supports. The participant functions as the common law employer or the co-employer of these workers. When the Employer Authority is utilized, the participant rather than a waiver provider agency carries out employer responsibilities for workers. The dimensions of participant decision making under the Employer Authority are specified in Appendix E-2-a of the application; and
- **Participant Budget Authority**. Under the Budget Authority, the participant has the authority and accepts the responsibility to manage a participant-directed budget. Depending on the dimensions of the budget authority that are specified in Appendix E-2-b, this authority permits the participant to make decisions about the acquisition of waiver goods and services that are authorized in the waiver service plan and to manage the dollars included in a participant-directed budget.

As noted above, these two authorities are often used in combination to promote full-featured participant direction of waiver services.

Supports for Participant Direction

When a waiver offers participant direction opportunities, two types of supports should be made available to facilitate participant direction. These supports may be furnished as a waiver service (as specified in Appendix C-3) or under another Medicaid payment authority (principally as a Medicaid administrative activity). Supports furnished as a Medicaid administrative activity must be in accordance with the approved cost allocation plan. When one or both types of supports are furnished under another payment authority, they are described in detail in Appendix E-1. These supports are:

- **Information and Assistance in Support of Participant Direction**. These supports are made available to participants to help them manage their waiver services. For example, assistance might be provided to help the participant locate workers who furnish direct

supports or in crafting the service plan. The type and extent of the supports that should be available to participants depends on the nature of the participant direction opportunities provided under the waiver.

- **Financial Management Services**. These services are furnished for two purposes: (a) to address federal, state and local employment tax, labor and workers' compensation insurance rules and other requirements that apply when the participant functions as the employer of workers and (b) to make financial transactions on behalf of the participant when the participant has budget authority. There are two types of FMS services that may be employed to support participants who exercise the Employer Authority: (1) Fiscal/Employer Agent (Government or Vendor) where the entity is the agent to the common law employer who is either the participant or his or her representative or (2) Agency with Choice, where the participant and the agency function as co-employers of the participant's worker(s).

  The Internal Revenue Service and the United States Department of Labor (Wage and Hour Division) have regulations concerning the pay of employees and tax withholding that may differ based on self-direction program characteristics. It is highly recommended that the state become familiar with these rules relative to self-direction and assure that Financial Management Services providers are competent in managing these requirements. These agencies are available to provide technical assistance to states as needed. It is the state's responsibility to ensure that it is operating the waiver consistently with all state and federal requirements.

While their main purpose is to facilitate participant direction of services, these supports also provide important protections and safeguards for participants who direct their own waiver services. More detailed information about each of these dimensions of participant direction is contained in the item-by-item instructions.

Detailed Instructions for Completing Appendix E

Appendix E needs to be completed when there is an affirmative response to Item 3-E in the Application Module.

When a concurrent 1915(j) state plan authority authorizes self-direction in the waiver, the state's Appendix E should reflect this with the state referring to the 1915(j) in regard to service definitions, supports for self-direction services and financial management services. Those services covered solely through the 1915(j) should not be listed in Appendix E and not included in Appendices C, I and/or J. A service that has both a 1915(j) and non-self-directed 1915(c) component should be included in all applicable appendices, with cost information based only on that portion covered by the 1915(c) waiver.

Appendix E: Initial Section

Item: Applicability

Instructions

Indicate whether the waiver provides for one or both of the participant direction opportunities that are specified in the Appendix. If the response is "no," do not complete the remainder of the Appendix. If "yes," proceed to Appendix E-1. This item in the web-based application is linked to Item 3-E in Module 1.

Technical Guidance

As discussed in the technical guidance for item 3-E in the Application Module, this selection should be made after carefully reviewing these instructions in order to determine the applicability of this Appendix.

Appendix E-1: Overview

Overview of Appendix E-1

In this Appendix, the following topics are addressed:

- The waiver's overall approach to participant direction;
- The participant direction opportunity or opportunities offered under the waiver;
- Whether there are limitations on the election of participant direction;
- The role of representatives in participant direction;
- The waiver services that may be participant directed along with the participant direction opportunity or opportunities that apply to each;
- How the waiver provides for FMS and information and assistance in support of participant direction;
- Whether independent advocacy is available to participants who direct their services;
- The circumstances under which participant direction may be terminated; and,
- The state's goals regarding the number of participants who will direct some or all of their waiver services.
- The circumstances under which participant direction may be terminated; and
- The state's goals regarding the number of participants who will direct some or all of their waiver services.

Detailed Instructions for Completing Appendix E-1

Item E-1-a: Description of Participant Direction

Instructions

In no more than two pages (12,000 characters), provide an overview description of the participant direction opportunities that are afforded in the waiver. This overview is intended to provide CMS with a broad understanding of the waiver's participant direction opportunities, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities (e.g., support brokers, case management, financial management services entities) that play a role in supporting individuals who direct their services and the types of supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction that may not be addressed elsewhere in this Appendix or the remainder of the application.

CMS Review Criteria

The overview contains a description of all of the following:

- The participant direction opportunities afforded to waiver participants;
- The process by which participants may access these participant direction opportunities;
- The entities involved in supporting participant direction; and,
- The types of supports that each entity provides.

Item E-1-b: Participant Direction Opportunities

Instructions

Select whether the waiver provides for the Employer Authority, the Budget Authority or both opportunities for participant direction in combination. When the Employer Authority is selected, Item E-2-a needs to be completed in Appendix E-2. When the Budget Authority is selected, Item E-2-b needs to be completed in Appendix E-2. When the "Both Authorities" selection is made, both Items E-2-a and E-2-b need to be completed in Appendix E-2.

Technical Guidance

In brief, these two opportunities for participant direction entail the following:

- **Employer Authority**. Under the Employer Authority, the participant exercises choice and control over workers who furnish supports. The participant directly selects and supervises the workers who furnish waiver services to which this authority applies (e.g., personal assistance, attendant services). As provided in Item E-2-a, this authority may be exercised by the participant functioning as the co-employer or the common law employer of support workers. Item E-2-a specifies the dimensions of participant decision-making authority under this opportunity. The Employer Authority has been used in its own right in many waivers in conjunction with the provision of personal assistance, attendant care and similar services. The principal defining characteristic of this authority is that the participant functions as the employer of workers.
- **Budget Authority**. Under the Budget Authority, the participant exercises decision-making authority and management responsibility for a participant-directed budget from which the participant authorizes the purchase of waiver goods and services that are authorized in the service plan. The participant also may be afforded the flexibility to shift funds among authorized services within the total amount of the budget without prior review and approval (however, changes that affect the service plan must be documented). Item E-2-b specifies the dimensions of participant decision-making authority under this opportunity, including how the participant-directed budget is determined. The principal defining characteristic of this authority is the establishment of a participant-directed budget. Budget authority usually means that the participant may exercise ongoing decision making over the mix of waiver services.

Each of these authorities may stand on its own. It is increasingly common practice for waivers to offer both authorities (i.e., the participant manages a budget and functions as the employer or co-employer of workers).

CMS Review Criteria

One or both opportunities must be selected.

Item E-1-c: Availability of Participant Direction by Type of Living Arrangement

Instructions

The waiver may limit participant direction by type of living arrangement. Here, by checking each choice that applies, specify whether participant direction is available for:

- Participants who live with their families or in their own private residence;
- Participants who reside in living arrangements where services (regardless of funding source) are furnished to fewer than four persons who are unrelated to the proprietor (e.g., supported living or housing); and/or
- Persons who reside in other living arrangements as specified by the state. Such living arrangements might include assisted living facilities and similar arrangements. This choice also may be selected when the first two choices do not accurately describe the living arrangements where participant direction is supported. For example, participant direction may be supported in some but not all types of smaller living arrangements. Specify the other types of living arrangements where participant direction is available in the text field, including the size of these living arrangements (i.e., the number of individuals who are served in each type of living arrangement).

Technical Guidance

A state has the option to limit opportunities for participant direction by type of participant living arrangement. Participant direction is commonly associated with individuals who live on their own or reside with their families. Participant direction may be less feasible when individuals are served in larger, provider-controlled living arrangements such as group homes. It is up to the state to decide whether participant direction is supported in some or all types of living arrangements. However, if the waiver will operate with a concurrent 1915(j) authority, the person self-directing may not reside in a provider owned or operated home.

There are two implications to limiting participant direction to some but not all types of participant living arrangements. The first implication is that, although a participant's service plan may include one or more waiver services that the state has designated (in Appendix C-3) as available for participant direction, participant direction of the service(s) will not be made available to participants who reside in a living arrangement where opportunities for participant direction are not supported. When participant direction is available in all types of living arrangements, then all participants regardless of living arrangement may elect to direct any service that has been designated in Appendix C-3 as participant-directed.

The second implication of limiting participant direction by type of living arrangements is that, in order to direct their services, participants who reside in living arrangements where participant direction is not supported must change their living arrangement to a type of living arrangement where participant direction is supported.

CMS Review Criteria

When the third choice (other living arrangement) is selected, the waiver specifies the types of other living arrangements where participant direction is supported.

Item E-1-d: Election of Participant-Direction

Instructions

Select one and only one of the three choices. When the third choice is selected, specify the additional criteria that are applied in determining whether a participant may direct some or all of their waiver services. These additional criteria should not include participant living arrangement (addressed in the foregoing item).

Technical Guidance

A waiver may be designed to serve only individuals who want to direct their services. When this is the case, select the first choice. If a waiver only serves persons who want to direct their services (e.g., it is expected that all waiver participants will direct at least some of their waiver services), Item B-1-b in Appendix B (additional targeting criteria) also needs to specify that the waiver is limited to individuals who want to direct some or all of their services.

The second selection applies in waivers where participants may elect to direct their waiver services but also have the option of receiving their waiver services solely on a provider-managed basis (i.e., the waiver does not solely target persons who want to direct their waiver services) or a combination of both service delivery options. The waiver must provide that there are comparable provider-managed services available for participants who elect not to direct their services. When this choice is selected, the waiver does not impose additional criteria on the election of participant direction. Any participant may freely elect to direct some or all of their waiver services.

If the waiver does not support participant direction in some types of living arrangements, then the election of participant direction choice applies only to participants who reside in living arrangements where participant direction is supported. The election of participant direction also is affected by whether a person's service plan includes services that may be participant-directed, as specified in Appendix C-3.

The third selection permits specifying whether the election of participant direction is subject to additional criteria (over and above participant living arrangement, if applicable). For example, participant direction might not be offered to participants who have substantial cognitive impairments and who do not have a representative or circle of support to assist in directing their services. Alternatively, participant direction might not be offered to persons who are involved in the criminal justice system or exhibit other challenges that require close supervision. A waiver may reasonably require that participant direction only will be offered to participants who have received an orientation to participant direction in advance of deciding to direct some or all of their services.

When additional criteria are specified that have the effect of restricting the participants who may elect participant direction, state them clearly in the text field. In general, these criteria should not deny the choice of participant direction based on factors that can be reasonably accommodated through the provision of information and assistance and other supports that would enable the participant to direct his/her services. For example, a participant's lack of experience in directing services generally is not a reasonable criterion for not offering participant direction since training and other supports can be offered to assist the participant to acquire the necessary skills. CMS urges states not to impose restrictions based on assessment of "ability" or "capacity" that have the effect of denying opportunity to direct their services based on disability. States will also wish to consider the Olmstead implications of such exclusions. Under this selection, participants who

are afforded the opportunity to direct their services also must have the option to receive provider-managed services exclusively. A determination not to afford a participant the opportunity to direct waiver services is not subject to the Fair Hearing process since participant direction is a method of service delivery and the services that the participant may receive are unaffected when the opportunity to direct the services is denied.

CMS Review Criteria

When the first choice is selected, the additional targeting criteria in Item B-1-b in Appendix B-1 specify that the waiver is limited to persons who want to direct their services. When the third choice is selected, the additional criteria that are used to determine whether a person may direct some or all of their services:

- Are specified and well-defined.
- Do not include a blanket exclusion of individuals solely on the basis that they have specific cognitive or other disabilities.
- Do not exclude participants solely on the basis of an assessment that the individual, in isolation, is unable to carry out some of the responsibilities associated with participant direction.

Item E-1-e: Information Furnished to Participants

Instructions

In the text field, specify: (a) the information about the participant direction opportunities (e.g., the benefits of participant-direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making about the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided. If the response cites formal state policies, procedures and/or written materials that are furnished to waiver participants to inform their decision making, the materials cited need to be readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Technical Guidance

There are many potential benefits to participants in directing their services. At the same time, participant direction entails the participant accepting many responsibilities that service providers usually assume (e.g., recruiting, hiring, supervising and discharging workers) and shouldering some potential liabilities (which may be mitigated through the provision of supports for participant direction). As a result, participants should have available timely information about participant direction to inform their decision making about whether to direct their waiver services. Information about participant direction may be furnished to participants during the service plan development process, through conducting separate orientations to participant direction, and/or by other means (the availability of employer skills training).

CMS Review Criteria

The waiver:

- Provides that participants are furnished information about the benefits and potential liabilities associated with participant direction along with information about their responsibilities when they elect to direct their services.
- Specifies a specific entity or entities that are responsible for furnishing this information.
- Describes the process (e.g., as part of service plan development or by other means) by which this information is provided to individuals and/or representatives.
- Provides that information is furnished on a timely basis to permit informed decision making by the participant – i.e., prior to or during entrance to the waiver or as part of service plan development – allowing sufficient time for the participant to weigh the pros and cons of participant direction and obtain additional information as necessary before electing participant direction.

Item E-1-f: Participant Direction by a Representative

Instructions

Select whether waiver services may be directed by a representative on behalf of the waiver participant and, if so, the type or types of representatives who may direct services. When a representative who is not a legal guardian may direct services, provide information about the policies that apply to the role of such representatives.

Technical Guidance

The waiver may provide that services may be directed by a representative on behalf of the participant. In the case of child (legal minors) waiver participants, parents exercise decision making on behalf of the child. For the purpose of the application, parents of minor children are considered to be legal representatives.

The waiver may limit decision making to legal representatives (e.g., legally appointed guardians of adults) and/or may provide that an individual who is not a legal representative and has been freely chosen by the participant may direct services in consultation with the participant. With respect to the latter, non-legal representatives could include a parent of an adult or a spouse who is not a legal guardian or representative. A non-legal representative also could be another relative of the participant or a friend of the participant.

When the waiver provides that a non-legal representative may direct services on behalf of the participant, specify in the text field the state's policies concerning the appointment of this type of representative (e.g., a requirement that the participant assign decision-making responsibility by executing a limited power of attorney) and the extent of the decision-making authority that these individuals may exercise on behalf of the participant.

When a non-legal representative may serve as a decision maker, the safeguards that ensure the representative will function in the best interests of the participant also should be specified. An example of such a safeguard could be that such a representative may not also be paid to provide waiver services to the participant.

CMS Review Criteria

The use of representatives to direct waiver services on behalf of a participant is at the discretion of the state. When waiver services may be directed by a non-legal representative:

- The waiver describes the process for the appointment of this type of representative and the extent of the decision-making authority exercised by the non-legal representative.
- The waiver includes safeguards to ensure that a non-legal representative functions in the best interests of the participant.

Item E-1-g: Participant Directed Services

Instructions

List in the table the services that are specified in Appendix C-3 as participant-directed. For each listed service, specify whether the Employer Authority, Budget Authority or both authorities apply to the service. In the web-based application, this table is auto-populated with the services that have been specified as participant-directed in Appendices C-1/C-3.

Technical Guidance

See the instructions for Appendix C-3 concerning the designation of a service as participant-directed, provider-managed or both.

CMS Review Criteria

- When the Employer Authority is offered (as specified in Item E-1-b), it applies to at least one waiver service.
- When the Budget Authority is offered (as specified in Item E-1-b), it applies to at least one but usually to two or more waiver services.

Overview: Financial Management Services

The next two application items concern Financial Management Services (FMS). FMS are a critical support for participant direction, especially under the section 1915(c) HCBS waiver framework. The section 1915(c) waiver authority does not permit making payments for services directly to a waiver participant, either to reimburse the participant for expenses incurred or enable the participant to directly pay a service provider. Instead, payments should be made through an intermediary organization that performs financial transactions (paying for goods and services or processing payroll for participants' workers included in the participant's service plan) on behalf of the participant.

A FMS entity plays this role when the waiver includes the Employer Authority or Budget Authority opportunity. Under the Employer Authority, when a participant functions as the employer of direct support workers, FMS are an important safeguard for participants and workers alike. The provision of Fiscal/Employer Agent FMS ensures that federal, state and local employment taxes and labor and workers' compensation insurance rules related to household employment and payroll are implemented in an accurate and timely manner and, if included in a state's Fiscal/Employer Agent FMS model, that invoices for goods and services included in the participant's service plan are paid appropriately and in a timely manner. The provision of Agency with Choice (co-employer) FMS ensures that the necessary employer-related duties and tasks, including payroll, are carried out. FMS provided under these two models is an important

safeguard for participants because it ensures that participants are in compliance with federal and state tax, labor, workers' compensation insurance and Medicaid regulations. The term "Financial Management Services" or "FMS" is used to distinguish this important participant direction support from the activities that are performed by intermediary organizations that function as Medicaid fiscal agents.

With respect to each participant direction opportunity, FMS entities generally perform the following basic functions:

Budget Authority

- Act as a neutral bank, receiving and disbursing public funds, tracking and reporting on the participant's budget funds (received, disbursed and any balances) (Fiscal/Employer Agent FMS);
- Process and pay invoices for goods and services in the participant's approved service plan (Fiscal/Employer Agent FMS); and
- Prepare and distribute reports (e.g., budget status and expenditure reports) to participants and other entities specified in the waiver (Fiscal/Employer Agent and Agency with Choice FMS).

Employer Authority

- Assist the participant in verifying workers' citizenship or legal alien status (e.g., completing and maintaining a copy of the BCIS Form I-9 for each support service worker the participant employs) (Fiscal/ Employer Agent and Agency with Choice FMS);
- Collect and processes support worker's timesheets; (Fiscal/ Employer Agent and Agency with Choice FMS) and
- Operate a payroll service, (including withholding taxes from workers' pay, filing and paying federal (e.g., income tax withholding, FICA and FUTA), state (e.g., income tax withholding and SUTA), and, when applicable, local employment taxes and insurance premiums); and, distribute payroll checks on the participant's behalf (Fiscal/ Employer Agent and Agency with Choice FMS).

When specified in the waiver, a FMS entity may perform additional functions, including executing provider agreements on behalf of the Medicaid agency or brokering and paying worker's compensation or other types of insurance premiums on behalf of participants. A waiver also might provide that the FMS entity furnishes orientation/skills training to participants about their responsibilities when they function as either the common law employer or co-employer of their direct support workers. The nature and scope of necessary FMS hinges on the participant direction opportunities that are available under the waiver. The scope of FMS is necessarily broader when the waiver provides for both the Employer and Budget Authorities.

FMS may be furnished as a waiver service. The "Core Service Definitions" attachment to the Appendix-C instructions includes information and guidance about the coverage of FMS as a waiver service. FMS also may be provided as a Medicaid administrative activity in accordance with the approved cost allocation plan. The technical guidance for Item E-1-j (below) provides more information about this option. As a general matter, under either option, a FMS entity may furnish the same range of supports to waiver participants who direct their services. However, there are some differences between the two ways of underwriting the costs

of FMS under Medicaid. The following table summarizes some of the key differences associated with funding FMS under either of the payment authorities and may assist in selecting the option under which FMS are furnished.

FMS: Waiver Service v. Administrative Activity		
	Payment Authority	
Feature	Waiver Service	Administrative Activity
FFP Rate	State's Federal Medical Assistance Percentage (FMAP) rate	Administrative FFP rate (50%)
FMS Entities	Any provider that meets qualifications specified in Appendix C-3	Administrative procurement (e.g., RFP) – The number of FMS entities may be limited.
Participant selection of FMS entity	Free choice of any qualified FMS provider	Limited to FMS entities contracted by the state
Contractual relationship between FMS and state	Medicaid provider agreement between FMS entity and the state	Contract between FMS entity and the state
Organized Health Care Delivery System (OHCDS) [N.B., See Appendix I-3 instructions, Item I-3-g-iii for a discussion of OHCDS]	FMS entity may function as an OHCDS by virtue of providing a waiver service (FMS)	May function as an OHCDS when entity meets the criteria to be designated as OHCDS (i.e., renders one Medicaid **service** directly).
Provider Agreements (for services other than FMS) (see also next section)	Non-OHCDS Arrangement Medicaid provider agreements are required for all providers. OHCDS Arrangement Medicaid provider agreement not required except for OHCDS entity; other providers need to have an agreement/contract with FMS/OHCDS	Non-OHCDS Arrangement Medicaid provider agreements are required, except for vendors of non-traditional retail goods and services, as provided in following section entitled "Purchase of Certain Goods and Services through an FMS Entity" OHCDS Arrangement Medicaid provider agreement not required except for OHCDS entity; other providers need to have an agreement/contract with FMS/OHCDS

Execution of Medicaid provider agreement	When FMS entity is not an OHCDS, FMS may execute provider agreement when expressly authorized by the state in accordance with the Medicaid agency's standards.	FMS may execute provider agreement when expressly authorized by the state in accordance with the Medicaid agency's standards (when entity is not an OHCDS).
Flow of billings for non-FMS waiver services	OHCDS Arrangement FMS entity submits billings to and receives payment from the state for all services furnished by providers affiliated with the OHCDS and with which there is an agreement/ contract. Non-OHCDS Arrangement FMS may function as a limited fiscal agent when authorized by the state	OHCDS Arrangement FMS entity submits billings to and receives payment from the state for all services furnished by providers affiliated with the OHCDS and with which there is an agreement/ contract. Non-OHCDS Arrangement FMS may function as a limited fiscal agent when authorized by the state

Purchase of Certain Goods and Services through an FMS Entity

In some instances, it is more economical and efficient to purchase goods and services on behalf of participants from vendors on a retail basis. Requiring that there be a formal agreement with such vendors could prove to be unnecessarily burdensome and delay the acquisition of goods and services that have been authorized in the service plan. For example, in lieu of securing the services of a homemaker, it might be more appropriate for a participant to engage a commercial cleaning company to perform tasks such as household cleaning. Some types of goods (e.g., household appliances) are readily obtainable through retail establishments.

When FMS entities function as an OHCDS, the state may include the provision of goods and services (when a covered as a service in the waiver) in its provider agreement with such entities. The FMS may then purchase goods and services authorized in the service plan on the participant's behalf and bill the costs of such goods and services to the state. An agreement with a vendor is not required but there should be documentation to verify the purchase of the good or service and the goods and services must meet the standards specified in the waiver. Providers of the goods and services benefit cannot be limited to those FMS entities willing to operate as an OHCDS.

When FMS entities do not function as an OHCDS (e.g., FMS is funded as an administrative activity and that entity does not meet the criteria to operate as an OHCDS), the state may specifically authorize in its agreement with such entities to acquire goods and services from retail vendors on behalf of the participant. In general, this authorization should only extend to incidental, non-routine purchases of goods and services on behalf of a waiver participant rather than services that are regularly provided to the participant. In its agreement with the FMS entity, the state should require the FMS entity to document such purchases by obtaining receipts or other documentation to verify that the goods and services were delivered in accordance with the

standards specified in the waiver. The agreement should hold the FMS entity accountable for such purchases.

Item E-1-h: Financial Management Services

Instructions

Specify whether FMS are provided. If such services are provided, indicate whether they are provided by governmental or private entities or both (by selecting both types). If the "no" response is selected, do not complete item E-1-i.

Technical Guidance

In almost all cases, the provision of FMS is a necessary feature of participant direction of waiver services. A wide range of entities may furnish FMS. When the participant is the common law employer of his or her worker, a state may choose to provide Fiscal/Employer Agent FMS directly or use a reporting or subagent through its fiscal intermediary in accordance with Section 3504 of the IRS code and Revenue Procedure 80-4 and Notice 2003-70 (See Attachment D). Or a state also may choose to provide Fiscal/Employer Agent FMS through vendor organizations that have the capabilities to perform the required tasks in accordance with Section 3504 of the IRS code and Revenue Procedure 70-6 (either through a contract or through a Medicaid provider agreement). When a state elects to furnish FMS solely through governmental entities, administrative claiming should be employed to underwrite the cost of FMS.

When the participant is a co-employer of his or her worker(s), agencies that support the philosophy of participant direction may provide Agency with Choice services acting as a co-employer with the participant. A state may allow a FMS entity or a traditional provider organization to fulfill such a function. In either event, the state should establish qualifications for agencies with choice.

When a state allows individuals the opportunity for a co-employer arrangement utilizing an agency with choice model, but utilizes traditional Medicaid payment mechanisms to remit payment to the provider (rendering a "no" response in E-1-h appropriate), or when the entity is more akin to FMS (rendering a "yes" in E-1-h), the state needs to describe in E-2-a.i, the entities serving as co-employers, the standards and qualifications that the state requires of such entities, and the safeguards in place to ensure that individuals maintain control and oversight of the employee.

In addition, states should consider conducting initial FMS readiness reviews and ongoing performance reviews of their FMS providers to ensure that the FMS providers are providing the required services in accordance with federal and state requirements.

CMS Review Criteria

The selection is at the discretion of the state. However, it is expected that in nearly all instances that the "yes" response will be selected. If the no response is selected, then the application should be reviewed to determine that the selection is appropriate.

Item E-1-i: Provision of Financial Management Services

Instructions

Specify whether FMS are provided as a waiver service or conducted as a Medicaid administrative activity.

Technical Guidance

As previously noted, FMS may be furnished as a waiver service or performed as a Medicaid administrative activity. If furnished as Medicaid administrative activity, it must be done in accordance with the approved cost allocation plan. Cost allocation plans are not approved via the HCBS Waiver application.

Information needs to be provided about the nature and scope of the activities performed by the FMS. In particular:

- **Types of Entities**. Specify the types of entities that furnish FMS (e.g., Vendor or Government Fiscal Employer Agent or Agency with Choice provider). See the discussion of this topic above. States should be cautious about using the Agency with Choice FMS option to support the Budget Authority, especially with respect to ensuring that waiver participants can exercise free choice of provider when the entity that serves as the Agency with Choice also furnishes other waiver services. Also describe the procurement method that is used to select entities to furnish FMS. When private entities furnish FMS, the procurement method must meet the requirements that are set forth in 45 CFR §92.42. The description of the procurement method also should include whether the procurement results in the selection of a single entity or multiple entities to furnish FMS.
- **Payment for FMS.** Specify how entities are compensated for furnishing FMS (e.g., a per transaction fee, a monthly fee per participant, a combination of both types of fees, or another method). FMS services may not be compensated on the basis of a percentage of the total dollar volume of transactions that a FMS entity processes. It is not necessary to specify the specific amount of the fees that are paid for FMS.

- **Scope of FMS**. This item provides for check offs for the FMS that are furnished in support of participants who exercise the Employer Authority and the Budget Authority. The first two sections lists the FMS participant-oriented supports that are related to each participant direction opportunity as described in the overview of financial management services above. Select the supports that are provided under each applicable authority.

  The final section ("additional administrative functions/activities") lists additional activities/functions. As discussed in the instructions for Appendix A, the Medicaid agency may specifically authorize in writing that another entity (including a FMS entity) may execute the Medicaid provider agreement. Under such an arrangement, the FMS entity, for example, may execute the provider agreement with personal assistants selected by the individual. The second check-off indicates that the FMS functions as a limited fiscal agent on behalf of the Medicaid agency. That is, the entity processes billings, receives payment from the Medicaid agency for approved claims and disburses funds to providers. The final check-off is linked to the Budget Authority. It identifies whether the FMS prepares and distributes reports about expenditures and the participant budget to other entities in addition to the participant.

  In each case, provision has been made for describing additional supports (e.g., training participants in worker supervision or maintaining a roster of qualified workers) in addition to those listed. When additional supports are specified, the activity must be

necessary for the proper and efficient administration of the waiver in order to qualify for administrative FFP.

- **Oversight of FMS Entities**. In the text field, specify: (a) the methods that are used to monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for performing this monitoring; and (c) how frequently performance is assessed. Performance monitoring and assessment may include conducting periodic audits of FMS activities, requiring that FMS entities conduct customer satisfaction surveys and periodically report the results of such surveys to the state, conducting independent participant satisfaction surveys, and/or using other methods/procedures.

CMS Review Criteria

The necessary minimum scope of financial management services hinges on the participant direction opportunities (Employer and/or Budget Authority) that are available under the waiver and further specified in Appendix E-2. FMS may be furnished either as a waiver service (as specified in Appendix C-3) or an administrative activity in accordance with an approved cost allocation plan (as specified in this item). Regardless of the payment authority (service or administrative) that is used to underwrite the costs of FMS, the minimum types of supports that must be furnished to participants under either authority are the same. In particular:

Employer Authority

The minimum supports that must be furnished are:

- Assist participants in verifying support worker citizenship status;
- Collect and processes timesheets of support workers; and
- Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance.

Budget Authority

- Maintain a separate account for each participant's budget.
- Track and report disbursements and balances of participant funds.
- Process and pay invoices for goods and services approved in the service plan
- Provide participant with periodic reports of expenditures and the status of the participant – directed budget.

When these supports are provided as a waiver service, the specification of FMS in Appendix C-3 must include the foregoing supports, depending on the participant direction opportunities available under the waiver. The service specification also must meet all other requirements associated with service coverage (e.g., freedom of choice of provider).

Criteria Specific to Administrative Claiming

When FMS are furnished as an administrative activity, the following specific review criteria apply:

- The types of entities that furnish FMS are specified.
- The method of procuring FMS services is specified and comports with the applicable regulations at 45 CFR § 92.42.
- The method of compensating FMS entities is specified.
- The scope of the supports the FMS entities provide is specified. When supports over and above those listed are included, the activities are necessary for the proper and efficient administration of the waiver.
- The method and frequency of assessing the performance of the FMS entities are specified.
- The entities responsible for assessing performance are specified.
- The CMS waiver analyst should advise the financial staff that the state has indicated that it is using administrative claiming. This applies to all Medicaid administrative claiming activities specified (for example, case management, financial management services and supports broker). Medicaid administrative claiming must be in accordance with the approved cost allocation plan. Cost allocation plans are not reviewed or approved under the 1915(c)-waiver process.

Information and Assistance in Support of Participant Direction: Overview

In addition to FMS, participants should have access to information and assistance to support their direction of services. The waiver should provide that these supports are *available* to participants; however, in general, participants may elect whether to avail themselves of these supports and may determine the extent of the support that they require (within any limits established by the state). The supports that should be available to a participant also depend on the extent of decision making authority that the participant elects to exercise. For example, if a participant decides to exercise the Budget Authority but not Employer Authority, only supports associated with the Budget Authority would pertain to the participant.

The type of information and assistance supports for participant direction that should be made available hinges on the waiver's participant direction opportunities and how these opportunities have been further defined in Appendix E-2. For example, if the waiver provides only for the employer authority opportunity, the types of supports that should be available will be less extensive than when both opportunities are offered.

In general, information and assistance should be available to support participants in exercising each of the specific decision making authorities that are specified for the Employer Authority (Appendix E-2, Item E-2-a-ii) and/or the Budget Authority (Appendix E-2, Item E-2-b-i). For example, if the participant has the authority to supervise staff, then support should be available to assist the participant in exercising this authority (by, for example, making information or training available concerning worker supervision). Other supports also may be furnished, including supporting the participant during the service plan development process.

As is the case with FMS, federal financial participation in the costs of information and assistance in support of participant direction may be claimed as a waiver service or as an administrative activity. Item E-1-j is structured to identify the payment authority or authorities that are used to underwrite the costs of these supports as well as specify the types of supports that are furnished.

Item E-1-j: Information and Assistance in Support of Participant Direction

Instructions

Select the payment authority or authorities under which information and assistance in support of participant direction are furnished. Where required, provide the additional information that is specified.

Technical Guidance

Information and assistance in support of participant direction may be underwritten in three ways. More than one payment authority may be used to furnish these supports:

- **Case Management Activity.** Information and assistance supports may be furnished as an element of waiver case management. When case management is covered as a waiver service, its service specifications in Appendix C-3 should specify the supports that case managers furnish to participants who direct their services.

  When the case management payment authority is employed to underwrite information and assistance supports, specify in detail the supports that are provided with respect to each participant direction opportunity under the waiver. When these supports are furnished as part of the provision of waiver case management services, it is sufficient to limit this description to a reference to the case management service specifications

contained in Appendix C-3 so long as those specifications clearly delineate the supports that are furnished. When case management is provided under another authority, provide a complete description of the supports that are provided.

