SUPPORTING STATEMENT FOR
THE HOME AND COMMUNITY-BASED-SERVICES WAIVER REQUEST
(CMS 8003) AND SUPPORTING REGULATIONS IN 42CFR 440.180
AND 441.300 - 441.310

A. BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) is requesting that the Office of Management and Budget (OMB) approve the information collection requirements contained in the attached State Medicaid Manual Revision. The information collection requirements contained in the manual instruction are currently approved under OMB Control number 0938-0449, the paperwork regulatory package.

Both statutory and regulatory authorities permit a State to offer, under a Secretarial waiver, a wide array of home and community-based services to individuals who otherwise would be institutionalized. States have the option of making these services available to both medically needy and categorically needy individuals. Additionally, since "statewideness" and "comparability" requirements may be waived, home and community-based services do not have to be provided throughout the State and can be targeted to a limited, select group of eligibles, such as the developmentally disabled. Therefore, a home and community-based services waiver offers States broad discretion not generally afforded under the State's plan so that the State can address the needs of individuals who would otherwise receive costly institutional care provided under the State Medicaid plan.

States also have the option of submitting a model waiver request in addition to or in lieu of a regular home and community-based services waiver. The model waiver is limited to a total of 200 waiver participants at any one time and permits coverage for various individuals who otherwise would be ineligible for Medicaid while living at home because of the Supplemental Security Income deeming rules. The model waiver request relates specifically to these individuals, as determined by the State, who have or would have established eligibility for Medicaid services based on institutionalization. The sole purpose of the request is to provide authority for the State to furnish such individuals with services in the home and community-based setting.

B. JUSTIFICATION

1. Need and Legal Basis. Section 2176 created section 1915(c) to the Social Security Act that authorizes the Secretary to waive Medicaid statutory requirements to cover home and community-based services. Under section 1915(c) of the Act and the implementing regulations, a State requesting waivers must provide satisfactory assurances to the Secretary that necessary safeguards (including provider standards) have been taken to protect the health and welfare of recipients receiving home and community-based care, that the program is cost-effective/cost neutral and that the services provided are appropriate. The State must furnish CMS with written documentation that supports these assurances and is part of the

waiver application process.

Upon development of the streamlined waiver format, each State was furnished with a computer disk and a hard copy of the waiver application. States were informed that CMS developed this application as a suggested format rather than a mandatory form in order to provide them with flexibility in designing their own programs and to better enable CMS to make timely changes to the format in light of comments received from States. The streamlined format has received positive comments from the States and most, if not all, waivers have been submitted on this format since its release.

We have also developed a suggested streamlined waiver renewal format that may be used by States in those instances where an entire waiver renewal package is not required. This streamlined waiver renewal format contains check offs for required statements and directions for reflecting changed information and indicates that Appendix G of the streamlined waiver application format may be used for the per capita expenditure estimates.

Below is a section-by-section justification of those parts of the current regular and model waiver manual instructions, which require the States to provide information.

4442.1 Scope of Waivers Requested

Under home and community-based services waivers the States are required to specify the geographic subdivisions, which the waivers will cover. The law specifically provides that a waiver granted under Section 1915(c) of the Act does not have to be applied throughout the State. A waiver of the amount, duration and scope of services is also required in order that services not otherwise available under the approved Medicaid State plan may be provided to individuals served on the waiver.

When HCBS are approved, only those geographic areas identified by the States will be eligible for FFP. The proper spending of the money will be monitored through State assessments if they opt to perform them and during the review of financial records.

Items 9 and 10 of the streamlined waiver format reflect these requirements.

4442.2 Description of Waiver Participants

1. The States are required to identify the categorical eligible group(s) (i.e., categorically needy, optional categorically needy or medically needy) to be included in the waiver. Although all of the groups may be eligible for FFP under the State plan, only those groups identified in the waiver would be eligible for Federal matching for HCBS. Any group not identified in the waiver would be considered ineligible for FFP under HCBS. A state wishing to cover a new group would have to submit a new waiver request or an amendment to its existing waiver program.

These requirements are reflected in Items 5, 6, 7, 8 and Appendix C-1 of the streamlined waiver format.

2. States are required to explain how they will treat the post-eligibility treatment of income and resources for those individuals who are eligible under a special income level of HCBS.

When an eligible individual's income exceeds the Supplemental Security Income level of an individual and/or the optional State supplement income level, special treatment of income computations can be applied for these individuals who are otherwise eligible for HCBS. However, the State must explain which acceptable Federal computation is being applied to determine proper payment.

