Application for a §1915(c) Home and Community-Based Waiver [Version 3.6, January 2019]

Instructions, Technical Guide and Review Criteria

Resource Attachments

Release Date:
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Disabled and Elderly Health Programs Group
Center for Medicaid and State Operations
Centers for Medicare & Medicaid Services
Department of Health and Human Services

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Attachment A: §1915(c) of the Social Security Act (as amended)

§1915(c) of the Social Security Act (as amended)

SEC. 1915. (c)(1) The Secretary may by waiver provide that a State plan approved under this title may include as "medical assistance" under such plan payment for part or all of the cost of home or community-based services (other than room and board) approved by the Secretary which are provided pursuant to a written plan of care to individuals with respect to whom there has been a determination that but for the provision of such services the individuals would require the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded the cost of which could be reimbursed under the State plan. For purposes of this subsection, the term "room and board" shall not include an amount established under a method determined by the State to reflect the portion of costs of rent and food attributable to an unrelated personal caregiver who is residing in the same household with an individual who, but for the assistance of such caregiver, would require admission to a hospital, nursing facility, or intermediate care facility for the mentally retarded.

(2) A waiver shall not be granted under this subsection unless the State provides assurances satisfactory to the Secretary that--

(A) necessary safeguards (including adequate standards for provider participation) have been taken to protect the health and welfare of individuals provided services under the waiver and to assure financial accountability for funds expended with respect to such services;

(B) the State will provide, with respect to individuals who--

(i) are entitled to medical assistance for inpatient hospital services, nursing facility services, or services in an intermediate care facility for the mentally retarded under the State plan,
(ii) may require such services, and
(iii) may be eligible for such home or community-based care under such waiver,

for an evaluation of the need for inpatient hospital services, nursing facility services, or services in an intermediate care facility for the mentally retarded;

(C) such individuals who are determined to be likely to require the level of care provided in a hospital, nursing facility, or intermediate care facility for the mentally retarded are informed of the feasible alternatives, if available under the waiver, at the choice of such individuals, to the provision of inpatient hospital services, nursing facility services, or services in an intermediate care facility for the mentally retarded;

(D) under such waiver the average per capita expenditure estimated by the State in any fiscal year for medical assistance provided with respect to such individuals does not exceed 100 percent of the average per capita expenditure that the State reasonably estimates would have been made in that fiscal year for expenditures under the State plan for such individuals if the waiver had not been granted; and

(E) the State will provide to the Secretary annually, consistent with a data collection plan designed by the Secretary, information on the impact of the waiver granted under this subsection on the type and amount of medical assistance provided under the State plan and on the health and welfare of recipients.

(3) A waiver granted under this subsection may include a waiver of the requirements of section 1902(a)(1) (relating to statewideness), section 1902(a)(10)(B) (relating to comparability), and section 1902(a)(10)(C)(i)(III) (relating to income and resource rules applicable in the community). A waiver under this subsection shall be for an initial term of three years and, upon the request of a State, shall be extended for additional five-year periods unless the Secretary determines that for the previous waiver period the assurances provided under paragraph (2) have not been met. A waiver may provide, with respect to post-eligibility treatment of income of all individuals receiving services under that waiver, that the maximum amount of the individual's income which may be disregarded for any month for the maintenance needs of the individual may be an amount greater than the maximum allowed for that purpose under regulations in effect on July 1, 1985.

(4) A waiver granted under this subsection may, consistent with paragraph (2)--

(A) limit the individuals provided benefits under such waiver to individuals with respect to whom the State has determined that there is a reasonable expectation that the amount of medical assistance provided with respect to the individual under such waiver will not exceed the amount of such medical assistance provided for such individual if the waiver did not apply, and

(B) provide medical assistance to individuals (to the extent consistent with written plans of care, which are subject to the approval of the State) for case management services, homemaker/home health aide services and personal care services, adult day health services, habilitation services, respite care, and such other services requested by the State as the Secretary may approve and for day treatment or other partial hospitalization services, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness.

Except as provided under paragraph (2)(D), the Secretary may not restrict the number of hours or days of respite care in any period which a State may provide under a waiver under this subsection.

(5) For purposes of paragraph (4)(B), the term "habilitation services"--

(A) means 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; and

(B) includes (except as provided in subparagraph (C)) prevocational, educational, and supported employment services; but

(C) does not include—

(i) special education and related services (as defined in section 602(16) and (17) of the Education of the Handicapped Act (20 U.S.C. 1401(16), (17)) which otherwise are available to the individual through a local educational agency; and
(ii) vocational rehabilitation services which otherwise are available to the individual through a program funded under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

(6) The Secretary may not require, as a condition of approval of a waiver under this section under paragraph (2)(D), that the actual total expenditures for home and community-based services under the waiver (and a claim for Federal financial participation in expenditures for the

services) cannot exceed the approved estimates for these services. The Secretary may not deny Federal financial payment with respect to services under such a waiver on the ground that, in order to comply with paragraph (2)(D), a State has failed to comply with such a requirement.

(7) (A) In making estimates under paragraph (2)(D) in the case of a waiver that applies only to individuals with a particular illness or condition who are inpatients in, or who would require the level of care provided in, hospitals, nursing facilities, or intermediate care facilities for the mentally retarded, the State may determine the average per capita expenditure that would have been made in a fiscal year for those individuals under the State plan separately from the expenditures for other individuals who are inpatients in, or who would require the level of care provided in, those respective facilities.

(B) In making estimates under paragraph (2)(D) in the case of a waiver that applies only to individuals with developmental disabilities who are inpatients in a nursing facility and whom the State has determined, on the basis of an evaluation under paragraph (2)(B), to need the level of services provided by an intermediate care facility for the mentally retarded, the State may determine the average per capita expenditures that would have been made in a fiscal year for those individuals under the State plan on the basis of the average per capita expenditures under the State plan for services to individuals who are inpatients in an intermediate care facility for the mentally retarded, without regard to the availability of beds for such inpatients.

(C) In making estimates under paragraph (2)(D) in the case of a waiver to the extent that it applies to individuals with mental retardation or a related condition who are resident in an intermediate care facility for the mentally retarded the participation of which under the State plan is terminated, the State may determine the average per capita expenditures that would have been made in a fiscal year for those individuals without regard to any such termination.

(8) The State agency administering the plan under this title may, whenever appropriate, enter into cooperative arrangements with the State agency responsible for administering the program for children with special health care needs under title V in order to assure improved access to coordinated services to meet the needs of such children.

(9) In the case of any waiver under this subsection which contains a limit on the number of individuals who shall receive home or community-based services, the State may substitute additional individuals to receive such services to replace any individuals who die or become ineligible for services under the State plan.

(10) The Secretary shall not limit to fewer than 200 the number of individuals in the State who may receive home and community-based services under a waiver under this subsection.

Attachment B: Medicaid Regulations Related to the Operation of HCBS Waivers

This attachment compiles selected Medicaid regulations that are related to the operation of HCBS waivers and cited in the application and/or instructions. Other regulations not included in this compilation may be accessed on the Internet via the Government Printing Office website at: http://www.gpo.gov

CFR Citation	Topic
42 CFR §430.25	Waivers of State Plan Requirements
42 CFR §431.10	Single State Medicaid Agency
42 CFR §431.200 (Subpart E)	Fair Hearings for Applicants and Recipients
42 CFR §435.217	Individuals Receiving Home and Community-Based Services
42 CFR §435.726	Post-eligibility treatment of income of individuals receiving home and community-based services furnished under a waiver: Application of patient income to the cost of care. (SSI States)
42 CFR §435.735	Post-eligibility treatment of income and resources of individuals receiving home and community-based services furnished under a waiver: Application of patient income to the cost of care. (209b States)
42 CFR §440.180	Home or Community-Based Services
42 CFR §441.300 – 441.310	Subpart G—Home and Community-Based Services: Waiver Requirements
42 CFR §447.50 – 447.57	Cost Sharing (Co-Payments)

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State of the time and place of the hear- ing.

(2) The hearing takes place not less than 30 days nor more than 60 days after the date of the notice, unless the State and the Administrator agree in writing on an earlier or later date.

(c) *Hearing procedures.* The hearing procedures are set forth in subpart D of this part.

(d) *Decision.* A decision affirming, modifying, or reversing the Administrator's original determination is made in accordance with § 430.102.

(e) *Effect of hearing decision.* (1) De- nial of Federal funds, if required by the Administrator's original determina- tion, will not be delayed pending a hearing decision.

(2) However, if the Administrator de- termines that his or her original decision was incorrect, CMS pays the State a lump sum equal to any funds incorrectly denied.

§ 430.20 Effective dates of State plans and plan amendments.

For purposes of FFP, the following rules apply:

(a) *New plans.* The effective date of a new plan—

(1) May not be earlier than the first day of the quarter in which an approv- able plan is submitted to the regional office; and

(2) With respect to expenditures for medical assistance, may not be earlier than the first day on which the plan is in operation on a statewide basis.

(b) *Plan amendment.* (1) For a plan amendment that provides additional services to individuals eligible under the approved plan, increases the pay- ment amounts for services already in- cluded in the plan, or makes additional groups eligible for services provided under the approved plan, the effective date is determined in accordance with paragraph (a) of this section.

(2) For a plan amendment that changes the State's payment method and standards, the rules of § 447.256 of this chapter apply.

(3) For other plan amendments, the effective date may be a date requested by the State if CMS approves it.

[53 FR 36571, Sept. 21, 1988, as amended at 56 FR 8845, Mar. 1, 1991]

§ 430.25 Waivers of State plan require- ments.

(a) *Scope of section.* This section de- scribes the purpose and effect of waiv- ers, identifies the requirements that may be waived and the other regula- tions that apply to waivers, and sets forth the procedures that CMS follows in reviewing and taking action on waiver requests.

(b) *Purpose of waivers.* Waivers are intended to provide the flexibility needed to enable States to try new or different approaches to the efficient and cost-effective delivery of health care services, or to adapt their programs to the special needs of particular areas or groups of beneficiaries. Waivers allow excep- tions to State plan requirements and permit a State to implement innova- tive programs or activities on a time- limited basis, and subject to specific safeguards for the protection of beneficiaries and the program. Detailed rules for waivers are set forth in sub- part B of part 431, subpart A of part 440, and subpart G of part 441 of this chap- ter.

(c) *Effect of waivers.* (1) Waivers under section 1915(b) allow a State to take the following actions:

(i) Implement a primary care case- management system or a specialty physician system.

(ii) Designate a locality to act as cen- tral broker in assisting Medicaid beneficiaries to choose among competing health care plans.

(iii) Share with beneficiaries (through provision of additional serv- ices) cost-savings made possible through the beneficiaries' use of more cost-effective medical care.

(iv) Limit beneficiaries' choice of providers (except in emergency situa- tions and with respect to family planning services) to providers that fully meet reimbursement, quality, and uti- lization standards, which are estab- lished under the State plan and are consistent with access, quality, and ef- ficient and economical furnishing of care.

(2) A waiver under section 1915(c) of the Act allows a State to include as ''medical assistance'' under its plan home and community based services furnished to beneficiaries who would otherwise need inpatient care that is

furnished in a hospital, SNF, ICF, or ICF/IID, and is reimbursable under the State plan.

(3) A waiver under section 1916 (a)(3) or (b)(3) of the Act allows a State to impose a deduction, cost-sharing or similar charge of up to twice the ''nominal charge'' established under the plan for outpatient services, if—

(i) The outpatient services are re- ceived in a hospital emergency room but are not emergency services; and

(ii) The State has shown that Med- icaid beneficiaries have actually avail- able and accessible to them alternative services of nonemergency outpatient services.

(d) *Requirements that are waived.* In order to permit the activities described in paragraph (c) of this section, one or more of the title XIX requirements must be waived, in whole or in part.

(1) Under section 1915(b) of the Act, and subject to certain limitations, any of the State plan requirements of sec- tion 1902 of the Act may be waived to achieve one of the purposes specified in that section.

(2) Under section 1915(c) of the Act, the following requirements may be waived:

(i) Statewideness—section 1902(a)(1).

(ii) Comparability of services—sec- tion 1902(a)(10)(B).

(iii) Income and resource rules—sec- tion 1902(a)(10)(C)(i)(III).

(3) Under section 1916 of the Act, paragraphs (a)(3) and (b)(3) require that any cost-sharing imposed on bene- ficiaries be nominal in amount, and provide an exception for nonemergency services furnished in a hospital emer- gency room if the conditions of para- graph (c)(3) of this section are met.

(e) *Submittal of waiver request.* The State Governor, the head of the Med- icaid agency, or an authorized designee may submit the waiver request.

(f) *Review of waiver requests.* (1) This paragraph applies to initial waiver re- quests and to requests for renewal or amendment of a previously approved waiver.

(2) CMS regional and central office staff review waiver requests and sub- mit a recommendation to the Adminis- trator, who—

(i) Has the authority to approve or deny waiver requests; and

(ii) Does not deny a request without first consulting the Secretary.

(3) A waiver request is considered ap- proved unless, within 90 days after the request is received by CMS, the Admin- istrator denies the request, or the Ad- ministrator or the Regional Adminis- trator sends the State a written re- quest for additional information nec- essary to reach a final decision. If addi- tional information is requested, a new 90-day period begins on the day the re- sponse to the additional information request is received by the addressee.

(g) *Basis for approval—*(1) *Waivers under section 1915 (b) and (c).* The Ad- ministrator approves waiver requests if the State's proposed program or activ- ity meets the requirements of the Act and the regulations at § 431.55 or sub- part G of part 441 of this chapter.

(2) *Waivers under section 1916.* The Ad- ministrator approves a waiver under section 1916 of the Act if the State shows, to CMS's satisfaction, that the Medicaid beneficiaries have available and accessible to them sources, other than a hospital emergency room, where they can obtain necessary non- emergency outpatient services.

(h) *Effective date and duration of waiv- ers*—(1) *Effective date.* Waivers receive a prospective effective date determined, with State input, by the Adminis- trator. The effective date is specified in the letter of approval to the State.

(2) *Duration of waivers—*(i) *Home and community-based services under section 1915(c) of the Act.* (A) The initial waiver is for a period of 3 years and may be re- newed thereafter for periods of 5 years.

(B) For waivers that include individ- uals who are dually eligible for Medi- care and Medicaid, 5-year initial ap- proval periods may be granted at the discretion of the Secretary for waivers meeting all necessary programmatic, financial and quality requirements, and in a manner consistent with the in- terests of beneficiaries and the objec- tives of the Medicaid program.

(ii) *Waivers under section 1915(b) of the Act.* (A) The initial waiver is for a pe- riod of 2 years and may be renewed for additional periods of up to 2 years as determined by the Administrator.

(B) For waivers that include individ- uals who are dually eligible for Medi- care and Medicaid, 5-year initial and

renewal approval periods may be granted at the discretion of the Secretary for waivers meeting all necessary programmatic, financial and quality requirements, and in a manner consistent with the interests of beneficiaries and the objectives of the Medicaid program.

(iii) *Waivers under section 1916 of the Act.* The initial waiver is for a period of 2 years and may be renewed for additional periods of up to 2 years as determined by the Administrator.

(3) *Renewal of waivers.* (i) A renewal request must be submitted at least 90 days (but not more than 120 days) before a currently approved waiver expires, to provide adequate time for CMS review.

(ii) If a renewal request for a section 1915(c) waiver proposes a change in services provided, eligible population, service area, or statutory sections waived, the Administrator may consider it a new waiver, and approve it for a period of three years.

[56 FR 8846, Mar. 1, 1991, as amended at 79 FR 3028, Jan. 16, 2014]

Subpart C—Grants; Reviews and Audits; Withholding for Failure To Comply; Deferral and Disallowance of Claims; Reduction of Federal Medicaid Payments

§ 430.30 Grants procedures.

(a) *General provisions.* (1) Once CMS has approved a State plan, it makes quarterly grant awards to the State to cover the Federal share of expenditures for services, training, and administration.

(2) The amount of the quarterly grant is determined on the basis of information submitted by the State agency (in quarterly estimate and quarterly expenditure reports) and other pertinent documents.

(b) *Quarterly estimates.* The Medicaid agency must submit Form CMS–37 (Medicaid Program Budget Report; Quarterly Distribution of Funding Requirements) to the central office (with a copy to the regional office) 45 days before the beginning of each quarter.

(c) *Expenditure reports.* (1) The State must submit Form CMS–64 (Quarterly

Medicaid Statement of Expenditures for the Medical Assistance Program) to the central office (with a copy to the regional office) not later than 30 days after the end of each quarter.

(2) This report is the State's account- ing of actual recorded expenditures. The disposition of Federal funds may not be reported on the basis of esti- mates.

(d) *Grant award*—(1) *Computation by CMS.* Regional office staff analyzes the State's estimates and sends a rec- ommendation to the central office. Central office staff considers the State's estimates, the regional office recommendations and any other rel- evant information, including any ad- justments to be made under paragraph (d)(2) of this section, and computes the grant.

(2) *Content of award.* The grant award computation form shows the estimate of expenditures for the ensuring quar- ter, and the amounts by which that es- timate is increased or decreased be- cause of an underestimate or overesti- mate for prior quarters, or for any of the following reasons:

(i) Penalty reductions imposed by law.

(ii) Accounting adjustments.

(iii) Deferrals or disallowances.

(iv) Interest assessments.

(v) Mandated adjustments such as those required by section 1914 of the Act.

(3) *Effect of award.* The grant award authorizes the State to draw Federal funds as needed to pay the Federal share of disbursements.

(4) *Drawing procedure.* The draw is through a commercial bank and the Federal Reserve system against a con- tinuing letter of credit certified to the Secretary of the Treasury in favor of the State payee. (The letter of credit payment system was established in ac- cordance with Treasury Department regulations—Circular No. 1075.)

(e) *General administrative requirements.* With the following exceptions, the pro- visions of 45 CFR part 74, which estab- lish uniform administrative require- ments and cost principles, apply to all grants made to States under this sub- part:

45 CFR part 74

Subpart G—Matching and Cost Sharing

431.701 Definitions.		431.954	Basis and scope.
431.702 State plan requirement.		431.958	Definitions and use of terms.
431.703 Licensing requirement.		431.960	Types of payment errors.
431.704 Nursing homes designated by other terms.		431.970	Information submission requirements.
431.705	Licensing authority.	431.972 Claims sampling procedures.	
431.706	Composition of licensing board.	431.974 Basic elements of Medicaid and	
431.707	Standards.	CHIP eligibility reviews.	
431.708 431.709	Procedures for applying standards. issuance and revocation of license.	431.978 Eligibility sampling plan and procedures.	
431.710	Provisional licenses. procedures.	431.980 Eligibility review	
431.711	Compliance with standards.	431.988 Eligibility case review completion	
431.712	Failure to comply with standards.	deadlines and submittal of reports.	
431.713	Continuing study and investigation. Corrective action plan.	431.992	

431.714	Waivers. and appeal
431.715	Federal financial participation.
431.998	Difference resolution process.

Subpart O [Reserved]

Subpart P—Quality Control

431.1002 Recoveries.

AUTHORITY: Sec. 1102 of the Social Security Act, (42 U.S.C. 1302).

	GENERAL PROVISIONS	SOURCE: 43 FR 45188, Sept. 29, 1978, unless
431.800	Scope of subpart.	otherwise noted.
431.802	Basis.	EDITORIAL NOTE: Nomenclature changes to
431.804	Definitions.	part 431 appear at 75 FR 48852, Aug. 11, 2010.
431.806	State plan requirements.	
431.808	Protection of beneficiary rights.	**§ 431.1 Purpose.**

MEDICAID ELIGIBILITY QUALITY CONTROL (MEQC) PROGRAM

431.810 Basic elements of the Medicaid eligi- bility quality control (MEQC) program.
431.812 Review procedures.
431.814 Sampling plan and procedures.
431.816 Case review completion deadlines and submittal of reports.
431.818 Access to records: MEQC program.
431.820 Corrective action under the MEQC program.
431.822 Resolution of differences in State and Federal case eligibility or payment findings.

MEDICAID QUALITY CONTROL (MQC) CLAIMS PROCESSING ASSESSMENT SYSTEM

431.830 Basic elements of the Medicaid qual- ity control (MQC) claims processing as- sessment system.
431.832 Reporting requirements for claims processing assessment systems.
431.834 Access to records: Claims processing assessment systems.
431.836 Corrective action under the MQC claims processing assessment systems.

FEDERAL FINANCIAL PARTICIPATION

431.861–431.864 [Reserved]
431.865 Disallowance of Federal financial participation for erroneous State pay- ments (for annual assessment periods ending after July 1, 1990).

Subpart Q—Requirements for Estimating Improper Payments in Medicaid and

CHIP

431.950 Purpose.

This part establishes State plan re- quirements for the designation, organi- zation, and general administrative ac- tivities of a State agency responsible for operating the State Medicaid pro- gram, directly or through supervision of local administering agencies.

Subpart A—Single State Agency

§ 431.10 Single State agency.

(a) *Basis, purpose, and definitions.* (1) This section implements section 1902(a)(4) and (5) of the Act.

(2) For purposes of this part—

Appeals decision means a decision made by a hearing officer adjudicating a fair hearing under subpart E of this part.

Exchange has the meaning given to the term in 45 CFR 155.20.

Exchange appeals entity has the mean- ing given to the term ''appeals entity,'' as defined in 45 CFR 155.500.

Medicaid agency is the single State agency for the Medicaid program.

(b) *Designation and certification.* A State plan must—

(1) Specify a single State agency es- tablished or designated to administer or supervise the administration of the plan; and

(2) Include a certification by the State Attorney General, citing the

legal authority for the single State agency to—

(i) Administer or supervise the administration of the plan; and

(ii) Make rules and regulations that it follows in administering the plan or that are binding upon local agencies that administer the plan.

(3) The single State agency is respon- sible for determining eligibility for all individuals applying for or receiving benefits in accordance with regulations in part 435 of this chapter and for fair hearings filed in accordance with sub- part E of this part.

(c) *Delegations.* (1) Subject to the re- quirement in paragraph (c)(2) of this section, the Medicaid agency—

(i)(A) May, in the approved state plan, delegate authority to determine eligibility for all or a defined subset of individuals to—

(1) The single State agency for the fi- nancial assistance program under title IV–A (in the 50 States or the District of Columbia), or under title I or XVI (AABD), in Guam, Puerto Rico, or the Virgin Islands;

(2) The Federal agency administering the supplemental security income pro- gram under title XVI of the Act; or

(3) The Exchange.

(B) Must in the approved state plan specify to which agency, and the individuals for which, authority to deter- mine eligibility is delegated.

(ii) Delegate authority to conduct fair hearings under subpart E of this part for denials of eligibility for indi- viduals whose income eligibility is de- termined based on the applicable modi- fied adjusted gross income standard de- scribed in § 435.911(c) of this chapter, to an Exchange or Exchange appeals enti- ty, provided that individuals who have requested a fair hearing of such a de- nial are given a choice to have their fair hearing instead conducted by the Medicaid agency.

(2) The Medicaid agency may dele- gate authority to make eligibility de- terminations or to conduct fair hear- ings under this section only to a gov- ernment agency which maintains per- sonnel standards on a merit basis.

(3) The Medicaid agency—

(i) Must ensure that any agency to which eligibility determinations or ap- peals decisions are delegated—

(A) Complies with all relevant Fed- eral and State law, regulations and policies, including, but not limited to, those related to the eligibility criteria applied by the agency under part 435 of this chapter; prohibitions against con- flicts of interest and improper incen- tives; and safeguarding confidentiality, including regulations set forth at sub- part F of this part.

(B) Informs applicants and bene- ficiaries how they can directly contact and obtain information from the agen- cy; and

(ii) Must exercise appropriate over- sight over the eligibility determina- tions and appeals decisions made by such agencies to ensure compliance with paragraphs (c)(2) and (c)(3)(i) of this section and institute corrective action as needed, including, but not limited to, rescission of the authority delegated under this section.

(iii) If authority to conduct fair hear- ings is delegated to the Exchange or Exchange appeals entity under para- graph (c)(1)(ii) of this section, the agency may establish a review process whereby the agency may review fair hearing decisions made under that del- egation, but that review will be limited to the proper application of federal and state Medicaid law and regulations, in- cluding sub-regulatory guidance and written interpretive policies, and must be conducted by an impartial official not directly involved in the initial de- termination.

(d) *Agreement with Federal, State or local entities making eligibility determina- tions or appeals decisions*. The plan must provide for written agreements be- tween the Medicaid agency and the Ex- change or any other State or local agency that has been delegated author- ity under paragraph (c)(1)(i) of this sec- tion to determine Medicaid eligibility and for written agreements between the agency and the Exchange or Ex- change appeals entity that has been delegated authority to conduct Med- icaid fair hearings under paragraph (c)(1)(ii) of this section. Such agree- ments must be available to the Sec- retary upon request and must include provisions for:

(1) The relationships and respective responsibilities of the parties, includ- ing but not limited to the respective

responsibilities to effectuate the fair hearing rules in subpart E of this part;

(2) Quality control and oversight by the Medicaid agency, including any reporting requirements needed to facilitate such control and oversight;

(3) Assurances that the entity to which authority to determine eligibility or conduct fair hearings will comply with the provisions set forth in paragraph (c)(3) of this section.

(4) For appeals, procedures to ensure that individuals have notice and a full opportunity to have their fair hearing conducted by either the Exchange or Exchange appeals entity or the Medicaid agency.

(e) *Authority of the single State agency.* The Medicaid agency may not delegate, to other than its own officials, the authority to supervise the plan or to develop or issue policies, rules, and regulations on program matters.

[44 FR 17930, Mar. 23, 1979, as amended at 77 FR 17202, Mar. 23, 2012; 78 FR 42300, July 15, 2013]

§ 431.11 Organization for administration.

(a) *Basis and purpose.* This section, based on section 1902(a)(4) of the Act, prescribes the general organization and staffing requirements for the Medicaid agency and the State plan.

(b) *Description of organization.* (1) The plan must include a description of the organization and functions of the Medicaid agency.

(2) When submitting a state plan amendment related to the designation, authority, organization or functions of the Medicaid agency, the Medicaid agency must provide an organizational chart reflecting the key components of the Medicaid agency and the functions each performs.

(c) *Eligibility determined or fair hearings decided by other entities.* If eligibility is determined or fair hearings decided by Federal or State entities other than the Medicaid agency or by local agencies under the supervision of other State agencies, the plan must include a description of the staff designated by those other entities and the functions

they perform in carrying out their responsibilities.

[44 FR 17931, Mar. 23, 1979, as amended at 77 FR 17203, Mar. 23, 2012; 78 FR 42301, July 15, 2013]

§ 431.12 Medical care advisory com- mittee.

(a) *Basis and purpose.* This section, based on section 1902(a)(4) of the Act, prescribes State plan requirements for establishment of a committee to advise the Medicaid agency about health and medical care services.

(b) *State plan requirement.* A State plan must provide for a medical care advisory committee meeting the re- quirements of this section to advise the Medicaid agency director about health and medical care services.

(c) *Appointment of members.* The agen- cy director, or a higher State author- ity, must appoint members to the advi- sory committee on a rotating and con- tinuous basis.

(d) *Committee membership.* The committee must include—

(1) Board-certified physicians and other representatives of the health pro- fessions who are familiar with the medical needs of low-income population groups and with the resources available and required for their care;

(2) Members of consumers' groups, including Medicaid beneficiaries, and consumer organizations such as labor unions, cooperatives, consumer-spon- sored prepaid group practice plans, and others; and

(3) The director of the public welfare department or the public health department, whichever does not head the Medicaid agency.

(e) *Committee participation.* The committee must have opportunity for participation in policy development and program administration, including fur- thering the participation of beneficiary members in the agency program.

(f) *Committee staff assistance and fi- nancial help.* The agency must provide the committee with—

(1) Staff assistance from the agency and independent technical assistance as needed to enable it to make effective recommendations; and

(2) Financial arrangements, if necessary, to make possible the participa- tion of beneficiary members.

(j) *Limits on scope of review: Civil money penalty cases.* In civil money penalty cases—

(1) The State's finding as to a NF's level of noncompliance must be upheld unless it is clearly erroneous; and

(2) The scope of review is as set forth in § 488.438(e) of this chapter.

[61 FR 32348, June 24, 1996, as amended at 62 FR 43935, Aug. 18, 1997; 64 FR 39937, July 23, 1999]

§ 431.154 Informal reconsideration for ICFs/IID.

The informal reconsideration must, at a minimum, include—

(a) Written notice to the facility of the denial, termination or nonrenewal and the findings upon which it was based;

(b) A reasonable opportunity for the facility to refute those findings in writ- ing, and

(c) A written affirmation or reversal of the denial, termination, or non-renewal.

[44 FR 9753, Feb. 15, 1979, as amended at 59 FR 56233, Nov. 10, 1994; 61 FR 32349, June 24, 1996]

Subpart E—Fair Hearings for Applicants and Beneficiaries

SOURCE: 44 FR 17932, Mar. 29, 1979, unless otherwise noted.

GENERAL PROVISIONS

§ 431.200 Basis and scope.

This subpart—

(a) Implements section 1902(a)(3) of the Act, which requires that a State plan provide an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon promptly;

(b) Prescribes procedures for an op- portunity for a hearing if the State agency or PAHP takes action, as stat- ed in this subpart, to suspend, termi- nate, or reduce services, or an MCO or PIHP takes action under subpart F of part 438 of this chapter; and

(c) Implements sections 1919(f)(3) and 1919(e)(7)(F) of the Act by providing an appeals process for any person who—

(1) Is subject to a proposed transfer or discharge from a nursing facility; or

(2) Is adversely affected by the pre- admission screening or the annual resi- dent review that are required by sec- tion 1919(e)(7) of the Act.

[67 FR 41094, June 14, 2002]

§ 431.201 Definitions.

For purposes of this subpart:

Action means a termination, suspen- sion, or reduction of Medicaid eligi- bility or covered services. It also means determinations by skilled nurs- ing facilities and nursing facilities to transfer or discharge residents and ad- verse determinations made by a State with regard to the preadmission screening and annual resident review requirements of section 1919(e)(7) of the Act.

Adverse determination means a determination made in accordance with sec- tions 1919(b)(3)(F) or 1919(e)(7)(B) of the Act that the individual does not re- quire the level of services provided by a nursing facility or that the individual does or does not require specialized services.

Date of action means the intended date on which a termination, suspen- sion, reduction, transfer or discharge becomes effective. It also means the date of the determination made by a State with regard to the preadmission screening and annual resident review requirements of section 1919(e)(7) of the Act.

De novo hearing means a hearing that starts over from the beginning.

Evidentiary hearing means a hearing conducted so that evidence may be pre- sented.

Notice means a written statement that meets the requirements of § 431.210.

Request for a hearing means a clear expression by the applicant or bene- ficiary, or his authorized representa- tive, that he wants the opportunity to present his case to a reviewing author- ity.

Send means deliver by mail or in electronic format consistent with § 435.918 of this chapter.

Service authorization request means a managed care enrollee's request for the provision of a service.

[44 FR 17932, Mar. 29, 1979, as amended at 57 FR 56505, Nov. 30, 1992; 67 FR 41095, June 14, 2002; 78 FR 42301, July 15, 2013]

§ 431.202 State plan requirements.

A State plan must provide that the requirements of §§ 431.205 through 431.246 of this subpart are met.

§ 431.205 Provision of hearing system.

(a) The Medicaid agency must be re- sponsible for maintaining a hearing system that meets the requirements of this subpart.

(b) The State's hearing system must provide for—

(1) A hearing before—

(i) The Medicaid agency; or

(ii) For the denial of eligibility for individuals whose income eligibility is determined based on the applicable modified adjusted gross income stand- ard described in§ 435.911(c) of this chap- ter, the Exchange or Exchange appeals entity to which authority to conduct fair hearings has been delegated under § 431.10(c)(1)(ii), provided that individ- uals who have requested a fair hearing are given the choice to have their fair hearing conducted instead by the Med- icaid agency; at state option the Ex- change or Exchange appeals entity de- cision may be subject to review by the Medicaid agency in accordance with § 431.10(c)(3)(iii); or

(2) An evidentiary hearing at the local level, with a right of appeal to the Medicaid agency.

(c) The agency may offer local hear- ings in some political subdivisions and not in others.

(d) The hearing system must meet the due process standards set forth in *Goldberg v. Kelly,* 397 U.S. 254 (1970), and any additional standards specified in this subpart.

[44 FR 17932, Mar. 29, 1979, as amended at 78 FR 42301, July 15, 2013]

§ 431.206 Informing applicants and beneficiaries.

(a) The agency must issue and pub- licize its hearing procedures.

(b) The agency must, at the time specified in paragraph (c) of this sec- tion, inform every applicant or bene- ficiary in writing—

(1) Of his right to a hearing;

(2) Of the method by which he may obtain a hearing; and

(3) That he may represent himself or use legal counsel, a relative, a friend, or other spokesman.

(c) The agency must provide the in- formation required in paragraph (b) of this section—(1) At the time that the individual applies for Medicaid;

(2) At the time of any action affect- ing his or her claim;

(3) At the time a skilled nursing fa- cility or a nursing facility notifies a resident in accordance with § 483.12 of this chapter that he or she is to be transferred or discharged; and

(4) At the time an individual receives an adverse determination by the State with regard to the preadmission screening and annual resident review requirements of section 1919(e)(7) of the Act.

(d) If, in accordance with § 431.10(c)(1)(ii), the agency has dele- gated authority to the Exchange or Ex- change appeals entity to conduct the fair hearing, the agency must inform the individual in writing that—

(1) He or she has the right to have his or her hearing before the agency, in- stead of the Exchange or the Exchange appeals entity; and

(2) The method by which the indi- vidual may make such election;

(e) The information required under this section may be provided in elec- tronic format in accordance with § 435.918 of this chapter.

[44 FR 17932, Mar. 29, 1979, as amended at 57 FR 56505, Nov. 30, 1992; 58 FR 25784, Apr. 28, 1993; 78 FR 42301, July 15, 2013]

NOT
ICE

§ 431.210 Content of notice.

A notice required under § 431.206 (c)(2), (c)(3), or (c)(4) of this subpart must contain—

(a) A statement of what action the State, skilled nursing facility, or nurs- ing facility intends to take;

(b) The reasons for the intended ac- tion;

(c) The specific regulations that sup- port, or the change in Federal or State law that requires, the action;

(d) An explanation of—

(1) The individual's right to request an evidentiary hearing if one is avail- able, or a State agency hearing; or

(2) In cases of an action based on a change in law, the circumstances under which a hearing will be granted; and

(e) An explanation of the cir- cumstances under which Medicaid is continued if a hearing is requested.

[44 FR 17932, Mar. 29, 1979, as amended at 57 FR 56505, Nov. 30, 1992]

§ 431.211 Advance notice.

The State or local agency must send a notice at least 10 days before the date of action, except as permitted under §§ 431.213 and 431.214.

[78 FR 42301, July 15, 2013]

§ 431.213 Exceptions from advance no- tice.

The agency may send a notice not later than the date of action if—

(a) The agency has factual informa- tion confirming the death of a bene- ficiary;

(b) The agency receives a clear writ- ten statement signed by a beneficiary that—

(1) He no longer wishes services; or

(2) Gives information that requires termination or reduction of services and indicates that he understands that this must be the result of supplying that information;

(c) The beneficiary has been admitted to an institution where he is ineligible under the plan for further services;

(d) The beneficiary's whereabouts are unknown and the post office returns agency mail directed to him indicating no forwarding address (See § 431.231 (d) of this subpart for procedure if the beneficiary's whereabouts become known);

(e) The agency establishes the fact that the beneficiary has been accepted for Medicaid services by another local jurisdiction, State, territory, or com- monwealth;

(f) A change in the level of medical care is prescribed by the beneficiary's physician;

(g) The notice involves an adverse de- termination made with regard to the preadmission screening requirements of section 1919(e)(7) of the Act; or

(h) The date of action will occur in less than 10 days, in accordance with § 483.12(a)(5)(ii), which provides excep-

tions to the 30 days notice require- ments of § 483.12(a)(5)(i).

[44 FR 17932, Mar. 29, 1979, as amended at 57 FR 56505, Nov. 30, 1992; 58 FR 25784, Apr. 28, 1993; 78 FR 42301, July 15, 2013]

§ 431.214 Notice in cases of probable fraud.

The agency may shorten the period of advance notice to 5 days before the date of action if—

(a) The agency has facts indicating that action should be taken because of probable fraud by the beneficiary; and

(b) The facts have been verified, if possible, through secondary sources.

RIGHT TO HEARING

§ 431.220 When a hearing is required.

(a) The State agency must grant an opportunity for a hearing to the fol- lowing:

(1) Any applicant who requests it be- cause his claim for services is denied or is not acted upon with reasonable promptness.

(2) Any beneficiary who requests it because he or she believes the agency has taken an action erroneously.

(3) Any resident who requests it be- cause he or she believes a skilled nurs- ing facility or nursing facility has erro- neously determined that he or she must be transferred or discharged.

(4) Any individual who requests it be- cause he or she believes the State has made an erroneous determination with regard to the preadmission and annual resident review requirements of section 1919(e)(7) of the Act.

(5) Any MCO or PIHP enrollee who is entitled to a hearing under subpart F of part 438 of this chapter.

(6) Any PAHP enrollee who has an action as stated in this subpart.

(7) Any enrollee who is entitled to a hearing under subpart B of part 438 of this chapter.

(b) The agency need not grant a hear- ing if the sole issue is a Federal or State law requiring an automatic change adversely affecting some or all beneficiaries.

[44 FR 17932, Mar. 29, 1979, as amended at 57 FR 56505, Nov. 30, 1992; 67 FR 41095, June 14, 2002; 67 FR 65505, Oct. 25, 2002]

§ 431.221 Request for hearing.

(a) The agency may require that a re- quest for a hearing be in writing.

(b) The agency may not limit or interfere with the applicant's or bene- ficiary's freedom to make a request for a hearing.

(c) The agency may assist the appli- cant or beneficiary in submitting and processing his request.

(d) The agency must allow the appli- cant or beneficiary a reasonable time, not to exceed 90 days from the date that notice of action is mailed, to re- quest a hearings.

§ 431.222 Group hearings.

The agency—

(a) May respond to a series of indi- vidual requests for hearing by con- ducting a single group hearing;

(b) May consolidate hearings only in cases in which the sole issue involved is one of Federal or State law or policy;

(c) Must follow the policies of this subpart and its own policies governing hearings in all group hearings; and

(d) Must permit each person to present his own case or be represented by his authorized representative.

§ 431.223 Denial or dismissal of re- quest for a hearing.

The agency may deny or dismiss a re- quest for a hearing if—

(a) The applicant or beneficiary with- draws the request in writing; or

(b) The applicant or beneficiary fails to appear at a scheduled hearing with- out good cause.

PROCEDURES

§ 431.230 Maintaining services.

(a) If the agency sends the 10-day or 5-day notice as required under § 431.211 or § 431.214 of this subpart, and the ben- eficiary requests a hearing before the date of action, the agency may not ter- minate or reduce services until a deci- sion is rendered after the hearing un- less—

(1) It is determined at the hearing that the sole issue is one of Federal or State law or policy; and

(2) The agency promptly informs the beneficiary in writing that services are to be terminated or reduced pending the hearing decision.

(b) If the agency's action is sustained by the hearing decision, the agency may institute recovery procedures against the applicant or beneficiary to recoup the cost of any services fur- nished the beneficiary, to the extent they were furnished solely by reason of this section.

[44 FR 17932, Mar. 29, 1979, as amended at 45 FR 24882, Apr. 11, 1980; 78 FR 42302, July 15, 2013]

§ 431.231 Reinstating services.

(a) The agency may reinstate serv- ices if a beneficiary requests a hearing not more than 10 days after the date of action.

(b) The reinstated services must con- tinue until a hearing decision unless, at the hearing, it is determined that the sole issue is one of Federal or State law or policy.

(c) The agency must reinstate and continue services until a decision is rendered after a hearing if—

(1) Action is taken without the ad- vance notice required under § 431.211 or § 431.214 of this subpart;

(2) The beneficiary requests a hearing within 10 days from the date that the individual receives the notice of ac- tion. The date on which the notice is received is considered to be 5 days after the date on the notice, unless the bene- ficiary shows that he or she did not re- ceive the notice within the 5-day pe- riod; and

(3) The agency determines that the action resulted from other than the ap- plication of Federal or State law or policy.

(d) If a beneficiary's whereabouts are unknown, as indicated by the return of unforwardable agency mail directed to him, any discontinued services must be reinstated if his whereabouts become known during the time he is eligible for services.

[44 FR 17932, Mar. 29, 1979, as amended at 78 FR 42302, July 15, 2013]

§ 431.232 Adverse decision of local evi- dentiary hearing.

If the decision of a local evidentiary hearing is adverse to the applicant or beneficiary, the agency must—

(a) Inform the applicant or bene- ficiary of the decision;

(b) Inform the applicant or bene- ficiary that he has the right to appeal the decision to the State agency, in writing, within 15 days of the mailing of the notice of the adverse decision;

(c) Inform the applicant or bene- ficiary of his right to request that his appeal be a *de novo* hearing; and

(d) Discontinue services after the ad- verse decision.

§ 431.233 State agency hearing after adverse decision of local evi- dentiary hearing.

(a) Unless the applicant or bene- ficiary specifically requests a *de novo* hearing, the State agency hearing may consist of a review by the agency hear- ing officer of the record of the local evidentiary hearing to determine whether the decision of the local hear- ing officer was supported by substan- tial evidence in the record.

(b) A person who participates in the local decision being appealed may not participate in the State agency hearing decision.

§ 431.240 Conducting the hearing.

(a) All hearings must be conducted—

(1) At a reasonable time, date, and place;

(2) Only after adequate written no- tice of the hearing; and

(3) By one or more impartial officials or other individuals who have not been directly involved in the initial deter- mination of the action in question.

(b) If the hearing involves medical issues such as those concerning a diag- nosis, an examining physician's report, or a medical review team's decision, and if the hearing officer considers it necessary to have a medical assess- ment other than that of the individual involved in making the original deci- sion, such a medical assessment must be obtained at agency expense and made part of the record.

(c) A hearing officer must have ac- cess to agency information necessary to issue a proper hearing decision, in- cluding information concerning State policies and regulations.

[44 FR 17932, Mar. 29, 1979, as amended at 78 FR 42302, July 15, 2013]

§ 431.241 Matters to be considered at the hearing.

The hearing must cover—

(a) Agency action or failure to act with reasonable promptness on a claim for services, including both initial and subsequent decisions regarding eligi- bility;

(b) Agency decisions regarding changes in the type or amount of serv- ices;

(c) A decision by a skilled nursing fa- cility or nursing facility to transfer or discharge a resident; and

(d) A State determination with re- gard to the preadmission screening and annual resident review requirements of section 1919(e)(7) of the Act.

[57 FR 56505, Nov. 30, 1992]

§ 431.242 Procedural rights of the ap- plicant or beneficiary.

The applicant or beneficiary, or his representative, must be given an oppor- tunity to—

(a) Examine at a reasonable time be- fore the date of the hearing and during the hearing:

(1) The content of the applicant's or beneficiary's case file; and

(2) All documents and records to be used by the State or local agency or the skilled nursing facility or nursing facility at the hearing;

(b) Bring witnesses;

(c) Establish all pertinent facts and circumstances;

(d) Present an argument without undue interference; and

(e) Question or refute any testimony or evidence, including opportunity to confront and cross-examine adverse witnesses.

[44 FR 17932, Mar. 29, 1979, as amended at 57 FR 56506, Nov. 30, 1992]

§ 431.243 Parties in cases involving an eligibility determination.

If the hearing involves an issue of eli- gibility and the Medicaid agency is not responsible for eligibility determina- tions, the agency that is responsible for determining eligibility must par- ticipate in the hearing.

§ 431.244

§ 431.244 Hearing decisions.

(a) Hearing recommendations or decisions must be based exclusively on evi- dence introduced at the hearing.

(b) The record must consist only of—

(1) The transcript or recording of tes- timony and exhibits, or an official re- port containing the substance of what happened at the hearing;

(2) All papers and requests filed in the proceeding; and

(3) The recommendation or decision of the hearing officer.

(c) The applicant or beneficiary must have access to the record at a conven- ient place and time.

(d) In any evidentiary hearing, the decision must be a written one that—

(1) Summarizes the facts; and

(2) Identifies the regulations sup- porting the decision.

(e) In a *de novo* hearing, the decision must—

(1) Specify the reasons for the deci- sion; and

(2) Identify the supporting evidence and regulations.

(f) The agency must take final ad- ministrative action as follows:

(1) Ordinarily, within 90 days from the earlier of the following:

(i) The date the enrollee filed an MCO or PIHP appeal, not including the num- ber of days the enrollee took to subse- quently file for a State fair hearing; or

(ii) If permitted by the State, the date the enrollee filed for direct access to a State fair hearing.

(2) As expeditiously as the enrollee's health condition requires, but no later than 3 working days after the agency receives, from the MCO or PIHP, the case file and information for any ap- peal of a denial of a service that, as in- dicated by the MCO or PIHP—

(i) Meets the criteria for expedited resolution as set forth in § 438.410(a) of this chapter, but was not resolved within the timeframe for expedited res- olution; or

(ii) Was resolved within the time- frame for expedited resolution, but reached a decision wholly or partially adverse to the enrollee.

(3) If the State agency permits direct access to a State fair hearing, as expe- ditiously as the enrollee's health condi- tion requires, but no later than 3 work- ing days after the agency receives, di-

rectly from an MCO or PIHP enrollee, a fair hearing request on a decision to deny a service that it determines meets the criteria for expedited resolution, as set forth in § 438.410(a) of this chapter.

(g) The public must have access to all agency hearing decisions, subject to the requirements of subpart F of this part for safeguarding of information.

[44 FR 17932, Mar. 29, 1979, as amended at 67 FR 41095, June 14, 2002]

§ 431.245 Notifying the applicant or beneficiary of a State agency decision.

The agency must notify the applicant or beneficiary in writing of—

(a) The decision; and

(b) His right to request a State agen- cy hearing or seek judicial review, to the extent that either is available to him.

§ 431.246 Corrective action.

The agency must promptly make cor- rective payments, retroactive to the date an incorrect action was taken, and, if appropriate, provide for admis- sion or readmission of an individual to a facility if—

(a) The hearing decision is favorable to the applicant or beneficiary; or

(b) The agency decides in the appli- cant's or beneficiary's favor before the hearing.

[57 FR 56506, Nov. 30, 1992]

FEDERAL FINANCIAL PARTICIPATION

§ 431.250 Federal financial participa- tion.

FFP is available in expenditures for—

(a) Payments for services continued pending a hearing decision;

(b) Payments made—

(1) To carry out hearing decisions; and

(2) For services provided within the scope of the Federal Medicaid program and made under a court order.

(c) Payments made to take correc- tive action prior to a hearing;

(d) Payments made to extend the benefit of a hearing decision or court order to individuals in the same situa- tion as those directly affected by the decision or order;

(e) Retroactive payments under para- graphs (b), (c), and (d) of this section in accordance with applicable Federal policies on corrective payments; and

(f) Administrative costs incurred by the agency for—

(1) Transportation for the applicant or beneficiary, his representative, and witnesses to and from the hearing;

(2) Meeting other expenses of the ap- plicant or beneficiary in connection with the hearing;

(3) Carrying out the hearing proce- dures, including expenses of obtaining the additional medical assessment specified in § 431.240 of this subpart; and

(4) Hearing procedures for Medicaid and non-Medicaid individuals appealing transfers, discharges and determina- tions of preadmission screening and an- nual resident reviews under part 483, subparts C and E of this chapter.

[44 FR 17932, Mar. 29, 1979, as amended at 45 FR 24882, Apr. 11, 1980; 57 FR 56506, Nov. 30, 1992]

Subpart F—Safeguarding Informa- tion on Applicants and Bene- ficiaries

SOURCE: 44 FR 17934, Mar. 29, 1979, unless otherwise noted.

§ 431.300 Basis and purpose.

(a) Section 1902(a)(7) of the Act re- quires that a State plan must provide safeguards that restrict the use or dis- closure of information concerning ap- plicants and beneficiaries to purposes directly connected with the adminis- tration of the plan. This subpart speci- fies State plan requirements, the types of information to be safeguarded, the conditions for release of safeguarded information, and restrictions on the distribution of other information.

(b) For purposes of this subpart, in- formation concerning an applicant or beneficiary includes information on a non-applicant, as defined in § 435.4 of this subchapter.

(c) Section 1137 of the Act, which re- quires agencies to exchange informa- tion to verify the income and eligi- bility of applicants and beneficiaries (see § 435.940 through § 435.965 of this subchapter), requires State agencies to

have adequate safeguards to assure that—

(1) Information exchanged by the State agencies is made available only to the extent necessary to assist in the valid administrative needs of the pro- gram receiving the information, and information received under section 6103(l)(7) of the Internal Revenue Code is exchanged only with agencies au- thorized to receive that information under that section of the Code; and

(2) The information is adequately stored and processed so that it is pro- tected against unauthorized disclosure for other purposes.

(d) Section 1943 of the Act and sec- tion 1413 of the Affordable Care Act.

[51 FR 7210, Feb. 28, 1986, as amended at 77 FR 17203, Mar. 23, 2012]

§ 431.301 State plan requirements.

A State plan must provide, under a State statute that imposes legal sanc- tions, safeguards meeting the require- ments of this subpart that restrict the use or disclosure of information con- cerning applicants and beneficiaries to purposes directly connected with the administration of the plan.

§ 431.302 Purposes directly related to State plan administration.

Purposes directly related to plan ad- ministration include—

(a) Establishing eligibility;

(b) Determining the amount of med- ical assistance;

(c) Providing services for bene- ficiaries; and

(d) Conducting or assisting an inves- tigation, prosecution, or civil or crimi- nal proceeding related to the adminis- tration of the plan.

§ 431.303 State authority for safe- guarding information.

The Medicaid agency must have au- thority to implement and enforce the provisions specified in this subpart for safeguarding information about appli- cants and beneficiaries.

§ 431.304 Publicizing safeguarding re- quirements.

(a) The agency must publicize provi- sions governing the confidential nature of information about applicants and

OPTIONS FOR COVERAGE OF FAMILIES AND CHILDREN AND THE AGED, BLIND, AND DISABLED

§ 435.210 Individuals who meet the in- come and resource requirements of the cash assistance programs.

The agency may provide Medicaid to any group or groups of individuals specified in § 435.201 (a)(1) through (a)(3) and (a)(5) and (a)(6) who are not manda- tory categorically needy, who meet the income and resource requirements of the appropriate cash assistance pro- gram for their status (that is, the State's approved AFDC plan or SSI, or optional State supplements in States that provide Medicaid to optional State supplement beneficiaries).

[58 FR 4927, Jan. 19, 1993]

§ 435.211 Individuals who would be eli- gible for cash assistance if they were not in medical institutions.

The agency may provide Medicaid to any group or groups of individuals specified in § 435.201(a) who are in title XIX reimbursable medical institutions and who:

(a) Are ineligible for the cash assist- ance program appropriate for their sta- tus (that is, AFDC or SSI, or optional State supplements in States that pro- vide Medicaid to optional State supple- ment beneficiaries) because of lower in- come standards used under the pro- gram to determine eligibility for insti- tutionalized individuals; but

(b) Would be eligible for aid or assist- ance under the State's approved AFDC plan, SSI, or an optional State supple- ment as specified in §§ 435.232 and 435.234 if they were not institutional- ized.

[58 FR 4927, Jan. 19, 1993]

§ 435.212 Individuals who would be in- eligible if they were not enrolled in an MCO or PCCM.

The State agency may provide that a beneficiary who is enrolled in an MCO or PCCM and who becomes ineligible for Medicaid is considered to continue to be eligible—

(a) For a period specified by the agen- cy, ending no later than 6 months from the date of enrollment; and

(b) Except for family planning serv- ices (which the beneficiary may obtain

from any qualified provider) only for services furnished to him or her as an MCO enrollee.

[56 FR 8849, Mar. 1, 1991, as amended at 67 FR 41095, June 14, 2002]

§ 435.217 Individuals receiving home and community-based services.

The agency may provide Medicaid to any group or groups of individuals in the community who meet the following requirements:

(a) The group would be eligible for Medicaid if institutionalized.

(b) In the absence of home and com- munity-based services under a waiver granted under part 441—

(1) Subpart G of this subchapter, the group would otherwise require the level of care furnished in a hospital, NF, or an ICF/IID; or

(2) Subpart H of this subchapter, the group would otherwise require the level of care furnished in an NF and are age 65 or older.

(c) The group receives the waivered services.

[57 FR 29155, June 30, 1992]

§ 435.218 Individuals with MAGI-based income above 133 percent FPL.

(a) *Basis.* This section implements section 1902(a)(10)(A)(ii)(XX) of the Act.

(b) *Eligibility*—(1) *Criteria.* The agency may provide Medicaid to individuals who:

(i) Are under age 65;

(ii) Are not eligible for and enrolled for mandatory coverage under a State's Medicaid State plan in accordance with subpart B of this part;

(iii) Are not otherwise eligible for and enrolled for optional coverage under a State's Medicaid State plan in accordance with section 1902(a)(10)(A)(ii)(I) through (XIX) of the Act and subpart C of this part, based on information available to the State from the application filed by or on be- half of the individual; and

(iv) Have household income that ex- ceeds 133 percent FPL but is at or below the income standard elected by the agency and approved in its Med- icaid State plan, for the applicable family size.

(2) *Limitations.* (i) A State may not, except as permitted under an approved phase-in plan adopted in accordance

(2) A physician has certified that either of the individuals is likely to return to the home within that period.

(3) For single individuals and couples, an amount (in addition to the personal needs allowance) for maintenance of the individual's or couple's home if—

(i) The amount is deducted for not more than a 6-month period; and

(ii) A physician has certified that either of the individuals is likely to return to the home within that period.

(e) *Determination of income*—(1) *Option.* In determining the amount of an individual's income to be used to reduce the agency's payment to the institution, the agency may use total income received, or it may project monthly income for a prospective period not to exceed 6 months.

(2) *Basis for projection.* The agency must base the projection on income received in the preceding period, not to exceed 6 months, and on income expected to be received.

(3) *Adjustments.* At the end of the prospective period specified in paragraph (e)(1) of this section, or when any significant change occurs, the agency must reconcile estimates with income received.

(f) *Determination of medical expenses*—

(1) *Option.* In determining the amount of medical expenses to be deducted from an individual's income, the agency may deduct incurred medical expenses, or it may project medical expenses for a prospective period not to exceed 6 months.

(2) *Basis for projection.* The agency must base the estimate on medical expenses incurred in the preceding period, not to exceed 6 months, and on medical expenses expected to be incurred.

(3) *Adjustments.* At the end of the prospective period specified in paragraph (f)(1) of this section, or when any significant change occurs, the agency must reconcile estimates with incurred medical expenses.

[43 FR 45204, Sept. 29, 1978, as amended at 45 FR 24884, Apr. 11, 1980; 48 FR 5735, Feb. 8, 1983; 53 FR 3595, Feb. 8, 1988; 55 FR 33705, Aug. 17, 1990; 56 FR 8850, 8854, Mar. 1, 1991; 58 FR 4932, Jan. 19, 1993]

§ 435.726 Post-eligibility treatment of income of individuals receiving home and community-based serv- ices furnished under a waiver: Ap- plication of patient income to the cost of care.

(a) The agency must reduce its pay- ment for home and community-based services provided to an individual spec- ified in paragraph (b) of this section, by the amount that remains after deduct- ing the amounts specified in paragraph (c) of this section from the individual's income.

(b) This section applies to individuals who are eligible for Medicaid under § 435.217 and are receiving home and community-based services furnished under a waiver of Medicaid require- ments specified in part 441, subpart G or H of this subchapter.

(c) In reducing its payment for home and community-based services, the agency must deduct the following amounts, in the following order, from the individual's total income (includ- ing amounts disregarded in deter- mining eligibility):

(1) An amount for the maintenance needs of the individual that the State may set at any level, as long as the fol- lowing conditions are met:

(i) The deduction amount is based on a reasonable assessment of need.

(ii) The State establishes a maximum deduction amount that will not be ex- ceeded for any individual under the waiver.

(2) For an individual with only a spouse at home, an additional amount for the maintenance needs of the spouse. This amount must be based on a reasonable assessment of need but must not exceed the highest of—

(i) The amount of the income stand- ard used to determine eligibility for SSI for an individual living in his own home, if the agency provides Medicaid only to individuals receiving SSI;

(ii) The amount of the highest in- come standard, in the appropriate cat- egory of age, blindness, or disability, used to determine eligibility for an op- tional State supplement for an indi- vidual in his own home, if the agency provides Medicaid to optional State supplement beneficiaries under § 435.230; or

(iii) The amount of the medically needy income standard for one person established under §§ 435.811 and 435.814, if the agency provides Medicaid under the medically needy coverage option.

(3) For an individual with a family at home, an additional amount for the maintenance needs of the family. This amount must—

(i) Be based on a reasonable assess- ment of their financial need;

(ii) Be adjusted for the number of family members living in the home; and

(iii) Not exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's AFDC plan or the medically needy income standard established under § 435.811 for a family of the same size.

(4) Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party in- cluding—

(i) Medicare and other health insur- ance premiums, deductibles, or coin- surance charges; and

(ii) Necessary medical or remedial care recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits the agency may establish on amounts of these expenses.

[46 FR 48539, Oct. 1, 1981, as amended at 50 FR 10026, Mar. 13, 1985; 57 FR 29155, June 30, 1992; 58 FR 4932, Jan. 19, 1993; 59 FR 37715, July 25, 1994]

§ 435.733 Post-eligibility treatment of income of institutionalized individuals in States using more restric- tive requirements than SSI: Appli- cation of patient income to the cost of care.

