

ATTACHMENT B**ELECTRONIC CODE OF FEDERAL REGULATIONS****e-CFR Data is current as of January 12, 2015**

Title 42 → Chapter IV → Subchapter C → Part 441 → Subpart G → §441.301

Title 42: Public Health

PART 441—SERVICES: REQUIREMENTS AND LIMITS APPLICABLE TO SPECIFIC SERVICES

Subpart G—Home and Community-Based Services: Waiver Requirements

§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]

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ELECTRONIC CODE OF FEDERAL REGULATIONS**e-CFR Data is current as of January 12, 2015**

Title 42 → Chapter IV → Subchapter C → Part 441 → Subpart M → §441.710

Title 42: Public Health

PART 441—SERVICES: REQUIREMENTS AND LIMITS APPLICABLE TO SPECIFIC SERVICES

Subpart M—State Plan Home and Community-Based Services for the Elderly and Individuals with Disabilities

§441.710 State plan home and community-based services under section 1915(i)(1) of the Act.

(a) Home and Community-Based Setting. States must make State plan HCBS available in a home and community-based setting consistent with both paragraphs (a)(1) and (a)(2) of this section.

(1) 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 above qualities at paragraphs (a)(1)(i) through (v) of this section, 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; and

(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; and

(F) Any modification of the additional conditions, under paragraphs (a)(1)(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:

(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.

(2) 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.

(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.

(3) Compliance and transition:

(i) States submitting state plan amendments for new section 1915(i) of the Act benefits must provide assurances of compliance with the requirements of this section for home and community-based settings as of the effective date of the state plan amendment;

(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(i) of the Act benefit 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 renewal or amendment request that sets forth the actions the State will take to bring the specific 1915(i) State plan benefit into compliance with this section. The 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 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) 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) 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.

(b) *Needs-Based Eligibility Requirement.* Meet needs-based criteria for eligibility for the State plan HCBS benefit, as required in §441.715(a).

(c) *Minimum State plan HCBS Requirement.* Be assessed to require at least one section 1915(i) home and community-based service at a frequency determined by the State, as required in §441.720 (a)(5).

(d) *Target Population.* Meet any applicable targeting criteria defined by the State under the authority of paragraph (e)(2) of this section.

(e) *Nonapplication.* The State may elect in the State plan amendment approved under this subpart not to apply the following requirements when determining eligibility:

(1) Section 1902(a)(10)(C)(i)(III) of the Act, pertaining to income and resource eligibility rules for the medically needy living in the community, but only for the purposes of providing State plan HCBS.

(2) Section 1902(a)(10)(B) of the Act, pertaining to comparability of Medicaid services, but only for the purposes of providing section 1915(i) State plan HCBS. In the event that a State elects not to apply comparability requirements:

(i) The State must describe the group(s) receiving State plan HCBS, subject to the Secretary's approval. Targeting criteria cannot have the impact of limiting the pool of qualified providers from which an individual would receive services, or have the impact of requiring an individual to receive services from the same entity from which they purchase their housing. These groups must be defined on the basis of any combination of the following:

(A) Age.

(B) Diagnosis.

(C) Disability.

(D) Medicaid Eligibility Group.

(ii) The State may elect in the State plan amendment to limit the availability of specific services defined under the authority of §440.182(c) of this chapter or to vary the amount, duration, or scope of those services, to one or more of the group(s) described in this paragraph.

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