This documentation can be found in Appendix C-2 of the streamlined waiver format.

3. States must specify the target groups they are planning to cover, i.e., aged and/or disabled, mentally retarded/developmentally disabled, mentally ill or a particular illness or condition and must indicate that services will not be provided to recipients who are inpatients of a hospital, NF or ICF/MR. This requirement will ensure that payment is made only for those individuals covered under the waiver.

These requirements are reflected in items 2, 3, 4 and 14 of the streamlined waiver format.

4442.3 Definition of Services

The State must identify which of the home and community-based services(s) specifically named in the statute it wishes to includes under the waiver. The statute also allows the States to include other home and community-based services for which they may receive Secretarial approval.

State are not limited to the list of services that appear in the statute or the services that are in their State plans. However, the State must provide documentation that these services are also cost effective and necessary to avoid institutionalization.

Items 11, 15 and Appendix B-1 of the streamlined format address these requirements.

4442.4 Safeguards-Assurances and Documentation

The State is required to submit a description of the safeguards it will impose to assure the health and welfare of the recipients of home and community-based services. States must also assure and document that all facilities covered by section 1616(e) of the Act, in which HCBS will be provided, are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

Section 1915(c) of the Act explicitly requires that a waiver may be approved only if the State

provides us with satisfactory assurance that the necessary safeguards have been taken to protect the health and welfare of the individuals provided services under the waiver. States generally have State licensure or certification requirements for providers who will furnish services under the waiver and for facilities covered by section 1616(e) of the Act. Where the only provider requirement is licensure or certification, States need only provide the applicable State or Federal statutory or regulatory citation. For services that require provider standards other than, or in addition to, State or Federal licensure or certification, States must specify the applicable educational, professional or other standards that they require for each service provider.

Items 12, 16a, 18 and Appendices B-2 and B-3 address these requirements.

4442.5 Evaluations-Assurances and Documentation

The Medicaid agency must submit a description of the agency's plan for evaluation and reevaluation of the need for institutional level of care for recipients and a copy of the evaluation instrument.

The Congressional intent is to allow States the flexibility in the development of appropriate evaluation procedures and in their implementation. States may decide who develops and conducts the evaluation and reevaluation of level of care and they may use whatever evaluation instrument that is appropriate.

Items 2, 16b and Appendices D-1 through D-3 of the streamlined format relate to these requirements.

4442.6 Plan of Care

States are required to provide a description of the qualifications of the individual or individuals who will be responsible for developing recipient plans of care. Section 1915(c)(2) requires States to have in place standards for provider participation, which include having in place employee standards. We believe the burden associated with this requirement is minimal, as generally State operated institutions and programs are required to have available records which reflect the individual employee's credentials when directly involved in the individual's plan of care or treatment. The States can meet this requirement by submitting copies of qualifications for the individual(s) involved.

Items 13 and Appendix E of the streamlined waiver format address these requirements.

4442.7 Freedom of Choice-Assurances and Documentation

The State must describe how it will inform eligible recipients they can choose either institutional services or home and community based services.

Section 1915(c)(2)(C) mandates the State to provide that individuals be informed of the feasible alternatives and given a choice. The requirement permits certain institutionalized individuals the option of leaving the institution and to receive community services at an equal or lower cost to Medicaid. The State must assure CMS in its waiver request that the recipient's choice requirement will be met and describe how it will be documented. Further, a recipient can request a fair hearing if denied a choice of services. The State may meet this requirement by submitting a description of its procedures.

Items 16c, 16d and Appendix D-4 of the streamlined waiver format address these requirements.

4442.8 Cost-Neutrality-Assurances and Documentation

The States must provide assurances that the average per capita expenditures and actual total expenditures will not exceed 100 percent of the amount that would be incurred absent a waiver and provide an explanation with supporting documentation of their annual average per capita expenditure estimates.

Section 441.303 describes the content of the documentation and provides a formula for determining the average per capita expenditures. States have readily available to them expenditures for institutional care. Therefore, they must only construct expenditures for home and community-based services. States must use a standard formula appearing in section 441.303(f)(1) to ensure that uniform procedures are applied for determining expenditures. To monitor the waiver programs effectively, CMS must have the necessary information in a consistent format.

The supporting documentation is intended to ensure that the State's estimates are reasonable, based on statistically sound and valid procedures and verifiable. States only have to submit data on those groups they intend to cover under the waiver (section 441.303(f)(3)). The assurances appear in item 16e and 16f of the streamlined waiver format and the formula format and documentation check offs appear in Appendix G.