- **Waiver Service Coverage.** Information and assistance in support of participant direction may be offered as one or more distinct waiver services. In order to receive FFP for a waiver service, these service or services must be specified in Appendix C-3, including the scope of supports that are furnished and provider qualifications. Some states have covered these supports as "support broker," "supports brokerage," or personal agent services. When these supports are covered as a waiver service, the participant has free choice from among all willing and qualified providers of these supports and the state must provide for the enrollment of all qualified providers in accordance with section 1902(a)(23) of the act and 42 CFR § 431.51. In addition, federal financial participation in the costs of these supports is available at the state's FMAP rate. When information and assistance supports are covered as distinct waiver services, enter the title or titles of the services. Especially with respect to the employer authority opportunity, such supports may be furnished as part of FMS. If this is the case and FMS also are a waiver service, specify that FMS is a source of these supports.

  When information and assistance supports are covered as a waiver service, they generally may not be combined with FMS when both are furnished as waiver services. Usually, both types of support are covered as distinct services. The main exception is that employer authority-related supports may be included as part of the scope off FMS. When information and assistance supports are covered as a service distinct from FMS as a waiver service, FMS providers may furnish information and assistance supports when they meet applicable qualifications. However, participants may not be required to receive both FMS and information and assistance supports from the same waiver service provider.

- **Administrative Activity**. Information and assistance supports also may be furnished as a Medicaid administrative activity, furnished either by Medicaid agency personnel or by one or more contracted entities. Select this choice when these supports are furnished as an administrative activity. The considerations in using the administrative payment authority rather than a service payment authority to underwrite the costs of these supports are much the same as those that apply to FMS. If furnished as Medicaid administrative activity, it needs to be done in accordance with the approved cost allocation plan. Cost allocation plans are not approved via the HCBS waiver application.

  When information and assistance supports are furnished as an administrative activity, specify the types of entities that furnish these supports, how the supports are procured and compensated; ***describe in detail the supports that are furnished in conjunction with each participant direction opportunity under the waiver***; and, the responsible entity (or entities), methods and frequency of assessing the performance of entities that furnish these supports.

As noted above, the waiver may use more than one payment authority to underwrite the provision of information and assistance supports. For example, some supports might be furnished as part of waiver case management and other supports as a distinct waiver service. When more than one payment authority is used, the state must have controls in place to ensure

that duplicate claims for federal financial participation are not made for supports that are furnished to waiver participants.

CMS Review Criteria

Sufficiency of Supports

The scope of information and assistance in support of participant direction needs to align with the range of participant decision-making authorities specified in Appendix E-2. This requirement may be met by employing one or more payment authorities. Consequently, the relevant service specifications in Appendix C-3 and the response to this item may have to be reviewed in tandem to ascertain whether the overall scope of supports is sufficient.

Criteria Specific to the Provision of Supports as Case Management Activity

- When information and assistance supports are furnished as part of waiver case management services, the case management service specification identifies the supports.
- When information and assistance supports are furnished as part of state plan services, the supports are detailed by participant direction opportunity. The nature of the supports is consistent with the statutory scope of the state plan service and the coverage of the state plan service contained in the state plan.

Criteria Related to Provision of Information and Assistance Supports as an Administrative Activity

- The types of entities that furnish information and assistance supports are specified.
- The method of procuring information and assistance supports is specified and comports with applicable regulations at 45 CFR § 92.42.
- The method of compensating entities for furnishing information and assistance is specified.
- The scope of information and assistance supports is specified by type of participant direction opportunity.
- The supports are necessary for the proper and efficient administration of the waiver.
- The method and frequency of assessing the performance of entities that furnish information and assistance are specified.
- The entity (or entities) responsible for assessing performance is specified.
- The CMS waiver analyst should advise the financial staff that the state has indicated that it is using administrative claiming. This applies to all Medicaid administrative claiming activities specified (for example, case management, financial management services and supports broker). Medicaid administrative claiming has to be in accordance with the approved cost allocation plan. Cost allocation plans are not reviewed or approved under the 1915(c) waiver process.

Item E-1-k: Independent Advocacy

Instructions

Select whether independent advocacy is available to participants who direct their services. If such advocacy is available, describe the nature of such advocacy and how participants may access this support.

Technical Guidance

Independent advocacy is advocacy that is furnished on behalf of a participant by an individual or organization that does not provide other direct services (under either the waiver or the state plan) to the participant, perform assessments, or conduct waiver monitoring, oversight or fiscal functions that have a direct impact on a participant. Independent advocacy is person-specific advocacy rather than advocacy that is performed on behalf of a group of individuals collectively. When independent advocacy is available, participants have a source of neutral assistance available to them to address problems that may arise with respect to any aspect of their waiver services, including participant direction. A state may contract for independent advocacy or enter into agreements with individuals or organizations to furnish this advocacy as needed.

While arranging for access to independent advocacy is encouraged for all waivers, it is not a general waiver approval requirement. When independent advocacy is available, describe its nature (including the types of individuals and/or entities that furnish the advocacy) and how participants may access such advocacy (e.g., by providing information to participants about how to contact organizations that have agreed to provide such advocacy and the types of problems/issues for which such organizations provide assistance). This function may be conducted through an alternate dispute resolution system as specified in Appendix F-2 (if applicable) or a grievance/complaint system specified in Appendix F-3 (if applicable) provided that the system is independent.

CMS Review Criteria

The waiver specifies:

- Whether individuals and/or organizations furnish other direct services or perform other waiver functions that have a direct impact on a participant. If yes, the waiver describes this independent advocacy and how participants may access it.

Item E-1-l: Voluntary Termination of Participant Direction

Instructions

In the text field, describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction to the alternative service delivery method.

Technical Guidance

Participants who elect to direct some or all of their services may decide to switch to provider-managed services instead. When a waiver includes participant direction, a state should establish policies and procedures to accommodate this choice, including processes that ensure the continuity of the participant's services and assure the participant's health and welfare during the transition period. Such policies and procedures are important participant safeguards. Transition may be accommodated by timely revision of the service plan and quickly linking the participant with alternate waiver providers so that there is no break in the delivery of vital services.

When a waiver program targets only individuals who want to direct their services, describe how individuals who decide to terminate participant direction will be accommodated (e.g., by providing for their timely transition to another waiver for which they are eligible or by arranging

for alternate services). In this instance, provision may be made for the use of provider-managed services during the transition period.

CMS Review Criteria

The waiver describes how:

- The choice to voluntarily terminate participant direction and receive provider-managed alternative services is accommodated.
- Service continuity is ensured and participant health and welfare is assured during the transition period.

Item E-1-m: Involuntary Termination of Participant Direction

Instructions

In the text field, specify the circumstances under which the state will *involuntarily* terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Technical Guidance

The waiver may provide for the involuntary termination of participant direction of services. Involuntary termination may be necessary when the participant does not carry out his/her responsibilities under participant direction. Involuntary termination of participant direction also may be necessary in order to assure the participant's health and welfare. The provision of additional supports may prevent involuntary termination of participant direction. Involuntary termination of participant direction is not a basis for terminating the person from the waiver except when a waiver targets only individuals who elect to direct their services. When termination from the waiver is necessary, the person must be informed of the opportunity to request a Fair Hearing in accordance with the procedures specified in Appendix F-1.

In this item, specify in detail the circumstances (if any) when participant direction will be involuntarily terminated and process for transitioning the person to provider-managed services (e.g., by revising the service plan). Also specify the steps that are taken to ensure continuity of services that are vital to the participant's well-being and assure the participant's health and welfare during the transition period.

If the waiver targets only persons who elect to self-direct, then provision should be made to transition the person to another waiver for which the person is eligible or by arranging for alternate services. In this instance, provision may be made for the use of provider-managed services during the transition period.

CMS Review Criteria

When participant direction is terminated involuntarily, the waiver specifies:

- The circumstances under which participant direction is terminated.
- The safeguards that ensure continuity of services and assure participant health and welfare during the transition period.

Item E-1-n: Goals for Participant-Direction

Instructions

In Table E-1-n, specify the state's *goal* for the unduplicated number of waiver participants who are expected to avail themselves of the waiver's participant direction opportunities. In the case of a new waiver, numeric goals should be provided for Years 1-3, or Years 1-5 if applicable, that the waiver is in effect. In the case of a renewal, a goal for each of the five years that the waiver will be in effect should be provided.

Technical Guidance

The information that is provided in this table will aid CMS in understanding the expected extent of the use of the waiver's participant direction opportunities. The use of the term "goal" is intentional – it recognizes that the use of participant direction opportunities depends on many factors, including primarily the choices that are made by waiver participants themselves. Over the duration of the waiver, the goal may be over or underachieved. The goals that a state establishes are not to be interpreted as a limit on how many individuals may elect to direct their services (except in the case of waivers that only serve participants who want to self-direct). Approval of the waiver is not contingent on a minimum number of waiver participants electing to direct their services.

The "Employer Authority Only" column is used when the waiver provides only for the Employer Authority. The second column is used when a waiver provides for only the Budget Authority or the combination of the Budget Authority and the Employer Authority. If the waiver provides only for the Budget Authority, enter the number of participants who are expected to use that authority. When a waiver provides for both authorities, enter the number of participants who are expected to use one or both authorities.

Appendix E-2: Opportunities for Participant Direction

Overview of Topics Addressed in Appendix E-2

Appendix E-2 specifies the dimensions of the Employer Authority and Budget Authority opportunities for participant direction in the waiver. Item E-2-a is completed when the waiver offers the Employer Authority opportunity. Item E-2-b is completed when the waiver offers the Budget Authority opportunity.

Detailed Instructions for Completing Appendix E-2

Item E-2-a: Participant – Employer Authority

Instructions

This item must be completed whenever the waiver offers the Employer Authority participant direction opportunity, as indicated in Appendix E-1, Item E-1-b.

Item E-2-a-i: Participant Employer Status

Instructions

Select the Co-Employer or Common Law Employer choice or both.

Technical Guidance

There are two ways in which to position the participant to direct staff who provide supports to the participant:

- **Co-Employment.** Under this approach, the participant is supported by an agency that functions as the common law employer of workers recruited by the participant. The participant directs the workers and is considered their co-employer (a.k.a., "managing employer"). This approach is sometimes termed the "Agency with Choice FMS model." The Agency with Choice FMS provider conducts all necessary payroll functions and is legally responsible for discharging the employment-related functions and duties for participant-selected workers with the participant based on the roles and responsibilities identified for the two co-employers. The agency performs financial management services tasks that are related to the Employer Authority. Under this option, the Agency with Choice provider must hold a provider agreement with the state in order to submit billings and receive payments for the waiver services furnished by participant-selected workers or enter into an administrative services agreement/contract to function as a limited fiscal agent. An Agency with Choice FMS provider may function solely to support participant employment of workers or it may provide other employer-related supports to the participant, including providing traditional agency-based support workers. When the Agency with Choice FMS option is selected, specify the types of agencies that support co-employment, the standards and qualifications that the state requires of such entities, and the safeguards in place to ensure that individuals maintain control and oversight of the employee.
- **Common Law Employer**. Under this approach, the participant is considered the legally responsible employer (common law employer) of workers whom he or she (or his or her representative) hires, supervises and discharges directly. The participant or his or her representative is liable for the performance of necessary employment-related tasks and uses a Government or Vendor Fiscal/Employer Agent. When this approach is used, a FMS entity is engaged to support the participant by performing necessary payroll and other employment related functions as the participant's agent in order to ensure that employer-related legal obligations are fulfilled. This entity must be an IRS-approved Fiscal/Employer Agent.

Indicate which of these approaches are used in the waiver. A waiver may use both approaches.

CMS Review Criteria

- When the co-employer option is selected, the types of agencies that serve as co-employers are specified as Agency with Choice FMS.
- The state has mechanisms in place to ensure that individuals maintain authority and control over employees when opting for a co-employer arrangement, and that the agency with choice service delivery model truly reflects the key elements of self-direction.

Item E-2-a-ii. Participant Decision Making Authority

Instructions

Indicate how the participant exercises decision making authority over workers by checking off the employment-related functions that the participant may perform under the Employer Authority in the list provided (additional functions may be indicated in text box associated with the "other" selection).

Technical Guidance

The employer functions listed are generally self-explanatory. The selection of an employer-related function means that the participant may conduct the function. The waiver may provide that the performance of any of the selected functions is a matter of participant choice.

Four of the listed functions warrant additional discussion:

- **Criminal History and/or Background Checks**. A state's policies concerning the performance of criminal history and/or background checks are described in Appendix C-2, Item C-2-a. When the participant is the common law employer, responsibility for conducting necessary background checks devolves to the participant whenever a participant-selected worker is subject to such a check under state law. However, a FMS or other entity may arrange for the background check on behalf of the participant. Under the Agency with Choice model, the agency is generally responsible for conducting necessary background checks. In either case, when workers are subject to mandatory background checks, this item should be checked. When participant-selected workers are not subject to such mandatory checks, the participant may request that such checks be conducted. The costs of conducting criminal history and/or background checks may be compensated as part of the payment to a FMS entity. In general, when such checks are mandated under state law, the costs of conducting these checks should not be deducted from the participant-directed budget unless the cost is incorporated into the budget. Describe how the costs of criminal history and/or background checks are compensated.
- **Additional Staff Qualifications**. In Appendix C-3, the provider qualifications for each service are specified. These qualifications are controlling – that is, providers must meet these qualifications regardless of whether a service is provider-managed or participant-directed. However, the waiver may provide that the participant may establish additional staff qualifications based on her/his needs and preferences. For example, if a participant is hearing-impaired, the participant may specify that workers must be able to sign. So long as the additional participant-specified qualifications do not contravene the qualifications set forth in Appendix C-3, they are permissible. See the instructions for Appendix C-3 for a discussion of policies concerning staff qualifications.
- **Staff Duties**. Under the Employer Authority, the participant – like any employer – exercises authority over workers by specifying their duties – i.e., the specific tasks that the worker will perform on behalf of the participant. These duties must fall within the scope of the pertinent service specifications contained in Appendix C-3. For example, the participant may determine the specific tasks that a personal assistant will perform. These tasks must fall within the scope of personal assistance services as specified in Appendix C-3 in order to be considered eligible for Medicaid payment. Tasks that are outside the scope of a service's specifications may not be billed to Medicaid.
- **Staff Compensation**. The waiver may provide that the participant has the authority to determine worker wages and benefits. In general, making provision for participant-determined wages and benefits implies that the participant also has Budget Authority. When this selection is made, the waiver may make participant decisions regarding worker wages and benefits subject to applicable state policies. For example, a state may establish a maximum hourly compensation amount but permit participants to negotiate hourly compensation rates that are lower than the maximum. Also, a state may provide

that participant-determined worker wages comport with applicable federal and state wage laws. When this selection is not made, worker wages and benefits are subject to the rates that the state establishes for each service.

The selections that are made for this item have important implications for the range of supports that the waiver makes available to participants who exercise Employer Authority. In general, the waiver must make support available to participants for each employer-related function that a participant may perform. This support may take the form of FMS and/or information and assistance in support of participant direction.

CMS Review Criteria

In order for the waiver to be considered to offer Employer Authority to participants, the participant should have the authority to conduct the following functions at a minimum:

- Recruit workers;
- Hire and discharge staff (common law employer);
- Refer for hire and discharge from providing services (co-employer);
- Specify staff qualifications including methods used to conduct background checks if the method varies from the Appendix C-2-a;
- Determine staff duties;
- Schedule staff;
- Supervise staff; and
- Evaluate staff performance.

Item E-2-b: Participant – Budget Authority

Instructions

This item must be completed whenever the waiver offers the Budget Authority participant direction opportunity, as indicated in Appendix E-1, Item E-1-b.

Item E-2-b-i: Participant Decision Making Authority

Instructions

Indicate how the participant exercises control over a participant-directed budget by checking the decision-making authorities that the participant may exercise under the Budget Authority in the list provided (additional functions may be indicated in text box associated with the "other" selection).

Technical Guidance

The selection of a budget control authority means that the participant may exercise decision making over a wide range of service delivery elements. The waiver may provide that the exercise of decision making authority for any particular element is a matter of participant choice. The budget control authorities are generally self-explanatory. With respect to the participant's determining the amount paid for a service, specifying additional provider qualifications, or specifying how services are provided, the considerations are parallel to those identified in the foregoing instructions for the Employer Authority.

As is the case with the Employer Authority, the selections that are made for this item have implications for the range of supports that the waiver makes available to participants who exercise Budget Authority. In general, the waiver must make support available to participants for

each decision-making authority that a participant may exercise. This support may take the form of FMS and/or information and assistance in support of participant direction.

CMS Review Criteria

In order for the waiver to be considered to offer Budget Authority to participants, the participant should at a minimum have the authority to:

- Determine the amount paid for each service in accordance with the state's policies.
- Schedule when services are provided.
- Identify service providers and refer for enrollment.
- Review and approve provider invoices.

Item E-2-b-ii: Participant-Directed Budget

Instructions

In the text field, describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Technical Guidance

The exercise of Budget Authority requires that the participant have a budget in hand to manage. The participant-directed budget (sometimes termed the individual budget) may encompass all the services included in a participant's service plan or only include the services that may be participant-directed (as provided in Appendix C-3) and that the participant decides to direct. In the case of the latter, services that fall outside the participant-directed budget are controlled by the authorizations in the service plan. The description of the budget methodology should clearly spell out the scope of the participant-directed budget.

The amount of the participant-directed budget may be determined in a variety of ways. For example, if prospective budget amounts are uniquely assigned to each participant or by level of support as provided in Appendix C-4, then the participant-directed budget may be based on the methods that are used to determine those budget amounts. Alternatively, the amount of the individual budget may be based on the amounts that are authorized in the service plan for the services that the participant has elected to direct. Other methods can be employed so long as they are based on reliable cost-estimating methodology that is described in detail. Whatever method is employed, the waiver must describe how it is applied consistently to each participant who elects to direct a budget. In addition, the waiver must provide that information about how the budget methodology is publicly available.

CMS Review Criteria

The state has specified:

- The basis of the method of determining participant-directed budget.
- How the method is rooted in the participant's service plan, the budget determination method spelled out in Appendix C-4 (if applicable), or an alternative approach that is based on reliable cost-estimating techniques.
- When the method provides that the budget may vary based on additional factors, the factors that are used and how they affect the budget.
- How the method is applied consistently to each waiver participant.
- How information about the budget methodology is made publicly available.

Item E-2-b-iii. Informing Participant of Budget Amount

Instructions

In the text field, describe the process by which the participant is informed of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Technical Guidance

The participant must be informed of the amount of his/her budget. This may be done during the service plan development process or through an alternate means. This information should be provided to the participant before the service plan is finalized. In addition, the waiver should include procedures by which the participant may request an adjustment in the budget amount (e.g., by requesting a review of the service plan). The procedures should be described in this item, including (if applicable) the policies that the state follows in considering an adjustment to the budget. When the budget functions as a limit on the amount of waiver goods and services that a participant may receive, the participant must be offered the opportunity to request a Fair Hearing when the participant's request for an adjustment to the budget is denied or the amount of the budget is reduced.

CMS Review Criteria

The waiver describes:

- How the participant is informed of the budget amount before the service plan is finalized.
- How the waiver provides for procedures for the participant to request an adjustment in the budget.
- How participants are afforded the opportunity to request a Fair Hearing when the participant's request for a budget adjustment is denied or the amount of the budget is reduced.

Item E-2-b-iv. Participant Exercise of Budget Flexibility

Instructions

Select whether participants who exercise Budget Authority may modify the services included in the participant-directed budget without advance approval of a change in the service plan.

Technical Guidance

The waiver service plan is the official authorization for the provision of waiver services to a participant. The service plan specifies the services that are furnished to the participant, including their amount, frequency and duration. The Budget Authority gives the participant control over a participant-directed budget. Such control implies the ability to reallocate funds among services. However, the waiver service plan and the participant-directed budget must be kept in alignment. This may be accomplished in one of two ways:

- The waiver may permit participants to reallocate funds among services without a prior change to the service plan so long as the reallocation of funds is documented in the service plan. If the waiver follows this policy, specify how changes in the participant-directed budget are documented, including updating the service plan. The waiver also may provide that, under specified circumstances (e.g., the participant wants to make a major change in the distribution of funds), a change in the budget is subject to prior review before it takes effect. If so, specify the circumstances when a budget change is subject to prior review.
- Alternatively, the waiver may provide that all changes in the participant budget must be preceded by a change in the service plan. In this instance, the waiver's procedures for updating or modifying the service plan are followed.

Budget flexibility may not be employed to permit the purchase of waiver goods and services that have not been authorized in the service plan. When a participant wishes to purchase waiver goods and services that are not included in the service plan, the service plan must be modified to include the desired goods and services, as specified within the waiver's parameters.

CMS Review Criteria

When the waiver provides that participants have the authority and flexibility to modify the distribution of funds in the participant-directed budget without prior change to the service plan, the waiver specifies:

- How the changes to the budget and service plan are documented.
- If applicable, the circumstances when changes are subject to prior review and the entity responsible for conducting this review.

Item E-2-b-v: Expenditure Safeguards

Instructions

In the text field, describe the safeguards that are in effect for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards.

Technical Guidance

The waiver must provide safeguards to prevent the premature depletion of the participant-directed budget. Similarly, there should be safeguards to identify potential service delivery problems that might be associated with budget underutilization (e.g., the participant is unable to arrange for waiver services). These safeguards may take various forms, including the monitoring of expenditures by a case manager or support broker; requiring the FMS entity to flag significant budget variances (over and under expenditures) and bring them to the attention of the participant,

case manager or support broker; and allocating the budget on a monthly or quarterly basis. The safeguards should be designed so that budget problems are identified on a timely basis so that corrective action may be taken, if necessary.

CMS Review Criteria

The waiver describes:

- Safeguards to prevent the premature depletion of the participant budget or address potential service delivery problems that may be associated with budget underutilization.
- Identifies the entity (or entities) responsible for ensuring the implementation of safeguards.
- How the safeguards ensure that potential budget problems are identified on a timely basis.
- Safeguards that include flagging potential budget over expenditures or budget underutilization.

Appendix F: Participant Rights

Brief Overview

Appendix F addresses the following:

- How participants are afforded the opportunity to request a Fair Hearing (Appendix F-1);
- Whether there is an alternate dispute resolution process available to participants to appeal decisions that adversely affect their services (Appendix F-2); and
- The system (if any) that is available to participants to register grievances and complaints about their services (Appendix F-3)

Appendix F-1: Opportunity to Request a Fair Hearing

Detailed Instructions for Completing Appendix F-1

Process for Offering Opportunity to Request a Fair Hearing

Instructions

In the text field, describe the policy and procedures under the waiver for informing individuals of the opportunity to request a fair hearing under the provisions of 42 CFR § 431, Subpart E. The description needs to include how, when and by whom individuals are informed of fair hearing procedures during entrance to the waiver. Procedures for notifying individuals of the opportunity to request a fair hearing must encompass the following adverse actions: (a) not providing an individual the choice of home and community-based services as an alternative to institutional care; (b) denying an individual the service(s) of their choice or the provider(s) of their choice; and, (c) actions to deny, suspend, reduce or terminate services. Include in the description how notice of an adverse action is given to individuals (e.g., by written notice only or verbally along with formal written notice). Specify the entity or entities responsible for notifying individuals and the extent of assistance that is provided to individuals affected by an adverse

action to request a Fair Hearing. Also specify where documentation concerning Fair Hearing notification is maintained and include references to the notice forms that are employed. As appropriate, include in the description references to applicable state laws, regulations and policies.

Technical Guidance

The opportunity to request a fair hearing is a fundamental protection that is afforded Medicaid beneficiaries under the provisions of section 1902(a)(3) of the Act. Federal fair hearing regulations are located in 42 CFR § 431, Subpart E (included in Attachment C to the Instructions) and are further detailed in Section 2900 of the State Medicaid Manual (also included in Attachment D). Medicaid Fair Hearing requirements apply to HCBS waivers. Individuals must be afforded the opportunity to request a fair hearing in all instances when they: (a) are denied the service(s) of their choice or the provider(s) of their choice; and/or, (b) their services are denied, suspended, reduced, or terminated.

Individuals must be informed in writing of the procedures for requesting a fair hearing as part of the waiver entrance process. If entrance to the waiver is denied, the person must be given formal written notice of the denial and information about how to request a Fair Hearing to appeal the denial of entrance to the waiver. In order to ensure that the participant is fully informed of their right to fair hearing, it may be appropriate and even necessary to supplement the written information with a verbal explanation of the right to fair hearing.

Whenever an action is taken that adversely affects a waiver participant post-enrollment (e.g., services are denied, reduced or terminated), the participant must be notified of the action in writing on a timely basis in advance of the effective date of the action in accordance with 42 CFR § 431.211. In accordance with 42 CFR § 431.210, the notice must include information about how the participant may appeal the action by requesting a fair hearing. Services may not be terminated or reduced pending hearing, except as permitted under 42 CFR § 431.230. Copies of notices must be maintained in the person's record. It is up to the participant to decide whether to request a fair hearing.

Ultimate responsibility for compliance with Fair Hearing requirements is vested with the Medicaid agency. However, the Medicaid agency may elect to delegate aspects of the fair hearing process to the operating agency as provided in 42 CFR § 431.10. This is often the case when waiver administration is delegated to counties or local authorities. For example, a state may offer beneficiaries the *option* of first pursuing an evidentiary hearing at the local level. In the event the outcome of that hearing is not satisfactory to the participant, the participant must be afforded the opportunity to pursue the fair hearing process at the state level. The participant cannot be required to pursue evidentiary hearing at the local level before requesting a fair hearing.

Concurrent Managed Care/Section 1915(c) Waiver. When an HCBS waiver operates concurrently with a concurrent Medicaid managed care authority, access to the fair hearing process may be affected by whether the state has provided that individuals must first avail themselves of the internal grievance process that an MCO or PIHP must operate. Indicate in the response to the item if this is the case and include a reference to the appropriate section of the managed care authority application.

CMS Review Criteria

- The description needs to specify how individuals are informed about the fair hearing process during entrance to the waiver, including how, when and by whom this information is provided to individuals to ensure that the participant is knowledgeable about their right to fair hearing.
- The description needs to address all instances when notice must be made to an individual of an adverse action: choice of provider or service; and denial, reduction, suspension or termination of service. The description must specify: (a) how notice is made; (b) the entity or entities responsible for issuing the notice; and (c) the assistance (if any) that is provided to individuals in pursuing a Fair Hearing.
- The description needs to specify how the participant is informed that services will continue during the period while the participant's appeal is under consideration unless the state is not required to continue the services in accordance with 42 CFR § 431.230.
- The description needs to specify where notices of adverse actions and the opportunity to request a fair hearing are kept.

Appendix F-2: Additional Dispute Resolution Process

Overview

Many states operate an additional dispute resolution process in addition to the fair hearing process. This is permissible so long as an individual is not required to use this process as a pre-requisite to accessing the Medicaid fair hearing process or the process operates in lieu of the fair hearing process. To be acceptable, the mechanism must preserve the individual's right to pursue a fair hearing in accordance with 42 CFR § 431, Subpart E. In this Appendix, indicate whether there is an additional dispute resolution process available to individuals and, if so, provide information about the process.

This item only applies to dispute resolution processes operated by a state agency. In some cases, dispute resolution processes are entirely local or provider-based. In these cases, it is required that participants be informed that the right to a Medicaid Fair Hearing is preserved when they elect to make use of the process.

Detailed Instructions for Completing Appendix F-2

Item F-2-a: Availability of Additional Dispute Resolution Process

Instructions

Select whether there is an additional dispute resolution process. If "yes" is selected, complete Item F-2-b. If "no," do not complete Item F-2-b.

Technical Guidance

Section 1915(c) Waivers. Select the "yes" response only if the additional dispute resolution process operates under the aegis of a state agency (e.g., a state agency operates the process or the process includes provision for referring disputes from the local level to the state for resolution). Do not select "yes" if additional dispute resolution processes are entirely local or provider-based. Also, do not select "yes" if the additional dispute resolution process only involves offering a person the opportunity for a local evidentiary hearing under the Fair Hearing process. Offering such hearings should be addressed in Item F-1-b instead.

Managed Care/1915(c) Concurrent Waivers. Select "yes" when the state contracts with Managed Care Organizations (MCOs) or Prepaid Inpatient Hospital Plans (PIHPs) for the provision of waiver services to reflect the requirement that such entities have an internal grievance system as required by 42 CFR § 438 Subpart H. Also, select "yes" when the state contracts with Prepaid Ambulatory Health Plans (PAHPs) for the provision of waiver services and the state elects to operate an optional PAHP grievance procedure as specified in the managed care authority application.

Item F-2-b: Description of Additional Dispute Resolution Process

Instructions

Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and (c) how the right to a Medicaid fair hearing is preserved when a participant elects to make use of the process. State laws, regulations, and policies referenced in the description need to be available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

In the case of managed care/section 1915(c) concurrent waivers that includes an internal grievance system or optional grievance procedure, the description may simply reference the Medicaid managed care authority application.

Technical Guidance

The operation of an additional dispute resolution process over and above the fair hearing process is not a federal requirement except in the case of certain managed care service delivery models. This item is included in the application in order to provide a complete picture of the procedural protections afforded to waiver participants. From a Medicaid perspective, the operation of an additional dispute resolution process must not impede in any way a person's opportunity to request a Fair Hearing.

CMS Review Criteria

When there is an additional dispute resolution process:

- The state agency that operates the dispute mechanism is identified.
- The state describes the types of disputes that can be addressed, including the process and timelines.
- When a participant elects to make use of the dispute mechanism, the participant is informed that the dispute resolution mechanism is not a pre-requisite or substitute for a Fair Hearing.

Appendix F-3: State Grievance/Complaint System

Overview

States often operate grievance and complaint systems that afford waiver participants the opportunity to identify and seek the resolution of problems and issues with the services that they receive and/or accessing services that they have been authorized to receive. The operation of such a system is not mandated under federal regulations. These systems typically address problems that are outside the scope of the Fair Hearing process (e.g., issues with provider performance in furnishing a waiver service). The operation of such a system may not in any

fashion undermine the opportunity of a participant to request a Fair Hearing to address problems that fall under the scope of the Fair Hearing process. Sometimes these systems are multi-tiered (e.g., designed to resolve a problem at the local level before the problem is referred to a state agency). In this Appendix, indicate whether there is a grievance and complaint system available to individuals and, if so, provide information about the process.

This item only applies to a grievance/complaint system operated by a state agency. In some cases, there are grievance/complaint systems that are entirely local or provider-based. When this is the case, participants must be informed that the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process.

Detailed Instructions for Completing Appendix F-3

Item F-3-a: Operation of Grievance/Complaint System

Instructions

Select whether there is a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver. When there is such a system, complete the remaining two items. If there is not a system, do not complete the remainder of Appendix F-3.

Technical Guidance

Only select "yes" when the grievance/complaint system is operated by the state (i.e., grievances or complaints are registered directly with the state) or, if operated at the local or provider agency level, the system provides for state involvement when the complaint or grievance cannot be satisfactorily resolved at the local or provider level). Do not select the affirmative response if grievance/complaint mechanisms are operated entirely locally or by providers with no direct involvement by a state agency.

Item F-3-b: Operational Responsibility

Instructions

Specify the state agency that is responsible for the operation of the grievance/complaint system.

Technical Guidance

The agency that operates the grievance/complaint system may be the Medicaid agency, the operating agency, or another state agency (e.g., a state ombudsman office). If more than one state agency is involved in addressing complaints and grievances, specify each and, in the response to the next item, distinguish the roles and responsibilities of these agencies in resolving grievances and complaints.

Item F-3-c: Description of System

Instructions

Describe the grievance/complaint system, including (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and (c) the mechanisms that are used to resolve grievances/complaints. When multiple entities are involved in the system, identify the role that each play. Also, specify how the system is structured to preserve the participant's opportunity to request a Fair Hearing. State laws, regulations, and policies that are referenced in the description need to be available when requested by CMS through the Medicaid agency or the operating agency (if applicable).

In the case of a managed care/1915(c) concurrent waiver that includes an internal grievance system or optional grievance procedure, the description may simply reference the Medicaid managed care application.

CMS Review Criteria

When there is a grievance/complaint system:

- The state agency that operates the grievance/complaint system is identified.
- The state describes the types of complaints that can be addressed, the process and timelines.
- When a participant elects to file a grievance or make a complaint, the participant is informed that doing so is not a pre-requisite or substitute for a Fair Hearing.