(a) *Basic rules.* (1) The agency must reduce its payment to an institution, for services provided to an individual specified in paragraph (b) of this section, by the amount that remains after deducting the amounts specified in paragraphs (c) and (d) of this section, from the individual's total income.

(2) The individual's income must be determined in accordance with para- graph (e) of this section.

(3) Medical expenses must be deter- mined in accordance with paragraph (f) of this section.

(b) *Applicability.* This section applies to the following individuals in medical institutions and intermediate care facilities:

(1) Individuals receiving cash assist- ance under AFDC who are eligible for Medicaid under § 435.110 and individuals eligible under § 435.121.

(2) Individuals who would be eligible for AFDC, SSI, or an optional State supplement except for their institu- tional status and who are eligible for Medicaid under § 435.211.

(3) Aged, blind, and disabled individ- uals who are eligible for Medicaid, under § 435.231, under a higher income standard than the standard used in de- termining eligibility for SSI or op- tional State supplements.

(c) *Required deductions.* The agency must deduct the following amounts, in the following order, from the individ- ual's total income, as determined under paragraph (e) of this section. In- come that was disregarded in determining eligibility must be considered in this process.

(1) *Personal needs allowance.* A per- sonal needs allowance that is reason- able in amount for clothing and other personal needs of the individual while in the institution. This protected per- sonal needs allowance must be at least—

(i) $30 a month for an aged, blind, or disabled individual, including a child applying for Medicaid on the basis of blindness or disability;

(ii) $60 a month for an institutional- ized couple if both spouses are aged, blind, or disabled and their income is considered available to each other in determining eligibility; and

(iii) For other individuals, a reason- able amount set by the agency, based on a reasonable difference in their per- sonal needs from those of the aged, blind, and disabled.

(2) *Maintenance needs of spouse.* For an individual with only a spouse at home, an additional amount for the maintenance needs of the spouse. This amount must be based on a reasonable assessment of need but must not ex- ceed the higher of—

(i) The more restrictive income standard established under § 435.121; or

(ii) The amount of the medically needy income standard for one person

established under § 435.811, if the agen- cy provides Medicaid under the medically needy coverage option.

(3) *Maintenance needs of family.* For an individual with a family at home, an additional amount for the mainte- nance needs of the family. This amount must—

(i) Be based on a reasonable assess- ment of their financial need;

(ii) Be adjusted for the number of family members living in the home; and

(iii) Not exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard es- tablished under § 435.811, if the agency provides Medicaid under the medically needy coverage option for a family of the same size.

(4) *Expenses not subject to third party payment.* Amounts for incurred ex- penses for medical or remedial care that are not subject to payment by a third party, including—

(i) Medicare and other health insur- ance permiums, deductibles, or coin- surance charges; and

(ii) Necessary medical or remedial care recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits the agency may establish on amounts of these expenses.

(5) *Continued SSI and SSP benefits.* The full amount of SSI and SSP bene- fits that the individual continues to re- ceive under sections 1611(e)(1) (E) and (G) of the Act.

(d) *Optional deduction: Allowance for home maintenance.* For single individ- uals and couples, an amount (in addi- tion to the personal needs allowance) for maintenance of the individual's or couple's home if—

(1) The amount is deducted for not more than a 6-month period; and

(2) A physician has certified that ei- ther of the individuals is likely to re- turn to the home within that period.

(e) *Determination of income*—(1) *Op- tion.* In determining the amount of an individual's income to be used to re- duce the agency's payment to the insti- tution, the agency may use total in- come received, or it may project total

monthly income for a prospective pe- riod not to exceed 6 months.

(2) *Basis for projection.* The agency must base the projection on income received in the preceding period, not to exceed 6 months, and on income expected to be received.

(3) *Adjustments.* At the end of the pro- spective period specified in paragraph (e)(1) of this section, or when any sig- nificant change occurs, the agency must reconcile estimates with income received.

(f) *Determination of medical expenses—*

(1) *Option.* In determining the amount of medical expenses that may be deducted from an individual's income, the agency may deduct incurred med- ical expenses, or it may project med- ical expenses for a prospective period not to exceed 6 months.

(2) *Basis for projection.* The agency must base the estimate on medical expenses incurred in the preceding pe- riod, not to exceed 6 months, and medical expenses expected to be incurred.

(3) *Adjustments.* At the end of the pro- spective period specified in paragraph (f)(1) of this section, or when any sig- nificant change occurs, the agency must reconcile estimates with incurred medical expenses.

[45 FR 24884, Apr. 11, 1980, as amended at 48 FR 5735, Feb. 8, 1983; 53 FR 3596, Feb. 8, 1988; 55 FR 33705, Aug. 17, 1990; 56 FR 8850, 8854, Mar. 1, 1991; 58 FR 4932, Jan. 19, 1993]

§ 435.735 Post-eligibility treatment of income and resources of individuals receiving home and community- based services furnished under a waiver: Application of patient in- come to the cost of care.

(a) The agency must reduce its pay- ment for home and community-based services provided to an individual spec- ified in paragraph (b) of this section, by the amount that remains after deduct- ing the amounts specified in paragraph (c) of this section from the individual's income.

(b) This section applies to individuals who are eligible for Medicaid under § 435.217, and are eligible for home and community-based services furnished under a waiver of State plan requirements specified in part 441, subpart G or H of this subchapter.

(c) In reducing its payment for home and community-based services, the

agency must deduct the following amounts, in the following order, from the individual's total income (includ- ing amounts disregarded in deter- mining eligibility):

(1) An amount for the maintenance needs of the individual that the State may set at any level, as long as the fol- lowing conditions are met:

(i) The deduction amount is based on a reasonable assessment of need.

(ii) The State establishes a maximum deduction amount that will not be ex- ceeded for any individual under the waiver.

(2) For an individual with only a spouse at home, an additional amount for the maintenance needs of the spouse. This amount must be based on a reasonable assessment of need but must not exceed the higher of—

(i) The more restrictive income standard established under § 435.121; or

(ii) The medically needy standard for an individual.

(3) For an individual with a family at home, an additional amount for the maintenance needs of the family. This amount must—

(i) Be based on a reasonable assess- ment of their financial need;

(ii) Be adjusted for the number of family members living in the home; and

(iii) Not exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard es- tablished under § 435.811 for a family of the same size.

(4) Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including—

(i) Medicare and other health insur- ance premiums, deductibles, or coin- surance charges; and

(ii) Necessary medical or remedial care recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits the agency may establish on amounts of these expenses.

[46 FR 48540, Oct. 1, 1981, as amended at 50 FR 10026, Mar. 13, 1985; 57 FR 29155, June 30, 1992; 58 FR 4932, Jan. 19, 1993; 59 FR 37716, July 25, 1994]

Subpart I—Specific Eligibility and Post-Eligibility Financial Re- quirements for the Medically Needy

§ 435.800 Scope.

This subpart prescribes specific fi- nancial requirements for determining the eligibility of medically needy indi- viduals under subpart D of this part.

[58 FR 4932, Jan. 19, 1993]

MEDICALLY NEEDY INCOME STANDARD

§ 435.811 Medically needy income standard: General requirements.

(a) Except as provided in paragraph (d)(2) of this section, to determine eligibility of medically needy individuals, a Medicaid agency must use a single in- come standard under this subpart that meets the requirements of this section.

(b) The income standard must take into account the number of persons in the assistance unit. Subject to the lim- itations specified in paragraph (e) of this section. The standard may not di- minish by an increase in the number of persons in the assistance unit. For ex- ample, if the income level in the standard for an assistance unit of two is set at $400, the income level in the standard for an assistance unit of three may not be less than $400.

(c) In States that do not use more re- strictive requirements than SSI, the income standard must be set at an amount that is no lower than the low- est income standards used under the cash assistance programs that are re- lated to the State's covered medically needy eligibility group or groups of in- dividuals under § 435.301. The amount of the income standard is subject to the limitations specified in paragraph (e) of this section.

(d) In States that use more restric- tive requirements for aged, blind, and disabled individuals than SSI:

(1) For all individuals except aged, blind, and disabled individuals, the in- come standard must be set in accord- ance with paragraph (c) of this section; and

(2) For all aged, blind, and disabled individuals or any combination of these groups of individuals, the agency

Medicare as a CAH (see subpart F of part 485 of this chapter), and (ii) are of a type that would be paid for by Medi- care when furnished to a Medicare beneficiary.

(2) Inpatient CAH services do not in- clude nursing facility services fur- nished by a CAH with a swing-bed ap- proval.

[43 FR 45224, Sept. 29, 1978, as amended at 45 FR 24889, Apr. 11, 1980; 46 FR 48540, Oct. 1, 1981; 58 FR 30671, May 26, 1993; 62 FR 46037, Aug. 29, 1997; 64 FR 67051, Nov. 30, 1999; 72 FR 73651, Dec. 28, 2007; 73 FR 77530, Dec. 19, 2008; 74 FR 31196, June 30, 2009]

§ 440.180 Home and community-based waiver services.

(a) *Description and requirements for services.* ''Home or community-based services'' means services, not otherwise furnished under the State's Medicaid plan, that are furnished under a waiver granted under the provisions of part 441, subpart G of this chapter.

(1) These services may consist of any or all of the services listed in paragraph (b) of this section, as those serv- ices are defined by the agency and approved by CMS.

(2) The services must meet the stand- ards specified in § 441.302(a) of this chapter concerning health and welfare assurances.

(3) The services are subject to the limits on FFP described in § 441.310 of this chapter.

(b) *Included services.* Home or commu- nity-based services may include the following services, as they are defined by the agency and approved by CMS:

(1) Case management services.

(2) Homemaker services.

(3) Home health aide services.

(4) Personal care services.

(5) Adult day health services.

(6) Habilitation services.

(7) Respite care services.

(8) Day treatment or other partial hospitalization services, psychosocial rehabilitation services and clinic serv- ices (whether or not furnished in a fa- cility) for individuals with chronic mental illness, subject to the condi- tions specified in paragraph (d) of this section.

(9) Other services requested by the agency and approved by CMS as cost

effective and necessary to avoid insti- tutionalization.

(c) *Expanded habilitation services, ef- fective October 1, 1997*—(1) *General rule.* Expanded habilitation services are those services specified in paragraph (c)(2) of this section.

(2) *Services included.* The agency may include as expanded habilitation services the following services:

(i) Prevocational services, which means services that prepare an indi- vidual for paid or unpaid employment and that are not job-task oriented but are, instead, aimed at a generalized result. These services may include, for example, teaching an individual such concepts as compliance, attendance, task completion, problem solving and safety. Prevocational services are dis- tinguishable from noncovered voca- tional services by the following cri- teria:

(A) The services are provided to per- sons who are not expected to be able to join the general work force or partici- pate in a transitional sheltered work- shop within one year (excluding sup- ported employment programs).

(B) If the beneficiaries are com- pensated, they are compensated at less than 50 percent of the minimum wage;

(C) The services include activities which are not primarily directed at teaching specific job skills but at un- derlying habilitative goals (for exam- ple, attention span, motor skills); and

(D) The services are reflected in a plan of care directed to habilitative rather than explicit employment objec- tives.

(ii) Educational services, which means special education and related services (as defined in sections 602(16) and (17) of the Education of the Handicapped Act) (20 U.S.C. 1401 (16 and 17)) to the extent they are not prohibited under paragraph (c)(3)(i) of this sec- tion.

(iii) Supported employment services, which facilitate paid employment, that are—

(A) Provided to persons for whom competitive employment at or above the minimum wage is unlikely and who, because of their disabilities, need intensive ongoing support to perform in a work setting;

(B) Conducted in a variety of set- tings, particularly worksites in which persons without disabilities are em- ployed; and

(C) Defined as any combination of special supervisory services, training, transportation, and adaptive equip- ment that the State demonstrates are essential for persons to engage in paid employment and that are not normally required for nondisabled persons en- gaged in competitive employment.

(3) *Services not included.* The following services may not be included as habili- tation services:

(i) Special education and related services (as defined in sections 602(16) and (17) of the Education of the Handi- capped Act) (20 U.S.C. 1401 (16) and (17)) that are otherwise available to the in- dividual through a local educational agency.

(ii) Vocational rehabilitation serv- ices that are otherwise available to the individual through a program funded under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

(d) *Services for the chronically mentally ill*—(1) *Services included.* Services listed in paragraph (b)(8) of this section in- clude those provided to individuals who have been diagnosed as being chron- ically mentally ill, for which the agen- cy has requested approval as part of ei- ther a new waiver request or a renewal and which have been approved by CMS on or after October 21, 1986.

(2) *Services not included.* Any home and community-based service, includ- ing those indicated in paragraph (b)(8) of this section, may not be included in home and community-based service waivers for the following individuals:

(i) For individuals aged 22 through 64 who, absent the waiver, would be insti- tutionalized in an institution for men- tal diseases (IMD); and, therefore, sub- ject to the limitation on IMDs speci- fied in § 435.1009(a)(2) of this chapter.

(ii) For individuals, not meeting the age requirements described in para- graph (d)(2)(i) of this section, who, ab- sent the waiver, would be placed in an IMD in those States that have not opted to include the benefits defined in § 440.140 or § 440.160.

[59 FR 37716, July 25, 1994, as amended at 65 FR 60107, Oct. 10, 2000; 71 FR 39229, July 12, 2006]

§ 440.181 Home and community-based services for individuals age 65 or older.

(a) *Description of services*— Home and community-based services for individ- uals age 65 or older means services, not otherwise furnished under the State's Medicaid plan, or services already furnished under the State's Medicaid plan but in expanded amount, duration, or scope, which are furnished to individ- uals age 65 or older under a waiver granted under the provisions of part 441, subpart H of this subchapter. Ex- cept as provided in § 441.310, the serv- ices may consist of any of the services listed in paragraph (b) of this section that are requested by the State, ap- proved by CMS, and furnished to eligi- ble beneficiaries. Service definitions for each service in paragraph (b) of this section must be approved by CMS.

(b) *Included services.* (1) Case manage- ment services.

(2) Homemaker services.

(3) Home health aide services.

(4) Personal care services.

(5) Adult day health services.

(6) Respite care services.

(7) Other medical and social services requested by the Medicaid agency and approved by CMS, which will con- tribute to the health and well-being of individuals and their ability to reside in a community-based care setting.

[57 FR 29156, June 30, 1992]

§ 440.182 State plan home and commu- nity-based services.

(a) *Definition.* State plan home and community-based services (HCBS) ben- efit means the services listed in para- graph (c) of this section when provided under the State's plan (rather than through an HCBS waiver program) for individuals described in paragraph (b) of this section.

(b) *State plan HCBS coverage.* State plan HCBS can be made available to individuals who—

(1) Are eligible under the State plan and have income, calculated using the otherwise applicable rules, including any less restrictive income disregards used by the State for that group under section 1902(r)(2) of the Act, that does not exceed 150 percent of the Federal Poverty Line (FPL); and

42 CFR §441.300 – 441.310 - Subpart G—Home and Community-Based Services: Waiver Requirements

§441.300 Basis and purpose.

Section 1915(c) of the Act permits States to offer, under a waiver of statutory requirements, an array of home and community-based services that an individual needs to avoid institutionalization. Those services are defined in §440.180 of this subchapter. This subpart describes what the Medicaid agency must do to obtain a waiver.

§441.301 Contents of request for a waiver.

(a) A request for a waiver under this section must consist of the following:

(1) The assurances required by §441.302 and the supporting documentation required by §441.303.

(2) When applicable, requests for waivers of the requirements of section 1902(a)(1), section 1902(a)(10)(B), or section 1902(a)(10)(C)(i)(III) of the Act, which concern respectively, statewide application of Medicaid, comparability of services, and income and resource rules applicable to medically needy individuals living in the community.

(3) A statement explaining whether the agency will refuse to offer home or community-based services to any beneficiary if the agency can reasonably expect that the cost of the services would exceed the cost of an equivalent level of care provided in—

(i) A hospital (as defined in §440.10 of this chapter);

(ii) A NF (as defined in section 1919(a) of the Act); or

(iii) An ICF/IID (as defined in §440.150 of this chapter), if applicable.

(b) If the agency furnishes home and community-based services, as defined in §440.180 of this subchapter, under a waiver granted under this subpart, the waiver request must—

(1) Provide that the services are furnished—

(i) Under a written person-centered service plan (also called plan of care) that is based on a person-centered approach and is subject to approval by the Medicaid agency.

(ii) Only to beneficiaries who are not inpatients of a hospital, NF, or ICF/IID; and

(iii) Only to beneficiaries who the agency determines would, in the absence of these services, require the Medicaid covered level of care provided in—

(A) A hospital (as defined in §440.10 of this chapter);

(B) A NF (as defined in section 1919(a) of the Act); or

(C) An ICF/IID (as defined in §440.150 of this chapter);

(2) Describe the qualifications of the individual or individuals who will be responsible for developing the individual plan of care;

(3) Describe the group or groups of individuals to whom the services will be offered;

(4) Describe the services to be furnished so that each service is separately defined. Multiple services that are generally considered to be separate services may not be consolidated under a single definition. Commonly accepted terms must be used to describe the service and definitions may not be open ended in scope. CMS will, however, allow combined service definitions (bundling) when this will permit more efficient delivery of services and not compromise either a beneficiary's access to or free choice of providers.

(5) Provide that the documentation requirements regarding individual evaluation, specified in §441.303(c), will be met; and

(6) Be limited to one or more of the following target groups or any subgroup thereof that the State may define:

(i) Aged or disabled, or both.

(ii) Individuals with Intellectual or Developmental Disabilities, or both.

(iii) Mentally ill.

(c) A waiver request under this subpart must include the following—

(1) *Person-centered planning process.* The individual will lead the person-centered planning process where possible. The individual's representative should have a participatory role, as needed and as defined by the individual, unless State law confers decision-making authority to the legal representative. All references to individuals include the role of the individual's representative. In addition to being led by the individual receiving services and supports, the person-centered planning process:

(i) Includes people chosen by the individual.

(ii) Provides necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions.

(iii) Is timely and occurs at times and locations of convenience to the individual.

(iv) Reflects cultural considerations of the individual and is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with §435.905(b) of this chapter.

(v) Includes strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants.

(vi) 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.

(vii) Offers informed choices to the individual regarding the services and supports they receive and from whom.

(viii) Includes a method for the individual to request updates to the plan as needed.

(ix) Records the alternative home and community-based settings that were considered by the individual.

(2) *The Person-Centered Service Plan.* The person-centered service plan must reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports. Commensurate with the level of

need of the individual, and the scope of services and supports available under the State's 1915(c) HCBS waiver, the written plan must:

(i) Reflect that the setting in which the individual resides is chosen by the individual. The State must ensure that the setting chosen by the individual is integrated in, and supports full access of individuals receiving Medicaid HCBS 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.

(ii) Reflect the individual's strengths and preferences.

(iii) Reflect clinical and support needs as identified through an assessment of functional need.

(iv) Include individually identified goals and desired outcomes.

(v) Reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports. Natural supports are unpaid supports that are provided voluntarily to the individual in lieu of 1915(c) HCBS waiver services and supports.

(vi) Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed.

(vii) Be understandable to the individual receiving services and supports, and the individuals important in supporting him or her. At a minimum, for the written plan to be understandable, it must be written in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with §435.905(b) of this chapter.

(viii) Identify the individual and/or entity responsible for monitoring the plan.

(ix) Be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation.

(x) Be distributed to the individual and other people involved in the plan.

(xi) Include those services, the purpose or control of which the individual elects to self-direct.

(xii) Prevent the provision of unnecessary or inappropriate services and supports.

(xiii) Document that any modification of the additional conditions, under paragraph (c)(4)(vi)(A) through (D) of this section, must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:

(A) Identify a specific and individualized assessed need.

(B) Document the positive interventions and supports used prior to any modifications to the person-centered service plan.

(C) Document less intrusive methods of meeting the need that have been tried but did not work.

(D) Include a clear description of the condition that is directly proportionate to the specific assessed need.

(E) Include a regular collection and review of data to measure the ongoing effectiveness of the modification.

(F) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.

(G) Include informed consent of the individual.

(H) Include an assurance that interventions and supports will cause no harm to the individual.

(3) *Review of the Person-Centered Service Plan.* The person-centered service plan must be reviewed, and revised upon reassessment of functional need as required by §441.365(e), at least every 12 months, when the individual's circumstances or needs change significantly, or at the request of the individual.

(4) *Home and Community-Based Settings.* Home and community-based settings must have all of the following qualities, and such other qualities as the Secretary determines to be appropriate, based on the needs of the individual as indicated in their person-centered service plan:

(i) The setting is integrated in and supports full access of individuals receiving Medicaid HCBS 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.

(ii) The setting 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.

(iii) Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.

(iv) 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.

(v) Facilitates individual choice regarding services and supports, and who provides them.

(vi) In a provider-owned or controlled residential setting, in addition to the qualities at §441.301(c)(4)(i) through (v), the following additional conditions must be met:

(A) 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.

(B) Each individual has privacy in their sleeping or living unit:

(1) Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.

(2) Individuals sharing units have a choice of roommates in that setting.

(3) Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.

(C) Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time.

(D) Individuals are able to have visitors of their choosing at any time.

(E) The setting is physically accessible to the individual.

(F) Any modification of the additional conditions, under §441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:

(1) Identify a specific and individualized assessed need.

(2) Document the positive interventions and supports used prior to any modifications to the person-centered service plan.

(3) Document less intrusive methods of meeting the need that have been tried but did not work.

(4) Include a clear description of the condition that is directly proportionate to the specific assessed need.

(5) Include regular collection and review of data to measure the ongoing effectiveness of the modification.

(6) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.

(7) Include the informed consent of the individual.

(8) Include an assurance that interventions and supports will cause no harm to the individual.

(5) *Settings that are not Home and Community-Based.* Home and community-based settings do not include the following:

(i) A nursing facility;

(ii) An institution for mental diseases;

(iii) An intermediate care facility for individuals with intellectual disabilities;

(iv) A hospital; or

(v) Any other locations that have qualities of an institutional setting, as determined by the Secretary. Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or 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 will be presumed to be a setting that has the qualities of an institution unless the

Secretary determines through heightened scrutiny, based on information presented by the State or other parties, that the setting does not have the qualities of an institution and that the setting does have the qualities of home and community-based settings.

(6) Home and Community-Based Settings: Compliance and Transition:

(i) States submitting new and initial waiver requests must provide assurances of compliance with the requirements of this section for home and community-based settings as of the effective date of the waiver.

(ii) CMS will require transition plans for existing section 1915(c) waivers and approved state plans providing home and community-based services under section 1915(i) to achieve compliance with this section, as follows:

(A) For each approved section 1915(c) HCBS waiver subject to renewal or submitted for amendment within one year after the effective date of this regulation, the State must submit a transition plan at the time of the waiver renewal or amendment request that sets forth the actions the State will take to bring the specific waiver into compliance with this section. The waiver approval will be contingent on the inclusion of the transition plan approved by CMS. The transition plan must include all elements required by the Secretary; and within one hundred and twenty days of the submission of the first waiver renewal or amendment request the State must submit a transition plan detailing how the State will operate all section 1915(c) HCBS waivers and any section 1915(i) State plan benefit in accordance with this section. The transition plan must include all elements including timelines and deliverables as approved by the Secretary.

(B) For States that do not have a section 1915(c) HCBS waiver or a section 1915(i) State plan benefit due for renewal or proposed for amendments within one year of the effective date of this regulation, the State must submit a transition plan detailing how the State will operate all section 1915(c) HCBS waivers and any section 1915(i) State plan benefit in accordance with this section. This plan must be submitted no later than one year after the effective date of this regulation. The transition plan must include all elements including timelines and deliverables as approved by the Secretary.

(iii) A State must provide at least a 30-day public notice and comment period regarding the transition plan(s) that the State intends to submit to CMS for review and consideration, as follows:

(A) The State must at a minimum provide two (2) statements of public notice and public input procedures.

(B) The State must ensure the full transition plan(s) is available to the public for public comment.

(C) The State must consider and modify the transition plan, as the State deems appropriate, to account for public comment.

(iv) A State must submit to CMS, with the proposed transition plan:

(A) Evidence of the public notice required.

(B) A summary of the comments received during the public notice period, reasons why comments were not adopted, and any modifications to the transition plan based

upon those comments.

(v) Upon approval by CMS, the State will begin implementation of the transition plans. The State's failure to submit an approvable transition plan as required by this section and/or to comply with the terms of the approved transition plan may result in compliance actions, including but not limited to deferral/disallowance of Federal Financial Participation.

[46 FR 48541, Oct. 1, 1981, as amended at 50 FR 10026, Mar. 13, 1985; 59 FR 37717, July 25, 1994; 65 FR 60107, Oct. 10, 2000; 79 FR 3029, Jan. 16, 2014]

§441.302 State assurances.

Unless the Medicaid agency provides the following satisfactory assurances to CMS, CMS will not grant a waiver under this subpart and may terminate a waiver already granted:

(a) *Health and Welfare*—Assurance that necessary safeguards have been taken to protect the health and welfare of the beneficiaries of the services. Those safeguards must include—

(1) Adequate standards for all types of providers that provide services under the waiver;

(2) Assurance that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver; and

(3) Assurance that all facilities covered by section 1616(e) of the Act, in which home and community-based services will be provided, are in compliance with applicable State standards that meet the requirements of 45 CFR part 1397 for board and care facilities.

(4) Assurance that the State is able to meet the unique service needs of the individuals when the State elects to serve more than one target group under a single waiver, as specified in §441.301(b)(6).

(i) On an annual basis the State will include in the quality section of the CMS-372 form (or any successor form designated by CMS) data that indicates the State continues to serve multiple target groups in the single waiver and that a single target group is not being prioritized to the detriment of other groups.

(ii) [Reserved]

(5) Assurance that services are provided in home and community based settings, as specified in §441.301(c)(4).

(b) *Financial accountability*— The agency will assure financial accountability for funds expended for home and community-based services, provide for an independent audit of its waiver program (except as CMS may otherwise specify for particular waivers), and it will maintain and make available to HHS, the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver, including reports of any independent audits conducted.

(c) *Evaluation of need.* Assurance that the agency will provide for the following:

(1) *Initial evaluation.* An evaluation of the need for the level of care provided in a hospital, a NF, or an ICF/IID when there is a reasonable indication that a beneficiary might need the services in the near future (that is, a month or less) unless he or she receives home or community- based services. For purposes of this section, "evaluation" means a review of an individual beneficiary's condition to determine—

(i) If the beneficiary requires the level of care provided in a hospital as defined in §440.10 of this subchapter, a NF as defined in section 1919(a) of the Act, or an ICF/IID as defined by §440.150 of this subchapter; and

(ii) That the beneficiary, but for the provision of waiver services, would otherwise be institutionalized in such a facility.

(2) *Periodic reevaluations.* Reevaluations, at least annually, of each beneficiary receiving home or community-based services to determine if the beneficiary continues to need the level of care provided and would, but for the provision of waiver services, otherwise be institutionalized in one of the following institutions:

(i) A hospital;

(ii) A NF; or

(iii) An ICF/IID.

(d) *Alternatives*—Assurance that when a beneficiary is determined to be likely to require the level of care provided in a hospital, NF, or ICF/IID, the beneficiary or his or her legal representative will be—

(1) Informed of any feasible alternatives available under the waiver; and

(2) Given the choice of either institutional or home and community-based services.

(e) *Average per capita expenditures.* Assurance that the average per capita fiscal year expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made in the fiscal year for the level of care provided in a hospital, NF, or ICF/IID under the State plan had the waiver not been granted.

(1) These expenditures must be reasonably estimated and documented by the agency.

(2) The estimate must be on an annual basis and must cover each year of the waiver period.

(f) *Actual total expenditures.* Assurance that the agency's actual total expenditures for home and community-based and other Medicaid services under the waiver and its claim for FFP in expenditures for the services provided to beneficiaries under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred by the State's Medicaid program for these individuals, absent the waiver, in—

(1) A hospital;

(2) A NF; or

(3) An ICF/IID.

(g) *Institutionalization absent waiver.* Assurance that, absent the waiver, beneficiaries in the waiver would receive the appropriate type of Medicaid-funded institutional care (hospital, NF, or ICF/IID) that they require.

(h) *Reporting.* Assurance that annually, the agency 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 beneficiaries.

(i) *Habilitation services.* Assurance that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver, are—

(1) Not otherwise available to the individual through a local educational agency under section 602 (16) and (17) of the Education of the Handicapped Act (20 U.S.C. 1401 (16 and 17)) or as services under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730); and

(2) Furnished as part of expanded habilitation services, if the State has requested and received CMS's approval under a waiver or an amendment to a waiver.

(j) *Day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services for individuals with chronic mental illness.* Assurance that FFP will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are—

(1) Age 22 to 64;

(2) Age 65 and older and the State has not included the optional Medicaid benefit cited in §440.140; or

(3) Age 21 and under and the State has not included the optional Medicaid benefit cited in §440.160.

[50 FR 10026, Mar. 13, 1985, as amended at 59 FR 37717, July 25, 1994; 65 FR 60107, Oct. 10, 2000; 79 FR 3031, Jan. 16, 2014]

§441.303 Supporting documentation required.

The agency must furnish CMS with sufficient information to support the assurances required by §441.302. Except as CMS may otherwise specify for particular waivers, the information must consist of the following:

(a) A description of the safeguards necessary to protect the health and welfare of beneficiaries. This information must include a copy of the standards established by the State for facilities that are covered by section 1616(e) of the Act.

(b) A description of the records and information that will be maintained to support financial accountability.

(c) A description of the agency's plan for the evaluation and reevaluation of beneficiaries, including—

(1) A description of who will make these evaluations and how they will be made;

(2) A copy of the evaluation form to be used; and if it differs from the form used in placing beneficiaries in hospitals, NFs, or ICFs/IID, a description of how and why it differs and an assurance that the outcome of the new evaluation form is reliable, valid, and fully comparable to the form used for hospital, NF, or ICF/IID placement;

(3) The agency's procedure to ensure the maintenance of written documentation on all evaluations and reevaluations; and

(4) The agency's procedure to ensure reevaluations of need at regular intervals.

(d) A description of the agency's plan for informing eligible beneficiaries of the feasible alternatives available under the waiver and allowing beneficiaries to choose either institutional services or home and community-based services.

(e) An explanation of how the agency will apply the applicable provisions regarding the post-eligibility treatment of income and resources of those individuals receiving home and community-based services who are eligible under a special income level (included in §435.217 of this chapter).

(f) An explanation with supporting documentation satisfactory to CMS of how the agency estimated the average per capita expenditures for services.

(1) The annual average per capita expenditure estimate of the cost of home and community-based and other Medicaid services under the waiver must not exceed the estimated annual average per capita expenditures of the cost of services in the absence of a waiver. The estimates are to be based on the following equation:

$D+D' \leq G+G'$.

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.

(2) For purposes of the equation, the prime factors include the average per capita cost for all State plan services and expanded EPSDT services provided that are not accounted for in other formula values.

(3) In making estimates of average per capita expenditures for a waiver that applies only to individuals with a particular illness (for example, acquired immune deficiency syndrome) or condition (for example, chronic mental illness) who are inpatients in or who would require the level of care provided in hospitals as defined by §440.10, NFs as defined in section 1919(a) of the Act, or ICFs/IID, the agency may determine the average per capita expenditures for these individuals absent the waiver without including expenditures for other individuals in the affected hospitals, NFs, or ICFs/IID.

(4) In making estimates of average per capita expenditures for a separate waiver program that applies only to individuals identified through the preadmission screening annual resident review (PASARR) process who are developmentally disabled, inpatients of a NF, and require the level of care provided in an ICF/IID as determined by the State on the basis of an evaluation under §441.303(c), the agency may determine the average per capita expenditures that would have been made in a fiscal year for those individuals based on the average per capita expenditures for inpatients in an ICF/IID. When submitting estimates of institutional costs without the waiver, the agency may use the average per capita costs of ICF/IID care even though the deinstitutionalized developmentally disabled were inpatients of NFs.

(5) For persons diverted rather than deinstitutionalized, the State's evaluation process required by §441.303(c) must provide for a more detailed description of their evaluation and screening procedures for beneficiaries to ensure that waiver services will be limited to persons who would otherwise receive the level of care provided in a hospital, NF, or ICF/IID, as applicable.

(6) The State must indicate the number of unduplicated beneficiaries to which it intends to provide waiver services in each year of its program. This number will constitute a limit on the size of the waiver program unless the State requests and the Secretary approves a greater number of waiver participants in a waiver amendment.

(7) In determining the average per capita expenditures that would have been made in a waiver year, for waiver estimates that apply to persons with Intellectual Disability or related conditions, the agency may include costs of Medicaid residents in ICFs/IID that have been terminated on or after November 5, 1990.

(8) In submitting estimates for waivers that include personal caregivers as a waiver service, the agency may include a portion of the rent and food attributed to the unrelated personal caregiver who resides in the home or residence of the beneficiary covered under the waiver. The agency must submit to CMS for review and approval the method it uses to apportion the costs of rent and food. The method must be explained fully to CMS. A personal caregiver provides a waiver service to meet the beneficiary's physical, social, or emotional needs (as opposed to

services not directly related to the care of the beneficiary; that is, housekeeping or chore services). FFP for live-in caregivers is not available if the beneficiary lives in the caregiver's home or in a residence that is owned or leased by the caregiver.

(9) In submitting estimates for waivers that apply to individuals with Intellectual Disability or a related condition, the agency may adjust its estimate of average per capita expenditures to include increases in expenditures for ICF/IID care resulting from implementation of a PASARR program for making determinations for individuals with Intellectual Disability or related conditions on or after January 1, 1989.

(10) For a State that has CMS approval to bundle waiver services, the State must continue to compute separately the costs and utilization of the component services that make up the bundled service to support the final cost and utilization of the bundled service that will be used in the cost-neutrality formula.

(g) The State, at its option, may provide for an independent assessment of its waiver that evaluates the quality of care provided, access to care, and cost-neutrality. The results of the assessment should be submitted to CMS at least 90 days prior to the expiration date of the approved waiver-period and cover the first 24 or 48 months of the waiver. If a State chooses to provide for an independent assessment, FFP is available for the costs attributable to the independent assessment.

(h) For States offering habilitation services that include prevocational, educational, or supported employment services, or a combination of these services, consistent with the provisions of §440.180(c) of this chapter, an explanation of why these services are not available as special education and related services under sections 602 (16) and (17) of the Education of the Handicapped Act (20 U.S.C. 1401 (16 and 17)) or as services under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. section 730);

(i) For States offering home and community-based services for individuals diagnosed as chronically mentally ill, an explanation of why these individuals would not be placed in an institution for mental diseases (IMD) absent the waiver, and the age group of these individuals.

[46 FR 48532, Oct. 1, 1981, as amended at 50 FR 10027, Mar. 13, 1985; 50 FR 25080, June 17, 1985; 59 FR 37718, July 25, 1994]

§441.304 Duration, extension, and amendment of a waiver.

(a) The effective date for a new waiver of Medicaid requirements to provide home and community-based services approved under this subpart is established by CMS prospectively on or after the date of approval and after consultation with the State agency. The initial approved waiver continues for a 3-year period from the effective date. If the agency requests it, the waiver may be extended for additional periods unless—

(1) CMS's review of the prior waiver period shows that the assurances required by §441.302 were not met; and

(2) CMS is not satisfied with the assurances and documentation provided by the State in regard to the extension period.

(b) CMS will determine whether a request for extension of an existing waiver is actually

an extension request or a request for a new waiver. If a State submits an extension request that would add a new group to the existing group of beneficiaries covered under the waiver (as defined under §441.301(b)(6)), CMS will consider it to be two requests: One as an extension request for the existing group, and the other as a new waiver request for the new group. Waivers may be extended for additional 5-year periods.

(c) CMS *may* grant a State an extension of its existing waiver for up to 90 days to permit the State to document more fully the satisfaction of statutory and regulatory requirements needed to approve a new waiver request. CMS will consider this option when it requests additional information on a new waiver request submitted by a State to extend its existing waiver or when CMS disapproves a State's request for extension.

(d) The agency may request that waiver modifications be made effective retroactive to the first day of a waiver year, or another date after the first day of a waiver year, in which the amendment is submitted, unless the amendment involves substantive changes as determined by CMS.

(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, changes in rate methodology or a constriction in the eligible population.

(2) A request for an amendment that involves a substantive change as determined by CMS, may only take effect on or after the date when the amendment is approved by CMS, and must be accompanied by information on how the State has assured smooth transitions and minimal effect on individuals adversely impacted by the change.

(e) The agency must provide public notice of any significant proposed change in its methods and standards for setting payment rates for services in accordance with §447.205 of this chapter.

(f) The agency must establish and use a public input process, for any changes in the services or operations of the waiver.

(1) This process must be described fully in the State's waiver application 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.

(2) This process must be completed at a minimum of 30 days prior to implementation of the proposed change or submission of the proposed change to CMS, whichever comes first.

(3) This process must be used for both existing waivers that have substantive changes proposed, either through the renewal or the amendment process, and new waivers.

(4) This process must include consultation with Federally-recognized Tribes, and in accordance with section 5006(e) of the American Recovery and Reinvestment Act of 2009 (Pub. L. 111-5), Indian health programs and Urban Indian Organizations.

(g)(1) If CMS finds that the Medicaid agency is not meeting one or more of the requirements for a waiver contained in this subpart, the agency is given a notice of CMS' findings and an opportunity for a hearing to rebut the findings.

(2) If CMS determines that the agency is substantively out of compliance with this subpart after the notice and any hearing, CMS may employ strategies to ensure compliance as described in paragraph (g)(3) of this section or terminate the waiver.

(3)(i) Strategies to ensure compliance may include the imposition of a moratorium on waiver enrollments, other corrective strategies as appropriate to ensure the health and welfare of waiver participants, or the withholding of a portion of Federal payment for waiver services until such time that compliance is achieved, or other actions as determined by the Secretary as necessary to address non-compliance with 1915(c) of the Act, or termination. When a waiver is terminated, the State must comport with §441.307.

(ii) CMS will provide states with a written notice of the impending strategies to ensure compliance for a waiver program. The notice of CMS' intent to utilize strategies to ensure compliance would include the nature of the noncompliance, the strategy to be employed, the effective date of the compliance strategy, the criteria for removing the compliance strategy and the opportunity for a hearing.

[50 FR 10028, Mar. 13, 1985; 50 FR 25080, June 17, 1985, as amended at 59 FR 37719, July 25, 1994; 79 FR 3032, Jan. 16, 2014]

§441.305 Replacement of beneficiaries in approved waiver programs.

(a) *Regular waivers.* A State's estimate of the number of individuals who may receive home and community-based services must include those who will replace beneficiaries who leave the program for any reason. A State may replace beneficiaries who leave the program due to death or loss of eligibility under the State plan without regard to any federally-imposed limit on utilization, but must maintain a record of beneficiaries replaced on this basis.

(b) *Model waivers.* (1) The number of individuals who may receive home and community-based services under a model waiver may not exceed 200 beneficiaries at any one time.

(2) The agency may replace any individuals who die or become ineligible for State plan services to maintain a count up to the number specified by the State and approved by CMS

within the 200-maximum limit.

[59 FR 37719, July 25, 1994]

§441.306 Cooperative arrangements with the Maternal and Child Health program.

Whenever appropriate, the State agency administering the plan under Medicaid may enter into cooperative arrangements with the State agency responsible for administering a program for children with special health care needs under the Maternal and Child Health program (Title V of the Act) in order to ensure improved access to coordinated services to meet the children's needs.

[59 FR 37720, July 25, 1994]

§441.307 Notification of a waiver termination.

(a) If a State chooses to terminate its waiver before the initial 3-year period or 5-year renewal period expires, it must notify CMS in writing 30 days before terminating services to beneficiaries.

(b) If CMS or the State terminates the waiver, the State must notify beneficiaries of services under the waiver in accordance with §431.210 of this subchapter and notify them 30 days before terminating services.

[46 FR 48541, Oct. 1, 1981. Redesignated at 59 FR 37719, July 25, 1994, as amended at 65 FR 60107, Oct. 10, 2000]

§441.308 Hearings procedures for waiver terminations.

The procedures specified in subpart D of part 430 of this chapter are applicable to

State requests for hearings on terminations. [50 FR 10028, Mar. 13, 1985. Redesignated

at 59 FR 37720, July 25, 1994]

§441.310 Limits on Federal financial participation (FFP).

(a) FFP for home and community-based services listed in §440.180 of this chapter is not available in expenditures for the following:

(1) Services provided in a facility subject to the health and welfare requirements described in §441.302(a) during any period in which the facility is found not to be in compliance with the applicable State standards described in that section.

(2) The cost of room and board except when provided as—

(i) Part of respite care services in a facility approved by the State that is not a private residence; or

(ii) For waivers that allow personal caregivers as providers of approved waiver services, a portion of the rent and food that may be reasonably attributed to the unrelated caregiver who resides in the same household with the waiver beneficiary. FFP for a live-in caregiver is not available if the beneficiary lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services (the caregiver). For purposes of this provision, “board” means 3 meals a day or any other full nutritional regimen and does not include meals provided as part of a program of adult day health services as long as the meals provided do not constitute a “full” nutritional regimen.

(3) Prevocational, educational, or supported employment services, or any combination of these services, as part of habilitation services that are—

(i) Provided in approved waivers that include a definition of “habilitation services” but which have not included prevocational, educational, and supported employment services in that definition; or

(ii) Otherwise available to the beneficiary under either special education and related services as defined in section 602(16) and (17) of the Education of the Handicapped Act (20 U.S.C. 1401(16) and (17)) or vocational rehabilitation services available to the individual through a program funded under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

(4) For waiver applications and renewals approved on or after October 21, 1986, home and community-based services provided to individuals aged 22 through 64 diagnosed as chronically mentally ill who would be placed in an institution for mental diseases. FFP is also not available for such services provided to individuals aged 65 and over and 21 and under as

an alternative to institutionalization in an IMD if the State does not include the appropriate optional Medicaid benefits specified at §§440.140 and 440.160 of this chapter in its State plan.

(b) FFP is available for expenditures for expanded habilitation services, as described in §440.180 of this chapter, if the services are included under a waiver or waiver amendment approved by CMS.

[59 FR 37720, July 25, 1994, as amended at 65 FR 60107, Oct. 10, 2000]

§ 447.10 Prohibition against reassign- ment of provider claims.

(a) *Basis and purpose.* This section implements section 1902(a)(32) of the Act which prohibits State payments for Medicaid services to anyone other than a provider or beneficiary, except in specified circumstances.

(b) *Definitions.* For purposes of this section:

Facility means an institution that furnishes health care services to inpa- tients.

Factor means an individual or an or- ganization, such as a collection agency or service bureau, that advances money to a provider for accounts receivable that the provider has assigned, sold or transferred to the individual organiza- tion for an added fee or a deduction of a portion of the accounts receivable. Factor does not include a business rep- resentative as described in paragraph (f) of this section.

Organized health care delivery system means a public or private organization for delivering health services. It in- cludes, but is not limited to, a clinic, a group practice prepaid capitation plan, and a health maintenance organiza- tion.

(c) *State plan requirements.* A State plan must provide that the require- ments of paragraphs (d) through (h) of this section are met.

(d) *Who may receive payment.* Pay- ment may be made only—

(1) To the provider; or

(2) To the beneficiary if he is a noncash beneficiary eligible to receive the payment under § 447.25; or

(3) In accordance with paragraphs (e), (f), and (g) of this section.

(e) *Reassignments.* Payment may be made in accordance with a reassign- ment from the provider to a govern- ment agency or reassignment by a court order.

(f) *Business agents.* Payment may be made to a business agent, such as a billing service or an accounting firm, that furnishes statements and receives payments in the name of the provider, if the agent's compensation for this service is—

(1) Related to the cost of processing the billing;

(2) Not related on a percentage or other basis to the amount that is billed or collected; and

(3) Not dependent upon the collection of the payment.

(g) *Individual practitioners.* Payment may be made to—

(1) The employer of the practitioner, if the practitioner is required as a con- dition of employment to turn over his fees to the employer;

(2) The facility in which the service is provided, if the practitioner has a contract under which the facility sub- mits the claim; or

(3) A foundation, plan, or similar or- ganization operating an organized health care delivery system, if the practitioner has a contract under which the organization submits the claim.

(4) In the case of a class of practi- tioners for which the Medicaid program is the primary source of service rev- enue, payment may be made to a third party on behalf of the individual prac- titioner for benefits such as health in- surance, skills training and other bene- fits customary for employees.

(h) *Prohibition of payment to factors.* Payment for any service furnished to a beneficiary by a provider may not be made to or through a factor, either di- rectly or by power of attorney.

[43 FR 45253, Sept. 29, 1978, as amended at 46 FR 42672, Aug. 24, 1981; 61 FR 38398, July 24, 1996; 79 FR 3039, Jan. 16, 2014]

§ 447.15 Acceptance of State payment as payment in full.

A State plan must provide that the Medicaid agency must limit participa- tion in the Medicaid program to pro- viders who accept, as payment in full, the amounts paid by the agency plus any deductible, coinsurance or copay- ment required by the plan to be paid by the individual. The provider may only deny services to any eligible individual on account of the individual's inability to pay the cost sharing amount im- posed by the plan in accordance with § 447.52(e). The previous sentence does not apply to an individual who is able to pay. An individual's inability to pay does not eliminate his or her liability for the cost sharing charge.

[78 FR 42307, July 15, 2013]

compliance with this section that the Administrator may require.

(Secs. 1102 and 1902(a)(37) of the Social Secu- rity Act (42 U.S.C. 1302, 1396a(a)(37)))

[44 FR 30344, May 25, 1979, as amended at 55 FR 1434, Jan. 16, 1990]

§ 447.46 Timely claims payment by MCOs.

(a) *Basis and scope.* This section im- plements section 1932(f) of the Act by specifying the rules and exceptions for prompt payment of claims by MCOs.

(b) *Definitions.* ''Claim'' and ''clean claim'' have the meaning given those terms in § 447.45.

(c) *Contract requirements*—(1) *Basic rule.* A contract with an MCO must pro- vide that the organization will meet the requirements of § 447.45(d)(2) and (d)(3), and abide by the specifications of § 447.45(d)(5) and (d)(6).

(2) *Exception.* The MCO and its pro- viders may, by mutual agreement, es- tablish an alternative payment sched- ule.

(3) *Alternative schedule.* Any alter- native schedule must be stipulated in the contract.

[67 FR 41115, June 14, 2002]

MEDICAID PREMIUMS AND COST SHARING

SOURCE: 78 FR 42307, July 15, 2013, unless otherwise noted.

§ 447.50 Premiums and cost sharing: Basis and purpose.

Sections 1902(a)(14), 1916 and 1916A of the Act permit states to require cer- tain beneficiaries to share in the costs of providing medical assistance through premiums and cost sharing. Sections 447.52 through 447.56 specify the standards and conditions under which states may impose such pre- miums and or cost sharing.

§ 447.51 Definitions.

As used in this part—

Alternative non-emergency services pro- vider means a Medicaid provider, such as a physician's office, health care clin- ic, community health center, hospital outpatient department, or similar pro- vider that can provide clinically appro- priate services in a timely manner.

Contract health service means any health service that is:

(1) Delivered based on a referral by, or at the expense of, an Indian health program; and

(2) Provided by a public or private medical provider or hospital that is not a provider or hospital of the IHS or any other Indian health program

Cost sharing means any copayment, coinsurance, deductible, or other similar charge.

Emergency services has the same meaning as in § 438.114 of this chapter. *Federal poverty level (FPL)* means the Federal poverty level updated periodi- cally in the FEDERAL REGISTER by the Secretary of Health and Human Serv- ices under the authority of 42 U.S.C. 9902(2).

Indian means any individual defined at 25 U.S.C. 1603(13), 1603(28), or 1679(a),
or who has been determined eligible as an Indian, under 42 CFR 136.12. This means the individual:

(1) Is a member of a Federally-recog- nized Indian tribe;

(2) Resides in an urban center and meets one or more of the following four criteria:

(i) Is a member of a tribe, band, or other organized group of Indians, in- cluding those tribes, bands, or groups terminated since 1940 and those recog- nized now or in the future by the State in which they reside, or who is a de- scendant, in the first or second degree, of any such member;

(ii) Is an Eskimo or Aleut or other Alaska Native;

(iii) Is considered by the Secretary of the Interior to be an Indian for any purpose; or

(iv) Is determined to be an Indian under regulations promulgated by the Secretary;

(3) Is considered by the Secretary of the Interior to be an Indian for any purpose; or

(4) Is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for In- dian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.

Indian health care provider means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are

defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

Inpatient stay means the services re- ceived during a continuous period of in- patient days in either a single medical institution or multiple medical institu- tions, and also includes a return to an inpatient medical institution after a brief period when the return is for treatment of a condition that was present in the initial period. Inpatient has the same meaning as in § 440.2 of this chapter.

Non-emergency services means any care or services that are not considered emergency services as defined in this section. This does not include any serv- ices furnished in a hospital emergency department that are required to be pro- vided as an appropriate medical screen- ing examination or stabilizing exam- ination and treatment under section 1867 of the Act.

Outpatient services for purposes of im- posing cost sharing means any service or supply not meeting the definition of an inpatient stay.

Preferred drugs means drugs that the state has identified on a publicly avail- able schedule as being determined by a pharmacy and therapeutics committee for clinical efficacy as the most cost ef-

fective drugs within each therapeuti- cally equivalent or therapeutically similar class of drugs, or all drugs within such a class if the agency does not differentiate between preferred and non-preferred drugs.

Premium means any enrollment fee, premium, or other similar charge.

§ 447.52 Cost sharing.

(a) *Applicability.* Except as provided in § 447.56(a) (exemptions), the agency may impose cost sharing for any serv- ice under the state plan.

(b) Maximum Allowable Cost Sharing.

(1) At State option, cost sharing im- posed for any service (other than for drugs and non-emergency services fur- nished in an emergency department, as described in §§ 447.53 and 447.54 respec- tively) may be established at or below the amounts shown in the following table (except that the maximum allow- able cost sharing for individuals with family income at or below 100 percent of the FPL shall be increased each year, beginning October 1, 2015, by the percentage increase in the medical care component of the CPI–U for the period of September to September of the pre- ceding calendar year, rounded to the next higher 5-cent increment):

Services	Maximum allowable cost sharing		
	Individuals with family income ≤100% of the FPL	Individuals with family income 101–150% of the FPL	Individuals with family income >150% of the FPL
Outpatient Services (*physician visit, physical therapy, etc.*).	$4	10% of cost the agency pays	20% of cost the agency pays.
Inpatient Stay	$75	10% of total cost the agency pays for the entire stay.	20% of total cost the agency pays for the entire stay.

(2) States with cost sharing for an in- patient stay that exceeds $75, as of July 15, 2013, must submit a plan to CMS that provides for reducing inpa- tient cost sharing to $75 on or before July 1, 2017.

(3) In states that do not have fee-for- service payment rates, any cost shar- ing imposed on individuals at any in- come level may not exceed the max- imum

amount established, for individ- uals with income at or below 100 per- cent of the FPL described in paragraph (b)(1) of this section.

(c) *Maximum cost sharing.* In no case shall the maximum cost sharing established by the agency be equal to or ex- ceed the amount the agency pays for the service.

(d) *Targeted cost sharing.*

(1) Except as provided in paragraph (d)(2) of this section, the agency may target cost shar- ing to specified groups of individuals with family income above 100 percent of the FPL.

(2) For cost sharing imposed for non- preferred drugs under § 447.53 and for non-emergency services provided in a hospital emergency department under § 447.54, the agency may target cost sharing to specified groups of individuals regardless of income.

§ 447.53

(e) *Denial of service for nonpayment.*

(1) The agency may permit a provider, including a pharmacy or hospital, to require an individual to pay cost shar- ing as a condition for receiving the item or service if—

(i) The individual has family income above 100 percent of the FPL,

(ii) The individual is not part of an exempted group under § 447.56(a), and

(iii) For cost sharing imposed for non-emergency services furnished in an emergency department, the conditions under § 447.54(d) of this part have been satisfied.

(2) Except as provided under para- graph (e)(1) of this section, the state plan must specify that no provider may deny services to an eligible individual on account of the individual's inability to pay the cost sharing.

(3) Nothing in this section shall be construed as prohibiting a provider from choosing to reduce or waive such cost sharing on a case-by-case basis.

(f) *Prohibition against multiple charges.* For any service, the agency may not impose more than one type of cost sharing.

(g) *Income-related charges.* Subject to the maximum allowable charges speci- fied in §§ 447.52(b), 447.53(b) and 447.54(b), the plan may establish dif- ferent cost sharing charges for individ- uals at different income levels. If the agency imposes such income-related charges, it must ensure that lower in- come individuals are charged less than individuals with higher income.

(h) *Services furnished by a managed care organization (MCO).* Contracts with MCOs must provide that any cost-shar- ing charges the MCO imposes on Med- icaid enrollees are in accordance with the cost sharing specified in the state plan and the requirements set forth in §§ 447.50 through 447.57.

(i) *State Plan Specifications.* For each cost sharing charge imposed under this part, the state plan must specify—

(1) The service for which the charge is made;

(2) The group or groups of individuals that may be subject to the charge;

(3) The amount of the charge;

(4) The process used by the state to—

(i) Ensure individuals exempt from cost sharing are not charged,

(ii) Identify for providers whether cost sharing for a specific item or serv- ice may be imposed on an individual and whether the provider may require the individual, as a condition for re- ceiving the item or service, to pay the cost sharing charge; and

(5) If the agency imposes cost sharing under § 447.54, the process by which hospital emergency room services are identified as non-emergency service.

§ 447.53 Cost sharing for drugs.

(a) The agency may establish dif- ferential cost sharing for preferred and non-preferred drugs. The provisions in § 447.56(a) shall apply except as the agency exercises the option under para- graph (d) of this section. All drugs will be considered preferred drugs if so identified or if the agency does not dif- ferentiate between preferred and non- preferred drugs.

(b) At state option, cost sharing for drugs may be established at or below the amounts shown in the following table (except that the maximum allow- able cost sharing shall be increased each year, beginning October 1, 2015, by the percentage increase in the medical care component of the CPI–U for the period of September to September of the preceding calendar year, rounded to the next higher 5-cent increment. Such increase shall not be applied to any cost sharing that is based on the amount the agency pays for the serv- ice):

Services	Maximum allowable cost sharing	
	Individuals with family income <150% of the FPL	Individuals with family income >150% of the FPL
Preferred Drugs	$4	$4.
Non-Preferred Drugs	$8	20% of the cost the agency pays.

(c) In states that do not have fee-for- service payment rates, cost sharing for prescription drugs imposed on individ- uals at any income level may not exceed the maximum amount established for individuals with income at or below 150 percent of the FPL in paragraph (b) of this section.

(d) For individuals otherwise exempt from cost sharing under § 447.56(a), the agency may impose cost sharing for non-preferred drugs, not to exceed the maximum amount established in para- graph (b) of this section.

(e) In the case of a drug that is iden- tified by the agency as a non-preferred drug within a therapeutically equiva- lent or therapeutically similar class of drugs, the agency must have a timely process in place so that cost sharing is limited to the amount imposed for a preferred drug if the individual's pre- scribing provider determines that a preferred drug for treatment of the same condition either will be less effec- tive for the individual, will have adverse effects for the individual, or both. In such cases the agency must ensure that reimbursement to the pharmacy is based on the appropriate cost sharing amount.

§ 447.54 Cost sharing for services fur- nished in a hospital emergency department.

(a) The agency may impose cost shar- ing for non-emergency services provided in a hospital emergency depart- ment. The provisions in § 447.56(a) shall apply except as the agency exercises the option under paragraph (c) of this section.

(b) At state option, cost sharing for non-emergency services provided in an emergency department may be estab- lished at or below the amounts shown in the following table (except that the maximum allowable cost sharing iden- tified for individuals with family in- come at or below 150 percent of the FPL shall be increased each year, be- ginning October 1, 2015, by the percent- age increase in the medical care com- ponent of the CPI–U for the period of September to September of the preceding calendar year, rounded to the next higher 5-cent increment):

Services	Maximum allowable cost sharing	
	Individuals with family income ≤150% of the FPL	Individuals with family income >150% of the FPL
Non-emergency Use of the Emergency Department	$8	No Limit.

(c) For individuals otherwise exempt from cost sharing under § 447.56(a), the agency may impose cost sharing for non-emergency use of the emergency department, not to exceed the max- imum amount established in paragraph (b) of this section for individuals with income at or below 150 percent of the FPL.

(d) For the agency to impose cost sharing under paragraph (a) or (c) of this section for non-emergency use of the emergency department, the hos- pital providing the care must—

(1) Conduct an appropriate medical screening under § 489.24 subpart G to determine that the individual does not need emergency services.

(2) Before providing non-emergency services and imposing cost sharing for such services:

(i) Inform the individual of the amount of his or her cost sharing obli- gation for non-emergency services pro- vided in the emergency department;

(ii) Provide the individual with the name and location of an available and accessible alternative non-emergency services provider;

(iii) Determine that the alternative provider can provide services to the in- dividual in a timely manner with the imposition of a lesser cost sharing amount or no cost sharing if the indi- vidual is otherwise exempt from cost sharing; and

(iv) Provide a referral to coordinate scheduling for treatment by the alter- native provider.

(e) Nothing in this section shall be construed to:

(1) Limit a hospital's obligations for screening and stabilizing treatment of

an emergency medical condition under section 1867 of the Act; or

(2) Modify any obligations under ei- ther state or federal standards relating to the application of a prudent- layperson standard for payment or cov- erage of emergency medical services by any managed care organization.

§ 447.55 Premiums.