4442.9 Annual Report-Assurance and Documentation

The State must provide CMS annually with information on the impact of the waiver, consistent with CMS' data collection plan.

The data collection plan will permit a comparison of the States' actual expenditures with its estimated expenditures to determine whether the State has met its assurances. The Forms CMS-372 (for waivers containing the 14 element formula) and CMS-372(S) (for waivers approved with the 4 element formula) are the annual State reports developed to capture this data.

The burden associated with this requirement is counted as burden for the data collection

instrument developed for documenting HCBS costs.

The assurance for this requirement can be found in item 16h of the streamlined waiver format.

4442.10 Financial Accountability-Assurance and Documentation

1. The State must submit a description of how it will assure an audit trail of funds expended under the waiver and include a description of the records and information that will be maintained to assure financial accountability.

Section 1915(c)(2)(A) specifies that the States must have in place safeguards to assure financial accountability.

2. The State must provide for an independent audit of its waiver program.

Section 1915(c)(2)(A) requires a State to assure us that it will take necessary safeguards to assure financial accountability of its waiver program. The independent audit is needed as a fiscal control for surveillance of the State programs. However, since States which conduct an audit under the provisions of the Single Audit Act will be deemed to have satisfied the independent audit requirement, there should be a minimal number of States which need to have an independent audit conducted.

The burden of keeping such information is no more burdensome than State standards for financial accountability. Also, States are given the flexibility of instituting State imposed standards for developing an audit trail. We also want to minimize the possibility of States using the waiver to circumvent Federal health and safety standards because other alternatives are less costly.
The assurances can be found in Item 16i and check offs for financial accountability/audit trail information can be found in Appendix F of the streamlined waiver format.

4442.11 Independent Assessment of the Waiver

The State may opt to provide for an independent assessment of its waiver program and submit the result to CMS at least 90 days prior to the expiration of the approved waiver period. If it opts to provide an assessment, the assessment must cover the period up to the final year of the waiver.

A new waiver is approved for a 3-year period. It may be extended for an additional 5-year period if the State has met its assurances during the previous waiver period. Section 1915(f)(1) of the Act requires us to monitor the implementation of a waiver and determine whether the requirements have been met. In addition to CMS' compliance reviews, the result of the independent assessment can be used to determine whether an extension of the State's waiver

is indicated. States have to submit the result at least 90 days before the expiration of the State's approved waiver period so we have enough time to determine whether it should be renewed.

Item 17 of the streamlined waiver format addresses this option.

4444. Procedures to Request Renewal of Approved Waivers

States must submit a formal request for a renewal of their existing waiver.

The State's request must indicate that all assurances and information provided in the approved waiver remain in effect, describe any changes from the original waiver and include copies of any revised forms, standards, qualifications or other pertinent information.

Per capita expenditure estimates for each year of the renewed waiver must also be submitted. This information is required to ensure that the waiver, with or without changes, continues to be cost-effective and complies with all statutory and regulatory requirements.

The streamlined renewal format may be used by States in those instances where an entire waiver package is not required.

4445. Amendments to Waivers

States are required to submit an amendment whenever there is any change in a waiver, which will result in the waiver no longer accurately reflecting the policies and procedures in the waiver document approved by CMS. The extent of documentation required for an amendment depends on the nature of the amendment. That is, more documentation would be required when an amendment has an impact on the cost or utilization of services than an amendment that is merely technical. This information is required to ensure that the waiver, as revised, is cost-effective and in compliance with the statutory and regulatory requirements.

States may use pages of the streamlined waiver format that are applicable to the amendment. Statutory and Regulatory requirements are contained in Section 1915(c) of the statute and 42CFR440.180 and 441.300ff of regulations.

2. Information Users

The Medicaid State agencies are the primary users of this information. CMS's Regional Offices (RO) and Central Office (CO) are also users of the waiver information along with the Secretary, the Comptroller General and their designees.

States wishing to furnish HCBS are required to submit the waiver request, supporting

documentation and required reports to the RO and CO for review and approval. A new application request, as well as any amendments to new waivers, is received in the CMS Center for Medicaid and State Operations (CMSO), where comments and supporting documentation are coordinated for review. Both CMSO and the appropriate RO review new waiver requests and amendments to new waivers to ensure that the budget estimates, eligibility information and supporting documentation are consistent with the statute and regulations. Waiver renewal requests, as well as amendments to renewed waivers, are received and reviewed by the appropriate CMS regional office with technical assistance provided by CO as requested by the ROs.

