Revisions to the 1915(c) Home and Community-Based Services (HCBS) Waiver Application and Technical Guide

Division of Long-Term Services and Supports
Medicaid Benefits and Health Programs Group
Centers for Medicaid and CHIP Services

CMS
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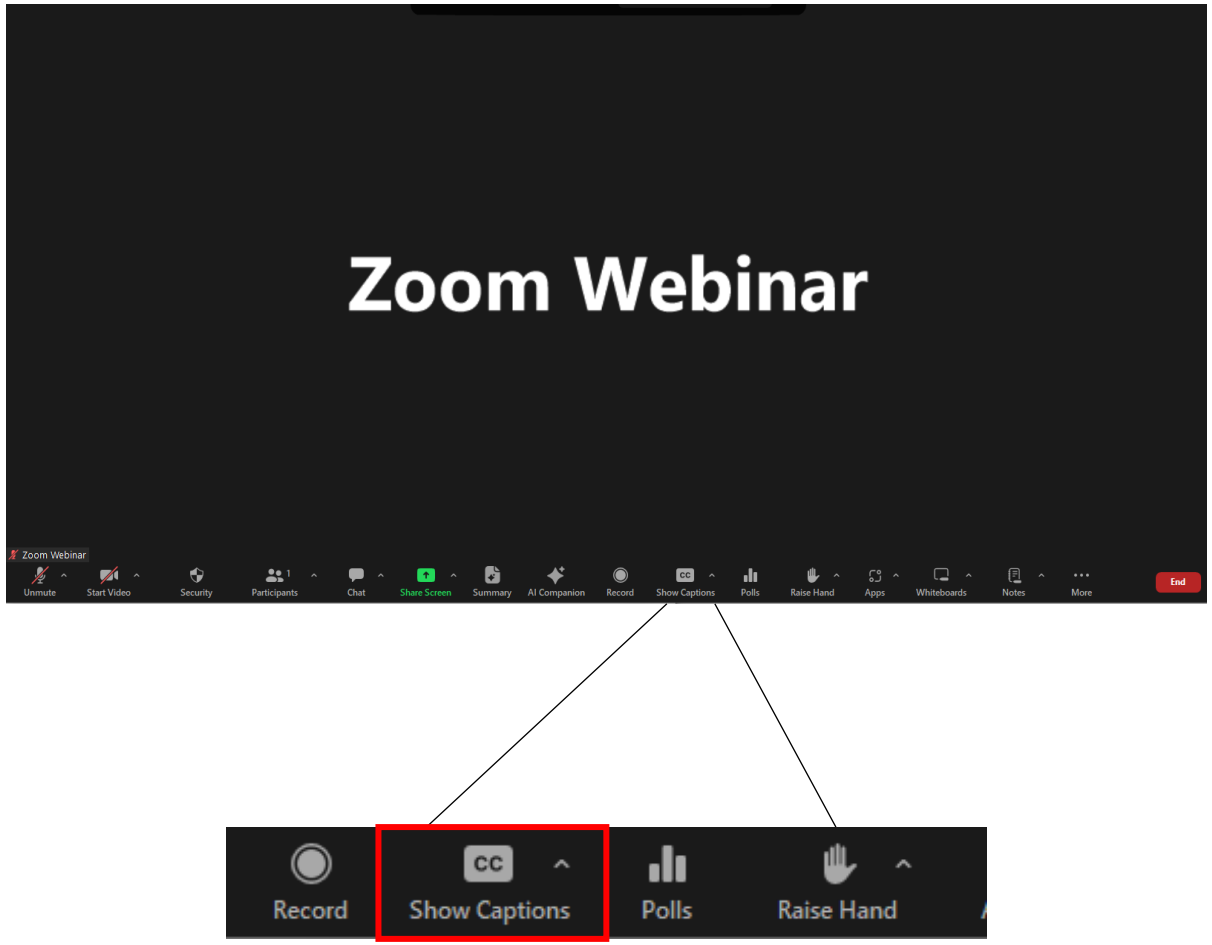

Presentation Objectives:

This session will provide:

- A brief overview of the 1915(c) Waiver Application and Technical Guide;
- A brief overview of minor technical changes to the 1915(c) Waiver Application and Technical Guide; and
- A detailed discussion of substantive changes to the 1915(c) Waiver Application and Technical Guide.

