NSCLC
National Senior Citizens Law Center

PROTECTING THE RIGHTS OF LOW-INCOME OLDER ADULTS

July 2, 2012

Marilyn Tavenner
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-2249-P2
P.O. Box 8016
Baltimore, Maryland 21244-8016

Re: Comments on Proposed Regulations for State Plan HCBS; 77 Fed. Reg. 26362 (May 3, 2012)

Submitted Electronically through www.regulations.gov; ID CMS-2008-0035-0058

Dear Administrator Tavenner:

The National Senior Citizens Law Center (NSCLC) appreciates the opportunity to comment on the proposed regulations for State plan Home and Community-Based Services, and the other provisions included in the same regulatory package. NSCLC is a non-profit organization whose principal mission is to protect the rights of low-income older adults through advocacy, litigation, and the education and counseling of local advocates. We have been involved for decades with federal and state policies relating to HCBS and other long-term services and supports.

Overview of Comments

We thank you and your staff for the careful work performed to implement the State plan HCBS benefit. Overall, the proposed regulations are faithful to the statutory authorization, and well-designed to provide older persons and persons with disabilities with a greater ability to receive necessary services in non-institutional environments.

Our comments include both a discussion of the relevant issues, and recommended revisions to regulatory language. The recommended revisions are placed together in the second part of this letter. In general, the material is organized in numerical order based on the section of the regulation; for example, the discussion of section 440.182 precedes

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the discussion of section 441.530 and, in the second part of the letter, the recommended revisions for section 440.182 precede the recommended revisions for section 441.530.

Sections 435.219 & 436.219 Eligibility

Eligibility for Individuals Who Would Be Eligible Under State's HCBS Waiver

We support the proposed eligibility standards set forth in proposed sections 435.219 (applicable in most jurisdictions) and 436.219 (applicable in Guam, Puerto Rico, and the Virgin Islands). As CMS notes, these proposed sections implement the statutory language of 42 U.S.C. § 1396a(a)(10)(A)(ii)(XXII), which was added by section 2402(d) of the Affordable Care Act. This amendment rectified a problem in the statutory language, which originally authorized HCBS state-plan services for persons who might not be Medicaid eligible in the first place. The amendment addresses this problem by establishing Medicaid eligibility standards that match the standards for receipt of State plan HCBS.

Specifically, under the amendment, a state has the option to provide Medicaid coverage to persons who can receive state-plan HCBS under either subsections (1)(A) or (6) of 42 U.S.C. § 1396n(i). Subsection (1)(A) describes needs-based criteria for receipt of state-plan HCBS. Subsection (6) authorizes state-plan HCBS to be provided to persons who would be eligible for HCBS under a waiver (either an HCBS waiver or a demonstration waiver).

Income Methodologies (first paragraph)

We support CMS's conclusion, in the Federal Register discussion accompanying the proposed regulations, that states should use the SSI income methodologies or, with CMS's approval, a less restrictive methodology. *See* 77 Fed. Reg. at 26,385. We note, however, that the proposed regulatory language is much less specific than the Federal Register discussion, and does not require that an alternative methodology be less restrictive than SSI methodology. We recommend revised language that, consistent with CMS's discussion in the Federal Register, 1) requires that income methodology be no more restrictive than the SSI methodology, and 2) requires that any income methodology be applied to all members of the eligibility group.

In our recommended language, we suggest a revision in the introductory paragraph of sections 435.219 and 436.219 to make it clearer that a state may choose to cover persons described in paragraph (a), persons described in paragraph (b), or both sets of persons. We suggest deleting the language "any group or groups of" because the language suggests inaccurately that a state might be able to cover some but not all of the persons described in either of paragraphs (a) or (b).

Income Cap of 150% of Federal Poverty Line (subsection (a)(2))

In relation to the first optional categorical eligibility group, the statutory language speaks of persons "who are eligible for HCBS under the needs-based criteria established under section [1396n(i)(1)(A)]." As CMS notes, the authorizing language does not explicitly mention an income standard. We agree with CMS that it is reasonable to infer an income cap of 150% of the federal poverty line, since a 150% FPL requirement is imposed on state-plan HCBS predicated on satisfying the needs-based criteria. *See* 42 C.F.R. §§ 435.219(a)(2), 436.210(a)(2) (as proposed by CMS).

No Resource Test (subsection (c))

We also support CMS's conclusion that this optional categorical eligibility group (for persons eligible under needs-based criteria) should not have a resource test. *See* 42 C.F.R. §§ 435.219(c), 436.210(c) (as proposed by CMS). This conclusion is consistent with the fact that no resource test will be imposed for the new eligibility category (effective in 2014) comprised of persons with incomes no more than 133% of the poverty line. 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII).

Section 440.182 Services

Persons with Chronic Mental Illness (subsection (c)(8))

Proposed subsection 440.182(c)(8) refers to conditions applicable to persons with chronic mental illness. The proposed regulation refers to conditions set forth at section 440.180; we propose instead a reference to section 440.180(d)(2). This is a more precise reference to the limitation relating to persons who qualify for residence in an institution for mental disease.

Habilitation Services (subsection (c)(6))

Proposed subsection 440.182(c)(6) specifies that habilitation services include those defined at subsection 440.182(c). We recommend that a slight revision to emphasize that the habilitation services include *but are not limited to* those specifically described services.

No Statutory Requirement that Services Be Cost-Effective (subsection (c)(9))

We understand that the list of services in proposed section 440.182(c) is drawn almost exactly from the list of HCBS *waiver* services in section 440.180(b). We support CMS's deletion of the phrase "as cost effective and necessary to avoid institutionalization": this phrase appears in section 440.180(b)(9) to describe the "other" services that might be authorized in an HCBS waiver, but does not appear in the corresponding language of proposed section 440.182(c)(9). The reason, of course, is that HCBS waivers are required by statute to be cost effective and to be provided to persons

who would require institutionalization, but those two requirements do not apply to HCBS provided through a State plan.

Sections 441.530 & 441.656 Home and Community Based-Setting

Overview of Proposed Regulatory Language for Home and Community Based Setting

We appreciate CMS's careful attention to this issue in recent years. In our recommendations, we also have attempted to balance multiple considerations, but with a particular emphasis on the nature and benefits of home and community-based services. The State plan HCBS benefit and the Community First Choice option were enacted to authorize non-institutional options. There may be instances in which a particular model of care is not eligible for Medicaid HCBS funding not because it is a bad model per se, but because it cannot legitimately be considered home or community-based.

As proposed by CMS, the provisions of section 441.530 are repeated in subsection 441.656(a). In each case, the proposed language sets standards for a home and community-based setting. Section 441.530 governs the Community First Choice option, whereas section 441.656 applies to the HCBS State plan option. In this letter, we have made recommended changes to both section 441.530 and section 441.656 but, to the extent that the those changes are identical in both sections, we discuss them only in this discussion of section 441.530.

Provider Requirements Based on Individual's Needs (subsection (a)(1))

We recommend deletion of the language that says the requirements are "based on the needs of the individual as indicated in their person-centered service plan." In general, the requirements should apply to all settings governed by the regulations, regardless of the contents of an individual's service plan. Without deletion or modification of this language, it would be too easy for a provider to evade regulatory requirements by arranging for insertion of certain language in a service plan. We discuss this issue in more detail below in regards to subsection (a)(1)(vi).