Appendix G: Participant Safeguards

Brief Overview

Appendix G addresses the following safeguards to assure the health and welfare of waiver participants:

- Response to Critical Events or Incidents (Appendix G-1)
- Safeguards Concerning Restraints and Restrictive Interventions (Appendix G-2)
- Medication Management and Administration (Appendix G-3)

Appendix G-1 and Appendix G-2 Item C-2-c-ii apply to all waivers. Appendices G-2 (except for Item C-2-c-ii) and G-3 may not apply to some waivers. See the instructions for these appendices for a discussion of their applicability.

Appendix G-1: Response to Critical Events or Incidents

Overview

This appendix applies to all waiver programs. It focuses on the identification and follow-up to critical events or incidents (e.g., abuse, neglect and exploitation) that bring harm, or create the potential for harm, to a waiver participant. *Effective incident management is essential to assuring the health and welfare of waiver participants.* In this appendix, the state describes the operational features of managing incidents at the individual and provider level as well as its activities to assure that reports are filed and incidents investigated in a timely fashion and to analyze incident data (e.g., about specific types of incidents, providers, participant characteristics, results of investigations, the timeliness of reports and investigations) in order to develop strategies to reduce the risk and likelihood of the occurrence of incidents in the future.

Detailed Instructions for Completing Appendix G-1

Item G-1-a: Critical Event or Incident Reporting and Management Process.

Instructions

Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.

Item G-1-b: State Critical Event or Incident Reporting Requirements

Instructions

List and briefly define the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action (e.g., a follow-up investigation) by an appropriate authority (e.g., child or adult protective services). Also identify the individuals and/or entities (e.g., waiver providers) that must report such events and incidents and the reporting method or methods that are employed. Specify the timeframes for reporting critical events and incidents. The response to this item may include citations of relevant state laws, regulations, and other published policies. Referenced documents need to be available through the Medicaid agency or the operating agency (if applicable) upon request by CMS.

Technical Guidance

This item focuses on critical events or incidents that the state itself deems as sufficiently serious to warrant near-term review and follow-up by an appropriate authority. Such incidents may include but are not limited to: (a) abuse and neglect as defined by the state; (b) the unauthorized use of restraint, seclusion or restrictive interventions; (c) serious injuries that require medical intervention and/or result in hospitalization; (d) criminal victimization; (e) death; (f) financial exploitation; (g) medication errors; and, (h) other incidents or events that involve harm or risk of harm to a participant. In general, the types of critical events and incidents that must be reported to and monitored by an appropriate authority are specified in state law, regulations or policies. When the waiver serves both children and adults, specify whether different reporting requirements apply to children and adults, including who has responsibility to report critical events or incidents.

CMS Review Criteria

- The state provides for the reporting and investigation of major and serious incidents (abuse, neglect, and exploitation at a minimum).
- The description includes:
  - Definitions of the types of critical events or incidents that must be reported;
  - Identification of the individuals/entities that must report critical events and incidents;
  - The timeframes within which critical events or incidents must be reported; and
  - The method of reporting (e.g., phone, written form, web-based reporting system)

Item G-1-c: Participant Training and Education

Instructions

Describe how training and/or information is provided to participants (and involved family or other unpaid caregivers, as appropriate) concerning the state's protections from abuse, neglect, and exploitation, including how participants (or their informal caregivers) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation. Identify the entity or entities that are responsible for providing this training and/or information and how frequently training and education are furnished.

Technical Guidance

This item focuses on how participants (and involved family or other unpaid caregivers, as appropriate) are informed about abuse, neglect and exploitation protections. This might involve

formal training concerning whom to contact when the participant believes that they have experienced abuse, neglect or exploitation. Alternatively, information about reporting might be furnished verbally and/or in written form to the participant and other involved individuals. The scope of the item does not include training/education that might be furnished to providers or direct support workers about identifying and reporting abuse, neglect, and exploitation.

CMS Review Criteria

The waiver describes:

- How training and/or information are furnished to participants or their informal caregivers concerning protections from abuse, neglect and exploitation, including how to notify the appropriate authorities.
- The entities responsible for providing training and/or information are specified.
- The frequency of providing training and/or information is specified.

Item G-1-d: Responsibility for Review of and Response to Critical Events or Incidents

Instructions

Identify the entity (or entities) to which reports are made of each type of critical event or incident specified in Item G-1-a above. Describe the methods employed to evaluate critical incident reports (e.g., determine that follow-up action is required), and the processes and time frames for responding to critical events or incidents, including conducting investigations.

Technical Guidance

The purpose of this item is to describe how reports of critical events or incidents are reviewed and how follow-up of reports is performed when warranted. Pursuant to 42 CFR § 441.302(a), the response must:

- For each type of critical incident or event identified in Item G-1-a, specify the entity or entities to which reports are submitted. Such entities might include the state's adult protective services agency, the child protective services agency, a licensing authority and/or a program authority (e.g., the state developmental disabilities agency);
- Identify the entity that is responsible for evaluating reports (e.g., making a determination that follow-up is necessary) and how reports are evaluated (e.g., the criteria that are applied in deciding whether follow-up action is warranted);
- Identify the entity that is responsible for follow-up investigations and how investigations are conducted (e.g., whether methods are determined based on severity according to a prescribed protocol, accommodations that are made for participant interviews);
- Include the timeframe for conducting and completing an investigation (i.e., how promptly an investigation is initiated) and the timeframe for completing an investigation (e.g., within 48-hours, 7-days, 30-days depending on severity and criticality); and
- Include the process and time frames for informing the participant (or the participant's family or legal representative as appropriate) and other relevant parties (e.g., the waiver provider, licensing and regulatory authorities, the operating agency) of the investigation results.

The description may be structured in any appropriate manner so long as it addresses each of the elements listed above.

CMS Review Criteria

The waiver specifies:

- The entity (or entities) that receives reports of each type of critical event or incident.
- The entity that is responsible for evaluating reports and how reports are evaluated.
- The entity that is responsible for conducting investigations and how investigations are conducted.
- The timeframes for conducting an investigation and completing an investigation.
- The process and timeframes for informing the participant including the participant (or the participant's family or legal representative as appropriate) and other relevant parties (e.g., the waiver providers, licensing and regulatory authorities, the waiver operating agency) of the investigation results.

Item G-1-e. Responsibility for Oversight of Critical Incidents and Events

Instructions

In the text field, identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events, how this oversight is conducted and how frequently.

Technical Guidance

An effective incident management system entails conducting oversight to make sure that applicable policies and procedures are being followed for the reporting of critical incidents or events and that necessary follow-up is being conducted on a timely basis. A critical element of effective oversight is the operation of data systems that support the identification of trends and patterns in the occurrence of critical incidents or events in order to identify opportunities for improvement and thus support the development of strategies to reduce the occurrence of incidents in the future.

Pursuant to 42 CFR § 441.302(a), The response to this item must specify the following:

- **The state agency or agencies responsible for overseeing the operation of the incident management system.** When this responsibility is not carried out directly by the Medicaid agency and/or the operating agency (if applicable), indicate how the information and findings from oversight activities are communicated to the Medicaid agency and/or the operating agency by the state agency (or agencies) responsible for oversight. Since addressing critical incidents or events is an integral component of assuring the health and welfare of waiver participants, it is critical that the Medicaid agency and/or the operating agency (if applicable) play an active role in the oversight of the operation of the incident management system. For example, if the state's adult protective services (APS) agency has primary oversight responsibility for incident management, there should be processes whereby the APS agency regularly furnishes the Medicaid agency and/or operating agency with information about critical incidents that involve waiver participants and that the agencies work together to identify strategies to reduce the occurrence of critical incidents.

- **How oversight is conducted.** System-wide oversight methods should include gathering information about types of incidents, participant characteristics, providers, how quickly reports are reviewed and investigated, how promptly follow-up takes place, the results of investigations, and whether participants are informed of the investigation results. Oversight includes using information to reduce the occurrence of incidents in the future. The response should describe:
  - How information about critical incidents and events is collected and compiled so that it can be analyzed to enable the identification of trends/patterns and the development of quality improvement strategies to reduce future occurrence of critical incidents or events. For example, reports may be filed by phone, in written form, or through the use of information technology, each of which requires specific practices to collect, compile and analyze the information.
  - How information from critical incident reports is used to identify issues within the waiver population, specific providers at a system-wide level, and how that information is used to develop strategies to reduce occurrences in the future.
  - The frequency of oversight activities.

CMS Review Criteria

The waiver specifies:

- The state entity or entities responsible for overseeing the operation of the incident management system.
- When oversight is not performed by the Medicaid agency or the operating agency (if applicable), the process for the oversight agency to communicate information and findings to the Medicaid agency and/or operating agency.
- The methods for overseeing the operation of the incident management system, including how data are collected, compiled, and used to prevent re-occurrence.
- The frequency of oversight activities.

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions

Overview

This Appendix concerns the use of restraints and/or restrictive interventions during provision of waiver services. When either is permitted, pursuant to 42 CFR § 441.302(a), the state must specify the safeguards that it has established concerning their use and how the state ensures that such safeguards are followed. Providing effective safeguards in the use of restraints and/or restrictive interventions is integral to assuring the health and welfare of waiver participants. When restraints and/or restrictive interventions are not permitted, the state must have a means to detect unauthorized use. The terms used in this Appendix are defined in the Glossary.

Detailed Instructions for Completion of Appendix G-2

Item G-2-a: Use of Restraints

Instructions

Select one of the two main choices. If the state does not permit the use of restraints as part of the provision of waiver services and/or their use is prohibited under state policy, select the first choice. Also, identify the state agency or agencies that are responsible for detecting the unauthorized use of restraints and how oversight is performed to ensure that unauthorized use does not take place. If the use of restraints by a paid caregiver is permitted during the course of providing waiver services, including in the participant's private residence, select the second choice and complete the next two items. Use of restraints must comport with the home and community-based setting requirements at Section 42 CFR §§ 441.301(c)(4)(iii) and (vi)(F), and person-centered service planning and plan requirements at 42 CFR §§ 441.301(c)(1) and (c)(2).

Technical Guidance

For the purposes of this item, restraints include personal restraints (e.g., holds), drugs used as restraints, and mechanical restraints. When a state prohibits the use of restraints during the delivery of waiver services, it still must have processes that are designed to detect their unauthorized use. Such processes may include regular monitoring of participant health and welfare, the performance of periodic provider quality reviews, and an incident management system in which unauthorized restraint is a reportable incident.

CMS Review Criteria

- When the first choice is selected, the response is consistent with the remainder of the waiver application.
- When the first choice is selected, the state provides specific methods to detect unauthorized use of restraints and specifies the state agency (or agencies) responsible for conducting this oversight.
- Use of restraints must comport with the home and community-based setting requirements at Section 42 CFR §§ 441.301(c)(4)(iii) and (vi)(F), and person-centered service planning and plan requirements at 42 CFR §§ 441.301(c)(1) and (c)(2).

Item G-2-a-i: Safeguards Concerning the Use of Restraints

Instructions

Specify the safeguards that have been established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). If state laws, regulations, and policies are referenced in the response to this item, they need to be available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

Technical Guidance

When the use of restraints is permitted, identify the types of restraints (i.e., personal restraints, drugs used as restraints, mechanical restraints) that are allowed and describe in detail the safeguards that the state has established concerning the use of each type of restraint that is permitted. If the use of specific types of restraint is explicitly prohibited in policy, identify the restraints that are not allowed. For example, personal restraints may be permitted but the use of mechanical restraints prohibited.

For each type of restraint that is allowed, the safeguards should address:

- Requirements concerning the use of alternative strategies to avoid the use of restraints;
- Methods for detecting the unauthorized use of or misapplication of restraints;
- The protocols that must be followed when restraints are employed (including the circumstances when their use is permitted and when they are not) and how their use is authorized;
- The practices that must be employed in the administration of a restraint to ensure the health and safety of individuals;
- Required documentation (record keeping) concerning the use of restraints; and,
- The education and training requirements that provider agency personnel must meet who are involved in the administration of a restraint.

CMS Review Criteria

For each type of restraint permitted, the state has identified safeguards that address:

- The use of alternative methods to avoid the use of restraints;
- Methods for detecting the unauthorized use of restraints;
- The protocols that must be followed when restraints are employed (including the circumstances when their use is permitted) and how their use is authorized;
- The practices that must be employed to ensure the health and safety of individuals;
- Required documentation concerning the use of restraints; and
- Education and training requirements that personnel who are involved in the administration of restraints must meet.

Item G-2-a-ii: State Oversight Responsibility

Instructions

Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed. Describe how this oversight is conducted and its frequency.

Technical Guidance

- **Identify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed**. When the Medicaid agency or the operating agency (if applicable) does not conduct this oversight, describe how the results of monitoring the use of restraints are regularly communicated to the agency that operates the waiver. Since the use of restraints has potential implications for the health and welfare of waiver participants, it is important that the agency that administers the waiver be informed and aware of potential violations of state policies concerning the use of restraints in order for them to undertake appropriate remedial and system improvement activities.
- **How oversight is conducted.** Oversight methods include monitoring the use of restraints to ensure that all applicable state requirements are followed and to detect unauthorized, inappropriate/ineffective use or overuse. Oversight methods should include gathering information about frequency, length of time of each use and the duration of use over time as well as the impact of restraints on the individual. Oversight also includes

using information to assure proper use and to reduce the use of restraints in the future. The response should include:

- How information about restraints is collected and compiled so that it can be analyzed to enable the identification of trends/patterns and the development of quality improvement strategies. For example, reports may be filed by phone, in written form, or through the use of information technology, each of which requires specific practices to collect and then compile and analyze the information;
- How information about the use of restraints is used to identify issues related to the waiver populations, providers at the system-wide level and how that information is used to develop strategies to ensure the proper use and achieve a reduction in the use of restraints; and
- The frequency of oversight activities.

CMS Review Criteria

The response specifies:

- The state agency (or agencies) responsible for overseeing the use of restraints and ensuring that the state's safeguards are followed.
- When oversight is not performed by the Medicaid agency or the operating agency (if applicable), the process for the oversight agency to communicate information and findings to the Medicaid agency and/or operating agency.
- Methods for detecting unauthorized use, overuse or inappropriate/ineffective use of restraints and ensuring that all applicable state requirements are followed.
- How data are analyzed to identify trends and patterns and support improvement strategies.
- The methods for overseeing the operation of the incident management system including how data are collected, compiled, and used to prevent re-occurrence.
- The frequency of the oversight activities.

Item G-2-b: Use of Restrictive Interventions

Instructions

Select one of the two main choices. If the state does not permit the use of restrictive interventions during the provision of waiver services and/or their use is prohibited under state policy, select the first choice. Also, identify the state agency or agencies that are responsible for detecting the unauthorized use of restrictive interventions and how oversight is performed to ensure that unauthorized use does not take place. If the use of restrictive interventions by a paid provider is permitted during the course of providing waiver services, including in the participant's private residence, select the second choice and complete the next two items. Use of restrictive interventions must comport with the home and community-based setting requirements at Section 42 CFR §§ 441.301(c)(4)(iii) and (vi)(F), and person-centered service planning and plan requirements at 42 CFR §§ 441.301(c)(1) and (c)(2).

Technical Guidance

Restrictive interventions limit an individual's movement; a person's access to other individuals, locations or activities, or restrict participant rights. Restrictive interventions also include the use of other aversive techniques (not including restraint or seclusion) that are designed to modify a person's behavior.

When a state prohibits the use of restrictive interventions during the delivery of waiver services, pursuant to 42 CFR § 441.302(a), it still must have specific processes that are designed to detect their unauthorized use.

CMS Review Criteria

- The response is consistent with the remainder of the waiver application.
- When the first choice is selected, the state specifies methods to detect unauthorized use of restrictive intervention, and the state agency (or agencies) responsible for conducting this oversight.
- Use of restrictive interventions must comport with the home and community-based setting requirements at Section 42 CFR §§ 441.301(c)(4)(iii) and (vi)(F), and person-centered service planning and plan requirements at 42 CFR §§ 441.301(c)(1) and (c)(2).

Item G-2-b-i: Safeguards Concerning the Use of Restrictive Interventions

Instructions

Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification need to be available to CMS upon request through the Medicaid agency or the operating agency.

Technical Guidance

The use of restrictive interventions has potential adverse ramifications for the health and welfare of waiver participants. Consequently, when their use is permitted during the course of the provision of waiver services, it is important that there be effective safeguards in place to ensure that such interventions are only used when necessary and are carried out in a manner that avoids harm to the waiver participant.

When the use of restrictive interventions is permitted during the course of the provision of waiver services, identify the types of interventions that are allowed (including the circumstances under which they are allowed) and the types of restrictive interventions that are specifically prohibited. For example, a state may prohibit the use of aversive methods altogether. Do not include here restraints or seclusion that already have been addressed in Item G-2-a and G-2-c.

Describe in detail the safeguards that have been established for each type of permitted restrictive intervention. These safeguards should address:

- First use of non-aversive methods (i.e., a requirement that aversive methods may only be employed as a last resort);
- Methods to detect the unauthorized use of restrictive interventions;
- Protocols for authorizing the use of restrictive interventions, including treatment planning requirements and review/reauthorization procedures (including, as applicable the use of Human Rights Committees);
- Required documentation (record keeping) when restrictive interventions are used; and
- Required education and training of personnel involved in the authorization and administration of restrictive interventions.

CMS Review Criteria

The response specifies:

- The types of restrictive interventions that are permitted, the circumstances under which they are allowed, and the types of restrictive interventions that are not allowed.
- For each type of restrictive intervention that is permitted, the state's safeguards address:
  - First use of non-aversive methods;
  - Methods to detect the unauthorized use of restrictive interventions;
  - Protocols for authorizing the use of restrictive interventions, including treatment planning requirements and review/reauthorization procedures;
  - Required documentation when restrictive interventions are used; and
- Required education and training of personnel involved in authorization and administration of restrictive interventions.

Item G-2-b-ii: State Oversight Responsibility

Instructions

Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions, how this oversight is conducted, and its frequency. When the state does not permit the use of restrictive interventions, the response to this item should focus on how the state detects the unauthorized use of restrictive interventions.

Technical Guidance

- **Identify the state agency (or agencies) responsible for overseeing the use of restrictive interventions and ensuring that state safeguards concerning their use are followed.** When this oversight is not carried out by the Medicaid agency or the operating agency (if applicable), describe how the results of monitoring the use of restrictive interventions are regularly communicated to the agency that operates the waiver. Since use of restrictive interventions has potential implications for the health and welfare of waiver participants, it is important that the agency that administers the waiver be aware of potential violations of state policies concerning the use of restrictive interventions in order for them to undertake appropriate remedial and system improvement activities.
- **How oversight is conducted.** Oversight methods include monitoring the use of restrictive interventions to ensure that all applicable state requirements are followed and detecting their unauthorized, inappropriate/ineffective use or overuse. Oversight methods should include gathering information about frequency, length of time of each use and the duration of use over time as well as the impact of restrictive interventions on the individual. Oversight also includes using information to assure proper use and to reduce the use of restrictive interventions in the future. The response should include:
  - How information about restrictive interventions is collected and compiled so that it can be analyzed to enable the identification of trends/patterns and the development of quality improvement strategies. For example, reports may be filed by phone, in written form, or through the use of information technology, each of which requires specific practices to collect, compile and analyze the information;

- How information about the use of restrictive interventions used to identify issues related to the waiver populations, providers and at the system-wide level and how that information is used to develop strategies to ensure the proper use and achieve a reduction in the use of restrictive interventions in the future; and
- The frequency of oversight activities.

CMS Review Criteria

The waiver specifies:

- The state agency (or agencies) responsible for overseeing the use of restrictive procedures and ensuring that the state's safeguards are followed.
- When oversight is not performed by the Medicaid agency or the operating agency (if applicable), the process for the oversight agency to communicate information and findings to the Medicaid agency and/or operating agency.
- Methods for detecting unauthorized use, overuse or inappropriate/ineffective use of restrictive procedures and ensuring that all applicable state requirements are followed.
- How data are analyzed to identify trends and patterns and support improvement strategies.
- The methods for overseeing the operation of the incident management system including how data are collected, compiled, and used to prevent re-occurrence.
- The frequency of oversight activities.

Item G-2-c: Use of Seclusion

Instructions

Select one of the two main choices. If the state does not permit the use of seclusion as part of the provision of waiver services and/or their use is prohibited under state policy, select the first choice. Also, identify the state agency or agencies that are responsible for detecting the unauthorized use of seclusion and how oversight is performed to ensure that unauthorized use does not take place. If the use of seclusion by a paid caregiver is permitted during the course of providing waiver services, including in the participant's private residence, select the second choice and complete the next two items. Use of seclusion must comport with the home and community-based setting requirements at Section 42 CFR §§ 441.301(c)(4)(iii) and (vi)(F), and person-centered service planning and plan requirements at 42 CFR §§ 441.301(c)(1) and (c)(2).

Technical Guidance

For the purposes of this item, seclusion means involuntarily isolating an individual as a means of controlling the person's behavior. Seclusion is distinguished from "time out" which does not involve preventing a person from leaving an area and which is considered to be a restrictive intervention. Consult the Glossary for the definition of the terms used in this item.

When a state prohibits the use of seclusion during the delivery of waiver services, pursuant to 42 CFR § 441.302(a), it still must have processes that are designed to detect their unauthorized use. Such processes may include regular monitoring of participant health and welfare, the performance of periodic provider quality reviews, and an incident management system in which unauthorized seclusion is a reportable incident.

CMS Review Criteria

- When the first choice is selected, the response is consistent with the remainder of the waiver application.
- When the first choice is selected, the state provides specific methods to detect unauthorized use of seclusion and specifies the state agency (or agencies) responsible for conducting this oversight.
- Use of restrictive interventions must comport with the home and community-based setting requirements at Section 42 §§ CFR 441.301(c)(4)(iii) and (vi)(F), and person-centered service planning and plan requirements at 42 CFR §§ 441.301(c)(1) and (c)(2).

Item G-2-c-i: Safeguards Concerning the Use of Seclusion

Instructions

Specify the safeguards that have been established concerning the use of seclusion. If state laws, regulations, and policies are referenced in the response to this item, they need to be available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

Technical Guidance

When the use of seclusion is permitted, describe in detail the safeguards that the state has established concerning the use of seclusion that is permitted. The safeguards should address:

- Requirements concerning the use of alternative strategies to avoid the use of seclusion;
- Methods for detecting the unauthorized use of or misapplication of seclusion;
- The protocols that must be followed when seclusion is employed (including the circumstances when it is permitted and when it is not) and how its use is authorized;
- The practices that must be employed in the administration of seclusion to ensure the health and safety of individuals;
- Required documentation (record keeping) concerning the use of seclusion; and,
- The education and training requirements that provider agency personnel must meet who are involved in the administration of seclusion.

CMS Review Criteria

For each type of seclusion permitted, the state has identified safeguards that address:

- The use of alternative methods to avoid the use of seclusion;
- Methods for detecting the unauthorized use of seclusion;
- The protocols that must be followed when seclusion is employed (including the circumstances when its use is permitted) and how its use is authorized;
- The practices that must be employed to ensure the health and safety of individuals;
- Required documentation concerning the use of seclusion; and
- Education and training requirements that personnel who are involved in the administration of seclusion must meet.

Item G-2-c-ii: State Oversight Responsibility

Instructions

Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning its use is followed. Describe how this oversight is conducted and its frequency.

Technical Guidance

- **Identify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning its use is followed**. When the Medicaid agency or the operating agency (if applicable) does not conduct this oversight, describe how the results of monitoring the use of seclusion are regularly communicated to the agency that operates the waiver. Since the use of seclusion has potential implications for the health and welfare of waiver participants, it is important that the agency that administers the waiver be informed and aware of potential violations of state policies concerning the use of seclusion in order for them to undertake appropriate remedial and system improvement activities.
- **How oversight is conducted.** Oversight methods include monitoring the use of seclusion to ensure that all applicable state requirements are followed and to detect unauthorized, inappropriate/ineffective use or overuse. Oversight methods should include gathering information about frequency, length of time of each use and the duration of use over time as well as the impact of seclusion on the individual. Oversight also includes using information to assure proper use and to reduce the use of seclusion in the future.
- The response should include:
    - How information about seclusion is collected and compiled so that it can be analyzed to enable the identification of trends/patterns and the development of quality improvement strategies. For example, reports may be filed by phone, in written form, or through the use of information technology, each of which requires specific practices to collect and then compile and analyze the information;
    - How information about the use of seclusion is used to identify issues related to the waiver populations, providers at the system-wide level and how that information is used to develop strategies to ensure the proper use and achieve a reduction in the use of seclusion; and
    - The frequency of oversight activities.

CMS Review Criteria

The response specifies:

- The state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that the state's safeguards are followed.
- When oversight is not performed by the Medicaid agency or the operating agency (if applicable), the process for the oversight agency to communicate information and findings to the Medicaid agency and/or operating agency.
- Methods for detecting unauthorized use, overuse or inappropriate/ineffective use of seclusion and ensuring that all applicable state requirements are followed.
- How data are analyzed to identify trends and patterns and support improvement strategies.
- The methods for overseeing the operation of the incident management system including how data are collected, compiled, and used to prevent re-occurrence.
- The frequency of the oversight activities.

Appendix G-3: Medication Management and Administration

Overview

This section addresses two distinct topics: (a) medication management, which means the review of waiver participant medication regimens (e.g., the appropriateness of the medications that a person receives) and (b) medication administration (the administration of medications to participants who are unable to administer their own medications by waiver providers). Both of these topics have potential ramifications for the health and welfare of waiver participants.

Detailed Instructions for Completing Appendix G-3

Item G-3-a: Applicability

Instructions

Select whether this section applies to the waiver. If it applies, then complete the remainder of the section. If not, do not complete the rest of the section.

Technical Guidance

Pursuant to 42 CFR § 441.302(a), this question must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The question does not need to be completed when waiver participants are served exclusively in their own private residences or in the home of a family member. However, a state may include this Appendix if it wishes. This may be the case when supporting waiver participants who live in their own private residences or the home of a family member entails the involvement of waiver providers in the management and/or administration of their medications.

Item G-3-b: Medication Management and Follow-Up

Medication management means the review of a participant's full medication regimen to ensure its appropriateness. When individuals receive medications for the purpose of modifying or controlling behavior, the state is expected to have policies and procedures concerning the effective use and management of such medications. Medication management also is relevant when a participant receives multiple medications in order to guard against over or inappropriate medication.

Item G-3-b-i: Responsibility

Instructions

Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

Technical Guidance

First-line responsibility for monitoring participant medication regimens resides with the medical professionals who prescribe medications. The response to this item should identify the entity or entities that conduct second-line monitoring.

This second-line monitoring may or may not be conducted by a state agency. Entities responsible for second-line monitoring may include licensing agencies, case or care managers, or others. Monitoring also might include the review of medication regimens by Medicaid agency utilization review staff or contractors. Pursuant to 42 CFR § 441.302(a), when behavior-modifying medications are employed, second line monitoring responsibility must be specified. It is not expected that in-depth monitoring will be conducted in the case of medications that are prescribed for the short-term treatment of an illness.

Pursuant to 42 CFR § 441.302(a), the response must describe how second-line monitoring is conducted, by whom and how frequently (e.g., periodic review of medication regimens by a care manager or nurse). Monitoring methods should be designed to detect potentially harmful practices and provide for follow-up to address such practices. Specify whether monitoring has been designed to focus on waiver participants who have especially complex medication regimens or who are prescribed behavior-modifying medications as part of their treatment programs. Monitoring may be conducted as part of the periodic monitoring of participant health and welfare.

CMS Review Criteria

The waiver specifies:

- The entity or entities responsible for ongoing monitoring of participant medication regimens.
- The scope of monitoring (i.e., whether monitoring is designed to focus on certain types of medications or medication usage patterns).
- Methods for conducting monitoring.
- Frequency of monitoring.
- How monitoring has been designed to detect potentially harmful practices and follow-up to address such practices.
- How second-line monitoring is conducted on the use of behavior modifying medications.

Item G-3-b-ii: State Oversight and Follow-up

Instructions

Describe how the state oversees or monitors second-line medication management processes to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and (c) the state agency (or agencies) responsible for follow-up.

Technical Guidance

Provide an overview of how the state oversees the performance of second-line medication monitoring processes to ensure that potentially harmful practices are identified and addressed. Specify the state agency (or agencies) responsible for this oversight and how frequently oversight is performed. If the Medicaid agency or operating agency (if applicable) does not directly conduct this oversight, describe how oversight results are regularly shared with the agency that administers the waiver program.

If improvements in oversight are planned during the period that the waiver is in effect, such improvements should be briefly identified here and described in more detail in Appendix H.

CMS Review Criteria

The waiver specifies:

- The state agency (or agencies) responsible for oversight.
- When oversight is not conducted by the Medicaid agency or the operating agency (if applicable), the process to communicate information and findings from monitoring are regularly communicated to the Medicaid agency and the operating agency (if applicable).
- How state monitoring is performed and how frequently.
- How the state monitoring program gathers information concerning potentially harmful practices and employs such information to improve quality.

Item G-3-c: Medication Administration by Waiver Providers

This item concerns the administration of medications by waiver providers to waiver participants who are not able to self-administer their medications or the oversight by waiver providers of participant self-administration of medications.

Item G-3-c.i: Provider Administration of Medications

Instructions

Select the "yes" response when waiver providers administer medications or oversee the self-administration of medications by waiver participants. Complete the remainder of the item. If waiver providers do not administer medications or oversee self-administration, select the second response. Do not complete the remainder of the item.

Item G-3-c.ii: State Policy

Instructions

Summarize the state policies that apply to administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical personnel. State laws, regulations, and policies that are referenced in the summary need to be available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Technical Guidance

When waiver providers administer medications to participants who are unable to self-administer, states typically have adopted formal policies (in law and/or regulation) that govern this practice. The response to this item should summarize the applicable policies, including whether administration is restricted to licensed medical personnel or may be performed by non-medical

waiver provider personnel. In the case of the latter, the summary should identify the training/education that such personnel must have in order to administer medications and the extent of oversight by licensed medical professionals that is performed. The summary also should describe the state's policies with respect to waiver providers overseeing the self-administration of medications by waiver participants.

CMS Review Criteria

The waiver specifies:

- Policies concerning the administration of medications to individuals who are unable to self-administer and the responsibilities of providers for overseeing self-administration.
- If applicable, the training/education that non-medical waiver providers must have in order to administer medications to participants who cannot self-administer and the extent of the oversight of these personnel by licensed medical professionals.

Item G-3-c.iii: Medication Error Reporting

Instructions

Select whether providers who administer medications to waiver participants who are unable to self-administer must both record and report medication errors to a state agency. If this choice is selected, specify the state agency to which errors are reported and the types of medication errors that providers must: (a) record and (b) report. If providers are required to record errors but not report them to a state agency, select the second choice and specify the types of errors that providers must record. If providers are not required to record and/or report errors or waiver providers do not administer medications but only oversee their self-administration by waiver participants, select the "not applicable" choice.

Technical Guidance

Medication error recording and reporting are important medication administration quality assurance/improvement tools. In some states, providers are required to record medication errors and report some or all errors to a state agency. In other states, providers are required to record but not report errors (in this instance, recorded errors may be reviewed during a periodic provider quality review). Medication errors include such errors as wrong dose, wrong time, wrong route, wrong medication or missed medication.

CMS Review Criteria

If applicable, the waiver specifies:

- The types of medication errors that providers must record and/or report.
- When reporting is required, the agency to which errors must be reported is specified.

Item G-3-c.iv: State Oversight Responsibility

Instructions

Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants who are unable to self-administer, how monitoring is performed and its frequency.

Technical Guidance

Here, describes how the performance of waiver providers in administering medications is monitored. If monitoring is not performed by the Medicaid agency or the operating agency (if applicable), describe how monitoring results are regularly communicated to the agency that is responsible for administering the waiver.

Monitoring may take the form of reviewing provider records or analyzing provider-reported errors. The response should indicate how frequently monitoring of medication administration is conducted. A state also may have linked the reporting of specific types of medication errors to its critical incident management system. Describe how this monitoring is designed to identify problems in provider medication administration, support remediation as appropriate and contribute to quality improvement efforts in this arena.

The response should describe how information about medication monitoring is compiled and explain how the collection of these data supports the identification of trends/patterns and the development of quality improvement strategies.