The revised 1915(c) Waiver Application and Technical Guide will be available on December 16, 2024, at: https://wms-mmdl.cms.gov/WMS/faces/portal.jsp.

Overview of 1915(c) HCBS Waiver Application and Technical Guide

Overview of 1915(c) Waiver Application and Technical Guide

- The Version 3.7 HCBS Waiver Application reflects current federal policy regarding the operation of HCBS waivers and is designed to ensure that CMS has the full range of information required to review and take action on a state's request to operate an HCBS waiver.
- The Version 3.7 Instructions, Technical Guide and Review Criteria can help states to design or amend an HCBS waiver. These instructions are expected to:
  - Improve understanding of applicable federal policies and their implications for the design and operation of an HCBS waiver and
  - Provide the review criteria that CMS uses to determine whether a waiver meets applicable statutory, regulatory, and other requirements.
- Since 2006, CMS has offered a web-based Waiver Management System (WMS) enabling states to submit 1915(c) waiver amendments and renewals.

Minor Technical Changes to the 1915(c) HCBS Waiver Application and Technical Guide

Note: Throughout the presentation, slides indicate when all the language is new/revised, otherwise [ ] and light orange highlights indicate new/revised language/content.

Minor Technical Changes to the 1915(c) HCBS Waiver Application and Technical Guide (1 of 3)

- Throughout the instructions and technical guide, applicable statutory and regulatory citations were added.
- The Quality Improvement Strategy: Overview subsection references the July 2022 standard HCBS measure set that may be used to satisfy some of the assurances available in Attachment D.
- Revisions to the assurance language were made to align with current practice.
- General information about Appendix K Emergency Preparedness and Response waiver amendments was added.
- Clarifications of existing requirements and processes for new waivers and temporary extensions of approved waivers were added.

Minor Technical Changes to the 1915(c) HCBS Waiver Application and Technical Guide (2 of 3)

- Throughout the instructions and technical guide, additions and changes to clarify existing requirements pertaining to the quality improvement strategy and 372 reporting.
- Item 6-F: Federal Financial Participation Limitation was updated to clarify that the Medicaid program functions as the payer of last resort.
- Across Quality Improvement sections:

New Language in Waiver Application is in Brackets and is Highlighted

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information

regarding responsible parties and GENERAL methods for problem correction[and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions.] In addition, provide information on the methods used by the state to document these items.

Minor Technical Changes to the 1915(c) HCBS Waiver Application and Technical Guide (3 of 3)

Appendix A in the Technical Guide and Application - **All New Language**

State Medicaid Agency (SMA) or a government agency delegated by the SMA in accordance with 42 CFR § 431.10. Thus, eligibility determinations for the group described in 42 CFR § 435.217 (which includes a level-of-care evaluation, because meeting a 1915(c) level of care is a factor of determining Medicaid eligibility for the group) must comply with 42 CFR § 431.10. Non-governmental entities can support administrative functions of the eligibility determination process that do not require discretion including, for example, data entry functions, IT support, and implementation of a standardized level-of-care evaluation tool. States should ensure that any use of an evaluation tool by a non-governmental entity to evaluate/determine an individual's required level-of-care involves no discretion by the non-governmental entity and that the development of the requirements, rules, and policies operationalized by the tool are overseen by the state agency.