Setting Integrated in Community (subsection(a)(1)(i))

Overall, we strongly support this provision. We recommend an amendment to specify that the employment-related provisions apply only to those individuals who are interested in being employed.

Choice of Service Provider (subsection (a)(1)(v))

CMS has solicited comments on whether a housing provider should be allowed to require an individual to receive services from that provider, or whether an individual can be required to receive a particular service as a condition of receiving services or of remaining in the setting. *See* 77 Fed. Reg. at 26379, 26384. Our answer to each question

is "no," and we recommend specific language at subsection (a)(1)(v), relating to an individual's right to choose a service provider. We note that Medicaid beneficiaries must have a free choice of provider (*see* 42 U.S.C. § 1396a(a)(23)) and that under that right, as explained by CMS, beneficiaries cannot be forced "to receive services from the same entity from which they purchase or who provide their housing." 77 Fed. Reg. at 26366; *see also* 77 Fed. Reg. at 26376 (almost identical language).

We understand that assisted living facilities and other long-term care facilities often bundle housing and services into one required package, but we believe that such facilities can operate under our recommended revision by providing services of a quality that appeals to individuals. The service providers will maintain their customer base by meeting individuals' needs, not by taking advantage of a captive pool of facility residents.

As for requiring that an individual receive a particular type of service, such a requirement cannot be reconciled with the concept of a home or community-based setting. CMS gives the example of a facility that requires substance abuse treatment for all residents — although such a facility may provide an important service, it should not be considered home or community-based. *See* 77 Fed. Reg. at 26379, 26384.

<u>Modification of Requirements Based on Service Plan Documentation (subsection (a)(1)(vi))</u>

The proposed language provides an extremely broad right for a service provider to modify *any* of the requirements, as long as the modification is supported by an assessed need and documented in the service plan. We strenuously oppose this language, as it would be too easy for a service provider to eliminate legal rights by simply reciting supposed justifications in a service plan. For many of the requirements — for example, the requirement that a setting be physically accessible — there is no reason for an exception under any circumstances. Accordingly, we recommend that the relevant language in subsection (a)(1)(vi) be deleted and replaced at subsection (a)(1)(vi)(F) with language that would allow the lockable door requirement to be modified as necessary to protect the individual, if the modification is justified and documented in the service plan.

CMS has solicited comments on whether modification rights should be limited in other ways —for example, whether a provider should be required to document that less intrusive measures have already been tried, or to collect data on a modification's effectiveness. 77 Fed. Reg. at 27379, 26383-84. Our recommended language does not address these ideas, and instead limits modifications only to the lockable door requirement. If, however, CMS were to promulgate final regulations with a broad right of modification, it would be important that providers be subject to the type of limitations raised for comment by CMS in the Federal Register.

Setting Occupied Under Legally Enforceable Agreement (subsection (a)(1)(vi)(A))

The phrase "another legally enforceable agreement" should be changed to "a legally enforceable agreement." The word "another" is not appropriate because there has not been a previous reference to an enforceable agreement.

In addition, individuals should not be subject to "the same *responsibilities* … that tenants have under the landlord tenant law" (emphasis added). For example, depending on the state, landlord tenant law might impose deposit requirements or advance notice requirements that otherwise do not apply to residents of the state's assisted living facilities. Unless the proposed language is deleted, the regulations in this regard will make Medicaid beneficiaries worse off than they otherwise would be.

CMS has explicitly solicited comments "as to whether there are other protections, not addressed by landlord tenant laws that should be included." 77 Fed. Reg. at 26379, 26383. In responding to this request, we recommend that this provision of the proposed regulations be amended to reference the Americans with Disabilities Act. In assisted living today, residents too frequently are evicted under a facility's claim that the facility can no longer meet the resident's needs, even though the facility is not legally prohibited from providing the level of care that the resident needs. In such situations, the Americans with Disabilities Act generally requires a provider to accommodate a resident's needs by making necessary services available, to the extent that the services are the type of services appropriately provided in an assisted living setting. This type of accommodation should be required in a community-based setting, as it values the individual's interest in staying in her home over a facility's interest in limiting the care needs that must be met.

Grammatical Change (subsection (a)(1)(vi)(B))

The current proposed language refers to an individual having privacy in "their" unit. We recommend that "their" be changed to "the," since "individual" is singular but "their" is plural.

Bathrooms (recommended addition to subsection (a)(1)(vi)(B))

In subsection (a)(1)(vi)(B) (governing provider-owned or controlled residential settings), we recommend that a bathroom be required in the unit for all settings with a capacity of six or more residents. CMS proposed a similar requirement last year (*see* 76 Fed. Reg. 21311, 21313 (2011)), and such a requirement is no less important today. It would be difficult to consider a setting "community-based" if, for example, a building housed 10 or 20 residents who shared a bathroom or bathrooms located off a main hallway, and a resident at 2 a.m. had to walk down the facility hallway in order to use the bathroom.

Locked Doors (subsection (a)(1)(vi)(B)(1))

We recommend the addition of the phrase "as appropriate," because there may be occasions when the setting will not have staff members with keys to living units. This recommended change is particularly advisable as we also recommend (as discussed below) to have subsection (a)(1)(vi)(B) apply not only to provider-owned or controlled residential settings, but also to "any setting limited to persons with disabilities."

Sharing of Units (subsection (a)(1)(vi)(B)(2))

The proposed language requires that "[i]ndividuals share units only at the individual's choice." We support that requirement, but recommend additionally that individuals not share bedrooms unless they are spouses, partners, or other family members. Currently, in many facilities certified to accept Medicaid HCBS reimbursement, unrelated recipients share bedrooms because the state Medicaid program and its reimbursement rate offer no real alternative. The resident "chooses" to share but it is not really a choice, given the lack of alternatives. This type of shared occupancy is not faithful to the principles of HCBS and, accordingly, we recommend that only spouses, partners, or other family members be allowed to share a bedroom under HCBS reimbursement.

Right to Decorate or Furnish Living Unit (subsection (a)(1)(vi)(B)(3))

We recommended this provision previously and appreciate its inclusion in CMS's proposed regulations. Inability to decorate or furnish a living unit would be a clear indicator of an institutional model; accordingly, a community-based setting must allow an individual to decorate or furnish his living unit.

Schedules, Activities and Food (subsection (a)(1)(vi)(C))

We support in general the proposal that individuals have the freedom and support to control their schedules and activities, but recommend that the word "control" be changed to "choose." Choice is a foundational element of HCBS. Merely allowing individuals to control schedules and activities is inadequate. On the other hand, supporting an individual in his or her choice of activities and providing the support necessary for participation (for example, the transportation to attend a selected activity) allows for full community living.

Visitors (subsection (a)(1)(vi)(D))

In general, we support the proposed language relating to visitors. We recommend a slight revision to specify that a visitor may stay overnight. Persons living in an apartment or house can choose to have a visitor stay overnight; furthermore, this is a right that normally accompanies one's entry into adulthood. A recipient in an HCBS setting must have the same freedom.

Physical Accessibility (subsection(a)(1)(vi)(D))

This is an essential provision. We are aware of assisted living settings that are not physically accessible and have nonetheless received HCBS waiver funding for the assisted living services.