CMS Review Criteria

The waiver specifies:

- The state agency (or agencies) responsible for the on-going monitoring of waiver provider agencies' performance in administering participant medications.
- When oversight is not conducted by the Medicaid agency or the operating agency (if applicable), the process to communicate information and findings to the Medicaid agency or the operating agency.
- Monitoring methods include the identification of problems in provider performance and support follow-up remediation actions and quality improvement activities.
- How data are acquired to identify trends and patterns and support improvement strategies.

Quality Improvement: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.

The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.

The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.

State policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.

The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.

Instructions

The QIS describes how the state Medicaid Agency will determine that each waiver assurance (and its associated component elements) is met. The waiver assurance is listed above. For each assurance, CMS expects the description will include:

- Activities or processes that are related to *discovery and remediation*, i.e., review, assessment or monitoring processes; who conducts the discovery or remediation activities and with what frequency, and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. These monitoring activities provide the foundation for quality improvement by generating information regarding compliance, potential problems and individual corrective actions. The information can be aggregated and analyzed to measure the overall system performance in meeting the waiver assurances. The types of information used to measure performance, should include relevant quality measures/indicators.
- The entity or entities responsible for reviewing the results (data and information) of discovery and remediation activities to determine whether the performance of the system reflects compliance with the assurances; and
- The frequency at which system performance is measured.

Technical Guidance

This QIS element focuses on discovery and remediation activities, that is, processes to assess, review, evaluate or otherwise analyze a program, process, operation, or outcome. Specifically, the evidence produced as a result of discovery and remediation activities should provide a clear picture of the state's compliance in meeting an assurance.

CMS Review Criteria

The discovery of compliance with this assurance and the remediation of identified problems must address:

- How the Medicaid agency assures compliance with the following health and welfare assurance:
  - The state, on an on-going basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation**.**
- How frequently oversight is conducted; and
- The entity (or entities) responsible for the discovery and remediation activities.

Appendix H: Systems Improvement

Detailed Instructions for Completing Appendix H

Quality Improvement Strategy

The initial quality improvement strategy (QIS) is submitted as part of the waiver application. When the waiver is renewed, an updated QIS is submitted as part of the waiver application. Modifications or updates to the QIS are submitted to CMS as part of the state's Annual Report on Home and Community-Based Services Waivers (HCFA 372(S) form), required under the provisions of 42 CFR § 441.302(h).

The state has been asked to provide components of a QIS in the appendices of the application as follows:

- The measures and processes the state will use to determine that each waiver assurance is met during the period that the waiver is in effect (discovery);
- The measures and processes employed to correct identified problems (remediation);

- The roles and responsibilities of the parties involved in measuring performance and making improvements;
- The processes employed to aggregate and analyze trends in the identification and remediation of problems;
- The processes employed to establish priorities, develop strategies for, and assess implementation of system improvements (system improvement);
- The process and timelines for compiling the information and communicating to waiver participants, families, service providers, other interested parties, and the public; and
- The frequency and processes used to evaluate and revise the QIS.

Additionally, Appendix H asks the state to describe:

- How information about performance is used to identify and prioritize areas for system improvement;
- How quality improvement information is compiled and communicated; and
- The process that the state will follow to assess the effectiveness of both the system improvement and the QIS and revise it as necessary and appropriate.

General Instructions

Instructions

Planned Quality Improvements. A state may not have a fully developed QIS when the waiver application is submitted. For example, a state may not have a system to compile information about the occurrence of and response to critical incidents but may plan to design and implement such a system during the period the waiver is in effect. Or a state may plan to create a quality improvement council to identify and prioritize quality improvement activities but does not expect the council to be established prior to the effective date of the waiver renewal. When elements of the QIS are not in place in a submitted application but will be developed and implemented during the period the waiver is in effect, the QIS should include a detailed work plan with specific steps and timelines for addressing the gap(s). The work plan should describe at minimum the specific tasks to be undertaken, major milestones associated with completing each task, estimated timeline for completion, and the entity (or entities) responsible for completing the tasks.

Multiple Waivers. It may be more efficient and effective for a QIS to span multiple HCBS waivers and other related long-term care services, especially when a state operates more than one waiver that serves the same or similar waiver target groups or multiple waivers employ similar quality improvement methods. While the QIS may span multiple waivers and/or other Medicaid long-term services, it must be designed to ensure it encompasses all requirements and assurances specific to each waiver. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information for each approved waiver program, i.e., employ a representative sample for each waiver. Also include: (a) the control numbers for the other waivers and (b) the other Medicaid long-term services to which the QIS applies.

Concurrent Managed Care/Section 1915(c) Waivers. When a section 1915(c) waiver operates concurrently with a Medicaid managed care authority, the quality-related requirements under each authority must be met in their own right. The managed care quality requirements do not supplant the section 1915(c) requirements and *vice versa*. In general, the Section 1915(c) waiver assurances are not addressed in the managed care authority application and, hence, must be addressed in the QIS. However, if there is information in the managed care authority application

that is pertinent to addressing a waiver assurance, include a reference to that section/item that is in the managed care authority application.

CMS Review Criteria

When the state does not have a fully developed quality improvement strategy, there is a work plan that addresses each element where improvements will take place during the waiver period including the following:

- Specific tasks associated with the improvement.
- Major milestones and dates for completing the improvements.
- The entity (or entities) responsible for completing these tasks.

When the QIS spans more than one waiver and/or other types of long-term care services under the Medicaid state Plan, the QIS:

- Stratifies information for each respective waiver.
- Provides control numbers of the other waivers.
- Provides the other long-term care services addressed in the QIS.

Quality Improvement Strategy: Systems Improvement

The initial QIS is submitted as part of the waiver application. When the waiver is renewed, an updated QIS is submitted as part of the waiver application. Modifications or updates to the QIS are submitted to CMS as part of the State's Annual Report on Home and Community-Based Services Waivers (CMS 372(S) form), required under the provisions of 42 CFR § 441.302(h).

In its application the state has been asked to provide components of a Quality Improvement Strategy (QIS) in the appendices of the application as follows:

- The measures and processes the state will use to determine that each waiver assurance is met during the period that the waiver is in effect (discovery);
- The measures and processes employed to correct identified problems (remediation);
- The roles and responsibilities of the parties involved in measuring performance and making improvements; and
- The processes employed to aggregate and analyze trends in the identification and remediation of problems.

Appendix H specifically asks the state to identify:

- The processes employed to establish priorities, develop strategies for, and assess implementation of system improvements (system improvement);
- The process and timelines for compiling the information and communicating to waiver participants, families, service providers, other interested parties, and the public;
- The frequency and processes used to evaluate and revise the QIS;
- How and by whom information about performance is used to identify and prioritize areas for system improvement;
- How quality improvement information is compiled and communicated;
- The process that the state will follow to assess the effectiveness of both the system improvement and the QIS and revise it as necessary and appropriate; and
- Information that the state gathers on participants' experience of care, if any.

Detailed Instructions for Completing Appendix H

Instructions

The Quality Improvement Strategy must describe roles and responsibilities of the parties involved in discovery, remediation, and improvement activities. In other appendices, the state has described the roles and responsibilities of parties involved in discovery and remediation. In Appendix H, the description should include the roles and responsibilities of the Medicaid agency, operating agency and non-state entities (as applicable), other state agencies, participants, families and advocates, providers, and other contractors (if appropriate) in effectuating the processes in the quality improvement strategy such as collecting and analyzing individual and system-level information, determining whether the waiver requirements and assurances are met, implementing remediation, and planning system improvement activities.

The focus of Appendix H is on identifying who is involved in appraising the state's performance in meeting the waiver assurances based on the results of discovery processes. The parties involved in performance appraisal may vary by assurance, depending on the nature of the assurance. The state may organize the involvement of individuals and entities in any number of ways including, but not limited to, establishing a quality improvement unit, forming quality improvement councils, and establishing standing committees. It is not necessary that the Medicaid agency directly conduct every aspect of the quality improvement strategy. However, since the QIS revolves around meeting the waiver assurances, it is necessary that the Medicaid agency be the source of the delegation of activities in the QIS, and the recipient of the monitoring, remediation and system improvement reports that pertain to meeting the assurances. The Medicaid agency must also perform its own monitoring of all delegated activities.

CMS Review Criteria

The QIS describes the roles and responsibilities of entities and persons involved in collecting and analyzing information derived from discovery and remediation activities (described in other appendices), recommending system improvements, and analyzing the effectiveness of the improvement initiatives.

QIS Processes to Establish Priorities, Develop, and Assess System Improvements

Instructions

The QIS must describe the processes employed to review findings from its discovery and remediation activities, to establish priorities for system improvement, and to evaluate the effectiveness of the improvements.

Technical Guidance

The purpose of state performance appraisal is to identify areas that warrant improvement. While remediation often addresses correction of individual situations, system improvements result from the analysis of the discovery and remediation activities. Often, the appraisals identify many potential opportunities for system improvement. CMS recognizes that it may be necessary to prioritize the design and implementation of system improvement strategies.

Appendix H asks for a description of how the state will identify, prioritize and develop strategies for system improvements. This is likely to involve multiple approaches, including the use of researchers, special advisory consultants, research organizations, and consumer and/or provider focus groups. The focus here is on describing the process the state will follow during the waiver

period, to identify the improvement initiatives it will pursue. The results of these initiatives will be reported in the CMS annual report.

CMS Review Criteria

The QIS describes the processes that are employed to review findings, establish priorities, develop strategies, and assess effectiveness of system improvements.

Compilation and Communication of Quality Improvement Information

Instructions

In Appendix H, the Quality Improvement Strategy must describe how the state compiles quality improvement information and the frequency with which the state communicates this information (in report or other forms) to waiver participants, families, waiver services providers, other interested parties and the public.

Technical Guidance

List and briefly summarize the major types of quality improvement information that will be prepared during the period the waiver is in effect. Indicate for each source of information, the topic addressed, the frequency with which it is developed and communicated, and the primary audience (i.e., the groups for which the report(s) are prepared). Quality improvement information may be designed to focus on specific areas of concern; may be related to a specific location, type of service or subgroup of participants; may be designed as administrative management reports; and/or may be developed to inform stakeholders and the public. Describe how quality improvement results are communicated to other agencies, participants, families, waiver providers, other interested parties, and the public. Results may be posted to a website. Not all sources of information need be disseminated to each stakeholder group.

Reports may be targeted to specific entities for the purpose of ongoing quality improvement such as routine incident management summary reports issued to providers for response and action or reports issued to Medicaid agency by the operating agency on compliance with assurance requirements.

CMS Review Criteria

The QIS describes:

- The types of quality improvement reports that are compiled.
- The frequency with which such reports are compiled.
- How results are communicated, and with what frequency, to agencies, waiver providers, participants, families and other interested parties, and the public.

Periodic Evaluation and Revision of the QIS

Instructions

Describe the process to periodically evaluate and revise, as appropriate, the quality improvement strategy.

Technical Guidance

Quality improvement strategies are dynamic. They can and do change over time in response to changing needs and conditions in the waiver program/state. Because of this dynamic nature, it is important for states to periodically evaluate their QI strategies. The results of the evaluation

might demonstrate the need to change priorities, use different approaches to measure progress, modify roles and responsibilities of key entities, and modify data sources in order to retrieve the information needed for measurement.

In this section, briefly describe the process that will be used to periodically evaluate the QIS and the frequency with which the evaluation/re-evaluation will occur. The description should also identify the key entities involved in the evaluation. It is up to the state to determine the frequency for evaluating the QIS. However, the QIS should be evaluated at least once during the waiver period and evaluated in advance of the submission of the waiver renewal application.

If the result of the evaluation process is revision of the QIS, the revised QIS should be communicated to CMS as part of the submission of the annual waiver report.

CMS Review Criteria

The QIS describes the process and frequency for evaluating and updating the QIS (i.e., once during the waiver period and prior to renewal).

Appendix I: Financial Accountability

Brief Overview

This appendix addresses the following financial elements of HCBS waiver operations:

- Financial Integrity and Accountability (Appendix I-1)
- Rates, Billings and Claims (Appendix I-2)
- Payments (Appendix I-3)
- Non-Federal Matching Funds (Appendix I-4)
- Exclusion of Medicaid Payment for Room and Board (Appendix I-5)
- Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver (Appendix I-6)
- Participant Co-Payments for Waiver Services and Other Cost Sharing (Appendix I-7)

NOTE: When an HCBS waiver operates concurrently with a Medicaid managed care authority and waiver services are furnished through managed care entities (e.g., MCOs, PIHPs or PAHPs), the responses to several items in Appendices I-1, I-2 and I-3 are affected. The instructions contain guidance about how responses to the certain items are affected when there is a concurrent waiver.

APPENDIX I-1: Financial Integrity and Accountability

Detailed Instructions for Completing Appendix I-1

Instructions

In the text field, describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the post-payment review program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of reviews that are conducted; and, (c) the agency (or agencies) responsible for conducting the periodic independent audit of the waiver program as required by the Single Audit Act.

Technical Guidance

This item focuses on how the state assures the integrity of payments made for waiver services. It concentrates on post-payment review activities rather than on the methods of ensuring the validity of provider billings prior to payment (those methods are addressed in Item 2-d below).

Pursuant to section 1902(a)(30)(A) of the Act and the related federal regulations at 42 CFR §§ 447.200-205, the description must address each of the following:

- **State requirements concerning the independent audit of provider agencies.** Specify whether waiver providers are required to secure an independent audit of their financial statements.
- **The state's own post-payment review program to ensure the integrity of provider billings for Medicaid payment of waiver services.** Describe the post-payment review activities that are used for *each* waiver service. The same review activities may be used for several waiver services. When this is the case, the description may group the services to which the same methods apply. In instances in which post-payment review activities differ by service type, states must clearly describe the differences pursuant to section 1902(a)(30)(A) of the Act and the related federal regulations at 42 CFR §§ 447.200-205. If the state documents fiscal integrity measures for self-directed services elsewhere in the application, it is not necessary to repeat that information if a reference to the appropriate appendix is provided. For each post-payment activity, the waiver application should address:
    - Methods for reviewing paid claims. A post-payment review program might include testing a sample of provider billings to ensure that they are properly supported by documentation of the actual provision of waiver services or the review of provider cost accounting systems to ensure that, when rates are based on provider costs, costs have been properly recorded and do not include unallowable expenses.
    - Methods for addressing findings. Describe how the results of reviews are communicated to providers. If the state requires corrective action plans from providers, specify how the state ensures corrective action plans are followed. When post-payment reviews identify retractable claims, the state must remove the claim from its FFP calculation and recoup the inappropriate payment.
    - Scope of the review. Describe how claims or records are selected for review. For example, the scope of a post-payment review might be the last six months of claims for a representative sample of providers, or a representative sample of claims for providers identified through a risk analysis.
    - Frequency of the review. Define how often post-payment activities are conducted. If the state does not perform post-payment activities at specific intervals, explain specific reasons and thresholds that would initiate a post-payment review.
- The state agency (or agencies) responsible for conducting the state's post-payment review activities. If post-payment reviews are conducted by contractors, specify the state agency responsible for overseeing contractor performance. If multiple agencies and/or contractors are performing post-payment reviews, then describe each agencies' method,

scope, and frequency of the post-payment reviews and ways to prevent any duplicative, unnecessary efforts during the review process.

- The state agency (or agencies) responsible for conducting the state's independent financial audit in accordance with the Single Audit Act. HCBS waivers (like other Medicaid services) also are subject to requirements of the Single Audit Act (31 U.S.C. 7501-7507) as amended by the Single Audit Act Amendments of 1996 (P.L. 104-146). If the financial audit program is conducted by contractors, specify the state agency responsible for overseeing contractor performance.

If the description cites applicable state laws, regulations, and policies, the documents cited must be readily available through the Medicaid agency or the operating agency (if applicable) when requested by CMS.

Section1915(c) Waivers that Operate with Concurrent Medicaid Managed Care

When the HCBS waiver operates concurrently with a Medicaid managed care authority, such as a section 1915(b) waiver, and waiver services are furnished through managed care entities (e.g., MCOs, PIHPs or PAHPs), the managed care authority financial accountability requirements apply. Under such arrangements, the state does not make payments directly to waiver providers but instead pays a capitated payment rate to the managed care entity for the delivery of waiver services and the entity in turn pays other providers (except, if applicable, services that are furnished on a fee-for-service basis outside the capitated rate). Alternative methods are used to ensure financial accountability, including ensuring that payments are only made to a managed care entity only for eligible persons who have been properly enrolled in the waiver. Therefore, the description of the methods to ensure payment integrity should only briefly address the methods to ensure the integrity of payments to managed care entities unless payments are also made on a fee-for-service basis for some waiver services outside the capitation rate. The summary may include references to the managed care authority application or provisions of the state's contract with managed care entities.

CMS Review Criteria

The waiver:

- Specifies whether providers are required to secure an independent audit of their financial statements.
- Describes the state's post-payment review program, including the methods, frequency, and scope of reviews.
- Provides for a post-payment review program that is adequate to assure the integrity of payments.
- Specifies responsibilities for conducting post-payment review activities.
- Identifies the entity responsible for conducting the periodic independent audit of the waiver program under the provisions of the Single Audit Act.

In the case of section 1915(c) waivers that operate with a concurrent Medicaid managed care authority, the foregoing criteria apply only to services not included in the capitation rate. Managed care requirements and criteria apply to ensuring financial accountability of payments made to managed care entities and this information is included under the appropriate managed care authority.

Quality Improvement: Financial Accountability

The state must demonstrate that it has designed and implemented an adequate system for insuring financial accountability of the waiver program.

The state provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.

The state provides evidence that rates remain consistent with the approved rate methodology throughout the five-year waiver cycle.

Instructions

The QIS must describe how the state Medicaid agency will determine that each waiver assurance (and its associated component elements) is met. The waiver assurance and component elements are listed above. For each component element, this description must include:

- Activities or processes that are related to *discovery and remediation*, i.e., review, assessment or monitoring processes; who conducts the discovery or remediation activities and with what frequency, and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. These monitoring activities provide the foundation for quality improvement by generating information regarding compliance, potential problems and individual corrective actions. The information can be aggregated and analyzed to measure the overall system performance in meeting the waiver assurances. The types of information used to measure performance, should include relevant quality measures/indicators.
- The entity or entities responsible for reviewing the results (data and information) of discovery and remediation activities to determine whether the performance of the system reflects compliance with the assurances; and
- The frequency at which system performance is measured.

Technical Guidance

This QIS element focuses on *discovery* and *remediation* activities, that is, processes to assess, review, evaluate or otherwise analyze a program, process, operation, or outcome. Specifically, the evidence produced as a result of discovery and remediation activities should provide a clear picture of the state's compliance in meeting an assurance.

CMS Review Criteria

The discovery of compliance with this assurance and the remediation of identified problems must address:

- How the Medicaid agency assures compliance with the following assurance:
  - State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.
- How frequently oversight is conducted; and
- The entity (or entities) responsible for the discovery and remediation activities.

APPENDIX I-2: Rates, Billing and Claims

Overview

This Appendix addresses the following topics: (a) waiver service rate determination methods; (b) the flow of provider billings (a.k.a., provider claims for payment for services furnished to waiver participants) to the state; (c) the practice of certifying public expenditures; (d) processes for validating provider payments; and (e) billing maintenance requirements.

Detailed Instructions for Completing Appendix I-2

Item I-2-a: Rate Determination Methods

Instructions

In the text field and in two pages or less (no more than 12,000 characters), describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process for establishing rates. Describe the state's rate review process to ensure that payment rates remain in compliance with section 1902(a)(30)(A) of the Act (i.e., "payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers"). If different methods are employed for various types of services, the description may group services where the same method is employed. If the state discusses rate-setting information specific to participant directed services in other appendices of the application, provide a reference to this information, or describe the rate setting methodology in detail in this section.

Technical Guidance

Waiver payment rates may be determined in a variety of ways and frequently the methods that are employed vary by type of service. While rate determination methods may vary, payments for waiver services (like other Medicaid services) must be consistent with the provisions of section 1902(a)(30)(A) of the Act and the related federal regulations at 42 CFR §§ 447.200-205. The state should have a monitoring process to ensure that these requirements are met. States must review their rate setting methodology, at minimum, every five years to ensure that rates are adequate to maintain an ample provider base and to ensure quality of services. This rate review process can encompass a variety of rate review methods. For example, a state could elect to rebase their existing rate setting methodology. Rate rebasing would involve evaluating an existing fee schedule rate setting methodology and adjusting or updating individual rate components with more current data. States must describe their rate review process. The state's description of the rate review process should include:

- When rates were initially set and last reviewed;
- How the state measures rate sufficiency and compliance with section 1902(a)(30)(A) of the Act;
- The rate review method(s) used; and
- The frequency of rate review activities.

Rates may be prospective or provide for retrospective cost settlement of interim rates. Rates may be established by maintaining a state established fee-for-service schedule. If the state uses a fee-for-service schedule, the rate model (i.e., underlying cost factors and assumptions) must be readily available through the Medicaid agency or operating agency (if applicable) when requested by CMS. The state may submit this information to CMS under "Additional Needed

Information (Optional)" under the Main Module Section of the application if there is not a space available in the Appendix I-2-a. CMS may request the rate model from the state during the informal or formal RAI process. Rates may incorporate "difficulty of care" factors to take into account the level of provider effort associated with serving individuals who have differing support needs; rates may also include geographic adjustment factors to reflect differences in the costs of furnishing services in different parts of a state. If state-established rates vary for different providers of a waiver service, indicate the basis for the variation. The same rate determination method may be used for several waiver services. When this is the case, the description may group the services to which the same method applies. When a service is available for participant direction, the state must expressly state whether the rate determination method differs from the methodology used when the service is provider-managed. If the rate determination method differs, the state must document how it differs. State laws, regulations or policies cited in this description must be readily available through the state Medicaid agency or the operating agency (if applicable) when requested by CMS.

Participant Direction. When a service may be participant directed, describe whether the method of rate determination in any way differs from the methodology that is utilized when service is provider managed.

Pursuant to section 1902(a)(30)(A) of the Act and the related federal regulations at 42 CFR §§ 447.200-205, a state must have uniform rate determination methods or standards that apply to each waiver service. Rates may be established by the operating agency so long as they are in accordance with methods or standards that have been adopted or approved by the Medicaid agency. The same methods or standards must be applied in all jurisdictions where waiver services are furnished. When local government agencies establish provider payment rates, the rates must be determined employing the uniform methods or standards that have been adopted by the state in order to ensure that payments across all areas of the state are equivalent (differences in rates are based on factors specified in the methodology or formula – e.g., difficulty of care or geographic adjustment factors). The description of rate determination methods must clearly identify the entity (or entities) that perform the rate determination function and the oversight process that is employed to assure the integrity of the rate setting activity (i.e., the methodology is adhered to and any differences in rates for a waiver service are consistent with the methodology). Also, describe the extent to which public comment is solicited concerning rate determination methods.

Also, describe how the state makes information available about payment rates available to waiver participants so that they are aware of the costs of waiver services.

Section1915(c) Waivers that Operate with Concurrent Managed Care

When the HCBS waiver operates concurrently with a managed care authority (sections 1915(b),1932(a),1115) and waiver services are furnished through managed care entities (e.g., MCOs, PIHPs or PAHPs), the state establishes a capitation (per member per month) payment rate that it makes the managed care entity. The managed care entity then establishes the payments it makes to waiver providers who furnish services to waiver participants. For these managed long-term services and supports (MLTSS) programs, or for programs that include MLTSS as part of an integrated care delivery system, the managed care capitation rates are actuarially certified and approved by the CMS Division of Managed Care Policy, Division of Managed Care Operations, and Office of the Actuary. When such arrangements are in effect,

only describe the rate setting methods that are employed for the waiver services that are not included in the capitation rate (i.e., services that will continue to be furnished on a fee-for-service basis). Do not describe how the capitation rate is established. Instead, simply make reference to the concurrent managed care authority application and associated materials.

Administrative Claiming

Some services such as case management, supports broker, and FMS may be provided as a Medicaid administrative activity rather than as a waiver service. The state needs to ensure that the administrative costs, necessary for the efficient administration of the Medicaid state plan, are in accordance with the approved cost allocation plan. Please note that cost allocation plans are not approved via approval of the HCBS waiver application.

CMS Review Criteria

The waiver:

- Describes the rate setting method that it used for *each* waiver service. If rates are not uniform for every provider of a waiver service, the waiver describes the basis for the variation.
- Describes the rate setting methodology for self-directed services, if applicable.
- Specifies the entity (or entities) responsible for rate determination and how oversight of the rate determination process is conducted.
- Specifies the year rates were set and the year in which rates were last reviewed.
- Describes how the Medicaid agency solicits public comments on rate determination methods.
- Describes how information about payment rates is made available to waiver participants.
- Describes the state's rate review methods and processes.

In the case of waivers with approved concurrent managed care authority (e.g., 1915(b), 1932(a), 1115), the foregoing criteria apply only to services not included in the capitation rate. The method of determining the capitation rate is subject to managed care requirements and criteria.

Item I-2-b: Flow of Billings

Instructions

Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities.

Technical Guidance

Indicate whether billings for waiver services flow directly from service providers to the state's Medicaid claims processing system (MMIS) or pass through intermediate entities (e.g., an Organized Health Care Delivery System, a FMS entity, a local government agency (e.g., county), a state agency or via another route). If the flow of billings differs among types or classes of waiver services, describe each flow of billings. The description should provide a clear picture of how a provider invoice becomes a claim for Medicaid payment.

There is no federal requirement that all waiver provider billings must flow directly from the waiver provider to the state. Alternative arrangements may be made to flow billings through intermediate entities (e.g., public or private local management entities or a limited fiscal agent). The various types of alternative arrangements that may be employed are subject to other federal requirements. Pursuant to section 1902(a)(32) of the Act, a state must provide that a provider may bill Medicaid directly rather than require that all billings flow through an intermediate entity such as an OHCDS, a county or local government, etc.

Section1915(c) Waivers that Operate with Concurrent Managed Care

When the HCBS waiver operates concurrently with a managed care authority and waiver services are furnished through managed care entities (e.g., MCOs, PIHPs or PAHPs), provider billings flow to the managed care entity except for services that are furnished on a fee-for-service basis outside the capitation (per member per month) payment to the managed care entity. Only describe the flow of billings for services that are furnished on a fee-for-service basis. Indicate that managed care entity billings to the state are made in accordance with the provisions of the managed care authority and provider billings to the managed care entity are made in the terms of the provider's contract with the managed care entity.

CMS Review Criteria

The waiver:

- Describes the flow of billings from the waiver service provider to the state so that it is clear how a provider invoice becomes a claim to Medicaid.
- Provides for the direct provider billing of waiver services to the state, or the option of direct provider billing of waiver services to the state.

In the case of section 1915(c) waivers that operate with a concurrent Medicaid managed care authority, the foregoing criteria apply only to services not included in the capitation rate. Otherwise, flow of billings is subject to managed care requirements and criteria.

Item I-2-c: Certifying Public Expenditures

Instructions

Select whether Certified Public Expenditures (CPEs) are made for waiver services and, if so, whether the CPEs are made by state and/or local government agencies, specifying: (a) the local government agencies that make the CPEs; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the CPEs are eligible for federal financial participation in accordance with 42 CFR § 433.51(b).

Technical Guidance

In some instances, a state or local government agency directly incurs the costs of furnishing waiver services and submits its costs (termed "certified public expenditures" or CPEs) to the Medicaid agency in lieu of providers billing the services directly to the Medicaid agency. For example, a state agency or county that contributes part or all of the cost of service may directly pay provider billings for waiver services on behalf of the Medicaid agency and then submit the total amount it paid for waiver services to the Medicaid agency via a CPE. The CPE serves as the basis for the Medicaid agency's claim to CMS for federal financial participation (FFP). The Medicaid agency would submit the CPE to CMS and FFP would be available as a percentage of the total cost incurred/payments made by the state or local government agency. The Medicaid agency payment to the state or local government agency would be the federal share of waiver

costs. *[N.B., CPEs also are addressed in Appendix I-4 where the sources of funds that underlie the CPEs must be detailed.]*

When CPEs are made as part of the state's claim for FFP, the state must have a process to assure that the CPE is based on total *computable* costs for waiver services. This means the CPE represents the total costs incurred/payments made by the state or local government agency and that FFP is available as a percentage of these total costs incurred/payments made. In addition, the CPE is net of any third party recoveries for the cost of services and/or waiver participant financial liability computed under post-eligibility treatment of income requirements). This process must be described in the response to this item. Finally, the state must have a process to verify that the CPEs are eligible for FFP in accordance with 42 CFR § 433.51(b). This process also must be described in the response to this item.

CMS Review Criteria

When CPEs are made, the waiver specifies:

- The state and/or local government agencies that certify the expenditures.
- The processes used to ensure that CPEs are based on total computable waiver costs.
- The processes to verify that the CPEs are eligible for federal financial participation.

Item I-2-d: Billing Validation Process

Instructions

In the text field, describe the process or processes that are employed to validate provider billings that are included in the state's claim for federal financial participation.

Technical Guidance

"Billing validation" means pre-payment and other processes that are designed to ensure that the provider's billing for waiver services meets essential tests and that only valid billings are included in the state's claim for federal financial participation. The essential tests are: (a) the individual was eligible for the Medicaid waiver payment on the date of service; (b) the service billed was included in the participant's approved service plan; and (c) the services were provided. Billing validation is essential for ensuring the integrity of payments for Medicaid services.

Billing validation may entail using the MMIS to validate claims (e.g., verifying that the individual for whom the billing was made was eligible for Medicaid on the date of service) and/or additional pre-payment audit activities conducted by other entities (e.g., verifying tha**t** the service billed was included in the participant's service plan). States have many pre-payment billing validation options, including:

- Predictive modeling;
- Pre-payment reviews;
- Visit verification systems;
- Third party liability processes; and
- Case management systems that interface eligibility, service plan and claims data.

Some billing validation processes may be conducted post-payment (e.g., surveillance and utilization review), including verification that the service billed was actually rendered. When a validation process that is conducted post-payment reveals a problem with a billing, the state is expected to remove the problem billing from its claim for FFP and recoup the inappropriate payment. For post-payment activities, the state may reference its response to Appendix I-1 of the waiver application.

CMS Review Criteria

The billing validation methods address the three essential tests (below):

- The individual was eligible for Medicaid waiver payment on the date of service;
- The service was included in the participant's approved service plan; and,
- The services were provided.

Item I-2-e: Billing and Claims Record Maintenance Requirement

Instructions

No response required.

Technical Guidance

Adequate records and information must be maintained to support financial accountability. In accordance with 45 CFR § 75.361, records and additional documentation to support financial accountability must be maintained, at a minimum, 3 years from the submission of each CMS-372(S) report. These records must be sufficient to ensure that there is an audit trail documenting payments made to providers for waiver services. The audit trail must begin at the point of service to the participant (and, thereby, include sufficient documentation that the service was actually rendered on the date shown on the provider billing) and continue through to the claim for FFP.

APPENDIX I-3: Payment

Overview

This section concerns processes for the payment of provider billings (i.e., the transmittal of funds from the state to the waiver provider who furnished the service). Item I-3-g also provides for the identification of other payment arrangements (e.g., reassignment of payments to a governmental agency) that are recognized under federal law.

Detailed Instructions for Completing Appendix I-3

Item I-3-a: Method of Payment -- MMIS

Instructions

Indicate whether payments to providers for waiver services are made exclusively through the state's Medicaid Management Information System (MMIS). If not, then select one of the other choices. Also, select the first choice because, in accordance with section 1902(a)(32)(A) of the Act, the Medicaid agency must always retain the capability to make direct payment to a provider whether or not it has other methods for making payment.

Technical Guidance

Usually, direct state payments to providers of waiver services are made through the state's MMIS. Use of the MMIS to make payments permits employing MMIS sub-systems to validate claims (e.g., ensuring that the individual for whom the payment is made was eligible on the date of service). Use of the MMIS provides a direct linkage between provider payments and the claim for FFP.

When payments to providers for some or all waiver services are made outside the MMIS, a complete description of the process that is employed needs to be provided, clearly identifying the entities that make payments and how the audit trail is maintained to ensure the integrity of payments (i.e., the payment for each waiver service can be directly linked to the original validated provider billing for the service). In the case of some waivers, an operating agency receives provider billings, processes the billings, and makes payment to providers. When this is the case, the arrangement should be further specified in Item I-3-b (limited fiscal agent) or Item I-3-g-i (reassignment to a governmental entity) as the case may be. Participant-directed services can give rise to another instance when payments to providers are made outside the MMIS when a FMS entity makes payments to participant-employed workers under an agreement with the Medicaid agency.