Updates to the 1915(c) HCBS Waiver Application and Technical Guide

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

New Language in Waiver Application is in Brackets and is Highlighted

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the state plan. The state applies all applicable federal financial participation limits under the plan. *Check all that apply:*

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR § 435.217)

- ☐ **[Parents and Other Caretaker Relatives (42 CFR § 435.110)]**
- ☐ **[Pregnant Women (42 CFR § 435.116)]**
- ☐ **[Infants and Children under Age 19 (42 CFR § 435.118)]**
- ☐ **SSI recipients**
- ☐ **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR § 435.121**
- ☐ **Optional state supplement recipients**

Item B-5: Post-eligibility Treatment of Income

New Language in Technical Guide is in Brackets and is Highlighted

- As of January 1, 2014, [***and extending through September 30, 2027 (or other date as required by law)***,] states must apply the eligibility and post-eligibility methodologies described in section 1924 of the Act (the spousal impoverishment statute) to all married individuals seeking eligibility under the category described at 42 CFR § 435.217.

Item C-1-b. Alternate Provision of Case Management Services to Waiver Participants (1 of 2)

New Technical Guide Language: "Given that case managers are critical for ensuring that regulatory requirements for both person-centered planning and HCBS settings are met, states should describe the training required of case managers on both topics."

New Language is in Brackets and is Highlighted

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

- Evaluation and/or re-evaluation of level of care;
- Assessment and/or reassessment of the need for waiver services;
- Development and/or review of the service plan;
- Coordination of multiple services and/or among multiple providers;
- Linking waiver participants to other federal, state and local programs;
- Monitoring the implementation of the service plan and participant health and welfare,
- Addressing problems in service provision;
- [Monitoring compliance with HCBS settings criteria;]
- [Reporting and following-up on critical incidents;]
- Responding to participant crises; and
- For waivers with cost or service duration limits, monitoring to detect and resolve situations when the needs of an individual might exceed the limit(s) to ensure health and welfare of waiver participants.

Item C-1-b. Alternate Provision of Case Management Services to Waiver Participants (2 of 2)

New Language in Waiver Application is in Brackets and is Highlighted

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ○ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

- ☐ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- ☐ **As a Medicaid state plan service under section 1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☐ **As a Medicaid state plan service under section 1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- ☐ **As an administrative activity.** *Complete item C-1-c.*
- ☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*
- ☐ **[As a Medicaid state plan service under section 1945 and/or section 1945A of the Act (Health Homes Comprehensive Care Management).** *Complete item C-1-c.]*

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

New Language in Waiver Application is in Brackets and is Highlighted

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants [and the requirements for their training on the HCBS settings regulation and person-centered planning requirements:]

Item C-1-d. Remote/Telehealth Delivery of Waiver Services (1 of 3)

All New Language in the Technical Guide

- "Telehealth" refers to a general service modality, and states may use other terms to reflect the use of telehealth in their HCBS waivers.
- If the state is planning to allow for any waiver services to be delivered remotely/via telehealth, include the following information in the waiver application:
  - How the remote service will be delivered in a way that respects the privacy of the individual especially in instances of toileting, dressing, etc.
  - How the telehealth service delivery will facilitate community integration.
  - How the telehealth will ensure the successful delivery of services for individuals who need hands on assistance/physical assistance, including whether the service may be rendered without someone who is physically present or is separated from the individual.

Item C-1-d. Remote/Telehealth Delivery of Waiver Services (2 of 3)

New Language in the Technical Guide is in Brackets and is Highlighted

- The state must also include the following information in the waiver application:
  - [How the state will support individuals who need assistance with using the technology required for telehealth delivery of the service.]
  - [How the telehealth will ensure the health and safety of an individual.]

New Language in Waiver Application is in Brackets and is Highlighted

C-1

[d. Remote/Telehealth Delivery of Waiver Services. Specify whether each waiver service that is specified in Appendix C-1/C-3 can be delivered remotely/via telehealth.]