Rebuttable Presumption to Disqualify Locations with Qualities of an Institutional Setting (subsection (a)(2)(v))

Allowing HCBS Funding in Settings within Senior Communities

Our recommendations regarding this subsection are informed in large part by our observation that older persons often seek out settings in which they can stay as they grow older and develop service needs. A significant number of older persons prefer to live in a senior community or similar setting that includes a nursing facility, particularly when one spouse or partner needs nursing facility care and the other does not. Accordingly, we recommend that being on the grounds of, or adjacent to an institution not be a disqualifying characteristic. As set forth in CMS's proposed regulatory language, sharing a building with an institution would remain a disqualifying characteristic.

Regarding the rebuttable presumption proposed for subsection 441.530(a)(2)(v), we agree with what we perceive to be the intent — to disqualify undesirable settings that segregate persons with disabilities, while retaining for CMS the ability to provide funding for settings that allow beneficiaries to age in place. The proposed use of a rebuttable presumption would give CMS discretion to make more individualized determinations when line-drawing is particularly difficult.

Nonetheless, we believe that the use of a rebuttable presumption is inadvisable. Although the concept of a rebuttable presumption may be attractive in the abstract, we do not believe that it could be operationalized effectively. Individualized determinations of the we-know-it-when-we-see-it variety cannot be used in this setting because beneficiaries and providers need clear guidance ahead of time — before the beneficiary moves in or the provider develops property.

For these same reasons, whether or not a rebuttable presumption is involved, we recommend deleting the proposed language in subsection (a)(2)(v) that would give CMS authority to disqualify "other locations that have qualities of an institutional setting, as determined by the Secretary." This language does not give enough guidance, particularly since it would be applied to settings that otherwise satisfy the requirements for a community-based setting.

Our final recommendation for subsection (a)(2)(v) is the deletion of "disability specific housing complex." This term is currently undefined and is potentially too broad, as it might be read to include housing designated for persons with dementia or other cognitive impairments. In evaluating CMS's proposed language, we could not think of a good reason why a dementia care facility might qualify as a community-based setting

(assuming all HCBS regulatory requirements were met), but a "disability specific housing complex" would not. Accordingly, we recommend adding the phrase "any setting limited to persons with disabilities" to subsection (a)(1)(vi) so that any setting limited to persons with disabilities would be subject to the same requirements that must be met by a provider-owned or controlled residential setting.

Recognizing Difference in Preferences Generally Between Older Persons and Persons with Disabilities

In recent weeks, we have discussed these proposed regulations with multiple stakeholders, and have reviewed draft comment letters from several of these stakeholders. On this particular issue — whether a community-based setting can be in close quarters with an institution — we perceive a consistent difference of opinion between those stakeholders representing older persons, and those representing persons with disabilities.

In general, older persons see the proximity of a nursing facility as a good thing; indeed, for many senior communities, the availability of a nursing facility is a strong selling point. Financially well-off older persons commonly spend significant amounts of their own income and savings to live in communities that include a nursing facility.

On the other hand, for persons with disabilities, the presence of an intermediate care facility or similar facility is almost always seen as a tremendous negative. The person does not want to move into such a facility, and feels that its presence creates unwanted segregation.

Given this divergence in opinion, we can appreciate the difficulty faced by CMS in attempting to craft regulations that work for each of these populations. At least in regard to the nearby-to-an-institution issue, it is possible that a regulation should not apply equally to both populations, and that CMS instead should develop a separate regulatory subsection for each population. There is precedent for drawing such distinctions: HUD offers funding for housing limited to older persons or to persons with disabilities, and the Fair Housing Act contains an exception that allows distinctions based on age.

If CMS were inclined to draw such distinctions, we suggest that useful language might carve out those settings that "provide multiple housing options to minimize the need to move as a person ages." In such settings, for example, HCBS funding might be available even if the setting shared grounds or possibly even a building with a nursing facility.

Section 441.650 Basis and Purpose

We suggest an addition and a deletion to proposed section 441.650, which describes the basis and purpose of State plan HCBS. The addition explicitly says that a state describes the relevant HCBS services in the state plan.

The deletion removes the phrase "with disabilities or individuals who are elderly." Statutory eligibility for State plan HCBS is not limited to elderly or disabled individuals, and instead is available broadly to "individuals eligible for medical assistance under the State plan." 42 U.S.C. § 1396n(i)(1). CMS restates this fact in the preamble to the proposed regulations: "To be eligible for the State plan HCBS benefit, an individual must be included in an eligibility group that is contained in the State plan." 77 Fed. Reg. at 26377. In accord, CMS specifically recognizes that children may be eligible: "Children included in eligibility groups under the State plan may meet the needs-based criteria and qualify for benefits under the State plan HCBS benefit." *Id.* While we understand that the statutory title for section 1396n(i) includes a reference to "elderly and disabled individuals," this language is merely a title which is not given effect in the statutory language itself.

Also, we note that the term "disability" has numerous different meanings. Using "disability" or "with disabilities" in a potentially limiting way could be confusing and unfair to beneficiaries.

Section 441.656 State Plan HCBS under the Act

Home and Community-Based Setting (subsection (a))

Subsection (a) repeats language from proposed section 441.530. Our recommended changes to subsection (a) are explained in our discussion of section 441.530, *supra*.

Specific Services (subsection (e)(2)(ii))

Subsection (e)(2)(ii) refers to "specific services defined under the authority of § 440.182(b)." The reference instead should be to subsection 440.182(c). Subsection 440.182(b) lists persons who may be eligible, while it is subsection 440.182(c) that lists the services that can be included in the State plan HCBS benefit.

Section 441.659 Needs-Based Criteria and Evaluation

Needs-Based Criteria (subsection (a))

We appreciate CMS's decision to distinguish needs-based criteria from targeting criteria, and agree that states without a needs-based component to their institutional level-of-care evaluation should establish needs-based criteria, so that criteria for institutional services can be accurately compared with criteria for the State plan HCBS benefit. The statute, of course, requires that participating states use needs-based criteria for determining eligibility for institutional services. *See* 42 U.S.C. § 1395n(i)(1)(B).

Grandfathering to Protect Beneficiaries Penalized by Increased Stringency of LOC for Nursing Facilities and Waiver Services (subsection (b))

This grandfathering provision applies to individuals who are receiving nursing facility services or waiver services when State plan HCBS becomes effective, to protect them from increased stringency in the applicable level-of-care (LOC) criteria. Federal financial participation "shall" continue to be available for such individuals "until such time as the individual is discharged from the institution or waiver program or no longer requires such level of care." 42 U.S.C. § 1396n(i)(5).

CMS, however, has interpreted this language so that the state will have the option but not the duty to "grandfather" these individuals. *See* 77 Fed. Reg. at 26375. Accordingly, CMS's proposed regulatory language sets forth that a state "may" continue to receive FFP for an individual who is receiving nursing facility services or HCBS waiver services under the institutional LOC criteria that applied prior to the initiation of the State Plan HCBS benefit, or prior to the modification of the LOC criteria that accompanied modification of standards for State plan HCBS. 42 C.F.R. § 441.659(b)(2) (as proposed by CMS).

We believe that CMS's interpretation is in error. The statutory language uses the mandatory term "shall" and, furthermore, refers to an individual person — an individual who has been receiving the nursing facility services or waiver services — thus suggesting that the benefit of this statutory provision falls upon each person eligible under its terms, without regard to any decision made by the state.