(a) The agency may impose pre- miums upon individuals whose income exceeds 150 percent of the FPL, subject to the exemptions set forth in § 447.56(a) and the aggregate limitations set forth in § 447.56(f) of this part, ex- cept that:

(1) Pregnant women described in de- scribed in paragraph (a)(1)(ii) of this section may be charged premiums that do not exceed 10 percent of the amount by which their family income exceeds 150 percent of the FPL after deducting expenses for care of a dependent child.

(i) The agency may use state or local funds available under other programs for payment of a premium for such pregnant women. Such funds shall not be counted as income to the individual for whom such payment is made.

(ii) Pregnant women described in this clause include pregnant women eligible for Medicaid under § 435.116 of this chapter whose income exceeds the higher of –

(A) 150 percent FPL; and

(B) If applicable, the percent FPL de- scribed in section 1902(l)(2)(A)(iv) of the Act up to 185 percent FPL.

(2) Individuals provided medical as- sistance only under sections 1902(a)(10)(A)(ii)(XV) or 1902(a)(10)(A)(ii)(XVI) of the Act and the Ticket to Work and Work Incen- tives Improvement Act of 1999 (TWWIIA), may be charged premiums on a sliding scale based on income.

(3) Disabled children provided med- ical assistance under section 1902(a)(10)(A)(ii)(XIX) of the Act in ac- cordance with the Family Opportunity Act, may be charged premiums on a sliding scale based on income. The ag- gregate amount of the child's premium imposed under this paragraph and any premium that the parent is required to pay for family coverage under section 1902(cc)(2)(A)(i) of the Act, and other cost sharing charges may not exceed:

(i) 5 percent of the family's income if the family's income is no more than 200 percent of the FPL.

(ii) 7.5 percent of the family's income if the family's income exceeds 200 per- cent of the FPL but does not exceed 300 percent of the FPL.

(4) Qualified disabled and working in- dividuals described in section 1905(s) of the Act, whose income exceeds 150 per- cent of the FPL, may be charged premiums on a sliding scale based on in- come, expressed as a percentage of Medicare cost sharing described at sec- tion 1905(p)(3)(A)(i) of the Act.

(5) Medically needy individuals, as defined in §§ 435.4 and 436.3 of this chapter, may be charged on a sliding scale. The agency must impose an appropriately higher charge for each higher level of family income, not to exceed $20 per month for the highest level of family income.

(b) *Consequences for nonpayment.* (1) For premiums imposed under para- graphs (a)(1), (a)(2), (a)(3) and (a)(4) of this section, the agency may not re- quire a group or groups of individuals to prepay.

(2) Except for premiums imposed under paragraph (a)(5) of this section, the agency may terminate an indi- vidual from medical assistance on the basis of failure to pay for 60 days or more.

(3) For premiums imposed under paragraph (a)(2) of this section—

(i) For individuals with annual in- come exceeding 250 percent of the FPL, the agency may require payment of 100 percent of the premiums imposed under this paragraph for a year, such that payment is only required up to 7.5 percent of annual income for individuals whose annual income does not exceed 450 percent of the FPL.

(ii) For individuals whose annual ad- justed gross income (as defined in section 62 of the Internal Revenue Code of 1986) exceeds $75,000, increased by infla- tion each calendar year after 2000, the agency must require payment of 100 percent of the premiums for a year, except that the agency may choose to subsidize the premiums using state funds which may not be federally matched by Medicaid.

(4) For any premiums imposed under this section, the agency may waive

payment of a premium in any case where the agency determines that re- quiring the payment will create an undue hardship for the individual or family.

(5) The agency may not apply further consequences or penalties for non-pay- ment other than those listed in this section.

(c) *State plan specifications.* For each premium, enrollment fee, or similar charge imposed under paragraph (a) of this section, subject to the require- ments of paragraph (b) of this section, the plan must specify—

(1) The group or groups of individuals that may be subject to the charge;

(2) The amount and frequency of the charge;

(3) The process used by the state to identify which beneficiaries are subject to premiums and to ensure individuals exempt from premiums are not charged; and

(4) The consequences for an indi- vidual or family who does not pay.

§ 447.56 Limitations on premiums and cost sharing.

(a) *Exemptions.* (1) The agency may not impose premiums or cost sharing upon the following groups of individ- uals:

(i) Individuals ages 1 and older and under age 18 eligible under § 435.118 of this chapter.

(ii) Infants under age 1 eligible under § 435.118 of this chapter whose income does not exceed the higher of—

(A) 150 percent FPL (for premiums) or 133 percent FPL (for cost sharing); and

(B) If applicable, the percent FPL de- scribed in section 1902(l)(2)(A)(iv) of the Act up to 185 percent FPL.

(iii) Individuals under age 18 eligible under § 435.120–§ 435.122 or § 435.130 of this chapter.

(iv) Children for whom child welfare services are made available under Part B of title IV of the Act on the basis of being a child in foster care and individ- uals receiving benefits under Part E of that title, without regard to age.

(v) At state option, individuals under age 19, 20 or age 21, eligible under § 435.222 of this chapter.

(vi) Disabled children, except as pro- vided at § 447.55(a)(4) (premiums), who

are receiving medical assistance by vir- tue of the application of the Family Opportunity Act in accordance with sections 1902(a)(10)(A)(ii)(XIX) and 1902(cc) of the Act.

(vii) Pregnant women, except for pre- miums allowed under § 447.55(a)(1) and cost sharing for services specified in the state plan as not pregnancy-re- lated, during the pregnancy and through the postpartum period which begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends.

(viii) Any individual whose medical assistance for services furnished in an institution, or at state option in a home and community-based setting, is reduced by amounts reflecting avail- able income other than required for personal needs.

(ix) An individual receiving hospice care, as defined in section 1905(o) of the Act.

(x) An Indian who is eligible to re- ceive or has received an item or service furnished by an Indian health care pro- vider or through referral under con- tract health services is exempt from premiums. Indians who are currently receiving or have ever received an item or service furnished by an Indian health care provider or through refer- ral under contract health services are exempt from all cost sharing.

(xi) Individuals who are receiving Medicaid because of the state's elec- tion to extend coverage as authorized by § 435.213 of this chapter (Breast and Cervical Cancer).

(2) The agency may not impose cost sharing for the following services:

(i) Emergency services as defined at section 1932(b)(2) of the Act and § 438.114(a) of this chapter;

(ii) Family planning services and supplies described in section 1905(a)(4)(C) of the Act, including con- traceptives and pharmaceuticals for which the State claims or could claim Federal match at the enhanced rate under section 1903(a)(5) of the Act for family planning services and supplies;

(iii) Preventive services, at a min- imum the services specified at § 457.520 of chapter D, provided to children under 18 years of age regardless of fam- ily income, which reflect the well-baby

and well child care and immunizations in the Bright Futures guidelines issued by the American Academy of Pediat- rics; and

(iv) Pregnancy-related services, in- cluding those defined at §§ 440.210(a)(2) and 440.250(p) of this chapter, and coun- seling and drugs for cessation of to- bacco use All services provided to preg- nant women will be considered as preg- nancy-related, except those services specifically identified in the state plan as not being related to the pregnancy.

(v) Provider-preventable services as defined in § 447.26(b).

(b) *Applicability.* Except as permitted under § 447.52(d) (targeted cost sharing), the agency may not exempt additional individuals from cost sharing obliga- tions that apply generally to the popu- lation at issue.

(c) *Payments to providers.* (1) Except as provided under paragraphs (c)(2) and (c)(3) of this section, the agency must reduce the payment it makes to a pro- vider by the amount of a beneficiary's cost sharing obligation, regardless of whether the provider has collected the payment or waived the cost sharing.

(2) For items and services provided to Indians who are exempt from cost shar- ing under paragraph (a)(1)(x) of this section, the agency may not reduce the payment it makes to a provider, in- cluding an Indian health care provider, by the amount of cost sharing that will otherwise be due from the Indian.

(3) For those providers that the agen- cy reimburses under Medicare reason- able cost reimbursement principles, in accordance with subpart B of this part, an agency may increase its payment to offset uncollected cost sharing charges that are bad debts of providers.

(d) *Payments to managed care organiza- tions.* If the agency contracts with a managed care organization, the agency must calculate its payments to the or- ganization to include cost sharing es- tablished under the state plan, for beneficiaries not exempt from cost sharing under paragraph (a) of this sec- tion, regardless of whether the organi- zation imposes the cost sharing on its recipient members or the cost sharing is collected.

(e) *Payments to states.* No FFP in the state's expenditures for services is available for—

(1) Any premiums or cost sharing amounts that recipients should have paid under §§ 447.52 through 447.55 (ex- cept for amounts that the agency pays as bad debts of providers under paragraph (c)(3) of this section; and

(2) Any amounts paid by the agency on behalf of ineligible individuals, whether or not the individual had paid any required premium, except for amounts for premium assistance to ob- tain coverage for eligible individuals through family coverage that may include ineligible individuals when au- thorized in the approved state plan.

(f) *Aggregate limits.* (1) Medicaid pre- miums and cost sharing incurred by all individuals in the Medicaid household may not exceed an aggregate limit of 5 percent of the family's income applied on either a quarterly or monthly basis, as specified by the agency.

(2) If the state adopts premiums or cost sharing rules that could place beneficiaries at risk of reaching the ag- gregate family limit, the state plan must indicate a process to track each family's incurred premiums and cost sharing through an effective mecha- nism that does not rely on beneficiary documentation.

(3) The agency must inform bene- ficiaries and providers of the beneficiaries aggregate limit and notify beneficiaries and providers when a beneficiary has incurred out-of-pocket ex- penses up to the aggregate family limit and individual family members are no longer subject to cost sharing for the remainder of the family's current monthly or quarterly cap period.

(4) The agency must have a process in place for beneficiaries to request a re- assessment of their family aggregate limit if they have a change in circumstances or if they are being termi- nated for failure to pay a premium.

(5) Nothing in paragraph (f) shall pre- clude the agency from establishing ad- ditional aggregate limits, including but not limited to a monthly limit on cost sharing charges for a particular service.

§ 447.57 Beneficiary and public notice requirements.

(a) The agency must make available a public schedule describing current

premiums and cost sharing require- ments containing the following infor- mation:

(1) The group or groups of individuals who are subject to premiums and/or cost sharing and the current amounts;

(2) Mechanisms for making payments for required premiums and cost sharing charges;

(3) The consequences for an applicant or recipient who does not pay a pre- mium or cost sharing charge;

(4) A list of hospitals charging cost sharing for non-emergency use of the emergency department; and

(5) A list of preferred drugs or a mechanism to access such a list, in- cluding the agency Web site.

(b) The agency must make the public schedule available to the following in a manner that ensures that affected ap- plicants, beneficiaries, and providers are likely to have access to the notice:

(1) Beneficiaries, at the time of their enrollment and reenrollment after a redetermination of eligibility, and when premiums, cost sharing charges, or aggregate limits are revised, notice to beneficiaries must be in accordance with § 435.905(b) of this chapter;

(2) Applicants, at the time of applica- tion;

(3) All participating providers; and

(4) The general public.

(c) Prior to submitting to the Centers for Medicare & Medicaid Services for approval a state plan amendment (SPA) to establish or substantially modify existing premiums or cost shar- ing, or change the consequences for non-payment, the agency must provide the public with advance notice of the SPA, specifying the amount of pre- miums or cost sharing and who is sub- ject to the charges. The agency must provide a reasonable opportunity to comment on such SPAs. The agency must submit documentation with the SPA to demonstrate that these re- quirements were met. If premiums or cost sharing is substantially modified during the SPA approval process, the agency must provide additional public notice.

§ 447.88 Options for claiming FFP pay- ment for section 1920A presumptive eligibility medical assistance pay- ments.

(a) The FMAP rate for medical as- sistance payments made available to a child during a presumptive eligibility period under section 1920A of the Act is the regular FMAP under title XIX, based on the category of medical as- sistance; that is, the enhanced FMAP is not available for section 1920A pre- sumptive eligibility expenditures.

(b) States have the following 3 op- tions for identifying Medicaid section 1920A presumptive eligibility expendi- tures and the application of payments for those expenditures:

(1) A State may identify Medicaid section 1920A presumptive eligibility expenditures in the quarter expended with no further adjustment based on the results of a subsequent actual eligi- bility determination (if any).

(2) A State may identify Medicaid section 1920A presumptive eligibility expenditures in the quarter expended but may adjust reported expenditures based on results of the actual eligi- bility determination (if any) to reflect the actual eligibility status of the indi- vidual, if other than presumptively eli- gible.

(3) A State may elect to delay sub- mission of claims for payments of sec- tion 1920A presumptive eligibility ex- penditures until after the actual eligi- bility determination (if any) is made and, at that time identify such expend- itures based on the actual eligibility status of individuals if other than pre- sumptively eligible. At that time, the State would, as appropriate, recat- egorize the medical assistance expendi- tures made during the section 1920A presumptive eligibility period based on the results of the actual eligibility de- termination, and claim them appro- priately.

[65 FR 33622, May 24, 2000]

§ 447.90 FFP: Conditions related to pending investigations of credible allegations of fraud against the Medicaid program.

(a) *Basis and purpose.* This section implements section 1903(i)(2)(C) of the Act which prohibits payment of FFP

PLEASE NOTE PROVISIONS IN THESE SMD LETTERS MAY HAVE BEEN SUPERCEDED BY RECENTLY PUBLISHED RULES.

Attachment C:
Selected State Medicaid Director Letters and Other Materials

This attachment compiles State Medicaid Director Letters and other materials that are referenced in the application and/or instructions. State Medicaid Director Letters also are available on the CMS website at: http://www.medicaid.gov

State Medicaid Director Letters		
Date	**Number**	**Subject**
6/3/2005	#05-002	Medicare Part D – Coverage of Excluded Drugs under Medicaid
8/17/2004	#04-005	Money Follows the Person
7/14/2003	#03-006	The Transition of Individuals From Institutional to Community Settings Through Medicaid Coverage of Medical Equipment (ME) Costs
5/9/2002	#02-008	1915(c) Transitioning Waivers (coverage of community transition services) + 11/15/2004 Q&A
7/17/2001	#01-024	American Indian/Alaska Native Health Policy Issues and Medicaid (Tribal Consultation)
1/10/2001	#01-006	Olmstead Update No.4
7/25/2000	N/A	Olmstead Update No. 3
12/20/1993	N/A	Provider/Payment Under Medicaid Home and Community-Based Services Waivers and State Plan Services

Other Materials
Office of Civil Rights, DHHS. August 2003 LEP Guidance (8/4/2003)
§1616(e) of the Social Security Act (Keys Amendment)
IRS Regulations on Self-Directed Programs
IRS Regulations on Exclusions from Income Allowed by the IRS for Difficulty of Care in Foster Care and other Medicaid Reimbursed Live-in Situations (including adult foster care)
State Medicaid Manual: Section 2900 – Fair Hearings and Appeals
Modifications to Quality Measures and Reporting in §1915(c) Home and Community-Based Waivers
Medicaid Home and Community-Based Services (HCBS) Taxonomy Category and Subcategory Definitions
CMCS Informational Bulletin with a reminder of the instructions for section 1915(c) home and community-based services waivers regarding actions that result in reductions
CMCS Informational Bulletin with updates to the §1915 (c) Waiver Instructions and Technical Guide regarding employment and employment related services

State Medicaid Director Letters

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

Center for Medicaid and State Operations

SMDL #05-002

June 3, 2005

Dear State Medicaid Director:

Beginning January 1, 2006, full benefit dual eligible individuals will receive drug coverage through the Medicare Prescription Drug Benefit (Part D) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, rather than through their state Medicaid programs. However, certain drugs are excluded from coverage under the new Medicare Prescription Drug Benefit. As described more fully in the Federal regulations at 42 CFR 423.772 of the final rule implementing the Medicare Prescription Drug Benefit, full benefit dual eligibles are individuals who have Medicare and full coverage under Medicaid. To the extent that state Medicaid programs cover the excluded drugs for Medicaid recipients who are not full benefit dual eligibles, states will be required to cover the excluded drugs for full benefit dual eligibles with Federal financial participation (FFP). This letter explains the requirements in Federal law for coverage of these excluded drugs and asks state Medicaid programs that cover these excluded drugs to consider continuing this coverage for all Medicaid recipients, including full benefit dual eligibles, after the transition of dual eligibles to the Medicare drug benefit.

Section 1935(d)(2) of the Social Security Act (the Act) and implementing Federal regulations at 42 CFR 423.906(c) give states the option to provide coverage of the excluded drugs: (1) in the same manner as provided for Medicaid recipients who are not full benefit dual eligibles, or (2) through an arrangement with a prescription drug plan (PDP) or a Medicare Advantage prescription drug plan (MA-PDP). Based on these provisions, a question has arisen as to whether state Medicaid programs can cover the excluded drugs for Medicaid recipients who are not full benefit dual eligibles without also covering such drugs for full benefit dual eligible individuals. As explained more fully below, the answer is no.

Section 1902(a)(10)(B) of the Act requires that the coverage afforded to each categorically needy individual eligible under the state plan be equal in amount, duration, and scope to the coverage afforded to all other categorically needy individuals. In addition, coverage afforded to categorically needy eligibles must be no less in amount, duration, and scope than that provided to medically needy individuals covered under the state plan. Neither section 1935(d)(2) of the Act nor the implementing regulations alter this requirement. Rather, these provisions give states that have chosen to cover the excluded drugs for all categorically eligible and/or medically needy individuals an option as to *how* to implement such coverage for full benefit dual eligible individuals. Accordingly, to the extent a state chooses to cover excluded drugs for Medicaid

recipients who are not full benefit dual eligibles, the state also must cover them for full benefit dual eligibles. Conversely, to the extent that a state chooses to cover excluded drugs for full benefit dual eligibles, the state also must cover them for Medicaid recipients who are not full benefit dual eligibles. This is the case regardless of whether the state Medicaid program opts to

cover such drugs for full benefit dual eligibles in the same manner as provided for Medicaid recipients who are not full benefit dual eligibles or through an arrangement with a PDP or MA-PDP.

The drugs excluded from coverage under the Medicare Prescription Drug Benefit include those drugs identified at section 1860D-2(e)(2)(A) of the Act and implementing Federal regulations at 42 CFR 423.100, and any other drug that does not meet the definition of a Part D drug under section 1860D-2(e)(1) of the Act and implementing Federal regulations at 42 CFR 423.100. Among the excluded drugs are certain drugs or classes of drugs, or their medical uses, that states have the authority to exclude under the Medicaid program as specified in section 1927(d)(2) of the Act. Benzodiazepines and barbiturates are included in this category and therefore cannot be covered by PDPs or MA-PDPs that offer a basic Medicare Prescription Drug Benefit. In accordance with the discussion above, however, state Medicaid programs can cover these drugs for full benefit dual eligibles and receive FFP for doing so.

Benzodiazepines and barbiturates are prescribed in the treatment of disorders such as generalized anxiety, insomnia, and seizures—disorders commonly diagnosed in the elderly population. State Medicaid programs currently spend about $56 million in state monies on benzodiazepines and barbiturates for the dual eligible population. The vast majority of benzodiazepines have been identified in the Beers List, a guide that identifies medications or classes of drugs that should be avoided by the elderly. Part D formularies will cover alternative treatment options for those disease states for which benzodiazepines are prescribed. However, because the potential exists for severe adverse effects in patients who abruptly discontinue the use of these drugs and because care must be taken to transition individuals to the safer alternatives, states that currently provide coverage of these drugs for the elderly may wish to continue to do so after the transition to Medicare in order to maintain continuity of care for this population.

If you have any questions regarding this letter and Medicaid coverage of prescription drugs, please contact Deirdre Duzor, Director of CMSO's Division of Pharmacy, at 410-786-4626. Please direct any questions on Medicaid eligibility to Ginni Hain, Director of CMSO's Division of Eligibility, Enrollment and Outreach, at 410-786-6036.

Sincerely,

/s/

Dennis G. Smith
Director

cc:
CMS Regional Administrators

CMS Associate Regional Administrators
for Medicaid and State Operations

Elaine Ryan
Deputy Executive Director
American Public Human Services Association

Joy Wilson
Director, Health Committee
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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-15
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations

SMDL # 04-005

August 17, 2004

Dear State Medicaid Director:

The Centers for Medicare & Medicaid Services (CMS) has supported states in the implementation of the principles of money follows the person (MFP) by providing resources and technical assistance. We are committed to continuing to assist states in implementing the principles of MFP under existing authorities.

A number of states have pursued strategies under existing authority that can be useful models to states interested in making immediate changes to their delivery systems. Previously, we highlighted MFP in two State Medicaid Director letters on August 13, 2002, and September 17, 2003, and provided technical assistance to states through the dissemination of "promising practices" on our Web site. In particular, we have highlighted innovative states including Arizona, Colorado, Indiana, Texas, Florida, New Jersey, Oregon, Utah, Vermont, Washington, and Wisconsin. Still other innovations are occurring under current law with the support of Real Choice Systems Change Grants for Community Living (Attachment #1).

As you know, the term "Money Follows the Person" refers to a system of flexible financing for long-term services and supports that enables available funds to move with the individual to the most appropriate and preferred setting as the individual's needs and preferences change. It is a market-based approach that gives individuals more choice over the location and type of services they receive. A system in which money follows the person is also one that can incorporate the philosophy of self-direction and individual control in state policies and programs.

We are committed to continuing to assist states in implementing the principles of MFP under existing authorities and hope to address areas of confusion that may be impeding efforts to rebalance long-term support systems. This letter intends to clarify a few issues that have been brought to our attention.

Issues Identified to Date

Home and Community-based Services (HCBS) Waiver Capacity and Cost Neutrality: Although states may implement MFP strategies without a waiver context, states that anticipate using HCBS waivers as part of their rebalancing strategy may be concerned about waiver capacity and demonstrating the cost neutrality of proposed waiver services. States may request

to amend their current HCBS waiver program to include additional participants. States that do so are still required to demonstrate the continued cost-neutrality of those programs;

however, most states have found that in the aggregate waiver programs continue to demonstrate cost neutrality even with the addition of waiver participants. Any state that has concerns in this area is asked to work with CMS to assess the underlying assumptions and structural issues of its cost neutrality estimates.

Backfilling of Nursing Home Beds:
States that implement MFP strategies will begin to achieve a more equitable balance between the proportion of total Medicaid long-term support expenditures used for institutional forms of service and the proportion of combined funds used for home health and personal care services under the state plan and waiver services. We anticipate that as individuals have greater choices in service delivery, a smaller proportion of individuals will choose institutional care. We encourage states to reduce nursing facility beds to assist a state in rebalancing its long-term care service system, but this is not a requirement.

Self-Directed Models:
Over the past several years, individuals and families have advocated for directly involving persons who receive Medicaid funded services and supports in the decisions that affect their lives, and providing those individuals with greater choices and control of their services and supports. For individuals to naturally select community services over institutional services, states must ensure that a broad array of quality services are provided under a long-term care system that recognizes service delivery options that are diverse and flexible. CMS is committed to supporting and further implementing models such as those contained in the *Cash and Counseling Demonstration and Evaluation Project* and the *Independence Plus* initiative. These programs not only realize MFP principles but use an individual budget to provide participants direct opportunities to make personalized decisions about the allocation of available resources. While CMS continues to encourage states to consider these system reforms, we also recognize other strategies for the provision of HCBS that expand the level of individual choice and control without making major modifications to state infrastructures. Quality community programs offer not just one model of delivering community services but rather a continuum of options in order to allow individuals to select the service delivery method that best meets their preferences, desires, and personal outcomes. The selection as to which option is best may vary depending on the level of other community supports available, or simply the inclination of the individual. Along this continuum, CMS has identified the following four basic service delivery models related to services and supports of personal attendant:

1. Traditional Model
2. Traditional Model Supporting Choice
3. Agency with Choice Model
4. Fiscal/Employer Agent

A description of these models and examples of state innovation is included in Attachment #2.

We will continue to help provide opportunities for people to live in the communities of their choice. We welcome your input and hope you find this information useful.

Sincerely,

/s/

Dennis G. Smith
Director

Enclosures

cc:
CMS Regional Administrators

CMS Associate Regional Administrators
for Medicaid and State Operations

Kathryn Kotula
Director, Health Policy Unit
American Public Human Services Association

Joy Wilson
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Jim Frogue
Director, Health and Human Services Task Force
American Legislative Exchange Council

Trudi Matthews
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Attachment #1

Examples of State Innovation
Under the Real Choice Systems Change Grants for Community Living:
Money Follows the Person Rebalancing Initiative

California

The California Department of Health Services (DHS) is developing models and systems that enable money to follow the person from institutional to home and community-based settings. Specifically, it is developing standardized protocols and processes, including a consumer-focused quality assurance model, a standardized consumer-oriented nursing facility transition care planning model, and a uniform assessment tool and protocol. A pilot project will test the developed tools and protocols, and inform statewide policy decisions about a Money Follows the Person Initiative in California using individual and aggregate data and fiscal analysis based on case examples.

Maine

The Maine Department of Behavioral and Developmental Services is adopting a standardized assessment and budgeting process for mental retardation waiver services that results in consistent, predictable, and truly portable budgets. The State is directing resources toward more person-centered, consumer-driven services offered in the most integrated and appropriate setting and identifying cross-system performance measures that enable Maine to comprehensively and coherently assess its success at achieving a balance of services across systems. Maine is piloting an individual budget tool and assessing its impact on consumer satisfaction, providers, budget neutrality, staffing requirements, and Medicaid management information systems.

Nevada

The Nevada Department of Human Resources is rebalancing the State's long-term services programs so that community services and supports are the primary source of support for people with disabilities. It is identifying individuals for community integration, implementing their transitions, and using peer advocates to assist in the transition process. In addition, Nevada is establishing a Housing Specialist at the Nevada Developmental Disabilities Council to help individuals locate affordable housing and access State and local housing assistance programs. The State is also revitalizing the Nevada Home of Your Own program, an initiative to help people with disabilities secure housing, and developing and maintaining a registry of affordable, accessible housing in Nevada.

Additional examples can be found on the CMS Web site at www.cms.gov/newfreedom.

Attachment # 2

Service Delivery Models for Attendant Care

Service delivery models have been evolving over the last decade and continue to be refined and clarified. The following are four basic models that CMS has identified based on state experiences. Each of these design approaches can be used by states to enable them to employ money follows the person principles. States are not limited in the various strategies they may employ.

Traditional Agency Model

Under a traditional agency model, an agency assumes responsibility for recruiting, hiring, managing, training, and dismissing employees who are hired to provide, at a minimum, basic assistance with activities of daily living to individuals living in the community. The agency sets the wages and hours, and directs the actions of the employee while in the participant's home and provides necessary back-up as needed. Services are provided based on a standardized assessment of needs typically performed by a medical professional. A Medicaid agreement executed with the Medicaid agency, and the provider agency, clearly articulates the scope of the services and identifies allowable tasks that may be performed. The agency is paid by the Medicaid agency to provide personal assistance services.

Traditional Model Supporting Choice

Many traditional provider agencies honor the principles of choice, control, and the person-centered planning process. These progressive agencies allow, or even encourage, participants to identify and refer to the agency, attendants they have selected and offer training in the philosophy of self-direction. Many agencies also provide a list of potential attendants that participants may interview. Back-up is provided by the agency. Attendants are expected to respect participant preferences. States implementing this model may do so without modifying their state plan or waiver services since the provider agency continues to operate under a traditional Medicaid Provider Agreement to provide personal assistance services and is reimbursed for providing these services. The agency continues as the responsible entity over the provision of personal assistance services and over the attendants who provide this service. While the participant has the ability to select his or her attendant, the agency continues its role as the employer of the attendant and retains responsibility for the oversight of the personal attendant service. The Trinity Respite Care in Lawrence, Kansas is an example of a Medicaid provider agency that gives its clients the opportunity to select their own attendants.

Agency with Choice

This model, first described in a research document entitled *Consumer-Directed Personal Assistance Services: Key Operational Issues for State CD-PAS Programs Using Intermediary Service Organizations* (1997) by Susan Flanagan and Pamela Green, provides an increased level of responsibility by designating the participant as the ***managing employer*** without becoming the common law employer (employer of record) of his or her attendant. For IRS purposes and other employment considerations, including making payment to the provider, the agency is the common law employer. The participant recruits, interviews, and selects the attendant care provider and refers him or her to an agency for the completion of payroll responsibilities. An individual budget may or may not be used to determine the available resource allocation. The

participant generally establishes the wages and sets the working hours. Once hired, the participant manages the attendant including the approval of timesheets. The participant may elect to train the individual or may direct the agency to provide training on his or her behalf. The agency may offer additional services to support the participants' ability to self-direct. These supports may include making other purchases (included in the individualized budget) on behalf of the participant, assisting with managing the individual budget or providing training on how to hire and manager attendants. While the agency and the participant share employer responsibilities, the agency executes a Medicaid Provider Agreement with the Medicaid agency to provide the personal care services and any supportive services. The agency may offer a traditional service model along with Agency with Choice services model, but clearly there is a formal distinction between the two models. The New Hampshire *Independence Plus* initiative, *In-Home Supports Wavier for Children with Developmental Disabilities,* adopts the Agency with Choice model.

Fiscal/Employer Agent Model:

The Fiscal/Employer Agent model provides Medicaid program participants with the greatest level of flexibility and empowerment. In this model, the participant or participant's designated representative is recognized as the common-law employer of his or her individually hired attendant(s). However, the representative generally delegates the employer-related responsibilities related to payrolling and filing of employer-related payroll taxes to an organization that serves as the program participant's "employer agent." The agency may offer a broad host of services that support the participant as he or she experiences self-direction, including skills training, brokering other benefits such as Workers Compensation or health insurance, or other support functions including assistance with managing the individual budget. The agency may be reimbursed for financial management services as a waiver service or as an administrative function. Many states, including all but one of the "Cash and Counseling" and "Independence Plus" waiver states (Arkansas, Florida, New Jersey, Louisiana, North Carolina, and South Carolina), use this model to allow Medicaid program participants and their families to self-direct.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Center for Medicaid and State Operations

SMDL #03-006

July 14, 2003

Dear State Medicaid Director:

In this letter, we outline several methods by which states may facilitate the transition of individuals from institutional to community settings through Medicaid coverage of medical equipment (ME) costs. This letter also serves to reiterate the July 25, 2000, State Medicaid Directors' letter on this issue and to encourage states to explore this opportunity for persons with disabilities.

Individuals seeking to move to the community from institutions often require ME for their personal use. In the community, ME is a mandatory component of the home health benefit under the State Plan. As Federal regulations do not define ME, each state determines which equipment to cover under its State Plan. Those adaptive aids that are not covered under a State Plan, as well as communication devices, can often be covered under Medicaid section 1915(c) waivers, other waivers or demonstrations.

Purchases of ME are typically made after the individual has moved into the community. However, the delay in receiving and adapting to such equipment often causes hardships for the individual and/or caregiver(s). The delay may also introduce unnecessary hazards into the transition and the first few weeks of community dwelling. In addition, the equipment is most effectively employed if it is obtained prior to institutional discharge and tested with the individual to ensure proper fit, use, adaptability to individual requirements, and appropriateness for the particular community environment to which the person will move. We further appreciate that it may take time, prior to discharge, to make unique accommodations to the equipment or to afford the individual reasonable opportunity to learn to use the equipment and become as independent and proficient in its use as possible.

We therefore wish to clarify several avenues for states to pursue in order to facilitate successful transitions to the community by making medically necessary ME available to beneficiaries in advance of placement in the community:

1. Utilize a Trial Period. States could arrange for manufacturers and other sellers of ME to make the equipment available for a trial period prior to community placement.

2. Utilize the Nursing Facility Benefit. States have the ability within their rate setting for institutional services to purchase specific ME that has utility within the institutional setting. For such institutional ME that is also tailored to the unique needs of an individual and would assist the beneficiary's participation in the community, States can arrange for its transition to the community with that individual. Any changes to rate methodologies are subject to

existing upper payment limits. Pennsylvania, for example, in conjunction with changing its case-mix methodology in 1996, created an "Exceptional Durable Medical Equipment (DME) Grants" program under which nursing facilities could purchase certain dedicated equipment separately from their per diem rate. Under Pennsylvania's Exceptional Grants program, one option for disposal of such dedicated DME is the transfer of the title to a beneficiary who has been discharged to the community.

3. Utilize an HCBS Waiver. States may claim for such ME furnished prior to the individual's discharge from the institutional setting and admission to the waiver when: (a) such ME is included as a service or a component of a service in an approved HCBS waiver; (b) such equipment is obtained no sooner than 60 days prior to the scheduled date of transition to a community living arrangement; and (c) the claim is not made until after the individual is discharged from the institutional setting and admitted to the waiver. If the individual dies after the ME is furnished and never enters the waiver, the Centers for Medicare & Medicaid Services (CMS) would allow the state to claim necessary expenditures as an administrative cost. Please refer to attachment 3-b (relating to environmental modifications) of the July 25, 2000, State Medicaid Directors' letter, for guidance on community transition expenses, accessible at Web site www.cms.gov/states/letters/smd725a0.asp.

In addition, CMS has recently established two Healthcare Common Procedure Coding System (HCPCS) codes to facilitate provider billing of services that enable beneficiaries to use ME as they move into the community: T1028 (assessment of home, physical, and family environment) and S5165 (home modifications, per service). CMS established these codes in order to enable states to comply with the Health Insurance Portability and Accountability Act of 1996 - known as HIPPA.

Finally, although ME coverage is required under Medicaid law, states are not required to purchase equipment needed in the community prior to a person's discharge. While CMS has highlighted several methods that states may utilize to facilitate provision of medically necessary ME to beneficiaries prior to community placement, it remains a matter of state discretion and a finding of individual need by the state or its agent(s) as to whether to do so.

Any questions concerning this letter may be referred to Mary Jean Duckett at (410) 786-3294.

Sincerely,

/s/

Dennis G. Smith
Director

cc:
CMS Regional Administrators

CMS Associate Regional Administrators
for Medicaid and State Operations

CMS Native American Contacts

Kathryn Kotula
Director, Health Policy Unit
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Center for Medicaid and State Operations

Letter Summary

This letter clarifies some methods by which HCBS waivers under section 1915(c) may aid in the transitioning of individuals from institutional settings to their own home in the community through coverage of one-time transitional expenses. This clarification was promised in the HHS New Freedom Report to the President.

SMDL #02-008

May 9, 2002

Dear State Medicaid Director:

Medicaid home and community-based services (HCBS) waivers are the statutory alternative to institutional care. Many states have found in HCBS waivers a cost-effective means to implement a comprehensive plan to provide services in the most integrated setting appropriate to the needs of individuals with disabilities.

However, individuals seeking a return to the community from institutions are faced with many one-time expenses, and many states are unclear about the extent to which waivers cover transition costs. Examples of those expenses include the cost of furnishing an apartment, the expense of security deposits, utility set-up fees, etc. Other states have expressed interest in having the waivers pay for apartment/housing rent. This letter is designed to answer such questions.

Federal funding under Medicaid HCBS waivers is not available to cover the cost of rent. States may offset rental expenses from state-only funds that augment federal HCBS resources, but federal financial participation (FFP) for such a purpose is not available for any apartment/housing rental expenses.

As the HHS Report for the President's *New Freedom Initiative* stated, however, states may secure federal matching funds under HCBS waivers for one-time, set-up expenses for individuals 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.

States may pay the reasonable costs of *community transition services*, including some or all of the following components:

- Security deposits that are required to obtain a lease on an apartment or home;
- Essential furnishings and moving expenses required to occupy and use a community domicile;
- Set-up fees or deposits for utility or service access (e.g. telephone, electricity, heating);
- Health and safety assurances, such as pest eradication, allergen control or one-time cleaning prior to occupancy.

By reasonable costs, we mean necessary expenses in the judgment of the state for an individual to establish his or her basic living arrangement. For example, essential furnishings in the above context would refer to necessary items for an individual to establish his or her basic living arrangement, such a bed, a table, chairs, window blinds, eating utensils, and food preparation items. We would not consider essential furnishings to include diversional or recreational items such as televisions, cable TV access or VCRs.

States that choose to include community transition services in their HCBS waivers must demonstrate that this service, in combination with other services furnished under the waiver, would be cost-neutral to the Medicaid program. (In the streamlined HCBS waiver format, this cost neutrality is demonstrated in appendix G.) To be eligible for FFP, the service must be included in the individual's written plan of care (service plan) and fit within the service definitions established by the state.

For more than three years CMS has awarded "Nursing Facility Transition Grants" to states in which transition costs have been paid from grant funds. Those states found that coverage of transition expenses has been manageable, cost-effective and has greatly facilitated the expeditious integration of individuals into their communities from prior institutional living arrangements. Contacts and other relevant information about those states may be found on the CMS website.

Any questions concerning this letter may be referred to Mary Jean Duckett at (410) 786-3294.

Sincerely,
/s/

Dennis G. Smith
Director

cc:

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CMS Associate Regional Administrators
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HCBS Transitions Services

On May 9, 2002, a letter was issued to all State Medicaid Directors announcing the coverage of Community Transition Services under Medicaid Home and Community-Based Services (HCBS) waivers, granted under section 1915(c) of the Social Security Act.

The following Question & Answer provides further definition of the amount of transitional expenses for which a state can claim match.

Q. Is there a limit to the amount of transitional expenses related to security deposits, for which a state operating a home and community based services (HCBS) waiver program can claim match?

A. According to the May 9, 2002 State Medicaid Director letter (#02-008) on coverage of one-time transitional expenses, states may secure federal matching funds under HCBS waivers for one-time, transitional expenses such as security deposits. However, "federal funds under Medicaid HCBS waivers are not available to cover rent."

To date, the Centers for Medicare and Medicaid Services (CMS) has neither defined the term security deposit nor set a cap on the amount allowed. Under a HCBS waiver program, a state could choose to pay for a one-time transitional expense in the form of a security deposit in an amount equal to or greater than the first month's rent to a willing landlord. The security deposit is a one-time expense and is not to be considered rent. In such cases, CMS will expect States to bill only for the security deposit and not break out the cost of rent even if the landlord chooses to waive the first month's rent. CMS does not expect such a security deposit to exceed the equivalent of two month's rent.

Links to Other Resources:

May 9, 2002 Letter to State Medicaid Directors

HCBS Waiver Home Page

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

Center for Medicaid and State Operations
7500 Security Boulevard
Baltimore, MD 21244-1850

SMDL #01-024

July 17, 2001

Dear State Medicaid Director:

This is one in a series of letters regarding American Indian and Alaska Native (AI/AN) health policy issues and the Medicaid program and the State Children's Health Insurance Program (SCHIP). This letter addresses the request of Federally recognized Tribes (hereafter known as "Tribes") to more actively participate in the planning and development of Medicaid and SCHIP waiver proposals and waiver renewals.

As set forth in the Constitution of the United States, treaties, statutes, Executive Orders, and court decisions, it has long been recognized that the United States has a unique relationship with Tribal Governments. This government-to-government relationship recognizes the right of Tribes to tribal sovereignty, self-government and self-determination. At the same time, because Tribes have a separate governmental structure that exists within State(s) border(s), it is important for States to work as closely as possible with Tribes on issues such as Medicaid and SCHIP to ensure the provision of health care for Medicaid and SCHIP enrolled Tribal members is no less than it would be for non-Tribal members equally enrolled.

The Centers for Medicare and Medicaid Services (CMS) (formerly the Health Care Financing Administration) is committed to ensuring full access to Medicaid and SCHIP for all eligible beneficiaries. Access to the decision-making process regarding the Medicaid and SCHIP programs is especially critical for Tribes for cultural, treaty, and statutory reasons. Participation in the decision-making process can best be achieved through an ongoing and effective consultation process that ensures the inclusion of Federally-recognized Tribal governments while preserving the right of State Medicaid agencies to make appropriate decisions based upon the needs of all Medicaid and SCHIP beneficiaries.

The Federal Government is also committed to an effective Tribal consultation process. Many States have established viable mechanisms to ensure an ongoing consultation process with Tribal governments. State experience has demonstrated that there is no single Tribal consultation process that can or should be imposed upon the States. That experience has demonstrated that State-Tribal consultation protocols can vary within a State depending upon inter-governmental relationships, expertise, and Tribal interest.

Although States may partner with a Tribe on a waiver proposal, because Federal law only allows CMS to consider Medicaid and SCHIP proposals submitted by States, we are encouraging States to be as responsive as possible to the issues and concerns expressed by the Tribes during the consultation process. CMS, during the review of Section 1915 and Section 1115 waivers, will look at the steps each State has taken to consult with Tribes based upon individual State considerations. CMS does not consider that consultation means that any or all Federally-recognized Tribal Government(s) in a particular State must approve the proposed waiver nor does it mean that Tribes must concur with a State's waiver request or waiverrenewal.

Therefore, in reviewing all Section 1915 and Section 1115 waiver requests submitted after October 1, 2001 CMS will look to see that

1. All Federally-recognized Tribal Governments maintaining a primary office and/or major population within that State are notified in writing at least 60 days before the anticipated submission date of the State's intent to submit a Medicaidwaiver request or waiver renewal to CMS.

2. The notification describes the purpose of the waiver or renewal and the anticipated impact on Tribal members. The description of the impact need not be Tribal specific if the impact is similar on all Tribes.

3. The notification also describes a method for appropriate Tribal representatives to provide official written comments and questions within a time frame that allows adequate time for State analysis, consideration of any issues that are raised, and time for discussion between the State and Tribes responding to the notification.

4. Tribal Governments were allowed a reasonable amount of time to respond to the notification. A minimum of 30 days is considered reasonable.

5. States, if requested by the Tribal Governments, provide an opportunity for an in-person meeting with Tribal representatives. A State does not need to have separate meetings with each Tribe, but may conduct one or more joint meetings with Tribes to discuss issues.

CMS will look to see that States have utilized these guidelines by looking at copies of correspondence sent by the State to the Tribal Governments notifying them of the State's intent to request a waiver or waiver renewal. Copies of any correspondence submitted by Tribal governments, and a discussion summary from any formal State-Tribal consultation meeting(s) as described in number 5 above, will also aid CMS's review of the proposed waiver or renewal request.

Because each State has developed a unique relationship with each of the Tribes within their borders, CMS will not compare the consultation process undertaken by a State with

the process used by other States. Each State process will be looked at based upon the thoroughness of the required documentation. If Tribes were notified of the proposed waiver in a timely manner and do not respond within the 30 day minimum timeframe, CMS will consider the intent of this letter was fulfilled by the State. Further, CMS staff encourages Tribal and State Governments to work directly with each other to the greatest extent possible in order to resolve any concerns and issues that arise.

This letter supplements the Tribal consultation guidance provided in the July 3, 1997 and the February 24, 1998 letters to State Medicaid Directors.

You will receive a copy of a letter to the Tribal Leaders in your State conveying a copy of this letter. In addition, please find enclosed a listing of the Native American Contacts (NACs), the States they cover, and their respective CMS Regional Office. If you have any questions regarding this policy, please contact the NAC in the appropriate CMS Regional Office.

We look forward to working with you in the future on this and other efforts.

Sincerely,

/s/

Penny R. Thompson
Acting Director

Enclosures

Cc:

CMS Regional Administrators

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Lee Partridge
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Director, Health Committee
National Conference of State Legislatures

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

Center for Medicaid and State Operations
7500 Security Boulevard
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SMDL #01-006

Olmstead Update No: 4
Subject: HCFA Update
Date: January 10, 2001

Dear State Medicaid Director:

This is the fourth in a series of letters designed to provide guidance and support to States in their efforts to enable individuals with disabilities to live in the most integrated setting appropriate to their needs, consistent with the Americans with Disabilities Act (ADA). In attachments to this letter, we address certain issues related to allowable limits in home and community-based services (HCBS) waivers under section 1915(c) of the Social Security Act.

In attachments to this letter, we address certain questions related to State discretion in the design and operation of HCBS waivers under section 1915(c) of the Social Security Act. We also explain some of the principles and considerations that the Health Care Financing Administration (HCFA) will apply in the review of waiver requests and waiver amendments. Finally, we respond to key questions that have arisen in the course of State or constituency deliberations to improve the adequacy and availability of home and community-based services, or recent court decisions.

We encourage you to continue forwarding your policy-related questions and recommendations to the ADA/Olmstead workgroup through e-mail at ADA/Olmstead@hcfa.gov.

HCFA documents relevant to Medicaid and the ADA are posted on the ADA/Olmstead website at **http://www.hcfa.gov/medicaid/olmstead/olmshome.htm**.

Sincerely,

Timothy M. Westmoreland
Director

Enclosures
Attachment 4-A "Allowable Limits and State Options in HCBS waivers"

State Medicaid Director – 2

cc:
HCFA Regional Administrators

HCFA Associate Regional Administrators for Medicaid and State Operations

Lee Partridge
Director, Health Policy Unit
National Association of State Medicaid Directors

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Matt Salo
Director of Health Legislation
National Governors' Association

Robert Glover
Director of Governmental Relations
National Association of State Mental Health Program Directors

Brent Ewig
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Lewis Gallant
Executive Director
National Association of State Alcohol and Drug Abuse Directors, Inc.

Robert Gettings
Executive Director
National Association of State Directors of Developmental Disabilities Services

Virginia Dize
Director, State Community Care Programs
National Association of State Units on Aging.

Attachment 4-A
Subject: Allowable Limits and State Options in HCBS Waivers
Date: January 10, 2001

In this attachment, we discuss limits that States may place on the number of persons served and on services provided under an HCBS waiver. Current law requires States to identify the total number of people who may be served in an HCBS waiver in any year. States may derive this overall enrollment limit from the amount of funding the legislature has appropriated. However, once individuals are enrolled in the waiver, the State may not cap or limit the number of enrolled waiver participants who may receive a covered waiver service that has been found necessary by an assessment.

We have received a number of questions regarding limits that States may, or are required to, establish in HCBS waivers under section 1915(c) of the Social Security Act. Many of these questions have arisen in the course of discussions about the ADA and the Supreme Court Olmstead decision. Others have arisen in the context of certain court cases premised on Medicaid law. Examples include:

1. ***Overall Number of Participants:*** May a State establish a limit on the total number of people who may receive services under an HCBS waiver?

2. ***Fiscal Appropriation:*** May a State use the program's funding appropriation to specify the total number of people eligible for an HCBS waiver?

3. ***Access to Services Within a Waiver***: May a State have different service packages within a waiver? Once a person is enrolled in an HCBS waiver, can the individual be denied a needed service that is covered by the waiver based on a State limit on the number of enrollees permitted access to different waiver services?

4. ***Sufficiency of Amount, Duration, and Scope of Service****s*: What principles will HCFA apply in reviewing limitations that States maintain with respect to waiver services?

5. ***Amendments that Lower the Potential Number of Participants*****:** May a State reduce the total number of people who may be served in an HCBS waiver? Are there special considerations that need attention in such a case?

6. ***Establishing Targeting Criteria for Waivers:*** How much discretion does a State have in establishing the targeting criteria that will be used in a waiver program? May a State define a target group for the waiver that encompasses more than one of the categories of individuals listed in 42 CFR 441.301(b)(6)?

In subjects 1 and 2, we explain current law and policy regarding the setting of limits on the total number of people who may be eligible for an HCBS waiver. In subject 3, we provide new clarification with respect to the access that waiver enrollees must be afforded within a waiver, consistent with recent court decisions. In subject 4, we explain that, while section 1915(c) permits a waiver of many Medicaid requirements, the requirement for adequate amount, duration, and scope is not waived. In subject 5, we discuss special considerations that HCFA will apply when reviewing any waiver amendment request in which the total number of eligible individuals would be reduced, so that the implications of the proposed amendment are fully addressed in light of all applicable legal considerations. In subject 6, we seek to reduce State administrative expenses by permitting States to develop a single waiver for people who have a disability or set of conditions that cross over more than one current waiver category.

The answers to the questions below are derived from Medicaid law. However, because Medicaid HCBS waivers affect the ability of States to use Medicaid to fulfill their obligations under the ADA and other statues, we have included these answers as an Olmstead/ADA update.

1. Overall Number of Participants

> *May a State establish a limit on the total number of people who may receive services under an HCBS waiver?*

Yes. Under 42 CFR 441.303(f)(6), States are required to specify the number of unduplicated recipients to be served under HCBS waivers:

> The State must indicate the number of unduplicated beneficiaries to which it intends to provide waiver services in each year of its program. This number will constitute a limit on the size of the waiver program unless the State requests and the Secretary approves a greater number of waiver participants in a waiver amendment.

Thus, unlike Medicaid State plan services, the waiver provides an assurance of service only within the limits on the size of the program established by the State and approved by the Secretary. The State does not have an obligation under Medicaid law to serve more people in the HCBS waiver than the number requested by the State and approved by the Secretary. If other laws (e.g., ADA) require the State to serve more people, the State may do so using non-Medicaid funds or may request an increase in the number of people permitted under the HCBS waiver. Whether the State chooses to avail itself of possible Federal funding is a matter of the State's discretion. Failure to seek or secure Federal Medicaid funding does not generally relieve the State of an obligation that might be derived from other legislative sources (beyond Medicaid), such as the ADA.

If a State finds that it is likely to exceed the number of approved participants, it may request a waiver

amendment at any time during the waiver year. Waiver amendments may be retroactive to the first day of the waiver year in which the request was submitted.

2. Fiscal Appropriation

May a State use the program's funding appropriation to specify the total number of people eligible for an HCBS waiver?

HCFA has allowed States to indicate that the total number of people to be served may be the lesser of either (a) a specific number pre-determined by the State and approved by HCFA (the approved "factor C" value), or (b) a number derived from the amount of money the legislature has made available (together with corresponding Federal match). The current HCBS waiver pre-print used by States to apply for waivers contains both options. States sometimes use the second option because of the need to seek Federal waiver approval prior to the appropriation process, and sometimes the legislative appropriations are less than the amount originally anticipated. In addition, the rate of turnover and the average cost per enrollee may turn out to be different than planned, thereby affecting the total number of people who may be served.

In establishing the maximum number of persons to be served in the waiver, the State may furnish, as part of a waiver application, a schedule by which the number of persons served will be accepted into the waiver. The Medicaid agency must inform HCFA in writing of any limit that is subsequently derived from a fiscal appropriation, and supply the calculations by which the number or limit on the number of persons to be served was determined. This information will be considered a notification to HCFA rather than a formal amendment to the waiver if it does not substantially change the character of the approved waiver program. If a State fails to report this limit, HCFA will expect the State to serve the number of unduplicated recipients specified in the approved waiver estimates.

3. Access to Services Within a Waiver

May a State have different service packages within a waiver? Once a person is enrolled in a HCBS waiver, can the individual be denied a needed service that is covered by the waiver based on a State limit on the number of enrollees permitted access to different waiver services?

No. A State is obliged to provide all people enrolled in the waiver with the opportunity for access to all needed services covered by the waiver and the Medicaid State plan. Thus, the State cannot develop separate and distinct service packages for waiver population subgroups within a single waiver. The opportunity for access pertains to all services available under the waiver that an enrollee is determined to need on the basis of an assessment and a written plan of care/support.

This does not mean that all waiver participants are entitled to receive all services that theoretically could be available under the waiver. The State may impose reasonable and appropriate limits or utilization

control procedures based on the need that individuals have for services covered under the waiver. An individual's right to receive a service is dependent on a finding that the individual needs the service, based on appropriate assessment criteria that the State develops and applies fairly to all waiver enrollees.

This clarification does mean, however, that States are not allowed to place a cap on the number of enrollees who may receive a particular service within the waiver. There is no authority provided under law or regulation for States to impose a cap on the number of people who may use a waiver service that is lower than the total number of people permitted in the waiver. Denial of a needed and covered service within a waiver would have the practical effect of: (a) undermining an assessment of need, (b) countermanding a plan of care/support based on such an assessment of need, (c) converting a feasible service into one that arbitrarily benefits some waiver participants but not others who may have an equal or greater need, and (d) jeopardizing an individual's health or welfare in some cases.

Similarly, a State may not limit access to a covered waiver service simply because the spending for such a service category is more than the amount anticipated in the budget. In the same way that nursing facilities may not deny nursing or laundry services to a resident simply because the nursing or laundry expenses for the year have exceeded projections, the HCBS waiver cannot limit access to services within the waiver based on the budget for a specific waiver-covered service. It is only the overall budget amount for the waiver that may be used to derive the total number of people the State will serve in the waiver. Once in the waiver, an enrolled individual enjoys protection against arbitrary acts or inappropriate restrictions, and the State assumes an obligation to assure the individual's health and welfare.

We appreciate that a State's ability to provide timely access to particular services within the waiver may be constrained by supply of providers, or similar factors. Therefore, the promptness with which a State must provide a needed and covered waiver service must be governed by a test of reasonableness. The urgency of an individual's need, the health and welfare concerns of the individual, the nature of the services required, the potential need to increase the supply of providers, the availability of similar or alternative services, and similar variables merit consideration in such a test of reasonableness. The complexity of "reasonable promptness" issues may be particularly evident when a change of living arrangement is required. Where the need for such a change is very urgent (e.g., as in the case of abuse in a person's current living arrangement), then "reasonable promptness" could mean "immediate." Where the need for a change of living arrangement for a particular person is clear but not urgent, application of the reasonableness test to determine "reasonable promptness" could provide more time.

We recognize the question of reasonable promptness is a difficult one. We wish to call the issue to your attention as a matter of considerable importance that merits your immediate review. The issue will receive more attention from us in the future and is already receiving attention by the courts. The essential message is that the State's ability to deliver on what it has promised is very important. During CY 2001, we expect to work closely with States to improve our common understanding of what reasonable promptness requires. We also hope to collaborate with you on the infrastructure

improvements that States may need to improve local ability to provide quality, customer-responsive and adequate services or supports in a timely manner.

4. Sufficiency of Amount, Duration and Scope of Services

What principles will HCFA apply in reviewing limitations that States maintain with respect to waiver services?

Federal regulations at 42 CFR 440.230(b) require that each Medicaid service must be sufficient in amount, duration, and scope to achieve the purpose of the service category. Within this broad requirement, States have the authority to establish reasonable and appropriate limits on the amount, duration and scope of each service.

In exercising discretion to approve new waiver requests, we will apply the same sufficiency concept to the entire waiver itself, i.e., whether the amount, duration and scope of all the services offered through the waiver (together with the State's Medicaid plan and other services available to waiver enrollees) is sufficient to achieve the purpose of the waiver to serve as a community alternative to institutionalization and assure the health and welfare of the individuals who enroll.

In applying this principle, it is not our intent to imply or establish minimum standards for the number or type of services that must be in an HCBS waiver. Because the waiver wraps around Medicaid State plan services, and because the needs of each target group vary considerably, it is clear that the sufficiency question may only be answered by a three-way review of (a) the needs of the selected target group, (b) the services available to that target group under the Medicaid State plan and other relevant entitlement programs, and (c) the type and extent of HCBS waiver services. Whether the combination of these factors would permit the waiver to meet its purpose, particularly its statutory purpose to serve as a communityalternative to institutionalization, is an analysis we would expect each State to conduct.

Where a waiver design is manifestly incapable of serving as such an alternative for a preponderance of the State's selected target group, we would expect the State to make the adjustments necessary to remedy the problem in its waiver application for any new waiver. In other cases, an exceptionally limited service design may prevent an existing waiver from being able to assure the health or welfare of the individuals enrolled. Where, subsequent to a HCFA review of quality in an existing waiver, it is very clear that the waiver design renders it manifestly incapable of responding effectively to serious threats to the health or welfare of waiver enrollees, we would expect the State to make the necessary design adjustments to enable the State to fulfill its assurance to protect health and welfare. The fact that States have the authority to limit the total number of people who may enroll in a waiver provides States with reasonable methods to control the overall spending. This means that States should be able to manage their waiver budgets without undermining the waiver purpose or quality by exceptional restrictions applied to services that will be available within the waiver.

5. Amendments That Lower the Potential Number of Participants

May a State reduce the total number of people who may be served in an HCBS waiver? Are there special considerations that need attention in such a case?

A State may amend an approved waiver to lower the number of potential eligibles, subject to certain limitations. The following represent special considerations that HCFA will take into account in reviewing such waiver amendments:

Existing Court Cases or Civil Rights Complaints: If the number of waiver eligibles is a material item to any ongoing legal proceeding, investigation, finding, settlement, or similar circumstance, we will expect the State to (a) notify HCFA and the court of the State's request for a waiver amendment, and (b) notify HCFA and the DHHS Office for Civil Rights whenever a waiver amendment is relevant to the investigation or resolution of any pending civil rights complaint of which the State is aware.

***Avoiding or Minimizing Adverse Effects on Current Participants*:** Under section 1915(c)(2)(A), HCFA is required to assure that the State has safeguards to protect the health and welfare of individuals provided services under a waiver. Thus, a key consideration in HCFA's review of requests to lower the number of unduplicated recipients for an existing waiver is the potential impact on the current waiver population. By "current waiver population," we refer to people who have been found eligible and have enrolled in the waiver. Any reduction in the number of potential waiver eligibles must be accomplished in a manner that continues to assure the health, welfare, and rights of all individuals already enrolled in the waiver. An important consideration is whether a proposed reduction in waiver services would adversely affect the rights of current waiver enrollees to receive services in the most integrated setting appropriate, consistent with the ADA. The State may address these concerns in several ways:

☒ The State may provide an assurance that, if the waiver request is approved, the State will have sufficient service capacity to serve at least the number of current participants enrolled in the waiver as of the effective date of the amendment.

☒ The State may assure HCFA that no individuals currently served on the waiver will be removed from the program or institutionalized inappropriately due to the amendment. For example, the State may achieve a reduction through natural attrition.

☒ The State may provide an assurance and methodology demonstrating how individuals currently served by the waiver will not be adversely affected by the proposed amendment. For example, a State that no longer requires its waiver, because it has added as a State plan

service the principal service(s) provided by the waiver, may specify a method of transitioning waiver participants to the State plan service. We note that any individual who is subject to removal from a waiver is entitled to a fair hearing under Medicaid law, and the methodology of transition is particularly important in that context.