1. [Will any in-person visits be required?]
   - [Yes]
   - [No]

C-3

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☐ **Provider managed**
- ☐ **[Remote/via Telehealth]**

Item C-1-d. Remote/Telehealth Delivery of Waiver Services (3 of 3)

All New Language in Waiver Application

2. *By checking each box below, the state assures that it will address the following when delivering the service remotely/via telehealth.*

☐ The remote service will be delivered in a way that respects privacy of the individual especially in instances of toileting, dressing, etc. *Explain*:

☐ How the telehealth service delivery will facilitate community integration. *Explain*:

☐ How the telehealth will ensure the successful delivery of services for individuals who need hands on assistance/ physical assistance, including whether the service can be rendered without someone who is physically present or is separated from the individual.*Explain*:

☐ How the state will support individuals who need assistance with using the technology required for telehealth delivery of the service. *Explain:*

☐ How the telehealth will ensure the health and safety of an individual. *Explain*:

Item C-2-b: Abuse Registry Screening

New Language in Waiver Application is in Brackets and is Highlighted

b. Abuse Registry Screening. Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

- ○ **No. The state does not conduct abuse registry screening.**
- ○ **Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; (c) the process for ensuring that mandatory screenings have been conducted; [and (d) the process for ensuring continuity of care for a waiver participant whose service provider was added to the abuse registry.] State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Item C-2-d: Provision of Personal Care or Similar Services by Legally Responsible Individuals (1 of 2)

New Language in Waiver Application is in Brackets and is Highlighted

- ○ **No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ○ **Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the [types of] legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) [the method for determining that the amount of personal care or similar services provided by a legally responsible individual is] "***extraordinary care***", [exceeding the ordinary care that would be provided to a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant and avoid institutionalization;] (c) the state [policies to determine] that the provision of services by a legally responsible individual is in the best interest of the participant; [(d) the state processes to ensure that legally responsible individuals who have decision-making authority over the selection of waiver service providers use substituted judgement on behalf of the individual; (e) any limitations on the circumstances under which payment will be authorized or the amount of personal care or similar services for which payment may be made; (f) any additional safeguards the state implements when legally responsible individuals provide personal care or similar services;] and, (g) the [procedures] that are [used to implement required state oversight, such as] ensuring that payments are made only for services rendered. Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.

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

All New Language in Technical Guide

- A state must:
  - Ensure waiver participants have informed consent of providers of such services in accordance with Appendix D-1-f;
  - Monitor the delivery of those services as provided in Appendix D-2, including the required documentation and assurance that the services are delivered in accordance with the service plan;
  - Implement payment review procedures to ensure that the services for which payment is made have been rendered in accordance with the service plan and the conditions that the state has placed on the provision of such services; and
  - Consider the authorization of legally responsible individuals to meet the requirement of ensuring the delivery of needed services. When used to deliver services, all required statutory and regulatory components of 1915(c) waivers must continue to be met.

Item C-2-e: State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians (1 of 2)

New Language in Waiver Application is in Brackets and is Highlighted

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

- ○ **The state does not make payment to relatives/legal guardians for furnishing waiver services.**
- ○ **The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the types of relatives/legal guardians to whom payment may be made, the services for which payment may be made, the specific circumstances under which payment is made, and [the method of determining that such circumstances apply. Also specify any limitations on the amount of services that may be furnished by a relative or legal guardian, and any additional safeguards the state implements when relatives/legal guardians provide waiver services. Specify the state policies to determine that that the provision of services by a relative/legal guardian is in the best interests of the individual. When the relative/legal guardian has decision-making authority over the selection of providers of waiver services, specify the state's process for ensuring that the relative/legal guardian uses substituted judgment on behalf of the individual.] Specify the [procedures] that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

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

New Language in Technical Guide is in Brackets and is Highlighted

States are required to:

- Specify any limitations on the types of relatives or legal guardians who may furnish services (e.g., whether legally responsible individuals are excluded).
- In Appendix C-3, for each waiver service that a relative or legal guardian may furnish, check off relative/legal guardian as a provider type.
- [Specify the state policies to determine that the provision of waiver services by a relative/legal guardian is in the best interests of the participant.]
- [When the relative/legal guardian has decision-making authority over the selection of providers of waiver services, describe the state's process for ensuring that the legally responsible individual uses substituted judgement on behalf of the individual.]
- Specify the procedures that have been established to ensure that payment is made only for services rendered.