Furthermore, the heading of this statutory subsection does not refer to a State option, but other subsection headings explicitly refer to an option. The heading for this grandfathering provision is labeled "Continuation of Federal financial participation for medical assistance provided to individuals as of effective date of State plan amendment." *See* 42 U.S.C. § 1396i(5). In contrast, other headings within section 1396i use the term "State option": for example, "State option to offer election for self-directed services" (subsection (1)(G)(iii)), "State option to provide home and community-based services to individuals eligible for services under a waiver" (subsection (6)), and "State option to offer home and community-based services to specific, targeted populations" (subsection

(7)). Similarly, statutory text gives a state the "option" whether to offer self-directed services (subsection (1)(G)(iii)(I)) or provide presumptive eligibility (subsection (1)(J)).

A general rule of statutory interpretation is that when "Congress includes particular language in one section of a statute but omits it in another section of the same Act, it is generally presumed that Congress acts intentionally and purposely in the disparate inclusion or exclusion."[1] In this instance, since Congress knew how to call for a state option but did not do so, no state option exists and grandfathering is required.

Modifying Criteria (subsection (c))

We appreciate implementation of the statutory requirement that a state notify CMS and the public 60 days in advance of any proposed modification of the needs-based eligibility criteria, and agree that notification to CMS should take the form of a State plan amendment. CMS's proposed regulatory language states that CMS "will" approve modification requests that meet specified requirements. We recommend that "will" be changed to "may," so that CMS will retain some discretion to adapt to unexpected circumstances. We note CMS's statement in the Federal Register that "the State's adjustment authority does not prevent the Secretary from disapproving a State plan amendment (SPA) that fails to comply with the statute and regulations." 77 Fed. Reg. at 26369.

If notice to the public is to be meaningful, however, the public must have an opportunity to weigh in on the proposed modification. Accordingly, we recommend a formal comment period, similar to that now required in Section 1115 waivers, to provide an established mechanism for public input prior to federal action. A formal comment period would be equally appropriate whenever a state proposes to change its level-of-care criteria for institutional care. Given the statutory requirement of 60 days notice, we believe a 30 day comment period would be appropriate, as it would provide CMS with time to review submitted comments. Our recommended regulatory language regarding process is adapted from section 431.416, which governs federal notice and approval for Section 1115 waivers.

Grandfathering to Protect Beneficiaries Penalized by Increased Stringency of LOC After Modification (subsection (c)(4))

This grandfathering provision applies to individuals receiving State plan HCBS, protecting them from being denied services due to the state performing a modification to make its criteria more stringent. The "old" criteria are to be applied to such an individual "until such time as the individual no longer meets the standard for receipt of such services under such pre-modified criteria." 42 U.S.C. § 1396n(i)(1)(D)(ii)(II).

The proposed regulations state that an individual found eligible for State plan HCBS prior to a modification "must remain eligible for the HCBS benefit until" he or she

[1] Russello v. United States, 464 U.S. 16, 23 (1983).

no longer meets the criteria, or "is no longer eligible for or enrolled in Medicaid or the HCBS benefit." 42 C.F.R. § 441.659(c)(4) (as proposed by CMS). We believe that this language is unduly restrictive, given the broader statutory language. The current regulatory language would end protection for an individual who leaves the program only temporarily — who might, for example, be in a hospital or nursing facility for a limited period of time, or temporarily be enrolled in a dual-eligible managed care plan. Accordingly, we recommend revision of the regulatory language to be consistent with the statutory language, so that grandfathering remain effective unless the individual no longer meets eligibility standards.

"Authorized" Representative (subsection (d)(3))

In both subsection 441.659(d)(3) (evaluations) and subsection 441.662(a)(i)(2) (assessments), CMS's proposed regulatory language provides for consultation with an "individual's authorized representative." We are concerned that the term "authorized" can cause confusion and perhaps narrow rights. Proposed section 441.671 includes a definition of "individual's representative" that includes both individuals authorized under state law and those authorized by policy of the State Medicaid Agency. For consistency with this defined term, we urge changing "individual's authorized representative" in sections 441.659(d)(3) and 441.662(a)(i)(2) to "individual's representative." This change will avoid any implication that the term is narrower or different than defined at section 441.671.

Section 441.662 Independent Assessment

Telemedicine (subsection (a)(1))

The statute requires that an assessment include a "*face-to-face* evaluation of the individual by an individual trained in the assessment and evaluation of individuals whose physical or mental conditions trigger a potential need for home and community-based services." 42 U.S.C. § 1396n(i)(1)(F)(ii) (emphasis added). Thus, the statute clearly anticipates an in-person evaluation, and we agree that an in-person evaluation is far more effective than the alternatives. This is particularly true for HCBS assessments, which are not purely medical, and also include an evaluation of the person's living situation. Accordingly, we recommend that in-person assessments be required or, alternatively, that telemedicine assessments be allowed only in very limited circumstances when in-person assessments cannot practically be performed.

The regulation as written, although offering some beneficiary protections, includes no limitation to rural areas or special circumstances. Under CMS's proposed language, a state could determine, in order to save money or for other reasons, to use telemedicine exclusively or primarily. Thus, if CMS is inclined to allow telemedicine for assessments, we recommend that they be allowed only if the state makes an individualized determination of the need for substituting telemedicine for genuinely in-person assessments.

Qualifying for Other Services (subsection (a)(8))

As proposed by CMS, this subsection would deny a service if that service would be available through another Medicaid program. While we understand that Medicaid is the payer of last resort with respect to other health insurance programs, we do not understand why, if an individual meets the criteria for the same or similar services available through different avenues within Medicaid, the individual should not be able to utilize the program that he believes best fits his needs and preferences. CMS's proposed language, however, seems to indicate that, in such a case, the individual could not choose State plan HCBS.

Similarly, CMS's proposed language denies a service that "would otherwise be available" through "other Federally funded programs." We are concerned that an individual could be denied a service because that service theoretically is available under some other federal program, and then be left to fend for herself in applying for those services, with no guarantee that the services ever will be made available. The principle of "no wrong door" needs to be incorporated into any protocol around this provision so that individuals denied State plan HCBS actually receive the services they need under the other federal program for which they qualify and, if they do not receive such services, that they are again evaluated and assessed for State plan HCBS.

No ADL Requirement for Services or Particular Level of Services (recommended discussion in preamble accompanying final regulations)

We recommend that CMS state clearly in the preamble to the final regulations that there is no particular ADL requirement for services or for a particular level of services. We believe that the intent of section 1396n(i)(1)(F)(i) was to make ADL function a required component of HCBS state plan services assessments, without any requirement for a particular outcome as a threshold for services. We agree with such a policy, and note that it is supported by the language in the statute requiring an "evaluation" of ADL inability, as opposed to (for example) a "determination." Therefore, we believe that no individual can be denied access to services simply because she fails to demonstrate inability or need for significant assistance to perform two or more ADLs. There is likely to be confusion on this point because the statutory language mentions two ADLs, and states may be prone to erroneously bar access to services based solely on ADL tests. We recommend that CMS clarify in the preamble that while ADL review is a required element of the assessment, the result of the ADL review cannot be a litmus test for access to services.