☒ The State may provide a plan whereby affected individuals will transition to other HCBS waivers without loss of Medicaid eligibility or significant loss of services. We anticipate that this may occur when a State seeks to consolidate two or more smaller waivers into one larger program.

This discussion should not be construed as limiting a State's responsibilities to provide services to qualified individuals with disabilities in the most integrated settings appropriate to their needs as required by the ADA or other Federal or State law.

6. Establishing Targeting Criteria for Waivers

How much discretion does a State have in establishing the targeting criteria that will be used in a waiver program? May a State define a target group for the waiver that encompasses more than one of the categories of individuals listed in 42 CFR 441.301(b)(6)?

Under 42 CFR 441.301(b)(6), HCBS waivers must "be limited to one of the following targeted groups or any subgroup thereof that the State may define: (i) aged or disabled or both, (ii) mentally retarded or developmentally disabled or both, (iii) mentally ill." States have flexibility in establishing targeting criteria consistent with this regulation. States may define these criteria in terms of age, nature or degree or type of disability, or other reasonable and definable characteristics that sufficiently distinguish the target group in understandable terms.

HCFA recognizes that discrete target groups may encompass more than one of the categories of individuals defined in this regulation. For example, persons with acquired brain injury may be categorized as either physically disabled in accordance with section 441.301(b)(6)(i) or developmentally disabled in accordance with section 441.301(b)(6)(ii) depending on the age of the person when the brain injury occurred. In such cases, HCFA will permit the State to have one waiver to serve the defined target population that could conceivably encompass more than one category of the regulations in order to avoid the unnecessary administrative expense resulting from the development of a second waiver for the target population.

Please refer any questions concerning this attachment to Mary Jean Duckett (410) 786-3294.

Attachment 4-B
Subject: EPSDT and HCBS Waivers
Date: January 10, 2001

In this attachment, we clarify ways in which Medicaid HCBS waivers and the Medicaid Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services interact to ensure that children receive the full complement of services they may need.

States may take advantage of Medicaid HCBS waivers under section 1915(c) of the Social Security Act to supplement the services otherwise available to children under Medicaid, or to provide services to children who otherwise would not be eligible for Medicaid. In both cases, States must ensure that (1) all children, including the children made eligible for Medicaid through their enrollment in a HCBS waiver, receive the EPSDT services they need, and (2) children receive all medically necessary 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.

Under EPSDT requirements, generally children under age 21 who are served under the Medicaid program should have access to a broad array of services. State Medicaid programs must make EPSDT services promptly available [for any individual who is under age 21 and who is eligible for Medicaid] whether or not that individual is receiving services under an approved HCBS waiver.

Included in the Social Security Act at section 1905(r), EPSDT services are designed to serve a twofold purpose. First, they serve as Medicaid's well-child program, providing regular screenings, immunizations and primary care services. The goal is to assure that all children receive preventive care so that health problems are diagnosed as early as possible, before the problems become complex and treatment more difficult and costly. Under federal EPSDT rules, States must provide for periodic medical, vision, hearing and dental screens. An EPSDT medical screen must include a comprehensive health and developmental history, including a physical and mental health assessment; a comprehensive unclothed physical examination; appropriate immunizations; laboratory tests, including lead blood level assessments appropriate for age and risk factors; and health education, including anticipatory guidance.

The second purpose of EPSDT services is to ensure that children receive the services they need to treat identified health problems. When a periodic or inter-periodic screening reveals the existence of a problem, EPSDT 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 Social Security Act. (Please note that we have long considered any encounter with a health care professional practicing within the scope of his/her practice inter-periodic screening.) That is, under EPSDT requirements, a State must cover any medically necessary services that could be part of the basic Medicaid benefit if the State elected the broadest benefits permitted under federal law (not including HCBS services, which are not a basic Medicaid benefit). Therefore, EPSDT must include access to case management, home health, and personal care services to the extent coverable under federal law

Medicaid's HCBS waiver program serves as the statutory alternative to institutional care. This program allows States to provide home or community-based services (other than room and board) as an alternative to Medicaid-funded long term care in a nursing facility, intermediate care facility for the mentally retarded, or hospital.

- Under an HCBS waiver, States may provide services that are not otherwise available under the Medicaid statute. These may include homemaker, habilitation, and other services approved by HCFA that are cost-effective and necessary to prevent institutionalization. Waivers also may provide services designed to assist individuals to live and participate in their communities, such as prevocational and supported employment services and supported living services. HCBS waivers may also be used to provide respite care (either at home or in an out-of-home setting) to allow family members some relief from the strain of caregiving.

- In addition, under a Medicaid HCBS waiver, a State may provide Medicaid to persons who would otherwise be eligible only in an institutional setting, often due to the income of a spouse or parent. This is accomplished through a waiver of section 1902(a)(10)(C)(i)(III) of the Social Security Act, regarding income and resource rules.

In all instances, HCBS waivers supplement but do not supplant a State's obligation to provide EPSDT services. A child who is enrolled in an HCBS waiver also must be assured EPSDT screening and treatment services. The waiver is used to provide services that are in addition to those available through EPSDT.

There are a number of distinctions between EPSDT services and HCBS waivers. 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. While States may limit the services provided under an HCBS waiver in the ways discussed in attachment 4-A, States may *not* limit medically necessary services needed by a child who is eligible for EPSDT that otherwise could be covered under Medicaid. Children who are enrolled in the HCBS waiver must also be afforded access to the full panoply 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" 42 CFR 441.61(b).

Similarly, a State may use an HCBS waiver to extend Medicaid eligibility to children who otherwise would be eligible for Medicaid only if they were institutionalized. Such children are also entitled to the full complement of EPSDT services. Children made eligible for Medicaid through their enrollment in an HCBS waiver cannot be limited to the receipt of waiver services alone.

The combination of EPSDT and HCBS waiver services can allow children with special health care, as well as developmental and behavioral needs, to remain in their own homes and communities and receive the supports and services they need. The child and family can benefit most when the State coordinates its Medicaid benefits with special education programs in such a way as to enable the family to experience one system centered around the needs of the child. In developing systems to address the needs of children with disabilities, we encourage you to involve parents and other family members as full partners in your planning and oversight activities. HCFA staff will be pleased to consult with States that are working to structure children's programs around the particular needs of children with disabilities and their families.

Please refer any questions concerning this attachment to Mary Jean Duckett (410) 786-3294.

Olmstead Update No: 3
Subject: HCFA Update
Date: July 25, 2000

Dear State Medicaid Director:

On January 14, 2000, we transmitted the first in a series of letters describing the Supreme Court's decision in the case of Olmstead v. L.C. We observed the fact that Medicaid may be of great assistance to States in fulfilling their civil rights responsibilities under the Americans with Disabilities Act (ADA). We also promised to review federal Medicaid policies and regulations to identify areas in which policy clarification or modification would facilitate your efforts to enable persons with disabilities to be served in the most integrated settings appropriate to their needs.

This letter summarizes some of the recent Health Care Financing Administration (HCFA) efforts to review Federal policies in order to facilitate fulfillment of the ADA. These efforts have been directed towards supporting States' initiatives in the following critical areas:

- Assisting people with disabilities to make a successful transition from nursing homes and other institutions into the community;
- Expanding the availability and quality of home and community-based services; and
- Ensuring that services are comparably available to all.

The attached enclosures consist of policy changes and clarifications that HCFA is making that will give States more flexibility to serve people with disabilities in different settings. These serve as guidance on how States may use the flexibility that Medicaid offers to expand services in a variety of ways.

We appreciate the ideas that you and members of the disability community have contributed so far. Most of the clarifications and policy reforms described in this letter emanate from your communications. We continue to invite new ideas because further policy work is required.

We have established an ADA/Olmstead website that contains questions and answers in response to inquiries received since the January 14th letter. The address is http://www.hcfa.gov/medicaid/olmstead/olmshome.htm. The website also contains related letters to State Medicaid Directors and Governors and links to other relevant websites. We encourage you to continue forwarding your policy-related questions and recommendations to the Olmstead workgroup through e-mail at ADA/Olmstead@hcfa.gov or in written correspondence to:

DHHS Working Group for ADA/Olmstead
c/o Center for Medicaid and State Operations
HCFA, Room S2-14-26, DEHPG
7500 Security Boulevard
Baltimore, MD 21244-1850

We look forward to a continuation of our work together to improve the nation's community-based services system.

Sincerely,

Timothy M. Westmoreland
Director

Enclosures
cc:
All HCFA Regional Administrators
All HCFA Associate Regional Administrators Division of Medicaid and State Operations
American Public Human Services Association
Association of State & Territorial Health Officials
National Association of State Alcohol and Drug Abuse Directors, Inc.
National Association of State Directors of Developmental Disabilities Services
National Association for State Mental Health Program Directors
National Association of State Units on Aging
National Conference of State Legislatures
National Governors' Association

HCFA POLICY CHANGES AND CLARIFICATIONS ATTACHED TO THIS LETTER

Policy	***Clarification/Interpretation/Policy Change:***
Purpose: Assisting people with disabilities to make a successful transition from nursing homes and other institutions into the community.	
Attachment 3-a: Earliest Eligibility Date in HCBS Waivers.	Discusses a policy change regarding the earliest date of service for which Federal financial participation (FFP) can be claimed.
Attachment 3-b: Community Transition	Explains some of the ways that Medicaid funding may be used to help elderly people and individuals with a disability transition from an institution to a community residence.
Attachment 3-c: Personal Assistance Retainer.	Discusses a HCFA policy change indicating that a State may make payment for personal assistance services under a Medicaid HCBS waiver while a waiver participant is temporarily hospitalized or away from home.
Purpose: Expanding the availability and quality of home and community-based service.	
Attachment 3-d: Habilitation.	Clarifies that habilitation services, including prevocational, educational, and supported employment services, are available under an HCBS waiver to people of all ages, in all target groups, if so specified by the State.
Attachment 3-e: Out -of- State Services.	Clarifies the circumstances under which Medicaid HCBS waiver services may be provided out-of-state.
Purpose: Ensuring that services are comparably available to all.	
Attachment 3-f: Services Provided Under a Nurse's Authorization.	Clarifies that States may receive FFP for services provided at the authorization of a nurse, if the providers meet qualifications specified under the State Plan or Medicaid waiver for these services.

Attachment 3-g: Prohibition of Homebound Requirements in Home Health.	Notifies that the use of a "homebound" requirement under the **Medicaid** home health benefit violates Federal regulatory requirements at 42 CFR 440.230(c) and 440.240(b).

Attachment 3-a
Subject: Earliest Eligibility Date in HCBS Waivers -- Policy Change
Date: July 25, 2000

Timely home and community-based services (HCBS) waiver eligibility determinations are particularly important to ensure that individuals awaiting imminent discharge from a hospital, nursing home, or other institution are able to return to their homes and communities.

Consequently, we have been asked to clarify the earliest date of service for which Federal financial participation (FFP) can be claimed for HCBS and other State plan services when a person's Medicaid eligibility is predicated upon receipt of Medicaid HCBS under a waiver.

Under current Health Care Financing Administration policy, States must meet several criteria (described below) before they can receive FFP for HCBS waiver services furnished to a beneficiary who has returned to the home or community setting. For example, section 1915(c)(1) of the Social Security Act (the Act) requires that HCBS waiver services be furnished pursuant to a written plan of care.

Policy Change: To facilitate expeditious initiation of waiver services, we will accept as meeting the requirements of the law a provisional written plan of care which identifies the essential Medicaid services that will be provided in the person's first 60 days of waiver eligibility, while a fuller plan of care is being developed and implemented. A comprehensive plan of care must be in place in order for waiver services to continue beyond the first 60 days.

The following chart summarizes the above and other requirements.

Earliest Date of HCBS Waiver Eligibility =
The Last Date All of the Following Requirements Have Been Met

1. Basic Medicaid Eligibility: The person is determined to be Medicaid-eligible if in a medical institution.

The eligibility group into which the person falls must be included in the State plan.

2. Level of Care: The person is determined to require the level of care provided in a hospital, nursing facility, or ICF/MR.

Level of care determinations must be made as specified in the approved waiver.

3. Special Waiver Requirements: The person is determined to be included in the target group and has been found to meet other requirements of eligibility specified in the State's approved waiver. These requirements include documentation from the individual that he or she chooses to receive waiver services.

The person must actually be admitted to the waiver.

4. Plan of Care: A written plan of care is established in conformance with the policies and procedures established in the approved waiver.

Policy Change: For eligibility determinations we will initially accept a provisional written plan of care which identifies the essential Medicaid services that will be provided in the person's first 60 days of waiver eligibility, while a fuller plan of care is being accomplished. A comprehensive care plan, designed to ensure the health and welfare of the individual, must be developed within this time.

5. Waiver Service: The plan of care must include at least one waiver service to be furnished to the individual, and the State must take appropriate steps to put the plan of care into effect.

When the eligibility determination has been made finding the individual eligible for the Medicaid HCBS waiver, the State may make a claim for FFP for services furnished beginning on the date on which all of these criteria are met. In subsequent attachments, we provide for special procedures to accommodate reimbursement for certain transition expenses that enable an individual residing in an institution to transition to community residence.

Any questions concerning this attachment may be referred to Mary Jean Duckett at (410) 786-3294 or Mary Clarkson at (410) 786-5918.

Attachment 3-b
Subject: Community Transition -- Policy Change
Date: July 25, 2000

Medicaid home and community-based services (HCBS) waivers are statutory alternatives to institutional care. Many States have found HCBS waivers to be a cost-effective means to provide comprehensive community services in the most integrated setting appropriate to the needs of the individuals enrolled.

Nursing facilities and intermediate care facilities for the mentally retarded (ICFs/MR) likewise play important roles in our long term care system. They are particularly important for short-term rehabilitation, sub-acute care, and crisis management that enable timely hospital discharge. However, short-term stays often become long term residence when complicated planning is required for a return home, special housing or housing modification needs to be arranged, or exceptional one-time expenses must be paid.

This attachment explains several means by which Medicaid may assist States to overcome these barriers to community transition. It addresses the following:

A. Case Management

1. Targeted Case Management Under the State Plan
2. HCBS Case Management
3. Administrative Case Management

B. Assessments for Accessibility

C. Environmental Modifications

D. Modifications Interrupted due to Death

A. Case management. Case management services are defined under section 1915(g)(2) of the Social Security Act (the Act) as "services which will assist individuals, eligible under the plan, in gaining access to needed medical, social, educational, and other services." Case management services are often used to foster the transitioning of a person from institutional care to a more integrated setting or to help maintain a person in the community. There are several ways that case management services may be furnished under the Medicaid program:

1) Targeted case management (TCM), defined in section 1915(g) of the Act, may be furnished as a service to institutionalized persons who are about to leave the institution, to facilitate the process of transition to community services and to enable the person to gain access to needed medical, social, educational and other services in the community. We are revising our guidelines to indicate that TCM may be furnished during the last 180 consecutive days of a Medicaid eligible person's institutional stay, if provided for the purpose of community transition. States may specify a shorter time period or other conditions under which targeted case management may be provided. Of course, FFP is not available for any Medicaid service, including targeted case management services, provided to persons who are receiving services in an institution for mental disease (IMD), except for services provided to elderly individuals and children under the age of 21 who are receiving inpatient psychiatric services.

2) HCBS Case Management may be furnished as a service under the authority of section 1915(c) when this service is included in an approved HCBS waiver. Persons served under the waiver may receive case management services while they are still institutionalized, for up to 180 consecutive days prior to discharge. However, Federal financial participation (FFP) is available on the date when the person leaves the institution and is enrolled in the waiver. In such cases, the case management service begun while the person was institutionalized is not considered complete until the person leaves the institution and is enrolled in the waiver. In these cases, the cumulative total amount paid is claimed as a special single unit of transitional case management. To claim FFP for case management services under the waiver, the State may consider the unit of service complete on the date the person leaves the facility and is enrolled in the waiver, and claim FFP for this unit of case management services furnished on that date. The cost of case management furnished as a HCBS waiver service must be estimated in factor D of the waiver's cost-neutrality formula.

3) Administrative Case Management may be furnished as an administrative activity, necessary for the proper and efficient administration of the State Medicaid plan. When case management is furnished in this fashion, FFP is available at the administrative rate, but may only be claimed for the establishment and coordination of Medicaid services that are not services funded by other payors for which the individual may qualify. Case management furnished as an administrative expense may be eligible for FFP even if the person is not eventually served in the community (e.g., due to death, the individual's choice not to receive waiver services, loss of Medicaid eligibility, etc.). This is because the service is performed in support of the proper and efficient administration of the State plan.

When a State elects to provide case management as both an administrative and a service expense (either under the targeted case management State plan authority, or as a service under a HCBS waiver), the State must have a policy on file with HCFA that clearly delineates the circumstances under which case management is billed as either an administrative or a service expense. This information must be included in the supporting documentation that the State forwards with its State plan or waiver request.

B. Assessments for Accessibility. Environmental modifications are often crucial to a State's ability to serve an individual in the most integrated setting appropriate to his/her needs. The State may assess the accessibility and need for modification in a person's home or vehicle at any time. FFP may be available in the costs of this assessment under several categories:

1) Administrative Expense: FFP may be claimed at the administrative rate for assessments to determine whether the person's home or vehicle may require modifications to ensure the health and welfare of the HCBS waiver participant. When the assessment is performed to determine whether the individual's needs can be met under an HCBS waiver, the administrative costs of the assessment may qualify for FFP regardless of whether or not the person is eventually served under the waiver;

2) Included in Environmental Modifications: The cost of environmental assessment may be included in the cost of environmental modification under an HCBS waiver; or

3) Included in a Relevant Service: The assessment may be performed by another service provider, such as a home health agency or an occupational therapist. FFP would be available at the service match rate when these providers perform assessments in addition to their other duties.

When a State elects to provide assessments for accessibility as a service expense under a HCBS waiver, the State must have a policy on file with HCFA that clearly delineates the circumstances under which these assessments are billed as either an administrative or a service expense. This information must be included in the supporting documentation that the State forwards in support of its HCBS waiver request.

The cost of reassessment may also be found eligible for FFP. Reassessment may be performed to determine whether new or additional modifications are needed, or whether existing (or newly installed) arrangements continue to be sufficient to meet the individual's needs.

C. Environmental Modifications: It may be necessary to make environmental modifications to an individual's home before an individiual transitions from an institution to the community. For example, a wheelchair ramp may need to be built and doors may need to be widened to permit the individual to access his/her home. In such cases, the home modification begun while the person was institutionalized is not considered complete until the date the individual leaves the institution and is enrolled in the waiver. A State may claim FFP for home modifications (including actual construction costs) furnished as a waiver service for up to 180 days prior to discharge when (a) these modifications have been initiated before the individual leaves the institution and enrolls in HCBS waiver, (b) home modifications are included in the approved HCBS waiver. The claim for FFP must indicate the date the individual leaves the institution and enrolls in the waiver as the date of service for allowable expenses incurred during the previous 180 days.

D. Policy change: Modifications Interrupted by Recipient's Death: The HCBS waivers serve a vulnerable population. Individuals who have chosen to relocate from an institutional to a community residence sometimes die before the relocation can occur. We believe that it would have a chilling effect if States were denied FFP for environmental assessments or modifications for individuals who died before their transition to home or community-based services. Therefore, we will allow the State to claim FFP at the administrative rate for services which would have been necessary for relocation to have taken place when the person has:

1) applied for waiver services,

2) been found eligible for the waiver by the State (but for the person's status as an inpatient in an institution), but

3) died before the actual delivery of the waiver services.

Any questions concerning this attachment may be referred to Mary Jean Duckett at (410) 786-3294 or Mary Clarkson at (410) 786-5918.

Attachment 3-c
Subject: Personal Assistance Retainer -- Policy Change
Date: July 25, 2000

Medicaid regulations at 42 CFR 447.40 permit States to make payment to "hold" an institutional bed open for a resident while that individual is hospitalized or away from the facility for a short period. States which make this payment must indicate their intentions (and applicable time limits) in their State plans. We are writing this guideline to inform you that you may choose to implement a similar policy to allow payment for personal assistance services (such as personal care or attendant services) under HCBS waivers. This would enable beneficiaries to have parity between nursing home care and HCBS care in terms of assuring continuity of care and services.

Individuals with disabilities utilize personal assistance services provided under a HCBS waiver to support various activities of daily living. These services are furnished by individuals employed by community-based agencies, or by persons who are self-employed or employed directly by the waiver participant. Typically low payment rates make it unlikely that a provider could afford to give up a day's or week's salary because the waiver consumer is hospitalized or otherwise absent. Rather than wait for the waiver consumer to return, providers are more likely to find permanent employment elsewhere. Those who are employed by agencies are often reassigned to other agency clients - and may not return. Lack of providers can be catastrophic for an individual with disabilities.

Personal assistance retainer payments, as described in this attachment, are limited to services furnished under HCBS waivers. To enable waiver participants to continue to receive services in the most integrated setting appropriate to their needs, we will permit continued payment to personal caregivers 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 its HCBS waiver request.

States that choose to make payments to be made for personal assistance retainers 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 payment for "bed-hold" in nursing facilities.

Any questions concerning this attachment may be referred to Mary Jean Duckett at (410) 786-3294 or Mary Clarkson at (410) 786-5918.

Attachment 3-d
Subject: Habilitation in HCBS Waivers -- Clarification
Date: July 25, 2000

Section 1915(c)(4)(B) of the Social Security Act (the Act) permits States to offer habilitation services under a Medicaid home and community-based services (HCBS) waiver. Habilitation services are defined in 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." The definition includes expanded services such as prevocational, educational, and supported employment services, if not otherwise excluded by law or the terms of a State's approved waiver.

Clarification: States have historically provided habilitation services under an HCBS waiver to individuals with mental retardation or related conditions which occurred before age 22. However, neither the law nor implementing regulations restrict who may receive habilitation services in an HCBS waiver. Other individuals who do not have mental retardation or related conditions, such as persons with traumatic brain injury or other physical disabilities that occurred after age 22, may also benefit from habilitation services under the waiver. Accordingly, States may provide habilitation services - including the expanded habilitation services of educational, prevocational and supported employment services - under an HCBS waiver to people of all ages who qualify for the waiver.

To receive services under a HCBS waiver, an individual must meet all targeting criteria set forth in the approved waiver. These criteria must include the institutional level or levels of care to which the waiver services provide an alternative.

We believe that this clarification will expand a State's choices of services which can be provided to persons with disabilities in home and community-based waiver programs. It may also assist States in fulfilling their responsibilities under the Americans with Disabilities Act.

States continue to have the flexibility to target waivers to specific populations and age groups within statutory allowances and to determine what services are provided under the waiver. Any questions concerning this attachment or the home and community-based waiver program may be referred to Mary Jean Duckett at (410) 786-3294 or Mary Clarkson at (410) 786- 5918.

Attachment 3-e
Subject: Out-of State Services -- Clarification
Date: July 25, 2000

Out-of-State services have been provided by several States for many years, with excellent results in quality of service and quality of life for the waiver participants. Regulations at 42 CFR 431.52 prescribe the conditions under which a State is required to provide out-of-State services. Section 1902(a)(23) of the Social Security Act (the Act) provides that an individual may receive Medicaid services (including home and community-based services (HCBS) waiver services) from any qualified provider willing to furnish the services.

Historically, out-of-State services have been used to support some individuals attending college, and enabled others to visit family members. In addition, there are some areas near State borders where the closest (or most convenient) provider is located in an adjacent State. When convenience or necessity make it advisable for services to be provided outside the State, there is no restriction to in-State services.

When residential out-of-State services are recommended by a State because services within the State are unavailable or insufficient to meet the person's needs, careful consideration must be given to the reason for providing the services, as well as alternatives which may contribute more to an individual's ability to receive quality supports in a community based setting. Services provided in a location remote from the individual's family and friends may not provide appropriate support for the person to live in the most integrated setting appropriate to his or her needs.

When services are provided out-of-State, the standard waiver requirements must continue to be met. Examples include the following:

Written plan of care: The services must be in the person's written plan of care (section 1915(c)(1) of the Act). The plan of care must identify the services to be provided, the amount and type of each service, and the type of provider. The requirement that the type of provider be included in the care plan does not mean that the name of the actual provider must be listed in the plan of care. The plan of care is subject to the approval of the Medicaid agency. The actual provider is subject to the approval of the individual receiving services.

Waiver-Qualified Provider: Services must be furnished by a qualified provider (section 1902(a)(23) of the Act). The provider must meet the standards for service provision that are set forth by the State in the waiver and approved by HCFA. Any standards of licensure or certification which are applicable to the provision of the service must also be met (42 CFR 441.302(a)(2)). This means that any standards applicable to the provision of the service in the State in which the service is furnished must be met, as well as those standards set forth in the approved waiver. If one State were to pay for a service furnished in another, the provider must be qualified under the standards in the waiver, and the service must also meet any applicable requirements in the State in which it is provided.

Quality Assurance: The State operating the waiver remains responsible for the assurance of the health and welfare of the beneficiary (section 1915(c)(2)(A) of the Act). Oversight may be performed directly by the home State or by the host State in which services are actually received. If it is done by the host State, there must be an interstate compact or agreement setting forth the responsibilities of each party. Under an interstate compact, the State in which services are provided can agree to take over monitoring responsibilities. Some States have compacts which recognize each other's provider agreements. Others recognize each other's provider standards. States have the opportunity to be quite creative in their utilization of these compacts to foster efficient and responsive HCBS programs. We recognize this as an opportunity to expand Medicaid services to meet the needs of individuals in the most integrated settings appropriate.

Choice of Provider: The provider must be chosen by the individual (section 1902(a)(23) of the Act). The provider of out-of-State services must be chosen just as freely as the provider of in-State services. We realize that in some cases, out-of-State services are much closer and more easily obtained than in-State services. This is particularly true when a neighboring State has a large city on or near a State border.

Provider Agreements: The provider must have a provider agreement with the Medicaid agency (section 1902(a)(27) of the Act); and Medicaid payment must be made directly to the provider (section 1902(a)(32) of the Act).

Any or all of the above requirements may be met directly by the State which operates the waiver, or indirectly through an interstate compact in which the second State attends to provider agreement and payment activities.

Any questions concerning this attachment may be referred to Mary Jean Duckett at (410) 786-3294 or Mary Clarkson at (410) 786-5918.

Attachment 3-f
Subject: Services Provided Under a Nurse's Authorization -- Clarification
Date: July 25, 2000

This attachment provides policy guidance regarding Medicaid coverage of services provided pursuant to a nurse's authorization by other providers and the availability of Federal Financial Participation (FFP) for those services. States have referred to these services as "nurse-delegated services" or "services provided under a nurse's delegation of authority." This guidance clarifies that States may enable individuals to receive services in the most integrated setting by permitting providers, such as personal care and attendant care providers, to furnish these services.

State Medicaid programs may cover any services authorized by a nurse that fit within a category of services covered under the Medicaid State plan, a home and community-based services (HCBS) waiver, a managed care waiver, or an approved demonstration project. FFP for the services must be claimed under the category appropriate for the service that was furnished. Under this interpretation, health-related services provided at the authorization of a nurse, which would otherwise be classified as nursing services, are billed in the category of the actual provider. For example, the health-related component of personal care services authorized by a nurse, which are provided by a personal care provider, would be billed and reimbursed as personal care services (Medicaid State plan, HCBS waiver, or other waiver).

As with all Medicaid services, the service for which FFP is claimed must meet the definition provided in the approved Medicaid State plan or HCBS waiver, and the actual provider must meet applicable provider qualifications and requirements. For example, if a State includes personal care services under its Medicaid State plan, FFP would be available for activities authorized by a nurse but furnished by a personal care provider who meets the provider qualifications and standards established by the State. States may wish to impose a requirement for authorization for any covered service when such a requirement would further the objective of ensuring appropriate high quality services. Of course, services provided under the authorization of a nurse must also be consistent with State law and regulations.

States may choose to design their payment methodologies to take into consideration the complexity of authorized tasks, and may impose reasonable provider qualifications applicable to particular tasks. For example, States may choose to have two levels of provider qualifications and payment methodologies for personal care providers under its State plan: a basic level applicable to all personal care providers, and a higher level with additional qualifications for personal care providers who provide more complex tasks, such as those authorized by nurses. Qualifications may include additional training and/or demonstrated competency related to tasks authorized by a nurse that would not be required for providers who do not furnish such tasks. As States also establish the qualifications and payment methodologies for waiver providers, these requirements and rates for waiver personal care services or attendant care services may also reflect the same multi-level approach.

Any questions concerning this attachment or Medicaid coverage of services authorized by a nurse may be directed to Mary Jean Duckett at (410) 786-3294 or Mary Clarkson at (410) 786-5918.

Attachment 3-g
Subject: Prohibition of Homebound Requirement in Medicaid Home Health -- Clarification
Date: July 25, 2000

The Medicaid home health benefit is an important tool for serving persons with disabilities in integrated settings. Medicaid regulations at 42 CFR 440.70(a)(1) require that home health services be provided to an individual at his or her place of residence. An individual's place of residence for purposes of home health services does not include a hospital, nursing facility, or intermediate care facility for the mentally retarded. Home health services must include part-time or intermittent nursing services, home health aide services, and medical supplies, equipment, and appliances suitable for use in the home. Physical or occupational therapy and speech pathology and audiology services are optional.

While current regulations specify that these services must be provided to an individual at his place of residence, it is not necessary that the person be confined to the home for the services to be covered under the Medicaid home health benefit. The "homebound" requirement is a Medicare requirement that does not apply to the Medicaid program. Imposing a homebound requirement on receipt of Medicaid home health benefits as explained below violates Medicaid regulations related to "amount, duration, and scope of services" at 42 CFR 440.230 and "comparability of services" at 42 CFR 440.240. However, States may still limit the home health benefit in the manner allowed by statute and regulation.

Section 42 CFR 440.230(c) indicates that "the Medicaid agency may not arbitrarily deny or reduce the amount, duration, or scope of a required service under sections 440.210 and 440.220 to an otherwise eligible recipient solely because of the diagnosis, type of illness, or condition." Sections 440.210 and 440.220 relate to required services for the categorically needy and to required services for the medically needy, including home health services. If a State limits home health services to persons who are homebound, while not providing medically necessary home health services to persons who are not homebound, it is arbitrarily denying the home health service based on the individual's condition (i.e., whether or not the individual is homebound) in violation of regulations at 440.230(c).

Section 42 CFR 440.240(b) indicates that "the plan must provide that the services available to any individual in the following groups are equal in amount, duration, and scope for all recipients within the group: (1) The categorically needy. (2) A covered medically needy group." Thus, if a State limits the provision of Medicaid home health services to individuals who are homebound, the State violates Federal requirements at 440.240(b) by providing the services to some individuals within the eligibility group and not to others within the group. However, States may still limit the home health benefit in the manner allowed by statute and regulation.

The restriction of home health services to persons who are homebound to the exclusion of other persons in need of these services ignores the consensus among health care professionals that community access is not only possible but desirable for individuals with disabilities. New developments in technology and service delivery have now made it possible for individuals with even the most severe disabilities to participate in a wide variety of activities in the community with appropriate supports. Further, ensuring that Medicaid is available to provide medically

necessary home health services to persons in need of those services who are not homebound is an important part of our efforts to offer persons with disabilities services in the most integrated setting appropriate to their needs, in accordance with the Americans with Disabilities Act.

For purposes of receipt of Medicaid home health services, a person's place of residence continues to be defined by the requirements of 42 CFR 440.70(c).

Any questions concerning this attachment or the home health benefit may be referred to Mary Jean Duckett at (410) 786-3294 or Mary Clarkson at (410) 786-5918.

December 20, 1993

Dear State Medicaid Director:

From the inception of the home and community-based services waiver program, States have used waivers to test innovative methods of service delivery and payment. Particularly with regard to waivers for the mentally retarded/developmentally disabled, many States established systems under which single providers (usually case managers) subcontracted with providers of other waiver services and were paid by the State for furnishing the entire "package" of care to an individual. However, this rendered the waivers vulnerable to problems with the statutory requirements of free choice of provider, direct payment and provider agreement.

Recently, the Medicaid Bureau has employed the concept of the organized health care delivery system (OHCDS) as a solution to the direct payment problem in certain waivers. An OHCDS is defined at 42 CFR 447.10(b) as, "...a public or private organization for delivering health services. It includes, but is not limited to, a clinic, a group practice prepaid capitation plan, and a health maintenance organization." Since there is no constricting background or history to this provision, it is open to interpretations broad enough to apply to systems which are not prepaid organizations.

Several States have proposed to expand this concept to other service arrangements under the regular Medicaid plan. As we have stipulated in the enclosed paper, the requirements for OHCDS which we have applied to waiver providers must be extended to the provision of the OHCDS services under the plan, i.e., the system must provide at least one service directly (utilizing its own employees, rather than contractors), and all other requirements of title XIX must be maintained. Where contracting is involved, the applicable requirements of 42 CFR 434 and 45 CFR must be met. As with all Medicaid services, those provided by an OHCDS must be furnished by individuals or entities which meet all provider requirements under the State's plan. Absent a section 1915(b) or (C) waiver, we do not believe this authority permits payment for services not otherwise included under the State's Medicaid plan. Recipient free choice of providers would be retained in its present form.

Enclosed is a paper detailing our position on the concept and applicability of OHCDS relative to the Medicaid program. We believe that this arrangement will allow you the opportunity for greater innovation and flexibility and be consistent with the Administration's health care initiatives.

Sally K. Richardson

Enclosure

cc:
Ms. Lee Partridge, APWA
Mr. Carl Volpe, NGA
Ms. Joy Wilson, NCSL

FME-41: MARY CLARKSON 64650
Stored: MCDIRLET HCBW #30 pc/wp
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Provider/Payment
Under Medicaid Home and Community-Based Services Waivers and State Plan Services

We have received several memoranda and questions concerning the options available to States in making payment for services provided under Medicaid home and community based services waivers, and for services furnished under State plans. We have also been made aware of reports written by consultants concerning this subject. However, we have found the material included in some of these reports to be misleading and of questionable accuracy. Therefore, we are providing the following guidance, since we believe that the issue warrants a full discussion.

Section 1902(a)(27) of the Social Security Act requires a provider agreement between the Medicaid agency and each provider furnishing services under the plan. This requirement is applicable to all Medicaid services, whether provided under the authority of the State plan or under a home and community-based services waiver. It must be met for Federal financial participation (FFP) to become available.

Section 1902(a)(32)of the Act requires that, with certain exceptions which are not germane to this discussion, Medicaid make payment directly to the providers of services.

Section 1902(a)(23) of the Act requires that an individual have free choice of all qualified providers. To be considered "qualified," an individual or entity must meet the applicable provider qualifications set forth in either the State plan or waiver. These qualifications must be considered reasonable by HCFA. We consider qualifications to be reasonable when they are directly related to the demands of the Medicaid service to be furnished. Absent specific statutory relief, the requirements for free choice of provider must be met.

The home and community based services waiver authority is contained in sections 1915(c) and (d) of the Social Security Act. Under these sections, States may be permitted to provide services not otherwise available through their Medicaid plans as an alternative to institutional care in a hospital, nursing facility, or intermediate care facility for the mentally retarded. Sections 1915(c) and (d) also provide the specific authority for the Secretary to waive certain portions of the Act: section 1902(a)(1), regarding statewide availability of

services; section 1902(a)(1O)(B), regarding comparability of services; and section 1902(a)(1O)(C)(i)(III), which contains eligibility provisions. However, the waiver law does not furnish the authority to waive other portions of the Social Security Act. These other sections include the requirements for free choice of providers (section 1902(a)(23) of the Act), provider agreement (section 1902(a)(27) of the Act), and the requirement that the Medicaid agency make payments directly to the provider of services (section 1902(a)(32) of the Act). Therefore, absent specific authority contained elsewhere in the Act, these mandates must be met.

However, these requirements do not prohibit a State from paying for subcontracted services in all cases. Nor do they necessarily prevent a State from utilizing an intermediate entity in paying for waiver services. We have identified the following methods by which the requirements for free choice, provider agreement and direct payment may be met.

TRADITIONAL METHOD:

Each provider furnishes the service directly. The provider may be an individual, a partnership, or an agency or corporation which furnishes services utilizing its own employees. Each provider meets the State's qualifications (as set forth in the plan or waiver) for service provision.

Each provider has a provider agreement with the Medicaid agency. (Other entities, such as case managers, Area Agencies on Aging, Departments of Developmental Disabilities, may be co-signatories to this agreement. Their involvement is optional with the State. What is necessary is that Medicaid and the provider sign the same agreement.)

Each individual has free choice of the providers of each service. Any provider, qualified to furnish a particular service (either under the State plan or the waiver), who undertakes to do so, is given the opportunity to provide services.

A provider of a service which has several components -— (e.g. home health care, clinic services) may contract with another individual or entity for the provision of a component part of the service. However, it is the provider who is held responsible for the provision of the service in toto, and each

component of the service (whether furnished directly by the provider, or by someone else under contract to the provider) must meet the applicable standards set for by the Medicaid agency for the provision of that component of care.
Medicaid either pays the provider directly, using its own staff and computer systems, or utilizes a fiscal agent which meets all Federal requirements for fiscal agency. If the State uses a fiscal agent, all MMIS requirements are also met.

REASSIGNMENT TO A GOVERNMENTAL AGENCY:

The authority for this alternative is found at section 1902(a)(32)(B) of the Act, and 42 CFR 447.10(e). Providers may reassign their rights to Medicaid payment to a governmental agency.

This reassignment must be voluntary. The State cannot mandate reassignment. Moreover, the State must make provision for direct payment of claims submitted by providers who do not choose to reassign their rights. In addition, the State may not make such reassignment a provider qualification (because reassignment is not related to the provision of the Medicaid-funded service), and the State may not restrict an individual's choice of provider to those who have reassigned claims to a governmental agency.

Multiple reassignments are possible (e.g., provider reassigns to the County Mental Retardation agency, which reassigns to the State Mental Retardation agency). However, each entity to which reassignment is made (this does not include the actual provider) must be an agency of State or local government and each reassignment must be voluntary.

A provider who has voluntarily chosen to reassign claims to a governmental agency must be free to cancel the arrangement. The provider must have a provider agreement with the Medicaid agency. (Other entities, such as case managers, Area Agencies on Aging and Departments of Developmental Disabilities, may be co-signatories to this agreement. Their involvement is optional with the State. What is necessary is that Medicaid and the provider sign the same agreement.)

FISCAL AGENCY

When services are provided under a home and community based services waiver, the State may find it reasonable to have a payment and tracking system which is separate from that used for State plan services. When an entity other than Medicaid is to perform the actual processing of provider claims, a fiscal agency contract should be executed. In this situation, Medicaid, acting through contract or interagency agreement, designates a separate agency or entity as a limited fiscal agent. "Limited" means that the agency or entity will only process waiver claims. The servicing Regional Office must approve any sole source contracts that are utilized.

The provider submits bills, which are then paid by this intermediate agency or entity (acting in its capacity of fiscal agent), utilizing an MNIS system. However, since the operation of a limited fiscal agent is actually a "sub-system" of the MMIS, FFP may be available at the 75 percent rate.

If upgrades are necessary to enable the limited fiscal agent's computer system to be brought on-line with the rest of the State's MNIS system, FFP may be available at the 90 percent rate for these upgrades, if they are found necessary (in advance) by the servicing Regional Office. Therefore, States considering this option should work closely with their Regional Office to ensure agreement on the nature and extent of the computer upgrades to be installed.

The limited fiscal agent may, if necessary, contract out part of its work (e.g., the actual printing of checks) to another agency or entity. All contractors and subcontractors must meet the requirements of 42 CFR Part 434, as well as those more generic requirements in 45 CFR which pertain to Medicaid contracts. As in the arrangements discussed above, the provider would have a provider agreement with the Medicaid agency. This may be a three or more party agreement, so long as the Medicaid provider agreement wording is included and the Medicaid agency and the provider sign the same agreement.

ORGANIZED HEALTH CARE DELIVERY SYSTEMS

Section 1902(a)(32) of the Act requires that the Medicaid agency make payment directly to the provider of a covered service furnished to an eligible individual. Regulations at 42 CFR Part 447 establish the rules for such payment. Section 447.10(g)(4). recognizes an organized health care delivery system as an entity to which Medicaid payment can properly be made. Regulations at 42 CFR 447.10(b) define organized health care delivery systems.

To be recognized as an organized health care delivery system, we believe that the entity must first be a system, at least one component of which is organized for the purpose of delivering health care. (There may be other components with other missions, such as education or food distribution, but there must be an identifiable component devoted to the delivery of health care.) To meet this test, we further believe that the entity must furnish at least one Medicaid-covered waiver or State plan service itself. The entity may, of course, furnish mare than one service, covered by Medicaid. In the case of an entity which furnishes more than one service directly (i.e., through its own employees), those individuals who actually furnish each service must meet the State's minimum qualifications for its provision. The provision of one Medicaid service does not automatically qualify the entity to provide any other service. The entity may provide other services only if the entity separately meets the provider qualifications set by the State for the other services. Thus, a clinic may furnish both physical therapy and dental services, when it employs qualified staff to provide each service, and meets all other requirements under the waiver or the plan.

An organized health care delivery system is not, however, limited to furnishing services through its own employees. So long as the entity continues to furnish at least one service itself, it may contract with other qualified providers to furnish Medicaid covered services. When services are furnished under contract, the specific requirements of 42 CFR 434 apply and must be met, as must the more general requirements of 45 CFR. This includes the rules for prepaid capitated payment, where the State has elected this form of compensation.

If the organized health care delivery system is a health maintenance organization or prepaid capitated plan, individuals are enrolled with the system, and receive services from the system, its employees and contractors. However, when there is no prepaid enrollment, individuals may not be restricted to providers within the organized health care delivery system, but must remain free to choose the provider(s) of each Medicaid service they receive. Thus, an individual may choose to receive physician services from Dr. Jones, physical therapy under a waiver from ABC Health Systems, and dental services from DEF Dental Systems, even though ABC Health Systems includes, a clinic which furnishes dental care as well as physical therapy.

A State which chooses to utilize organized health care delivery systems to implement its waiver program or part of its State plan may not require that a provider be a part of such a system. Further, qualifications of providers must always be* reasonably related to the service to be furnished. However, because it is the system itself which acts as a Medicaid provider, it is not necessary for each subcontractor of an organized health care delivery system to sign a provider agreement with the Medicaid agency. The system must have such an agreement and is responsible for ensuring that services it furnishes are provided in accordance with Medicaid law and regulations - including the minimum educational/professional standards for service provision.

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Stored: MCROMEMO HCBW #25 pc/wp
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Other Materials

FEDERAL RESERVE SYSTEM

Formations of, Acquisitions by, and Mergers of Bank Holding Companies

The companies listed in this notice have applied to the Board for approval, pursuant to the Bank Holding Company Act of 1956 (12 U.S.C. 1841 *et seq.*) (BHC Act), Regulation Y (12 CFR Part 225), and all other applicable statutes and regulations to become a bank holding company and/or to acquire the assets or the ownership of, control of, or the power to vote shares of a bank or bank holding company and all of the banks and nonbanking companies owned by the bank holding company, including the companies listed below.

The applications listed below, as well as other related filings required by the Board, are available for immediate inspection at the Federal Reserve Bank indicated. The application also will be available for inspection at the offices of the Board of Governors. Interested persons may express their views in writing on the standards enumerated in the BHC Act (12 U.S.C. 1842(c)). If the proposal also involves the acquisition of a nonbanking company, the review also includes whether the acquisition of the nonbanking company complies with the standards in section 4 of the BHC Act (12 U.S.C. 1843). Unless otherwise noted, nonbanking activities will be conducted throughout the United States. Additional information on all bank holding companies may be obtained from the National Information Center Web site at *www.ffiec.gov/nic/*.

Unless otherwise noted, comments regarding each of these applications must be received at the Reserve Bank indicated or the offices of the Board of Governors not later than September 4, 2003.

A. Federal Reserve Bank of Atlanta (Sue Costello, Vice President) 1000 Peachtree Street, N.E., Atlanta, Georgia 30309–4470:

1. Community Capital Bancshares, Inc., Albany, Georgia; to acquire 100 percent of the voting shares of First Bank of Dothan, Dothan, Alabama.

B. Federal Reserve Bank of Dallas (W. Arthur Tribble, Vice President) 2200 North Pearl Street, Dallas, Texas 75201–2272:

1. North American Bancshares, Inc., Sherman, Texas; to acquire 100 percent of the voting shares of Pioneer Bankshares, Inc., Fredericksburg, Texas, and thereby indirectly acquire Pioneer II Bankshares, Inc., Dover, Delaware, and Pioneer National Bank, Fredericksburg, Texas.

Board of Governors of the Federal Reserve System, August 4, 2003.

Jennifer J. Johnson,

Secretary of the Board.

[FR Doc. 03–20242 Filed 8–7–03; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons

AGENCY: Health and Human Services, HHS.

ACTION: Policy guidance document.

SUMMARY: The Department of Health and Human Services (HHS) publishes revised Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons (''Revised HHS LEP Guidance''). This revised HHS LEP Guidance is issued pursuant to Executive Order 13166. HHS is seeking comment on the revised HHS LEP Guidance for a 120-day period ending on January 6, 2004.

DATES: This Guidance is effective immediately. Comments must be submitted on or before January 6, 2004. HHS will review all comments and will determine if modifications to the Guidance are necessary. This Guidance supplants existing guidance on the same subject originally published at 65 FR 52762 (August 30, 2000).

ADDRESSES: Comments should be addressed to Deeana Jang with ''Attention: LEP Comments,'' and should be sent to 200 Independence Avenue, SW, Room 506F, Washington, DC 20201. Comments may also be submitted by e-mail at *LEP.comments@hhs.gov.*

FOR FURTHER INFORMATION CONTACT: Onelio Lopez at the Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 506F, Washington, DC 20201, addressed with ''Attention: LEP Comments;'' telephone 202–205– 0192; TDD: toll-free 1–800–537–7697. Arrangements to receive the policy in an alternative format may be made by contacting the named individual.

SUPPLEMENTARY INFORMATION: The United States Department of Health and Human Services (HHS) is publishing revised ''Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons'' (''Revised HHS LEP Guidance''). This guidance was originally published on August 30, 2000, and included a 60-day comment period. See 65 FR 52762. This original guidance was republished for additional comment on February 1, 2002, pursuant

LEP Guidance

to a memorandum issued by the United States Department of Justice on October 26, 2001. See 67 FR 4968.

On March 14, 2002, the Office of Management and Budget (OMB) issued a Report to Congress entitled ''Assessment of the Total Benefits and Costs of Implementing Executive Order No. 13166: Improving Access to Services for Persons with Limited English Proficiency.'' Among other things, the Report recommended the adoption of uniform guidance across all federal agencies, with flexibility to permit tailoring to each agency's specific recipients. Consistent with this OMB recommendation, DOJ published LEP Guidance for DOJ recipients, which was drafted and organized to also function as a model for similar guidance documents by other Federal grant-making agencies. See 67 FR 41455 (June 18, 2002).

This revised HHS LEP Guidance reflects consideration of the comments received and the subsequent guidance of DOJ. HHS welcomes comments from the public on the revised guidance document, and has announced the extended comment period to encourage comment from the public and from recipients regarding experience in applying this revised guidance. Following the comment period, HHS will evaluate whether further revisions to the guidance are necessary or appropriate.

The text of the guidance appears below. Appendix A to the guidance is a series of questions and answers that provides a useful summary of a number of the major aspects of the guidance.

It has been determined that this revised HHS LEP Guidance does not constitute a regulation subject to the rulemaking requirements of the Administrative Procedure Act, 5 U.S.C. 553, and is not subject to Executive Order 12866 (Regulatory Review and Planning, September 30, 1993).

Dated: August 4, 2003.

Richard M. Campanelli,

Director, Office for Civil Rights.

I. Background and Legal History

Section 601 of Title VI of the Civil Rights Act of 1964, 42 U.S.C. 2000d, provides that no person shall ''on the ground of race, color, or national origin, be excluded from participation in, be

denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.'' Section 602 authorizes and directs federal agencies that are empowered to extend federal financial assistance to any program or activity ''to effectuate the provisions of [section 601] * * * by issuing rules, regulations, or orders of general applicability.'' 42 U.S.C. 2000d–1.

Department of Health and Human Services regulations promulgated pursuant to section 602 forbid recipients from ''utiliz[ing] criteria or methods of administration which have the effect of subjecting individuals to discrimination because of their race, color, or national origin, or have the effect of defeating or substantially impairing accomplishment of the objectives of the program with respect to individuals of a particular race, color, or national origin.'' 45 CFR 80.3(b)(2).

The Supreme Court, in Lau v. Nichols, 414 U.S. 563 (1974), interpreted regulations promulgated by the former Department of Health, Education, and Welfare (HHS's predecessor), 45 CFR 80.3(b)(2), to hold that Title VI prohibits conduct that has a disproportionate effect on LEP persons because such conduct constitutes national-origin discrimination. In Lau, a San Francisco school district that had a significant number of non-English speaking students of Chinese origin was required to take reasonable steps to provide them with a meaningful opportunity to participate in federally funded educational programs.

On August 11, 2000, Executive Order 13166 was issued. ''Improving Access to Services for Persons with Limited English Proficiency,'' 65 FR 50121 (August 16, 2000). Under that order, every federal agency that provides financial assistance to non-federal entities must publish guidance on how their recipients can provide meaningful access to LEP persons and thus comply with Title VI regulations forbidding funding recipients from ''restrict[ing] an individual in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any service, financial aid, or other benefit under the program'' or from ''utiliz[ing] criteria or methods of administration which have the effect of subjecting individuals to discrimination because of their race, color, or national origin, or have the effect of defeating or substantially impairing accomplishment of the objectives of the program as respects individuals of a particular race, color, or national origin.''

On that same day, the Department of Justice (''DOJ'') issued a general guidance document addressed to ''Executive Agency Civil Rights Officers'' setting forth general principles for agencies to apply in developing guidance documents for recipients pursuant to the Executive Order. ''Enforcement of Title VI of the Civil Rights Act of 1964 National Origin Discrimination Against Persons With Limited English Proficiency,'' 65 FR 50123 (August 16, 2000) (''DOJ LEP Federal Guidance'').

Subsequently, federal agencies raised questions regarding the requirements of the Executive Order, especially in light of the Supreme Court's decision in Alexander v. Sandoval, 532 U.S. 275 (2001). On October 26, 2001, Ralph F. Boyd, Jr., Assistant Attorney General for the Civil Rights Division, issued a memorandum for ''Heads of Departments and Agencies, General Counsels and Civil Rights Directors.'' This memorandum clarified and reaffirmed the DOJ LEP guidance for recipients of DOJ federal financial assistance in light of Sandoval.[1] The Assistant Attorney General stated that because Sandoval did not invalidate any Title VI regulations that proscribe conduct that has a disparate impact on covered groups—the types of regulations that form the legal basis for the part of Executive Order 13166 that applies to federally assisted programs and activities—the Executive Order remains in force.

Consistent with Executive Order 13166, HHS developed its own guidance document for recipients and initially issued it on August 30, 2000. ''Title VI of the Civil Rights Act of 1964; Policy Guidance on the Prohibition Against National Origin Discrimination As It Affects Persons With Limited English Proficiency,'' 65 FR 52762 (August 30, 2000) (''HHS Guidance''). Following the instructions in the October 26, 2001 memorandum from Ralph F. Boyd, Jr., the Department republished, on February 1, 2002, its existing guidance document for additional public comment. ''Office for Civil Rights; Title VI of the Civil Rights Act of 1964; Policy Guidance on the Prohibition Against National Origin Discrimination As It Affects Persons With Limited English Proficiency,'' 67 FR 4968 (February 1, 2002).

[1] The memorandum noted that some commentators had interpreted Sandoval as impliedly striking down the disparate-impact regulations promulgated under Title VI that form the basis for the part of Executive Order 13166 that applies to federally assisted programs and activities. See, *e.g.*, Sandoval, 532 U.S. at 286, 286 n.6 (''[W]e assume for purposes of this decision that section 602 confers the authority to promulgate disparate-impact regulations; . . . We cannot help observing, however, how strange it is to say that disparate-impact regulations are 'inspired by, at the service of, and inseparably intertwined with Sec. 601 * * * when Sec. 601 permits the very behavior that the regulations forbid.''). The memorandum, however, made clear that DOJ disagreed with the commentators' interpretation. DOJ stated that Sandoval holds principally that there is no private right of action to enforce Title VI disparate-impact regulations. It did not address the validity of those regulations or Executive Order 13166, or otherwise limit the authority and responsibility of federal grant agencies to enforce their own implementing regulations.

II. Revised HHS LEP Guidance

Following republication of our guidance in February 2002, the Department received nearly 200 public comments. Most comments were in full support of the principles behind the HHS Guidance, and a number supported maintaining the guidance without change. While the comments reflected recognition that effective communication is critical for necessary health and human services, many commentors raised serious concerns about coverage, compliance costs, and use of family and friends as interpreters. In addition, many providers of services requested assistance from the Office for Civil Rights on how to comply with both general and specific provisions of the guidance.

On July 8, 2002, Assistant Attorney General Boyd issued a memorandum expressing the need for consistency across federal agency LEP guidance documents. Specifically, he requested that the Department (and all other affected agencies) use the DOJ LEP guidance (published at 67 FR 41455, June 18, 2002) as a model, and revise and republish the HHS guidance based on that model for public comment.

The DOJ's role under Executive Order 13166 is unique. The Executive Order charges DOJ with responsibility for providing LEP Guidance to other Federal agencies and for ensuring consistency among each agency-specific guidance. DOJ's guidance stated the following principles. ''Consistency among Departments of the federal government is particularly important. Inconsistency or contradictory guidance could confuse recipients of federal funds and needlessly increase costs without rendering the meaningful access for LEP persons that this Guidance is designed to address. As with most government initiatives, this requires balancing several principles. While this Guidance discusses that balance in some detail, it is important to note the basic principles behind that balance. First, we must ensure that federally assisted programs aimed at the American public do not leave some behind simply because they face challenges communicating in English.

This is of particular importance because, in many cases, LEP individuals form a substantial portion of those encountered in federally assisted programs. Second, we must achieve this goal while finding constructive methods to reduce the costs of LEP requirements on small businesses, small local governments, or small non-profits that receive federal financial assistance.''

HHS believes that the DOJ model guidance responds to the important issues raised in comments on the HHS document published in February, and the Department is confident that the DOJ LEP Guidance serves as an appropriate model for HHS to adopt. The Department notes that it has made certain modifications for purposes of clarity and organization, and a few additional modifications to accommodate particular programmatic needs and purposes.

There are many productive steps that the federal government, either collectively or as individual agencies, can take to help recipients reduce the costs of language services without sacrificing meaningful access for LEP persons. Without these steps, certain smaller recipients of Federal financial assistance may well choose not to participate in federally assisted programs, threatening the critical functions that the programs strive to provide. To that end, the Department plans to continue to provide assistance and guidance in this important area. In addition, HHS plans to work with representatives of state health and social service agencies, hospital associations, medical and dental associations, managed care organizations, and LEP persons to identify and share model plans, examples of best practices, and cost-saving approaches. Moreover, HHS intends to explore how language assistance measures, resources and cost-containment approaches developed with respect to its own federally conducted programs and activities can be effectively shared or otherwise made available to recipients, particularly small businesses, small local governments, and small non-profits. An interagency working group on LEP has developed a Web site, *http://www.lep.gov*, to assist in disseminating this information to recipients, federal agencies, and the communities being served.

As discussed earlier, in certain circumstances, the failure to ensure that LEP persons can effectively participate in, or benefit from, federally-assisted programs and activities may violate the prohibition under Title VI of the Civil Rights Act of 1964, 42 U.S.C. 2000d, and the Title VI regulations against national origin discrimination. Specifically, the failure of a recipient of Federal financial assistance from HHS to take reasonable steps to provide LEP persons with meaningful opportunity to participate in HHS-funded programs may constitute a violation of Title VI and HHS's implementing regulations. The purpose of this policy guidance is to assist recipients in fulfilling their responsibilities to provide meaningful access to LEP persons under existing law. This policy guidance clarifies existing legal requirements for LEP persons by providing a description of the factors recipients should consider in fulfilling their responsibilities to LEP persons.[2] These are the same criteria HHS will use in evaluating whether recipients are in compliance with Title VI and the Title VI regulations.

III. Who Is Covered?

Department of Health and Human Services regulations, 45 CFR 80.3(b)(2), require all recipients of federal financial assistance from HHS to provide meaningful access to LEP persons.[3] Federal financial assistance includes grants, training, use of equipment, donations of surplus property, and other assistance.

Recipients of HHS assistance may include, for example:

- Hospitals, nursing homes, home health agencies, and managed care organizations.
- Universities and other entities with health or social service research programs.
- State, county, and local health agencies.
- State Medicaid agencies.
- State, county and local welfare agencies.
- Programs for families, youth, and children.
- Head Start programs.
- Public and private contractors, subcontractors and vendors.
- Physicians and other providers who receive Federal financial assistance from HHS.

Recipients of HHS assistance do not include, for example, providers who only receive Medicare Part B payments.[4]

Subrecipients likewise are covered when federal funds are passed through from one recipient to a subrecipient.

Coverage extends to a recipient's entire program or activity, *i.e.*, to all parts of a recipient's operations. This is true even if only one part of the recipient receives the federal assistance.[5]

Example: HHS provides assistance to a state department of health to provide immunizations for children. All of the operations of the entire state department of health—not just the particular immunization programs—are covered.

Finally, some recipients operate in jurisdictions in which English has been declared the official language. Nonetheless, these recipients continue to be subject to federal non-discrimination requirements, including those applicable to the provision of federally assisted services to persons with limited English proficiency.