3. Improved Information Technology

States were furnished with a computer disk containing the streamlined waiver format and streamlined renewal format applications.

4. Duplicate/Similar Information

The information contained in the regular waiver request does not overlap the information contained in the model waiver request. However, in both types of waiver requests, States must comply with and meet all of the provisions in the statute and regulations. The model waiver request differs in that it is limited to a maximum of 200 individuals at any one time for each model waiver and applies only to blind and disabled individuals whose Medicaid eligibility would be affected due to the deeming of a spouse's or parent's income. There is no similar information being collected by other Federal agencies.

5. Small Business

These requirements affect State agencies only.

6. Less Frequent Collection

Per Section 1915(c)(3) of the Social Security Act, requests for waivers once approved only need to be reapproved after the expiration of the initial 3-year period and every 5 years thereafter. Therefore, we do not have the option of less frequent data collection if a State desires to continue its home and community-based services waiver program. A State may request as many waivers as it feels necessary.

7. Special Circumstances

These requirements comply with all general information collection guidelines in 5 CFR 1320.6. There are no special circumstances for collection information from States requesting home and community-based services waivers.

8. Federal Register Notice/Outside Consultation

CMS published a 60-day Federal Register notice on July 3, 2008.

Outside consultation was not specifically solicited regarding the collection of data required in these manual instructions but individuals were afforded a 60 day comment period on the final rule with comment period, published July 25, 1994, that establishes the basis for manual instructions.

9. Payment/Gift to Respondent

CMS does not provide any payment or gift to respondents, other than the usual Federal Financial Participation amounts paid to States under the Medicaid program.

10. Confidentiality

No assurances of confidentiality have been provided.

11. Sensitive Questions

No questions of a sensitive nature are asked.

12. Estimates of Burden

In the 3-year period from 1/04to 1/07 a total of 183 new and renewed regular and model waiver requests have been received from 49 States for an annual average of approximately 61 requests. All of the States submitted more than one request for different target groups. We expect to continue to receive about 55-60 waiver requests per year. During this same period, we also received approximately 223 amendment requests, which results in an approximate annual average of 75 requests.

We estimate that a State requires 160 hours on the average to prepare and document each new and renewed waiver request using the streamlined format and 80 hours using the streamlined renewal format. For almost all requests, CMS has had to request additional information from the State in order to make its determination. These figures include this additional development time. Burden time is computed as follows: 11 waivers on streamlined format x 160 hours burden = 1,760 hours per year and 50 renewal waivers on the streamlined format x 80 hours burden = 4,000 for a total of 5,760 hours and a weighted average of 100 hours per year. We estimate that a State requires 30 hours on the average to prepare and document each waiver amendment, including any additional development time. Burden time for amendments is computed as follows: 75 amendments x 30 hours burden = 2,250 hours per year. Thus, the combined burden time to prepare and document new and renewed waivers and amendments is estimated to be 8,010 hours per year.

We attribute an hourly cost at $40.63 (equivalent to a grade 13, step one, plus fringe

benefits) to the burden. The total would thus be $325,446. The Federal government matches administrative costs; therefore, the States' burden is $162,723 annually, or $3,254 per State.

13. Capital Costs

There are no capital costs.

14. Cost to Federal Government

We estimate CO and RO review and approval of new and renewed waivers require a combined average total of 80 hours per request. We also estimate the review and approval of waiver amendments require approximately 16 hours per request. The total cost of processing new and renewed waivers and amendments is $247,030 per year.

Salary/Labor	
61 waiver requests x 80 hours = 4,880 Hrs.	
4,880 Hours x $40.63* per hr.	
(*GS13-1 CY 2002 Federal pay scale divided by 2080 hrs. + 8.8% retirement/ins.)	$ 198,274
75 waiver amendments x 16 Hours = 1,200 Hrs.	
1,200 hours x $40.63* per hr.	48,756
Overhead (18% of Salary/Labor)	44,465
Computer and other costs	4,000
Estimated Federal Cost	$291,495

We also match the States' costs: $162,723

Total Estimated Federal Cost
$454,218

15. Program Changes/Burden Changes

The change in burden is due to increased in the number of responses.

16. Publication and Tabulation Data

This collection of information is not intended for publication.

17. Expiration Date

CMS would like to display the expiration date.

18. Certification Statement

There are not exceptions to the certification statement.

B. Collection of Information Employing Statistical Methods

This collection of information does not employ statistical methods to collect/analyze data.

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