Section 441.665 Person-Centered Service Plan

Overall, we strongly support the proposed requirements for a person-centered planning process and a person-centered service plan.

Person-Centered Planning Process (subsection (a))

We recommend adding a requirement that the process "is physically and linguistically accessible to the individual." While we believe this requirement is already implicit within the concept of person-centered planning, we think it is helpful to make the requirement explicit.

Person-Centered Service Plan (subsection (b))

We recommend adding a requirement that the plan "be translated into the individual's preferred language." While we believe this requirement is already implicit within the requirement that the plan be "understandable," we think it is helpful to make the requirement explicit.

Section 441.668 Provider Qualifications

Protecting Health and Welfare (subsection (a))

We generally support the requirement that the state have written provider standards that ensure protection of individuals' health and welfare. We recommend a revision to specify that such standards should not be construed to limit the ability of self-directing individuals who have employer authority to hire, train, manage or discharge providers pursuant to section 441.674.

Nondiscrimination (recommended addition)

We recommend adding a requirement in a subsection (d) that service providers not discriminate against recipients on the basis of race, color, national origin, religion, sex, sexual orientation, gender identity, marital status, source of payment, or mental or physical disability. Our recommended language is similar to that used in the regulations for the Program for All-Inclusive Care for the Elderly (PACE). *See* 42 C.F.R. §§ 460.98(b)(3), 460.112(a).

Section 441.674 Self-Directed Services

Overall, we strongly support CMS's inclusion of a self-directing option for all HCBS, as well as the agency's efforts to ensure clarity regarding the scope of the individual's authority.

Employer Authority (subsection (c))

We recommend that CMS include training as one aspect of employer-authority activities that self-directing beneficiaries may be allowed to exercise.

Budget Authority (subsection (d)(5))

We recommend amending subsection (d)(5) to make it clear that self-directing individuals with budget authority may be allowed to pay providers directly. In some state programs, this "advance pay" option is an important method of maximizing the autonomy and authority of the self-directing individual.

Section 441.677 State Responsibilities and Quality Improvement

References to Targeting Criteria (subsections (a)(1)(ii)(B), (a)(2)(ii), and (a)(2)(vi))

Subsections (a)(1)(ii)(B), (a)(2)(ii), and (a)(2)(vi) each refer to targeting criteria established by section "441.656(b)(2)." The reference instead should be to section 441.656(e)(2)(i), which explains that targeting criteria can take account of age, diagnosis, disability or Medicaid eligibility group, but must not limit the pool of qualified providers or require a beneficiary to receive services from his or her housing provider.

Grammatical Changes (subsections (a)(2)(i)(A), (a)(2)(i)(B), and (a)(2)(ii))

In subsection (a)(2)(i)(A) (relating to presumptive eligibility), we have made small suggested changes to make a sentence easier to understand. In the following subsection (a)(2)(i)(B), we have deleted the word "and" because it seems out of place.

To correct what is evidently a typographical mistake, we suggest adding the word "of" to subsection (a)(2)(ii), so that the phrase would be "the provision of services."

Timelines (subsection (a)(2)(ii)(3))

We recommend referring to a "five-year period of approval" rather than a "five year approval," and adding the phrase "and continuously thereafter for all approved periods of time," to make clear that enrollment cannot be limited after the initial phasing-in has been completed.

Modifications (subsection (a)(2)(v))

We suggest that the word "agency" be replaced by "State" in subsection (a)(2)(v).

Periods of Approval (subsection (a)(2)(vi))

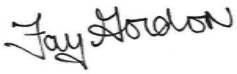
We recommend that "meeting the State's objectives with respect to quality improvement and beneficiary outcomes" be adding as an explicit requirement for renewal

of a State Plan Amendment. Our recommended language is taken directly from the statute, which requires that renewal is dependent upon CMS determining "that the State has … met the State's objectives with respect to quality improvement and beneficiary outcomes." 42 U.S.C. § 1396n(i)(7)(C)(ii).

Conclusion

Thank you for the opportunity to comment on these proposed regulations, and for your thoughtful development of these regulations and of home and community-based services generally.

Sincerely,



Eric Carlson
Directing Attorney

Fay Gordon
Staff Attorney

RECOMMENDED REGULATORY LANGUAGE

Sections 435.219 & 436.219 Eligibility

If the agency provides home and community-based services to individuals described in section 1915(i)(1), the agency, under its State plan, may, in addition, provide Medicaid to ~~any group or groups of~~ individuals in the community who are described in ~~one or both of the paragraphs under~~ paragraphs (a) or (b) of this section, in paragraph (a) only, or paragraph (b) only, at the agency's option as approved in the State plan.

(a) …

(c) For purposes of determining eligibility under paragraph (a) of this section, the agency may not take into account an individual's resources and must use income standards that are reasonable, consistent with the objectives of the Medicaid program, simple to administer, and in the best interests of the beneficiary. The agency should apply i~~I~~ncome methodologies from the SSI program or, upon ~~may include use of existing income methodologies, such as the SSI program rules. However, subject to~~ the Secretary's approval, ~~the agency may use~~ other income methodologies that meet the requirements of this paragraph (c) and are less restrictive than SSI income methodologies. Any less restrictive methodology should apply to all members of the eligibility group.

Section 440.182 State Plan Home and Community-Based Services

(a) …

(c) Services. The State plan HCBS benefit consists of one or more of the following services:

(1) Case management services.

(2) Homemaker services.

(3) Home health aide services.

(4) Personal care services.

(5) Adult day health services.

(6) Habilitation services, which include but are not limited to expanded habilitation services as specified in § 440.180(c) of this subpart.

(7) Respite care services.

(8) Subject to the conditions in § 440.180(d)(2) of this subpart, for individuals with chronic mental illness:

(i) Day treatment or other partial hospitalization services;

(ii) Psychosocial rehabilitation services;

(iii) Clinic services (whether or not furnished in a facility).

(9) Other services requested by the agency and approved by the Secretary as consistent with the purpose of the benefit.

(d) …

Section 441.530 Home and Community-Based Setting

(a) States must make available attendant services and supports in a home and community-based setting consistent with both paragraphs (a)(1) and (2) of this section.

(1) Home and community-based settings shall 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 facilitates the individual's full access to, the greater community, including opportunities to seek employment and work in competitive integrated settings (for those individuals interested in being employed), engage in community life, control personal resources, and receive services in the community, in the same manner as individuals without disabilities.

(ii) The setting is selected by the individual from among all available alternatives and is identified in the person-centered service plan.

(iii) An individual's essential personal rights of privacy, dignity and respect, and freedom from coercion and restraint are protected.

(iv) Individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact are optimized and not regimented.

(v) Individual choice regarding services and supports, and who provides them, is facilitated, and accordingly the individual can receive services under the benefit from any provider meeting the standards of section 441.668, cannot be required to receive services from the housing provider or from a service provider affiliated with or recommended by the housing provider, and cannot be required to receive any particular service as a condition of receiving services or remaining in the setting.