IV. Who Is a Limited English Proficient Individual?

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, or ''LEP,'' and may be eligible to receive language assistance with respect to a particular type of service, benefit, or encounter.

Examples of populations likely to include LEP persons who are encountered and/or served by HHS recipients and should be considered when planning language services may include such as those:

- Persons seeking Temporary Assistance for Needy Families (TANF), and other social services.
- Persons seeking health and health-related services.
- Community members seeking to participate in health promotion or awareness activities.
- Persons who encounter the public health system.

[2] The policy guidance is not a regulation but rather a guide. Title VI and its implementing regulations require that recipients take reasonable steps to ensure meaningful access by LEP persons. This guidance provides an analytical framework that recipients may use to determine how best to comply with statutory and regulatory obligations to provide meaningful access to the benefits, services, information, and other important portions of their programs and activities for individuals who are limited English proficient.

[3] Pursuant to Executive Order 13166, the meaningful access requirement of the Title VI regulations and the four-factor analysis set forth in the DOJ LEP Guidance are to apply additionally to the programs and activities of federal agencies, including HHS.

[4] HHS's Title VI regulations do not apply to (i) Any federal financial assistance by way of insurance or guaranty contracts, (ii) the use of any assistance by any individual who is the ultimate beneficiary under any program which receives federal financial assistance, and (iii) any employment practice, under any such program, or any employer, employment agency, or labor organization, except as otherwise described in the Title VI regulations. 45 CFR 80.2.

[5] However, if a federal agency were to decide to terminate federal funds based on noncompliance with Title VI or its implementing regulations, only funds directed to the particular program or activity that is out of compliance could be terminated. 42 U.S.C. 2000d–1.

• Parents and legal guardians of minors eligible for coverage concerning such programs.

V. How Does a Recipient Determine the Extent of Its Obligation To Provide LEP Services?

Recipients are required to take reasonable steps to ensure meaningful access to their programs and activities by LEP persons. While designed to be a flexible and fact-dependent standard, the starting point is an individualized assessment that balances the following four factors: (1) The number or proportion of LEP persons eligible to be served or likely to be encountered by the program or grantee; (2) the frequency with which LEP individuals come in contact with the program; (3) the nature and importance of the program, activity, or service provided by the program to people's lives; and (4) the resources available to the grantee/recipient and costs. As indicated above, the intent of this guidance is to suggest a balance that ensures meaningful access by LEP persons to critical services while not imposing undue burdens on small business, small local governments, or small nonprofits.

After applying the above four-factor analysis, a recipient may conclude that different language assistance measures are sufficient for the different types of programs or activities in which it engages, or, in fact, that, in certain circumstances, recipient-provided language services are not necessary. (As discussed below, recipients may want to consider documenting their application of the four-factor test to the services they provide.) For instance, some of a recipient's activities will be more important than others and/or have greater impact on or contact with LEP persons, and thus may require more in the way of language assistance. The flexibility that recipients have in addressing the needs of the LEP populations they serve does not diminish, and should not be used to minimize, the obligation that those needs be addressed. HHS recipients should apply the following four factors to the various kinds of contacts that they have with the public to assess language needs and decide what reasonable steps, if any, they should take to ensure meaningful access for LEP persons.

(1) The Number or Proportion of LEP Persons Served or Encountered in the Eligible Service Population

One factor in determining what language services recipients should provide is the number or proportion of LEP persons from a particular language group served or encountered in the eligible service population. The greater the number or proportion of these LEP persons, the more likely language services are needed. Ordinarily, persons ''eligible to be served, or likely to be directly affected, by'' a recipient's program or activity are those who are served or encountered in the eligible service population. This population will be program-specific, and includes persons who are in the geographic area that has been approved by a federal grant agency as the recipient's service area. However, where, for instance, a particular office of the county or city health department serves a large LEP population, the appropriate service area is most likely that office, and not the entire population served by the department. Where no service area has previously been approved, the relevant service area may be that which is approved by state or local authorities or designated by the recipient itself, provided that these designations do not themselves discriminatorily exclude certain populations. When considering the number or proportion of LEP individuals in a service area, recipients should consider whether the minor children their programs serve have LEP parent(s) or guardian(s) with whom the recipient may need to interact.

Recipients should first examine their prior experiences with LEP encounters and determine the breadth and scope of language services that were needed. In certain circumstances, it is important in conducting this analysis to include language minority populations that are eligible for their programs or activities but may be underserved because of existing language barriers. Other data should be consulted when appropriate to refine or validate a recipient's prior experience, including the latest census data for the area served, data from school systems and from community organizations, and data from state and local governments.[6] Community agencies, school systems, religious organizations, legal aid entities, and others can often assist in identifying populations which may be underserved because of existing language barriers and who would benefit from the recipient's program, activity, or service, were language services provided.

(2) The Frequency With Which LEP Individuals Come in Contact With the Recipient's Program, Activity or Service

Recipients should assess, as accurately as possible, the frequency with which they have or should have contact with an LEP individual from different language groups seeking assistance. The more frequent the contact with a particular language group, the more likely that enhanced language services in that language are needed. The steps that are reasonable for a recipient that serves an LEP person on a one-time basis will be very different than those expected from a recipient that serves LEP persons daily. It is also advisable to consider the frequency of different types of language contacts. For example, frequent contacts with Spanish-speaking people who are LEP may require certain assistance in Spanish. Less frequent contact with different language groups may suggest a different and less intensified solution. If an LEP individual accesses a recipient's program, activity, or service on a daily basis, a recipient has greater duties than if an LEP individual's contact with the recipient's program, activity, or service is unpredictable or infrequent. But even recipients that serve LEP persons on an unpredictable or infrequent basis should use this balancing analysis to determine what to do if an LEP individual seeks services under the program in question. This plan need not be intricate. It may be as simple as being prepared to use one of the commercially available telephonic interpretation services to obtain immediate interpreter services. For example, a drug treatment program that encounters LEP persons on a daily basis most likely may have a greater obligation than a drug treatment program that encounters LEP persons sporadically. The obligations of both programs are greater than that of a drug treatment program which has never encountered a LEP individual where the service area includes few or no LEP individuals.

In applying this standard, certain recipients should take care to consider whether appropriate outreach to LEP persons could increase the frequency of contact with LEP language groups. For example, in areas where a community health center serves a large LEP population, outreach may be appropriate. On the other hand, for most individual physicians or dentists, outreach may not be necessary.

[6] The focus of the analysis is on lack of English proficiency, not the ability to speak more than one language. Note that demographic data may indicate the most frequently spoken languages other than English and the percentage of people who speak that language who speak or understand English less than well. Some of the most commonly spoken languages other than English may be spoken by people who are also overwhelmingly proficient in English. Thus, they may not be the languages spoken most frequently by limited English proficient individuals. When using demographic data, it is important to focus in on the languages spoken by those who are not proficient in English.

(3) The Nature and Importance of the Recipient's Program, Activity, or Service

The more important the recipient's activity, information, service, or program, or the greater the possible consequences of the contact to the LEP individuals, the more likely language services are needed. A recipient needs to determine whether denial or delay of access to services or information could have serious or even life-threatening implications for the LEP individual. Thus, the recipient should consider the importance and urgency of its program, activity, or service. If the activity is both important and urgent—such as the communication of information concerning emergency surgery and the obtaining of informed consent prior to such surgery—it is more likely that relatively immediate language services are needed. Alternatively, if the activity is important, but not urgent—such as the communication of information about, and obtaining informed consent for, elective surgery where delay will not have any adverse impact on the patient's health, or communication of information regarding admission to the hospital for tests where delay would not affect the patient's health—it is more likely that language services are needed, but that such services can be delayed for a reasonable period of time. Finally, if an activity is neither important nor urgent—such as a general public tour of a facility—it is more likely that language services would not be needed. The obligation to communicate rights to a person whose benefits are being terminated or to provide medical services to an LEP person who is ill differ, for example, from those to provide medical care for a healthy LEP person or to provide recreational programming.

Decisions by a federal, state, or local entity to make an activity compulsory, such as job search programs in welfare to work programs, can serve as strong evidence of the program's importance.

(4) The Resources Available to the Recipient and Costs

A recipient's level of resources and the costs that would be imposed on it may have an impact on the nature of the steps it should take to comply with Title VI. Smaller recipients with more limited budgets are not expected to provide the same level of language services as larger recipients with larger budgets. In addition, reasonable steps may cease to be ''reasonable'' where the costs imposed substantially exceed the benefits.

Resource and cost issues, however, can often be reduced by technological advances; the sharing of language assistance materials and services among and between recipients, advocacy groups, and Federal grant agencies; and reasonable business practices. Where appropriate, training bilingual staff to act as interpreters and translators, information sharing through industry groups, telephonic and video conferencing interpretation services, pooling resources and standardizing documents to reduce translation needs, using qualified translators and interpreters to ensure that documents need not be ''fixed'' later and that inaccurate interpretations do not cause delay or other costs, centralizing interpreter and translator services to achieve economies of scale, or the formalized use of qualified community volunteers, for example, may help reduce costs.[7] Recipients should carefully explore the most cost-effective means of delivering competent and accurate language services before limiting services due to resource concerns. Large entities and those entities serving a significant number or proportion of LEP persons should ensure that their resource limitations are well-substantiated before using this factor as a reason to limit language assistance. Such recipients may find it useful to be able to articulate, through documentation or in some other reasonable manner, their process for determining that language services would be limited based on resources or costs.

* * * * *

This four-factor analysis necessarily implicates the ''mix'' of LEP services required. Recipients have two main ways to provide language services: Oral interpretation either in person or via telephone interpretation service (hereinafter ''interpretation'') and written translation (hereinafter ''translation''). Oral interpretation can range from on-site interpreters for critical services provided to a high volume of LEP persons, to access through commercially-available telephonic interpretation services. Written translation, likewise, can range from translation of an entire document to translation of a short description of the document. In some cases, language services should be made available on an expedited basis while in others the LEP individual may be referred to another office of the recipient—or to another recipient—for language assistance. In certain circumstances, pursuant to an arrangement, where there is no discriminatory intent, the purpose is beneficial and will result in better access for LEP persons, it may be appropriate for a recipient to refer the LEP beneficiary to another recipient. For example, if two physicians in the same field, one with a Spanish-speaking assistant and one with a Vietnamese-speaking assistant, practice in the same geographic area and have a custom/practice of referring patients between each other, it may be appropriate for the first doctor to refer LEP Vietnamese patients to the second doctor and for the second doctor to refer LEP Spanish patients to the first doctor. In certain circumstances, a referral would not be appropriate: for example, a Korean speaking LEP woman comes to a battered women's shelter requesting assistance. Although the shelter has space, it has no arrangement to provide language assistance for LEP persons. Instead, as with all LEP persons, the staff only offer her a prepared list of three shelters in the neighborhood that generally provide language assistance. The staff does not check to assure that any of the three alternative shelters can actually provide the Korean language assistance she needs, or that any have space available for her.

The correct mix should be based on what is both necessary and reasonable in light of the four-factor analysis. In some circumstances, where the importance and nature of the activity, the number or proportion and frequency of contact with LEP persons may be high and the relative costs and resources needed to provide language services may be low, it may be appropriate for a recipient to hire bilingual staff or staff interpreters. In contrast, there may be circumstances where the importance and nature of the activity and number or proportion and frequency of contact with LEP persons may be low and the costs and resources needed to provide language services may be high, in which case language services for the particular activity may not be necessary. In situations that fall in between the two, it may be appropriate for recipients to use contract interpreters or telephone language lines to provide language services to LEP persons in contact with their program or activity. A hospital emergency room in a city with a significant Hmong population may need immediately available oral interpreters and may want to give serious consideration to hiring some bilingual staff. (Of course, many hospitals have already made such arrangements.) On the other hand, a physician's practice which encounters one LEP Hmong patient per month on a walk-in basis

[7] Recipients with limited resources may find that entering into a bulk telephonic interpretation service contract will prove cost effective.

may want to use a telephone interpreter service. In contrast, a dentist in an almost exclusively English-speaking neighborhood who has rarely encountered a patient who did not speak English and has never encountered a Hmong-speaking patient may not need, pursuant solely to Title VI, to provide language services for a LEP Hmong individual who comes in for a dental cleaning.

VI. Selecting Language Assistance Services

Recipients have two main ways to provide language services: oral and written language services (interpretation and translation, respectively). Regardless of the type of language service provided, quality and accuracy of those services is critical to avoid serious consequences to the LEP person and to the recipient. Recipients have substantial flexibility in determining the appropriate mix.

A. Considerations Relating to Competency of Interpreters and Translators

Competence of Interpreters. Recipients should be aware that competency requires more than self-identification as bilingual. Some bilingual staff and community volunteers, for instance, may be able to communicate effectively in a different language when communicating information directly in that language, but not be competent to interpret in and out of English. Likewise, they may not be able to perform written translations.

Competency to interpret, however, does not necessarily mean formal certification as an interpreter, although certification is helpful. When using interpreters, recipients should take reasonable steps, given the circumstances, to assess whether the interpreters:

Demonstrate proficiency in and ability to communicate information accurately in both English and in the other language and identify and employ the appropriate mode of interpreting (*e.g.,* consecutive, simultaneous, summarization, or sight translation);

To the extent necessary for communication between the recipient or its staff and the LEP person, have knowledge in both languages of any specialized terms or concepts peculiar to the recipient's program or activity and of any particularized vocabulary and phraseology used by the LEP as the recipient employee for whom they are interpreting and/or to the extent their position requires;

Understand and adhere to their role as interpreters without deviating into other roles—such as counselor or legal advisor—where such deviation would be inappropriate (particularly in administrative hearings contexts).

Some recipients, such as some state agencies, may have additional self-imposed requirements for interpreters. Where individual rights depend on precise, complete, and accurate interpretation or translations, particularly in the context of administrative proceedings, the use of certified interpreters is strongly encouraged.[9]

While quality and accuracy of language services is critical, the quality and accuracy of language services is nonetheless part of the appropriate mix of LEP services required. The quality and accuracy of language services in a hospital emergency room, for example, should be as high as possible, given the circumstances, while the quality and accuracy of language services in other circumstances need not meet the same exacting standards.

Finally, when interpretation is needed and is reasonable, it should be provided in a timely manner. To be meaningfully effective, language assistance should be timely. While there is no single definition for ''timely'' applicable to all types of interactions at all times by all types of recipients, one clear guide is that the language assistance should be provided at a time and place that avoids the effective denial of the service, benefit, or right at issue or the imposition of an undue burden on or delay in important rights, benefits, or services to the LEP person. When the timeliness of services is important, and delay would result in the effective denial of a benefit, service, or right, language assistance likely cannot be benefit, or right is not effectively precluded by a reasonable delay, language assistance can likely be delayed for a reasonable period.

For example, language assistance could likely not be delayed in a medical emergency, or when the time period in which an individual has to exercise certain rights is shortly to expire. On the other hand, when an LEP person is seeking a routine medical examination or seeks to apply for certain benefits and has an ample period of time to apply for those benefits, a recipient could likely delay the provision of language services by requesting the LEP person to schedule an appointment at a time during which the recipient would be able to have an appropriate interpreter available.

Competence of Translators. As with oral interpreters, translators of written documents should be competent. Many of the same considerations apply. However, the skill of translating is very different from the skill of interpreting; a person who is a competent interpreter may or may not be competent to translate.

Particularly where legal or other vital documents are being translated, competence can often be achieved by use of certified translators. As noted above, certification or accreditation may not always be possible or necessary. Competence can often be ensured by having a second, independent translator ''check'' the work of the primary translator. Alternatively, one translator can translate the document, and a second, independent translator could translate it back into English to check that the appropriate meaning has been conveyed. This is called ''back translation.''

Translators should understand the expected reading level of the audience and, where appropriate, have fundamental knowledge about the target language group's vocabulary and phraseology. Sometimes direct translation of materials results in a translation that is written at a much more difficult level than the English language version or has no relevant equivalent meaning.[10] Community

Understand and follow confidentiality and impartiality rules to the same extent the recipient employee for whom they are interpreting and/or to the extent their position requires, to maintain confidentiality unless otherwise required by law or authorized by the person; [8]

[8] Many languages have ''regionalisms,'' or differences in usage. For instance, a word that may be understood to mean something in Spanish for someone from Cuba may not be so understood by someone from Mexico. In addition, the interpreter should be aware when languages do not have an appropriate direct interpretation of certain terms and be able to provide the most appropriate interpretation. The interpreter should likely make the recipient aware of the issue, so that the interpreter and recipient can work to develop a consistent and appropriate set of descriptions of these terms in that language that can be used again, when appropriate.

[9] For those languages in which no formal accreditation or certification currently exists, certain recipients may want to consider a formal process for establishing the credentials of the interpreter, or assess whether a particular level of membership in a professional translation association can

provide some indicator of professionalism.

[10] For instance, there may be languages which do not have an appropriate direct translation of some specialized medical terms and the translator should be able to provide an appropriate translation. The translator should likely also make the recipient aware of this. Recipients can then work with translators to develop a consistent and appropriate set of descriptions of these terms in that language that can be used again, when appropriate.
Recipients may find it more effective and less costly if they try to maintain consistency in the words and phrases used to translate terms of art and other

organizations may be able to help consider whether a document is written at a good level for the audience. Likewise, consistency in the words and phrases used to translate terms of art, legal, or other technical concepts helps avoid confusion by LEP individuals and may reduce costs.

While quality and accuracy of translation services is critical, the quality and accuracy of translation services is nonetheless part of the appropriate mix of LEP services required. For instance, to translate nonvital documents that have no legal or other consequence for LEP persons who rely on them, a recipient may use translators that are less skilled than the translators it uses to translate vital documents with legal or other information upon which reliance has important consequences. The permanent nature of written translations, however, imposes additional responsibility on the recipient to take reasonable steps to determine that the quality and accuracy of the translations permit meaningful access by LEP persons.

B. Oral Language Services (Interpretation)

Interpretation is the act of listening to something in one language (source language) and orally translating it into another language (target language). Where interpretation is needed and is reasonable, recipients should consider some or all of the following options for providing competent interpreters in a timely manner:

Hiring Bilingual Staff. When particular languages are encountered often, hiring bilingual staff offers one of the best, and often most economical, options. Recipients can, for example, fill public contact positions, such as social service eligibility workers or hospital emergency room receptionists/workers, with staff who are bilingual and competent to communicate directly with LEP persons in their language. If bilingual staff are also used to interpret between English speakers and LEP persons, or to orally interpret written documents from English into another language, they should be competent in the skill of interpreting. In addition, there may be times when the role of the bilingual employee may conflict with the role of an interpreter (for instance, a bilingual law clerk would probably not be able to perform effectively the role of a child support administrative hearing interpreter and law clerk at the same time, even if the law clerk were a qualified interpreter). Effective management strategies, including any appropriate adjustments in assignments and protocols for using bilingual staff, can ensure that bilingual staff are fully and appropriately utilized. When bilingual staff cannot meet all of the language service obligations of the recipient, the recipient should turn to other options.

Hiring Staff Interpreters. Hiring interpreters may be most helpful where there is a frequent need for interpreting services in one or more languages. Depending on the facts, sometimes it may be necessary and reasonable to provide on-site interpreters to provide accurate and meaningful communication with an LEP person.

Contracting for Interpreters. Contract interpreters may be a cost-effective option when there is no regular need for a particular language skill. In addition to commercial and other private providers, many community-based organizations and mutual assistance associations provide interpretation services for particular languages. Contracting with and providing training regarding the recipient's programs and processes to these organizations can be a cost-effective option for providing language services to LEP persons from those language groups.

Using Telephone Interpreter Lines. Telephone interpreter service lines often offer speedy interpreting assistance in many different languages. While telephone interpreters can be used in numerous situations, they may be particularly appropriate where the mode of communicating with an English proficient person would also be over the phone. Although telephonic interpretation services are useful in many situations, it is important to ensure that, when using such services, the interpreters used are competent to interpret any technical or legal terms specific to a particular program that may be important parts of the conversation. Nuances in language and non-verbal communication can often assist an interpreter and cannot be recognized over the phone. Video teleconferencing, if available, may sometimes help to resolve this issue where necessary. In addition, where documents are being discussed, it may be important to give telephonic interpreters adequate opportunity to review the document prior to the discussion and any logistical problems should be addressed.

Using Community Volunteers. In addition to consideration of bilingual staff, staff interpreters, or contract interpreters (either in-person or by telephone) as options to ensure meaningful access by LEP persons, use of recipient-coordinated community volunteers, working with, for instance, community-based organizations may provide a cost-effective supplemental language assistance strategy under appropriate circumstances. Because such volunteers may have other demands on their time, they may be more useful in providing language access for a recipient's less critical programs and activities where the provision of language services can reasonably be delayed. To the extent the recipient relies on community volunteers, it is often best to use volunteers who are trained in the information or services of the program and can communicate directly with LEP persons in their language. Just as with all interpreters, community volunteers used to interpret between English speakers and LEP persons, or to orally translate documents, should be competent in the skill of interpreting and knowledgeable about applicable confidentiality and impartiality rules. Recipients should consider formal arrangements with community-based organizations that provide volunteers to address these concerns and to help ensure that services are available more regularly.

Use of Family Members or Friends as Interpreters. Some LEP persons may feel more comfortable when a trusted family member or friend acts as an interpreter. However, when a recipient encounters an LEP person attempting to access its services, the recipient should make the LEP person aware that he or she has the option of having the recipient provide an interpreter for him/her without charge, or of using his/her own interpreter. Although recipients should not plan to rely on an LEP person's family members, friends, or other informal interpreters to provide meaningful access to important programs and activities, the recipient should, except as noted below, respect an LEP person's desire to use an interpreter of his or her own choosing (whether a professional interpreter, family member, or friend) in place of the free language services expressly offered by the recipient. However, a recipient may not require an LEP person to use a family member or friend as an interpreter.

In addition, in emergency circumstances that are not reasonably foreseeable, a recipient may not be able to offer free language services, and temporary use of family members or friends as interpreters may be necessary.

technical concepts. Creating or using already-created glossaries of commonly used terms may be useful for LEP persons and translators and cost effective for the recipient. Providing translators with examples of previous translations of similar material by the recipient, other recipients, or federal agencies may be helpful.

However, with proper planning and implementation, recipients should be able to avoid most such situations.

If the LEP person voluntarily chooses to provide his or her own interpreter, a recipient should consider whether making a record of that choice, and of the recipient's offer of assistance, is appropriate.

As with the use of other non-professional interpreters, the recipient may need to consider issues of competence, appropriateness, conflicts of interest, and confidentiality in determining whether it should respect the desire of the LEP person to use an interpreter of his or her own choosing. Recipients should take reasonable steps to ascertain that family, legal guardians, caretakers, and other informal interpreters are not only competent in the circumstances, but are also appropriate in light of the circumstances and subject matter of the program, service or activity, including protection of the recipient's own administrative or enforcement interest in accurate interpretation.

In some circumstances, family members (especially children) or friends may not be competent to provide quality and accurate interpretations. Issues of confidentiality, privacy, or conflict of interest may also arise. LEP individuals may feel uncomfortable revealing or describing sensitive, confidential, or potentially embarrassing medical, law enforcement (*e.g.,* sexual or violent assaults), family, or financial information to a family member, friend, or member of the local community. In addition, such informal interpreters may have a personal connection to the LEP person or an undisclosed conflict of interest, such as the desire to protect themselves or another perpetrator in a domestic violence matter. For these reasons, where the LEP individual has declined the express offer of free language assistance and has chosen to use a family member, friend or other informal interpreter, if a recipient later determines that a family member or friend is not competent or appropriate, the recipient should provide competent interpreter services to the LEP person in place of or, if appropriate, as a supplement to the LEP individual's interpreter. For HHS recipient programs and activities, this is particularly true, for example, in administrative hearings, child or adult protective service investigations, situations in which life, health, safety, or access to important benefits and services are at stake, or when credibility and accuracy are important to protect an individual's rights and access to important services. Where precise, complete, and accurate interpretations or translations of information and/or testimony are critical, or where the competency of the LEP person's interpreter is not established, a recipient may want to consider providing its own, independent interpreter, even if an LEP person wants to use his or her own interpreter as well.

Extra caution should be exercised when the LEP person chooses to use a minor as the interpreter. While the LEP person's decision should be respected, there may be additional issues of competency, confidentiality, or conflict of interest when the choice involves using minor children as interpreters. The recipient should take reasonable steps to ascertain whether the LEP person's choice is voluntary, whether the LEP person is aware of the possible problems if the preferred interpreter is a minor child, and whether the LEP person knows that a competent interpreter could be provided by the recipient at no cost.

Again, while the use of a family member or friend may be appropriate, if that is the choice of the LEP person, the following are examples of where the recipient should provide an interpreter for the LEP individual:

- A woman or child is brought to an emergency room and is seen by an emergency room doctor. The doctor notices the patient's injuries and determines that they are consistent with those seen with victims of abuse or neglect. In such a case, use of the spouse or a parent to interpret for the patient may raise serious issues of conflict of interest and may, thus, be inappropriate.
- A man, accompanied by his wife, visits an eye doctor for an eye examination. The eye doctor offers him an interpreter, but he requests that his wife interpret for him. The eye doctor talks to the wife and determines that she is competent to interpret for her husband during the examination. The wife interprets for her spouse as the examination proceeds, but the doctor discovers that the husband has cataracts that must be removed through surgery. The eye doctor determines that the wife does not understand the terms he is using to explain the diagnosis and, thus, that she is not competent to continue to interpret for her husband. The eye doctor stops the examination and calls an interpreter for the husband. A family member may be appropriate to serve as an interpreter if preferred by the LEP person in situations where the service provided is of a routine nature such as a simple eye examination. However, in a case where the nature of the service becomes more complex, depending on the circumstances, the family member or friend may not be competent to interpret.

C. Written Language Services (Translation)

Translation is the replacement of a written text from one language (source language) into an equivalent written text in another language (target language).

What Documents Should be Translated? After applying the four-factor analysis, a recipient may determine that an effective LEP plan for its particular program or activity includes the translation of vital written materials into the language of each frequently-encountered LEP group eligible to be served and/or likely to be affected by the recipient's program.

Whether or not a document (or the information it solicits) is ''vital'' may depend upon the importance of the program, information, encounter, or service involved, and the consequence to the LEP person if the information in question is not provided accurately or in a timely manner. Where appropriate, recipients are encouraged to create a plan for consistently determining, over time and across their various activities, what documents are ''vital'' to the meaningful access of the LEP populations they serve.

Classifying a document as vital or non-vital is sometimes difficult, especially in the case of outreach materials like brochures or other information on rights and services. Awareness of rights or services is an important part of ''meaningful access.'' Lack of awareness that a particular program, right, or service exists may effectively deny LEP individuals meaningful access. Thus, where a recipient is engaged in community outreach activities in furtherance of its activities, it should regularly assess the needs of the populations frequently encountered or affected by the program or activity to determine whether certain critical outreach materials should be translated. In determining what outreach materials may be most useful to translate, such recipients may want to consider consulting with appropriate community organizations.

Sometimes a document includes both vital and non-vital information. This may be the case when the document is very large. It may also be the case when the title and a phone number for obtaining more information on the contents of the document in frequently-encountered languages other than English is critical, but the document is sent out to the general public and cannot reasonably be translated into many languages. Thus, vital information may include, for instance, the provision

of information in appropriate languages other than English regarding where a LEP person might obtain an interpretation or translation of the document.

Given the foregoing considerations, vital written materials could include, for example:

- Consent and complaint forms.
- Intake forms with the potential for important consequences.
- Written notices of eligibility criteria, rights, denial, loss, or decreases in benefits or services, actions affecting parental custody or child support, and other hearings.
- Notices advising LEP persons of free language assistance.
- Written tests that do not assess English language competency, but test competency for a particular license, job, or skill for which knowing English is not required.
- Applications to participate in a recipient's program or activity or to receive recipient benefits or services.

Nonvital written materials could include:

- Hospital menus.
- Third party documents, forms, or pamphlets distributed by a recipient as a public service.
- For a non-governmental recipient, government documents and forms.
- Large documents such as enrollment handbooks (although vital information contained in large documents may need to be translated).
- General information about the program intended for informational purposes only.

Into What Languages Should Documents be Translated? The languages spoken by the LEP individuals with whom the recipient has contact determine the languages into which vital documents should be translated. A distinction should be made, however, between languages that are frequently encountered by a recipient and less commonly-encountered languages. Some recipients may serve communities in large cities or across the country. They regularly serve LEP persons who speak dozens and sometimes over 100 different languages. To translate all written materials into all of those languages is unrealistic. Although recent technological advances have made it easier for recipients to store and share translated documents, such an undertaking would incur substantial costs and require substantial resources. Nevertheless, well-substantiated claims of lack of resources to translate all vital documents into dozens of languages do not necessarily relieve the recipient of the obligation to translate those documents into at least several of the more frequently-encountered languages and to set benchmarks for continued translations into the remaining languages over time. As a result, the extent of the recipient's obligation to provide written translations of documents should be determined by the recipient on a case-by-case basis, looking at the totality of the circumstances in light of the four-factor analysis. Because translation is usually a one-time expense, consideration should be given to whether the up-front cost of translating a document (as opposed to oral interpretation) should be amortized over the likely lifespan of the document when applying this four-factor analysis.

Safe Harbor. Many recipients would like to ensure with greater certainty that they comply with their Title VI obligations to provide written translations in languages other than English. Paragraphs (a) and (b) outline the circumstances that can provide a ''safe harbor'' for recipients regarding the requirements for translation of written materials. A ''safe harbor'' means that if a recipient provides written translations under these circumstances, such action will be considered strong evidence of compliance with the recipient's written-translation obligations.

The failure to provide written translations under the circumstances outlined in paragraphs (a) and (b) does not mean there is non-compliance. Rather, they provide a common starting point for recipients to consider whether and at what point the importance of the service, benefit, or activity involved; the nature of the information sought; and the number or proportion of LEP persons served call for written translations of commonly-used forms into frequently-encountered languages other than English. Thus, these paragraphs merely provide a guide for recipients that would like greater certainty of compliance than can be provided by a fact-intensive, four-factor analysis.

Example: Even if the safe harbors are not used, if written translation of a certain document(s) would be so burdensome as to defeat the legitimate objectives of its program, the translation of the written materials is not necessary. Other ways of providing meaningful access, such as effective oral interpretation of certain vital documents, may be acceptable under such circumstances.

Safe Harbor. The following actions will be considered strong evidence of compliance with the recipient's written-translation obligations:

(a) The HHS recipient provides written translations of vital documents for each eligible LEP language group that constitutes five percent or 1,000, whichever is less, of the population of persons eligible to be served or likely to be affected or encountered. Translation of other documents, if needed, can be provided orally; or

(b) If there are fewer than 50 persons in a language group that reaches the five percent trigger in (a), the recipient does not translate vital written materials but provides written notice in the primary language of the LEP language group of the right to receive competent oral interpretation of those written materials, free of cost.

These safe harbor provisions apply to the translation of written documents only. They do not affect the requirement to provide meaningful access to LEP individuals through competent oral interpreters where an application of the four factor test leads to the determination that oral language services are needed and are reasonable. Conversely, oral interpretation of documents may not substitute for translation of vital written documents. For example, oral interpretation of the rules of a half-way house or residential treatment center may not substitute for translation of a short document containing the rules of the half-way house or residential treatment center and the consequences of violating those rules.

VII. Elements of Effective Plan on Language Assistance for LEP Persons

If, after completing the four-factor analysis, a recipient determines that it should provide language assistance services, a recipient may develop an implementation plan to address the identified needs of the LEP populations it serves. Such recipients have considerable flexibility in developing this plan. The development and maintenance of a periodically updated written plan on language assistance for LEP persons (''LEP plan'') for use by a recipient's employees who serve or interact with the public could be an appropriate and cost-effective means of documenting compliance with Title VI and providing a framework for the provision of timely and reasonable language assistance. Moreover, such written plans may provide additional benefits to a recipient's managers in the areas of training, administration, planning, and budgeting. These benefits may lead recipients to document in a written LEP plan their language assistance services, and how staff and LEP persons can access those services. Despite these benefits, certain HHS

recipients, such as recipients serving very few LEP persons and recipients with very limited resources, may choose not to develop a written LEP plan. However, the absence of a written LEP plan does not obviate the underlying Title VI obligation to ensure meaningful access by LEP persons to a recipient's program or activities. Accordingly, in the event that a recipient elects not to develop a written plan, it may want to consider alternative and reasonable ways to articulate how it is providing meaningful access in compliance with Title VI. Entities having significant contact with LEP persons, such as schools, religious organizations, community groups, and groups working with new immigrants can be very helpful in providing important input into this planning process from the beginning.

For the recipient who decides to develop a written implementation plan, the following five steps may be helpful in designing such a plan; they are typically part of effective implementation plans.

(1) Identifying LEP Individuals Who Need Language Assistance

The first two factors in the four-factor analysis require an assessment of the number or proportion of LEP individuals eligible to be served or encountered and the frequency of encounters. Similarly, this step of an LEP implementation plan requires recipients to identify LEP persons with whom it has contact.

One way to determine the language of communication is to use language identification cards (or ''I speak cards''), which invite LEP persons to identify their language needs to staff. Such cards, for instance, might say ''I speak Spanish'' in both Spanish and English, ''I speak Vietnamese'' in both English and Vietnamese, etc. To reduce costs of compliance, the federal government has made a set of these cards available on the Internet. The Census Bureau ''I speak card'' can be found and downloaded at *http://www.usdoj.gov/crt/cor/13166.htm,* and accessed at *http://www.lep.gov.* When records are normally kept of past interactions with members of the public, the language of the LEP person can be included as part of the record. In addition to helping employees identify the language of LEP persons they encounter, this process will help in future applications of the first two factors of the four-factor analysis. In addition, posting notices in commonly encountered languages notifying LEP persons of language assistance will encourage them to identify themselves.

(2) Language Assistance Measures

An effective LEP plan would likely include information about the ways in which language assistance will be provided. For instance, recipients may want to include information on at least the following:

- Types of language services available.
- How staff can obtain those services.
- How to respond to LEP callers.
- How to respond to written communications from LEP persons.
- How to respond to LEP individuals who have in-person contact with recipient staff.
- How to ensure competency of interpreters and translation services.

(3) Training Staff

An effective LEP plan would likely include a process for identifying staff who need to be trained regarding the recipient's LEP plan, a process for training them, and the identification of the outcomes of the training. Staff should know their obligations to provide meaningful access to information and services for LEP persons. An effective LEP plan may include training to ensure that:

- Staff know about LEP policies and procedures.
- Staff having contact with the public are trained to work effectively with in-person and telephone interpreters.

Recipients may want to include this training as part of the orientation for new employees. It may be important to take reasonable steps to see to it that all employees in public contact positions are properly trained. Recipients have flexibility in deciding the manner in which the training is provided. The more frequent the contact with LEP persons, the greater the need will be for in-depth training. Staff with little or no contact with LEP persons may only have to be aware of an LEP plan. However, management staff, even if they do not interact regularly with LEP persons, should be fully aware of and understand the plan so they can reinforce its importance and ensure its implementation by staff.

(4) Providing Notice to LEP Persons

An effective LEP plan would likely include a description of the process by which to provide notice of the services that are available to the LEP persons it serves or, to the extent that a service area exists, that reside in its service area and are eligible for services. Once a recipient has decided, based on the four factors, that it will provide language services, it may be important for the recipient to let LEP persons those services are available and that they are free of charge. Recipients should provide this notice in a language LEP persons will understand. Examples of notification that recipients may want to consider include:

- Posting signs in intake areas and other entry points. When language assistance is needed to ensure meaningful access to information and services, it is important to provide notice in appropriate languages in intake areas or initial points of contact so that LEP persons can learn how to access those language services. This is particularly true in areas with high volumes of LEP persons seeking access to certain health, safety, or public benefits and services, or activities run by HHS recipients. For instance, signs in intake offices could state that free language assistance is available. The signs should be translated into the most common languages encountered. They should explain how to get the language help.[11]
- Stating in outreach documents that language services are available from the recipient. Announcements could be in, for instance, brochures, booklets, and in outreach and recruitment information. These statements should be translated into the most common languages and could be ''tagged'' onto the front of common documents.
- Working with community-based organizations and other stakeholders to inform LEP individuals of the recipients' services, including the availability of language assistance services.
- Using a telephone voice mail menu. The menu could be in the most common languages encountered, and provide information about available language assistance services and how to get them.
- Including notices in local newspapers in languages other than English.
- Providing notices on non-English-language radio and television stations about the available language assistance services and how to get them.
- Presentations and/or notices at schools and religious organizations.

(5) Monitoring and Updating the LEP Plan

An effective LEP plan would likely include a process for a recipient to monitor its implementation of its plan and for updating its plan as necessary. For example, determining, on an ongoing basis, whether new documents,

know that

[11] The Social Security Administration has made such signs available at *http://www.ssa.gov/multilanguage/langlist1.htm,* which also can be accessed at *http://www.lep.gov.* These signs could, for example, be modified for recipient use.

programs, services, and activities need to be made accessible for LEP individuals may be appropriate, and recipients may want to provide notice of any changes in services to the LEP public and to employees. In addition, changes in demographics, types of services, or other needs may require annual reevaluation of an LEP plan. Less frequent reevaluation may be more appropriate where demographics, services, and needs are more static. One good way to evaluate the LEP plan may be to seek feedback from the community.

In their reviews, recipients may want to consider assessing changes in:

- Current LEP populations in service area or population affected or encountered.
- Frequency of encounters with LEP language groups.
- Nature and importance of activities to LEP persons.
- Availability of resources, including technological advances and sources of additional resources, and the costs imposed.
- Whether existing assistance is meeting the needs of LEP persons.
- Whether staff knows and understands the LEP plan and how to implement it.
- Whether identified sources for assistance are still available and viable.

In addition to these five elements, effective plans set clear goals and establish management accountability. Some recipients may also want to consider whether they should provide opportunities for community input and planning throughout the process.

VIII. Voluntary Compliance Effort

The goal for Title VI and Title VI regulatory enforcement is to achieve voluntary compliance. The requirement to provide meaningful access to LEP persons is enforced and implemented by the HHS Office for Civil Rights through the procedures identified in the Title VI regulations. These procedures include complaint investigations, compliance reviews, efforts to secure voluntary compliance, and technical assistance.

The Office for Civil Rights, and the entire Department, are committed to assisting recipients of HHS financial assistance in complying with their obligations under Title VI of the Civil Rights Act of 1964. HHS believes that, on the whole, its recipients genuinely desire to comply with their obligations, but that some may lack knowledge of what is required of them or information concerning the resources that are available to them that would assist in meeting their Title VI obligations. Accordingly, HHS is committed to engaging in outreach to its recipients and to being responsive to inquiries from its recipients. Through its Administration on Children and Families, Administration on Health Care Quality and Research, Administration on Aging, Centers for Medicare and Medicaid Services, Health Resources Services Administration, Office for Civil Rights, and Office of Minority Health, HHS provides a variety of practical technical assistance to recipients to assist them in serving LEP persons. This technical assistance includes translated forms and vital documents; training and information about best practices; and grants and model demonstration funds for LEP services. HHS also provides a variety of services for LEP persons who come in contact with the Department. These services include oral language assistance services such as language lines and interpreters, translation of written materials, and foreign language Web sites.

Further, HHS is committed to working with representatives of state and local health and social service agencies, organizations of such agencies, hospital associations, medical and dental associations and managed care organization to identify and share model plans, examples of best practices, cost-saving approaches, and information on other available resources, and to mobilize these organizations, to educate their members on these matters.

HHS continues to explore how it can share with its recipients language assistance measures, resources, cost-containment approaches, and other information and knowledge, developed with respect to its own federally conducted programs and activities, and welcomes suggestions and comments in this regard. The HHS Office for Civil Rights, in conjunction with other HHS components, through direct contact and its Web site at *http://www.hhs/gov/ocr,* will continue to provide technical assistance that assists HHS recipients in understanding and complying with their obligations under Title VI, and assists recipients and the public by identifying resources offered by the Office for Civil Rights and other HHS components that facilitate compliance with Title VI, with respect to LEP persons. This and other helpful information may also be accessed at *http://www.lep.gov.*

The Title VI regulations provide that HHS will investigate whenever it receives a complaint, report, or other information that alleges or indicates possible noncompliance with Title VI or its regulations. If the investigation results in a finding of compliance, HHS will inform the recipient in writing of this determination, including the basis for the determination. However, if a case is fully investigated and results in a finding of noncompliance, HHS must inform the recipient of the noncompliance through a Letter of Findings that sets out the areas of noncompliance and the steps that must be taken to correct the noncompliance. It must attempt to secure voluntary compliance through informal means. If the matter cannot be resolved informally, HHS must secure compliance through the termination of federal assistance after the HHS recipient has been given an opportunity for an administrative hearing and/or by referring the matter to DOJ to seek injunctive relief or pursue other enforcement proceedings. HHS engages in voluntary compliance efforts and provides technical assistance to recipients at all stages of an investigation. During these efforts, HHS proposes reasonable timetables for achieving compliance and consults with and assists recipients in exploring cost-effective ways of coming into compliance. In determining a recipient's compliance with the Title VI regulations, HHS's primary concern is to ensure that the recipient's policies and procedures provide meaningful access for LEP persons to the recipient's programs and activities.

While all recipients must work toward building systems that will ensure access for LEP individuals, HHS acknowledges that the implementation of a comprehensive system to serve LEP individuals is a process and that a system will evolve over time as it is implemented and periodically reevaluated. As recipients take reasonable steps to provide meaningful access to federally assisted programs and activities for LEP persons, HHS will look favorably on intermediate steps recipients take that are consistent with this Guidance, and that, as part of a broader implementation plan or schedule, move their service delivery system toward providing full access to LEP persons. This does not excuse noncompliance with Title VI, but instead recognizes that full compliance in all areas of a recipient's activities and for all potential language minority groups may reasonably require a series of implementing actions over a period of time. However, in developing any phased implementation schedule, HHS recipients should ensure that the provision of appropriate assistance for significant LEP populations or with respect to activities having a significant impact on the health, safety, legal rights, or livelihood of beneficiaries is addressed first. Recipients are

encouraged to document their efforts to provide LEP persons with meaningful access to federally assisted programs and activities.

Appendix A

Questions and Answers Regarding the Department of Health and Human Services Guidance to Federal Financial Assistance Recipients Regarding the Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons

1. Q. What is the purpose of the guidance on language access released by the Department of Health and Human Services (HHS)?

A. The purpose of the Policy Guidance is to clarify to members of the public, and to providers of health and social services who receive Federal financial assistance from HHS, the responsibility of such providers to Limited English Proficient (LEP) persons, pursuant to Title VI of the Civil Rights Act of 1964. Among other things, this guidance clarifies existing legal requirements by providing a description of the factors providers of health and social services who receive Federal financial assistance from HHS should consider in determining and fulfilling their responsibilities to LEP persons under Title VI.

2. Q. What does the policy guidance do?

A. The policy guidance does the following:

• Reiterates the principles of Title VI with respect to LEP persons.

• Discusses the reasonable policies, procedures and other steps that recipients can take to ensure meaningful access to their program by LEP persons.

• Clarifies that failure to take one or more of these steps does not necessarily mean noncompliance with Title VI.

• Explains to recipients of Federal financial assistance that OCR will determine compliance on a case by case basis, in light of the following four factors: (1) The number or proportion of LEP persons eligible to be served or likely to be encountered by the program, activity or service provided by the recipient; (2) the frequency with which LEP individuals come in contact with the recipient's program, activity or service; (3) the nature and importance of the recipient's program, activity, or service; and (4) the resources available to the recipient and costs.

• Provides that, based on these four factors, recipients with limited resources will not have the same compliance responsibilities applicable to recipients with greater resources. All recipients will have a great deal of flexibility in achieving compliance.

• Provides that OCR will offer extensive technical assistance for recipients.

3. Q. Does the guidance impose new requirements on recipients?

A. No. Since its enactment, Title VI of the Civil Rights Act of 1964 has prohibited discrimination on the basis of race, color or national origin in any program or activity that receives Federal financial assistance. Title VI requires that recipients take reasonable steps to ensure meaningful access to their programs and activities by LEP persons. Over the past three decades, OCR has conducted thousands of investigations and reviews involving language differences that affect the access of LEP persons to medical care and social services. This guidance synthesizes the legal requirements that OCR has been enforcing for over three decades.

4. Q. Who is covered by the guidance?

A. Covered entities include any state or local agency, private institution or organization, or any public or private individual that (1) Operates, provides or engages in health, or social service programs and activities, and (2) receives Federal financial assistance from HHS directly or through another recipient/covered entity. Examples of covered entities include but are not limited to the following entities, which may receive federal financial assistance: hospitals, nursing homes, home health agencies, managed care organizations, universities and other entities with health or social service research programs; state, county and local health agencies; state Medicaid agencies; state, county and local welfare agencies; federally-funded programs for families, youth and children; Head Start programs; public and private contractors, subcontractors and vendors; physicians; and other providers who receive Federal financial assistance from HHS.

5. Q. How does the guidance affect small practitioners and providers who are recipients of federal financial assistance?

A. Small practitioners and providers will have considerable flexibility in determining precisely how to fulfill their obligations to take reasonable steps to ensure meaningful access for persons with limited English proficiency. OCR will assess compliance on a case by case basis and will take into account the following factors: (1) The number or proportion of LEP persons eligible to be served or likely to be encountered by the recipient's program, activity or service; (2) the frequency with which LEP individuals come in contact with the program, activity or service; (3) the nature and importance of the program, activity, or service provided by the recipient; and (4) the resources available to the recipient and costs. There is no ''one size fits all'' solution for Title VI compliance with respect to LEP persons, and what constitutes ''reasonable steps'' for large providers may not be reasonable where small providers are concerned. Thus, smaller recipients with smaller budgets will not be expected to provide the same level of language services as larger recipients with larger budgets. OCR will continue to be available to provide technical assistance to HHS recipients, including sole practitioners and other small recipients, seeking to operate an effective language assistance program and to comply with Title VI.

6. Q. The guidance identifies some specific circumstances which OCR will consider to be strong evidence that a program is in compliance with its obligation under Title VI to provide written materials in languages other than English. Does this mean that a recipient/covered entity will be considered out of compliance with Title VI if its program does not fall within these circumstances?

A. No. The circumstances outlined in the guidance are intended to identify circumstances which amount to a ''safe harbor'' for recipients who desire greater certainty with respect to their obligations to provide written translations. This means that if a recipient provides written translations under these circumstances, such action will be considered strong evidence of compliance with the recipient's written-translation obligations. However, the failure to provide written translations under the circumstances outlined in the ''safe harbor''does not mean there is non-compliance. Rather, the safe harbor provides a tool which recipients may use to consider whether the number or proportion of LEP persons served call for written translations of vital documents into frequently encountered languages other than English. However, even if the safe harbors are not used, if written translation of certain documents would be so financially burdensome as to defeat the legitimate objectives of its program, the translation of the written materials is not necessary. Other ways of providing meaningful access, such as effective oral interpretation of certain vital documents, might be acceptable under such circumstances when, upon application of the four factors, translation services are required.

7. Q. The guidance makes reference to ''vital documents'' and notes that, in certain circumstances, a recipient/covered entity may have to translate such documents into other languages. What is a vital document?

A. As clarified by the guidance, the extent of Title VI obligations will be evaluated based on a four-factor test including the nature or importance of the service. In this regard, the guidance points out that documents deemed ''vital'' to the access of LEP persons to programs and services may often have to be translated. Whether or not a document (or the information it contains or solicits) is ''vital'' may depend upon the importance of the program, information, encounter, or service involved, and the consequence to the LEP person if the information in question is not provided accurately or in a timely manner. Where appropriate, recipients are encouraged to create a plan for consistently determining, over time and across their various activities, what documents are ''vital'' to the meaningful access of the LEP populations they serve. Thus, vital documents could include, for instance, consent and complaint forms, intake forms with potential for important health consequences, written notices of eligibility criteria, rights, denial, loss, or decreases in benefits or services, actions affecting parental custody or child support, and other hearings, notices advising LEP persons of free language assistance, written tests that do not assess English language competency, but test competency for a particular license, job or skill for which knowing English is not required, or applications to participate in a recipient's program or activity or to receive recipient benefits or services.

8. Q. Will recipient/covered entities have to translate large documents such as managed care enrollment handbooks?

A. Not necessarily. Some large documents may contain no vital information, and others will contain vital information that will have to be translated. Again, the obligation to

translate will depend on application of the four factors. In this context, vital information may include, for instance, the provision of information in appropriate languages other than English, or identifying where a LEP person might obtain an interpretation or translation of the document. However, depending on the circumstances, large documents such as enrollment handbooks may not need to be translated or may not need to be translated in their entirety.

9. Q. May an LEP person use a family member or friend as his or her interpreter?

A. Some LEP persons may feel more comfortable when a trusted family member or friend acts as an interpreter. When an LEP person attempts to access the services of a recipient of federal financial assistance, who upon application of the four factors is required to provide an interpreter, the recipient should make the LEP person aware that he or she has the option of having the recipient provide an interpreter for him/her without charge, or of using his/her own interpreter. Recipients should also consider the special circumstances discussed in the guidance that may affect whether a family member or friend should serve as an interpreter, such as whether the situation is an emergency, and concerns over competency, confidentiality, privacy, or conflict of interest.

10. Q. May a recipient/covered entity require a LEP person to use a family member or a friend as his or her interpreter?

A. No.

11. Q. How does low health literacy, non-literacy, non-written languages, blindness and deafness among LEP populations affect the responsibilities of federal fund recipients?

A. Effective communication in any language requires an understanding of the literacy levels of the eligible populations. However, where a LEP individual has a limited understanding of health matters or cannot read, access to the program is complicated by factors not generally directly related to national origin or language and thus is not a Title VI issue. Under these circumstances, a recipient should provide remedial health information to the same extent that it would provide such information to English-speakers. Similarly, a recipient should assist LEP individuals who cannot read in understanding written materials as it would non-literate English-speakers. A non-written language precludes the translation of documents, but does not affect the responsibility of the recipient to communicate the vital information contained in the document or to provide notice of the availability of oral translation. Of course, other law may be implicated in this context. For instance, Section 504 of the Rehabilitation Act of 1973 requires that federal fund recipients provide sign language and oral interpreters for people who have hearing impairments and provide materials in alternative formats such as in large print, braille or on tape for individuals with visual impairments; and the Americans with Disabilities Act imposes similar requirements on health and human service providers.

12. Q. What assistance is available to help to recipients who wish to come into compliance with Title VI?

A. For over three decades, OCR has provided substantial technical assistance to recipient/covered entities who are seeking to ensure that LEP persons can meaningfully access their programs or services. Our regional staff is prepared to work with recipients to help them meet their obligations under Title VI. As part of its technical assistance services, OCR can help identify best practices and successful strategies used by other federal fund recipients, identify sources of federal reimbursement for translation services, and point providers to other resources.

In addition, the entire Department is also committed to assisting recipients of HHS financial assistance in complying with their obligations under Title VI of the Civil Rights Act of 1964. Through its Administration on Children and Families, Administration on Health Care Quality and Research, Administration on Aging, Centers for Medicare and Medicaid Services, Health Resources and Services Administration, Office for Civil Rights, Office of Minority Health and Substance Abuse and Mental Health Services Administration, HHS provides a variety of practical technical assistance to recipients to assist them in serving LEP persons. This technical assistance includes translated forms and vital documents; training and information about best practices; and grants and model demonstration funds for LEP services. HHS believes that, on the whole, its recipients genuinely desire to comply with their obligations, and that increased understanding of compliance responsibilities and knowledge about cost-effective resources that are increasingly available to them, will assist recipients/covered entities in meeting Title VI obligations. Accordingly, HHS is committed to providing outreach to its recipients and to being responsive to queries from its recipients. It is also committed to working with representatives of state and local health and social service agencies, organizations of such agencies, hospital associations, medical and dental associations and managed care organizations to identify and share model plans, examples of best practices, cost-saving approaches, and information on other available resources, and to mobilize these organizations to educate their members on these matters. HHS will continue to promote best practices in language access and fund model demonstration programs in this area. The HHS Office for Civil Rights, in conjunction with other HHS components, will continue to provide technical assistance and outreach to HHS recipients to assist them in understanding and complying with their obligations under Title VI and to provide information to recipients and the public through its Web site at *http://www.hhs/gov/ocr.* LEP information and resources can also be found at *http://www.lep.gov.*

13. Q. How will OCR enforce compliance by recipient/covered entities with the LEP requirements of Title VI?

A. The goal for Title VI and Title VI regulatory enforcement is to achieve voluntary compliance. The requirement to take reasonable steps to provide meaningful access to LEP persons is enforced and implemented by OCR through the procedures identified in the Title VI regulations. These procedures include complaint investigations, compliance reviews, efforts to secure voluntary compliance, and technical assistance.

The Title VI regulations provide that OCR will investigate whenever it receives a complaint, report, or other information that alleges or indicates possible noncompliance with Title VI or its regulations. If the investigation results in a finding of compliance, OCR will inform the recipient in writing of this determination, including the basis for the determination. However, if a case is fully investigated and results in a finding of noncompliance, OCR must inform the recipient of the noncompliance through a Letter of Findings that sets out the areas of noncompliance and the steps that must be taken to correct the noncompliance. It must attempt to secure voluntary compliance through informal means. If the matter cannot be resolved informally, OCR may secure compliance through the termination of federal assistance after the recipient has been given an opportunity for an administrative hearing. OCR may also refer the matter to the Department of Justice to secure compliance through any other means authorized by law.

At all stages of an investigation, OCR engages in voluntary compliance efforts and provides technical assistance to recipients. During these efforts, OCR proposes reasonable timetables for achieving compliance and consults with and assists recipients in exploring cost-effective ways of coming into compliance. In determining a recipient's compliance with the Title VI regulations, OCR's primary concern is to ensure that the recipient's policies and procedures contain reasonable steps to provide meaningful access for LEP persons to the recipient's programs, activities or services. As a result, the vast majority of all complaints have been resolved through such voluntary efforts.

14. Q. Does issuing this guidance mean that OCR will be changing how it enforces compliance with Title VI?

A. No. How OCR enforces Title VI is governed by the Title VI implementing regulations. The methods and procedures used to investigate and resolve complaints, and conduct compliance reviews, have not changed.

15. Q. What is HHS doing to promote access for LEP persons to its own programs and services?

A. HHS provides a variety of services for LEP persons who come in contact with the Department. These services include oral language assistance services such as language lines and interpreters; translation of written materials; and foreign language web sites. HHS will continue to explore how it can share with its recipients language assistance measures, resources, cost-containment approaches, and other information and knowledge, developed with respect to its own federally conducted programs and activities, and welcomes any suggestions in this regard.

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Part III

Administrative, Procedural, and Miscellaneous

26 CFR 31.3504-1: Designation of Agent by Application

Rev. Proc. 2013-39

SECTION 1. PURPOSE

This Revenue Procedure describes and updates the procedure for requesting the IRS authorize a person to act as agent under section 3504 of the Internal Revenue Code (Code) and §31.3504-1 of the Employment Tax Regulations for purposes of Chapters 21, 22, 24, and 25 of the Code. Special instructions are also set forth for agents authorized to perform acts for purposes of Chapter 23 of the Code.

SECTION 2. BACKGROUND

.01 Chapters 21, 22, 23, 24, and 25 of the Code impose obligations on employers with regard to employment taxes. Specifically, Chapter 21 imposes Federal Insurance Contributions Act (FICA) tax, Chapter 22 imposes Railroad Retirement Tax Act (RRTA) tax, Chapter 23 imposes Federal Unemployment Tax Act (FUTA) tax,

Chapter 24 imposes Collection of Income Tax at Source on Wages (income tax withholding), and Chapter 25 provides general provisions relating to employment taxes.

.02 Section 3504 of the Code authorizes the Secretary to promulgate regulations to authorize a fiduciary, agent, or other person ("agent") who has the control of, receives, has custody of, disposes of, or pays the wages of an employee or group of employees, employed by one or more employers, to perform certain specified acts required of employers. Under section 3504, all provisions of law (including penalties) applicable with respect to an employer are applicable to the agent and remain applicable to the employer. Accordingly, both the agent and employer are liable for the employment taxes and penalties associated with the employer's employment tax obligations undertaken by the agent.

.03 Section 31.3504-1(a) as amended by T.D. 9649**,** effective December 12, 2013, provides that the Internal Revenue Service (IRS) may authorize a person who pays, controls, receives, has custody of, or disposes of (collectively "paid") wages or compensation of an employee or group of employees employed by one or more employers as an agent. The regulation provides that applications for authorization to act as agent shall be signed by the agent and employer and made on the form prescribed by the IRS, and shall be filed with the IRS as prescribed in the instructions to the form and other applicable guidance. Generally this authorization is applicable to FICA tax, RRTA tax, and income tax withholding and relevant general employment tax provisions under the Code.

.04 Section 31.3504-1(b) as amended by T.D. 9649**,** effective December 12,

2013, permits an agent authorized for purposes of FICA tax and income tax withholding to perform acts required of an employer who is a home care service recipient to also be authorized for purposes of FUTA tax. Section 31.3504-1(b)(2) defines “home care services” to include health care and personal attendant care services rendered to the home care service recipient. Section 31.3504-1(b)(3) defines a “home care service recipient” as an individual who receives home care services while enrolled, and for the remainder of the calendar year after ceasing to be enrolled, in a program administered by a Federal, state, or local government agency that provides Federal, state, or local government funds to pay, in whole or in part, for home care services for that individual.