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

All New Language in Waiver Application

g. State Option to Provide HCBS in Acute Care Hospitals in accordance with Section 1902(h)(1) of the Act. Specify whether the state chooses the option to provide waiver HCBS in acute care hospitals. *Select one*:

- o No, the state does not choose the option to provide HCBS in acute care hospitals.
- o Yes, the state chooses the option to provide HCBS in acute care hospitals under the following conditions. ***By checking the boxes below, the state assures:***

  - ☐ The HCBS are provided to meet the needs of the individual that are not met through the provision of acute care hospital services;
  - ☐ The HCBS are in addition to, and may not substitute for, the services the acute care hospital is obligated to provide;
  - ☐ The HCBS must be identified in the individual's person-centered service plan; and
  - ☐ The HCBS will be used to ensure smooth transitions between acute care setting and community-based settings and to preserve the individual's functional abilities.

  And specify:

  (a) The 1915(c) HCBS in this waiver that can be provided by the 1915(c) HCBS provider that are not duplicative of services available in the acute care hospital setting;

  (b) How the 1915(c) HCBS will assist the individual in returning to the community; and

  (c) Whether there is any difference from the typically billed rate for these HCBS provided during a hospitalization. If yes, please specify the rate methodology in Appendix I-2-a.

Appendix C-3: Waiver Services Specifications (1 of 4)

New Language in Technical Guide is in Brackets and is Highlighted

- Relationship of Waiver Services to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services
  - Thus, in a waiver that serves children, services such as rehabilitative services (as defined in 42 CFR § 440.130), private duty nursing (as defined in 42 CFR § 440.80), physical and occupational therapy (as defined in 42 CFR § 440.110), and nurse practitioner services (as defined in 42 CFR § 440.166) may not be furnished as waiver services to children [***unless the waiver authorizes these services beyond what is considered medically necessary under EPSDT***].

Appendix C-3: Waiver Services Specifications (2 of 4)

- **New Language in Technical Guide is in Brackets and is Highlighted**
  - D. Children's Education Services
    - **[Section 1915(c)(5)(C) of the Act indicates that habilitative services may not include special education and related services under the provisions of Individuals with Disabilities Education Improvement Act of 2004 (IDEA).]** The funding of such services is the responsibility of state and local education agencies.

    - **[As indicated in the December 15, 2014 letter to State Medicaid Directors, Medicaid-covered services furnished in schools are eligible for reimbursement when Medicaid program requirements are met. Aside from the habilitative services prohibition, this includes 1915(c) waiver services.]**

Appendix C-3: Waiver Services Specifications (3 of 4)

All New L. Electronic/Remote Monitoring HCBS

The state needs to explain in the service definition:

- Who will be responsible for the remote monitoring activity, including whether they are on-site or on-call.
- How the remote monitoring will facilitate community integration.
- How the state will ensure that the individual's right to privacy is being met, as well as that of others in the home and what safeguards will be in place to protect individual rights and privacy.
- How the state will ensure that the waiver participant, involved family members and/or guardian has agreed to the use of remote monitoring and that this is documented in the individual's person-centered service plan prior to use.
- How the remote monitoring will ensure the individual's needs are being met and that health and welfare needs are being addressed.
- The back-up plan in the event of equipment/technology failure (e.g., evaluation of the existence or availability of back-up power sources, alarms, additional person(s) to assist, etc.).

Appendix C-3: Waiver Services Specifications (4 of 4)

All New L. Electronic/Remote Monitoring HCBS, cont.