(vi) In a provider-owned or controlled residential setting, or in any setting limited to persons with disabilities, the following additional conditions must be met. ~~Any modification of the conditions, for example, to address the safety needs of an individual with dementia, must be supported by a specific assessed need and documented in the person-centered service plan~~:

(A) The unit or room is a specific physical place that can be owned, rented or occupied under a~~nother~~ 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, and the housing provider and service provider are obligated under the standards of the Americans with Disabilities Act to accommodate individual needs;

(B) Each individual has privacy in the~~ir~~ sleeping or living unit:

(1) Units have lockable entrance doors, with appropriate staff having keys to doors as applicable;

(2) Units include at least one full bathroom (unless the setting is in a building with a capacity of six or fewer residents);

~~(2)~~(3) Individuals share units only at the individual's choice, with individual bedrooms unless shared with a spouse, partner, or other family member; and

~~(3)~~(4) Individuals have the freedom to furnish and decorate their sleeping or living units.

(C) Individuals have the freedom and support to ~~control~~ choose 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, including overnight; and

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

(F) The conditions of subsection (B)(1), relating to lockable doors, may be modified to the extent necessary to protect the individual's safety or health, but only if any such modification is supported by a specific assessed need and documented in the person-centered service plan.

(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 the mentally retarded;

(iv) A hospital providing long-term care services; or

(v) Any ~~other locations that have qualities of an institutional setting, as determined by the Secretary. The Secretary will apply a rebuttable presumption that a setting is not a home and community-based setting, and engage in heightened scrutiny, for 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 disability-specific housing complex~~.

Section 441.650 Basis and Purpose

Section 1915(i) of the Act permits States to offer one or more home and community-based services (HCBS) under their State Medicaid plans to qualified individuals ~~with disabilities or individuals who are elderly~~. Those services are listed in § 440.182 of this chapter, and are described by the State in the State plan, including any limitations of the services. This optional benefit is known as the State plan HCBS benefit. This subpart describes what a State Medicaid plan must provide when the State elects to include the optional benefit, and defines State responsibilities.

Section 441.656 State Plan Home and Community-Based Services under the Act

(a) Home and Community-Based Setting. Under section 1915(i)(1) of the Act, States must make State plan HCBS available in a home and community-based setting consistent with both paragraphs (a)(1) and (2) of this section.

(1) Home and community-based settings shall 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 facilitates the individual's full access to, the greater community including opportunities to seek employment and work in competitive integrated settings (for those individuals interested in being employed), engage in community life, control personal resources, and receive services in the community, in the same manner as individuals without disabilities.

(ii) The setting is selected by the individual from among all available alternatives and is identified in the person-centered service plan.

(iii) An individual's essential personal rights of privacy, dignity and respect, and freedom from coercion and restraint are protected.

(iv) Individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact are optimized and not regimented.

(v) Individual choice regarding services and supports, and who provides them, is facilitated, and accordingly the individual can receive services under the benefit from any provider meeting the standards of section 441.668, cannot be required to receive services from the housing provider or from a service provider affiliated with or recommended by the housing provider, and cannot be required to receive any particular service as a condition of receiving services or remaining in the setting.

(vi) In a provider-owned or controlled residential setting, or in any setting limited to persons with disabilities, the following additional conditions must be met. ~~Any modification of the conditions, for example, to address the safety needs of an individual with dementia, must be supported by a specific assessed need and documented in the person-centered service plan~~:

(A) The unit or room 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, and the housing provider and service provider are obligated under the standards of the Americans with Disabilities Act to accommodate individual needs;

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

(1) Units have lockable entrance doors, with appropriate staff having keys to doors as applicable;

(2) Units include at least one full bathroom (unless the setting is in a building with a capacity of six or fewer residents);

~~(2)~~(3) Individuals share units only at the individual's choice, with individual bedrooms unless shared with a spouse, partner, or other family member; and

~~(3)~~(4) Individuals have the freedom to furnish and decorate their sleeping or living units.

(C) Individuals have the freedom and support to ~~control~~ choose 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, including overnight; and

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

(F) The conditions of subsection (B)(1), relating to lockable doors, may be modified to the extent necessary to protect the individual's safety or health, but only if any such modification is supported by a specific assessed need and documented in the person-centered service plan.

(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 the mentally retarded;

(iv) A hospital; or

(v) Any ~~other locations that have qualities of an institutional setting, as determined by the Secretary. The Secretary will apply a rebuttable presumption that a setting is not a home and community-based setting, and engage in heightened scrutiny, for 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 disability-specific housing complex~~.

(b) …

Section 441.659 Needs-Based Criteria and Evaluation.

(a) …

(b) More stringent institutional and waiver needs-based criteria. The State plan HCBS benefit is available only if the State has in effect needs-based criteria (as defined in paragraph (a) of this section), for receipt of services in nursing facilities as defined in section 1919(a) of the Act, intermediate care facilities for the mentally retarded as defined in § 440.150 of this chapter, and hospitals as defined in § 440.10 of this chapter for which the State has established long-term level of care (LOC) criteria, or waivers offering HCBS, and these needs-based criteria are more stringent than the needs-based criteria for the State plan HCBS benefit. If the State defines needs-based criteria for individual State plan home and community-based services, it may not have the effect of limiting who can benefit from the State plan HCBS in an unreasonable way, as determined by the Secretary.

(1) These more stringent criteria must meet the following requirements:

(i) Be included in the LOC determination process for each institutional service and waiver.

(ii) Be submitted for inspection by CMS with the State plan amendment that establishes the State Plan HCBS benefit.

(iii) Be in effect on or before the effective date of the State plan HCBS benefit.

(2) In the event that the State modifies institutional LOC criteria to meet the requirements under paragraph (b) or (c)~~(7)~~(6) of this section that such criteria be more stringent than the State plan HCBS needs-based eligibility criteria, the State shall continue to apply the LOC criteria previously in effect to those individuals receiving institutional services or waiver HCBS at the time of the modification, and the State shall continue to receive FFP for such individuals ~~receiving institutional services or waiver HCBS under the LOC criteria previously in effect~~.

(c) Adjustment authority. The State may modify the needs-based criteria established under paragraph (a) of this section, without prior approval from the Secretary, if the number of individuals enrolled in the State plan HCBS benefit exceeds the projected number submitted annually to CMS. The Secretary ~~will~~ may approve a retroactive effective date for the State plan amendment modifying the criteria, as early as the day following the notification period required under paragraph (c)(1) of this section, if all of the following conditions are met:

(1) The State provides at least 60 days notice of the proposed modification to the Secretary, the public, and each individual enrolled in the State plan HCBS benefit and the Secretary has provided the public at least a 30 day period in which to submit comments regarding the proposed modification, pursuant to paragraphs (c)(7)-(12).

(2) The State notice to the Secretary is submitted as an amendment to the State plan.

(3) The adjusted needs-based eligibility criteria for the State plan HCBS benefit are less stringent than needs-based institutional and waiver LOC criteria in effect after the adjustment.

(4) Individuals who were found eligible for the State plan HCBS benefit before modification of the needs-based criteria under this adjustment authority must remain eligible for the HCBS benefit unless~~until such time as~~:

(i) The individual no longer meets the needs-based criteria used for the initial determination of eligibility; or

(ii) The individual is no longer eligible for or enrolled in Medicaid ~~or the HCBS benefit~~.

(5) Any changes in service due to the modification of needs-based criteria under this adjustment authority are treated as actions as defined in § 431.201 and are subject to the requirements of Part 431 Subpart E of this chapter.