.05 Rev. Proc. 70-6, 1970-1 C.B. 420, sets forth procedures to be followed in requesting authorization to act as agent under section 3504 for purposes of FICA tax, RRTA tax, income tax withholding, and general provisions relating to employment tax. It provides that application for authorization should be made in writing by the agent, accompanied by Form 2678, Employer Appointment of Agent, executed by each employer for whom the agent is to act. The agent must file one return for each tax-return period, and maintain records that will disclose the full wages paid to each employee on behalf of, and identified by, each employer for whom the agent acts.

.06 Rev. Proc. 80-4, 1980-1 C.B. 581, sets forth the procedures to be followed by state and local health and welfare agencies wishing to act as agents under section 3504 for welfare recipients who become the employers of individuals furnished by the agencies to provide in-home domestic service for the welfare recipients. It provides that the state or local agency does not need to receive a Form 2678 from each welfare

recipient/employer, so long as its application to the IRS references the document that the welfare recipient/employer filed with the agency appointing the agency as agent. The guidance also provides that when a welfare recipient/employer is liable for FUTA tax, the IRS will interpose no objection if the state or local agency acting as an agent for FICA tax and income tax withholding, also acts as an agent for FUTA tax. However, Rev. Proc. 80-4 does not apply to state and local welfare agencies that contract with outside organizations to provide the in-home domestic services.

.07 Notice 95-18, 1995-1 C.B. 300, provides guidance to household employers on rules regarding federal employment taxes and income tax withholding under section 2 of the Social Security Domestic Employment Reform Act of 1994 (the Act), Pub. L. 103-387. The Act added section 3510 to the Code to provide that returns with respect to domestic service employment taxes be made on a calendar year basis, and amended the FICA provisions of the Code to establish an annual threshold for cash remuneration paid by an employer to an employee for domestic service in a private home of the employer in order to be subject to FICA tax. The notice explains the major changes made by the Act and has a series of questions and answers related to household employers.

Specifically, the notice provides that state and local government health and welfare agencies that act as agents pursuant to Rev. Proc. 80-4 should obtain a separate employer identification number (EIN) for use in reporting taxes with respect to individuals furnished by the agencies to provide household services for recipients of public assistance. It also provides that the IRS will waive penalties for these state and

local government health and welfare agencies for failure to deposit the FICA and FUTA taxes and withheld income taxes on wages paid to household employees during 1995, provided all taxes are deposited on or before the due date of the applicable return.

.08 Notice 2003-70, 2003-2 C.B. 916, proposes a revenue procedure giving updated guidance to state and local government agencies on how they can serve as agents ("state agents") under section 3504 for disabled individuals and other welfare recipients ("service recipients") who employ home-care service providers to assist them in their homes. The notice provides that until a final version of the proposed revenue procedure is issued, the IRS will not challenge the way a state meets the employment tax obligations with respect to home-care service providers employed in its in-home domestic services program if the employment taxes are being timely withheld, reported, and paid, and the procedures for reporting and paying the taxes are based on a reasonable, good faith interpretation of existing guidance, including on positions set forth in the proposed revenue procedure.

Notice 2003-70 proposes to modify Rev. Proc. 80-4 to apply not only to state and local agencies that furnish individuals to provide in-home domestic services, but also to state and local agencies that do not furnish the individuals who provide in-home domestic services. The notice allows the state agent to remit taxes with a timely filed return rather than make deposits according to the schedule that would otherwise be applicable under §31.6302-1. It also allows the service recipient to designate the state agent without having to obtain an EIN as he or she would otherwise be required to do in order to execute a Form 2678.

Notice 2003-70 also provides guidance on withholding and reporting rules for third parties acting either as a “reporting agent” of the state agent or as a “subagent” of the state agent. The notice explains that a reporting agent is an accounting service, franchiser, bank, service bureau or other entity authorized to perform one or more acts on behalf of an employer, including sign and file Forms 940, Employer’s Annual Federal Unemployment Tax Act (FUTA) Return, and 941, Employer’s QUARTERLY Federal Tax Return, and make federal tax deposits for the taxes reported on these forms. The notice defines a subagent as an individual or entity designated as an agent by a state agent in accordance with Rev. Proc. 70-6 and the notice. Notice 2003-70 provides that both a reporting agent and subagent of a state agent should use the special EIN of the state agent, and file one Form 940 using the name and special EIN of the state agent on behalf of all service recipients for whom it acts. The notice allows the reporting agent of the state agent to remit taxes with a timely filed return. The subagent of the state agent must follow the deposit schedule in §31.6302-1 that is otherwise applicable.

.09 The purpose of this revenue procedure is to update and consolidate the previously issued guidance discussed in this section and incorporate recently finalized rules related to home care service recipients (HCSRs). The updates to the prior guidance principally reflect changes already implemented in IRS administrative processes. For example, the IRS no longer requires an application for authorization to act as agent to accompany Form 2678. Also, Form 941-X, Adjusted Employer’s QUARTERLY Federal Tax Return or Claim for Refund, has replaced Form 941c, Supporting Statement To Correct Information, for correcting wages, and since 2010,

agents have been required to attach allocation schedules to their aggregate returns. Other changes that modify current procedures are noted.

.10 The term “wages” as used in this revenue procedure shall be construed to include compensation under the RRTA unless the context indicates otherwise.

SECTION 3. GENERAL RULES TO REQUEST AUTHORIZATION TO ACT AS AGENT

.01 To request that the IRS authorize an agent under §31.3504-1 to perform acts required of an employer, the parties must use Form 2678, Employer/Payer Appointment of Agent.

.02 The employer submits a properly executed Form 2678 to the person it wishes to appoint as agent, indicating on Form 2678 the acts for which it seeks to appoint the agent and whether the agent will be appointed with regard to some or all of the employer’s employees. If the employer anticipates paying any wages (such as taxable noncash fringe benefits or bonuses) to any of its employees, the employer must indicate on Form 2678 that the appointment of the agent is only for some of its employees. To accept the appointment, the agent files Form 2678 with the IRS as provided in the form instructions. If either the employer or the person the employer wishes to appoint as agent has not obtained an EIN prior to the filing of the Form 2678, the agent must include a properly executed Form SS-4, Application for Employer Identification Number, with the Form 2678 to request an EIN for the employer or agent as necessary.

.03 If the IRS approves the request, the IRS sends a letter of approval to the agent and employer, except as provided in section 10.03 of this revenue procedure.

The authorization to act as agent is effective on the date indicated in the letter of approval mailed by the IRS.

.04 If the IRS approves the request and the authorization is with respect to all the employer's employees, the employer may need to file a final return for any form the agent is authorized to file. Specifically, the employer enters its name and EIN in the spaces provided for the employer and indicates that it is a final return in the manner provided in the form instructions. If the agent was authorized for some employees only (including because the employer was expecting to pay some wages in accordance with section 3.02 of this revenue procedure), the employer does not file a final return, but must continue filing a return with regard to the other employees (or wages). The employer does not file a final return if the employer was not required to file a return prior to the agent's authorization, for example, because the employer had not previously paid wages to any employees.

.05 The provisions of law (including penalties) applicable with respect to an employer that are made applicable to the agent under section 3504 remain applicable to the employer and agent.

SECTION 4. FILING OF RETURNS BY AGENT WITH APPROVED FORM 2678

.01 The agent with an approved Form 2678 is required to file one return for each tax-return period reporting the wages and employment taxes on the wages paid to its employees, and the wages and employment taxes on the wages paid by the agent to the employees of each employer for whom the agent is authorized to act ("aggregate return").

.02 The agent's name and EIN are entered in the spaces provided for the employer on the returns, and the returns are to be executed in accordance with the form instructions.

.03 The agent must complete an allocation schedule and attach it to each aggregate return as described in the form instructions. On the allocation schedule, the agent lists the name and EIN of each employer for whom the agent is authorized to act and allocates the wages, taxes, and payments reported on the aggregate return to each employer. For example, the IRS has designated Schedule R (Form 941), Allocation Schedule for Aggregate Return Filers, as the allocation schedule to attach to an aggregate Form 941. The agent is responsible for maintaining records that show the wages paid by the agent to each employee on behalf of, and identified by, each employer for whom the agent is authorized to act. The employer is responsible for maintaining records that show the wages paid by the agent to its employees. See §§31.6001-1 through 31.6001-5.

.04 The wages paid to an employee are considered with respect to each employer separately, and not in conjunction with the wages paid to the employee by the agent as employer or by the agent on behalf of any other employer, for purposes of any dollar threshold or wage base applicable in determining the employment tax liability.

.05 Generally, the agent furnishes and files one Form W-2, Wage and Tax Statement, for each employee. The agent's EIN is entered in the spaces provided for the employer. The name of the agent, followed by "Agent for (name of employer)," is entered in the space provided for the employer. If the agent (a) is acting as an agent for

two or more employers or is an employer and is acting as an agent for another employer, (b) pays social security wages to an individual on behalf of more than one employer, and (c) the total of the individual's social security wages from these employers is greater than the social security wage base, the agent furnishes and files separate Forms W-2 for the affected employee reflecting the wages paid by each employer.

SECTION 5. DEPOSITS BY AGENT WITH APPROVED FORM 2678

Except as provided in section 10.05 of this revenue procedure, the deposit rules apply to the agent with an approved Form 2678 based on the total employment taxes accumulated by the agent for its own employees and on behalf of all employers for whom the agent is authorized to act. The deposit rules that would have applied to any employer for whom the agent acts, had the agent not been authorized, do not apply to the agent.

SECTION 6. CORRECTIONS OF WAGES BY AGENT WITH APPROVED FORM 2678

Wages erroneously reported by the agent must be corrected by the agent on behalf of the employer using the form that corresponds to the return being corrected. For example, the IRS has designated Form 941-X as the form to correct errors on a previously filed Form 941. The agent attaches an allocation schedule as prescribed in the instructions for the form being filed. The name and EIN of the agent are entered in the spaces provided for the employer as it appeared on the return being corrected. Generally, the agent’s obligation to make the correction is not affected by a subsequent revocation of the authorization as discussed in section 9 of this revenue procedure.

However, an agent may not make corrections after its authorization to act as agent is revoked by the IRS under section 9.02 of this revenue procedure.

SECTION 7. USE OF REPORTING AGENT BY AGENT WITH APPROVED FORM 2678

.01 A reporting agent is an accounting service, franchiser, bank, service bureau, or other entity authorized to perform one or more acts on behalf of a taxpayer. See Rev. Proc. 2012-32, 2012-35 IRB 1, for rules related to reporting agent authorizations and a description of the acts that may be performed by reporting agents. An agent with an approved Form 2678 may designate a reporting agent to sign and file certain employment tax returns and make tax deposits on behalf of the agent.

.02 The reporting agent files only one return on behalf of the agent for each tax return period. The agent's name and EIN, not the reporting agent’s name and EIN, are entered in the spaces provided for the employer on the returns. If the return instructions prescribe an allocation schedule, the reporting agent is required to enter the name and EIN of the agent as shown on the return, and list the name and EIN of each employer for whom the agent is authorized to act in the spaces provided for clients.

.03 The deposit rules that apply to the agent continue to apply with regard to deposits made by the reporting agent.

.04 The agent is responsible for maintaining records that show the wages paid by the agent to each employee on behalf of, and identified by, each employer for whom the agent is authorized to act. The employer is responsible for maintaining records that show the wages paid by the agent to its employees. See §§31.6001-1 through

31.6001-5.

.05 The provisions of law (including penalties) applicable with respect to an employer that are made applicable to the agent under section 3504 remain applicable to the employer and agent.

SECTION 8. USE OF SUBAGENT BY AGENT WITH APPROVED FORM 2678

.01 An agent with an approved Form 2678 ("first agent" for purposes of this section) may want to appoint an agent under section 3504 ("subagent") using the procedures described in section 3 of this revenue procedure.

.02 If the subagent is authorized by the IRS, the rules described in section 4 related to filing of returns apply to the subagent as an agent. For example, the subagent is required to attach Schedule R (Form 941) with its own name and EIN entered as shown on the return, and list the name and EIN of each employer who appointed the first agent, and for whom the subagent is authorized to act, in the spaces provided for clients. Unless the subagent is appointed to deposit, pay, and file on behalf of the first agent in the agent's capacity as employer, the first agent is not listed as a client on Schedule R (Form 941).

.03 The rules described in section 5 of this revenue procedure related to deposits and section 6 of this revenue procedure related to corrections of wages apply to the subagent as an agent.

.04 The subagent and agent are responsible for maintaining records that show the wages paid by the subagent to each employee on behalf of, and identified by, each employer for whom the subagent is authorized to act. The employer is responsible for

maintaining records that show the wages paid by the agent and subagent to its employees. See §§31.6001-1 through 31.6001-5.

.05 The provisions of law (including penalties) applicable with respect to an employer that are made applicable to the subagent and the first agent under section 3504 remain applicable to the employer, first agent, and subagent.

SECTION 9. REVOCATION OF AUTHORIZATION OF AGENT WITH APPROVED FORM 2678

.01 The employer or agent with an approved Form 2678 may request the IRS revoke an existing authorization using Form 2678, executed by the party seeking to revoke the appointment. Except as provided in section 10.07 of this revenue procedure, the IRS confirms the revocation by letter to the agent and employer, and the revocation is effective on the date indicated in the letter mailed by the IRS.

.02 The IRS may independently revoke an existing authorization if the facts and circumstances indicate such revocation is warranted. Except as provided in section 10.07 of this revenue procedure, the revocation is by notice to the agent and employer. The revocation of the authorization is effective when the IRS mails the notice.

.03 An agent files Form 2678 to revoke an authorization if there is no longer an agency relationship, for example, because the employer or agent goes out of business, the employer no longer exists due to a merger or acquisition, the employer is deceased, or the employer appoints another person on Form 2678 to act as agent for the same acts the agent is authorized to perform.

.04 If the agency relationship is being terminated because the employer appoints

another person to act as agent, the agent whose authorization is being revoked is liable to report, deposit, and pay taxes on behalf of the employer with regard to wages it paid during periods for which it was authorized to act as agent of the employer. It remains liable for such employment taxes even after the authorization is revoked as provided in this section.

SECTION 10. SPECIAL RULES FOR AGENTS OF HOME CARE SERVICE RECIPIENTS, INCLUDING FOR STATE AGENTS

.01 Except as otherwise provided in this section, the rules generally applicable to agents and employers described in sections 3, 4, 5, 6, 7, 8, and 9 of this revenue procedure shall apply to a person authorized to act as agent for an employer who is a home care service recipient (HCSR) as defined in §31.3504-1(b)(3). This section also sets forth special rules that apply to state agents. For purposes of this revenue procedure, a state agent is a state or local government agency administering a program to provide home care services, as defined in §31.3504-1(b)(2), which has been authorized by the IRS as agent for a HCSR. Only government agencies can be state agents. Third parties, whether nonprofit or for-profit, that are engaged by a government agency to administer all or some aspects of a home care services program are not state agents for purposes of this revenue procedure.

.02 Section 31.3504-1(b) provides that the IRS may authorize a person to act as agent on behalf of an employer who is a HCSR with respect to FUTA taxes imposed on wages paid for home care services, as defined in §31.3504-1(b)(2), provided that the person has been authorized to act as agent for the HCSR for income tax withholding

and FICA tax purposes under §31.3504-1(a).

.03 The general rules to request authorization to act as agent set forth in section 3 of this revenue procedure apply to request authorization to act as agent for a HCSR, including for FUTA tax purposes, except that the letter mailed by the IRS approving the request will only be sent to the agent. Sections 10.03(1) through 10.03(3), below, provide special rules for state agents when requesting authorization to act as agent of HCSRs.

(1) A state agent may request authorization from the IRS without filing Form 2678 on behalf of each HCSR for whom the state agent seeks to act. In lieu of Form 2678, the state agent may solicit appointment by each HCSR on the forms the individuals must complete in order to enroll in the program administered by the state agent. The state agent submits a letter to the IRS address to which it would have been required to submit the Forms 2678. The letter must reference the forms appointing the state agent and identify each HCSR for whom the state agent wishes to be authorized by either (a) including each HCSR's name and EIN on a list, or (b) including a properly executed Form SS-4 for the HCSR if the HCSR has not previously obtained an EIN, with its letter to the IRS. State agents were not previously required to notify the IRS of the HCSRs for whom they acted; however, notification is now necessary to ensure the IRS' records properly reflect the parties' filing requirements and to ensure the correct taxes are reported and paid by the agent on behalf of each HCSR. The notification procedures apply with respect to each HCSR who enrolls in the program and wishes to appoint the state agent. The state agent must also notify the IRS of each HCSR for

whom its authority to act as agent is revoked.

(2) Because Rev. Proc. 80-4 allowed HCSRs to appoint state agents without filing Form 2678, Notice 2003-70, Q&A 10, provided that HCSRs who appoint state agents do not need to obtain an EIN if an EIN is not required for any other purpose. The IRS now requires all agents to file allocation schedules which show information for each employer, identified by the employer's EIN. Therefore, all HCSRs, including those whose agents were authorized before the effective date of this revenue procedure, must now obtain an EIN so the state agent may fulfill its reporting obligations to the IRS. See also section 6109 and §31.6011(b)-1. As indicated in section 10.03(1) of this revenue procedure, if the HCSR has not previously obtained an EIN, the state agent may assist a HCSR in applying for an EIN by including a properly executed Form SS-4 on behalf of the HCSR with the state agent's request for authorization to act as agent. HCSRs whose agents were authorized before the effective date of this revenue procedure who do not have an EIN must apply for an EIN within a reasonable period of time after the effective date of this revenue procedure.

(3) All state agents should use Form SS-4 to request a special EIN for the state agent to report and pay taxes on behalf of the HCSRs for whom the state agent acts. The application for the special EIN should indicate the state agent is a government entity. The state agent may not use its special EIN to report or pay employment taxes for wages paid for services other than home care services, or for an employer who is not a HCSR.

.04 The filing of return procedures set forth in section 4 of this revenue

procedure apply to agents authorized to act on behalf of a HCSR for any returns the agent is authorized to file. For example, the agent with an approved Form 2678 for FUTA tax purposes files one aggregate Form 940 for each tax-return period reporting the FUTA tax liability related to wages it pays to its employees and to wages it pays for home care services to employees of each HCSR for whom the agent is authorized to act. The IRS has designated Schedule R (Form 940), Allocation Schedule for Aggregate Form 940 Filers, as the allocation schedule to attach to an aggregate Form 940. Sections 10.04(1) through 10.04(3), below, provide special rules for state agents filing returns on behalf of HCSRs.

(1) As indicated in section 10.03(3) of this revenue procedure, state agents should obtain a separate EIN to report and pay employment taxes on behalf of HCSRs. The state agent enters its own name and special EIN in the spaces provided for the employer.

(2) If the state agent designates a reporting agent, the reporting agent must uses the state agent's name and special EIN to report and pay employment taxes on behalf of the HCSRs for whom the state agent is authorized to act.

(3) If the state agent appoints a subagent, the subagent must use its own name and EIN to report and pay employment taxes on behalf of the HCSRs for whom the state agent is authorized to act. Notice 2003-70, Q&A 27 permitted the subagent to use a state agent's special EIN in order to be able to report and pay FUTA taxes on behalf of HCSRs. However, now that §31.3504-1(b) provides that any person, not just a state agent, may be authorized as agent of a HCSR with respect to FUTA taxes owed for

home care services, it is no longer necessary for the subagent to use the state agent's special EIN in order to act as an agent for FUTA tax purposes. Furthermore, because the subagent is subject to normal deposit rules, and the deposit rules that apply to the state agent discussed in section 10.06 of this revenue procedure do not apply to the subagent, the use of the state agent's special EIN by the subagent is not appropriate.

.05 An agent authorized to act on behalf of a HCSR furnishes and files a Form W-2 for each employee on behalf of each HCSR, unless the compensation is excepted from both income tax withholding and FICA tax.

.06 The deposit procedures set forth in section 5 of this revenue procedure apply to an agent authorized to act on behalf of a HCSR for any deposits the agent is required to make. Sections 10.06(1) through 10.06(3), below, provide special rules for state agents when making deposits.

(1) A state agent may remit FICA tax, FUTA tax, and income tax withholding on behalf of a HCSR with a timely filed return, and the IRS will not assess any penalties for failure to deposit timely. Other penalties may apply, for example, if taxes are not paid or if a correct return is not timely filed.

(2) If the state agent uses a reporting agent, the reporting agent may deposit taxes with a timely filed return.

(3) If the state agent uses a subagent, the deposit rules apply to the subagent based on the total taxes accumulated by the subagent for its employees and on behalf of all employers, including HCSRs, for whom it is authorized to act. The deposit rules that would have applied to any employer, or to the state agent, had the subagent not

been appointed, do not apply to the subagent.

.07 The revocation procedures set forth in section 9 of this revenue procedure are generally followed to revoke an appointment of an agent authorized to act on behalf of a HCSR, except that the letter confirming the revocation will only be sent to the agent. Sections 10.07(1) through 10.07(4), below, provide special rules related to revocations for FUTA tax purposes.

(1) Under §31.3504-1(b), the agent may only act for FUTA tax purposes for a HCSR while the HCSR is enrolled, and for the remainder of the calendar year in which he or she ceases to be enrolled, in a government program. If a HCSR ceases to be enrolled in a government program during the year, an agent may report and pay FUTA taxes on behalf of that HCSR either for the entire calendar year, or for a portion of the calendar year, as described in sections 10.07(2) and 10.07(3) below.

(2) The agent may report and pay FUTA taxes on wages it paid for home care services for the HCSR for the entire calendar year in which the HCSR ceases to be enrolled, but not after such year. The agent files a Form 2678 to request the IRS to revoke the authorization with respect to FUTA taxes by the end of the calendar year in which the individual ceases to be a HCSR.

(3) The agent may report and pay FUTA taxes only for the portion of the year it paid wages for home care services for the HCSR. If the agent stops paying wages for home care services for the HCSR before the end of the calendar year, the agent must file a Form 2678 to request the IRS to revoke the authorization for FUTA taxes when the agent stops paying wages or otherwise stops acting as agent with respect to the

HCSR's FUTA taxes.

(4) Under either sections 10.07(2) or 10.07(3), above, the agent may still act as agent with respect to the individual's FICA tax and income tax withholding responsibilities.

SECTION 11. EXAMPLES

The rules provided in this revenue procedure are illustrated by the following examples.

Example 1. *Final return.* Employer B and Agent W complete and file Form 2678 to request the IRS authorize Agent W to file Form 941 with respect to all of Employer B's employees. The IRS approves the authorization effective April 1, 2014. Employer B files a Form 941 for the first quarter of 2014, indicating that it is a final return by checking the appropriate box and entering that it stopped paying wages as of March 31, 2014. For periods beginning on and after April 1, 2014, Agent W pays wages to all of Employer B's employees, makes related employment tax deposits and payments, and reports the wages and taxes on an aggregate Form 941. Agent W attaches Schedule R (Form 941) listing Employer B as a client.

Example 2. *No final return.* Same facts as Example 1, except that Employer B is a new business that has not paid wages to any employees prior to the effective date of the authorization. Therefore, Employer B does not file a final Form 941.

Example 3. *Authorization for some employees.* Employer C and Agent V complete and file Form 2678 to request the IRS authorize Agent V to file Form 941 with respect to some of Employer C's employees. The IRS approves the authorization

effective April 1, 2014. For periods beginning on and after April 1, 2014, Agent V pays wages to some of Employer C's employees, makes related employment tax deposits and payments, and reports the wages and taxes on an aggregate Form 941. Agent V attaches Schedule R (Form 941) listing Employer C as a client. Employer C continues to pay wages for some employees, make related employment tax deposits, and report the wages and taxes on its Form 941.

Example 4. *HCSR and other employer.* Agent Y is authorized to file Form 941 for Employer S and for Employer T, who is a home care service recipient (HCSR) as defined in §31.3504-1(b)(3). Agent Y is also authorized to file Form 940 for Employer T.

Agent Y pays wages to all of Employer S's and Employer T's employees, makes related employment tax deposits and payments, and reports the wages and taxes on an aggregate Form 941. Agent Y attaches Schedule R (Form 941) listing Employer S and Employer T as clients. Agent Y also reports wages and taxes with respect to home care services provided to Employer T on an aggregate Form 940. Agent Y attaches Schedule R (Form 940) listing Employer T as a client. Employer S files Form 940 with respect to wages paid to its employees.

Example 5. *State agent.* State K funds a program to provide home care services to eligible individuals. Department H administers the home care services program, including disbursing the funds to pay for the services. Each of the individuals enrolled in the program is a HCSR, as defined in § 31.3504-1(b)(3).

As part of the enrollment process, each HCSR completes a form to appoint Department H as agent under section 3504 of the Code to file Form 940 and Form 941

for the HCSRs. Department H sends a letter to the IRS stating it is a government agency that wishes to become a state agent. Department H attaches to the letter a sample copy of the form it uses to be appointed by a HCSR, a list of the names and EINs of each HCSR that has appointed Department H as agent, and a Form SS-4 with respect to each HCSR named in its letter that does not have an EIN. Department H also attaches a Form SS-4 to apply for a special EIN for it to use as state agent of the HCSRs enrolled in its home care services program that have appointed Department H as agent. Department H receives a letter from the IRS authorizing it as agent for each HCSR.

Department H pays wages to the HCSR's employees and reports the wages and taxes on an aggregate Form 941, with its name and special EIN entered in the space provided for the employer. Department H attaches Schedule R (Form 941), listing each HCSR as a client. Because Department H is a state agent, it remits payment with its timely filed aggregate Form 941.

Department H also reports wages and taxes with respect to the HCSRs on an aggregate Form 940 with its name and special EIN entered in the space provided for the employer. Department H attaches Schedule R (Form 940), listing each HCSR as a client. Because Department H is a state agent, it remits payment with its timely filed aggregate Form 940.

Example 6. *State agent designates reporting agent.* Same facts as Example 5. The following year (Year 2) Department H designates reporting agent R with respect to HCSRs for whom Department H is authorized as state agent, by following the

procedures described in Rev. Proc. 2012-32. Reporting agent R enters Department H's name and special EIN in the space provided for the employer on the aggregate employment tax returns and on the attached allocation schedules. Reporting agent R lists each HCSR as a client on each allocation schedule. Reporting agent R also remits payment for employment taxes with the timely filed employment tax returns.

Example 7. *State agent appoints subagent.* Same facts as Example 5, except in Year 2, Department H appoints S as its subagent on Form 2678 with respect to the HCSRs for whom Department H is authorized as state agent. The IRS approves the authorization.

Subagent S pays wages to the HCSRs' employees, makes related employment tax deposits and payments, and reports the wages and taxes on an aggregate Form 941, with its name and EIN entered in the space provided for the employer. Subagent S attaches Schedule R (Form 941), listing each HCSR as a client. Subagent S also reports wages and taxes with respect to the HCSRs on an aggregate Form 940 with its name and EIN entered in the space provided for the employer. Subagent S attaches Schedule R (Form 940), listing each HCSR as a client.

Example 8. *Form 940 revocation – end of year.* Individual A, a HCSR as defined in §31.3504-1(b)(3), has only home care service employees. Individual A and Agent X complete and file Form 2678 to request the IRS to authorize Agent X to file Form 941 and Form 940 with respect to the employees providing home care services to Individual A. The IRS approves the authorization effective January 1, 2014.

On July 31, 2014, Individual A ceases to be enrolled in the government program

but continues to receive home care services which Agent X pays for with private funds provided by Individual A. Under §31.3504-1(b)(3), Individual A continues to be a HCSR for the remainder of the calendar year after ceasing to be enrolled in the government program.

Agent X reports the wages and taxes with respect to Individual A for the entire year on an aggregate Form 940. Agent X attaches Schedule R (Form 940) listing Individual A as a client.

The IRS approves Agent X's request, filed on Form 2678, to revoke its authorization to file Form 940 for Individual A, effective December 31, 2014. Agent X remains authorized to file Form 941 for Individual A.

Example 9. *Form 940 revocation – before end of year.* Same facts as Example 8, except that the IRS approves Agent X's request, filed on Form 2678, to revoke its authorization to file Form 940 for Individual A, effective August, 1, 2014.

Agent X reports the wages and taxes accrued with respect to Individual A on or before July 31, 2014, on an aggregate Form 940. Agent X attaches Schedule R (Form 940), listing Individual A as a client. Individual A is responsible for reporting wages and taxes accrued with respect to wages paid for home care services on or after August 1, 2014.

SECTION 12. EFFECT ON OTHER DOCUMENTS

Notice 95-18, 1995-1 C.B. 300, is modified in part. Rev. Proc. 70-6, 1970-1 C.B. 420, Rev. Proc. 80-4, 1980-1 C.B. 581, and Notice 2003-70, 2003-2 C.B. 916, are modified and superseded. This document does not affect authorizations in effect under

Rev. Proc. 70-6, Rev. Proc. 80-4, or by reasonable reliance on Notice 2003-70, as of the effective date of this revenue procedure. However, agents must follow the rules of this revenue procedure after its effective date to make requests for authorization to act as agent and, with regard to all authorizations, to make employment tax payments and deposits, and to file and correct employment tax returns.

SECTION 13. EFFECTIVE DATE

This revenue procedure is effective on and after December 12, 2013.

SECTION 14. DRAFTING INFORMATION

The principal author of this revenue procedure is Michelle R. Weigelt of the Office of Division Counsel/Associate Chief Counsel (Tax Exempt and Government Entities). For further information regarding this revenue procedure contact Michelle R. Weigelt at 202-317-6798 (not a toll free call).

Part III - Administrative, Procedural, and Miscellaneous

Notice 2014-7

PURPOSE

This notice provides that certain payments received by an individual care provider under a state Medicaid Home and Community-Based Services Waiver (Medicaid waiver) program, described in this notice, are difficulty of care payments excludable under § 131 of the Internal Revenue Code.

BACKGROUND

Qualified foster care payments

Section 131(a) excludes qualified foster care payments from the gross income of a foster care provider.

Section 131(b)(1) defines a qualified foster care payment, in part, as any payment under a foster care program of a state or a political subdivision that is either (1) paid to the foster care provider for caring for a qualified foster individual in the foster care provider's home, or (2) a difficulty of care payment.

Section 131(b)(2) defines a qualified foster individual as any individual who is living in a foster family home in which the individual was placed by an agency of a state or political subdivision or by a qualified foster care placement agency.

Section 131(b)(3) defines a qualified foster care placement agency, in part, as a placement agency that is licensed or certified for the foster care program of a state or political subdivision of a state.

Section 131(c) defines a difficulty of care payment as compensation to a foster care provider for the additional care required because the qualified foster individual has a physical, mental, or emotional handicap. The provider must provide the care in the provider's foster family home, a state must determine the need for this compensation, and the payor must designate the compensation for this purpose. In the case of any foster home, difficulty of care payments are not excludable to the extent that the payments are for more than 10 qualified foster individuals who have not attained age 19 or 5 qualified foster individuals who have attained age 19. See § 131(c)(2).

State Medicaid waiver programs

Under § 1915(c) of the Social Security Act (42 U.S.C. § 1396n(c)), a state may obtain a Medicaid waiver that allows the state to include in the state's Medicaid program the cost of home or community-based services (other than room and board) provided to individuals who otherwise would require care in a hospital, nursing facility, or intermediate care facility (eligible individuals). Home or community-based services include personal care services, habilitation services, and other services that are "cost effective and necessary to avoid institutionalization." See 42 C.F.R. § 440.180. Personal care services are defined under rules of the Centers for Medicare and Medicaid Services to include assistance with eating, bathing, dressing, toileting, transferring, maintaining continence, personal hygiene, light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, medication management, and money management. Skilled services that only a health professional may perform are not personal care services. Habilitation services, defined in 42

U.S.C. § 1396n(c)(5)(A), assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings.

Medicaid waiver programs generally do not compensate a family member for providing personal care services to an eligible individual if the family member is legally responsible for the individual (for example, a minor child). See 42 C.F.R. § 440.167(a)(2) and (b). Some states compensate family members, as well as unrelated individual care providers, for residential habilitation, foster/companion care, or transportation services provided as a part of an eligible individual's plan of care. A plan of care is a term defined by the state, but generally means an individualized plan of treatment, services, and/or providers.

A state, directly or indirectly through an agency under contract with the state, certifies individuals and entities as Medicaid providers to provide services to eligible individuals. An entity that is a certified Medicaid provider may contract with an individual care provider to care for an eligible individual in the care provider's home. A state or an agency under contract with the state approves the plan of care for the eligible individual in the provider's home and monitors the eligible individual's care.

State agencies, certified Medicaid provider entities, and individual care providers have asked whether Medicaid waiver payments for the care of eligible individuals, who are related or unrelated to the individual care provider, in the individual care provider's home may be treated as difficulty of care payments excludable under § 131.

Current treatment of government-funded payments for home care

The Service historically has challenged the excludability of payments to individual

care providers caring for related individuals in the provider's home. See *Alexander v. Commissioner*, T.C. Summary Opinion 2011-48, filed April 12, 2011 (Medicaid waiver payments to taxpayers caring for a taxpayer's parents residing in the taxpayers' home are not excludable under § 131 because the taxpayers did not show that they operated a "foster family home" under state law and the parents were not "placed" in the taxpayers' home by the state). See also *Bannon v. Commissioner*, 99 T.C. 59 (1992) (payments received by the taxpayer for caring for her adult disabled daughter residing in the taxpayer's home under a state program for in-home supportive services are not excludable under the general welfare exclusion) and *Harper v. Commissioner*, T.C. Summary Opinion 2011-56, filed May 2, 2011 (following *Bannon*). Similarly, Program Manager Technical Advice (PMTA 2010-007) concludes that a biological parent of a disabled child may not exclude payments under § 131 because the ordinary meaning of foster care excludes care by a biological parent.

Section 131 does not explicitly address whether payments under Medicaid waiver programs are qualified foster care payments. Medicaid waiver programs and state foster care programs, however, share similar oversight and purposes. The purpose of Medicaid waiver programs and the legislative history of § 131 reflect the fact that home care programs prevent the institutionalization of individuals with physical, mental, or emotional handicaps. See 128 Cong. Rec. 26905 (1982) (stating that "[difficulty of care payments] are not income to the [foster] parents, regardless of whether they, dollar for dollar only cover expenses. [These] parents are saving the taxpayers' money by preventing institutionalization of these children."); S. Rep. No. 97-139 at 481 (1981) (describing the purpose of the amendment to 42 U.S.C. section

1396n, allowing Medicaid waivers for home and community-based services, as "[permitting] the Secretary to waive the current definition of covered [M]edicaid services to include certain nonmedical support services, other than room and board, which are provided pursuant to a plan of care to an individual otherwise at risk of being institutionalized and who would, in the absence of such services be institutionalized"). Both programs require state approval and oversight of the care of the individual in the provider's home. The programs share the objective of enabling individuals who otherwise would be institutionalized to live in a family home setting rather than in an institution, and both difficulty of care payments and Medicaid waiver payments compensate for the additional care required.

GUIDANCE

Treatment of qualified Medicaid waiver payments under § 131

To achieve consistent federal tax treatment of Medicaid waiver payments among the states and individual care providers, this notice provides that as of January 3, 2014, the Service will treat qualified Medicaid waiver payments as difficulty of care payments under § 131(c) that are excludable under § 131, and this treatment will apply whether the care provider is related or unrelated to the eligible individual. Accordingly, as of January 3, 2014, the Service will no longer assert the position in PMTA 2010-007, or apply *Alexander*, *Bannon*, or *Harper*, to conclude that a caregiver of a biological relative receiving qualified Medicaid waiver payments may not qualify as a foster care provider under § 131. For purposes of this notice, qualified Medicaid waiver payments are payments made by a state or political subdivision thereof, or an entity that is a certified Medicaid provider, under a Medicaid waiver program to an individual care provider for

nonmedical support services provided under a plan of care to an eligible individual (whether related or unrelated) living in the individual care provider's home.

Section 131(c) defines a difficulty of care payment as compensation to a foster care provider for the additional care required because the qualified foster individual has a physical, mental, or emotional handicap. Qualified Medicaid waiver payments compensate a care provider for providing the additional care required because of an eligible individual's physical, mental, or emotional handicap for which a state has determined that there is a need for additional compensation. Thus, the treatment of qualified Medicaid waiver payments as "difficulty of care payments" is consistent with the definition under § 131(c).

Under § 131, payments are excludable as difficulty of care payments only if the care is provided to a "qualified foster individual," meaning any individual who is living in a "foster family home" in which the individual was "placed" by an agency of a state or a political subdivision thereof, or a qualified foster care placement agency. Section 131(b)(2). The term "foster family home" is not defined under § 131. However, the Tax Court has concluded that, for purposes of § 131, "a person's 'home' is where he resides." See *Stromme v. Commissioner*, 138 T.C. 213, 218 (2012), citing *Dobra v. Commissioner*, 111 T.C. 339 (1998). Therefore, an eligible individual receiving care under a Medicaid waiver program lives in a "foster family home" because the eligible individual is a qualified "foster" individual who receives care in a "family home" setting, as opposed to an institution, where the individual care provider also resides. Medicaid waiver payments made to a provider for care outside of the home where the provider resides are not qualified Medicaid waiver payments and are not excludable under § 131.

Similarly, the term "placed" is not defined in § 131. Under state foster care programs, a state or political subdivision thereof, or a qualified foster care placement agency, may assist in locating a home that meets the qualified foster individual's needs, negotiate or approve the foster care payment rates, and contract with the foster care providers for the provision of foster care. The Tax Court has determined that these activities constitute "placement" for purposes of § 131(b)(2). *Micorescu v. Commissioner*, T.C. Memo 1998-398. States perform similar activities with respect to individuals participating in Medicaid waiver programs. Under a Medicaid waiver program, a state, an agency of a state or political subdivision thereof, or a certified Medicaid provider may assist in locating a home for an eligible individual or approve the eligible individual's choice to reside in the individual care provider's home, approve an eligible individual's plan of care, assess the suitability of the home for fulfilling the eligible individual's plan of care, and enter into a contract or other arrangement with the individual care provider for services provided to the eligible individual. Thus, an eligible individual receiving care in the home of the individual care provider under the Medicaid waiver program will be treated as "placed" by an agency of a state or political subdivision thereof, or a qualified foster care placement agency, for purposes of § 131. Accordingly, an eligible individual receiving care in the individual care provider's home under a Medicaid waiver program is a "qualified foster individual" under § 131(b)(2).

Section 131(d)(2) provides that a provider may not exclude payments for the care of more than 10 eligible individuals under age 19 or more than five eligible individuals who are age 19 or over. Because qualified Medicaid waiver payments are difficulty of care payments, they are subject to these limits.

This notice does not address whether qualified Medicaid waiver payments excluded from income under this notice may be subject to tax under the Federal Insurance Contributions Act (FICA) or the Federal Unemployment Tax Act (FUTA) in certain circumstances.

EFFECTIVE DATE

This notice is effective for payments received on or after January 3, 2014. Taxpayers may apply this notice in taxable years for which the period of limitation on claims for a credit or refund under § 6511 has not expired.

DRAFTING INFORMATION

The principal author of this notice is Victoria J. Driscoll of the Office of Associate Chief Counsel (Income Tax & Accounting). For further information regarding this notice, contact Ms. Driscoll at (202) 317-4718 (not a toll-free call).

2900 FAIR HEARINGS AND APPEALS

Section 1902(a)(3) of the Social Security Act requires that States "provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness." Regulations implementing this section of law are found at 42 CFR 431 Subpart E. In addition, certain court decisions further amplify and modify the law and regulations governing the provision of notices and hearings to Medicaid applicants and recipients. Where appropriate, those decisions are cited .

2900.1 Basic Responsibility (42 CFR 431.200 and 431.205).--Establish policies and procedures for assuring a system of fair hearings that meet all the requirements of the regulations and instructions.

Notify and make available to the applicant or recipient the hearing procedures required by regulations and these instructions, if any of the following events occur:

- denial of eligibility,
- the claim is not acted upon with reasonable promptness,
- termination of eligibility or covered services,
- suspension of eligibility or covered services, or
- reduction of eligibility or covered service

2900.2 Publication And Distribution Of Hearing Procedures (42 CFR 431.206(a)). --Issue and publicize your hearing procedures. The publication and wide distribution of hearing procedures in the form of rules and regulations or a clearly stated pamphlet to appellants, recipients, and other interested groups and individuals helps to emphasize the purposes and importance of the procedure and to inform aggrieved individuals about the existence and use of this procedure. It not only contributes to the fairness and orderliness of the hearing, but also emphasizes the principles of equity and due process throughout the administration of medical assistance.

2900.3 Information And Referral For Legal Services (42 CFR 431.206(b)(3)).--Advise individuals appealing an agency decision of their right to be represented by a person or organization of their choice. You are not required to provide legal services. Legal aid societies, neighborhood legal services, lawyers in private practice, and perhaps other sources may be able and willing to provide representation for Medicaid applicants and recipients. In order to carry out the intent of the regulation, agencies should keep informed about such services and be prepared to advise appellants about them.

Because of the difficulties many recipients have in representing themselves in fair hearings, you have a special responsibility to assist persons in being represented by others and to help establish that such representation is not a violation of State law concerning non-legal representation, in those States where this has been an issue. Advise the appellant of any legal services which may be available to him (see §2909) and any provisions you have for payment of legal fees for representation at fair hearings.

2900.4 Informing Individuals of their Appeal Rights (42 CFR 431.206).--Notify in writing any applicant or recipient of the right to a hearing and the procedure for requesting a hearing at the time of application and at the time of any action by the agency. (See §2900.1 defining the action requiring Notice of Appeal Rights.)

You may give written notification on the application form or on other forms you routinely send to applicants and recipients. If you publish an agency pamphlet describing the provisions of your Medicaid program, include an explanation of the applicant's and recipient's appeal rights.

For applicants and recipients not familiar with English, include a translation into a language understood by the applicant or recipient of the appeal rights available to them. This should be done for all written communications with such applicants and recipients. You should also orally explain, in understandable language, the applicant's and recipient's appeal rights at the time of any face to face interview conducted by the agency.

2901. NOTICE AND OPPORTUNITY FOR A FAIR HEARING

2901.1 Advance Notice of Intent to Terminate, Reduce or Suspend Medicaid (42 CFR 431.211 and 431.213).—

A. Advance Notice.

1. 10-Day Advance Notice.--Whenever you propose to terminate, reduce or suspend Medicaid covered services, mail advance notice of the pending action to the recipient at least 10 days prior to the time of the anticipated action, except as provided in subsections A2 and B. With respect to eligibility factors known in advance, such as attainment of age 18 or increased hours or wages of employment, (42 CFR 435.112), send the notice even earlier, thus allowing more time to resolve any issue or questions.

2. 30-Day Advance Notice.--Give an applicant or recipient 30 days advance notice whenever you propose to deny, terminate, reduce, or suspend eligibility or covered services because of data disclosed through a matching program covered under the Computer Matching and Privacy Protection Act of 1988 (P.L. 100-503).

This legislation amended the Privacy Act to establish procedures governing computer matches between Federal source agencies and State agencies. Adverse action resulting from a covered matching program cannot be taken until the adverse data have been independently verified. This verification can be satisfied by verification from the source agency or from the applicant or recipient. Independent verification may be done during the advance notice period, except for data covered by 42 CFR 435.952 and 435.955 which must be verified prior to notification. Where the information involves income or resources, the law requires that at least the following must be verified:

- The applicant's/recipient's total income and/or total value of owned assets;
- The applicant/recipient has or did have access to the assets or income;
- Confirmation of the period of time when the applicant/recipient owned the asset or earned the income.

Before you may deny, suspend, terminate, or reduce benefits to an applicant/recipient as a result of information produced from a matching program, the following conditions must be met:

- The applicant/recipient must receive a written notice identifying the adverse data you propose using and the action you propose to take because of this data;
- The applicant/recipient must be given 30 days advance notice of the opportunity to contest the data and findings before you may take adverse action; and
- You must allow the 30-day period to expire before taking adverse action against the applicant or recipient.

If the individual contests SDX data and alleges receiving an ongoing SSI check, ask the individual to bring in the most recent SSI notice or a copy of the next check as verification. Continue Medicaid eligibility based on receipt of SSI if the recipient does so. Contact SSA for verification of SDX data only if the recipient contests the data but is completely unable to provide evidence to refute the SDX and you are otherwise unable to verify the SDX data.

B. Less Than 10 days Advance Notice.--In the following circumstances advance notice may be reduced or is not necessary. Advance notice may be reduced to 5 days in cases where you have facts indicating action should be taken because of probable fraud by the recipient.

You do not have to send advance notice if:

- o You have factual information that the recipient has died;
- o The recipient has stated in writing that he no longer wishes Medicaid or the information he has given requires termination of Medicaid and the recipient knows that is the result of giving the information;
- o The recipient has been admitted to an institution where he is ineligible under the State Plan for services. For example, in a State which does not provide Medicaid to inpatients over 65 years old, in a mental institution, a recipient admitted to such an institution is not eligible for such services;
- o The recipient moves to another State (or another county in county administered programs) and has been determined eligible for Medicaid in the new jurisdiction; and
- o The recipient's whereabouts are unknown. You may determine that the recipient§s whereabouts are unknown if mail sent to the recipient is returned as undeliverable.

2901.2 Notice When a Change in Level of Care Occurs.--In the following circumstances send a notice reflecting a change in the level of care an institutionalized recipient receives:

- o The recipient continues to be a patient of the institution,
- o The change in level of care was ordered by the recipient's physician, and
- o The change in level of care is to a lower level of care covered by the program.

If all of the preceding conditions are met, notice may be sent on the date of action.

If all of the conditions above are not met, send advance notice as required by §2901.1.

2901.3 Opportunity for a Fair Hearing --All applicants and recipients sent a notice as required by §2901.1 may request a Fair Hearing. Except as provided elsewhere in this section grant a timely request for a hearing and render a decision in the name of the agency.

In providing an opportunity for a Fair Hearing, regulations at §431.221 require that you must establish a reasonable time period not to exceed 90 days from the date notice of action is mailed to request a hearing.

A period of not less than 20 days after mailing a notice of action ensures that applicants and recipients have sufficient time in which to request a hearing. HCFA considers a period of less than 20 days for appeal as unreasonable, because delays in receipt of the notice provide too little time in which to make a timely appeal.

Make every effort to assist applicants and recipients to exercise their appeal rights. For example, you may need to help applicants or recipients who do not have anyone else to assist them in preparing for a hearing. If you provide an informal conference, make it clear to the applicant or recipient that such a conference is not part of the hearing process.

You do not have to grant a hearing if the sole issue being appealed is a State or Federal law or policy, including a change in law or policy adversely affecting some or all applicants or recipients. See §2902.3 for a discussion of the distinction between issues of fact and issues of policy.

2902. HEARINGS

2902.1 Request for a Hearing--A request for a hearing must be in writing and signed by the applicant or recipient, or the authorized representative of the applicant/recipient.

In the case of authorized representatives, you must have evidence that the individual claiming to represent the applicant/recipient has been authorized to do so.

Oral inquiries about the opportunity to appeal should be treated as requests for appeal for purposes of establishing the earliest possible date for an appeal.

If you provide a conference to applicants or recipients who have been sent notices of action the applicant may request a hearing without first having a conference and such conference may not substitute for the hearing.

Promptly acknowledge every hearing request received.

2902.2 Continuation and Reinstatement of Services Pending a Hearing Decision--

A. Required Continuation or Reinstatement.--Continue to provide or reinstate Medicaid services until a hearing decision has been rendered in the following circumstances.

1. Continue Services.--If you mail the 10 day or 5 day notice as required and the recipient requests a hearing before the date of action, continue Medicaid services.

2. Reinstate services if:

o You take action without the advance notice required;

o The recipient's whereabouts are unknown (agency mail is returned as undeliverable) but during the time the recipient is eligible for services the recipient's whereabouts become known, or

o The recipient requests a hearing within 10 days of mailing the notice of action; and

o You determine that the action results from other than the application of Federal or State law or policy.

B. Optional Reinstatement.--You may reinstate services if the recipient requests a hearing not more than 10 days after the date of action.

C. When Maintained for Reinstated Services May be Stopped.--You must continue to provide services maintained or reinstated after an appeal until a hearing decision is rendered unless the hearing officer, at the hearing, determines that the sole issue is one of Federal or State law or policy. When the hearing officer determines the appeal is one of law or policy, you may discontinue services but only after promptly informing the recipient in writing that services will be discontinued pending the hearing decision.

2902.3 Dismissal of A Hearing Request.--

A. Dismissal.--You may dismiss a request for a hearing when:

o The claimant or his representative requests in writing that the request for hearing be withdrawn; or

o The claimant abandons his right to a hearing as described in subsection B.

B. Abandonment.--The hearing request may be considered abandoned when neither the claimant nor his representative appears at scheduled hearing, and if within a reasonable time (of not less than 10 days) after the mailing of an inquiry as to whether he wishes any further action on his request for a hearing no reply is received.

2902.4 Nature Of The Issue.--Determine whether the appeal involves issues of law or policy, or issues of fact or judgement. The decision will affect whether a hearing is granted and whether Medicaid will be continued pending the hearing decision. The distinction between issues of fact or judgment and issues of State law or agency policy will not usually be difficult to make. Issues of fact or judgement include issues of the application of State law or policy to the facts of the individual situation.

A. Issues of Law or Policy.--An example of an issue involving application of agency policy to the individual situation may arise from the use of spenddown. If there is a question whether the formula for computing spenddown was correctly applied in an individual case, it is an issue of fact or judgment and assistance must be continued. If the individual challenges the use of spenddown, he is questioning the policy itself, and assistance would not need to be continued during the fair hearing process.

An example of an issue of agency policy is the alleged inadequacy of the State program, e.g., the failure to include eyeglasses or dental care in the services for which recipients are eligible. Such inadequacies are grounds for requesting a fair hearing. However, the agency is not in a position to rule in favor of the appellant without a change in agency policy or, in some instances, in State law. You are not required to continue assistance during appeals of this type.

B. Issues of Fact or Judgment.--Examples of situations where issues of fact or judgment may arise are:

o An agency decision of permanent and total disability. There may be a difference of opinion as to whether the condition is such as to justifya finding of disability (team's judgment) as defined in 42 CFR 435.541 or there may be a question as to the "facts" in the medical report; or

o Whether a father works a sufficient number of hours to exclude the family from being eligible on the basis of excess hours or earnings (42 CFR 435.112).

2902.5 Group Hearings (42 CFR 431.222).--Joint or group hearings when more than one individual protests identical issues of agency policy (if the State grants a hearing in such circumstances) may be economical for the agency and beneficial to the aggrieved individuals. A joint or group hearing makes available to each appellant the opportunity for presenting his case with others when all have the same complaint. For example, a number of recipients may ask for a hearing on the State's decision to delete from coverage a certain drug because it has not been proven effective.

If there is disagreement between agency and appellant as to whether the appeal concerns policy and identical facts or the facts of his personal situation, and thus whether it may be included in a group hearing, the hearing officer makes the decision. When an appellant's request for a fair hearing involves issues in addition to the one serving as a basis for the group hearing, you should sever his appeal from the group and handle separately. Likewise, a claimant scheduled for a group hearing may withdraw and request an individual hearing.

In a group hearing, accord individual appellants the right to make individual presentations and to be represented by their own representatives. Set up procedures to assure an orderly process in a group hearing.

2902.6 Convenience of the Claimant Considered (42 CFR 431.240(a)(1)-- Consider the convenience of the claimant in setting the date, place, and time for the hearing. Give written notice for the claimant with adequate preliminary information about the hearing procedure. The agency has not discharged its responsibility unless it has done what it can to enable a claimant who has requested a hearing to attend the hearing in person and to be represented by a person of his own choosing. There may be instances in which the claimant is housebound, hospitalized or in a nursing home, or lives far from the office in which hearings are usually held. In these and other hardship instances, make special plans, as necessary, for the convenience of the claimant. For instance, the hearing may be held in the claimant's home. You may also conduct the hearing by telephone when the claimant is unable to attend in person. Telephone hearings must follow all of the due process required of in person hearings.

2902.7 Impartiality Of Official Conducting The Hearing (42 CFR 431.240(a)(3)).--The State official or panel conducting the hearing shall not have been connected in any way with the previous actions or decisions on which the appeal is made. For example, a field supervisor who has advised the local agency in the handling of a case would be disqualified from acting as the hearing officer, however a different field supervisor could serve.

2902.8 Claimant's Right To A Different Medical Assessment (42 CFR 431.240(b)).--An appeal on medical issues may involve a challenge to the Medical Review Team's decision regarding disability; or there may be disagreement about the content of reports concerning the appellant's physical or mental condition or the individual's need for medical care requiring prior authorization. When the assessment by a medical authority, other than the one involved in the decision under question, is requested by the claimant and considered necessary by the hearing officer, obtain it at agency expense. The medical source should be one satisfactory to the claimant. The assessment by such medical authority shall be given in writing or by personal testimony as an expert witness and shall be incorporated into the record.

2902.9 Rights Of Claimants During Hearings (42 CFR 431.242).--Provide the appellant or his representative an opportunity to examine all materials to be used at the hearing. Non-record or confidential information which the claimant or his representative does not have the opportunity to see is not made a part of the hearing record or used in a decision on an appeal. If the hearing officer reviews the case record, or other material, including the hearing summary proposal by agency staff, such material must also be made available to the appellant or his representative. The hearing officer must enable the appellant and his witnesses to give all evidence on points at issue and the appellant and his representative to advance arguments without undue interference. Give the appellant the opportunity to confront and cross-examine witnesses at the hearing and to present evidence in rebuttal. Do not use application of the rules for the conduct of the hearing to suppress the appellant's claim. Allow the claimant to present his case in the way he desires. For example, some claimants wish to tell their own story or have a relative or friend present the evidence for them and others may be represented by legal counsel or other spokesman. Make provisions to secure an interpreter when an appellant can't speak English.

2902.10 Prompt, Definitive And Final Action (42 CFR 431.244(f).--The requirement for prompt, definitive, and final administrative action means that all requests for a hearing are to receive prompt attention and will be carried through all steps necessary to completion. The requirement is not met if the State dismisses such a request for any reason other than withdrawal or abandonment of the request by the claimant or as permitted elsewhere in these instructions. Adhere to the time limit of 90 days between the date of the request for the hearing and the date of the final administrative action except where the agency grants a delay at the appellant's request, or when required medical evidence necessary for the hearing can not be obtained within 90 days. In such case the hearing officer may, at his discretion, grant a delay up to 30 days.

2903. HEARING DECISION

2903.1 Basis for Hearing Officer Recommendation, Decision, And Opportunity to Examine Official Record (42 CFR 431.244).--The hearing officer's recommendation or decision shall be based only on the evidence and testimony introduced at the hearing. The record of the proceedings, which consists of the transcript or recording of the hearing testimony, any exhibits, papers or requests filed in the appeal, including the documents and reasons upon which the determination being appealed is based, and the hearing officer's written recommendation or decision shall be available to the claimant or his representative at a convenient time and at a place accessible to him or his representative, to examine upon request. If any additional material is made part of the hearing record it too shall be made available.

2903.2 Hearing Decision And Notification to Claimant (42 CFR 431.232, 233, 244(b)and(d) and 431.245).--

A. General.--A conclusive decision in the name of the State agency shall be made by the hearing authority. That authority may be the highest executive officer of the State agency, a panel of agency officials, or an offical appointed for the purpose. No person who has previously participated at any level in the determination upon which the final decision is based may participate in the decision. For example, a person who participated in the original determination being appealed may not participate in the appeal; nor may a person who participated in a local hearing participate in the agency hearing.

The officially designated hearing authority may adopt the recommendations of the hearing officer, or reject them and reach a different conclusion on the basis of the evidence, or refer the matter back to the hearing officer for a resumption of the hearing if the materials submitted are insufficient to serve as basis for a decision except where the appeal involves the issue of disability and SSA has issued a disability determination which is binding on the program. Remanding the case to the local unit for further consideration is not a substitute for "definitive and final administrative action."

B. Hearing Records.--All hearing recommendations or decisions must be based exclusively on evidence introduced at the hearing. The record must consist only of:

- The transcript or recording of testimony and exhibits, or an official report containing the substance of what happened at the hearing; and
- All papers and requests filed during the appeal; and
- The recommendation or decision of the hearing officer.

C. Local Evidentiary Hearing--Where you provide a local evidentiary hearing, include the following information in the decision and take the action described.

- Inform the applicant or recipient of the decision;
- Inform the applicant or recipient that he has the right to appeal the decision to the State agency within 15 days of mailing the decision;
- Inform the applicant or recipient of his right to request that the appeal be a de novo hearing, subject to the limit set forth in paragraph A;

o The decision shall state the specific reasons for the decision, identify the supporting data, and be issued promptly to the claimant in writing; and

5. The State shall discontinue services after the decision if it is adverse to the recipient.

D. State Agency Hearing.--

o Unless the claimant specifically requests a de novo hearing, the hearing may consist of a review of the local evidentiary hearing, by the agency hearing officer to determine whether the local hearing decision was supported by substantial evidence.

o A person who participated in the local decision may not participate in the State agency hearing.

o In the final decision give the specific reasons for the decision, identify the supporting data, and issue it promptly to the claimant in writing.

o In the notice of decision advise the claimant of the right of judicial review if it is prescribed by State statute specifically authorizing review of agency decisions on the basis of the record of administrative proceedings, or if there is other provision for judicial review under State law.

2903.3 State Agency Responsibility In Carrying Out The Hearing Decision (42 CFR 431.244(f)).--

A. General.--The hearing authority's decision is binding upon the State and Local agencies. You are responsible for assuring that the decision is carried out promptly. Various methods, such as report by the local agency on action taken, or follow-up by State office staff, may be used.

B. Final Administrative Action.--Section 431.244(f) requires that you take final administrative action within 90 days of the request for hearing. In implementing this regulation it is reasonable to allow additional time to meet this standard when a delay beyond 90 days is due to claimant requests or untimely receipt by the hearing authority of documentation needed to render a decision which had been requested timely. Any delay can not exceed 30 days.