Section 1915(c) Waivers that Operate with Concurrent Managed Care

In the case a section 1915(c) waiver that operates with a concurrent Medicaid managed care authority, payments to providers are made by the managed care entity which receives a capitated payment from the state. Describe how payments are made to managed care entities, including how such payments are made through the MMIS.

CMS Review Criteria

When payments to providers are made outside the MMIS, the waiver specifies:

- The processes that are used to make payment.
- How the processes ensure the maintenance of a proper audit trail.
- Providers may receive payment directly from the Medicaid agency.
- When payments for waiver services are made by a managed care entity or entities, the waiver describes how the monthly capitated payments are made to the managed care entity or entities.

Item I-3-b: Direct Payment

Instructions

Check each applicable mechanism that is employed to make payments to waiver providers.

Technical Guidance

Section 1902(a)(32) of the Act requires payments to be made directly by the Medicaid agency to the actual providers of waiver and state plan services. This requirement is satisfied when the Medicaid agency itself makes the payment or the payment is made by the same state fiscal agent that makes payments on behalf of the Medicaid agency for other Medicaid services. As a general matter, the Medicaid agency must always retain the capability to make direct payment to a provider and, thus, the first choice always should be selected.

In the alternative, payments may be made by a limited fiscal agent that is subject to Medicaid agency oversight. If a limited fiscal agent is used, identify the agent, describe the functions that the limited agent performs, and describe how the Medicaid agency exercises oversight of this agent. A limited fiscal agent might be a waiver operating agency or a FMS entity. This selection should be made when payments for some or all waiver services are made outside the MMIS, as indicated in Item I-3-b.

Section 1915(c) Waivers that Operate with Concurrent Managed Care

In the case of a section 1915(c) waiver that operates with a concurrent Medicaid managed care authority, only describe how payments are made for services that are not included in the capitation rate that is paid to the managed care entity. If no services are paid outside the capitation rate, simply respond "not applicable."

CMS Review Criteria

- The waiver specifies that the Medicaid agency makes payments directly to providers of waiver services.
- When a limited fiscal agent is employed, the waiver specifies:
  - The entity or entities that serve as a limited fiscal agent.
  - The payment functions performed by the limited fiscal agent.
  - How providers are informed about the process for billing Medicaid directly.
  - How the Medicaid agency exercises appropriate oversight of the limited fiscal agent.
- When providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity, the waiver specifies how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Item I-3-c: Supplemental or Enhanced Payments

Instructions

Indicate whether supplement or enhanced payments are made to the providers of waiver services. If they are, then provide the additional information specified.

Technical Guidance

A supplemental or enhanced payment is a payment for waiver services that is in addition to the amount billed by the provider for a service. Section 1902(a)(30)(A) of the Act requires that payments for Medicaid services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) of the Act provides for FFP to states for expenditures for services under an approved state plan/waiver.

If any additional payments are made, describe (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-federal share of the supplemental or enhanced payments; and (d) whether providers eligible to receive the

supplemental or enhanced payment must be able to retain 100% of the total computable expenditure claimed by the Medicaid agency to CMS. An example of a type of payment that might be classified as a supplement or enhanced payment is the payment of a performance incentive. For the purpose of this item, payments that are made to providers as adjustments to interim payment rates or for reconciliation purposes are not considered supplemental or enhanced payments. When supplemental or enhanced payments are made, the state is expected to furnish CMS upon request detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Section 1915(c) Waivers that Operate with Concurrent Managed Care

In the case of a section 1915(c) waiver that operates with a concurrent Medicaid managed care authority, the managed care authority might provide for payments in addition to the monthly capitation rate based on performance or other factors. If so, select the "yes" response and reference the applicable provisions of the managed care authority.

CMS Review Criteria

When supplement or enhanced payments are made:

- The waiver specifies the nature of the payments that are made and the waiver services for which these payments are made;
- The types of waiver providers that receive such payments.
- The waiver specifies the source of the non-federal share of the supplemental or enhanced payments.
- The waiver specifies that providers eligible to receive the supplemental or enhanced payment must be able to retain 100% of the total computable expenditure claimed by the Medicaid agency to CMS.
- The basis of such payments is transparent (i.e., it is clear to the public which providers would receive the additional payments and under what circumstances).

Item I-3-d: Payments to State or Local Government Providers

Instructions

Indicate whether payment is made to state or local government providers for the provision of waiver services. If so, specify the state or local government providers that receive payment and the waiver services that they furnish. Also, complete Item I-3-e.

Technical Guidance

State or local governmental entities may furnish waiver services, provided that they meet the pertinent provider qualifications. A state may not limit the provision of any waiver service solely to state or local government providers.

CMS Review Criteria

When state or local government providers furnish waiver services, the waiver specifies the types of entities that furnish services and the services that they furnish.

Item I-3-e: Amount of Payment to State or Local Government Providers

Instructions

When payment is made to state or local government providers for the provision of waiver services, indicate whether state or local government providers are paid the same amount as other providers of the same service. If not, then indicate whether payments to state or local government providers in the aggregate exceed their reasonable costs of providing waiver services. Pursuant to section 1902(a)(30)(A) of the Act, states must describe in this section how the state recoups the excess and returns the federal share of the excess to CMS using the quarterly expenditure report.

Technical Guidance

Medicaid payments to state or local government providers are subject to an additional test when the amount paid to a state or local government provider differs from the amount paid to other providers of the same service. Specifically, the aggregate payments to state or local government providers (including regular and supplemental or enhanced payments) that exceed their reasonable costs of furnishing a service would be an area of significant interest during CMS' review and would likely require additional information.

Payments to state or local government providers may differ from payments to other providers when the payment amount itself is based on the reasonable costs that state or local government providers incur in furnishing the service. Select the second choice when payments are based on a determination of reasonable costs.

Otherwise, the state should have in effect mechanisms to determine whether the aggregate payments made to state or local government providers exceed their reasonable costs in furnishing waiver services. When it is determined that aggregate payments exceed reasonable costs, the state must recoup the excess payment and return the federal share of the excess payment to the federal government within 60-days. Federal Medicaid funds may not be diverted to underwrite the costs of state or local providers furnishing non-approved services or providing services to ineligible individuals.

CMS Review Criteria

When the third choice is selected (when state or local government providers receive payments that in the aggregate exceed the cost of waiver services), the waiver specifies:

- How the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report; and
- A satisfactory recoupment process.

Item I-3-f: Provider Retention of Payments

Instructions

Indicate whether providers receive and retain 100 percent of the total computable expenditure claimed by the Medicaid agency to CMS for waiver services. In the case of a section 1915(c) waiver that operates with a concurrent managed care authority, select the second choice and indicate whether managed care entities receive and retain 100 percent of the amount that the state claims for capitation payments to such entities.

Technical Guidance

Pursuant to section 1902(a)(30)(A) of the Act, the amount claimed to CMS for waiver services must match the amount paid to waiver providers less the application of any third party (e.g., Medicare) recoveries and additional adjustment adjustments for co-pays or participant financial liability as determined through the post-eligibility treatment of income process. In other words, the computable costs of waiver services must match adjudicated provider billings less the foregoing adjustments. A state may not claim an amount that exceeds the computable costs of waiver services. Provider payments may not be claimed but then reduced in a manner that has the effect of reducing the non-federal share of waiver services, including requiring that providers return some portion of their payments to the state. Claims to CMS for FFP for waiver services must represent actual expenditures of public funds.

Section 1915(c) Waivers that Operate with Concurrent Managed Care

In the case of a section 1915(c) waiver that operates with a concurrent Medicaid managed care authority, indicate in the text field whether the capitation payments that are made to managed care entities are reduced or returned to the state in a fashion that results in a disparity between the amount that is claimed to CMS and the amounts actually paid to managed care entities. If so, describe the methodology for reduced or returned payments and specify the use of the funds retained or returned to the state.

CMS Review Criteria

Waiver providers must receive and retain 100 percent of the total computable expenditure claimed by the Medicaid agency to CMS.

Item I-3-g: Additional Payment Arrangements

This item addresses additional payment arrangements that may be employed for waiver services. Two of these arrangements (reassignment of payment to a governmental agency and Organized Health Care Delivery System) are recognized exceptions to the requirement contained in section 1902(a)(32) of the Act that prohibits state payments for Medicaid services to any entity other than the provider of the service.

Item I-3-g-i: Voluntary Reassignment of Payments to a Governmental Agency

Instructions

Indicate whether the state provides for the voluntary reassignment of payments for waiver services and, if so, specify the governmental agency or agencies to which such reassignments may be made.

Technical Guidance

Under the provisions of 42 CFR § 447.10(e), a provider may reassign the payment for waiver services to a governmental agency. This provision is a recognized exception to the requirement contained in section 1902(a)(32) of the Act that prohibits state payments for Medicaid services to any entity other than the provider of a service. Reassignment is typically employed when a governmental agency pays a provider for a service and reassignment is used to permit the governmental agency to recover its outlay. Reassignment arrangements must be voluntary on the part of the provider and the state must provide for the payment to providers who elect not to reassign payment. Reassignment is described further in the December 20, 1993 State Medicaid Director letter included in Attachment C.

Item I-3-g-ii: Organized Health Care Delivery System

Instructions

Indicate whether the waiver employs OHCDS arrangements. If so, in the text field provide the additional information specified in the item.

Technical Guidance

Waiver services may be provided by an Organized Health Care Delivery System (OHCDS), as defined in 42 CFR § 447.10. An OHCDS must provide at least one Medicaid service directly (utilizing its own employees) and may contract with other qualified providers to furnish other waiver services. When an OHCDS arrangement is used, the required Medicaid provider agreement is executed between the state and the OHCDS. Since the OHCDS acts as the Medicaid provider, it is not necessary for each subcontractor of an OHCDS to sign a provider agreement with the Medicaid agency. However, subcontractors must meet the standards under the waiver to provide waiver services for the OHCDS. The use of an OHCDS arrangement does not alter fundamental waiver requirements with respect to provider qualifications or service standards.

When an OHCDS arrangement is used to provide waiver services, payment is made directly to the OHCDS and the OHCDS reimburses its subcontractors. Waiver providers may not be required to affiliate with an OHCDS. Such an arrangement must be voluntary and the state must provide for entering into a provider agreement with providers that elect not to affiliate with an OHCDS. Moreover, waiver participants may not be required to secure services exclusively through an OHCDS. Additional information concerning OHCDS arrangements is contained in the December 20, 1993 State Medicaid Director letter located in Attachment C.

When a waiver provides for participant direction of services and FMS are furnished as a waiver service (rather than as an administrative activity), entities that furnish FMS may be designated as an OHCDS (by virtue of the fact that their employees furnish a waiver service). Designation of FMS providers as OHCDS entities may facilitate contracting for and purchase of participant-directed services.

When OHCDS arrangements are employed, the waiver needs to specify:

- The entities that are or may be designated as an OHCDS and how these entities qualify for designation as an OHCDS;

- The procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS. Again, it is important to keep in mind that providers may not be mandated to contract with an OHCDS;
- The method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed. Participants must be able to select any qualified provider that has contracted with the OHCDS or select a provider that has not contracted with the OHCDS;
- The method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under this waiver. The use of an OHCDS arrangement does not in any way negate the requirement that providers meet applicable qualifications;
- How the state assures that OHCDS contracts with subcontracted providers meet applicable Medicaid requirements (e.g., the maintenance of necessary documentation for the services furnished by the subcontractor); and
- How the state assures financial accountability when an OHCDS arrangement is used. That is, how the state ensures that the billings made by the OHCDS are valid. In addition, describe how the flow of billings and payments between the state and the OHCDS and its subcontractors must not result in excessive payments to the OHCDS.

When an OHCDS arrangement is employed, it may not be structured in a fashion that has the effect of claiming administrative expenses as service expenses. For example, when an OHCDS entity performs administrative activities, a state may compensate the OHCDS for such activities and claim such costs at the appropriate administrative claiming rate and in accordance with the approved cost allocation plan. In other words, the amount that the OHCDS is paid for the provision of waiver services may not be diverted to administrative activities.

Similarly, the amount that an OHCDS bills for waiver services are expected to match in the aggregate the amount that it expends to provide services plus the amount that it pays its subcontractors. An OHCDS may not retain excess payments and divert those payments to other uses.

CMS Review Criteria

When a waiver employs OHCDS arrangements:

- The state describes the types of entities that are designated as an OHCDS.
- The state's methods of designating entities to function as OHCDS are specified, and these entities meet the regulatory definition of an OHCDS.
- OHCDS arrangements preserve participant free choice of providers.
- Waiver providers are not required to contract with an OHCDS in order to furnish services to participants.
- There are adequate safeguards to ensure that OHCDS subcontractors possess the required qualifications.
- The OHCDS arrangement provides for appropriate financial accountability safeguards.

Item I-3-g-iii: Contracts with MCOs, PIHPs or PAHPs

Instructions

Indicate whether the state contracts with MCOs, PIHPs, or PAHPs to furnish waiver services. If so, specify whether such contracts fall under the authority of section 1915(a)(1) of Act or are entered into under the provisions of a managed care/section 1915(c) concurrent waiver. When the state does not contract with managed care entities to furnish waiver services, select "not applicable."

Technical Guidance

When a state contracts with managed care entities under the provisions of section 1915(b)/1915(c) concurrent waiver, the section 1915(b) waiver application will be reviewed by CMS to obtain information about the types of entities with which the state contracts. In addition, state contracts with managed care entities are subject to CMCS review.

Under the provisions of section 1915(a)(1) of the Act, a state may contract with a Managed Care Organization (MCO), a prepaid inpatient health plan (PIHP) or prepaid ambulatory health plan (PAHP) organizations (as defined in 42 CFR § 438.2) to furnish waiver and other services to waiver participants. Such organizations may furnish not only waiver services but also other services under the state plan. Contracts with these organizations may be risk-based, provide for shared risk, or be no-risk arrangements. The state may make capitated prepayments to these organizations. Absent a concurrent section 1915(b) waiver, waiver participants may not be required to obtain waiver services through these organizations. Participants must have free choice in electing to enroll with a health plan to obtain waiver or other services or to obtain services from other waiver providers not affiliated with the health plan.

MCO, PIHP and PAHP contracts entered into under the provisions of section 1915(a)(1) are subject to separate CMS review. This 1915(c) waiver application itself does not provide the authority for a state to contract with such organizations. When managed care entities are used to furnish waiver services under the provisions of section 1915(a)(1), specify (a) the geographic areas served by these organizations; (b) the waiver and other services furnished by these organizations; and (c) how payments are made to organizations.

CMS Review Criteria

When waiver services are furnished by managed care entities under the provisions of §1915(a)(1) that provide for the voluntary enrollment of waiver participants, the waiver specifies:

- The geographic areas served by these organizations.
- The services furnished by these organizations.
- How payments are made to organizations.

APPENDIX I-4: Non-Federal Matching Funds

Overview

In this section, the sources of the non-federal share (e.g., matching funds) of computable waiver costs needs to be delineated. "Computable waiver costs" means adjudicated payments that have been made to waiver providers less any adjustments that change the cost of the service to Medicaid (e.g., the liability by another party for part of the cost of care, such as co-pays

indicated in Appendix I-7, or third party (e.g., Medicare) obligations). Only computable waiver costs may be claimed for federal financial participation. The non-federal share of computable waiver costs must be provided exclusively by the state or by the state and local governmental entities (e.g., counties), as provided in 42 CFR §433.51.

The Appendix requires the identification of the sources of the non-federal share provided by the state and, if applicable, localities. In each case, the sources are broken down into various subcategories. Terms used in this Appendix are defined as follows:

Intergovernmental Transfer (IGT) means funds are transferred from another state agency or a local government entity to the Medicaid agency to be utilized as the non-federal share. For example, if funds are appropriated to a state's developmental disabilities agency that operates the waiver but provider billings are paid using the MMIS system at the Medicaid agency, the developmental disabilities agency may make an intergovernmental transfer to the Medicaid agency to provide the non-federal share. Similarly, if local government entities are obligated to provide all or a portion of the non-federal share, they may meet this obligation by transferring funds to the Medicaid agency.

Certified Public Expenditure (CPE) means that a state or local government agency expends funds (i.e., pays providers for waiver services or directly incurs expenses for services furnished by the entity) and submits the total amount expended to the state Medicaid agency. For example, a county may be responsible for 20% of the costs of waiver services. The county pays providers of waiver services using county funds and submits the amount of its total computable payments to the state Medicaid agency. The Medicaid agency would submit the CPE to CMS and FFP would be available as a percentage of the total computable cost of the service. The Medicaid agency payment to the county would be the federal share of the county waiver costs funded through CPEs. The state Medicaid agency would make payment to the county for the remaining 80% of the computable costs of waiver services whereby the non-federal share is derived from other state sources (e.g., appropriations to the state Medicaid agency or an IGT from another state agency).

It is permissible for local government resources to constitute a portion of the non-federal share of waiver computable costs, as provided in 42 CFR § 433.53(b). However, in accordance with 42 CFR § 433.53(c)(2), whenever a state provides for local financial participation in the costs.

Detailed Instructions for Completing Appendix I-4

Item I-4-a: State Government Level Source(s) of the Non-Federal Share of Computable Waiver Costs

Instructions

Select the applicable state sources of the non-federal share of computable waiver costs. Where specified, provide the additional information about these sources.

Technical Guidance

State sources of the non-federal share may include:

- The direct appropriation of state tax revenues to the State Medicaid agency;
- State tax revenues appropriated to another state agency that are transferred to the state Medicaid agency via IGT or are certified as expenditures (CPE). When the source of the non-federal share is another state agency, specify the state agency or entity to which the

appropriation is made, the underlying sources of revenue of the funds that are transferred (e.g., state tax revenues), and describe in detail the mechanism (IGT or CPE) that is utilized to transfer the funds to the Medicaid agency; and,

- If there are other state level source(s) of funds other than the appropriation of state tax revenues, specify in detail: (a) the source of funds (e.g., program revenues, provider fees (but not taxes)); (b) the state entity or agency that receives the funds; and, (c) the mechanism (IGT or CPE) that is employed to transfer and/or certify the funds to the Medicaid agency. Also specify any matching arrangement (e.g., whether the funds fully provide for the non-federal share or only a portion of the non-federal share).

CMS Review Criteria

When the non-federal share is from sources other than the direct appropriation of state tax revenues to the Medicaid agency:

- The state-level sources of the non-federal share of computable waiver costs are specified.
- When funds are transferred from another state agency or other funds are used for the non-federal share, the underlying sources of these funds meet applicable federal requirements.
- When IGTs or CPEs are used, the mechanism used to transfer funds to the state Medicaid agency or verify the expenditures are specified and meet federal requirements.
- When CPEs are utilized, the criteria must be consistent with I-2-c.

Item I-4-b: Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs

Instructions

If local government entities do not provide any part of the non-federal share through IGT or CPE, select not applicable. If local governments provide a portion of the non-federal share, select one or both of the next two responses and provide the information requested.

Technical Guidance

When local government entities provide a portion of the non-federal share, provide the following as applicable:

- **Appropriation of Local Government Revenues**. When the funds provided by local government are local tax revenues, specify the governmental body that levies taxes that underwrite the non-federal share, the sources of revenue that are utilized as the non-federal share, and the mechanism (IGT) or (CPE) for transferring and/or certifying funds to the Medicaid agency. Include a citation for any applicable state laws concerning the provision of local funds to the state to meet the non-federal share of computable waiver costs.
- **Other Local Government Sources**. If there are local government sources of funds other than local tax revenues that are used to meet the non-federal share of computable waiver costs, specify the source(s) of these funds, the local government entity or agency that receives these funds, and the mechanism (IGT or CPE) used to transfer and/or certify funds to the Medicaid agency.

CMS Review Criteria

When there are local government sources of the non-federal share:

- The local government sources of the non-federal share of computable waiver costs are specified.
- When local tax funds are transferred by local governments or other funds are used for the non-state federal share, the underlying sources of these funds meet applicable federal requirements.
- When IGTs or CPEs are used, the mechanism used to transfer funds to the state Medicaid agency or verify the expenditures are specified and meet federal requirements.
- When CPEs are utilized, the criteria must be consistent with I-2-c.

Item I-4-c: Information Concerning Certain Sources of Funds

Instructions

Indicate whether any of the sources of funds listed make up any part of the non-federal share of computable waiver costs. If any are used, describe the source of funds in detail.

Technical Guidance

- **Health Care-Related Taxes**. The levying of health care-related taxes to meet the non-federal share of Medicaid costs is controlled by the regulations at 42 CFR § 433.55 et seq. Waiver services are not among the classes of services for which a broad-based provider tax may be levied.
- **Provider-Related Donations**. Provider-related donations are considered a permissible source of the non-federal share of the computable costs of waiver services to the extent that such donations comply with the provisions of 42 CFR § 433.54 concerning bona fide provider-related donations.
- **Federal Funds.** In general, federal funds regardless of source may not be used to meet the non-federal share of computable waiver costs. One exception has been the CMS-approved use of Real Choice Systems Change grant funds in some instances to meet the non-federal share of Medicaid services furnished under the auspices of a grant. Only when there is specific authorization in federal law may federal funds be used for the non-federal share.

CMS Review Criteria

Only permissible sources may be utilized to fund the non-federal share.

APPENDIX I-5: Exclusion of Medicaid Payment for Room and Board

Overview

42 CFR § 441.310(a)(2) prohibits making Medicaid payments for room and board (i.e., housing, food, and utility costs) except when the participant is receiving respite outside of a private residence in a facility approved by the state or when the participant requires a live-in caregiver (addressed in Appendix I-6). For purposes of this provision, the term "board" means three meals a day or any other full nutritional regime. Medicaid payments may be made for a meal provided to a person in a day activity such as adult day health services. The state must assure CMS that

payments are not made for room and board except as explicitly allowed in 42 CFR § 441.310(a)(2).

When waiver services are provided in residential settings that are not the participant's own home or the family home, the state needs to describe the methodology that is employed to exclude the costs of room and board from the payments for the services furnished in such living arrangements (i.e., ensure that payment is only made for the service component).

Detailed Instructions for Completing Appendix I-5

Item I-5-a: Services Furnished in Residential Settings

Instructions

Select whether waiver services are furnished in residential settings other than the participant's own private residence. If so, complete Item I-5-b. Otherwise, do not complete I-5-b.

Item I-5-b: Method for Excluding the Cost of Room and Board Furnished in Residential Settings

Instructions

In the text field, describe the methodology that is used to exclude Medicaid payment for room and board in residential settings.

Technical Guidance

Acceptable methods to exclude the costs of room and board may include separating room and board costs from service costs in determining payment rates or basing payments solely on service costs.

CMS Review Criteria

The methodology that is employed assures that the costs of room and board have been isolated and excluded from payments for services in applicable residential settings.

APPENDIX I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Overview

Section 4741(a) of the Omnibus Budget Reconciliation Act of 1990 amended section 1915(c)(1) of Act to provide that the room and board exclusion does not include an amount established by the state to reflect the portion of costs of rent and food attributable to an *unrelated* personal caregiver who resides in the same household with a participant who requires a live-in caregiver. Regulations concerning this provision are located at 42 CFR § 441.310(a)(2)(ii). Unrelated is defined as someone who is unrelated by blood or marriage to any degree. A personal caregiver provides a covered waiver service (as specified in the waiver) to meet the participant's physical, social, or emotional needs (as opposed to services not directly related to personal care giving, i.e., housekeeping or chore services). When a waiver service is provided by an unrelated, live-in personal caregiver, FFP is available to compensate the waiver recipient for the additional costs they may incur for the rent and food for such caregiver. Under Medicaid and section 1634 and SSI criteria rules, in order for the payment not to be considered income to the recipient, payment for the portion of the costs of rent and food attributable to an unrelated live-in personal caregiver must be routed through the provider specifically for the reimbursement of the waiver participant.

FFP for live-in caregivers is not available in situations when the participant lives in the caregiver's home or a residence owned or leased by the provider of waiver services.

This provision does not provide an exception to other Medicaid requirements resulting in a change in the way an individual's income may be counted in determining Medicaid eligibility or allow payment to a participant rather than a provider of service.

In the application, live-in caregiver is treated as a waiver service and needs to be included in the list of services contained in Appendix C-1 and specified in Appendix C-3. The costs of live-in caregiver needs to be broken out separately in Appendix J-2 in the computation of Factor D.

Completion of Appendix I-6

Instructions

Select whether the waiver provides for the payment of the rent and food expenses of an unrelated caregiver. If so, explain: (a) the method that is used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs that routes payment through the provider.

Technical Guidance

Any reasonable method may be employed to apportion the cost of rent and food, subject to CMS review and approval, so long as the method is based on the costs incurred by the participant. Reimbursement to the participant must be made by the provider (e.g., passed along by the provider to the participant).

CMS Review Criteria

When payment is made for the rent and food expenses of an unrelated caregiver:

- The apportionment method used should provide that only the additional rent and food costs to the participant associated with having a live-in caregiver are reimbursed.
- Only costs incurred by the participant are reimbursed.
- The method of making payment for live-in caregiver must route the payment through the provider but clearly provide for the reimbursement of the participant.

APPENDIX I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing

Overview

In this Appendix, the state specifies whether it imposes co-payments on waiver services (in Item I-7-a) or imposes other cost-sharing arrangements associated with participation in a waiver (in Item I-7-b). The imposition of co-payments or other cost sharing are governed by the provisions of section 1916 and section 1916A of the Act. The amount of these charges that may be imposed is subject to federal limits. As described at 42 CFR §§ 447.51 through 447.57, states have flexibility to impose cost sharing for most covered services. In general, cost sharing is limited to nominal amounts (approximately $4 or less), but states have flexibility to charge higher cost sharing to individuals with income above 100% of the federal poverty level.

Any nominal cost sharing is generally applicable to all Medicaid beneficiaries, except those specifically exempted by statute or regulation. States have the option to exempt HCBS waiver

recipients from all cost sharing, if they are subject to the post-eligibility treatment of income requirements. And because section 1915(c) of the Social Security Act provides for a waiver of comparability, states may exempt additional individuals beyond those specifically exempted in statute and regulation.

When co-payments are imposed, no provider may deny services to an individual who is eligible for the services on account of the individual's inability to pay the cost sharing unless the person's income exceeds 100% of poverty and the state elects to permit the provider to enforce the cost-sharing. In addition, when a co-payment is imposed, the amount of the co-payment must be deducted in determining the amount of the computable claim for FFP regardless of whether the participant actually made the co-payment. Co-payments are considered to have been collected by the provider regardless of whether the participant makes an actual payment to the provider.

The post eligibility treatment of income process which determines the individual's patient liability (if any) does not fall under the cost sharing requirements specified at section 1916 and section 1916A of the Act. Therefore, **post eligibility is not included in Appendix-I**. Post eligibility treatment of income is included in Appendix B-5 of the waiver application.

Detailed Instructions for Completing Appendix I-7

Both items I-7-a and I-7-b need to be completed.

Item I-7-a: State Requirement for Co-pays

Instructions

Indicate whether co-payments or similar charges are imposed on waiver participants for one or more waiver services. If no co-payments are charged, proceed to Item I-7-b. If co-payments are charged, complete the remaining items before proceeding to Item I-7-b.

Item I-7-a-i: Co-Pay Arrangement

Instructions

Specify the type of charge that is imposed on waiver participants.

Technical Guidance

Charges may include a nominal deductible, co-insurance, co-payment or other similar charge. If another type of charge is imposed, it needs to be described in detail. Typically, if a charge is made, it usually takes the form of a co-payment (i.e., a fixed charge per unit of service).

Item I-7-a-ii: Participants Subject to Co-pay Charges for Waiver Services

Instructions

Specify the groups of waiver participants who are subject to co-payment.

Technical Guidance

As described at 42 CFR § 447.56 specific groups of individuals are exempt from all cost sharing charges. For example, children up to the age of 18 (or up to age 19, 20 or 21 at the option of the state) are excluded from all cost sharing, with certain exceptions. Because section 1915(c) of the Act allows for a waiver of comparability, states may exempt additional groups of waiver participants.

Item I-7-a-iii: Amount of Co-Pay Charges for Waiver Services

Instructions

Specify each waiver service for which a co-payment charge is made, the amount of the charge, and the basis of the charge.

Technical Guidance

In the case of waiver participants with incomes less than 100% of federal poverty level, the amount of the co-payment charge may not exceed the maximum amounts described in 447.52(b). Express the amount of the charge on a per-unit basis (e.g., $1.50/ visit). Persons with incomes in excess of 100% of federal poverty level may be charged cost sharing of up to 10% of the cost of the service and those with incomes above 150% of federal poverty level may be charged cost sharing of up to 20% of the cost of the service. If different charges are made to one or both of these higher income groups, specify those charges and specify the basis of the charge. The basis may be the waiver's standard, fixed fee payment schedule for the services subject to co-payment.

Item I-7-a-iv: Cumulative Maximum Charges

Instructions

Specify whether there is a cumulative maximum amount of co-payments that may be charged to a waiver participant. When there is a maximum, specify the amount and the period (e.g., month, quarter) to which the maximum applies.

Technical Guidance

Per 42 CFR § 447.54(d), the waiver may specify a cumulative maximum amount of co-payments (e.g., no more than $10 per month). When the participant is subject to co-payments for other state plan services, the state may apply the maximum amount provided under the state plan for all Medicaid services.

Item I-7-b: Other State Requirement for Cost Sharing

Instructions

Select whether the state imposes a premium, enrollment fee, or similar charge on waiver participants. If so, describe the arrangement in detail.

Technical Guidance

42 CFR § 447.55 allows states to impose premiums, enrollment fees or other similar charges on individuals with income above 150% of poverty. Under a premium arrangement, the recipient must make a fixed, periodic payment (as opposed to a co-payment which is imposed on a per service basis). Indicate whether there is such an arrangement associated with the waiver. If so, specify in detail:

- The type of arrangement;
- The amount of the charge;
- The groups of participants who are subject to the charge and the groups excluded in compliance with 42 CFR § 447.56. The groups who are excluded must include all individuals described in 42 CFR § 447.56; and may include additional groups of waiver participants,

- The mechanisms for the collection of charges and reporting the amount collected on the CMS 64. Premium and cost sharing amounts must be applied to reduce the computable claim for federal financial participation.

CMS Review Criteria

The cost sharing arrangement complies with the applicable requirements contained in 42 CFR § 447.50 *et seq*.

When the state imposes a premium, enrollment fee, or similar charge on waiver participants, the state has specified:

- The type of charge
- The amount of the charge
- The groups of participants who are subject to the charge and the groups excluded- this must comply with 42 CFR § 447.56.
- For each waiver service for which a co-payment is made, the amount and basis of the charge. The amount of the co-payment charge may not exceed the schedule of allowable charges contained in 42 CFR § 447.54(a)(3) that establishes maximum charges based on the cost of a service.
- Whether there is a cumulative maximum amount of co-payments that may be charged to a waiver participant?
- The mechanisms for the collection of charges and reporting the amount collected on the CMS 64. Premium and cost sharing amounts must be applied to reduce the computable claim for the federal financial participation.

Appendix J: Cost Neutrality Demonstration

Brief Summary

In order for a waiver to be approved, in accordance with section 1915(c)(2)(D) of the Act and 42 CFR § 441.302(e), the state must demonstrate to the satisfaction of CMS that the waiver is cost neutral during each year that the waiver is in effect. In this Appendix, the cost neutrality of the waiver is demonstrated. The Appendix has two components:

- Appendix J-1 provides a composite overview of the demonstration that the waiver is cost neutral.
- Appendix J-2 contains the basis of the estimates of the factors that make up the cost neutrality demonstration.

Cost Neutrality Formula

Section 1915(c)(2)(D) of the Act requires that the state assure that the average per capita expenditure under the waiver during each waiver year not exceed 100 percent of the average per capita expenditures that would have been made during the same year for the level of care provided in a hospital, nursing facility, or ICF/IID under the state plan had the waiver not been granted.

42 CFR § 441.302(e) requires that the expenditures upon which the cost neutrality demonstration

is based be reasonably estimated and well documented and that the estimate must be annualized and cover each year of the waiver period.

The equation set forth in 42 CFR § 441.303(f)(1) specifies the components of the cost neutrality demonstration. This equation is:

D+D′ ≤ G+G′.

Where:

- The symbol ‘‘≤’’ means that the result of the left side of the equation must be less than or *equal* to the result of the right side of the equation.
- D = the estimated annual average per capita Medicaid cost for home and community-based services for individuals in the waiver program.
- D′ = the estimated annual average per capita Medicaid cost for all other services provided to individuals in the waiver program.
- G = the estimated annual average per capita Medicaid cost for hospital, NF, or ICF/IID care that would be incurred for individuals served in the waiver, were the waiver not granted.
- G′ = the estimated annual average per capita Medicaid costs for all services other than those included in factor G for individuals served in the waiver, were the waiver not granted.