(6) In the event that the State also needs to modify institutional LOC criteria to meet the requirements under paragraph (b) of this section that such criteria be more stringent than the State plan HCBS needs-based eligibility criteria, the State may adjust the modified institutional LOC criteria under this adjustment authority. The adjusted institutional LOC criteria must be at least as stringent as those in effect before they were modified to meet the requirements in paragraph (b) of this section.

(7) Within 15 days of receipt of a request from the State for modification of needs-based criteria under paragraph (c) or institutional LOC criteria under paragraph(c)(6), CMS will:

(i) Send the State a written notice informing the State of receipt of the modification request, the date on which the Secretary received the request, the start date of the 30-day public notice process, and an end date of a 60-day minimum Federal decision-making period.

(ii) Publish a written notice acknowledging receipt of the State's completed application on its Web site within the same 15-day timeframe.

(8) Upon notifying the State of receipt of a modification request, CMS will solicit public comment regarding such request for 30 days by doing the following:

(i) Publishing the following on the CMS Web site:

(A) The written notice of CMS's receipt of the State's modification request.

(B) The State's request for modification, including any supporting information submitted by the State.

(C) The proposed effective date of the modification.

(D) Addresses to which inquiries and comments from the public may be directed to CMS by mail or email.

(ii) Notifying interested parties through a mechanism, such an electronic mailing list, that CMS will create for this purpose.

(9) CMS will publish on its Web site, at regular intervals, appropriate information, which may include, but is not limited to the following:

(i) Relevant status update(s);

(ii) A listing of the issues raised through the public notice process.

(10) (i) CMS will publish written comments electronically through its Web site or an alternative Web site.

(ii) CMS will review and consider all comments received by the deadline, but will not provide written responses to public comments. While comments may be submitted after the deadline, CMS cannot assure that these comments will be considered.

(11) CMS will not render a final decision on a modification request until at least 45 days after notice of receipt of a completed application, to receive and consider public comments.

(12) CMS will maintain, and publish on its public Web site, an administrative record that may include, but is not limited to the following:

(i) The modification request from the State.

(ii) Written public comments sent to the CMS and any CMS responses.

(iii) If a request is approved, the approval letter and any other related communication sent to the State.

(iv) If a request is denied, the disapproval letter sent to the State.

(d) Independent evaluation and determination of eligibility. Eligibility for the State plan HCBS benefit must be determined through an independent evaluation of each individual according to the requirements of § 441.656(a)(1) through (5) of this subpart. The independent evaluation complies with the following requirements:

(1) Is performed by an agent that is independent and qualified as defined in § 441.668 of this subpart.

(2) Applies the needs-based eligibility criteria that the State has established under paragraph (a) of this section, and the general eligibility requirements under § 441.656(a)(1) through (3) and (b)(2) of this subpart.

(3) Includes consultation with the individual, and if applicable, the individual's ~~authorized~~ representative.

(4) Assesses the individual's support needs.

(5) Uses only current and accurate information from existing records, and obtains any additional information necessary to draw valid conclusions about the individual's support needs.

(6) Evaluations finding that an individual is not eligible for the State plan HCBS benefit are treated as actions defined in § 431.201 of this chapter and are subject to the requirements of part 431 subpart E of this chapter.

(e) Periodic redetermination. Independent reevaluations of each individual receiving the State plan HCBS benefit must be performed at least every 12 months, to determine

whether the individual continues to meet eligibility requirements. Redeterminations must meet the requirements of paragraph (d) of this section.

Section441.662 Independent Assessment

(a) Requirements. For each individual determined to be eligible for the State plan HCBS benefit, the State must provide for an independent assessment of needs, which may include the results of a standardized functional needs assessment, in order to establish a service plan. In applying the requirements of section 1915(i)(1)(F) of the Act, the State must:

(1) Perform a face-to-face assessment of the individual by an agent that is independent and qualified as defined in § 441.668 of this subpart and with a person-centered process guided by best practice and research on effective strategies that result in improved health and quality of life outcomes.

~~*(i) For the purposes of this section, a face-to-face assessment may include assessments performed by telemedicine, or other information technology medium, if the following conditions are met:*~~

~~*(A) The health care professional(s) performing the assessment meets the provider qualifications defined by the State, including any additional qualifications or training requirements for the operation of required information technology.*~~

~~*(B) The individual receives appropriate support during the assessment, including the use of any necessary on-site support staff.*~~

~~*(C) The individual provides informed consent for this type of assessment.*~~

~~*(ii) [Reserved]*~~

(2) Conduct the assessment in consultation with the individual, and if applicable, the individual's ~~*authorized*~~ *representative, and include the opportunity for the individual to identify other persons to be consulted, such as, but not limited to, the individual's spouse, family, guardian, and treating and consulting health and support professionals responsible for the individual's care.*

(3) Examine the individual's relevant history including the findings from the independent evaluation of eligibility, medical records, an objective evaluation of functional ability, and any other records or information needed to develop the service plan as required in § 441.665 of this subpart.

(4) Include in the assessment the individual's physical and behavioral health care and support needs, strengths and preferences, available service and housing options, and

when unpaid caregivers will be relied upon to implement the service plan, a caregiver assessment.

(5) Apply the State's needs-based criteria for each service (if any) that the individual may require. Individuals are considered enrolled in the State plan HCBS benefit only if they meet the eligibility and needs-based criteria for the benefit, and are also assessed to require and receive at least one home and community-based service offered under the State plan for medical assistance.

(6) Include in the assessment, if the State offers individuals the option to self-direct a State plan home and community-based service or services, any information needed for the self-directed portion of the service plan, as required in § 441.674(b) of this subpart, including the ability of the individual (with and without supports) to exercise budget or employer authority.

(7) Include in the assessment, for individuals receiving habilitation services, documentation that no Medicaid services are provided which would otherwise be available to the individual, specifically including but not limited to services available to the individual through a program funded under section 110 of the Rehabilitation Act of 1973, or the Individuals with Disabilities Education Improvement Act of 2004.

(8) Include in the assessment and subsequent service plan, for individuals receiving Secretary approved services under the authority of § 440.182 of this chapter, documentation that no State plan HCBS services are provided which ~~would otherwise be~~ are immediately available to the individual through ~~other Medicaid services or~~ other Federally funded programs.

(9) …

Section 441.665 Person-Centered Service Plan

(a) Person-centered planning process. Based on the independent assessment required in § 441.662 of this subpart, the State must develop (or approve, if the plan is developed by others) a written service plan jointly with the individual (including, for purposes of this paragraph, the individual and the individual's authorized representative if applicable). The person-centered planning process is driven by the individual. The process:

(1) Includes people chosen by the individual.

(2) 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.

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

(4) Reflects cultural considerations of the individual.

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

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

(7) Includes a method for the individual to request updates to the plan.

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

(9) Is physically and linguistically accessible to the individual.

(b) 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 plan HCBS benefit, the plan must:

(1) Reflect that the setting in which the individual resides is chosen by the individual.

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

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

(4) Include individually identified goals and desired outcomes.

(5) 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 cannot supplant needed paid services unless the natural supports are unpaid supports that are provided voluntarily to the individual in lieu of State plan HCBS.

(6) Reflect risk factors and measures in place to minimize them, including Individualized backup plans.

(7) Be understandable to the individual receiving services and supports, and the individuals important in supporting him or her.