- For remote monitoring devices/equipment/technology, the state also needs to describe in the waiver application service definition:
  - Where devices/monitors will be placed, including whether the state will permit placement of video cameras/monitors in bedrooms and bathrooms. If the state will permit video cameras/monitors to be placed in bedrooms and bathrooms, how the state will ensure that this is determined to be necessary on an individual basis and justified in the person-centered service plan.
  - The control that the waiver participant will have over the equipment, including whether the waiver participant can turn off the remote monitoring device/equipment, if they choose to do so, and how they are informed of this option and how to do it.

Appendix C-5: Home and Community-Based Settings Requirements (1 of 4)

New Language in Waiver Application is in Brackets and is Highlighted

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR §§441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings [in which 1915(c) HCBS are received. (*Specify and describe the types of settings in which waiver services are received)]*

2. [Description of the means by which the state Medicaid agency ascertains that all settings in which HCBS are received meet federal HCB settings requirements, at the time of this submission and in the future as part of ongoing monitoring. (Describe the process that the state will use to assess each setting including a detailed explanation of how the state will perform on-going monitoring across residential and non-residential settings in which waiver HCBS are received.)]

Appendix C-5: Home and Community-Based Settings Requirements (2 of 4)

All New Language in Waiver Application

3. *By checking each box below, the state assures that the process will ensure that each setting will meet each requirement:*

- ☐ 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.
- ☐ 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. (*see Appendix D-1-d-ii*)
- ☐ Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.
- ☐ Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.
- ☐ Facilitates individual choice regarding services and supports, and who provides them.
- ☐ Home and community-based settings do not include a nursing facility, an institution for mental diseases, an intermediate care facility for individuals with intellectual disabilities, a hospital; or any other locations that have qualities of an institutional setting.

Appendix C-5: Home and Community-Based Settings Requirements (3 of 4)

All New Language in Waiver Application

- ☐ 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.
- ☐ Each individual has privacy in their sleeping or living unit:
  - Units have entrance doors lockable by the individual:
  - Only appropriate staff have keys to unit entrance doors.
  - Individuals sharing units have a choice of roommates in that setting.
- ☐ Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.
- ☐ Individuals have the freedom and support to control their own schedules and activities.
- ☐ Individuals have access to food at any time.
- ☐ Individuals are able to have visitors of their choosing at any time.
- ☐ The setting is physically accessible to the individual.
- ☐ Any modification of these additional conditions for provider-owned or controlled settings, 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 (*see Appendix D-1-d-ii of this waiver application*).

Appendix C-5: Home and Community-Based Settings Requirements (4 of 4)

Revised Language in Technical Guide is in Brackets and is Highlighted

Settings that Isolate

Some settings have the effect of isolating individuals receiving HCBS from the broader community. [As described in the State Medicaid Director's Letter #19-001 issued on March 22, 2019 (in Attachment C), CMS intends to take the following factors into account in determining whether a setting may have the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving HCBS:]

- [Due to the design or model of service provision in the setting, individuals have limited, if any, opportunities* for interaction in and with the broader community, including with individuals not receiving Medicaid-funded HCBS;]
- [The setting restricts beneficiary choice to receive services or to engage in activities outside of the setting; or]
- [The setting is physically located separate and apart from the broader community and does not facilitate beneficiary opportunity to access the broader community and participate in community services, consistent with a beneficiary's person-centered service plan.]

["Opportunities", as well as identified supports to provide access to and participation in the broader community, should be reflected in both individuals' person-centered service plans and the policies and practices of the setting in accordance with 42 CFR §§ 441.301(c)(1)-(3) and (4)(vi)(F), 42 CFR §§ 441.530(a)(1)(vi)(F) and 441.540, and 42 CFR §§ 441.710(a)(1)(vi)(F) and 441.725.]*

Appendix C Attachment: Core Service Definitions (1 of 4)

All Revised Language in Technical Guide

15. **Clinic Services**

Background

Clinic services under the state plan are defined in 42 CFR §440.90 as preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. Clinic services (whether or not furnished in a facility) for individuals with chronic mental illness are also permitted under 1915(c) waivers in accordance with 42 CFR § 440.180. There are two core service definitions provided below.