C. Corrective Action--If the hearing decision is favorable to the claimant, or if the agency decides in favor of the claimant prior to a hearing, promptly take action to reinstate Medicaid eligibility and process any unpaid providers claims within the standard set forth in B.

2903.4 Accessibility Of Hearing Decisions To Local Agencies And The Public (42 CFR 431.244(g)).--Select a method for informing all local public welfare agencies of all hearing decisions and of making such decisions available to all interested members of the general public. The method may provide for a summary presentation. Where several decisions centered around the same question, it is permissible to treat one decision with some detail, and then indicate in a much more abbreviated fashion for each of the subsequent decision that it raises the same question and follows the precedent of the initial case. Such information must be preserved in a manner consistent with requirements for safeguarding information concerning applicants and recipients in 42 CFR 431 Subpart F.

2903.5 Responsibility for Hearings Under Medicaid (431.243).--If the hearing involves an issue of eligibility and the Medicaid agency is not responsible for eligibility determinations, the State agency that is responsible for determining eligibility must participate in the hearing.

The two agencies should work out the precise arrangement between them for conducting such hearings. In doing so, the Medicaid agency may use the hearing process employed by the State agency which made the eligibility determination; the hearing officer in such cases will make a recommendation to the Medicaid agency. That agency is responsible for presenting to the hearing officer the agency's justification for the decision it made, and the evidence upon which it is based.

The decision rendered as a result of a hearing described in this situation will be made in the name of the Medicaid agency. The Medicaid agency is responsible for the implementation of the decision. However, none of the procedures allowed by this section may be used to deny a claimant any of the due process rights contained elsewhere in these instructions.

2904. REOPENING AND RECOVERY

2904.1 Reopening Final Determinations Of Eligibility.--Reopening a final determination permits the correction of errors in that determination. It is particularly suited to changing a determination which was reasonable when rendered but is now unreasonable because new evidence concerning the determination has been submitted which may alter that determination. However, unrestricted reopening would seriously impair due process, administrative efficiency and that certainty in determinations which applicants and recipients have the right to expect. Consequently, reopening should be permitted only when there is good cause to question the accuracy of a determination. The following discussion sets out procedures which you may wish to follow in designing rules to govern reopening of fair hearing determinations.

A. Who May Reopen An Initial, Revised Determination Or Hearing Decision.--You may reopen and revise any determination you have issued within the time limits and for the reasons described below.

B. Action Permitting Reopening--

o Written request by the applicant, recipient or his representative, within the time limit, alleging good cause for reopening a previously final determination, or

o You may, on your own notion, reopen a determination when you have information documenting that the previous determination is incorrect or there is other good cause.

C. Definition of Good Cause for Reopening.--

1. New and Material Evidence.--Any evidence which was not considered when the previous determination was made and which shows facts that may result in a conclusion different from the previous decision, even though the previous determination was entirely resonable when it was made.

It is also possible that the evidence may justify or require that further development be undertaken before making a revised determination.

2. Clerical Error.--Any mechanical, computer or human mistakes in mathematical computations. For example, errors in computing resources, income, or spenddown requirements for Medicaid eligibility.

3. Error on the Face of the Evidence.--Any error in making a Medicaid determination which causes that determination to be incorrect at the time it is made. For example, evidence is on file to show that the applicant's resources meet the State's standard for eligibility yet the application is denied.

D. Time Limit for Reopening.--You may reopen a previously final Medicaid determination within 1 year of that determination when the conditions in paragraph C are met, except when the determination involves fraud. In such cases there is no time limit.

E. Reopening at any time.--You may reopen a previously final Medicaid determination at any time if you have evidence that the determination was obtained through fraud.

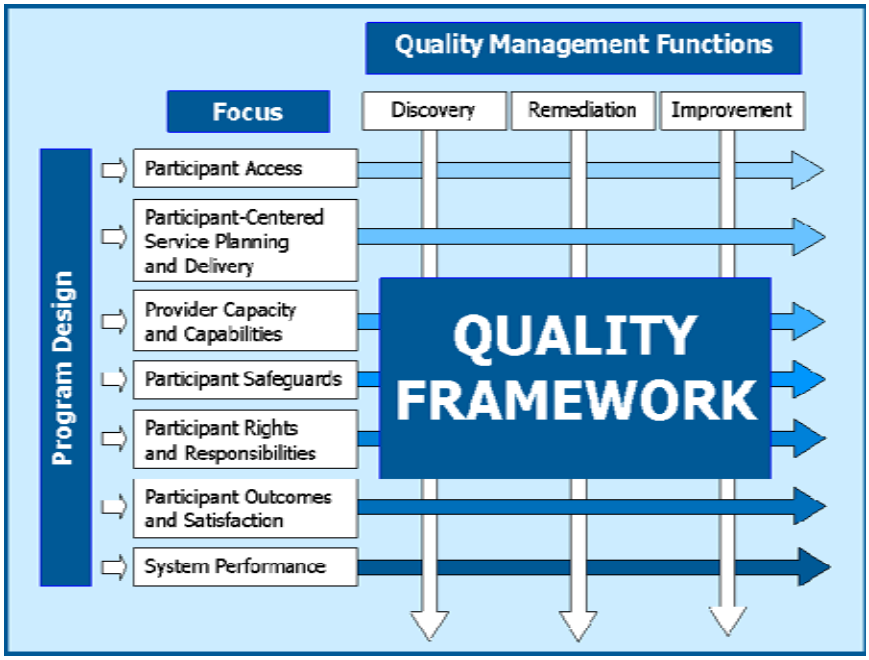
2904.2 Recovery.--

A. You may recover from the recipient money you paid for services provided the recipient if:

- The services were provided as a result of §2902.2A1, and
- The recipient's appeal is unsuccessful.

B. Inform the recipient of this provision at the time a hearing is requested if you employ recovery.

HCBS QUALITY FRAMEWORK



The Home and Community-Based Services (HCBS) Quality Framework provides a common frame of reference in support of productive dialogue among all parties who have a stake in the quality of community services and supports for older persons and individuals with disabilities. The Framework focuses attention on participant-centered **desired outcomes** along seven dimensions.

Program design sets the stage for achieving these desired outcomes. Program design addresses such topics as service standards, provider qualifications, assessment, service planning, monitoring participant health and welfare, and critical safeguards (e.g., incident reporting and management systems).

Quality management encompasses three functions:

Discovery: Collecting data and direct participant experiences in order to assess the ongoing implementation of the program, identifying strengths and opportunities for improvement.

Remediation: Taking action to remedy specific problems or concerns that arise.

Continuous Improvement: Utilizing data and quality information to engage in actions that lead to continuous improvement in the HCBS program.

Quality management gauges the effec- tiveness and functionality of program design and pinpoints where attention should be devoted to secure improved outcomes.

Program design features and quality management strategies will vary from program to program, depending on the nature of the program's target population, the program's size and the services that it offers, its relationship to other public pro- grams, and additional factors.

The Framework was developed in part- nership with the National Associations of State Directors of

Developmental Disabilities Services, State Units on Aging, and State Medicaid Directors.

Focus	Desired Outcomes
Participant Access	*Individuals have access to home and community-based services and supports in their communities.*
Participant-Centered Service Planning and Delivery	*Services and supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences and decisions concerning his/her life in the community*
Provider Capacity and Capabilities	*There are sufficient HCBS providers and they possess and demonstrate the capability to effectively serve participants.*
Participant Safeguards	*Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.*
Participant Rights and Responsibilities	*Participants receive support to exercise their rights and in accepting personal responsibilities.*
Participant Outcomes and Satisfaction	*Participants are satisfied with their services and achieve desired outcomes.*
System Performance	*The system supports participants efficiently and effectively and constantly strives to improve quality.*

HCBS QUALITY FRAMEWORK
QUALITY FOCUS AREAS

Focus I: Participant Access

Desired Outcome: *Individuals have access to home and community-based services and supports in their communities.*

I.A Information/Referral

Desired Outcome: *Individuals and families can readily obtain information concerning the availability of HCBS, how to apply and, if desired, offered a referral.*

I.B. Intake and Eligibility

I.B.1 User-Friendly Processes

Desired Outcome: *Intake and eligibility determination processes are understandable and user-friendly to individuals and families and there is assistance available in applying for HCBS.*

I.B.2 Referral to Community Resources

Desired outcome: *Individuals who need services but are not eligible for HCBS are linked to other community resources*.

I.B.3 Individual Choice of HCBS

Desired Outcome: *Each individual is given timely information about available services to exercise his or her choice in selecting between HCBS and institutional services.*

I.B.4 Prompt Initiation

Desired Outcome: *Services are initiated promptly when the individual is determined eligible and selects HCBS.*

Focus II: Participant-Centered Service Planning and Delivery

Desired Outcome: *Services and supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences and decisions concerning his/her life in the community.*

II.A Participant-Centered Service Planning

II.A.1 Assessment

Desired Outcome: *Comprehensive information concerning each participant's preferences and personal goals, needs and abilities, health status and other available supports is gathered and used in developing a personalized service plan.*

II.A.2 Participant Decision Making

Desired Outcome: *Information and support is available to help participants make informed selections among service options.*

II.A.3 Free Choice of Providers

Desired Outcome: *Information and support is available to assist participants to freely choose among qualified providers.*

II.A.4 Service Plan

Desired Outcome: *Each participant's plan comprehensively addresses his or her identified need for HCBS, health care and other services in accordance with his or her expressed personal preferences and goals.*

II.A.5 Participant Direction

Desired Outcome: *Participants have the authority and are supported to direct and manage their own services to the extent they wish.*

II.B Service Delivery

II.B.1 Ongoing Service and Support Coordination

Desired Outcome: *Participants have continuous access to assistance as needed to obtain and coordinate services and promptly address issues encountered in community living.*

II.B.2 Service Provision

Desired *Outcome*: *Services are furnished in accordance with the participant's plan.*

II.B.3 Ongoing Monitoring

Desired Outcome: *Regular, systematic and objective methods – including obtaining the participant's feedback – are used to monitor the individual's well being, health status, and the effectiveness of HCBS in enabling the individual to achieve his or her personal goals.*

II.B.4 Responsiveness to Changing Needs

Desired Outcome: *Significant changes in the participant's needs or circumstances promptly trigger consideration of modifications in his or her plan.*

Focus III: Provider Capacity and Capabilities

Desired Outcome: *There are sufficient HCBS providers and they possess and demonstrate the capability to effectively serve participants.*

III.A Provider Networks and Availability

Desired Outcome: *There are sufficient qualified agency and individual providers to meet the needs of participants in their communities.*

III.B Provider Qualifications

Desired Outcome: *All HCBS agency and individual providers possess the requisite skills, competencies and qualifications to support participants effectively.*

III.C Provider Performance

Desired Outcome: *All HCBS providers demonstrate the ability to provide services and supports in an effective and efficient manner consistent with the individual's plan.*

Focus IV: Participant Safeguards

Desired Outcome: *Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.*

IV.A Risk and Safety Planning

Desired Outcome: *Participant health risk and safety considerations are assessed and potential interventions identified that promote health, independence and safety with the informed involvement of the participant.*

IV.B Critical Incident Management

Desired Outcome: *There are systematic safeguards in place to protect participants from critical incidents and other life-endangering situations.*

IV.C Housing and Environment

Desired Outcome: *The safety and security of the participant's living arrangement is assessed, risk factors are identified and modifications are offered to promote independence and safety in the home.*

IV.D Behavior Interventions

Desired Outcome: *Behavior interventions – including chemical and physical restraints – are only used as a last resort and subject to rigorous oversight.*

IV.E. Medication Management

Desired Outcome: *Medications are managed effectively and appropriately.*

IV.F Natural Disasters and Other Public Emergencies

Desired Outcome: *There are safeguards in place to protect and support participants in the event of natural disasters or other public emergencies.*

Focus V: Participant Rights and Responsibilities

Desired Outcome: *Participants receive support to exercise their rights and in accepting personal responsibilities.*

V.A Civic and Human Rights

Desired Outcome: *Participants are informed of and supported to freely exercise their fundamental constitutional and federal or state statutory rights.*

V.B Participant Decision Making Authority

Desired Outcome: *Participants receive training and support to exercise and maintain their own decision-making authority.*

V.C Due Process

Desired Outcome: *Participants are informed of and supported to freely exercise their Medicaid due process rights.*

V.D Grievances

Desired Outcome: *Participants are informed of how to register grievances and complaints and*

supported in seeking their resolution. Grievances and complaints are resolved in a timely fashion.

Focus VI: Participant Outcomes and Satisfaction

Desired Outcome: *Participants are satisfied with their services and achieve desired outcomes.*

VI.A Participant Satisfaction

Desired Outcome: *Participants and family members, as appropriate, express satisfaction with their services and supports.*

VI.B Participant Outcomes

Desired Outcome: *Services and supports lead to positive outcomes for each participant.*

Focus VII: System Performance

Desired Outcome: *The system supports participants efficiently and effectively and constantly strives to improve quality.*

VII.A System Performance Appraisal

Desired Outcome: *The service system promotes the effective and efficient provision of services and supports by engaging in systematic data collection and analysis of program performance and impact.*

VII.B Quality Improvement

Desired Outcome: *There is a systemic approach to the continuous improvement of quality in the provision of HCBS.*

VII.C Cultural Competency

Desired Outcome: *The HCBS system effectively supports participants of diverse cultural and ethnic backgrounds.*

VII.D Participant and Stakeholder Involvement

Desired Outcome: *Participants and other stakeholders have an active role in program design, performance appraisal, and quality improvement activities.*

VII. E Financial Integrity

Desired Outcome: *Financial accountability is assured and* p*ayments are made promptly in accordance with program requirements.*

Department of Health & Human Services
Centers for Medicare & Medicaid Services
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Modifications to Quality Measures and Reporting in §1915(c) Home and Community-Based Waivers

March 12, 2014

This document provides information on modifications to the quality assurance systems needed to meet the assurances for §1915(c) waivers. The National Association of States United in Aging and Disability (NASUAD), National Association of State Directors of Developmental Disabilities Services (NASDDDS) and National Association of Medicaid Directors (NAMD), along with waiver administrators from eleven states and the National Quality Enterprise worked with CMS for over a year to develop and refine these changes. Other stakeholders also had opportunity to comment through conference and webinar sessions.

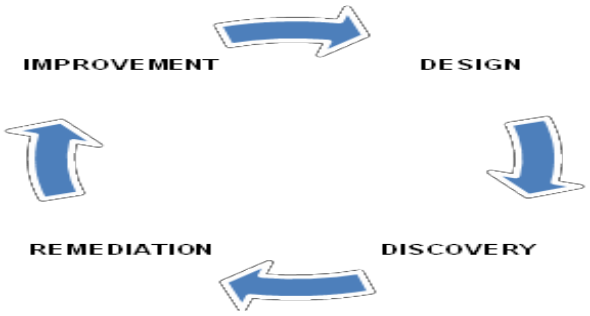
These changes strengthen the oversight of beneficiary health and welfare and realign the reporting requirements. We believe this changed emphasis will improve the success of home and community based programs.

The current quality assurance system requires that states develop and measure performance indicators in fourteen areas (one each for waiver administrative authority, health and welfare of participants, and financial integrity, three each to measure levels of care and that providers meet qualifications, and five in the area of service planning and delivery). Each waiver must have its own quality assurance system. States submit an evidentiary report on all of their performance measures approximately eighteen months prior to the waiver renewal date that includes the remediation taken for each systemic and individual instance when a performance measure has less than 100% compliance.

The highlights of this modified quality assurance system include:

1. Health and welfare monitoring and outcomes are emphasized;
2. Although states must continue to remediate issues, the reporting on individual remediation to CMS will not be required except in substantiated instances of abuse, neglect or exploitation; and
3. States' quality improvement projects/remediation will be required when the threshold of compliance with a measure is at or below 85%.

The statutory requirements for §1915(c) waivers are not changed and states are still required to monitor all of the waiver assurances as before. This update clarifies the expectations of CMS on the reporting that states should provide to meet the waiver assurances. The continuous quality improvement cycle remains the same as illustrated below.



This communication covers the following topics:

1. Assurances and Subassurances (Discovery)
2. Reporting on Individual Remediation (Remediation)
3. Quality Improvement Projects (Improvement)
4. Consolidating Reporting Across Multiple Waivers
5. Determining if an Assurance has Been Met
6. Timeframes for Implementation
7. Appendix I: Crosswalk of Former and New Subassurances
8. Appendix II: Technical Guidance for Including the Quality Improvements in Version 3.5 of the Waiver Management System (WMS) §1915(c) Template

CMS encourages states to think creatively about performance measures, and to measure those items of most importance to the individuals being served, such as those seen on incident reports or reported as concerns by stakeholders. In this way, we think the needs of those using waiver services can be best met. We will work with a state that wants to track progress over time (i.e. specific annual targets on a type of incident).

1. Assurances and Subassurances (Discovery)

The assurances and subassurances continue to be built on the statutory requirements of the §1915(c) waiver. Appendix I of this bulletin contains a crosswalk of the previous and new assurances and subassurances language.

Administrative Authority: There is no change in the Administrative Authority assurance, and there is still no subassurance for this section. A performance measure should be developed and tracked for any authority that the State Medicaid Agency (SMA) delegates to another agency unless it is already captured in another performance measure for that waiver. For example, if the SMA delegates the service plan responsibilities, but there is already a performance measure that

tracks service plans, there would be no need to include another performance measure for that activity in the administrative authority section.

Level of Care: There is no change in the Level of Care assurance, although the subassurance to measure annual levels of care (reassessments) will no longer be reported. States are still expected to be sure that annual levels of care are determined, but no longer are asked to track a performance measure in this area. The other two subassurances (that applicants with reasonable likelihood of needing services receive a level of care determination, and that the processes are followed as documented in the waiver application) remain the same. The detailed changes are located in Appendix I: Crosswalk of Former and New Subassurances.

Qualified Providers: The qualified provider assurance and three subassurances remain the same. The state must still have performance measures that track that providers meet licensure/certification standards, that non-certified providers are monitored to assure adherence to waiver requirements, and that the state verifies that training is given to providers in accordance with the waiver. These are detailed in Appendix I: Crosswalk of Former and New Subassurances.

Service Plan: The service plan assurance remains the same, although one subassurance (development of service plans in accordance with waiver policy) will no longer require reporting of a performance indicator. A change was made to the subassurance that requires a performance measure on choice between institutional and waiver services as well as between waiver services and providers so that it now requires a measure on choice of waiver services and providers only. States are still required by statute to offer waiver beneficiaries a choice of institutional care, but CMS no longer expects reporting on that choice. The other two service plan subassurances (that plans address all assessed needs and goals, and that services are delivered in accordance with the service plan) remain the same. The detailed changes are located in Appendix I: Crosswalk of Former and New Subassurances.

Health and Welfare: The state associations and state representatives' workgroup agreed that health and welfare is one of the most important assurances to track, and requires more extensive tracking to benefit the individuals receiving services for instance, by using data to prevent future incidents. The current quality system has modified the assurance, turned the previous assurance into a new subassurance, and added three additional health and welfare subassurances. The resulting health and welfare assurance and subassurances are as follows:

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

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

- Subassurance - The State demonstrates that an incident management system is in place that effectively resolves incidents and prevents further similar incidents to the extent possible.
- Subassurance - The State policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.
- Subassurance - 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: Like health and welfare, financial accountability previously had an assurance but no subassurances. Waiver program integrity is critically important and can only be achieved with strong financial accountability in addition to the other waiver assurances covered in this bulletin. Although the workgroup did not recommend changes in financial accountability reporting, CMS modified the assurance, making the previous assurance into a subassurance, and creating a new subassurance as follows:

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

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

2. Reporting on Individual Remediation

CMS is modifying the requirements about individual remediation. Although states must continue to remediate problem areas, we require reporting on individual activities only in the instances of substantiated abuse, neglect and/or exploitation. Previously, in the quality reporting required for each waiver cycle, CMS required a report on individual remediation activities conducted for each performance measure. This will allow the state to focus energy on remediation of systemic problem areas which will continue to be reported (see Quality Improvement Projects, below). This refocus on system's review will provide the greater protections for individuals by ensuring the system adjusts to meet the needs of the individuals served.

3. Quality Improvement Projects

In the current quality system, CMS requires that states investigate whenever a performance indicator is not fully met, and conduct systemic remediation (Quality Improvement Projects – QIP) unless they can demonstrate the QIP is not warranted. However, in collaboration with the workgroup, quality improvement projects will now be required when the performance indicator falls below a threshold of 86%. Any performance measure with less than an 86% success rate warrants further analysis to determine the cause. A QIP must be implemented once the cause is found unless the state provides justification accepted by CMS that a QIP is not necessary. CMS strongly encourages states to seek stakeholder involvement in the development of QIPs.

A QIP may take any of several forms. It may be training, revised policies/procedures, additional staff, different staffing patterns, etc. There may be an existing state initiative for a specific

problem area that can be targeted to waiver participants at-risk, such as a falls prevention program. There may be an information systems change to alert for timeliness of home visits, levels of care and service plans, potentially addressing several performance measures at once. We encourage use of existing state or regional resources wherever they will address the problem area.

Each QIP must measure the impact to determine whether it was effective. If not, other interventions should be explored. This will ensue that the needs of the individuals served are addressed and resolved in a systemic manner. The Evidence Report submitted for each waiver must document QIP(s) including status to date. Although it may take time for an effect to occur, the benchmark of 86% is the expectation.

4. Consolidating Reporting Across Multiple Waivers

When waivers are managed and monitored similarly, it is expected that discovery and improvement activities would be the same, and that the state will achieve some administrative efficiencies by consolidating quality improvement activities. In addition, this holistic measure will ensure that the system for the waivers is responsive to the needs of all individuals served. CMS may accept a consolidated evidence report for multiple waivers when they meet the following five conditions:

1. Design of the waivers is the same or very similar;
2. This sameness or similarity is determined by comparing waivers on the approved waiver application appendices:
    a. Participant Services,
    b. Participant Safeguards, and
    c. Quality Management;
3. The quality management approach is the same or very similar across waivers, including:
    a. Methodology for discovering information (e.g., data systems, sample selection),
    b. Manner in which individual issues are remedied,
    c. Process for identifying and analyzing patterns/trends, and
    d. Majority of the performance indicators are the same;
4. The provider network is the same or very similar; and
5. Provider oversight is the same or very similar.

A simple random sample of the combined populations with a confidence level of at least .95 is sufficient if the conditions listed above are met. Results of this sampling will reflect the performance of the combined system.

Each 1915(c) waiver application (initial, amendment, or renewal) must identify other waivers with which it will be consolidated for reporting purposes. This application will also propose when the consolidated evidence report will be submitted. When some performance indicators are not the same, the state will also propose when the measures will be reported. They can either be reported with the consolidated measures, or at the time when that particular waiver's evidence report would be due if the reporting wasn't consolidated.

5. Determining If An Assurance Has Been Met

The CMS Regional Office will evaluate each evidentiary report to determine whether the waiver(s) has/have met each of the assurances. In order to meet each assurance, the following must occur:

1. Performance measure evidence is presented for each subassurance;
2. The performance measure evidence for each subassurance is at or above 86% in all waiver years, OR quality improvement projects have been initiated for each subassurance with a measure below 86%, OR CMS accepts justification for why a performance improvement plan was not initiated to address the performance issue; and
3. The state has provided an aggregated report on the individual remediation of substantiated instances of abuse, neglect and exploitation under the Health and Welfare Subassurance Two.

An assurance is not considered met if a performance measure for any subassurance stays below 86% for three or more consecutive years regardless of whether a performance improvement project has been implemented unless the measure has had steady improvement over the years and the state and CMS agree that performance is likely to exceed 85% the following year

6. Timeframe for Implementation

All new waiver applications and renewals submitted after June 1, 2014 must incorporate these modifications. The state may elect to adopt these quality changes earlier through submission of an amendment, renewal or new §1915(c) waiver following March 1, 2014. States may want to consider that consolidation of waivers will necessitate amendments to each consolidated waiver's quality plan.

Appendix II provides a technical guide on how to incorporate the new changes in the Waiver Management System version 3.5 Waiver Template. Narrative changes, such as consolidation of multiple waiver evidentiary reporting should be described in Appendix H of the Waiver Application as illustrated in Appendix II.

APPENDIX I

CROSSWALK: CURRENT vs. REVISED ASSURANCES/SUBASSURANCES

LEVEL OF CARE - CURRENT	LEVEL OF CARE – REVISED	*REVISION SUMMARY*
Assurance - The State demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with care provided in a hospital, NF, or ICF/ID-DD **a. Subassurance -** An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future. **b. [Subassurance -** The LOC of enrolled members is reevaluated at least annually or as specified in the approved waiver.] **c. Subassurance -** The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.	**Assurance -** The State demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with care provided in a hospital, NF, or ICF/ID-DD **I. Subassurance** - An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future. **II. Subassurance** - The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine initial participant level of care.	***Assurance --*** *No change in assurance description.* ***Subassurances --*** *Current LOC-b subassurance regarding reevaluations has been deleted. States, per statutory requirement, must still conduct annual reevaluations, but are no longer required to report evidence on reevaluations.* *Revised LOC-ii will be applicable to initial LOCs only. States will no longer be required to report evidence on annual reevaluations.*

SERVICE PLAN - CURRENT	SERVICE PLAN - REVISED	*REVISION SUMMARY*
Assurance- The State demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants**.**	**Assurance-** The State demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.	***Assurance*** *-- No change in assurance description.*
a. Subassurance - Service plans address all members' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means. **b. [Subassurance** The state monitors service plan development in accordance with its policies and procedures.] **c. Subassurance -** Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs. **d. Subassurance -** Services are delivered in accordance with the service plan, including the type, scope, amount, duration, and frequency specified in the service plan. **e. Subassurance -** Participants are afforded choice: ~~[~~Between waiver services and institutional care; and] between/among waiver services and providers.	**i. Subassurance-** Service plans address all members' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means. **ii. Sub -assurance-** Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs. **iii. Subassurance -** Services are delivered in accordance with the service plan, including the type, scope, amount, duration, and frequency specified in the service plan. **iv. Subassurance -** Participants are afforded choice between/among waiver services and providers.	***Subassurances*** *-- Current SP-b subassurance has been deleted. States must still develop service plans in accordance with their policies and procedures, but will not be required to report evidence on adherence to their policies/procedures.* *Current SP-e has been revised as SP-iv. SP-iv now focuses on monitoring participants' choice between/among waivers services and providers. States, per statutory requirement, must still offer individuals choice between institutional and HCBS care, but will no longer be required to report evidence on whether such choice was provided*.

QUALIFIED PROVIDERS - CURRENT	QUALIFIED PROVIDERS - REVISED	*REVISION SUMMARY*
Assurance - The State demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers. a. **Subassurance** - 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. b. **Subassurance** - The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. c. **Subassurance** - The State implements its policies and procedures for verifying that training is provided in accordance with State requirements and the approved waiver.	**Assurance -** The State demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers. i. **Subassurance** - 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. ii. **Subassurance** - The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. iii. **Subassurance** - The State implements its policies and procedures for verifying that training is provided in accordance with State requirements and the approved waiver.	***Assurance --*** *No change in assurance description.* ***Subassurances --*** *No change in subassurances.*

HEALTH AND WELFARE - CURRENT	HEALTH AND WELFARE - REVISED	*REVISION SUMMARY*
Assurance-- On an ongoing basis the state identifies addresses and seeks to prevent instances of abuse, neglect and exploitation.	**Assurance -** The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. i. **Subassurance --** The State demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death. ii. **Subassurance --** 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. iii. **Subassurance --** The State policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed. iv. **Subassurance --** 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.	***Assurance --*** *Assurance description revised to focus on health and welfare more broadly.* ***Subassurances*** *-- Four new subassurances added that provide specificity to the intent of the Health and Welfare Assurance, consistent with what is reflected in the Waiver Application, Appendix G -- Safeguards.*

FINANCIAL ACCOUNTABILITY - CURRENT	FINANCIAL ACCOUNTABILITY - REVISED	*REVISION SUMMARY*
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.	**Assurance** –The State must demonstrate that it has designed and implemented an adequate system for insuring financial accountability of the waiver program. i. Subassurance - The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiverand only for services rendered. ii. Subassurance - The State provides evidence that rates remainconsistent with the approved ratemethodology throughout the five year waiver cycle.	***Assurance --*** *Assurance wording revised to more broadly reflect the financial accountability requirement.* ***Subassurance --*** *CMS added one subassurance to address rate methodology, with expectation that the State would continue to report evidence that claims are coded and paid in accordance with the rate methodology specified in the approved waiver.*

ADMINISTRATIVE AUTHORITY - CURRENT	ADMINISTRATIVE AUTHORITY - REVISED	*REVISION SUMMARY*
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.	**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.	***Assurance*** *-- No change in assurance description.* ***Subassurance*** *-- This Assurance currently has no subassurances associated with it, and none have been added.* *Performance Measures (PMs) are required for delegated functions unless covered by PMs associated with other Assurances.* *And as necessary and applicable, States should continue to focus performance measures on:* • *Uniformity of development/execution of provider agreements throughout 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*

REMEDIATION REPORTING - **CURRENT**	**REMEDIATION REPORTING –** **REVISED**	***REVISION SUMMARY***
Evidence Report must include aggregated remediation reports • Tables/charts on number and types of remediation actions taken in response to instances of < 100% compliance on a given Performance Measure • Constitutes evidence that remediation at individual level has occurred	Remediation does not have to be reported in Evidence Report • <u>Exception: Substantiated instances of abuse, neglect and exploitation</u> Expectation that State has a mechanism for measuring its effectiveness in addressing non-performance • Mechanism and measurement results are subject to audit by CMS	*Changed from requiring remediation reports to only reporting on substantiated* cases of *abuse, neglect and exploitation.* *States may be audited to ensure they are conducting remediation where indicated by a lower than 86% performance.*

APPENDIX II: Technical Guidance for Including the Quality Changes in Version 3.5 of the Waiver Management System (WMS) §1915(c) Template

The following sections include excerpts from the Waiver Management System (WMS). Pertinent sections to quality system changes are highlighted. Instructions and/or directions enclosed in brackets no longer apply. The text in blue italics is taken from the WMS, and the text in black instructs what should be done to incorporate the new quality improvements. Please note the sampling and remediation sections are still needed for each assurance.

Appendix A: Administrative Authority

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.

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. [Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).] This last sentence no longer applies for this or any performance measure.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section 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 how recommendations are formulated, where appropriate.

Performance Measure/Indicator

Add Performance Measure Performance Indicators for Administrative Authority are needed to assure the Medicaid Agency is monitoring specific tasks delegated to an operating or other agency when performance on those tasks are not already being captured in other performance measures.

For this and all subsequent performance measures complete the full charts as in the past.

Appendix B: Level of Care:

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

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. [Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).]

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section 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 how recommendations are formulated, where appropriate.

Performance Measure/Indicator

Add Performance Measure At least one performance indicator needed

[Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.] This sub-assurance does not need to be reported on any longer.

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. [Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).] Not applicable

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section 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 how recommendations are formulated, where appropriate.

Performance Measure/Indicator

[*Add Performance Measure]* Not needed for this subassurance

1. *Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.*

   Performance Measures

   For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. [Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).] Not applicable

   For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section 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 how recommendations are formulated, where appropriate.

Performance Measure/Indicator

Add Performance Measure At least one performance indicator needed

Appendix C: Qualified Providers

Sub-Assurances:

1. *Sub-Assurance: 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.*

   Performance Measures

   For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. [Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).] Not applicable

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section 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 how recommendations are formulated, where appropriate.

Performance Measure/Indicator

Add Performance Measure At least one performance indicator needed

2. *Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.*

   For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. [Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).] Not applicable

   For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section 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 how recommendations are formulated, where appropriate.

Performance Measure/Indicator

Add Performance Measure At least one performance indicator needed

3. *Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.*

   For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. [Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).] Not applicable

   For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the

performance measure. In this section 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 how recommendations are formulated, where appropriate.

Performance Measure/Indicator

Add Performance Measure At least one performance indicator needed

Appendix D: Service Plans

Sub-Assurances:

1. *Sub-assurance: 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.*

   Performance Measures

   For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. [Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).] Not applicable

   For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section 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 how recommendations are formulated, where appropriate.

Performance Measure/Indicator

Add Performance Measure At least one performance indicator needed

2. *Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.*

   Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. [Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).] Not applicable

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section 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 how recommendations are formulated, where appropriate.

Performance Measure/Indicator

[*Add Performance Measure]* No longer needed for this subassurance

3. *Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.*

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. [Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).] Not applicable

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section 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 how recommendations are formulated, where appropriate.

Performance Measure/Indicator

Add Performance Measure At least one performance indicator needed

4. *Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.*

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. [Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).] Not applicable

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section 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 how recommendations are formulated, where appropriate.

Performance Measure/Indicator

Add Performance Measure At least one performance indicator needed

5. *Sub-assurance: Participants are afforded choice: [Between waiver services and institutional care; and] between/among waiver services and providers.*

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. [Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).] Not applicable.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section 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 how recommendations are formulated, where appropriate.

Performance Measure/Indicator

Add Performance Measure At least one performance indicator needed to measure availability of choice between/among waiver services and providers.

Appendix E: Participant Direction of Services *and* Appendix F: Participant Rights

There is no space in the Version 3.5 Appendix E or Appendix F to add performance measures. However, the state may add measures for either or both of these areas in Appendix G: Participant Safeguards.

Appendix G: Participant Safeguards

Assurance: The State, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. [Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).] Not applicable

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section 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 how recommendations are formulated, where appropriate.

Performance Measure/Indicator

Add Performance Measure Add at least one performance indicator for the assurance above, PLUS add one for each of the following subassurances:

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

- **Subassurance --** 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.

The state may elect to include performance measures on participant direction and/or participant rights in this section as well.

Appendix I: Financial Accountability

1. *Methods for Discovery: Financial Accountability*

State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. [Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).] Not applicable

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section 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 how recommendations are formulated, where appropriate.

Performance Measure/Indicator

Add Performance Measure Add at least one performance indicator for this assurance above, PLUS add one for the following subassurance:

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

Medicaid Home and Community-Based Services (HCBS) Taxonomy Category and Subcategory Definitions

The following table defines categories and subcategories in the HCBS Taxonomy. To acknowledge state variation, categories and subcategories are defined based on the minimum definition necessary to establish mutually distinct categories and subcategories. Sometimes, the definition is based on what is NOT included as well as what is included in a service. For example, the difference between companion services and personal care is that companion services do not include assistance with activities of daily living (ADLs) such as bathing, dressing, eating, and toileting.

Some of the subcategories reflected below, including but not limited to personal care, case management, home health aide, and physician services, may (and in some case, must) also be covered under the Medicaid State Plan. The definitions below only define these subcategories for purposes of Section 1915(c) Waivers. States interested in reflecting services as "extended state plan" services must offer them in accordance with state plan service definitions. Consult with the CMS Division of Benefits and Coverage in those instances to ensure definition alignment.

The categories and subcategories are arranged in order of consideration for placing a particular service in the taxonomy. If one is not sure how to map a state's service to the taxonomy, one should first consider Case Management, then Round-the-Clock Services, then Supported Employment, etc.

Category 01: Case Management

Definition: The development of a comprehensive, written individualized support plan. In addition, case management often includes assisting people in gaining access to necessary services, assessment of a person's needs, ongoing monitoring of service provision and/or a person's health and welfare, assistance in accessing supports to transition from an institutional setting (but not the transition services themselves), and development of a 24-hour individual back-up plan with formal and informal supports.

Table 1: Case Management Subcategory

Subcategory	Common Names (where applicable)	Definition
01010 case management	care management supports coordination	Same definition as category 01.

Medicaid Home and Community-Based Services (HCBS) Taxonomy Category and Subcategory Definitions

Category 02: Round-the-Clock Services

Definition: Services by a provider that has round-the-clock responsibility for the health and welfare of residents, except during the time other services (e.g., day services) are furnished. If these services are provided in a 1915(c) waiver, the state must complete Appendix G-3 of the 1915(c) waiver application regarding medication management and administration.

Table 2: Round-the-Clock Services Subcategories

Subcategory	Common Names (where applicable)	Definition
02011 group living, residential habilitation	group home services	Assistance in acquiring, retaining, and improving self-help, socialization, and/or adaptive skills by a provider with round-the-clock responsibility for the residents' health and welfare in a residence that is NOT a person's own home or apartment or a single family residence where one or more people with a disability live with a person or family who furnishes services.
02012 group living, mental health services	not applicable	Mental health services by a provider with round-the-clock responsibility for the residents' health and welfare in a residence that is NOT a person's own home or apartment or a single family residence where one or more people with a disability live with a person or family who furnishes services.
02013 group living, other	assisted living	Health and social services not identified in subcategories 02011 and 02012 by a provider with round-the-clock responsibility for the residents' health and welfare in a residence that is NOT a person's own home or apartment or a single family residence where one or more people with a disability live with a person or family who furnishes services.
02021 shared living, residential habilitation	family living host homes	Assistance in acquiring, retaining, and improving self-help, socialization, and/or adaptive skills provided in a single family residence where one or more people with a disability live with a person or family who furnishes services and has round-the-clock responsibility for the residents' health and welfare.
02022 shared living, mental health services	not applicable	Mental health services provided in a single family residence where one or more people with a disability live with a person or family who furnishes services and has round-the-clock responsibility for the residents' health and welfare.
02023 shared living, other	adult foster care	Health and social services not identified in subcategories 02021 and 02022 provided in a single family residence where one or more people with a disability live with a person or family who furnishes services and has round-the-clock responsibility for the residents' health and welfare.

02031 in-home residential habilitation	supported living	Assistance in acquiring, retaining, and improving self-help, socialization, and/or adaptive skills provided in a person's home or apartment where a provider has round-the-clock responsibility for the person's health and welfare.

Subcategory	Common Names (where applicable)	Definition
02032 in-home round-the-clock mental health services	not applicable	Mental health services provided in a person's home or apartment where a provider has round-the-clock responsibility for the person's health and welfare.
02033 in-home round-the-clock services, other	not applicable	Health and social services not identified in subcategories 02031 and 02032 provided in a person's home or apartment where a provider has round-the-clock responsibility for the person's health and welfare.

Category 03: Supported Employment

Definition: Assistance to help a person obtain or maintain paid employment or self-employment.

Table 3: Supported Employment Subcategories

Subcategory	Common Names (where applicable)	Definition
03010 job development	not applicable	Assistance to locate and obtain paid employment or self-employment.
03021 ongoing supported employment, individual	not applicable	Assistance to maintain self-employment or paid employment in an individual job placement (i.e., person is working with people without disabilities).
03022 ongoing supported employment, group	not applicable	Assistance to maintain paid employment in a group placement (i.e., person is working on a team of people with disabilities).
03030 career planning	not applicable	Focused, time-limited assistance to identify a career direction and develop a plan to achieve employment.

Medicaid Home and Community-Based Services (HCBS) Taxonomy Category and Subcategory Definitions

Category 04: Day Services

Definition: Services other than supported employment typically provided outside the person's home during the working day (i.e., Monday through Friday between 8 a.m. and 5 p.m.). These services provide a range of supports and are often, but not always, provided on a regularly scheduled basis at a site specifically established to provide day services.

Table 4: Day Services Subcategories

Subcategory	Common Names (where applicable)	Definition
04010 prevocational services	not applicable	Time-limited services to provide learning and work experiences, including volunteer work, to acquire general skills that help a person obtain paid employment in integrated community settings.
04020 day habilitation	not applicable	Regularly scheduled activities in settings separate from the participant's residence, including assistance in acquiring, retaining, and improving self-help, socialization, and/or adaptive skills. This service includes community-based volunteer activities that include acquiring, retaining, and improving self-help, socialization, and adaptive skills. This service can include the supports offered in adult day health, adult day services (social model), and community integration if these supports are provided along with assistance in acquiring, retraining, and improving self-help, socialization, and/or adaptive skills.
04030 education services	not applicable	Services to help a person access post-secondary education.
04040 day treatment/ partial hospitalization	not applicable	Services necessary for the diagnosis or treatment of the person's mental illness provided in a fixed site facility during the working day.
04050 adult day health	not applicable	Skilled health services and other support services, NOT including habilitation (i.e., assistance in acquiring, retaining, and improving self-help, socialization, and/or adaptive skills), provided to adults in a fixed site facility during the working day. This service can include the supports offered in adult day services (social model) if these supports are provided along with skilled health services.
04060 adult day services (social model)	not applicable	Support services, NOT including skilled health services and not including habilitation (i.e., assistance in acquiring, retaining, and improving self-help, socialization, and/or adaptive skills), provided to adults in a fixed site facility during the working day.
04070 community integration	escort	Assistance in participating in community activities, NOT including assistance with activities of daily living or assistance in acquiring, retraining, and improving self-help, socialization, and/or adaptive skills. This service can include supports furnished in the person's residence related to community participation.

04080 medical day care for children	not applicable	Medical services beyond typical day care responsibilities provided during the working day for infants, toddlers, and pre-school age children.

Category 05: Nursing

Definition: Services within the scope of the state's nurse practices act provided by a licensed nurse.

Table 5: Nursing Subcategories

Subcategory	Common Names (where applicable)	Definition
05010 private duty nursing	not applicable	Licensed nursing services provided on a continuous or full-time basis (e.g., for more than 4 consecutive hours per day and for more than 60 days). This service can include the supports offered in health assessment, health monitoring, and medication assessment if the service also includes other services within the scope of the state's nurse practices act.
05020 skilled nursing	not applicable	Licensed nursing services provided on a part-time or intermittent basis. This service can include the supports offered in health assessment, health monitoring, and medication assessment if the service also includes other services within the scope of the state's nurse practices act.

Category 06: Home Delivered Meals

Definition: Prepared meals sent to a person's home, which may not comprise a full nutritional regimen.

Table 6: Home Delivered Meals Subcategory

Subcategory	Common Names (where applicable)	Definition
06010 home delivered meals	not applicable	Same definition as category 06.

Category 07: Rent and Food Expenses for Live-in Caregiver

Definition: Payment for the additional costs of rent and food that can be attributed to an unrelated direct support worker living with the person. This service does not include payment for the direct support worker's services, which may be covered as part of other services such as personal care.

Table 7: Rent and Food Expenses for Live-in Caregiver Subcategory

Subcategory	Common Names (where applicable)	Definition
07010 rent and food expenses for live-in caregiver	not applicable	Same definition as category 07.

Category 08: Home-Based Services

Definition: Services that support a person in his or her home or apartment, when the provider does not have round-the-clock responsibility for the person's health and welfare. These services can be provided in other community settings, but are primarily furnished in a person's home or apartment.

Table 8: Home-Based Services Subcategories

Subcategory	Common Names (where applicable)	Definition
08010 home-based habilitation	supported living (provided on an hourly basis)	Assistance in acquiring, retaining, and improving self-help, socialization, and/or adaptive skills provided in the person's home when the provider does NOT have round-the-clock responsibility for the person's health and welfare. This service can include the supports offered in community integration, home health aide, personal care, companion, and homemaker if these supports are provided along with assistance in acquiring, retraining, and improving self-help, socialization, and/or adaptive skills.

Medicaid Home and Community-Based Services (HCBS) Taxonomy Category and Subcategory Definitions

Subcategory	Common Names (where applicable)	Definition
08020 home health aide	not applicable	Assistance with activities of daily living (ADLs) and/or health-related tasks provided in a person's home and possibly other community settings that are supervised by a registered nurse or licensed therapist and provided by a licensed home health agency. Home health aide may include assistance with instrumental activities of daily living (IADLs). Home health aide may include the supports offered in companion and homemaker if these supports are provided along with assistance with ADLs and/or health-related tasks. Home health aide does NOT include habilitation (assistance in acquiring, retaining, and improving self-help, socialization, and/or adaptive skills).
08030 personal care	attendant care personal assistance personal attendant services	Assistance with ADLs and/or health-related tasks provided in a person's home and possibly other community settings, NOT including both provision by a licensed home health agency and a requirement for supervision by a licensed nurse or therapist. Personal care may include assistance with IADLs. Personal care may include the supports offered in companion and homemaker if these supports are provided along with assistance with ADLs and/or health-related tasks. Personal care does NOT include habilitation (assistance in acquiring, retaining, and improving self-help, socialization, and/or adaptive skills).
08040 companion	adult companion night supervision	Supervision and/or social support provided in a person's home and possibly other community settings. Companion may also include performance of light housekeeping tasks (the supports offered in homemaker). Companion does NOT include assistance with ADLs or habilitation (assistance in acquiring, retaining, and improving self-help, socialization, and/or adaptive skills).
08050 homemaker	not applicable	Performance of light housekeeping tasks provided in a person's home and possibly other community settings NOT including supervision and social support, assistance with ADLs, or habilitation (assistance in acquiring, retaining, and improving self-help, socialization, and/or adaptive skills).
08060 chore	not applicable	Performance of heavy household chores provided in a person's home and possibly other community settings NOT including supervision and social support, assistance with ADLs, or habilitation (assistance in acquiring, retaining, and improving self-help, socialization, and/or adaptive skills).

Category 09: Caregiver Support

Definition: Assistance to people who provide ongoing support to the person with a disability when assisting the support person is the primary purpose of the service. In most cases, the support person is unpaid. However, respite can be provided to relieve providers who furnish shared living (subcategories 02021, 02022, and 02023).

Table 9: Caregiver Support Subcategories

Subcategory	Common Names (where applicable)	Definition
09011 respite, out-of-home	not applicable	Short-term services provided because a support person is absent or needs relief NOT provided in a person's home or apartment when relieving the support person is the primary purpose of the service.
09012 respite, in-home	not applicable	Short-term services provided because a support person is absent or needs relief provided in a person's home or apartment when relieving the support person is the primary purpose of the service.
09020 caregiver counseling and/or training	not applicable	Counseling, emotional support, and/or training provided to a family member or friend providing support when providing counseling or training to the support person is the primary purpose of the service. Examples of training topics include a) skills to provide specific treatment regimens or help the person improve function, b) information about the person's disability or conditions, and c) navigation of the service system.

Category 10: Other Mental Health and Behavioral Services

Definition: Services NOT identified in previous categories that support people in improving or maintaining mental or behavioral health.

Table 10: Other Mental Health and Behavioral Services Subcategories

Subcategory	Common Names (where applicable)	Definition
10010 mental health assessment	not applicable	Assessment or evaluation of mental health status when the assessment is the primary purpose of the service. This service can include medication assessment if the assessment includes other mental health information.

10020 assertive community treatment	not applicable	A range of mental health supports characterized by assertive engagement of the person, availability 24 hours a day, and support by an interdisciplinary team.

Subcategory	Common Names (where applicable)	Definition
10030 crisis intervention	crisis support	Response to stabilize a person exhibiting behavior that puts the person at risk of hospitalization or institutionalization.
10040 behavior support	behavior analysis behavior therapy	Services specifically to encourage positive behaviors and to decrease challenging behaviors, including a) assessment to identify antecedents to behaviors and b) development of a plan to improve behaviors.
10050 peer specialist	peer support	Mental health support services provided by a trained and credentialed person with a mental illness.
10060 counseling	not applicable	Individual or group therapy to develop coping skills or improve mental health function.
10070 psychosocial rehabilitation	not applicable	Assistance to improve or restore function in ADLs, IADLs, and social or adaptive skills NOT identified in previous categories or subcategories.
10080 clinic services	not applicable	Services for individuals with chronic mental illness furnished in a clinic or based in a clinic NOT identified in previous categories or subcategories.
10090 other mental health and behavioral services	not applicable	Services NOT identified elsewhere in category 10 that support people in improving or maintaining mental or behavioral health.

Category 11: Other Health and Therapeutic Services

Definition: Services NOT identified in previous categories that support people in improving or maintaining health or functional capacity.

Table 11: Other Health and Therapeutic Services Subcategories

Subcategory	Common Names (where applicable)	Definition
11010 health monitoring	not applicable	Ongoing monitoring of physical health status when monitoring is the primary purpose of the service. This service can include medication monitoring if other aspects of a person's health also are monitored.
11020 health assessment	not applicable	Assessment or evaluation of physical health status when the assessment is the primary purpose of the service. This service can include medication assessment if the assessment includes other health information.

11030 medication assessment and/or management	not applicable	Assessment of medication administration and/or possible drug interactions—and/or oversight of ongoing medication administration—when the management of medications is the primary purpose of the service.

Medicaid Home and Community-Based Services (HCBS) Taxonomy Category and Subcategory Definitions

Subcategory	Common Names (where applicable)	Definition
11040 nutrition consultation	not applicable	Assistance to a person to help him or her plan and implement changes to nutritional intake.
11050 physician services	not applicable	Services by a licensed physician. This service can include health assessment, medication assessment, and/or mental health assessment if other physician services are also provided.
11060 prescription drugs	not applicable	Prescription drugs.
11070 dental services	not applicable	Services by a licensed dentist.
11080 occupational therapy	not applicable	Services by a licensed occupational therapist.
11090 physical therapy	not applicable	Services by a licensed physical therapist.
11100 speech, hearing, and language therapy	not applicable	Services by a licensed speech, hearing, and language therapist. This service includes services by a speech pathologist or a qualified audiologist.
11110 respiratory therapy	not applicable	Services by a licensed respiratory therapist.
11120 cognitive rehabilitative therapy	not applicable	Assistance to manage or restore cognitive function.
11130 other therapies	not applicable	Therapeutic interventions to maintain or improve function NOT identified in previous categories or subcategories. This subcategory includes specialized interventions such as those using art, music, dance, or trained animals.

Category 12: Services Supporting Self-Direction

Definition: Services that assist a person and/or his or her representative in managing participant-directed services, as identified in the Participant Direction of Services section of the 1915(c) waiver or 1915(i) State Plan Amendment application.

Table 12: Services Supporting Self-Direction Subcategories

Subcategory	Common Names (where applicable)	Definition
12010 financial management services in support of self-direction	not applicable	Assistance to help a person and/or representative manage participant-directed services by a) performing financial tasks to facilitate the employment of staff; b) managing the disbursement of funds in a participant-directed budget; and/or c) performing fiscal accounting and making expenditure reports to the person, representative, and/or state authorities.
12020 information and assistance in support of self-direction	not applicable	Training the person and/or representative in directing or managing services. Topics include: a) the person's rights and responsibilities in participant direction; b) recruiting and hiring staff; c) managing staff and solving problems regarding services; and d) managing a participant-directed budget.

Category 13: Participant Training

Definition: Training provided to a participant when training the participant is the primary purpose of the service. Topics may include: a) specific treatment regimens, b) the person's disability or condition, and c) navigation of the service system.

Table 13: Participant Training Subcategory

Subcategory	Common Names (where applicable)	Definition
13010 participant training	not applicable	The same definition as category 13.

Category 14: Equipment, Technology, and Modifications

Definition: Material goods to help a person improve or maintain function.

Table 14: Equipment, Technology, and Modifications Subcategories

Subcategory	Common Names (where applicable)	Definition
14010 personal emergency response system (PERS)	not applicable	Devices that enable participants to signal a response center to secure help in an emergency. This service can include installation, maintenance, and monthly response center fees.
14020 home and/or vehicle accessibility adaptations	home and/or vehicle modifications	Physical changes to a private residence, automobile, or van, to accommodate the participant or improve his or her function.
14031 equipment and technology	assistive technology specialized medical equipment	The purchase or rent of items, devices, or product systems to increase or maintain a person's functional status. This service can include designing, fitting, adapting, and maintaining equipment, as well as training or technical assistance to use equipment.
14032 supplies	not applicable	The purchase of disposable medical supplies, including nutritional supplements.

Category 15: Non-Medical Transportation

Definition: Transportation not provided as part of another category such as round-the-clock services or a day services. This category may include: a) transportation to and from other waiver services; b) transportation to community activities where waiver services are not provided; and/or c) the purchase of public transit tokens or passes.

Table 15: Non-Medical Transportation Subcategory

Subcategory	Common Names (where applicable)	Definition
15010 non-medical transportation	not applicable	Same definition as category 15.

Category 16: Community Transition Services

Definition: Non-recurring set-up expenses for moving to a residence where the person is responsible for living expenses.

Table 16: Community Transition Services Subcategory

Subcategory	Common Names (where applicable)	Definition
16010 community transition services	not applicable	Same definition as category 16.

Category 17: Other Services

Definition: Services NOT identified in previous categories.

Table 17: Other Services Subcategories

Subcategory	Common Names (where applicable)	Definition
17010 goods and services	Individually directed goods and services	Services, equipment, or supplies in the person's support plan NOT otherwise provided in the Medicaid program.
17020 interpreter	not applicable	Services provided by an individual to support communication by someone who has limited English proficiency or verbal skills, such as a sign language interpreter or communicator.
17030 housing consultation	not applicable	Information and assistance to help a person identify and select housing.
17990 other	not applicable	Services NOT identified in previous categories and subcategories.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Center for Medicaid and CHIP Services

CMCS Informational Bulletin

DATE: April 16, 2012

FROM: Cindy Mann, Director
Center for Medicaid and CHIP Services (CMCS)

SUBJECT: Delay of ICD-10 and Reminder of Section 1915(c) Waiver Instructions

This Informational Bulletin provides information on two topics:

The delay in ICD-10 implementation, and
A reminder of the instructions for section 1915(c) home and community-based services waivers regarding actions that result in reductions.

Delay of ICD-10

CMS announced a proposed regulation on April 9 on HIPAA Administrative Simplification. The rule proposes a HIPAA standard health plan identifier and delays required compliance by one year– from Oct. 1, 2013, to Oct. 1, 2014– for new codes used to classify diseases and health problems. These codes, known as the International Classification of Diseases, 10th Edition diagnosis and procedure codes, or ICD-10, will include new procedures and diagnoses and improve the quality of information available for quality improvement and payment purposes.

Many provider groups have expressed serious concerns about their ability to meet the Oct. 1, 2013, compliance date. The proposed change in the compliance date for ICD-10 would give providers and other covered entities more time to prepare and fully test their systems to ensure a smooth and coordinated transition to these new code sets.

This proposed rule is the third in a series of administrative simplification rules in the new health care law. HHS released the first in July of 2011 and the second in January of 2012, and plans to announce more in the coming months. More information on the proposed rule is available on fact sheets at http://www.cms.gov/apps/media/fact_sheets.asp. Comments are due 30 days after publication in the Federal Register.

Reminder on §1915 (c) Waiver Instructions and Technical Guide regarding waiver actions that result in any type of reduction

Due to the difficult budgetary situations States are facing, there has been a significant increase in waiver actions, specifically amendments, which seek to reduce services, rates or numbers of waiver participants served. We have recently encountered several situations where

amendment requests to reduce services, rates or numbers of participants in waivers were submitted with retroactive effective dates. Any type of change to a waiver that may result in a reduction needs to be approved by CMS prospectively. States are, however, permitted to submit amendments to retroactively increase the unduplicated number of participants back to the beginning of the waiver year at any time during that waiver year cycle.

This guidance does not constitute new policy, but rather highlights guidance from relevant sections of the current Waiver Technical Guide Version 3.5 that was issued in January of 2008. Prospective approvals are always required for new waivers and are also required for renewals that make any reductions to the previously approved waiver. In other words, if a state submits an amendment or renewal to an approved waiver that makes reductions, the reductions are effective for the remainder of the approved period, but cannot be applied retroactively to the waiver's or renewal's approval date.

It is imperative that States submit any action that may result in a reduction with sufficient time to allow for review and prospective approval from CMS. Although CMS will make every effort to work with the State as quickly as possible, such actions must be submitted a minimum of 90 days prior to the anticipated date by which the State would like to implement the change. When a formal Request for Additional Information (RAI) is issued concerning a waiver action, the clock is stopped and only restarted (with a full 90-day clock) once the state responds to the RAI. Therefore, in some instances, the review period necessary may be as long as 180 days prior to implementation if the action requires a second 90-day clock.

Given the critical nature and timing of such waiver actions related to State budgetary plans, we strongly recommend that States consult with CMS prior to the submission. Informal consultation prior to the formal submission may expedite CMS review of the formal submission.

When an amendment would have the effect of reducing the number of waiver participants, the State should also review CMS guidance in Olmstead Letter #4 (located in Attachment C to the instructions of the Waiver Technical Guide and available at the following link: http://www.cms.gov/smdl/downloads/smd011001a.pdf)

Additional information and a link to the Waiver Technical Guide is available at http://www.hcbswaivers.net. Specifically, pages 30-31 of the Waiver Technical Guide, provide more detail about the procedures for submission and review of waiver amendments of various types. If you have any additional questions about this guidance, please contact Mr. Ralph Lollar, Director, Division of Long Term Services and Supports at 410-786-0777 or Ralph.Lollar@cms.hhs.gov.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services
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Center for Medicaid, CHIP and Survey & Certification

CMCS Informational Bulletin

DATE: September 16, 2011

FROM: Cindy Mann, JD
Director
Center for Medicaid, CHIP and Survey & Certification (CMCS)

SUBJECT: Updates to the §1915 (c) Waiver Instructions and Technical Guide regarding employment and employment related services

This Informational Bulletin is intended to provide clarification of existing CMS guidance on development and implementation of §1915 (c) Waivers regarding employment and employment related services. Specifically, this letter provides updates to several sections of the current Waiver Technical Guide Version 3.5, which was released in January of 2008, in advance of a future release of Technical Guide Version 3.6.

This guidance does not constitute new policy, but rather highlights the opportunities available to use waiver supports to increase employment opportunities for individuals with disabilities within current policy. Further, it underscores CMS's commitment to the importance of work for waiver participants and provides further clarification of CMS guidance regarding several core service definitions.

While States have the flexibility to craft their own service definitions and modify CMS core service definitions, many States rely on CMS language for their waiver core service definitions. We hope that by emphasizing the importance of employment in the lives of people with disabilities, updating some of our core service definitions, and adding several new core service definitions to better reflect best and promising practices that it will support States' efforts to increase employment opportunities and meaningful community integration for waiver participants.