This equation takes into account both waiver services (factor D) and institutional costs (factor G) as well as the costs of furnishing other Medicaid services to waiver participants (factor D′) and the non-institutional Medicaid costs for persons receiving institutional care (factor G′). For purposes of the equation, the prime factors (D′ and G′) include the average per capita cost for all state plan services and expanded Early & Periodic Screening, Diagnosis and Treatment (EPSDT) services (when the waiver covers children) that have been utilized but not accounted for in other formula values. Costs associated with the waiver that are claimed for administrative FFP, are not included in the formula.

Also, for purposes of this equation the term “per capita cost” means estimated expenditures during each year of the waiver divided by the number of *unduplicated* service recipients during each waiver year. The estimates of per capita costs may not be based on an estimate of the number of “full year equivalents” who will be served each year.

Factor D in the equation is derived from the estimates of service utilization and costs in Appendix J-2-d (discussed below). Factor D′ is estimated using experience from previous waiver periods (renewal applications) or other sources of information (in the case of a new waiver application). Factor G is estimated based on the costs of institutional services for the specific level(s) of care specified in the waiver. Factor G′ is estimated based on the costs of other Medicaid services furnished to individuals who receive institutional services for the specific level(s) of care specified in the waiver. The basis for the estimates of each of these factors were derived is described out in Appendix J-2-c.

For waivers that cover individuals with a particular diagnosis or condition, states may utilize target-group specific data. For example, in estimating cost for waiver participants, a state may estimate the average per capita expenditure for the targeted individuals without including expenditures of other individuals (not meeting targeting criteria) who are inpatients of the institutional comparison group. If target-group specific data is used, cost/utilization data documenting how the state’s estimates were derived need to be included with the waiver

application (i.e., a claims summary listing to document the average per capita institutional expenditure for the target population). This documentation is provided in Appendix J-2-c.

Once the waiver is approved, in accordance with 42 CFR § 441.302(h), the state must annually submit financial and statistical information to CMS concerning each equation factor and, in the case of factor D, detailed information concerning service utilization and costs for each service included in the waiver. This information is submitted via Form CMS-372(S). Please note that functions that are provided as an administrative activity are expected to be done so in accordance with the approved cost allocation plan. The cost allocation plan is not approved via the 1915(c) application.

Appendix J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Overview

This Appendix provides an overview of the cost neutrality demonstration for each waiver year.

Detailed Instructions for Completion of Appendix J-1

Instructions

In the row captioned "level(s) of care," specify the level or levels of care for which the waiver serves as an alternative (as specified in Item 1-F of the Application). For each year the waiver will be in effect, insert the appropriate values for each cost neutrality formula factor into the table.

Technical Guidance

When a waiver serves individuals at more than one level of care (e.g., nursing facility and hospital), the estimates of Factors D', G, and G' that are inserted into the table are the weighted average of each factor (Note: Factor D is estimated across all waiver participants and, thereby, already is a weighted average). A weighted average is calculated as follows:

- For each level of care, calculate the total estimated expenditures associated with each factor for each waiver year. Total estimated expenditures are calculated by multiplying the level-of-care estimate of the formula value for the waiver year by the unduplicated number of individuals who are expected to utilize the services associated with the formula factor;
- Sum the total estimated expenditures for the formula factor for the waiver year; and
- Divide the sum of total expenditures by the sum of the total unduplicated number of individuals who are expected to utilize the services associated with the formula factor.

Level of Care	Factor G Estimate	# of Users	Total Expenditures
Level of Care 1	$30,000	100	$3,000,000
Level of Care 2	$60,000	100	$6,000,000
Total	N/A	200	$9,000,000
Weighted Average ($9,000,000/200)			$45,000

The underlying calculations of the weighted averages of the formula factors are not submitted with the waiver application. However, the work sheets containing these calculations are expected to be available to CMS upon request through the Medicaid agency and/or the operating agency (if applicable). When a waiver encompasses more than one level of care, it is not required that the waiver be cost neutral at each level of care so long as it is cost-neutral on a composite basis.

The CMS-372(S) report requires reporting each cost neutrality formula factor by level of care and on a composite, weighted average basis.

CMS Review Criteria

- The data makes sense and aligns across the waiver years.
- The waiver is cost neutral each waiver year.

Appendix J-2 - Derivation of Estimates

Overview

In this Appendix, information is provided about how the estimate for each cost neutrality formula factor has been derived. The Appendix also provides for showing the detailed estimate of Factor D.

Detailed Instructions for Completing Appendix J-2

Item J-2-a: Number of Unduplicated Participants Served

Instructions

In Table J-2-a, insert the total number of unduplicated individuals who will receive waiver services during each year the waiver is in effect. This number needs to match the corresponding figures in Table B-3-a in Appendix B-3. In the web-based application, the two tables are linked to ensure consistency. When a waiver serves individuals at more than one level of care, show the breakdown of waiver participants by level of care in the table, noting each level of care in the column heading.

Technical Guidance

The total number of unduplicated waiver participants who will be served each year the waiver is in effect is an essential element in calculating Factor D in the cost neutrality formula. The figures included in this table need to match the corresponding figures in the year-by-year estimates of Factor D that are derived in Item J-2-d. When a waiver serves individuals at more than one level of care, the sum of the two right hand columns needs to equal the total in column headed “total unduplicated number of waiver participants.”

CMS Review Criteria

The unduplicated count aligns and makes sense across the waiver years.

Item J-2-b: Average Length of Stay

Instructions

In the text field, describe the basis of the estimate of the average length of stay on the waiver by participants in Item J-2-d.

Technical Guidance

Average length of stay (ALOS) is a statistic that describes the number of days on average during a waiver year that an individual participates in the waiver. ALOS can be affected by a variety of factors, including participant turnover (the entry and exit of individuals from the waiver) and the phase-in or phase-out of the waiver. ALOS is calculated by dividing the total number of "enrolled days" of all waiver participants by the unduplicated number of participants. In the case of an approved waiver, ALOS information is reported on CMS-372(S) report.

As noted previously, ALOS usually affects the calculation of Factor D in the cost neutrality equation. For example, 220 daily units of a service such as adult day health would be provided to participants who are continuously enrolled throughout the entire waiver year. However, if the ALOS length of stay on the waiver is 292 days, then the expected utilization rate of adult day health services per unduplicated participant would be 176 daily units (292/365 = O.8; 0.8 x 220 = 176). As a general matter, ALOS should be factored in when estimating the utilization of each waiver service in the calculation of Factor D.

In response to this item, describe the basis of the ALOS estimate that is included in the estimate of Factor D tables in item J-2-d. The basis of the estimate may be based on:

- **CMS 372(S) Data**. In the case of a waiver renewal, the ALOS estimate may be based on actual prior year experience. Indicate whether the estimate is based on CMS-372(S) data and the year of the report. In the case of a waiver renewal, when the estimate departs from the CMS-372(S) baseline data, explain the basis of the alternate estimate.
- **Phase-In/Phase-Out Schedule**. When waiver capacity is being phased-in or phased out, ALOS is affected. For example, if capacity is being phased in, the ALOS estimate will increase each waiver year until the phase-in is completed. If a phase-in/phase out schedule is submitted along with the application (as Attachment #1 to Appendix B-3), that schedule may serve as the basis of the ALOS estimate for the years affected by phase-in/phase-out. Once the phase-in is completed, explain the basis of the ALOS estimate for the subsequent waiver years.
- **Experience in Similar Waivers**. In the case of a new waiver, the ALOS estimate may be based on experience in another waiver that the state (or another state) operates which serves a similar target population.
- **Alternative Basis**. Especially in the case of a new waiver, the estimate may be based on the experience of a state-funded program that serves a similar target group or from other data sources. Provide a complete description of the information that was employed to estimate the ALOS.

However, the ALOS estimate is derived, provide a complete description of the basis of the estimate.

CMS Review Criteria

The state provided a complete description of the basis of the ALOS estimate.

Item J-2-c: Derivation of Estimates of Each Factor

In this item, the derivation for the estimates of each factor in the cost-neutrality formula is specified. In the case of a renewal waiver (or a new waiver to replace an approved waiver), as a general matter it is expected that the basis of the derivation of each factor will be the data that the state has reported via the CMS-372(S) trended forward to reflect inflation adjustments. Departures from the CMS -372(S) baseline are expected to be explained and justified. For each factor derivation, describe the source of baseline data used to calculate the factor, including the date from which the baseline data represents. Describe the basis of growth trends or inflationary adjustments used, including:

- Data source used to obtain the trend or inflation rate
- How the trend or inflation rate was calculated
- If the growth trend is not based on CMS-372(S) data, why an alternate basis was used

When a renewal includes new services or modifications to current services, the estimates for these services are expected to be explained and justified.

For waivers that apply only to individuals with a specific illness or condition, estimates that are based only on the particular group may be used. As necessary and appropriate, include references to supporting documentation for how these values were derived. As necessary, CMS may request that the state supply the supporting documentation through the Medicaid agency and/or the operating agency (if applicable).

Item J-2-c-i: Factor D Derivation

Instructions

In the text field, describe the basis of the estimates of Factor D.

Technical Guidance

The Factor D value is calculated by completing the tables contained in item J-2-d. See also the instructions for completing Item J-2-d. Here, provide a complete explanation of the how the values (except for ALOS and the unduplicated number of participants) contained in that table were derived. In the case of a waiver amendment, if the state amends the cost estimate table in Appendix J-2-d due to a change in Factor D, the state should also amend the Factor D derivation in Appendix J-2-c to document the basis of the amended estimates.

The Factor D estimate is derived by estimating: (a) the unduplicated number of participants who are expected to utilize each waiver service; (b) the number of units of services these participants are expected to utilize during a waiver year (taking into account ALOS); and (c) the expected average unit cost of each waiver service. These elements lead to the calculation of the total estimated cost for each waiver service. These service-by-service costs are summed and divided by the total number of unduplicated waiver participants for the waiver year in order to estimate Factor D.

The explanation of the derivation of the Factor D estimate is expected to include the basis and methodology used to calculate the estimates for: (a) the estimated number of service users; (b) the estimate of the number of units/user; and (c) the average per unit cost. In particular:

- **Estimated number of users**. In the case of waiver renewals and amendments, this estimate should be based on actual experience as reported via the CMS-372(S) (e.g., the

percentage of waiver participants who utilize a service), modified as appropriate to take into account changes in the number of persons who will be served during the renewal period. If the estimated number of users departs from the previous actual experience, explain and justify the basis of the deviation.

In the case of new waivers or when additional services are being added in a waiver renewal or an amendment, the explanation should detail the source of the information upon which the estimate is based. The source may be a state study, utilization of similar services in other waiver programs, or experience in other states that operate similar waivers.

- **Units/User**. The utilization rate should be reasonably estimated based on needs of the target population and the average length of stay. Again, for waiver renewals, this estimate should start with the actual experience as reported via the CMS-372(S) as the baseline. If the estimated number of units/user departs from the previous actual experience, explain and justify the basis of the deviation.

  In the case of new waivers or when additional services are being added in a waiver renewal, the explanation is expected to detail the source of the information upon which the estimate is based. The source may be a state study, utilization of similar services in other waiver programs, or the experience of other states that operate waivers that serve a similar target population and offer comparable services.

- **Cost/Unit**. For waiver renewals and amendments, this estimate should be based on actual experience as reported via the most recently approved CMS-372(S). If the estimated number of users departs from the previous actual experience, explain and justify the basis of the deviation.

  In the case of new waivers or when additional services are being added in a waiver renewal, the explanation is expected to detail the source of the information upon which the estimate is based. The source may be a state study, utilization of similar services in other waiver programs, or experience in other states. The explanation should identify the factor or factors that were used to trend unit costs forward across all waiver years. If a particular service has several intensity levels or settings and associated unit costs, the explanation of the derivation of unit costs should include information about each level (i.e., the derivation of the weighted average unit cost included in the table in item J-2-d).

  CMS reviews the estimates of unit costs with regard to the requirement that payments are consistent with economy, efficiency, and quality of care. A state may be required to provide additional justification if the amount of the payment appears to be excessive in light of experience with waivers that provide similar services to like target populations.

Item J-2-c-ii: Factor D' Derivation

Instructions

In the text field, describe the basis of the estimates of Factor D'.

Technical Guidance

Factor D' is the estimated annual average per capita Medicaid cost for all services (state plan and services required under EPSDT (when a waiver serves children)) that are furnished in addition to waiver services while the individual is in the waiver. This calculation includes institutional costs

when a person leaves the waiver for the institution and returns to the waiver in the same waiver year. If a waiver participant does not return to the waiver following institutionalization, do not include the cost of institutional care under D'. Do not include institutional costs incurred before the person is admitted into the waiver. If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in the calculation of Factor D'. If a waiver service is covered under the state plan and the service is defined identically except for utilization limits, the state plan service, up to the imposed limit, would be included under D'. The services under the waiver that exceed the state plan utilization limits would be included under factor D as waiver costs.

In the case of section 1915(c) waivers that will operate with a concurrent Medicaid managed care authority, include in factor D only the cost of capitation payments. Any additional services provided by the managed care organization through savings or under section 1915(b)(3) do not affect factor D, since they are funded by the capitation payment. Additional services, if provided under the managed care authority application out of the HCBS waiver capitation payment, are not considered section 1915(c) services and are not listed in the section 1915(c) application.

Estimates of Factor D' should not include the costs of prescribed drugs that will be furnished to Medicare/Medicaid dual eligibles under the provisions of Part D. Include an explanation of how the D' value is derived. In general, the D' value should be greater than or equal to the G' value. Typically, institutional payments encompass the costs of health care services that are furnished to institutional residents and, therefore, included in Factor G. In the case of waiver participants, most health care services are obtained via the state plan. If factor D' is less than factor G', provide an explanation of the reasons why this is the case. This situation may arise when institutional payments do not encompass all services that are furnished to institutional residents (for example, when the costs of day habilitation services furnished to ICF/IID residents are paid for separately under the state plan). Factor D' may be computed using the CMS-372(S) or statistically valid methods which are specified and submitted with the application. If the D' is developed through sampling a comparable population, provide information on the process used and how the D' value was derived.

Item J-2-c-iii: Factor G Derivation

Instructions

In the text field, describe the basis of the estimates of Factor G.

Technical Guidance

The Factor G value needs to reflect the average cost for the level(s) of institutional care that would otherwise be furnished to waiver participants. Provide data ONLY for the level(s) of care indicated in the waiver request. For waivers that apply only to individuals with a specific illness or condition, estimates may be based on the institutional costs incurred for individuals with the specific illness or condition. If institutional respite care is provided as a service under the waiver, calculate its cost under Factor D. Do not duplicate these costs in the calculation of Factor G.

New Waivers

When cost-neutrality estimates are based on the comparison of community costs to institutional costs and the state does not wish to base its estimate of institutional costs on the costs of serving individuals with specific illnesses or conditions, the projected first year and subsequent year

Factor G values through the end of the waiver is expected to be based on the actual costs of institutional services for all individuals at the relevant level(s) of care for the most recent year for which such data are available. These actual costs may be trended forward by applying inflation adjustments based on the current Medical Consumer Price Index unless higher rates are justified or the state employs a different basis for estimating future costs (e.g., observed state trends in the costs of institutional services). Specify the source of the data upon which the estimate of Factor G is based and how those costs are adjusted year-by-year.

When a waiver serves persons who have a specific illness or condition, derive Factor G (for each level of care) from the following: (1) except as discussed below, trends shown by CMS-372(S) for another waiver that serves a similar population at this level of care (specify the other waiver and related CMS-372(S) form that was used and indicate any adjustments made to the numbers.); (2) actual case histories of individuals institutionalized with the specified disease or condition at the relevant level of care. When this method is used, describe the methods that were used to derive the estimate of Factor G; (3) state DRGs for the disease(s) or condition(s) indicated in the request; or, (4) other method (include a description). In the application, provide a complete explanation of how the derivation of the estimate of Factor G.

Renewal Applications

In the case of renewal applications, when the Factor G figures reported via the CMS-372(S) were the same as the figures in the approved waiver rather than actual costs, a state may not use the CMS-372(S) as the basis of its estimate of Factor G for the renewal period, including the derivation of trend factors. Instead, the state should obtain and employ actual data for prior periods in order to establish a revised baseline estimate of Factor G and the expected trend.

Item J-2-c-iv: Factor G' Derivation

Instructions

In the text field, describe the basis of the estimates of Factor G'.

Technical Guidance

Factor G' includes the cost of all other Medicaid services furnished while the individual is institutionalized (including state plan and services required under EPSDT) and the cost of short-term hospitalization (furnished with the expectation that the person would return to the institution). When the waiver serves children, the G' value includes services required under EPSDT that are not accounted for in the G value. In situations where a waiver will provide services to individuals who, although requiring a NF level of care, are hospitalized because NF placement is not possible, the actual cost of caring for these individuals in a hospital should be shown in G'. When institutional respite care is provided as a service under this waiver, calculate its cost under Factor D. Do not duplicate these costs in the calculation of Factor G'.

Explain how the G' value is derived, including any supporting documentation. The projected first year G' value should not deviate substantially from previous year trends unless the state has altered its Medicaid program. Inflation adjustments should reflect data in current Medicaid Consumer Price Index unless other rates are justified.

In the case of waiver renewals, the estimate of Factor G' may be based on figures reported via the CMS-372(S) only when the reported CMS-372(S) figures represented actual expenditures. If the reported CMS-372(S) figures were the same as the figures in the approved waiver, a state may not use the CMS-372(S) as the basis of its estimate of Factor G', including the derivation of trend

factors. Instead, the state should obtain and employ actual data for recent prior periods in order to establish a revised baseline estimate of Factor G' and the expected trend.

Estimates of Factor G' should not include the costs of prescribed drugs that will be furnished to Medicare/Medicaid dual eligibles under the provisions of Part D.

CMS Review Criteria

- The state described the basis and the methodology used to determine the Factor D value which is based on the estimated number of users, units/user, and cost/unit.
- If Factor D' is not greater than or equal to Factor G', the state provided an explanation for this.
- If Factor D' is developed through sampling a comparable population, the state has provided information on the process used and how the D' value was derived.
- The projected first year G' value does not deviate substantially from previous year trends unless the state has altered its Medicaid program.

For all cost-neutrality formula factors:

- The basis of all Factor estimates is fully documented, and estimates are evidence-based and appropriately justified.
- Deviations from CMS-372(S) data are adequately explained, justified and documented.
- The state's factor D, D', G and G' derivation details the trend factors, including details of the data sources, how factors were trended forward, and justification of using sources outside of CMS-372(S) reports.

Item J-2-d: Estimate of Factor D

Instructions

Select whether the waiver operates concurrently with a section 1915(b) waiver, or other Medicaid authority utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). If not, complete the tables included in Item J-2-d-i. If so, complete the tables included in Item J-2-d-ii.

Technical Guidance

The two sets of tables are similar. However, in the case of managed care/section 1915(c) concurrent waivers, additional information needs to be provided (see below).

In the case of a waiver amendment, if the state amends the cost estimate table in Appendix J-2-d due to a change in Factor D, the state should also amend the Factor D derivation in Appendix J-2-c to document the basis of the amended estimates.

J-2-d-i: Non-Concurrent Waivers

The table is expected to be completed for each year that the waiver is in effect. This table is auto-populated by the entries in Appendices C-1/C-3. When a service listed in Appendix C-1 encompasses two or more discrete services that are reimbursed separately, these component services must be shown in the table. For example, if a state covers "day supports" but day supports is composed of day habilitation, supported employment and community access services, each component of day support needs to be listed and accounted for separately. When a service in Appendix C-1 is a bundled service, each component of the service needs to be shown.

With respect to column 1, the unit of service (for example, day, hour, month, trip, etc.) needs to be identified for each service. The unit should be descriptive of the service and not a generic term, such as 'unit'. With respect to column 3, keep in mind that the estimated number of units per user should reflect the estimated ALOS rather than the potential maximum number of service units that a participant may utilize. Partial units may not be used. See the State Medicaid Manual for additional information on units of service.

The average cost per unit (column 4) is expected to be reasonably estimated. The estimate should be based on expected payment rates for the service. When payment rates vary, the estimate should be based on the expected mix of payment rates.

The figures in this table should follow these rules:

- **Average Number of Users.** The average number of users needs to be expressed as a whole number (i.e., 235 users not 234.8 users);
- **Average Number of Units per User**. May be expressed as a whole number or in decimal form.
- **Average Cost per Unit**. Express in dollars and cents.
- **Total Cost**. Total cost is expressed as the product of the average number of users, the average number of units per user and the average cost per unit. Total cost is expressed in dollars and cents.

The total cost is auto calculated based on the number of users, average number of units per user, and average cost per unit.

CMS Review Criteria

- The unit of service is identified for each service.
- The estimated number of units per user reflect the estimated ALOS rather than the potential maximum number of service units that a participant may utilize.

J-2-d-ii: Concurrent Waivers

The Factor D table for concurrent section 1915(b)/1915(c) waivers or other concurrent managed care authorities utilizing capitated payment arrangements (i.e., 1915(a), 1932(a), Section 1937) includes an additional column to indicate whether a waiver service is included in the capitation rate paid to managed care entities or will be paid outside the capitation rate (i.e., the state will make payment directly for the service). For waiver services included in the capitation rates paid to managed care entities, states need to indicate this by checking off the "Capitated" column in the Appendix J-2-d-ii table.

When there are services paid outside the capitation rate, states need to calculate the total of all waiver costs and calculate separately the subtotals for services paid within the capitation rate and services paid outside the rate. These estimates are calculated automatically. It also is necessary to calculate the average cost per unduplicated participant for all waiver services and the average costs for services paid within the capitation rate and outside the capitation rate. This information will be employed by CMS in evaluating the cost-effectiveness of the section 1915(b) waiver.

CMS Review Criteria

If there are services paid outside the capitation rate, the state has calculated:

- The total of all waiver costs,
- The subtotal for services paid within the capitation rate,
- The subtotal for services paid outside the rate,
- The average cost per unduplicated participant for all waiver services, AND
- The average costs for services paid within and outside the capitation rate.

Glossary of Terms and Abbreviations

90-day Clock	The informal term for the ninety-day calendar period within which CMS must approve or disapprove a state's request to amend its State plan, initiate a new waiver, renew a waiver, or amend a waiver. The 90-day clock begins on the date that CMS receives the request from a state, either electronically or by other delivery method.
Section 209(b) State	Refers to the statutory authority allowing states to have more restrictive financial methodologies for the aged, blind, or disabled than those of the SSI program. States electing this option may not use more restrictive standards than were in effect on January 1, 1972 and must permit individuals to deduct incurred medical expenses from income through Medicaid spenddown so that they may qualify for Medicaid.
300% of SSI Group	See Special Income Group
§ 435.217 Group	See Special Home and Community-Based Waiver Group
Section 1115 Research and Demonstration Waiver	Research and demonstration programs that operate under waivers that are granted under the provisions of section1115 of the Social Security Act to authorize experimental, pilot, or demonstration project(s) that, in the judgment of the Secretary of Health and Human Services are likely to assist in promoting the objectives of the Act, including but not limited to Title XIX (the Medicaid statute) of the Act. The 1115 research and demonstration authority has been employed to implement alternative approaches to the delivery of Medicaid services.
Section 1634 State	A state that has entered into a contract with the Social Security Administration (SSA) under the provisions of section 1634(a) of the Act for SSA to determine Medicaid eligibility at the same time that eligibility for SSI benefits and/or Federally- administered state supplementary payments is determined. In 1634 states, SSI beneficiaries do not make a separate application for Medicaid.
Section 1915(b)	A provision of the Social Security Act that authorizes the Secretary of HHS to grant certain waivers of Medicaid statutory requirements. The 1915(b) authority may be used to: (a) mandate the enrollment of Medicaid beneficiaries into managed care plans (1915(b)(1)); (b) employ a central enrollment broker (1915(b)(2)); (c) use cost savings to

	provide additional services to enrollees (1915(b)(3); and/or, (d) limit the number of providers through selective contracting (1915(b)(4)). Waivers granted under the provisions of 1915(b) may be effective for a period of two years and may be renewed for subsequent two-year periods.
Section 1915(b)/1915(c) Concurrent Waivers	Simultaneous use of the §1915(b) and §1915(c) waiver authorities may be used to integrate delivery of home and community-based services with State plan services in order to provide a coordinated array of services to beneficiaries. States also use the §1915(b) authority to limit free of choice of provider while employing the §1915(c) authority to provide the home and community-based services. A state can implement a §1915(b)/§1915(c) concurrent waiver as long as all Federal requirements for both waiver programs are met. Therefore, when submitting applications for concurrent §1915(b)/(c) programs, a state must submit a separate application for each waiver type and satisfy all of the applicable requirements under each authority.
Section 1915(c)	The provision of the Social Security Act that authorizes the Secretary of HHS to grant waivers of certain Medicaid statutory requirements so that a state may furnish home and community services to Medicaid beneficiaries who need a level of institutional care that is provided in a hospital, nursing facility or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).
Section 1915(g)(1)	A provision of the Social Security Act that permits a state to furnish "targeted case management services" under the State plan to groups of Medicaid beneficiaries specified by the state on a statewide or less than statewide basis. See also "targeted case management."
Section 1915(i)	A provision of the Social Security Act enacted through the Deficit Reduction Act of 2005 (DRA), that permits a state to furnish home and community services under the State plan without regard to whether Medicaid beneficiaries require an institutional level of care.
AAA	See Area Agency on Aging
Abuse	The infliction of injury, unreasonable confinement, intimidation, punishment, mental anguish, sexual abuse or exploitation on an individual. Types of abuse include (but are not necessarily limited to): (a) physical abuse (a physical act by an individual that may cause physical injury to another individual); (b) psychological abuse (an act, other than verbal, that may inflict emotional harm, invoke fear and/or humiliate, intimidate, degrade or demean an individual); (c) sexual abuse (an act or attempted act such as rape, incest, sexual molestation, sexual exploitation or sexual harassment and/or inappropriate or unwanted touching of an individual by another); and, (d) verbal abuse (using words to threaten, coerce, intimidate, degrade, demean, harass or humiliate an individual).
Abuse Registry	An official, state-maintained listing of individuals who have been convicted of abuse or found through a civil/administrative procedure to have committed abuse against a person.

Accreditation	An evaluative process through which a provider organization undergoes an examination of its policies, procedures and performance by a nationally recognized external organization ("accrediting body") to determine that the provider meets predetermined criteria.
Act	The Federal Social Security Act (42 U.S.C. §1396 *et seq*.)
Activities of Daily Living (ADL)	Basic personal everyday activities that include bathing, dressing, transferring (e.g., from bed to chair), toileting, mobility and eating. The extent to which a person requires assistance to perform one or more ADLs often is a level of care criterion.
ADL	See Activities of Daily Living
Administration	Necessary activities that are undertaken by a state to implement and operate its Medicaid program, including complying with Federal administrative requirements. Administrative activities include but are not limited to the payment of provider billings, utilization management, and the operation of an MMIS.
Administrative FFP	The Federal share of the expenses for performing activities that are necessary for the proper and efficient administration of the State plan. Federal Financial Participation (FFP) rates for administrative activities vary by function, not by state. The general FFP administrative rate is 50%. Some administrative functions qualify for enhanced FFP administrative rates of 75 percent or more as specified in 42 CFR §433.15. (e.g., survey and certification, fraud control units).
Aged	As provided in §1905(a)(iii) of the Act, persons aged 65 and older.
Agency Provider	A public or private organization/entity that holds a Medicaid provider agreement and furnishes services to waiver participants using its own employees or subcontractors.
Agency with Choice (Model)	One of the two Employer Authority options that may be made available to waiver participants who direct some or all of their services. Also known as the “co- employment option,” an arrangement wherein an organization (a co-employment agency) assumes responsibility for: (a) employing and paying workers who have been selected by waiver participants to provide services to them; (b) reimbursing allowable services; (c) withholding, filing and paying Federal, state and local income and employment taxes; and (d) sometimes providing other supports to the participant. Under this model, the participant acts as the “Managing Employer” and is responsible for hiring, managing, and possibly dismissing the worker. The Agency with Choice model can enable participants to exercise choice and control over services while relieving them of the burden of carrying out financial matters and other legal responsibilities associated with the employment of workers. Under this model, the co-employment agency is considered the common law employer of workers who are selected/hired by the waiver participant.
ALOS	See Average Length of Stay

Amendment	A formal request submitted by a state to modify an approved waiver.
Amount (of services)	A term that refers to the total volume of services (measured in units or dollars) that are furnished to an individual.
Annual Waiver Report	See CMS-372(S)
Approved Waiver	A waiver that has been approved by CMS and is in effect.
Area Agency on Aging (AAA)	Agencies established in each state under the provisions of the Federal Older Americans Act to meet the needs of persons aged 60 and over in local communities.
Assessment	One or more processes that are used to obtain information about an individual, including his/her condition, personal goals and preferences, functional limitations, health status and other factors that are relevant to the authorization and provision of services. Assessment information supports the determination that an individual requires waiver services as well as the development of the service plan.
Assisted Living	An assisted living facility provides residents personal care and other assistance as needed with ADLs and IADLs but does not provide round-the-clock skilled nursing services. Assisted living facilities generally provide less intensive care than nursing facilities and emphasize resident privacy and choice.
Assurance	The commitment by a state to operate a HCBS waiver program in accordance with statutory requirements. Approval of a new waiver is contingent on CMS determining that the program's design will result in meeting the assurances contained in 42 CFR §441.302. Renewal of a waiver is contingent on CMS finding that a waiver has been operated in accordance with the assurances and other Federal requirements.
Average Length of Stay (ALOS)	The average number of days during a waiver year that a waiver participant is served on a waiver.
Backup	Provision for alternative arrangements for the delivery of services that are critical to participant well-being in the event that the provider responsible for furnishing the services fails or is unable to deliver them.
BBA-97	Balanced Budget Act of 1997 (P.L. 105-33)
Beneficiary	An individual who is eligible for and enrolled in the Medicaid program.
Billing	The request for payment by a provider from the state for services rendered.
Budget Authority	The participant direction opportunity through which a waiver participant exercises choice and control over a specified amount of waiver funds (participant-directed budget). Under the budget authority, the participant has decision-making authority regarding who will provide a service, when the service will be provided, and how the service will be provided consistent with the waiver's service specifications and other requirements. The participant has the authority to make changes in the distribution of funds among the waiver services included in the participant-directed budget. Budget changes and the service plan need to be synchronized.