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

(9) Be finalized and agreed to in writing by the individual and signed by all individuals and providers responsible for its implementation.

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

(11) Include those services, the purchase or control of which the individual elects to self-direct, meeting the requirements of § 441.574(b) through (d) of this subpart.

(12) Prevent the provision of unnecessary or inappropriate care.

(13) Be translated into the individual's preferred language.

(13) Other requirements as determined by the Secretary.

(c) Reviewing the person-centered service plan. The person-centered service plan must be reviewed, and revised upon reassessment of functional need as required in § 441.662 of this subpart, at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual.

Section 441.668 Provider Qualifications

(a) Requirements. The State must provide assurances that necessary safeguards have been taken to protect the health and welfare of enrollees in State plan HCBS, and must define in writing standards for providers (both agencies and individuals) of HCBS services and for agents conducting individualized independent evaluation, independent assessment, and service plan development. Such standards shall not be construed to limit the ability of self-directing individuals who have employer authority to hire, train, manage, or discharge providers pursuant to section 441.674.

(b) …

(d) Nondiscrimination. Providers of State plan HCBS must not discriminate against recipients on the basis of race, color, national origin, religion, sex, sexual orientation, gender identity, marital status, source of payment, or mental or physical disability.

Section 441.674 Self-Directed Services

(a) …

(d) Budget authority. If the service plan includes an individualized budget (which identifies the dollar value of the services and supports under the control and direction of the individual), the plan must meet the following requirements:

(1) Describe the method for calculating the dollar values in the budget, based on reliable costs and service utilization.

(2) Define a process for making adjustments in dollar values to reflect changes in an individual's assessment and service plan.

(3) Provide a procedure to evaluate expenditures under the budget.

(4) Specify the financial management supports, as required in paragraph (e) of this section, to be provided.

(5) Not result in payment for medical assistance to the individual, but without limiting the individual's right to pay the provider directly, if such direct payment is authorized by the State plan.

(e) …

Section 441.677 State Responsibilities and Quality Improvement

(a) State plan HCBS administration. (1) State responsibilities. The State must carry out the following responsibilities in administration of its State plan HCBS:

(i) Number served. The State will annually provide CMS with the projected number of individuals to be enrolled in the benefit and the actual number of unduplicated individuals enrolled in State plan HCBS in the previous year.

(ii) Access to services. The State must grant access to all State plan HCBS assessed to be needed in accordance with a service plan consistent with § 441.665 of this subpart, to individuals who have been determined to be eligible for the State plan HCBS benefit, subject to the following requirements:

(A) A State must determine that provided services meet medical necessity criteria;

(B) A State may limit access to services through targeting criteria established by § 441.656~~(b)(2)~~(e)(2)(i) of this subpart; and

(C) A State may not limit access to services based upon the income of individuals, the cost of services, or the individual's location in the State.

(iii) Appeals. A State must provide individuals with the right to appeal terminations, suspensions, or reductions of Medicaid eligibility or covered services as described in part 431, subpart E.

(2) Administration. (i) Option for presumptive payment. (A) The State may provide for a period of presumptive payment, not to exceed 60 days, for Medicaid eligible individuals the State has reason to believe may be eligible for the State plan HCBS benefit. FFP is available both for ~~both~~ services that meet the definition of medical assistance and necessary administrative expenditures, for evaluation of eligibility for the State plan

HCBS benefit under § 441.659(d) of this subpart and assessment of need for specific HCBS under § 441.662(a) of this subpart, prior to an individual's receipt of State plan HCBS services or determination of ineligibility for the benefit.

(B) If an individual the State has reason to believe may be eligible for the State plan HCBS benefit ~~and~~ is evaluated and assessed under the presumptive payment option and found not to be eligible for the benefit, FFP is available for services that meet the definition of medical assistance and necessary administrative expenditures. The individual so determined will not be considered to have enrolled in the State plan HCBS benefit for purposes of determining the annual number of participants in the benefit.

(ii) Option for Phase-in of Services and Eligibility. (A) In the event that a State elects to establish targeting criteria through § 441.656~~(b)(2)~~(e)(2)(i) of this subpart, the State may limit the enrollment of individuals or the provision of services to enrolled individuals based upon criteria described in a phase-in plan, subject to CMS approval. A State which elects to target the State plan HCBS benefit and to phase-in enrollment and/or services must submit a phase-in plan for approval by CMS that describes, at a minimum:

(1) The criteria used to limit enrollment or service delivery;

(2) The rationale for phasing-in services and/or eligibility; and

(3) Timelines and benchmarks to ensure that the benefit is available statewide to all eligible individuals within the initial 5-year period of approval, and continuously thereafter for all approved periods of time.

(B) If a State elects to phase-in the enrollment of individuals based on highest need, the phase-in plan must use the needs-based criteria described in § 441.659(a) of this subpart to establish priority for enrollment. Such criteria must be based upon the assessed need of individuals, with higher-need individuals receiving services prior to individuals with lower assessed need.

(C) If a State elects to phase-in the provision of any services, the phase-in plan must include a description of the services that will not be available to all eligible individuals, the rationale for limiting the provision of services, and assurance that all individuals with access to a willing and qualified provider may receive services.

(D) The plan may not include a cap on the number of enrollees.

(E) The plan must include a timeline to assure that all eligible individuals receive all included services prior to the end of the first 5-year approval period, described in paragraph (a)(2)(vi) of this section.

(iii) Reimbursement methodology. The State plan amendment to provide State plan HCBS must contain a description of the reimbursement methodology for each covered service. To the extent that the reimbursement methodologies for any self-directed services

differ from those descriptions, the method for setting reimbursement methodology for the self-directed services must also be described.

(iv) Operation. The State plan amendment to provide State plan HCBS must contain a description of the State Medicaid agency line of authority for operating the State plan HCBS benefit, including distribution of functions to other entities.

(v) Modifications. The ~~agency~~ State may request that modifications to the benefit be made effective retroactive to the first day of a fiscal year quarter, or another date after the first day of a fiscal year quarter, in which the amendment is submitted, unless the amendment involves substantive change. Substantive changes may include, but are not limited to, the following:

(A) Revisions to services available under the benefit including elimination or reduction in services, and changes in the scope, amount and duration of the services.

(B) Changes in the qualifications of service providers, rate methodology, or the eligible population.

(1) Request for Amendments. A request for an amendment that involves a substantive change as determined by CMS--

(i) May only take effect on or after the date when the amendment is approved by CMS; and

(ii) Must be accompanied by information on how the State will ensure for transitions with minimal adverse impact on individuals impacted by the change.

(2) [Reserved]

(vi) Periods of approval. (A) If a State elects to establish targeting criteria through § 441.656~~(b)(2)~~(e)(2)(i) of this subpart, the approval of the State Plan Amendment will be in effect for a period of 5 years from the effective date of the amendment. To renew State plan HCBS for an additional 5-year period, the State must provide a written request for renewal to CMS at least 180 days prior to the end of the approval period. CMS approval of a renewal request is contingent upon the State adhering~~ence~~ to Federal requirements and meeting the State's objectives with respect to quality improvement and beneficiary outcomes.

(B) If a State does not elect to establish targeting criteria through § 441.656~~(b)(2)~~(e)(2)(i) of this subpart, the limitations on length of approval does not apply.

(b) …