The major changes in the Instructions and Technical Guide are summarized below:

- Highlights the importance of competitive work for people with and without disabilities and CMS's goal to promote integrated employment options through the waiver program
- Acknowledges best and promising practices in employment support, including self direction and peer support options for employment support
- Clarifies that Ticket to Work Outcome and Milestone payments are not in conflict with payment for Medicaid services rendered because both Ticket to Work and Milestone payments are made for an outcome, not service delivery
- Adds a new core service definition- by splitting what had previously been supported employment into two definitions- individual and small group supported employment
- Includes a new service definition for career planning, that may be separate or rolled into the

other employment related service definitions

- Emphasizes the critical role of person centered planning in achieving employment outcomes
- Modifies both the prevocational services and supported employment definitions to clarify that volunteer work and other activities that are not paid, integrated community employment are appropriately described in pre-vocational, not supported employment services
- Explains that pre-vocational services are not an end point, but a time limited (although no specific limit is given) service for the purpose of helping someone obtain competitive employment

I hope that you will find this information helpful. States and other interested parties may also find information contained in the attachments at www.hcbswaivers.net. If you have any additional questions about this guidance, please contact Ms. Nancy Kirchner, Health Insurance Specialist, Division of Long Term Services and Supports at 410-786-8641 or nancy.kirchner@cms.hhs.gov.

Attachments (2):

1 - Revisions to the Instructions and Technical Guide for §1915 (c) Waivers - Supported Employment and Prevocational Services

2 - Revisions to the Core Service Definitions for Employment and Employment related services in the Instructions and Technical Guide for §1915 (c) Waivers

Attachment 1
Revisions to the Instructions and Technical Guide for §1915 (c) Waivers for Supported Employment and Prevocational Services

Work is a fundamental part of adult life for people with and without disabilities. It provides a sense of purpose, shaping who we are and how we fit into our community. Meaningful work has also been associated with positive physical and mental health benefits and is a part of building a healthy lifestyle as a contributing member of society. Because it is so essential to people's economic self sufficiency, as well as self esteem and well being, people with disabilities and older adults with chronic conditions who want to work should be provided the opportunity and support to work competitively within the general workforce in their pursuit of health, wealth and happiness. All individuals, regardless of disability and age, can work – and work optimally with opportunity, training, and support that build on each person's strengths and interests. Individually tailored and preference based job development, training, and support should recognize each person's employability and potential contributions to the labor market.

Peer support is a powerful best practice model for helping support people to be successful in the world of employment. Most specifically for people with mental illness, the evidenced based practice of peer support has been a critical component of successful community living, including employment. Additionally, various types of employment and employment related supports may be provided by consumer operated service programs, independent nonprofit organizations that have a majority consumer board of directors. There is broader applicability for peer support and self advocacy for other disability population groups to ease the transition into community living and/or to develop stronger ties in those communities through the support and guidance from others who have navigated those situations and can now mentor others and offer mutual support. States may wish to consider provider qualifications for employment supports that draw on peer support models. Additional information concerning peer support services is contained in the August 15, 2007 State Medicaid Director letter #07-011at http://www.cms.gov/SMDL/downloads/SMD081507A.pdf.

Self directed service delivery models can also be used to provide employment supports. In a self-directed model, individuals may hire their own job coaches and employment support staff, rather than relying exclusively on agency based staffing models. This may be particularly useful as individuals seek to expand the pool of people who can provide employment supports and services to include friends, family members, co-workers and other community members that do not view themselves as part of the traditional Medicaid provider employment supports workforce.

Customized employment is another approach to supported employment. Customized employment means individualizing the employment relationship between employees and employers in ways that meet the needs of both. It is based on an individualized determination of the strengths, needs, and interests of the person with a disability, and is also designed to meet the specific needs of the employer. It may include employment developed through job carving, self-employment or entrepreneurial initiatives, or other job development or restructuring strategies that result in job responsibilities being customized and individually negotiated to fit the needs of individuals with a disability. Customized employment assumes the provision of reasonable accommodations and

supports necessary for the individual to perform the functions of a job that is individually negotiated and developed. (Federal Register, June 26, 2002, Vol. 67. No. 123 pp 43154 -43149).

Co-worker models of support to deliver on the job supports are effective service delivery methods that are often less expensive to provide and less intrusive to the flow of a business, helping the employee with a disability not just learn the task based elements of the job, but also the cultural norms and relationships within that job setting. Co-worker models of support rely on regular employees within the work setting who provide on the job training and ongoing support to the waiver participant that is beyond what is typically provided as part of supervision or training to employees. Co-worker supports may be delivered on a volunteer basis or paid through a stipend or other statewide payment methodology and unit cost as described in the waiver application Appendices I and J. Importantly, payment for co-worker supports is not payment to the employer for hiring the individual. Instead, it is encouraging the forging of natural work relationships with individuals already present and participating in the work environment. These models are not intended to replace the support provider's work, rather, it would be an additional mentoring/support role for which co-workers could receive additional compensation above what they receive in the course of their typical job responsibilities.

The Ticket to Work Program (TTW) is an employment support program offered through the Social Security Administration (SSA) which is available to SSA beneficiaries with disabilities who want to achieve and maintain their employment goals and can work in a complementary fashion with waiver services. Ticket Outcome and Milestone payments do not conflict with CMS regulatory requirements and do not constitute an overpayment of Federal dollars for services provided since payments are made for an outcome, rather than for a Medicaid service rendered. Additional information regarding the receipt of Federal funds under the SSA's Ticket to Work program is contained in the January 28, 2010 State Medicaid Director letter SMD# 10-002 at http://www.cms.gov/SMDL/SMD/list.asp.

Supported employment and prevocational services may be furnished as expanded habilitation services under the provisions of §1915(c)(5)(C) of the Act. They may be offered to any target group for whom the provision of these services would be beneficial in helping them to realize their goals of obtaining and maintaining community employment in the most integrated setting. As provided in Olmstead Letter #3 (included in Attachment D), the provision of these services is not limited to waiver participants with intellectual or developmental disabilities, and can be a meaningful addition to the service array for any of the regulatorily identified target groups.

It is important to note that such services may only be furnished to a waiver participant to the extent that they are not available as vocational rehabilitation services funded under section 110 of the Rehabilitation Act of 1973. When a state covers any category of supported employment services and/or prevocational services in a waiver, the waiver service definition of each service must specifically explain that the services do not include services that are available under section 110 of the Rehabilitation Act of 1973 or, in the case of youth, under the provisions of the Individuals with Disabilities Education Act (IDEA), as well as assure 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 delivered in facility based or sheltered work settings, where individuals are supervised for the primary purpose of producing goods or performing services. 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 *such as attendance, task completion, problem solving, interpersonal relations and safety,* as outlined in the individual's person-centered services and supports plan. Prevocational services should be designed to create a path to 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.

Although this is guidance with respect to the 1915 (c) Waiver 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 interpreting the integration regulations of those statutes. Consistent with the *Olmstead* decision and with person centered planning principles, an individual's plan of care regarding employment services should be constructed in a manner that reflects individual choice and goals relating to employment and ensures provision of services in the most integrated setting appropriate.

Attachment 2

Revisions to the Core Service Definitions for Employment and Employment related services in the Instructions and Technical Guide for §1915 (c) Waivers

Day Habilitation
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 plan. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day).
Day habilitation services focus on enabling the participant to attain or maintain his or her maximum potential and shall be coordinated with any needed therapies in the individual's person-centered services and supports 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 must 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 producing goods or performing services).

• 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 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.
• Day habilitation services may be furnished to any individual who requires 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 stand alone service definition.

Prevocational Services
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.

Individuals receiving prevocational services must have employment-related goals in their person-centered services and supports plan; the general habilitation activities must 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 optimal 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; Examples include, but are 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 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 service 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 must include 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
• 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 work and optimally to perform competitive, 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 optimal outcome of the provision of prevocational services is 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 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 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 learning and training activities that prepare a person for entry into the paid workforce.
• Prevocational services 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.

Supported Employment -Individual Employment Support
Core Service Definition
Supported Employment -Individual Employment Support services are the 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 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. 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 support, training and planning, transportation, asset development and career advancement services, and 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.
Documentation is maintained 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 is not 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.

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 supports services and the cost of this transportation is included in the rate paid to providers of supported employment individual employment supports services, 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 individual 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 individual 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 stand alone 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.

Supported Employment - Small Group Employment Support
Core Service Definition
Supported Employment Small Group employment support are services and training activities provided in regular business, industry and community settings for groups of two (2) to eight (8) workers with disabilities. Examples include mobile crews and other business-based workgroups employing small groups of workers with disabilities in employment in the community. Supported employment small group employment support must be provided in a manner that promotes integration into the workplace and interaction between participants and people without disabilities in those workplaces. The outcome of this service is 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. Small group employment support does not include vocational services provided in facility based work settings.

Supported employment small group employment 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 support, training and planning 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.
Documentation is maintained 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 is not 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.

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, the service definition must include a statement to that effect.

Guidance
• Supported employment small group employment support does not include vocational services provided in 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 more appropriately 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 stand alone service definition.
• Supported employment small group employment support services may be furnished to any individual who requires and chooses them. If a state offers both supported employment- individual and small group employment support services, individuals should be provided information to make an informed decision in choosing between these services. Supported employment small group employment support services are not limited to persons with intellectual or developmental disabilities.

Career Planning
Core Service Definition
Career planning is 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).
• 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 stand alone 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.

Attachment D:
Sampling Guide

SAMPLING

A Practical Guide for Quality Management in Home & Community-Based Waiver Programs

A product of the
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Introduction

In the past decade we have witnessed appreciable changes in quality management (QM) for community-based long-term care services and supports provided to elders and people with disabilities. The number of people receiving services and supports in the community, along with the complexity of the systems for delivering those services, has increased dramatically. In response, states have worked to develop QM processes that can both address individual concerns and identify system-wide issues.

At the same time, the Centers for Medicare and Medicaid Services (CMS), which helps fund many of these services through the Medicaid 1915c waiver program, has refocused its quality oversight responsibility for home and community-based services (HCBS) at the federal level to reflect three important principles. These are:

- States have first-line responsibility for assuring the quality of services and supports provided through their HCBS waiver programs, and for assuring the health and welfare of program participants.

- CMS oversight of this responsibility must be continuous over the life of an approved waiver, and requires sustained and on-going communication between the federal government and state waiver staff.

- The focus of quality management efforts should be on meeting the waiver assurances articulated in federal regulations and on continuous quality improvement within individual waiver programs.

These principles have direct implications for the design and practice of quality management at the state level. They require that a state develop the ability to retrieve and analyze information from state and local agencies, providers and participants, and use this information for quality improvement up, down, and across the organizational hierarchy.

In recognition of these three principles, CMS revised its quality review process for Medicaid HCBS waivers through implementation of the Interim Procedural Guidance for Assessing HCBS Waivers, in January 2004.[1] The new procedures shifted the paradigm of federal oversight from a point-in-time, on-site review of waivers to a continuous quality improvement cycle, characterized by two processes:

- On-going dialogue between federal reviewers and state staff; and

[1] CMS plans to replace the Interim Procedural Guidance with an annual report (the proposed CMS 373Q) from the state to CMS on the quality achieved in their waivers.

- Provision of evidence by states that illustrates they have systems in place to identify, in a timely manner, when quality issues occur; to take action to remedy individual quality issues; and to prevent their reoccurrence through appropriate intervention(s).

Inherent in the quality improvement cycle are the three functions of **Discovery, Remediation, and Improvement**, as articulated in the *HCBS Quality Framework*, released by CMS in 2004.[2] Each of these functions relies on accurate and representative information to identify and address quality issues.

Discovery is the first step in managing and improving quality, and provides information (in accordance with the CMS Assurances) on whether program participants are provided appropriate and adequate access to services and supports; that these services and supports are delivered as intended; that participants' health and welfare is achieved; that providers of services and supports are qualified; that the financial integrity of the program is maintained; and that the single state Medicaid agency oversees and is actually involved in the quality management enterprise.

In implementing Discovery approaches, states face questions of what types of information to gather and what data sources can provide the needed information. For example, Discovery around health and welfare might involve aggregated data from case manager supervisory record reviews; from independent case record reviews by the Medicaid agency; from a survey of program participants; from a comparison of plans of care with claims data, and so forth. Each of these discovery methods focuses on a different kind of information from a different source, but all have the potential of providing important information about whether beneficiaries are receiving the necessary services and supports and/or are achieving outcomes consistent with the intent of the program.

Gathering information from each waiver participant or service plan, however, can be costly and time intensive, and is not always necessary. Depending upon the size and scope of the state's waiver program, it is often sufficient and more cost effective to draw representative samples in order to gather information and make inferences about an aspect of program quality overall. In its oversight role, CMS does not prescribe sampling methods for states to use. It does, however, expect that states will use sound and reasonable processes to gather information from which conclusions about quality can be drawn and acted upon.

To that end, this Guide is designed to provide states with practical information about sampling techniques and strategies that they can employ in their quality management work. Its purpose is to offer states information to consider when deciding whether to sample, and to identify issues for consideration once the decision to sample has been made. The information presented here is intended to familiarize the reader with basic concepts and considerations; it should not take the place of seeking technical expertise in sampling methodology. States are strongly advised to consult with a statistician or research methodologist when designing sampling plans.

[2] The *HCBS Quality Framework* is available at http://www.cms.hhs.gov/HCBS/05_Quality%20Oversight.asp#TopOfPage

How to Use This Guide

This Guide seeks to provide a user-friendly, step-by-step approach to explaining sampling, identifying alternatives among different sampling techniques, and understanding how to use these techniques for specific purposes in a quality management strategy. Much of this Guide should be useful to agencies that have already made the decision to sample, by providing guidance on implementing that decision.

However, before launching into sampling, states must first assess whether or not sampling is the best means for securing the information they are seeking. Sometimes sampling is not the most appropriate way to gather data. Certain types of information, such as health and safety data, are routinely gathered for all program participants, and states may find it more useful to examine data from the entire population of program beneficiaries when analyzing trends.

To help users determine the purpose of a proposed data collection effort, the Guide begins with a discussion of issues to consider when deciding whether to sample (*To Sample or Not?*). The subsequent sections address various sampling considerations and techniques (*Defining the Target Population, Sampling Methods, Determining Sample Size, Stratification* and *Sources of Error*). Critical terms are defined in call-out boxes throughout the text, and highlighted words are defined in the Glossary found at the end of the Guide.

The Guide is intended for use in quality management for Medicaid HCBS waivers serving any population, and for any type of service or support. Examples of applications in different types of waiver programs are provided throughout the text. Additional references for applying these concepts are provided in the Appendices, which include: a list of Sampling Resources, such as web-based calculators for determining sample size (Appendix A) and a Glossary of terms (Appendix B).

To Sample or Not?

A sample is a subset of a population. Since it is sometimes impractical, or not necessary, to collect information on the universe of individuals or other entities of interest, such as providers or care plans, a smaller segment of the population is selected to estimate the characteristics of the whole. The purpose of sampling is to collect information that can be generalized to the broader population from which the sample is drawn.

When drawing a sample, the goal is to select one that is representative of the population of interest. A sample is considered representative of the population if the characteristics of, or outcomes associated with, the sample (e.g., age, type of disability, percent receiving a level of care determination on time; percent getting their needs addressed) are similar to their distribution in the population. Ideally, sample characteristics/outcomes should mirror their manifestation in the population. For example, if 40 percent of the population lives in group homes, than approximately 40 percent of the sample should, too.

However, before any discussions about sampling design can begin, states should examine the purpose of the data collection effort and determine the best approach for gathering information. This section takes the reader through some basic issues to consider when making the decision whether or not to sample.

Representative Sample

A sample is considered representative of the population if the characteristics of the sample (e.g., age, gender, type of disability) are similar to the distribution of these characteristics in the overall population.

Determining the Need for New Information

States continually gather information from many disparate sources for a variety of different purposes, including quality assurance and improvement. Before an agency decides to sample, it must first determine exactly what information it needs and if this information is already available. Sometimes the needed information, such as use of dental services, can be drawn from an existing source, e.g. claims data. If it cannot, the next consideration is how these new data should be collected. To first assess the need for collecting new data, administrators must answer three fundamental questions:

1. What is the question to be answered?

2. What is the source of information that can answer/address the question?
3. Is it necessary to collect new information, or can existing information be used?

For example, a state agency may have questions about waiver beneficiaries' access to transportation services based on concerns raised by case managers. After discussion among members of state's Quality Committee, the following question emerges: What proportion of participants in the state's aged/disabled waiver actually used the county-run van service in the past 12 months? The committee then identifies two potential sources of information to answer this question. The first is the billing system used by the transportation service, which submits an electronic invoice for each trip that includes information on the number of riders. The second is a proposed survey of waiver participants assessing their use of the transportation service in the past year. After further investigating these options, the committee determines that the invoices are not an adequate source of information because they cannot be used to estimate an unduplicated number of users. As a result, committee members decide they must collect new data.

Collecting New Information

After a state has determined it needs to obtain new information, the next consideration is how best to collect these data. In some cases, it may be sufficient or preferable to collect information from only part of the population of interest and use these data to estimate the outcomes of the overall population. In other cases, sampling the population may not be appropriate. Each of these scenarios is discussed below.

Deciding to Sample

Sampling to collect new information should be considered when:

- It is not necessary to collect information about the entire population to determine if there is a problem or to answer a question.
- It would take too long to gather information systematically about an entire population, particularly if the population is large and/or geographically dispersed;
- Collecting information about a full population would be labor-intensive and require significant staff time and money.

If any of these conditions are met, state officials should consider drawing a sample, and collecting information only on the sample. In the example from the previous section, let's assume that the number of aged/disabled waiver participants is quite large and contacting all of them would be very time-consuming and labor-intensive. The Quality Committee is confident that any transportation problems experienced by a representative sample of waiver participants would be indicative of access issues for the waiver population overall. In this case, they determine that using a sample for their proposed survey is the best method to collect new information.

There are a variety of methods that can be used to select samples from populations. Some of these methods are more likely to yield a representative sample than others. These techniques are discussed in detail in the next section.

Deciding Not to Sample

Sometimes, collecting new information about the full population- called a census - is more appropriate than sampling, for both methodological and pragmatic reasons. For example, collecting new information from an entire population could be useful when:

- The size of the population of interest is so small that it is feasible to collect information from all members of that population.
- There is a legislative or regulatory mandate to collect information about all members of the population. For example, if a state is required to gather data about all service providers for certification and licensure, selecting a sample of providers would not be acceptable.
- Collecting information from all members of the population may be perceived by stakeholders as more legitimate or credible.
- Information on the entire population is readily available (e.g., automated information on critical incidents, automated data on claims and plans of care to assess degree to which authorized services are actually delivered). Sampling always involves some amount of error, so if you have the information you need on the entire population and it is readily available, it makes sense to use it rather than to sample.

Census

A process used to collect information about the full population, as opposed to a sample or subset of the population.

Other Methods for Collecting New Information

Even when states determine that new information is necessary and sampling is the best path, a state may still determine that its resources are not adequate, and drawing a truly representative sample is not a practical option. In these instances, states can consider a range of other

approaches to gathering information. States frequently and effectively use other qualitative methods of inquiry, such as:

- Focus Groups – structured discussions used to gather information and insight from a small group of individuals
- Public Forums – larger gatherings used to present information and gather feedback from individuals in specific communities
- Targeted Reviews – examinations of a single issue, with a group of selected individuals
- Root Cause Analysis – in-depth examination from a systemic perspective of a seminal event
- Quality Improvement Committees – appointed bodies whose purpose is to advise a public system

Sampling considerations and methods to use when applying these types of qualitative approaches are beyond the scope of this guide.

Defining the Target Population

One of the first and most important steps in sampling is to define the target population (i.e., population of interest). The target population is the collection of entities you want to study. There needs to be a clear and explicit definition of the whole population or universe before the sample is drawn from it. If the population is not well specified, it is difficult to determine whether the sample is representative of the population and erroneous generalizations or conclusions may result. It is important to note, however, that the term "population" can refer to elements or units other than people. In addition to individuals, states frequently will examine provider organizations, records, critical incident reports, and plans of care, as well as other populations in their quality management systems.

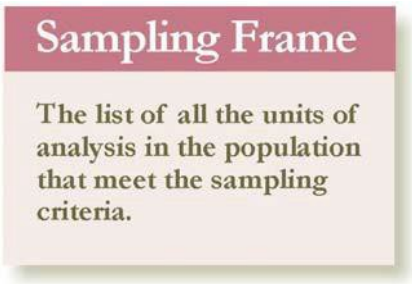
Inclusion and Exclusion Criteria

Clear inclusion and exclusion criteria are necessary to specify the population of interest. These criteria indicate who is eligible (or not eligible) to be selected from the target population into the sample. Inclusion and exclusion criteria specify the characteristics of individuals or entities to be included or excluded, respectively, in the sampling frame (e.g., age, type of disability, type of residential setting, geographic location). These criteria help to clarify the boundaries of the specific target population. Regardless of the inclusion/exclusion criteria used, the rules must be consistently applied and explicitly documented. Doing so allows states to make accurate estimates about the population based on what they have learned from the sample. If these criteria are not carefully outlined, it is possible to make erroneous generalizations. For example, if you decide to include only waiver participants with mobility problems, you will only be able to generalize your findings to that group, not to the entire waiver population (even though persons with mobility problems are a subset of the larger waiver population).

Sometimes the definition of the target population may be based upon certain operational considerations, such as litigation or legislation. For example, if a class action settlement mandates that annual surveys be conducted to assess state agency compliance in providing services to protected "class members," then the target population by definition is all of the individuals who are members of this protected class. Other times there may be practical considerations, such as the lack of interpreters or foreign language surveys, which affect the scope of the target population.

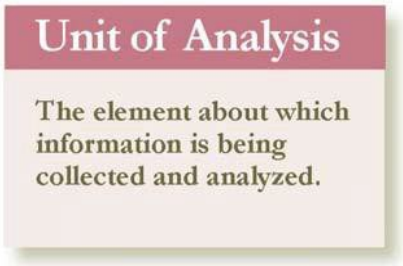
Sampling Frame and Units of Analysis

The actual list of the target population, created by applying the inclusion and exclusion criteria, is referred to as the sampling frame. The sampling frame operationally defines the target population. It is the list of people or entities from which the sample is drawn. In many cases, the sampling frame consists of individuals – for example, a list of program participants currently served by an agency, or a list of people who are on a waiting list for environmental modification services. The unit of analysis is the element about which information is collected and will provide the basis for the analysis. Sometimes the unit of analysis in the sampling frame includes elements other than individuals – for example, a list of home health care service providers, grievance reports, or individual support plans. For different analyses in the same inquiry, there may be different units of analyses.



The sampling frame must be as accurate as possible. If the list of people or entities in the target population is incomplete or outdated, the resulting sample may be biased and therefore not truly representative of the population. For instance, a year-old roster for a waiver with a high death rate (due, for example, to the acuity of the program participants) or short average length of stay may not be very accurate for defining the sampling frame. Therefore, the list must be screened for completeness and accuracy immediately prior to drawing the sample. Common inaccuracies in sampling frames include omissions, duplications, or ineligible cases. Bias due to coverage errors (selecting the wrong people or selecting too few or too many people with certain characteristics) or inaccurate conclusions can result if certain members of the population are:

- mistakenly omitted from the sampling frame;
- listed more than once in the sampling frame; or
- mistakenly included in the sampling frame when they do not meet the inclusion criteria.

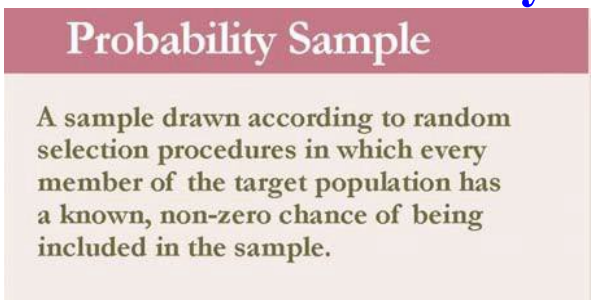


In some situations, a complete list of the population may not exist, or the list may not be available or accessible for sampling (e.g., due to privacy and confidentiality issues, data access problems, or organizational constraints). In many cases, one "master list" is not available, but can be constructed by combining lists from different data sources. Cooperation and/or agreements with sister agencies may be necessary to secure accurate and complete lists. If multiple lists are combined, it is important to screen for duplication. Sometimes an initial outlay of effort is necessary, such as checking for current address, but then processes can be put in place to reduce effort in the future. If these hurdles can not be overcome, it may be necessary to define your population more narrowly.

Sampling Methods

There are two broad types of samples: probability and non-probability. In this section, probability sampling methods are described first, followed by discussion of non-probability sampling methods. In a probability sample, every member of the target population has a known, non-zero probability (or likelihood) of being included in the sample. That is, everyone in the target population has a chance of being selected into the sample, and their chances of selection (likelihood) are greater than zero. A probability sample is considered "representative" of the population, and therefore the findings based on the sample can be generalized to the population overall. Probability samples are essential if the goal of the data collection is to make estimates about the whole population or to use data from the sample to draw conclusions. When drawing probability samples, specific random selection procedures are used that eliminate subjectivity or bias in the sample. "Random" selection in this context does not mean haphazard or coincidental. Rather, it refers to precise procedures based upon probability theory.

Probability Sampling Methods



In order to use probability sampling methods, a complete list of the target population (the sampling frame) is needed. Common probability samples typically fall into one of two types: single stage random samples and multi-stage random samples. Single stage random sampling methods assist states to generalize across the entire target population, and frequently are more cost-efficient. However, when states want to ensure that sub-populations are adequately represented in their sample, they use a multi-stage probability technique.

Some of the common probability sampling methodologies are described below.

Single Stage Sampling Techniques

Simple random sampling:

Using simple random sampling, each unit in the sampling frame (e.g., each individual on the population list) is assigned a number and then numbers are randomly selected using a random numbers table or a computerized random selection program. Numbers are randomly drawn until the desired number of cases for the sample has been reached.

Systematic sampling:

In systematic sampling, selection typically begins at a random place in the population list (sampling frame) to identify the first case to be selected into the sample and then cases are selected at regular intervals from the list – for example, every 6th person is selected, or every 10th person. This type of sampling is typically less cumbersome than simple random sampling, particularly if the population list is long. It is considered as accurate and unbiased as a simple random sample, provided that there is no repetitive pattern or ordering to the sampling frame list. If there is an inherent cycle in the list, linked, for example, to age or residence, selecting every "nth" person might reflect this order bias and result in under- or over-representing certain types of cases on the list.

To determine the appropriate "interval" for your sample (e.g., every "nth" case) divide the population size by the desired sample size. For example, if the sampling frame lists 1000 names, and a sample of 200 is desired, then the sampling interval is 5 (1000/200). That is, every 5th person on the list would be selected into the sample. Determining the appropriate sample size is discussed in more detail below.

Multi-stage Sampling Techniques

Stratified Sampling:

In this technique, the population is first divided into homogeneous strata or sub-samples (grouping of individuals or entities based on characteristics they share), and then simple random sampling or systematic sampling is used to select cases within each stratum. Stratified sampling is used when the state wants to control the relative size of each stratum or sub-sample, instead of leaving this to chance in sampling the full population. A common reason for stratification is to ensure representation of small groups that might otherwise not have a large enough presence in the sample about which to make statistical generalizations. For example, agency administrators may want to compare participant outcomes across five geographic regions of a state and be assured that the sample size within each region is sufficient for making credible generalizations about each region. To use stratified sampling, administrators would first divide cases of the sampling frame into the five state regions (strata) and then randomly sample participants from within each region. This ensures that cases from each stratum are adequately represented in the full sample.

In order to use stratified sampling, there must be sufficient information about the population to decide in advance to which subgroup or stratum each member belongs. The principles of sample size (see next section, *Determining Sample Size*) will apply to each stratum, however, and in order to make accurate analyses and reduce errors, administrators must ensure adequate size of the strata. Additionally, when examining the data in the aggregate, strata may need to be weighted to mathematically account for the disproportionate contributions of the various strata. For a more information regarding analysis of stratified samples, see the *Stratification* section of this guide and consider consulting with a statistical analyst.

Cluster Sampling:

Cluster sampling is typically used in large-scale studies covering broad geographic areas or organizational units, and it involves a multi-stage process. Cluster sampling is used when a complete centralized sampling frame is not available; however, complete sampling frames for each cluster must be available. The first step in drawing a cluster sample is to identify key geographic groups or distinct information clusters (e.g., census tracts, counties, regional offices, differing data sources), then a random sample of these clusters is drawn, and, finally, cases within the randomly selected clusters are randomly selected into the sample.

Cluster sampling is not generally recommended for agency-initiated inquiries as this technique is costly, complex and requires more intensive efforts to control error. While cluster sampling allows agencies to use random selection techniques throughout the process, in the absence of a centralized population list, this technique is considered somewhat less reliable than other "pure" forms of random sampling. There is potential for sampling errors and inaccuracies at each step of this multi-stage process, particularly at the cluster selection stage. Moreover, weighting the results of a cluster sample back to the population is highly complex. Cluster sampling should not be attempted without the services of a seasoned sampling statistician.

Non-Probability Sampling Techniques

In a non-probability sample, the likelihood of selecting any one case from the population into the sample is not known. Random selection procedures are not used in non-probability samples. Instead, cases are selected from the population based upon other criteria such as the judgment of the people doing the study, requirements of other entities, or availability of subjects; there is greater potential for subjectivity or bias in non-probability sample selection. Non-probability samples are often used when a sampling frame is not available, and/or when the time requirements or costs of using probability methods are prohibitive. A non-probability sample may not accurately represent the population, and the generalizability of findings is limited.
Despite of these limitations, non-probability samples can be useful and appropriate in certain situations such as descriptive, exploratory, and qualitative studies in which generalizability of findings to broader populations may not be necessary.

Non–Probability Sample

A sample drawn without random selection procedures; the likelihood of selecting any one subject is not known and generalizability to the population is limited.

Some common types of non-probability samples are:

- *Availability or convenience sample*: Sampling those people readily available or convenient to study -- for example, surveying available and willing participants in a day program about their experience with program staff.

- *Purposive sample*: Selecting individuals from the population based upon professional experience, knowledge, or judgment (i.e., purposely handpicking sample members) – for example, purposefully selecting typical or atypical cases for inclusion in the sample or critical cases judged by quality management staff to be important to investigate.

- *Quota sample*: Setting a quota for inclusion of specified numbers of people with certain characteristics (e.g., establishing a sample quota of 25 adults with MR/DD living in community settings, 25 adults with psychiatric conditions in community settings, 25 people with physical disabilities in community settings). Individuals with these characteristics are selected, not necessarily randomly or from a known list, until the specified quota is achieved.

- *Snowball sample*: Making initial contact with known members of the population, and then asking those sample members for referrals to other members of the population. This chain-like informal word of mouth referral process is especially helpful in identifying hard-to-reach populations such as people who are homeless, undocumented immigrants, or people who are socially isolated.

The advantages of these non-probability methods are that they are often less time-consuming and resource intensive than probability methods. While they may be appropriate in certain contexts as described above, the findings based upon these methods are limited in terms of generalizability to the broader population.

Determining Sample Size

State officials frequently grapple with the question: How large should our sample be? The answer is, "it depends." This section will discuss some of the factors that states should consider when making decisions about sample size. To make this decision, states need to evaluate several factors, balance tradeoffs, and ultimately decide what works best, given their specific information objectives, resources, and constraints.

Relationship between Sample Size and Population Size

One consideration when determining sample size is the size of the population. The table below displays sample sizes that were calculated using different-sized populations, all at 95% confidence level and +/-5% margin of error. (These terms will be explained below.) This table illustrates that once the population size reaches the thousands, the required sample size increases very incrementally.

A common misconception is that samples should be determined based on a certain "percentage" or fraction of the population. This is not true. Looking at an online calculator or a statistical table it is clear that the formulas behind the calculations are not based on percentages of the total population.

Sample Sizes for Different Size Populations

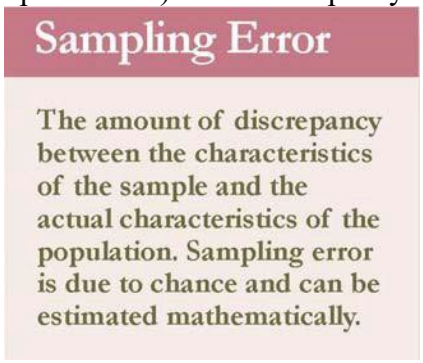
Population	Sample*
300	169
1,000	278
2,000	322
3,000	341
30,000	379
300,000	384

*95% Confidence Level and +/- 5% margin of error

Degree of Accuracy

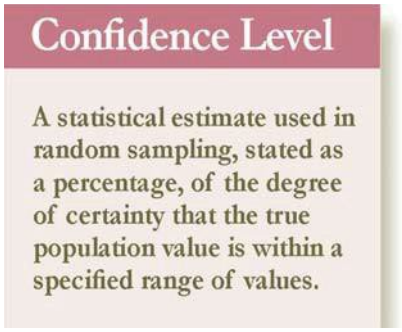
Whether you decide to use a statistician, an online calculator, or your old statistics textbook to determine sample size, you will need to be familiar with several key terms related to accuracy. Critical concepts include: sampling error, confidence level, and margin of error. As discussed earlier, probability sampling methods that use random selection procedures are considered to have a higher degree of accuracy than non-probability methods. Random sampling allows one to make generalizations about the population based upon the data collected from the sample.

However, even when random sampling is used, the sample characteristics (also called sample statistics) are likely to differ somewhat from the true population values (also called population parameters). This discrepancy is referred to as sampling error.



Sampling error occurs simply as a result of the process of drawing a sample. It is a type of error that is due to mathematical chance, or the probability of selecting cases that do not estimate exactly the population parameter. There are two pieces of "good news" about sampling error.

First, increasing sample size reduces the amount of sampling error. The larger the sample size, the more likely the sample values will be close to the true population values. Second, if random sampling methods are used, it is possible to estimate mathematically the amount of sampling error – that is, the extent to which the sample may differ from the population.



The next important concepts to understand are confidence level, confidence interval, and margin of error. These concepts are inter-related and can all be traced back to sampling error. Key decisions will need to be made about these factors, which will then be used to determine sample size.

In a nutshell, states need to decide how much sampling error they are willing to tolerate and their desired confidence level, given their specific objectives. There are statistical tables in many research texts and computerized software programs that calculate the sample sizes necessary to provide population estimates at various levels of precision, by specifying confidence levels and confidence intervals. (A list of web-based and print resources is included in the Appendix of this guide.) Because of the complexity of determining the best approach for a particular research effort, states may want to consult with a statistician or survey methodologist about whether and how to use these resources to determine appropriate sample size, confidence level, and confidence interval. Keeping this caveat in mind, the basic concepts related to accuracy are illustrated below.

Confidence Interval

A statistical estimate of the range of values within which the true population value is likely to fall. Confidence intervals are often denoted by a single number that identifies the margin of error, such as + or - 5%.

Random sampling allows us to estimate statistically the range of values within which the true target population is likely to fall (the "confidence interval") and how certain we can be that the true population value is within that range of values (the "confidence level"). This allows us to make a statement like:

> *Based upon the sample data, we are 95% certain [confidence level] that between 65% and 74% [confidence interval] of E/D waiver participants have been visited by a case manager in the past two months.*

Because sampling error is due to mathematical chance, the sample is just as likely to underestimate as it is to overestimate true population values. The confidence interval (also referred to as "margin of error") is sometimes expressed as "plus or minus" the number of units around the sample statistic. The statement above could also be written as:

> *Based upon the sample data, we are 95% certain [confidence level] that 69.5%, +/- 4.5% [margin of error] of E/D waiver participants have been visited by a case manager in the past two months.*

A common confidence level used in scientific reporting is 95%, and a generally acceptable margin of error is +/-5%. The larger the sample size, the more accurate population estimates will be. However, once a sample reaches a certain size, there are diminishing returns on accuracy.
The table below displays the margin of error associated with different samples sizes selected to represent a population of 1500 and based on a confidence level of 95%. As you can see, the margin of error is significantly higher for a small sample than it is for larger samples. As sample size increases from 30 to 200, the margin of error drops dramatically from +/-17.7% (which is unacceptable) to +/-6.5% (much better). However, increasing the sample size from 600 to 800

only changes the margin of error from +/-3.1% to +/-2.4% (both of which indicate high levels of accuracy). It is important to understand these concepts when determining sample size so that states can ensure the level of accuracy selected is appropriate and acceptable for the purpose of the inquiry.

Relationship Between Accuracy and Sample Size

Sample	Margin of Error*
30	+/-17.7%
200	+/-6.5%
400	+/-4.2%
600	+/-3.1%
800	+/-2.4%

*For a population of 1,500 and a 95% confidence level

Degree of Variability in Population

The more variability in the population, the larger the sample size needs to be. For example, if the research question relates to health conditions and medication use and there is an indication that the target population is quite varied in terms of these two characteristics, then a larger sample size will be needed to capture the diversity (heterogeneity) of that population. The opposite is true when population members are quite similar in terms of health conditions or medications. Of course, there are many situations where we do not know in advance how diverse the population is likely to be in terms of various characteristics. In fact, states may often collect data to examine the characteristics of the population. When the variability of the sample is unknown, it is generally better to be conservative, assume large variability within the population, and draw a larger sample to capture potential diversity within the population.[3]

[3] On-line calculators typically assume the greatest variability possible in the population and build this assumption into the sample size calculation. Therefore, the resulting sample size is somewhat larger than if more homogeneity is assumed. However, when the level of variability in the population is unknown, this assumption is the safest and most reasonable.

Number of Variables to Be Examined

Larger sample sizes are advised if you intend to examine large numbers of variables simultaneously. For example, if a state plans to analyze 15 different demographic, clinical, and environmental factors that may predict client satisfaction with services, the analysis will likely involve multivariate statistical techniques that simultaneously investigate how these various factors may in combination affect client satisfaction. The more variables that are investigated in combination, the larger the sample size should be. A statistical analyst or survey methodologist can help advise about whether multivariate analysis is relevant and its implications for sample size.

Non-Response Rate

Even if a state follows proper procedures to select a random sample of cases or individuals, ultimately some of those selected will not respond to the inquiry. "Non-response" of potential participants occurs for a variety of reasons and has implications for sample size. If a state anticipates that there may be appreciable non-response (e.g., due to refusals, inability to make contact, cancellations, unexpected illness, etc.), given their knowledge of the population and past experiences, then it may be wise to draw a larger sample than needed in order to compensate for the potential non-response factor. This process is referred to as "oversampling." For example, a state may decide to randomly select 400 program participants, in hopes of actually ending up with information from a desired sample size of 350. Non-response also varies by the research method chosen. For example, response rates to mail surveys are usually low, and to ensure an adequate sample size the state must over-sample by a much larger factor than they would for face-to-face interviewing.

Non-response also has implications for error. It is helpful if states have access to some background demographic data about the non-respondents in order to analyze whether and how non-respondents may differ from the actual sample respondents. If non-respondents are significantly different from the respondents (e.g., in terms of type of disability, age, type of services, socio-economic factors, language proficiency, etc.), then the final sample has limited generalizability to the population and may be considered skewed.

Budget Resources and Time Constraints

States need to factor in all of these concerns and evaluate the relevance of these issues within their particular operational context. Ultimately, states must balance the tradeoffs of obtaining a sufficient sample size within their existing budgetary resources and time constraints. They must anticipate the costs of drawing a sample and the related tasks of data collection, data entry and management, and data analysis when determining an appropriate and feasible sample size.

As a rule, a sample should be large enough for the state to feel confident in the generalizability and consequent credibility of its results. However, samples large enough to satisfy conventionally acceptable levels of accuracy and precision may require more resources than a state has at its disposal. As such, states must weigh their need for data accuracy and precision against their budget concerns and resource constraints.

Stratification

This section provides additional information about stratified random sampling methods.

Sample Stratification

In stratified sampling, the population is divided first into mutually exclusive subgroups (called strata), and then random samples are drawn from each stratum. This approach helps ensure representation of key subgroups of the population, which is helpful when there are differences in the relative size of groups within the overall population of interest. To use this sampling method, there must be sufficient information for categorizing each member of the population into a stratum (subgroup). This information must be present BEFORE the sample is drawn.
Stratification is only possible if the state can divide the list of the target population (i.e., the sampling frame) into non-overlapping homogeneous subgroups from which to draw a random sample. The strata membership (or subgroups) of individuals must be known in advance of selecting the sample members. Moreover, it is also imperative that all strata are mutually exclusive; for example, using age as stratification criteria, only ONE strata can include persons 18-44 years old and only ONE strata can include those 45-64 years old.

Typically a population is stratified based on a key variable upon which comparisons will be made, such as demographic, administrative, or background characteristics. For example, a state agency may decide to stratify its sample by geographic region in order to ensure an adequate sample size within each region, especially if it believes there are differences in service use, service availability, or other resources between regions. Other variables that states often use to stratify a population include service or provider type (e.g., day/residential/supports) and residential setting (e.g., community residence, family home, assisted living facility.)

In some cases a state may decide to stratify the population based upon two or more variables, such as stratifying simultaneously by both region and provider type. First, the population list would be divided into specific regions, and then into provider subgroups within each region, to create a series of mutually exclusive subgroups called “cells.” A sample of individuals would then be randomly selected from each sampling cell. A note of caution -- the more stratifying variables used, the more complex the sampling and analysis procedures, and the larger the sample size required for a given confidence level. If the population is subdivided into too many strata, there is the risk of having too few cases within each of these cells to make statistically valid and reliable comparisons.

Variable

A characteristic of an individual or case. The characteristic must be able to take on more than one value and must be measurable.

Proportionate and Disproportionate Stratified Samples

Samples that are randomly selected within each stratum can be proportionate or disproportionate to the population size. In a proportionate stratified sample, the number of cases selected from each stratum is based upon the subgroup's size relative to the population size. That is, if 40% of the total population resides in Region 1, then residents of Region 1 (the stratum) should comprise 40% of the total sample as well. And, if only 10% of the population resides in Region 2, then Region 2 should comprise only 10% of the sample in a proportionate sample. This is the simplest method of stratification – the number of individuals or elements taken from each stratum or group is proportionate to their distribution in the overall population. While a simple random sample of sufficient size should also result in fairly accurate proportions of each subgroup, proportionate stratified sampling *guarantees* that the subgroups will be proportionate to their known sizes in the population. This helps ensure that key subgroups are accurately represented in the sample. The table below illustrates an example of a proportionate sample, stratified by regional subgroups. In this example, the overall sample of 513 represents a confidence level of 95% and a margin of error of +/-4%. The sample size of each region is based upon the region's size relative to the population. For example, 14% of the overall population lives in the West region, so 14% of the total sample was randomly selected from that region. A proportionate stratified sample is used to ensure that the regional distribution of the sample members matching the regional distribution of the population.

Proportionate Sample

Subgroup	Population		Sample	
	No.	% of Pop.	No.	% of Sample
(1) East	500	14%	72	14%
(2) West	700	20%	103	20%
(3) Central	850	24%	123	24%
(4) North	300	9%	46	9%
(5) South	1150	33%	169	33%
TOTALS	**3500**	**100%**	**513**	**100%**

In a disproportionate stratified sample, the size of each sampled subgroup is not proportionate to its size in the overall population. Some subgroups may be over-sampled or under-sampled relative to their actual proportion in the population. This type of sampling method is typically used when states want to ensure adequate representation of smaller subgroups within a population. For example, states may choose to over-sample or disproportionately select cases from smaller size regions, or from low incidence disability groups, or from ethnic minority groups because proportionate samples would yield too few cases from these small groups.
Further, for some types of statistical analyses, a minimum sample size is needed for each subgroup, and disproportionate sampling may help achieve the necessary sample size for each stratum. It is best to consult a statistician about sample size if your state plans to examine subgroups.

The table below illustrates an example of a disproportionate stratified sample. The total sample of 625 will yield an overall confidence level of 95% and a margin of error of +/-4%. In this example, the goal was to obtain a minimum of 125 sample members from each ethnic subgroup, to allow for statistical comparison between subgroups. To ensure adequate representation of each ethnic subgroup, certain subgroups (African-American, Hispanic, and Asian) were over-sampled, while the Caucasian subgroup was under-sampled. For example, 20% of the total sample was drawn from the Asian subgroup (to achieve a minimum number of 125 Asian respondents), although only 8% of the cases in the overall population were from this subgroup. On the other hand, 40% of the sample respondents were Caucasian, compared to 65% in the overall population.

Disproportionate Sample

Subgroup	Population		Sample	
	No.	% of Pop.	No.	% of Sample
Caucasian	6500	65%	250	40%
African-American	1500	15%	125	20%
Hispanic	1200	12%	125	20%
Asian	800	8%	125	20%
TOTALS	**10,000**	**100%**	**625**	**100%**

One cautionary note about reporting data based upon disproportionate samples-if a state plans to report on an estimate about the sample (e.g., proportion with unmet need in transportation), the estimate(s) must be statistically "weighted" back to the population; this is true for estimates based on the entire sample or subgroups (strata). The weighting process accounts for the under• and over-representation of strata that occurred during sampling. States should consult with a statistician or survey methodologist to ensure proper weighting techniques are applied.[4]

[4] Also, if there is interest in estimating statistical differences between subgroups or conducting multivariate analyses (e.g., regression), professional help is recommended in controlling for the "design effect" which results from disproportionate sampling. Many statistical software packages have the ability to weight data and account for design effect.

Sources of Error

Neither a probability sample nor a large sample alone can guarantee accurate or reliable results. Indeed, a large sample obtained through non-probability sampling methods is not considered as representative as a smaller-sized sample obtained through probability methods. Non-sampling factors can influence the accuracy of the sample and the credibility of the findings. There are four types of error that can affect the accuracy of sampled data:

- sampling error
- non-response error (surveys)
- coverage error
- measurement error

States should pay attention to all of these in their attempt to produce accurate, reliable, and credible results.

Sampling Error

As discussed earlier, sampling error is the amount of discrepancy between the characteristics of the sample and the "true" population values. It occurs due to chance and can be estimated statistically. The generalizability of the sample to the population is limited to the extent that sampling error occurs. The best way to minimize sampling error is to use probability sampling methods that employ random selection techniques.

Non-Response Error

Non-response error occurs when an appreciable number of participants initially selected in a survey sample do not participate in the survey and these non-respondents systematically differ, in terms of key characteristics, from participants who do respond. This type of error is a common problem in survey research. Potential respondents may decline to participate for a variety of reasons, including lack of interest, lack of time, concerns about privacy and confidentiality, discomfort with being interviewed, or inability to give informed consent. Another common cause of non-response may be that program participants are away from home at the time of the survey (e.g., at school, doctor's appointment, on vacation, shopping, out with friends, in the hospital, in a nursing home).

The response rate is calculated by dividing the number of individuals who actually participate in a survey (numerator) by the number of eligible participants who were selected into the sample (denominator). For example, if a state randomly selects 300 waiver participants from its target population for participation in a satisfaction survey, and 225 actually participate (i.e., 75 refuse to participate or cannot be located), then the response rate is 225/300 or 75%.

What is a reasonable response rate for a survey? Similar to the sample size question, there is no one answer. A reasonable response rate depends upon the goals of the survey, the nature of the population being surveyed, the degree of potential non-response error that the state and its constituencies are willing to tolerate, how the results will be used, and what other sources of information will be used to supplement or validate survey results.

Some researchers warn that response rates under 60 to 70% are a red flag, and some agency standards require a minimum 75% response rate. Response rates are usually higher if the inquiries are relatively short, well designed, and relevant to potential respondents. Surveys that use in-person interviews tend to yield higher rates of response, while mail surveys lower ones. Surveys that include follow-up or reminder notices to potential eligible respondents are likely to produce higher response rates than surveys that contact potential respondents only once. In order to improve response rates, some studies offer incentives (such as payment) to individuals for their participation. Incentives, however, may not be practical or appropriate for state agency surveys. Other common approaches to minimize non-response error include:

- clearly explaining the survey and its purpose to potential respondents
- ensuring that confidentiality of data will be protected to the extent possible
- sending reminder notices
- following up by telephone

When conducting a study, an analysis of the respondents and non-respondents is highly recommended. Such analyses can be used to identify systematic bias in the results. (See also *Determining Sample Size – Non-Response Rate*.)

Coverage Error

Coverage error occurs when the sampling frame (the list used to draw the sample) is incomplete or inaccurate, and therefore does not include all individuals or cases in the target population. Any discrepancy between the target population and the actual list used for the sampling frame is a source of potential bias. For example, if the target population of a state survey is intended to include adults with disabilities age 18 years and older, but the agency list used to draw the sample only contains adults age 22 and over, then coverage error is a source of bias, as the sample will systematically exclude people age 18 to 22. To avoid coverage error, states need to use up-to-date, accurate sampling lists consistent with the clearly defined target population and inclusion and exclusion criteria. Death is another common source of coverage error – especially in the elderly population. (See also *Defining the Target Population –Sampling Frame and Units of Analysis.*)

Measurement Error

Another non-sampling source of error is measurement error, which refers to inaccuracies or ambiguities in the measurement or collection of data. Measurement error can stem from poorly worded survey questions, ambiguous response options or coding criteria, inadequately trained interviewers, improper administration of a survey, or respondents who cannot provide reliable survey responses. While these sources of error do not relate directly to sampling issues, they are equally important considerations that states need to consider. It is strongly recommended that, whenever possible, states select measures or tools that have been professionally assessed for reliability and validity. And, if such measures are not available, the state can reduce measurement error by careful attention to the construction and wording of survey questionnaires and thorough training and preparation of interviewers.

Appendix A: Resources

Handbooks and Texts

Alreck, P.L. and Settle, R.B. (1995)
The Survey Research Handbook: Guidelines and Strategies for Conducting a Survey, 2nd edition
New York: Irwin Professional Publishing
This survey handbook includes a detailed chapter (with step-by-step guidelines) on designing the sample, reliability and validity, sample size determination, and sample selection methods.

Fink, A. (1995)
The Survey Handbook
Thousand Oaks, CA: SAGE Publications
This nine-volume survey kit helps users prepare surveys and collect data. Volumes in the kit include how to: ask survey questions; conduct self-administered and mail surveys; conduct interviews by telephone and in person; design surveys; sample in surveys; measure survey reliability and validity; analyze survey data; and report on surveys.

Fink, A. (1995)
How to Sample in Surveys
Thousand Oaks, CA: SAGE Publications
This is Volume 6 of *The Survey Handbook* (see above reference), designed to guide the reader in selecting and using appropriate sampling methods. The handbook provides information about probability and non-probability sampling methods and statistical issues related to sampling, including calculation of sample size and acceptable response rate.

Henry, G.T. (1990)
Practical Sampling, Applied Social Research Methods Series, Volume 21
Thousand Oaks, CA: SAGE Publications
This book provides detailed examples of practical sampling designs related to sample selection, sampling frames, sampling techniques, sample size considerations, and post-sampling choices.

Salant, P. and Dillman, D. A. (1994)
How to Conduct Your Own Survey **New**
York: John Wiley & Sons
This helpful handbook about designing and conducting practical surveys includes a chapter that discusses when to use sampling and how to select a sample.

Web Resources

National Audit Office Publication: A Practical Guide to Sampling
http://www.nao.gov.uk/publications/samplingguide.pdf
This guide provides helpful information about sample design, sampling methods, interpreting and reporting the results. The guide provides case examples and colorful graphics.

The Survey System Sample Size Calculator
http://www.surveysystem.com/resource.htm
A web-based public service of the Creative Research Systems – an on-line "calculator" used to determine how large a sample is needed in order to get results that reflect the target population as precisely as needed.

The Research Methods Knowledge Base
http://www.socialresearchmethods.net/kb/index.htm
This web-based textbook by William M. Trochim at Cornell University addresses topics in a typical introductory undergraduate or graduate course in social research methods including: formulating research questions; sampling (probability and nonprobability); measurement (surveys, scaling, qualitative, unobtrusive); research design (experimental and quasi- experimental); and data analysis. The sampling section is quite basic and uses helpful graphics.

W.K. Kellogg Foundation Evaluation Handbook
http://www.wkkf.org
This handbook provides a framework for thinking about evaluation as a relevant and useful program tool. While this handbook does not specifically address sampling issues, it discusses many important issues that relate to sampling, such as identifying stakeholders, developing evaluation questions, determining data collection methods, collecting data, and analyzing and interpreting data. The handbook can be found on the website in the "Publications and Resources" section under "Toolkits."

Sage Publications Website
http://www.sagepub.com
This publishing company offers reference books on research methods and evaluation (including some titles listed above) for order on their website.

Appendix B: Glossary

Availability or Convenience Sample

A non-probability sampling method of selecting readily available individuals or cases into the sample.

Census
A process used to collect information about the full population, as opposed to a sample or subset of the population.

Cluster Sample
A multi-stage process typically covering broad geographic areas or organizational units, used when a complete centralized sampling frame is not available. Key geographical groups or clusters are identified; then a random sample of these clusters is selected; and then cases within the randomly selected clusters are selected into the sample.

Confidence Interval
A statistical estimate of the range of values within which the true population value is likely to fall. Confidence intervals are often denoted by a single number that identifies the margin of error, such as + or – 5%.

Confidence Level
A statistical estimate used in random sampling, stated as a percentage, of the degree of certainty that the true population value is within a specified range of values.

Coverage Error
A source of bias that occurs when the sampling frame (the list used to draw the sample) is incomplete or inaccurate, and therefore does not include all individuals or cases within the target population.

Disproportionate Stratified Sample
A type of probability sampling method in which the number of cases selected from each stratum of the population is disproportionate to the overall population size – that is, some subgroups may be over-sampled or under-sampled relative to their actual size in the population.

Exclusion Criteria
Rules for defining which individuals or cases are excluded from the sampling frame.

Inclusion Criteria
Rules for defining which individuals or cases are included in the sampling frame.

Measurement Error
A source of bias resulting from inaccuracies or ambiguities in the measurement or collection of data, such as poorly worded survey questions, ambiguous response choices in question items,

inadequately trained interviewers, or respondents who cannot provide reliable survey responses.

Non-Probability Sample
A sample drawn without using random selection procedures. The likelihood of selecting any one case from the population into the sample is not known and is usually different for each person or case in the sample.

Non-Response Error
A source of bias that occurs when an appreciable number of individuals in the sample do not respond/participate and these non-respondents differ in terms of key characteristics from individuals who do respond.

Non-Response Rate
A number that describes the proportion of individuals selected into the sample who do not respond/participate, typically due to the inability to locate the individuals, ineligibility, or their refusal to participate.

Non-Sampling Errors
Types of errors due to flaws in the design of how the sample is drawn or how the data are collected. Non-sampling errors cause bias in one direction or another and cannot be estimated mathematically.

Population
The full universe of individuals or entities from which the sample is drawn.

Population Parameter
A number that represents the true value or occurrence of something in the total population. The theory behind sampling is that the values obtained from a sample will approximate or estimate the population parameters; however, exact population parameters can only be obtained through a complete census.

Power Analysis
A technique used by statisticians to decide how large a sample is needed to make statistically accurate and reliable judgments, as well as how likely the selected statistical tests will be able to detect significant differences.

Probability Sample
A sample drawn according to random selection procedures in which every member of the target population has a known, non-zero chance of being included in the sample.

Proportionate Stratified Sample
A type of probability sampling method in which the number of individuals or cases selected from each stratum of the population is based upon the subgroup's size relative to the overall population size.

Purposive Sample
A non-probability sampling method that involves selecting "typical" individuals or cases from the population based upon professional experience, knowledge, or judgment.

Quota Sample
A non-probability sampling method that involves setting a quota for inclusion of specified numbers of individuals or cases with certain characteristics, and then selecting cases on an availability basis.

Random Sample Selection
A process, based on scientific probability theory, that ensures individuals or cases in a population have an equal chance of being selected into the sample.

Representative Sample
A sample is considered representative of the population if the characteristics of the sample (e.g., age, gender, type of disability) are similar to the distribution of these characteristics in the overall population.

Response Rate
A number (expressed as a percentage) that describes the proportion of individuals who actually participate in the inquiry (the numerator) divided by the number of eligible respondents who were selected from the population and asked to participate (the denominator).

Sample
A subset of individuals or cases selected to represent a particular population.

Sample Statistic
A number that represents the value or occurrence of something in the sample.

Sampling Error
The amount of discrepancy between the characteristics of the sample and the true population values. Sampling error is due to chance and can be estimated mathematically.

Sampling Frame
The list of all units from which the sample is drawn.

Significant Difference
A term used to describe an observed result that cannot be attributed to sampling error alone. A finding is described as statistically significant if the probability of obtaining such a difference by chance alone is very low (for example, 5 in 100, if the significance level chosen is 95%).

Simple Random Sample
A probability-based sampling method that ensures that each member of the population has an equal probability of being selected into the sample (as if pulling individual names out of a hat).

Snowball Sample
A non-probability sampling method that involves a chain-like referral process. Initial contact is made with known individuals in the population, and then these individuals are asked to refer others for inclusion in the sample.

Strata
Subgroups defined within a population.

Stratified Sample
A multi-stage probability sampling method in which the population is first divided into homogeneous strata or subsamples (grouping individuals or cases based on characteristics they share) and then random samples are selected from each stratum.

Systematic Sample
A probability-based method in which individuals or cases are selected at regular intervals from the sampling frame (e.g., every 10th name).

Target Population
The population of interest in the study; the larger group from which the sample is drawn and which the sample is intended to represent.

Unit of Analysis
The element about which information is being collected and analyzed.

Variable
A characteristic of an individual or case. The characteristic must be able to take on more than one value and must be measurable.