Bundled Service	A waiver service that encompasses two or more discrete services that are not closely related. When a state proposes to cover a bundled service, it needs to demonstrate that such bundling will result in more efficient and economical delivery of services and ensure that waiver participants enjoy free choice of provider.
Buy-in	See Medicaid Buy-In
Capitation Payment	A method of payment for an array of services wherein a single fixed payment is made periodically (usually monthly) to a provider (e.g., a managed care entity) on behalf of each beneficiary who is enrolled with the provider and for whom the provider is obligated to furnish the services included in the array. The state makes the payment regardless of the actual number or nature of the services provided. Capitation payment methods are commonly employed in managed care arrangements.
Caregiver	A person who helps care for someone who is ill, has a disability, and/or has functional limitations and requires assistance. Informal caregivers are relatives, friends or others who volunteer their help. Paid caregivers provide services in exchange for payment for the services rendered.
Case Management	A set of activities that are undertaken to ensure that the waiver participant receives appropriate and necessary services. Under a HCBS waiver, these activities may include (but are not necessarily limited to) assessment, service plan development, service plan implementation and service monitoring as well as assistance in accessing waiver, State plan, and other non-Medicaid services and resources. Case management sometimes is referred to as “service coordination,” or “support coordination.”
Categorical Eligibility	A phrase that describes Medicaid’s policy of restricting eligibility to individuals in certain specified groups or categories, such as children, older persons (the aged), or individuals with disabilities (the disabled). In order to be determined eligible for Medicaid, individuals who fall into approved, statutorily recognized categories must also satisfy financial eligibility requirements, including income and, in most cases, resource tests imposed by the state in which they reside.
Categorically Needy	A phrase that describes certain groups of Medicaid beneficiaries who qualify for the basic mandatory package of Medicaid benefits. There are mandatory categorically needy groups that states must cover, such as pregnant people and infants with incomes at or below 133 percent of the Federal Poverty Level (FPL). There are also optional categorically needy groups that states may elect to cover at their option, such as pregnant people and infants with incomes above 133 percent and up to 185 percent of the FPL. Unlike the medically needy, categorically needy individuals do not spenddown to qualify for Medicaid (except in 209(b) States).
Certified Public Expenditure (CPE)	The expenditure by a state or local public agency to provide or purchase services that qualify for Medicaid Federal financial participation. The public agency certifies these expenditures to the Medicaid agency which

	(a) includes them in its claim for FFP and (b) pays the certifying public agency the Federal share of allowable expenditures.
Claim	The formal request by the state for Federal financial participation in the costs of services furnished to beneficiaries and expenses for the administrative activities that the state has incurred to operate its Medicaid program.
Centers for Medicare & Medicaid Services (CMS)	The agency in the Department of Health and Human Services that is responsible for Federal administration of the Medicaid, Medicare, and Children's Health Insurance Program (CHIP) programs. CMS was formerly known as the Health Care Financing Administration (HCFA).
Center for Medicaid and CHIP Services (CMCS)	The component within CMS that is responsible for Federal administration of the Medicaid, the Children's Health Insurance Program (CHIP) program, and the Basic Health Program.
Certification	The result of formal processes that are undertaken by a state to verify that a provider meets regulatory standards for the delivery of a service.
CFR	Code of Federal Regulations. The CFR contains the regulations that have been officially adopted by Federal agencies. Federal regulations that govern the Medicaid program are contained in 42 CFR §430 *et seq*.
Chore Services	Assistance with household tasks such as home repairs, yard work, and heavy housecleaning.
Chronic Illness	A long-term or permanent illness (e.g., diabetes, arthritis) that may result in some type of disability for which assistance may be required on a continuing basis.
Chronic Mental Illness	See Serious Mental Illness
CMCS	See Center for Medicaid and CHIP Services
CMS	See Centers for Medicare & Medicaid Services
CMS-372(S)	The annual report that a state must submit to CMS following the completion of each waiver year that details: (a) the number of unduplicated individuals who participated in a waiver during the waiver year; (b) the unduplicated number of persons who utilized each waiver service and the amount of funds expended for each service; (c) expenditures for Medicaid State plan services on behalf of waiver participants; and, (d) information concerning assuring the health and welfare of waiver participants. The information submitted via the CMS-372(S) provides evidence of the waiver's cost-neutrality on an ongoing basis.
CMS Waiver Number	The unique numeric identifier assigned by CMS to each HCBS waiver program.
Co-Employment Agency	See Agency with Choice model.
Co-Employer	See Agency with Choice model
Co-Insurance	A fixed percentage of the cost of a specific service that must be paid by the beneficiary. Under Medicaid, co-insurance amounts may not

	generally exceed 10% of the cost of the service. Co-insurance is distinguished from co-payment where a fixed dollar amount is charged to a beneficiary for a service.
Common Law Employer	A common law employer-employee relationship generally exists when the person for whom services are performed has the authority to control and direct the individual who performs the services, not only as to the result to be accomplished but also as to the detail and means by which that result is accomplished.
Common Law Employer (Option)	One of the two Employer Authority options that may be made available to waiver participants who direct some or all of their services. Under this option, the waiver participant is the common law employer of workers who furnish services and supports and assumes all responsibilities associated with being the employer of such workers. When this option is selected, a Fiscal/Employer Agent performs employer-related tasks on behalf of the participant but does not serve as the common law employer of participant-hired workers.
Community Transition	Activities that are undertaken to assist an institutionalized person to return to the community or facilitate a person served in a congregate living arrangement in the community to reside in a private residence.
Comparability	The requirement contained in §1902(a)(10)(B) of the Act that a state must offer services in the same amount, duration, and scope to individuals within categorically or medically needy groups covered under its State plan and that services available to any categorically needy recipient cannot be less than those available to a medically need recipient. A state must request a waiver of this provision in order to operate an HCBS waiver.
Complaint	The formal expression of dissatisfaction by a participant with the provision of a waiver service or the performance of an entity in conducting other activities associated with the operation of a waiver.
Computable Waiver Costs	The amount expended by the state for waiver services net of adjustments for offsets such as participant post-eligibility treatment of income financial liability and cost-sharing. Only computable waiver costs are eligible for Federal financial participation.
Continuous Improvement	The utilization of systematically complied data and quality information derived from discovery activities in order to engage in actions to secure better performance in the operation of a waiver.
Co-Payment	A fixed dollar amount that a Medicaid beneficiary is expected to pay at the time of receiving a specified covered service from a provider. Co-payments, like other forms of Medicaid beneficiary cost-sharing (e.g., deductibles, coinsurance), may only be imposed by a state upon certain groups of beneficiaries, only with respect to certain services, and only in amounts as specified in Federal law.
Cost Neutrality	The requirement that an HCBS waiver must be designed and operated so that the average cost per unduplicated participant of furnishing waiver services and other Medicaid benefits is no greater than the average cost per unduplicated individual of furnishing institutional

	services and other Medicaid benefits to institutionalized persons at the same level of care. Cost neutrality must be demonstrated prospectively in order for a new waiver or a waiver renewal to be approved. It also must be verified each year that the waiver is in effect (by the submission of the annual CMS 372(S) report).
Cost-Sharing	The required out-of-pocket payment that an individual must pay for a covered service. Cost sharing generally takes one of three forms: co-insurance, co-payments or deductibles.
Countable Income or Resources	The amount of income or resources that is left after the application of all financial eligibility methodologies and that is compared to the applicable income or resource standard for the purpose of determining Medicaid eligibility.
CPE	See Certified Public Expenditures
Criminal History/ Background Investigation	A process that is undertaken to determine whether a person who would provide services has been convicted of a crime. Requirements for conducting criminal history/background investigations are typically established under state law/regulations. Under such requirements, a human services agency or health care provider must conduct an investigation prior to hiring a person or permitting an employee to furnish services directly to individuals and, in some cases, may prohibit the employment of individuals who have been convicted of specified crimes.
Critical Incident (Event)	An alleged, suspected, or actual occurrence of: (a) abuse (including physical, sexual, verbal and psychological abuse); (b) mistreatment or neglect; (c) exploitation; (d) serious injury; (e) death other than by natural causes; (f) other events that cause harm to an individual; and, (g) events that serve as indicators of risk to participant health and welfare such as hospitalizations, medication errors, use of restraints or behavioral interventions.
DAC	See Disabled Adult Child
Deductible	A specified dollar amount that the beneficiary must incur before Medicaid will pay for services. The amount of the deductible must comply with Medicaid federal law.
Deemed Status	The use of the findings of a private accreditation organization, in whole or in part, to supplement or substitute for state verification of provider quality standards.
Deficit Reduction Act of 2005	The federal legislation (P.L. 109-171) that made numerous changes to federal Medicaid law, including provisions that affect beneficiary cost sharing and the permit the coverage of certain home and community services under the state plan.
Design	The process of structuring an HCBS waiver (including its benefits and operational processes) in order to achieve its intended purpose(s).
Developmental Disability	As provided in The Developmental Disabilities Assistance and Bill of Rights Act of 2000 (P.L.106-402 – 42 USC §15002(8)(A) &(B)):

	(A) IN GENERAL.—The term ‘‘developmental disability’’ means a severe, chronic disability of an individual that— (i) is attributable to a mental or physical impairment or combination of mental and physical impairments; (ii) is manifested before the individual attains age 22; (iii) is likely to continue indefinitely; (iv) results in substantial functional limitations in 3 or more of the following areas of major life activity: (I) Self-care. (II) Receptive and expressive language. (III) Learning. (IV) Mobility. (V) Self-direction. (VI) Capacity for independent living. (VII) Economic self-sufficiency; and (v) reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated. (B) INFANTS AND YOUNG CHILDREN.—An individual from birth to age 9, inclusive, who has a substantial developmental delay or specific congenital or acquired condition, may be considered to have a developmental dis ability without meeting 3 or more of the criteria described in clauses (i) through (v) of subparagraph (A) if the individual, without services and supports, has a high prob ability of meeting those criteria later in life. [N.B., The foregoing definition is not the same as the Medicaid specification of individuals who may receive ICF/IID services. ICF/IID services are furnished to persons with intellectual disability and other related conditions (see below). When a waiver targets individual with developmental disabilities, a state should define its use of the term "developmental disability."]
DHCBSO	See Division of HCBS Operations and Oversight
Disability	For Social Security purposes and as provided in section 1614(a)(3) of the Act, disability means the inability of a person aged 18 or older to engage in substantial gainful activity (work) by reason of any medically determinable physical or mental condition that can be expected to result in death or to last for a continuous period of not less than 12 months. In the case of children (persons aged 17 and younger), the child must have a physical or mental condition that results in marked and severe functional limitations. The condition also must be expected to result in death or to last for a continuous period of not less than 12 months.
Disabled	As provided in section 1905(a)(vii) of the Act, for Medicaid purposes the term "disabled" means persons under the age of 65 who have been determined to have a disability for Social Security purposes (as provided in section 1614(a)(3) of the Act). A 209(b) state may use a more restrictive definition for "disability."
Disabled Adult Child (DAC)	A SSDI beneficiary whose disability began before age 22. For an adult with disabilities to become eligible for this benefit, one of his or her parents must: (a) be receiving Social Security retirement or disability benefits or (b) must have died and have worked long enough under Social Security. These benefits are also payable to an adult who

	received dependents benefits on a parent's Social Security earnings record prior to age 18, if he or she is disabled at age 18.
Discovery	Engaging in activities to collect data about the conduct of processes, the delivery of services, and direct participant experiences in order to assess the ongoing implementation of a waiver, identifying both concerns as well as other opportunities for improvement. Examples of discovery activities include, but are not limited to, monitoring, complaint systems, incident management systems, and regular systematic reviews of critical processes such as participant-centered planning and level of care determinations. Discovery activities are usually designed to identify problems that may require remediation and sometimes lead to systemic changes/improvements.
Disregard	An informal term for the state's methodology for counting or excluding income and resources in determining Medicaid eligibility. For certain eligibility categories, such as poverty-related children or working disabled adults, states may disregard – that is, not count – certain income or resources in determining whether the individual meets its Medicaid income or resource standards. The effect of an income or resource disregard is to enable an individual to qualify for Medicaid even if his or her gross income or resources exceed the state eligibility standard.
Division of HCBS Operations and Oversight (DHCBSO)	The unit within MCOG that serves as the first point-of-contact for the states concerning the HCBS waiver program. DHCBSO is also tasked with oversight of the waivers and engaging in ongoing dialogue with the state concerning waiver operations and performance. DHCBSO shares responsibilities with DLTSS for reviewing waiver applications and requests for amendments and providing technical assistance to states concerning the design and operation of waivers.
Division of Long-Term Services and Supports (DLTSS)	The unit within MBHPG that has direct line responsibility for the HCBS waiver program. DLTSS shares responsibilities with DHCBSO for reviewing waiver applications and requests for amendments and providing technical assistance to states concerning the design and operation of waivers.
DLTSS	See Division of Long-Term Services and Supports
Donation	The transfer of funds from a provider or provider organization to the state to provide the non-federal share of Medicaid expenditures. Allowable donations are termed "bona fide donations," as defined in 42 CFR § 433.54. Other donations are generally not allowable.
DRA	See Deficit Reduction Act of 2005
Drug Used as Restraint	Any drug that: (1) is administered to manage an individual's behavior in a way that reduces the safety risk to the individual or others; (2) has the temporary effect of restricting the individual's freedom of movement; and (3) is not a standard treatment for the individual's medical or psychiatric condition.
Dual Eligible (Full	An individual who is eligible for both Medicare Parts A and B and for

Benefit)	full Medicaid coverage, including the payment of the person's Medicare premium, deductibles, and co-insurance.
Duration (of services)	The length of time that a service will be provided. A limit on the duration of services means that the service will no longer be provided after a specified period of time or, after a specified period of time, the necessity for the service is subject to review and reauthorization.
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	Medicaid's comprehensive child health program for individuals under the age of 21. EPSDT is authorized under section 1905(r) of the Act and includes the performance of periodic screening of children, including vision, dental, and hearing services. Section 1905(r)(5) of the Act requires that any medically necessary health care service that is listed in section1905(a) of the Act be provided to an EPSDT beneficiary even if the service has not been specifically included in State plan. Federal EPSDT regulations are located in 42 CFR § 441.50 *et seq*.
Eligibility Determination	Refers to the processes that are employed to ascertain whether an individual meets the requirements specified in the state plan to receive Medicaid benefits. Such requirements include the determination of whether a person is a member of an eligibility group specified in the state plan and meets the applicable income and resource standards associated with the group. Eligibility determination must be performed by the Medicaid agency or another agency specified in 42 CFR § 431.10(c) with which the Medicaid agency has an agreement as provided in 42 CFR § 431.10(d).
Eligibility Group	Any one of the distinct groups of individuals identified in §1905(a) of the Act or elsewhere in the Act to which a state must or may furnish Medicaid benefits.
Emergency Backup	See Backup.
Employer Authority	The participant direction opportunity by which the waiver participant exercises choice and control over individuals who furnish waiver services authorized in the service plan. Under the employer authority, the participant may function as the co- employer (managing employer) or the common law employer of workers who furnish direct services and supports to the participant.
Enhanced Payment	See Supplemental Payment
Enrollment	An informal term used to describe the processes that result in the entry of an individual into a HCBS waiver. Synonymous with the term "entrance."
Entrance	The result of completing all processes that must be completed in order for an individual to begin to receive waiver services. A person may start to receive waiver services when: (a) the person has been determined to meet applicable Medicaid eligibility criteria; (b) there has been a determination that the person is member of a target group that is included in the waiver; (c) there has been a determination that the person requires a level of care specified for the waiver; (d) the person

	has exercised freedom of choice and has elected to receive waiver instead of institutional services; and, (e) a service plan has been developed that includes one or more waiver services. FFP is not available for the costs of services furnished to an individual until all of these steps have been completed. Entrance may be expedited by the preparation of an interim service plan.
EPSDT	See Early and Periodic Screening, Diagnosis and Treatment
Evaluation	The processes that are undertaken to determine whether an individual requires the level of care specified for the waiver.
Evidence	Data or facts that support determining whether something is true or not true.
Evidence-Based	A broad term that is used to describe methods or practices that have been demonstrated (through formal research and systematic analysis of data) to secure specified outcomes efficiently and efficaciously.
Exploitation	An act of depriving, defrauding or otherwise obtaining the personal property of an individual by taking advantage of a person's disability or impairment.
Extended State Plan Service	The coverage in a waiver of a state plan service for the purpose of furnishing the state plan service in an amount, frequency or duration that is greater than allowed under the state plan.
Extension	The approved continued operation of an HCBS waiver beyond its expiration date until a determination is made by CMS whether to renew the waiver. An extension must be requested by the state and approved by CMS and is limited to a single 90- day period.
Fair Hearing	The administrative procedure established in section 1902(a)(3) of the Act and further specified in 42 CFR Subpart E (42 CFR §431.200 through §431.246) that affords individuals the statutory right and opportunity to appeal adverse decisions regarding Medicaid eligibility or benefits to an independent arbiter. An individual has the opportunity to request a Fair Hearing when denied eligibility, when eligibility is terminated, or when denied a covered benefit or service.
FBR	See Federal Benefit Rate
Feasible Alternatives	The types of waiver services that may be available to an individual who is a candidate for entrance to the waiver (e.g., meets requirements for entrance such as the need for a level of care specified in the waiver). During the waiver entrance process, a person must be informed of the feasible alternatives under the waiver so that the person may exercise freedom of choice between waiver and institutional services.
Federal Benefit Rate (FBR)	The maximum federal monthly payment that is paid to an SSI recipient or a couple who has no other countable income. The amount of the FBR is updated annually to take into account inflation by applying a Cost of Living Adjustment (COLA). The new COLA-adjusted FBR takes effect on January 1 of each calendar year.
Federal Financial Participation	The technical term for federal Medicaid matching funds paid to states for allowable expenditures for Medicaid services or administrative

(FFP)	costs. Except in certain circumstances, states receive FFP for service expenditures at different rates (FMAPs), depending on each state's per capita incomes. FFP for Medicaid administrative expenditures (see Administrative FFP) also varies in its rate, depending upon the type of administrative function, as provided in section1903(a)(2) of the Act.
Federal Insurance Contributions Act (FICA)	The federal law that authorizes taxes on the wages of employed persons to provide for contributions to the Federal Old Age, Survivors and Disability Insurance (OASDI – Social Security) and Medicare Health Insurance (Part A) programs. Covered workers and their employers pay FICA taxes in equal amounts.
Federal Medical Assistance Percentage (FMAP)	The statutory term for the federal Medicaid matching rate for medical assistance furnished under the State plan – i.e., the share of the costs of Medicaid *services* that the federal government bears. In most cases, FMAP varies from 50 to 83 percent, depending upon a state's per capita income. FMAP rates are re- calculated annually under the formula set forth in section 1903(b) of the Act.
Federal Poverty Level (FPL)	The federal government's working definition of poverty that is used as the reference point for the income standard for Medicaid eligibility for certain groups of beneficiaries. The FPL is adjusted annually for inflation and is published by the Department of Health and Human Services in the form of Poverty Level Guidelines by household size.
Federal Register (FR)	The official federal daily publication that contains proposed rules, final regulations and notices of federal agencies and organizations as well as Executive Orders and other Presidential documents. The Federal Register is cited by volume number and page number(s).
Federal Unemployment Tax Act (FUTA)	The Federal Employment Tax Act authorizes the Internal Revenue Service to collect a federal employer tax used to fund state workforce agencies. Employers pay this tax annually by filing IRS Form 940. FUTA covers the costs of administering the Unemployment Insurance and Job Service programs in all states. In addition, FUTA pays one-half of the cost of extended unemployment benefits (during periods of high unemployment) and provides for a fund from which states may borrow, if necessary, to pay benefits.
Fee for Service	A method of paying providers for services rendered to individuals. Under a fee- for-service system, the provider is paid for each discrete service rendered to an individual.
FFP	See Federal Financial Participation
FICA	See Federal Insurance Contribution Act.
Financial Accountability	The assurance by a state that its claims for federal financial participation in the costs of waiver services are based on state payments for waiver services that have been rendered to waiver participants, authorized in the service plan, and properly billed by qualified waiver providers in accordance with the approved waiver.
Financial Eligibility	In order to qualify for Medicaid, an individual must meet both categorical (e.g., have a disability) and financial eligibility requirements.

	Financial eligibility requirements vary state-to-state and by eligibility category. These requirements generally include limits on the amount of countable income (income standard) and the amount of countable resources (resource standard) an individual is allowed to have in order to qualify for coverage.
Financial Management Services	A support that is provided to waiver participants who direct some or all of their waiver services. This support may be furnished as a waiver service or conducted as an administrative activity. When used in conjunction with employer authority, this support includes (but is not necessarily limited to) operating a payroll service for participant employed workers and making required payroll withholdings. When used in conjunction with budget authority, this support includes (but is not necessarily limited to) paying invoices for waiver goods and services and tracking expenditures against the participant-directed budget.
Fiscal Agent	The entity that processes or pays Medicaid vendor billings under contract with the Medicaid agency and that meets the requirements contained in 42 CFR §434.10. Sometimes referred to as a "financial intermediary."
Fiscal/Employer Agent	A term used by the IRS for entities that perform tax withholding for employers.
FMAP	See Federal Medical Assistance Percentage
FPL	See Federal Poverty Level
FR	See Federal Register
Fraud and Abuse	In the context of provider billings for Medicaid services, fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law. Abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary costs to the Medicaid program. State plan requirements concerning fraud detection and investigation are located in 42 CFR §455.12 et seq.
Free Choice of Provider	As specified in section 1902(a)(23) of the Act and 42 CFR § 431.51, the right of a Medicaid beneficiary to obtain Medicaid services from any institution, agency, pharmacy, person, or organization that is (a) qualified to furnish the services; and (b) willing to furnish them to the beneficiary. Free choice of provider may be limited under a waiver granted under section 1915(b) of the Act. Section 1915(c) of the Act (the statute authorizing the HCBS waiver program) does not grant the Secretary the authority to waive section1902(a)(23) of the Act.
Freedom of	The right afforded an individual who is determined to be likely to

Choice	require a level of care specified in a waiver to choose either institutional or home and community-based services, as provided in section 1915(c)(2)(C) of the Act and in 42 CFR § 441.302(d).
Frequency (of services)	How often a service will be furnished to a beneficiary.
FUTA	See Federal Unemployment Tax Act
GAGAS	See Generally Accepted Government Auditing Standards
Generally Accepted Government Auditing Standards (GAGAS)	Standards for financial audits issued by the Comptroller General of the United States through the U.S. General Accountability Office. The standards and guidance apply to audits and attestation engagements of government entities, programs, activities, and functions, and of government assistance administered by contractors, nonprofit entities, and other nongovernmental entities. A number of statutes and other mandates require that auditors follow GAGAS. The Single Audit Act Amendments of 1996 (Public Law 104-156) require that GAGAS be followed in audits of state and local governments and nonprofit entities that receive federal awards. The use of GAGAS is also required by Office of Management and Budget (OMB) Circular A-133, Audits of States, Local Governments, and Non-Profit Organizations, which provides the government- wide guidelines and policies on performing audits to comply with the Single Audit Act.
Grievance	A formal, beneficiary complaint about the way that a service provider is furnishing a Medicaid service or about the conduct of a waiver administrative process.
Habilitation	Services that are provided in order to assist an individual to acquire a variety of skills, including self-help, socialization and adaptive skills. Habilitation is aimed at raising the level of physical, mental, and social functioning of an individual. Habilitation is contrasted to rehabilitation which involves the restoration of function that a person has lost.
HCBS	Home and Community-Based Services
Health Insurance Portability and Accountability Act of 1996 (HIPAA)	The federal law (P.L. 104-191) that requires (among its other provisions) that each state's Medicaid management information system (MMIS) have the capacity to exchange data with the Medicare program and that contains "Administrative Simplification" provisions that require state Medicaid programs to use standard, national codes for electronic transactions related to the processing of health claims. HIPAA also mandates certain standards and practices with regard to the privacy of consumer health information.
HHS	U.S. Department of Health and Human Services
HIPAA	See Health Insurance Portability and Accountability Act of 1996
Home Health Aide	A person who, under the supervision of a home health, assists elderly, ill or a person with a disability with household chores, bathing, personal care, and other daily living needs.
Home Health	As specified in 42 CFR §440.70, the provision of part-time or

Services	intermittent nursing care and home health aide services and, at a state's option, physical therapy, occupational therapy, speech pathology and audiology services, medical equipment, medical supplies, and appliances that are provided to Medicaid beneficiaries in their place of residence. Home health services are a mandatory Medicaid benefit. Home health services must be ordered by a physician under a plan of care that the physician reviews at least every sixty days.
Homemaker Services	The performance of general household tasks (e.g., meal preparation and routine household care) provided by a qualified homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home.
IADL	See Instrumental Activities of Daily Living
IBA	See Individual Budget Amount
ICF/IID	See Intermediate Care Facility for Individuals with Intellectual Disabilities
IDEA	See Individuals with Disabilities Education Improvement Act of 2004
IGT	See Intergovernmental Transfer
IMD	See Institutions for Mental Disease
Income Standard	The maximum amount of countable income that a person can have and still be financially eligible for Medicaid.
Indicator	A key quality characteristic that is measured, over time, in order to assess the performance, processes, and outcomes of service delivery components.
Individual Budget Amount (IBA)	As used in the waiver application, the term "individual budget amount" means a prospectively determined amount of funds that the state makes available for the provision of waiver services to a participant. The IBA may encompass all waiver services or a subset of waiver services. An IBA may serve as the basis for but is not necessarily synonymous with the term "participant-directed budget" when a waiver provides for the Budget Authority participant direction opportunity.
Individual Cost Limit	A limitation on the entrance of individuals to a waiver that is based on the comparison of the expected costs of HCBS waiver and state plan services to the expected costs of institutional and State plan services that the person would receive in lieu of participation in the waiver. When a state adopts an individual cost limit, the state denies entrance to the waiver when the expected cost of HCBS waiver and State plan services required by an individual exceeds the limit established by the state.
Individual Risk Agreement (Contract)	An agreement that outlines the risks and benefits to the participant of a particular course of action that might involve risk to the participant, the conditions under which the participant assumes responsibility for the agreed upon course of action, and the accountability trail for the decisions that are made. A risk agreement permits individuals to assume responsibility for their choices personally, through surrogate decision

	makers, or through planning team consensus.
Individuals with Disabilities Education Improvement Act of 2004 (IDEA)	The federal law (P.L. 108-446; 20 USC §1400 *et seq*.) that ensures "that all children with disabilities have available to them a free appropriate public education that emphasizes special education and related services designed to meet their unique needs and prepare them for further education, employment, and independent living."
Information and Assistance in Support of Participant Direction	Activities that are undertaken to assist a waiver participant to direct and manage his/her waiver services. Such activities might include assisting a participant in carrying out employer responsibilities under the employer authority or locating sources of waiver goods and services and managing the participant-directed budget. This support is furnished by individuals or entities that work on behalf of and under the direction of the person. These activities may be provided as a distinct waiver service, in conjunction with the provision of case management, as an administrative activity or using a combination of delivery methods. Also sometimes known as "supports brokerage" or "personal agent."
Interagency Agreement	A formal document that sets forth the responsibilities that are assumed by two or more governmental agencies in their pursuit of common goals and objectives. In the context of the HCBS waiver, the Medicaid agency may enter into an interagency agreement (or, alternatively, a Memorandum of Understanding or MOU) with another state agency to operate a waiver, provided that the Medicaid agency retains ultimate authority over the administration of the waiver.
Institution	In the context of the waiver application, a hospital, nursing facility or ICF/IID for which the state makes Medicaid payment under the state plan.
Institutions for Mental Disease (IMD)	As defined in 42 CFR § 435.1009, an IMD is a public or private facility that has more than 16 beds and is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases (disorders). This includes not just public or private hospitals for individuals with mental illness but also nursing homes or other long-term care facilities that primarily serve such individuals. As provided in 42 CFR § 435.1008, federal Medicaid matching funds are not available for the costs of any Medicaid services furnished to individuals under 65 years of age who reside in an IMD except that, per 42 CFR § 440.160, a state may provide optional inpatient coverage for individuals under age 21 in accredited psychiatric facilities. Per 42 CFR § 440.140, a state may provide optional coverage for individuals aged 65 and older in hospitals or nursing facilities that are IMDs. A facility that serves fewer than 17 individuals with mental disorders is not considered to be an IMD.
Instrumental Activities of Daily Living (IADL)	Activities related to independent living, including preparing meals, managing money, shopping for groceries or personal items, performing light or heavy housework, and communication. The extent to which a person requires assistance in performing IADLs is often assessed in conjunction with the evaluation of level of care.
Intellectual	A condition/disability that is manifested by (1) significant sub-average

Disability	intellectual functioning as measured on a standardized intelligence test; (2) significant deficits in adaptive behavior/functioning (e.g., daily living, communication and social skills); and (3) on-set during the developmental period of life (prior to age 18).
Intergovernmental Transfer (IGT)	The transfer of non-federal public funds from a local government or another state agency to the Medicaid agency for the purpose of providing the non-federal share of a Medicaid expenditure in order to draw down federal Medicaid matching funds.
Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)	A public or private facility that provides health and habilitation services to individuals with intellectual disability or related conditions (e.g., cerebral palsy). The ICF/IID benefit is an optional Medicaid service that is authorized in §1905(d) of the Act. ICFs/IID facilities have four or more beds and must provide active treatment to their residents.
IRS	Internal Revenue Service
Katie Beckett Option	The popular name for the Medicaid optional eligibility group under section 1902(e)(3) of the Act that permits a state to extend Medicaid eligibility to children with disabilities or chronic conditions under the age of 19 who require the level of care provided in a hospital, nursing facility, or ICF/IID but who can be cared for at home and would not otherwise qualify for Medicaid unless institutionalized. This option is sometimes called the TEFRA 134 option. Federal regulations concerning this optional eligibility group are located in 42 CFR § 435.225.
Keys Amendment	The popular name for the requirement contained in section 1616(e) of the Act which requires that each state establish, maintain, and insure the enforcement of standards for any category of institutions, foster homes, or group living arrangements in which a significant number of SSI recipients resides or is likely to reside. The standards must be: (a) appropriate to the needs of residents and the character of the facilities involved and (b) govern such matters as admission policies, safety, sanitation, and protection of civil rights.
Legal Representative	A person who has legal standing to make decisions on behalf of another person (e.g., a guardian who has been appointed by the court or an individual who has power of attorney granted by the person).
Legally Responsible Individual	A person who has a legal obligation under the provisions of state law to care for another person. Legal responsibility is defined by State law, and generally includes the parents (natural or adoptive) of minor children, legally assigned caretaker relatives of minor children, and sometimes spouses.
LEP	See Limited English Proficient Persons
Level of Care	The specification of the minimum amount of assistance that an individual must require in order to receive services in an institutional setting under the state plan.
License	Proof of official or legal permission issued by the government for an

	entity or individual to perform an activity or service. In the absence of a license, the entity or individual is debarred from performing the activity or service.
Limited English Proficient (LEP) Persons	Individuals who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English may be limited English proficient (LEP) and eligible to receive language assistance in conjunction with a particular type of service, benefit, or encounter. Recipients of federal assistance are required to provide language assistance to LEP persons in accordance with 42 CFR § 435.905(b).
Line of Authority	In the context of the waiver application, the specification of whether a waiver is operated by the Medicaid agency or by another state agency under the supervision of the Medicaid agency.
Live-In Caregiver	An unrelated personal caregiver who resides in the same household as the waiver participant. For purposes of the waiver, a live-in caregiver does not include staff or personnel who reside with a participant or participants in a residence that is owned or leased by a provider of Medicaid services.
Local/Regional Non- State Entity	A local or regional public agency or a non-governmental organization that performs waiver operational and administrative functions on behalf of the state. Such entities do not include the local or regional offices of state agencies.
Long-Term Care	A variety of services that help people with health or personal needs and activities of daily living over a period of time. Long-term care can be provided at home, in the community, or in various types of facilities, including nursing homes and assisted living facilities.
Maintenance Allowance	A term that is sometimes used for the amount of income that a waiver participant in the §435.217 group is permitted to retain in order to meet shelter, food and other living expenses of the individual (and his/her spouse and family, if applicable) in the community. See Personal Needs Allowance (PNA) for the parallel allocation for residents of institutions.
Managed Care	A method of organizing and financing the delivery of health care and other services that emphasizes cost-effectiveness and coordination of care. Managed care organizations receive a fixed amount of money per member per month (called a capitation), no matter how much care a member needs during that month. Managed care integrates the financing and delivery of appropriate services to covered individuals by means of arrangements with selected providers to furnish an array of services to members; explicit criteria for the selection of health care providers; and financial incentives for members to use providers and procedures associated with the plan. Federal Medicaid managed care regulations are located in 42 CFR §438.
Managed Care Organization (MCO)	As defined in 42 CFR §438.2, an entity that has a comprehensive risk contract with the Medicaid agency and is (1) a federally qualified Health Maintenance Organization (HMO) or (2) makes the services it provides to its Medicaid enrollees as accessible (in terms of timeliness, amount,

	duration, and scope) as those services are to other Medicaid recipients within the area served by the entity.
Managing Employer	See Agency with Choice Model.
Mandatory	The term used to describe the eligibility groups and services that a state which participates in the Medicaid program must include in its program.
MCO	See Managed Care Organization
MCOG	Medicaid and CHIP Operations Group
Measure	A numeric value associated with an indicator. In the quality improvement context, a quality indicator describes the attributes of care or services related to quality. A measure is a way of quantifying attributes. For example, a quality indicator might be expressed as "eligibility is determined promptly." A measure associated with this indicator could be "the average number of days to complete eligibility determination."
Mechanical Restraint	Any device attached or adjacent to an individual's body that he or she cannot easily remove that restricts freedom of movement or normal access to his or her body.
Medicaid	The joint federal and state program to assist states in furnishing medical assistance to eligible needy persons. Federal law concerning the Medicaid program is located in Title XIX of the Act. Within broad national guidelines established by federal statutes, regulations, and policies, each state (1) establishes its own eligibility standards; (2) determines the type, amount, duration, and scope of services; (3) sets the rate of payment for services; and (4) administers its own program.
Medicaid agency	See Single State Agency
Medicaid Benefits Health Program Group (MBHPG)	The organization within CMCS that, among its other duties, is responsible for Federal administration of the HCBS waiver program.
Medicaid and CHIP Operations Group (MCOG)	The organization within CMCS that, among its other duties, conducts programmatic oversight and monitoring of the HCBS waiver program.
Medicaid Buy-In	Refers to the Medicaid eligibility options that were created in BBA-97 and the Ticket to Work and Work Incentives Improvement Act of 1999 that permit states to provide Medicaid to working people with disabilities whose earnings are otherwise too high for them to qualify for Medicaid. In particular, states may elect to cover: • Working individuals with disabilities with incomes up to 250% of poverty (BBA-97; §§1902(a)(10)(A)(ii)(XIII)) of the Act • Working individuals with disabilities who are at least age 16, but less than 65 years of age using income and resource limits set by the State (TWWIIA; §1902(a)(10)(A)(ii)(XV) of the Act, and • Employed individuals covered under the group described above who lose that coverage due to medical improvement, but who still have a medically determinable severe impairment.