Core Service Definition

Services (whether or not furnished in a facility, that include preventive, diagnostic, therapeutic, rehabilitative, or palliative services provided to individuals with chronic mental illness.

Core Service Definition (Extended State Plan Service):

Services that are provided when clinic services (as defined in 42 CFR § 440.90) furnished under the approved state plan limits are exhausted. The scope and nature of these services do not otherwise differ from clinic services furnished under the state plan. The provider qualifications specified in the state plan apply.

Appendix C Attachment: Core Service Definitions (2 of 4)

New Language in Technical Guide is in Brackets and is Highlighted

[Case management services are an optional benefit that a state may furnish under its state plan, as provided in 42 CFR § 440.169. Case management services are also identified as 1915(c) waiver home and community-based services at 42 CFR § 440.180(b)(1).]

Core Service Definition

Services that assist participants in gaining access to needed waiver and other state plan services, as well as medical, social, educational, and other services, regardless of the funding source for the services to which access is gained.

Appendix C Attachment: Core Service Definitions (3 of 4)

All New Language in Technical Guide

19. Assistance in Community Integration – Housing Supports

Background

There is no regulatory definition for Assistance in Community Integration – Housing Supports; however, related guidance regarding community integration can be found in SHO letter # 21-001, Opportunities in Medicaid and CHIP to Address Social Determinants of Health (located in Attachment C).

Core Service Definition

Services that enable participants to maintain their own housing as set forth in the participant's approved person-centered service plan. Services must be provided in the home or a community setting. ***When not otherwise available,*** *the service may include the following components:*

- *Conducting a community integration assessment identifying the participant's preferences related to housing (type, location, living alone or with someone else, identifying a roommate, accommodations needed, or other important preferences) and needs for support to maintain community integration (including what type of setting works best for the individual, assistance in budgeting for housing/living expenses, assistance in obtaining/accessing sources of income necessary for community living, assistance in establishing credit and in understanding and meeting obligations of tenancy).*
- *Assisting participant with finding and securing housing as needed. This may include arranging for or providing transportation.*

Appendix C Attachment: Core Service Definitions (4 of 4)

All New Language in Technical Guide, cont.

- *Assisting participant in securing supporting documents/records, completing/submitting applications, securing deposits, and locating furnishings.*
- *Developing an individualized community integration plan based upon the assessment as part of the overall person-centered service plan. Identify and establish short and long-term measurable goal(s) and establish how goals will be achieved and how concerns will be addressed.*
- *Participating in person-centered service plan meetings at re-determination and/or revision plan meetings as needed.*
- *Providing supports and interventions per the person-centered service plan (individualized community integration portion). Identify any additional supports or services needed outside the scope of this service and address among the team.*
- *Supports to assist the individual in communicating with the landlord and/or property manager regarding the participant's disability (if authorized and appropriate), detailing accommodations needed, and addressing components of emergency procedures involving the landlord and/or property manager.*
- *This service will provide supports to preserve the most independent living arrangement and/or assist the individual in locating the most integrated option appropriate to the individual.*

Item D-1-a: Responsibility for Service Plan Development

All New Language Added to Technical Guide and HCBS Waiver Application

- *Given the importance of the role of the person-centered service plan in HCBS provision, should include for these individuals the training or competency requirements for the HCBS settings criteria and person-centered plan development.*

Item D-1-b: Service Plan Development Safeguards

New Language in Waiver Application is in Brackets and is Highlighted

○ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

○ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.** ***[Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can develop the service plan:]***

(*Complete only if the second option is selected)* The state has established the following safeguards to mitigate the potential for conflict of interest in service plan development .[*By checking each box, the state attests to having a process in place to ensure:]*

- ☐ [Full disclosure to participants and assurance that participants are supported in exercising their right to choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;]
- ☐ [An opportunity for the participant to dispute the state's assertion that there is not another entity or that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;]
- ☐ [Direct oversight of the process or periodic evaluation by a state agency;]
- ☐ [Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and]
- ☐ [Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.]