	(TWWIIA §1902(a)(10)(A)(ii)(XVI) of the Act).
Medicaid Management Information System (MMIS)	A CMS-approved information technology system that supports the operation of the Medicaid program. The MMIS includes the following types of sub-systems or files: recipient eligibility, Medicaid provider, claims processing, pricing, SURS, MARS, and potentially encounter processing.
Medical Assistance	The term used in Title XIX of the Act to refer to the payment for items and services covered under a state's Medicaid program on behalf of Medicaid beneficiaries.
Medical Assistance Unit	The state government entity established in accordance with 42 CFR § 431.11(b). The Medical Assistance Unit may be the same as the Medicaid agency or a subordinate division/unit within the Medicaid agency.
Medically Necessary	Services or supplies that are proper and needed for the diagnosis or treatment of a medical condition, are provided for the diagnosis, direct care, and treatment of the condition, and meet the standards of good medical practice.
Medically Needy	A term used to describe an optional Medicaid eligibility group made up of individuals who qualify for coverage because of high medical expenses, commonly hospital or nursing home care. These individuals meet Medicaid categorical requirements (i.e., they are children or parents or aged or individuals with disabilities), but their income is too high to permit them to qualify for categorically needy coverage. Instead, they qualify for coverage by spending down (i.e., reducing their income by incurring medical expenses). States that elect to cover the medically needy do not have to offer the same benefit package to them as they offer to the categorically needy.
Medically Needy Income Level (MNIL)	The maximum amount of income remaining after spenddown that permits an individual to qualify for the medically needy eligibility group. The MNIL varies by state.
Medicare	The federally administered health insurance program established in Title XVIII of the Act for persons aged 65 and older and certain persons with disabilities under age 65. Medicare eligibility is determined by the Social Security Administration. Medicare has four parts: Part A (hospital insurance); Part B (optional medical insurance which covers physicians' services and outpatient care in part and which requires the payment of a monthly premium); Part C (managed care arrangements for the delivery of Medicare benefits); and Part D (prescription drugs).
Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA)	The federal legislation (P.L. 108-173) that, among its other provisions, created the Part D Prescription Drug Benefit for Medicare beneficiaries.
Medication Administration	The provision of a medication by a service provider to an individual who is not able to self-administer his/her own medications.

Medication Error	A mistake in medication administration that includes but is not necessarily limited to the following: (a) wrong medication (an individual receives and takes medication which is intended for another person, discontinued, or inappropriately labeled; (b) wrong dose (an individual receives the incorrect amount of medication); (c) wrong time (an individual receives medication dose at an incorrect time interval); and, (d) omission (missed dose) is when an individual does not receive a prescribed dose of medication, not including when an individual refuses to take medication.
Medication Management	Processes and activities that are undertaken in order to ensure that the full range of medications that a person receives is appropriate. Medication management may include periodic review of medications to determine their necessity, to identify possible over medication, and to identify contraindicated medications.
Memorandum of Understanding (MOU)	See Interagency Agreement.
Methodology (Eligibility)	The rules that a state uses in counting an individual's income or resources in determining whether he or she meets its Medicaid eligibility standards. For some eligibility categories, states have the flexibility to disregard certain income and resources in determining whether the individual qualifies for Medicaid.
Miller Trust	Trusts composed only of pension, Social Security and other income of the individual, in states which make individuals eligible for institutional care under the special income level, but do not cover institutional care in a Nursing Facility for the medically needy. Also termed "Qualified Income Trust." As provided in §1917(d)(4)(B) of the Act (enacted in the Omnibus Budget Reconciliation Act of 1993 (P.L. 103-66)), a state that extends eligibility for institutional care to individuals under a special income level (i.e., persons who have incomes up to 300% of the SSI FBR) but not under a medically needy standard may permit a person who has income that exceeds the special income level to establish an irrevocable trust so that the person can qualify for Medicaid. Under such an arrangement, a person directs sufficient income (but not assets) into trust to reduce the individual's income to the amount necessary to qualify under the special income level. Upon the death of the person, any funds remaining in the trust are paid to the state up to the amount of unreimbursed medical assistance paid on the person's behalf during the individual's lifetime.
MMA	See Medicare Prescription Drug, Improvement, and Modernization Act of 2003.
MNIL	See Medically Needy Income Level.
Model Waiver	A HCBS waiver that is designed to serve no more than 200 individuals at any point in time. It is a state option to designate a waiver as a model waiver.

Monitoring	The ongoing oversight of the provision of waiver and other services to determine that they are furnished according to the participant's service plan and effectively meet his/her needs, including assuring health and welfare. Monitoring activities may include (but are not limited to) telephone contact, observation, interviewing the participant and/or the participant's family (as appropriate) (in person or by phone), and/or interviewing service providers.
MOU	Memorandum of Understanding; see also Interagency Agreement
Neglect	The failure to provide an individual the reasonable care that s/he requires, including but not limited to food, clothing, shelter, medical care, personal hygiene, and protection from harm.
Non-Federal Share	The amount of funds that a state must provide from its own funds or other permissible funding sources (e.g., local tax revenues) toward the cost of Medicaid services or administrative activities.
Non-Risk Contract	A type of Medicaid contract under which a provider furnishes an array of Medicaid services but is not at financial risk for changes in utilization or for costs incurred under the contract, subject to the upper payment limits specified in 42 CFR § 447.362. The provider may be reimbursed by the state at the end of the contract period on the basis of the incurred costs, subject to the specified limits.
Nursing Facility (NF)	Sometimes referred to as nursing homes. Nursing facility services for individuals aged 21 and older are a mandatory Medicaid benefit. A state may provide nursing facility services to individuals under age 21 on an optional basis. Nursing facilities are institutions that primarily provide: • Skilled nursing care and related services for residents who require medical or nursing care; • Rehabilitation services for the rehabilitation of injured, disabled or sick persons; and/or • Health-related care and services, on a regular basis, to individuals who because of their mental or physical condition require care and services, above the level of room and board, which can be made available to them only through institutional facilities.
OASDI	See Old-Age, Survivors, and Disability Insurance
Office of Inspector General (OIG)	The agency within HHS charged with the responsibility to protect the integrity of HHS programs, as well as the health and welfare of the beneficiaries of those programs. The OIG has a responsibility to report both to the Secretary and to the Congress program and management problems and recommendations to correct them. OIG duties are carried out through a nationwide network of audits, investigations, inspections and other mission-related functions performed by OIG components.
OHCDS	See Organized Health Care Delivery System
Old-Age, Survivors, and	The Social Security programs that pay monthly cash benefits to (1) retired-worker (old-age) beneficiaries, their spouses and children, and

Disability Insurance (OASDI)	survivors of deceased insured workers (OASI); and (2) disabled-worker beneficiaries and their spouses and children and for providing rehabilitation services to the disabled (SSDI). These programs are established in Title II of the Social Security Act.
Operating Agency	A state agency other than the Medicaid agency that is responsible for the day-to- day operation and administration of a waiver. An operating agency conducts waiver operation and administration functions under an interagency agreement or memorandum of understanding with the Medicaid agency.
Operation (Waiver)	The constellation of administrative activities and processes that are necessary so that individuals may receive services through the waiver. Such activities may include functions such as payment rate determination, training and technical assistance, utilization management, and prior authorization.
Ombudsman	A representative of a public agency or a private nonprofit organization who is empowered under state law to investigate and resolve complaints made by or on behalf of individuals who receive services. Under the provisions of the Older Americans Act, each state has established a Long-Term Care Ombudsman Office to investigate and resolve complaints about services in nursing and certain other long-term care facilities. Some states have established similar programs for individuals with disabilities.
Optional	The term used to describe Medicaid eligibility groups or service categories that states may cover if they choose and for which they may receive FFP.
Organized Health Care Delivery System (OHCDS)	As defined in 42 CFR §447.10, an OHCDS is an organization that provides at least one Medicaid service directly (utilizing its own employees) and contracts with other qualified providers to furnish other services. When there is an OHCDS, the required Medicaid provider agreement is executed between the state and the OHCDS. Since the OHCDS acts as the Medicaid provider, it is not necessary for each subcontractor of an OHCDS to sign a provider agreement with the Medicaid agency (however, subcontractors must still meet the standards under the waiver to provide waiver services). When the OHCDS provides waiver services, payment is made directly to the OHCDS and the OHCDS reimburses the subcontractors. Waiver providers may not be restricted to participating only through an OHCDS. Such an arrangement must be voluntary. In addition, participants may not be required to secure services exclusively through an OHCDS.
Outcome	The result of the performance (or nonperformance) of a function or process, including the provision of services.
Outcome Indicator	A key quality characteristic that is measured, over time, in order to assess whether the provision of services or the performance of activities resulted in the desired result.
PACC	See Program for All-Inclusive Care for Children
Part D	The Medicare Prescription Drug Benefit that was established by the

	Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) to take effect on January 1, 2006.
Participant	An individual who has met waiver entrance requirements, chooses to receive waiver services, enters the waiver, and subsequently receives waiver services authorized in a service plan.
Participant Cap	A term used to describe the maximum number of individuals who may participate in a waiver during the year.
Participant-Centered	A general term used to describe waiver processes and activities that are designed to address each participant's unique goals, preferences and needs.
Participant-Directed Budget	An amount of waiver funds that is under the control and direction of the waiver participant when a waiver makes available the budget authority participant direction opportunity. Sometimes called the "individual budget."
Participant-Directed Service	A waiver service that the state specifies may be directed by the participant using employer authority, budget authority or both.
Participant Direction	Provision of the opportunity for a waiver participant to exercise choice and control in identifying, accessing, and managing waiver services and other supports in accordance with their needs and personal preferences.
Performance Measure	A gauge used to assess the performance of a process or function of any organization. Quantitative or qualitative measures of the services that are delivered to individuals (process) or the end result of services (outcomes). Performance measures also can be used to assess other aspects of an individual or organization's performance such as access and availability of care, utilization of care, health plan stability, beneficiary characteristics, and other structural and operational aspect of health care services.
Person-Centered Planning	An assessment and service planning process are directed and led by the individual, with assistance as needed or desired from a representative or other persons of the individual's choosing. The process is designed to identify the strengths, capacities, preferences, needs, and desired outcomes of the individual. The process may include other persons, freely chosen by the individual, who are able to serve as important contributors to the process. The PCP process enables and assists the individual to identify and access a personalized mix of paid and non-paid services and supports that assist him/her to achieve personally defined outcomes in the community.
Personal Agent	See Information and Assistance in Support of Participant Direction
Personal Care Services	A range of human assistance provided to persons with disabilities and chronic conditions of all ages to enable them to accomplish tasks that they would normally do for themselves if they did not have a disability. Assistance may take the form of hands-on assistance or as cueing so that the person performs the task by him/herself. Such assistance most often relates to performance of activities of daily living (ADLs) and instrumental activities of daily living (IADLs),

	which includes assistance with daily activities such as eating, bathing, dressing, toileting, transferring, personal hygiene, light housework, medication management, etc. Personal care may be furnished in the home or outside the home. Also sometimes known as "personal assistance" or "attendant care." Personal care is an optional State plan benefit (42 CFR § 440.167) and is a waiver service that is recognized in section 1915(c) of the Act.
Personal Needs Allowance	In the case of a Medicaid beneficiary who is a resident of a nursing facility or ICF/IID, the amount of monthly income that he or she is allowed to keep for personal expenses like haircuts and laundry. The remainder of the beneficiary's monthly income is applied to the costs of care at the facility. The minimum PNA that a state must allow an institutionalized beneficiary is $30 per month. See Maintenance Allowance for the parallel allocation for waiver participants whose eligibility is established via the 42 CFR § 435.217 group.
Personal Restraint	Personal restraint means the application of physical force without the use of any device, for the purposes of restraining the free movement of an individual's body.
Person-Centered Service Plan	As used in the waiver application, and as defined in § 441.301(c)(2), the written document that specifies the waiver and other services (regardless of funding source) along with any informal supports that are furnished to meet the needs of and to assist a waiver participant to remain in the community. The service plan must contain, at a minimum, the types of services to be furnished, the amount, the frequency and duration of each service, and the type of provider to furnish each service. FFP may only be claimed for the waiver services that are furnished to a waiver participant when they have been authorized in the service plan. In the application, "person centered service plan" is synonymous with the statutory term "plan of care."
Persons Living With AIDS (PLWAs)	Individuals who have Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) Infection
PETI	See Post Eligibility Treatment of Income
Phase-In	The planned implementation or expansion of an HCBS waiver program over a specified period of time by increasing the waiver participant cap in staged increments across one or more waiver years.
Phase-Out	The planned contraction of an HCBS waiver program over a specified period of time by decreasing the participant cap in specified decrements across one or more waiver years.
Plan of Care	See Person-Centered Service Plan
Post Eligibility Treatment of Income (PETI)	The determination of the financial liability (if any) of waiver participants who are in the §435.217 group for their share of the costs of waiver services. PETI calculations are only made for members of the §435.217 group. A state must provide for an allowance for the needs of the waiver participant to meet shelter, food and other living expenses in

	the community (“maintenance allowance” or “personal needs allowance”), an allowance for the needs of a spouse and the participant’s family (if applicable), and medical and remedial care expenses for services not covered under the State plan.
Poverty-Level Groups	A popular term for eligibility groups, both mandatory and optional, for whom Medicaid income eligibility is determined against an income standard that is based on a percentage of the Federal poverty level (FPL) (e.g., pregnant people and infants with family incomes at or below 133 percent of the FPL).
Premium	A regularly paid specified dollar amount that a Medicaid beneficiary must pay by virtue of enrollment in the Medicaid program.
Prepaid Health Plan	A prepaid managed care entity that provides less than comprehensive services on an at-risk basis or one that provides any benefit package on a non-risk basis. BBA-97 defined two types of prepaid health plans: prepaid ambulatory plans and prepaid inpatient plans.
Prepaid Ambulatory Health Plan (PAHP)	As defined in 42 CFR § 438.2, an entity that: (1) provides medical services to Medicaid enrollees under contract with the Medicaid agency on the basis of prepaid capitation payments, or other payment arrangements that do not use state plan payment rates; (2) does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract.
Prepaid Inpatient Health Plan (PIHP)	As defined in 42 CFR § 438.2, an entity that: (1) provides medical services to enrollees under contract with the Medicaid and on the basis of prepaid capitation payments, or other payment arrangements that do not use state plan payment rates; (2) provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and, (3) does not have a comprehensive risk contract.
Prior Authorization	A mechanism that is employed to control the use of covered items (such as durable medical equipment or prescription drugs) or services (such as inpatient hospital care). When an item or service is subject to prior authorization, payment is not made unless approval for the item or service is obtained in advance either from state agency personnel or from a state fiscal agent or other contractor.
Private Residence	As used in the waiver application: (1) The home that a waiver participant owns or rents in his or her own right or the home where a waiver participant resides with other family members or friends. A private residence is not a living arrangement that is owned or leased by a service provider; or, (2) The home of a caregiver who furnishes foster or respite care to a waiver participant
Process	A goal-directed, interrelated series of actions, events, mechanisms, or steps.
Process	A methodology utilized to make improvements to a process through the

Improvement	use of continuous quality improvement methods.
Process Indicator	A gauge that measures a goal-directed interrelated series of actions, events, mechanisms, or steps.
Program for All-Inclusive Care for Children (PACC)	A program offering a blended package of curative and palliative care services designed to provide support for children with life-threatening conditions and their families.
Provider	A qualified individual or entity that undertakes to render Medicaid services to beneficiaries and has an agreement with the Medicaid agency.
Provider Agreement	The contract between the Medicaid agency and a service provider under which the provider or organization agrees to furnish services to Medicaid beneficiaries in compliance with state and Federal requirements. Federal regulations concerning provider agreements are located in 42 CFR § 431.107.
Provider-Managed Service	A waiver service for which a provider is responsible for directing and managing in accordance with the service plan on behalf of a waiver participant. In the waiver application, a state may designate a service as provider managed, participant-directed or both.
Provider Qualification	Standards established by the state that specify the education, training, skills, competencies and attributes that an individual or provider agency must possess in order to furnish services to waiver participants.
Provider Tax	A tax, fee, assessment, or other mandatory payment that health care providers are required to make to the state. In limited circumstances, a state may use revenues derived from provider taxes to meet the non-federal share of Medicaid expenditures. These circumstances are specified in federal Medicaid law and regulations (see 42 CFR § 433.55 – 433.74).
Public Input	As used in the waiver application, processes that are undertaken in order to obtain the comments, suggestions and recommendations of parties affected by a waiver concerning its design and operation.
QIS	See Quality Improvement Strategy
Qualified Income Trust	See Miller Trust
Quality Assurance	The process of looking at how well a service is provided. The process may include formally reviewing the services furnished to a person or group of persons, identifying and correcting problems, and then checking to see if the problem was corrected.
Quality Improvement	The performance of discovery, remediation, and quality improvement activities in order to ascertain whether the waiver meets the assurances, correct shortcomings, and pursue opportunities for improvement. Quality improvement also is employed to address other areas of waiver performance.
Quality Improvement Strategy (QIS)	The document that is submitted with the waiver application that describes how the state will continually assess whether it operates the waiver in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired

	outcomes, and how it identifies opportunities for improvement. A QIS describes the processes of discovery, remediation, and quality improvement activities; the frequency of those processes; the source and types of information gathered, analyzed, and utilized to measure performance; and key roles and responsibilities for managing quality. The QIS may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and extend beyond regulatory requirements. Updates to the QIS will be submitted with the annual waiver report.
RAI	See Request for Additional Information
Reassignment (of Payment)	The voluntary assignment of the payment for Medicaid services by the provider to a governmental entity.
Reevaluation	The periodic but at least annual review of an individual's condition and service needs to determine whether the person continues to need a level of care specified in the waiver.
Regular Waiver	A waiver program that is not a model waiver. A regular waiver may serve any number of participants specified by the state.
Rehabilitation	Services that have the purpose of improving/restoring a person's physical or mental functioning. Such services may include therapeutic services such as occupational and physical therapy services, as well as mental health services such as individual and group psychological therapies, psychosocial services, and addiction treatment services. Rehabilitative services may be provided at home, in the community or in long-term care facilities. Medicaid rehabilitation services, defined at 42 CFR § 440.130(d), may be covered as an optional state plan benefit or as waiver services.
Related Conditions	For the purpose of ICF/IID services and as provided in 42 CFR § 435.1009, persons with related conditions are individuals who have a severe, chronic disability that meets all of the following conditions: (a) It is attributable to-- (1) Cerebral palsy or epilepsy; or (2) Any other condition, other than mental illness, found to be closely related to intellectual disability because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with an intellectual disability, and requires treatment or services similar to those required for these persons. (b) It is manifested before the person reaches age 22. (c) It is likely to continue indefinitely. (d) It results in substantial functional limitations in three or more of the following areas of major life activity: (1) self-care; (2) understanding and use of language; (3) learning; (4) mobility; (5) self-direction; (6) capacity for independent living.
Remediation	Activities designed to correct identified problems at the individual, provider or system level. Examples of individual level remediation

	include providing additional needed services when discovery activities indicate that an individual/participant has not received necessary services. Provider level remediation includes sanctioning a provider for failure to furnish services in accordance with state requirements. System-level remediation activities may include the correction of underlying waiver design problems.
Representative	A person who may act on behalf of another. A representative may be: (a) a legal representative (a court-appointed guardian, a parent of a minor child, or a spouse) or (b) an individual (family member or friend) selected by an adult to speak for and/or act on his/her behalf.
Request for Additional Information (RAI)	A formal, written document issued by CMS that identifies serious problems with a waiver request that potentially could cause CMS to disapprove the request. A RAI stops the 90-day clock. Once a state responds to the RAI, a new 90-day clock is started. During the second clock CMS may not issue a RAI — it must approve or disapprove the request.
Resources	Sometimes referred to as assets, resources are items of economic value that are not income. Resources include financial instruments such as savings accounts and certificates of deposit, personal property such as an automobile (above a specified value), and real estate (other than an individual's home). Some Medicaid eligibility groups must meet a resource test; others (at state option) are not subject to a resource test. In establishing a resource test, a state must specify both the resource standard (e.g., the amount of countable resources an individual may retain and still be eligible for Medicaid) and the resource methodology (e.g., the resources that are counted and how are they valued).
Resource Standard	The maximum amount of countable resources a person can have and still be eligible for Medicaid.
Restraint	Any physical, chemical or mechanical intervention that is used to control acute, episodic behavior that restricts the movement or function of the individual or a portion of the individual's body.
Restrictive Intervention	An action or procedure that limits an individual's movement, a person's access to other individuals, locations or activities, or restricts participant rights. Restraints or seclusion are a subset of restrictive interventions.
Risk	Factors that, if unaddressed, might pose a high threat to an individual's health and welfare. These include: (a) health risk (medical conditions that require continuing care and treatment); (b) behavioral risk (behaviors or conditions that might cause harm to the person or others); and (c) personal safety risk (e.g., safe evacuation).
Risk Management Agreement	See Individual Risk Agreement
Room and Board	The term "room" means shelter type expenses, including all property-related costs such as rental or purchase of real estate and furnishings, maintenance, utilities, and related administrative services. The term "board" means three meals a day or any other full nutritional regimen. Board does not include the provision of a meal at an adult day health or

	similar facility outside the participant's home. Board also does not include the delivery of up to two meals per day and which do not constitute a full nutritional regimen to a participant at his/her own home through a meals-on-wheels service.
Safeguard	Policies or procedures that are designed to prevent harm to an individual or to ensure that the application of a policy takes into account potentially adverse effects on a person.
Seclusion	Seclusion means the involuntary confinement of an individual alone in a room or an area from which the individual is physically prevented from having contact with others or leaving.
Secretary	Secretary of the U.S. Department of Health and Human Services
Self-Administration	The administration of medications or other procedures by a person without assistance.
Self-Direction	See Participant Direction
Serious Emotional Disturbance	The range of diagnosable emotional, behavioral, and mental disorders that are of sufficient duration so as to result in functional impairment that substantially interferes with or limits one or more major life activities of children and adolescents up to age 18 in the home, school, or community. Such disorders include externalizing behavior disorders (e.g., attention deficit hyperactivity disorder and conduct disorder), internalizing emotional disorders (e.g., anxiety and depression) and other disorders of lesser frequency but often great severity, such as bipolar disorder, pervasive developmental disorder, and psycho-physiological disorder.
Serious Injury	An injury that requires the provision of medical treatment beyond what is commonly considered first aid.
Serious Mental Illness	Pursuant to section 1912(c) of the Public Health Service Act, adults with serious mental illnesses are persons: (1) age 18 and over and (2) who currently have, or at any time during the past year have had a diagnosable mental, behavioral or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM- IV or their ICD-9-CM equivalent (and subsequent revisions) with the exception of DSM-IV "V" codes, substance use disorders, and developmental disorders, which are excluded, unless they co-occur with another diagnosable serious mental illness and (3) for whom the disorder has resulted in functional impairment, which substantially interferes with or limits one or more major life activities.
Single Audit Act Amendments of 1996	The Federal law (P.L. 104-156, U.S.C. Title 31, Chapter 75) that establishes the standards and requirements for the performance of audits of entities that receive federal funds, including Medicaid.
Single State Agency	The agency within state government that has been designated pursuant to section 1902(a)(5) of the Act as responsible for administration of the state plan. The single state agency is not required to directly administer the entire Medicaid program; it may provide that administrative functions are conducted by other state (or local) agencies or private

	contractors (or both) so long as the Single State Agency maintains ultimate authority and responsibility for the administration of the state plan. In the waiver application, the Single State Agency is referred to as the Medicaid agency.
SSI Criteria State	A state that uses the SSI income and resource criteria to determine eligibility for Medicaid for aged, blind, and disabled individuals but requires that such individuals apply separately to the state for Medicaid.
Social Security Act	Public Law 74-271, enacted on August 14, 1935, and its subsequent amendments. The Medicaid program is authorized in Title XIX of the Act; the Medicare program is authorized in Title XVIII of the Act; and, Title XXI of the Act establishes the State Children's Health Insurance Program.
Social Security Administration (SSA)	The federal agency that, among its other duties, administers the Old Age, Survivors, and Disability Insurance (OASDI) and Supplemental Security Income (SSI) programs and determines the initial entitlement to and eligibility for Medicare benefits.
Social Security Disability Insurance (SSDI)	The system of federally provided payments to eligible workers (and, in some cases, their families) when they are unable to continue working because of a disability. Benefits begin with the sixth full month of disability and continue until the individual is capable of substantial gainful activity.
SPA	See State Plan Amendment
Special Home and Community-Based Waiver Group	The eligibility group defined in 42 CFR §435.217 that is composed of individuals in the community who would be eligible for Medicaid if institutionalized to whom the state elects to provide waiver services. Also referred to as the §435.217 group.
Special Income Group	The eligibility group defined in 42 CFR § 435.236 that is composed of individuals in institutions who have too much income to qualify for SSI benefits but not enough income to cover their expensive long-term care. This group also is referred to as individuals who qualify for Medicaid under the 300% of SSI rule. A state may provide that persons with incomes up to 300% (or a lower percentage specified the state) of the SSI FBR may qualify for Medicaid when institutionalized.
Spenddown	For most Medicaid eligibility categories, having countable income above a specified amount disqualifies an individual from Medicaid. However, in some eligibility categories—most notably the "medically needy"—individuals may qualify for Medicaid coverage even though their countable incomes are higher than the specified income standard by "spending down" to the medically needy income level. Under this process, the medical expenses that an individual incurs during a specified period are deducted from the individual's income during that period. Once the individual's income has been reduced to a state-specified level by subtracting incurred medical expenses, the individual qualifies for Medicaid benefits for the remainder of the period.
Spousal Impoverishment	The term used to describe the set of eligibility rules that states are required to apply under the provisions of section 1924 of the Act in the

Protections	case when a Medicaid beneficiary resides in a nursing facility and his or her spouse remains in the community. The rules, which specify minimum amounts of income and resources each spouse is allowed to retain without jeopardizing the institutionalized spouse's eligibility for Medicaid benefits, are designed to prevent the impoverishment of the community spouse. Under certain circumstances, a state may elect to use these rules in determining eligibility for a waiver.
SSA	See Social Security Administration
SSDI	See Social Security Disability Insurance
SSI	See Supplemental Security Income
State Medicaid Director (SMD) Letter	A formal letter issued by the Director of the Center for Medicaid and State Operations (CMCS) to state Medicaid directors for the purpose of providing technical guidance or updated information regarding the operation of the Medicaid program.
State Medicaid Plan (State Plan)	The document that specifies the eligibility groups that a state will serve through its Medicaid program, the benefits that the state covers, and how the state addresses additional Federal Medicaid statutory requirements concerning the operation of its Medicaid program. The state plan must be submitted to and approved by CMS, acting on behalf of the Secretary of HHS. Proposed changes to the state plan take the form of state plan amendments (SPAs) that are submitted to, reviewed and approved by CMS.
State Plan	See State Medicaid Plan
State Plan Amendment (SPA)	In order to change its Medicaid eligibility criteria or its covered benefits or its provider reimbursement methodology, a state must amend its state Medicaid plan to reflect the proposed change. Similarly, states must conform their state plans to changes in federal Medicaid law. In either case, the state must submit a state plan amendment (SPA) to CMS for approval.
State Supplementary Payment (SSP)	The amount (if any) by which a state elects to supplement the basic SSI cash assistance payment to individuals and couples.
State Unemployment Tax (SUTA)	The tax paid to a state workforce agency that is used solely for the payment of benefits to eligible unemployed workers.
Statewideness	The requirement in section 1902(a)(1) of the Act that a state must operate its Medicaid programs throughout the state and may not exclude individuals residing in, or providers operating in, particular counties or municipalities. This requirement may be waived under section 1115, section 1915(b), and section 1915(c) waivers.
Supplemental (or Enhanced) Payment	Any payment to a Medicaid provider that is in addition to the state's standard direct payment for services rendered to a Medicaid beneficiary and billed by a provider.
Supplemental Security Income	The federal entitlement program established under Title XVI of the Act to provide cash assistance to certain persons who are aged, blind, or

(SSI)	disabled and whose income and resources fall below the SSI income and resource standards that are set by the Federal government.
Supports Broker (Brokerage)	See Information and Assistance in Support of Participant Direction
SUTA	See State Unemployment Tax
Target Group	A group of Medicaid beneficiaries who have similar needs, conditions or characteristics to whom a state elects to furnish waiver services. Common HCBS waiver target groups include older persons, individuals with physical disabilities, persons who have experienced a brain injury, and persons with developmental disabilities. A state must specify the target group(s) that it serves in the waiver.
Targeted Case Management	As provided in section 1915(g) of the Act, optional state plan services that are furnished to assist Medicaid beneficiaries to gain access to needed medical, social, educational, and other services. TCM services may be furnished to target groups specified by the state on a statewide or less than statewide basis.
Technology Dependent	A person who needs both a medical device to compensate for the loss of a vital body function and substantial and ongoing nursing care to avert death or further disability.
TCM	See Targeted Case Management
TEFRA 134	See Katie Beckett Option
Telemedicine	The use of communication equipment to link health care practitioners and patients in different locations. This technology is used by health care providers for many reasons, including increased cost efficiency, reduced transportation expenses, improved patient access to specialists and mental health providers, improved quality of care, and better communication among providers.
Temporary Assistance for Needy Families (TANF)	A block grant program that makes federal matching funds available to states for cash and other assistance to low-income families with children. TANF replaced the Aid to Families with Dependent Children (AFDC) program. States may but are not required to extend Medicaid coverage to all families who receive TANF benefits; however, as provided in section 1931 of the Act, a state must extend Medicaid to families with children who meet the eligibility criteria that were in effect under its AFDC programs as of July 16, 1996.
Third Party Liability (TPL)	The Medicaid term used to refer to another source of payment for Medicaid covered services provided to a beneficiary. For example, if a Medicaid beneficiary is also eligible for Medicare, the Medicare program is liable for the costs of that beneficiary's hospital and physician services, up to the limit of Medicare's coverage. From the Medicaid program's standpoint, Medicare is a liable third party. Other examples include private health insurance coverage, automobile and other liability insurance, and medical child support.
Timeout	Time out means the restriction of an individual for a period of time to a designated area from which the person is not physically prevented from

	leaving for the purpose of providing the person an opportunity to regain self-control.
Title XIX	Refers to Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), the Federal statute that authorizes the Medicaid program.
TPL	See Third-Party Liability
Tribal Government	The government of an ‘‘Indian tribe,’’ including an Indian or Alaska Native tribe, band, nation, pueblo, village, or community that the Secretary of the Interior acknowledges to exist as an Indian tribe pursuant to the Federally Recognized Indian Tribe List Act of 1994, 25 U.S.C. 479a.
TWWIIA	Ticket to Work & Work Incentives Improvement Act of 1999 (P.L. 106-170). See also Medicaid Buy-In.
Unduplicated Participant	A unique individual who receives waiver services at any point during a waiver year, regardless of the length of time that the person is enrolled in the waiver or the amount of waiver services that the person receives. A person who enters, exits and then reenters the waiver is considered to be one unduplicated participant.
Waiver Capacity	A term used to describe the maximum unduplicated number of individuals who may participate in a waiver during a year.
Waiver Period	The period of time that a waiver is in effect. In the case of a new waiver, the waiver period is three years. In the case of a renewal, the waiver period is five years.
Waiver Year	The 12-month period that begins on the date the waiver takes effect and the 12- month period following each subsequent anniversary date of the waiver.
Workers’ Compensation	State-mandated system under which employers assume the cost of medical treatment and wage losses for employees who suffer job-related illnesses or injuries, regardless of who is at fault.

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