Item D-1-d-i. Service Plan Development Process

New Language in Technical Guide is in Brackets and is Highlighted

- When provision is made to develop a temporary interim [***or provisional***] service plan in order to initiate services in advance of the finalization of a full-service plan, describe the procedures used to develop the interim[***/provisional***] plan and the duration of the interim plan [***(not to exceed 60 days)***].

Item D-1-d-ii. HCBS Settings Requirements for the Service Plan

All New Language in Technical Guide

ii. HCBS Settings Requirements for the Service Plan. *By checking these boxes, the state assures that the following will be included in the service plan*:

- ☐ The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.
- ☐ For provider owned or controlled settings, any modification of the additional conditions under 42 CFR § 441.301(c)(4)(vi)(A) through (D) must be supported by a specific assessed need and justified in the person-centered service plan and the following will be documented in the person-centered service plan:
    - ☐ A specific and individualized assessed need for the modification.
    - ☐ Positive interventions and supports used prior to any modifications to the person-centered service plan.
    - ☐ Less intrusive methods of meeting the need that have been tried but did not work.
    - ☐ A clear description of the condition that is directly proportionate to the specific assessed need.
    - ☐ Regular collection and review of data to measure the ongoing effectiveness of the modification.
    - ☐ Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
    - ☐ Informed consent of the individual.
    - ☐ An assurance that interventions and supports will cause no harm to the individual.

Item D-1-g: Process for Making Service Plan Subject to the Approval of the Medicaid Agency

New Language Added to Technical Guide is in Brackets and is Highlighted

- When this oversight is conducted through an in-depth review of a sample of service plans, specify the basis for the size of the sample, how frequently retrospective review is conducted, the methods for conducting the review, and the persons or entities who conduct the review. [***The state sample of service plans must be representative of the demographic makeup of the waiver population.***]
- ***CMS Review Criteria also includes new language that:***
  - [***The waiver includes a review process to ensure a practice of person-centered service planning in accordance with § 441.301(c).***]
  - [***The state ensures that the sample of service plans is representative of the demographic makeup of the waiver population.***]

Item D-1-h: Service Plan Review and Update

New Language in Waiver Application is in Brackets and is Highlighted

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update, [when the individual's circumstances or needs change significantly, or at the request of the individual,] to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ○ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Item D-2-b: Monitoring Safeguards (1 of 2)

New Language in Waiver Application is in Brackets and is Highlighted

b. Monitoring Safeguards. [Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for monitoring the implementation of the service plan except, at the option of the state, when providers are given this responsibility because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections.] *Select one:*

○ **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, [and adherence to the HCBS settings requirements] may not provide other direct waiver services to the participant.**

Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, [and adherence to the HCBS settings requirements] may provide other direct waiver services to the participant [because they are the only the only willing and qualified entity in a geographic area who can monitor service plan implementation. ***(Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can monitor service plan implementation).]***

Item D-2-b: Monitoring Safeguards (2 of 2)

All New Language in Waiver Application

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in monitoring of service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements. *By checking each box, the state attests to having a process in place to ensure:*

- ☐ Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;
- ☐ An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;
- ☐ Direct oversight of the process or periodic evaluation by a state agency;
- ☐ Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and
- ☐ Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.

Next Steps

- The changes in the waiver application will be effective in WMS for all waiver actions newly created by states on December 16, 2024, or later.
- There will be an e-mail notification to all WMS users on December 16, 2024.
- If you have questions or need assistance, reach out to your CMS contact.
- The waiver application as well as the instructions and technical guide for the waiver application will be posted in the waiver downloads section of the WMS website: https://wms-mmdl.cms.gov/WMS/faces/portal.jsp.

Questions?

Feedback

Please complete a brief survey to help CMS monitor the quality and effectiveness of our presentations.

Please use the survey link:
https://www.surveymonkey.com/r/12_11_2024_DLTSSTrainingSurvey

WE WELCOME YOUR FEEDBACK!