1915(c) Waiver Application PRA Comments

Comment Summary

One commenter recommended revisions to the instructions in the technical guide for Appendix B-5: Post-Eligibility Treatment of Income to include information about authority enacted in 2019 that permits states the option to disregard spousal income and resources when determining Medicaid eligibility for individuals in need of HCBS. CMS issued guidance on this state option in State Medicaid Director (SMD) letter #21-004 (December 7, 2021).

CMS Response: We agree that information about this state option would be useful to include in the technical guide and will incorporate revisions in Appendix B-4-b to include reference to it.

Action Taken: We are including new revisions to incorporate this information, but we are not accepting the commenter's proposed revisions verbatim. In particular, we are not accepting the commenter's recommendation that the description of the current mandate that states apply the financial rules of section 1924 of the Act be modified with the word "generally". The authority for states to apply financial disregards in determining eligibility of certain "institutionalized spouses" does not offer an exception to the rules of section 1924 of the Act; the rules are still technically being applied even where disregards are used. Additionally, income disregards are only applied in determining underlying income eligibility, not in the post-eligibility treatment-of-income (PETI) calculation, and we therefore are similarly not accepting the commenter's suggestion that we incorporate references to disregard-related authority into the "Overview" and "Allowance for a Spouse" descriptions in the PETI section. We also note that states that elect disregard-related authority confirm any new elections, consistent with 42 CFR § 435.601(f)(2), in their state plans rather than through modifications of a 1915(c) waiver terms. Additionally, the authority is not limited to disregards of spousal income and resources, nor does it require that a spouse's' income or resources be disregarded. The new revisions more accurately set forth both the scope of the authority as well as the method for adopting it.

Comment Summary

One commenter recommended deleting references to the time period prior to January 1, 2014 in relation to spousal impoverishment protections, saying that these instructions are unnecessary.

CMS Response: Prior to the enactment of the Affordable Care Act (ACA), application of the spousal impoverishment rules in determining eligibility for prospective recipients of HCBS coverage was only a state option and limited to married individuals seeking eligibility in the eligibility group described in 42 C.F.R. § 435.217. Section 2404 of the ACA requires that the spousal impoverishment rules be applied in determining eligibility for married individuals who may be eligible for HCBS authorized under section 1915(c), (d), (i), or (k), or through section 1115 authority, starting on January 1, 2014, and running through the provision's end date, which has been extended several times and is currently September 30, 2027. As 1915(c) waivers may only be approved for a maximum period of five years, and as January 1, 2014 is now more than five years ago, we agree that it is not necessary to include references to the period prior to January 1, 2014. We will continue to require states to affirm that they apply spousal impoverishment provisions during the period in which the application of such rules is mandatory (i.e., beginning January 1, 2014 and running through the current expiration) and confirm whether they will apply spousal impoverishment rules if and when the ACA provision expires.

Action Taken: We are making revisions to subsections of Appendix B-5 that currently reference the period prior to January 1, 2014 to instead refer only to periods during the mandatory application of the spousal impoverishment provisions for 1915(c) waiver participants and after the expiration of the mandatory application of such rules.

Comment Summary

One commenter recommended a grammatical revision to add the word "a" before "section 1634 state" in the instructions for Appendix B-4. The commenter also recommended a revision to clarify that a 209(b) state's election to use rules more restrictive than SSI methodology does not permit the state to impose more restrictive standards than were in effect in the state on January 1, 1972.

CMS Response: We agree the proposed revisions provide appropriate and relevant clarity to Appendix B-4-a-1.

Action Taken: We are making revisions to the technical guide aligning with the commenter's recommendations.

Comment Summary

One commenter wrote that the description of the mandate to apply the spousal impoverishment post-eligibility treatment-of-income (PETI) rules through September 30, 2027, does not include reference to the authority states have to apply financial disregards in determining eligibility for individuals who may be eligible to participate in section 1915(c) services. The commenter recommends as a solution that a description of the authority be added to the page, with a box that states would be required to check if they adopt such disregard authority. The commenter also recommends removing the phrase “prior to January 1, 2014” in all instances in which it appears in this section.

CMS Response: We do not agree with the suggestion to add text relating to the states’ disregard-related authority, or a corresponding election box, to this section. Disregards elected under a state’s Medicaid state plan do not create an exception to the application of the spousal impoverishment rules, nor are they relevant in the PETI calculation. We agree that references to the time period prior to January 1, 2014 are not necessary.

Action Taken: As described above, we are removing the phrase “prior to January 1, 2014” from this section.

Comment Summary

Several commenters asked for clarification on whether the practice of using a contracted entity to perform level of care assessments used to inform the state’s determination of an individual’s eligibility for the waiver can continue to be allowed, as long as the state Medicaid agency is responsible for making the final determination. One of these commenters proposed that CMS spend additional time outreaching states to determine the national impact of modifying level of care determination requirements prior to finalizing changes. This commenter also recommended a broader interpretation of 42 CFR § 431.10 pointing out that many states create and oversee the assessment tools used by contracted non-state entities with a series of algorithms developed and maintained by the state Medicaid agency to determine whether the person meets waiver eligibility in a process that cannot be overridden by an assessor.

Conversely, another commenter stated that the proposed language changes broaden the types of eligibility decisions that may be delegated further than is allowed by regulation, and that contractors are not allowed to make eligibility decisions that require discretion (and, for some populations, that eligibility for a waiver is the determination of their Medicaid eligibility). This commenter reflected that level of care evaluations involve significant discretionary decision-making and stated that just as only merit based employees make discretionary decisions about what financial documents are appropriate to rely upon, discretionary decisions about whether a person's need for assistance is a certain score that ties to eligibility also should be only made by merit based employees. They further stated that the power of delegated entities regarding eligibility must not be made broader and given the breadth of discretionary decisions that many contractors are making in long term services and supports already, there should be stronger language about the obligation of the Medicaid agency to monitor and limit eligibility-related discretionary decision making.

CMS Response: Some commenters have perceived the changes in this PRA package as changes to existing policy or requirements. CMS affirms that it is not modifying level of care determination requirements with this PRA package. We note that other entities besides the State Medicaid Agency (SMA) and government agencies delegated by the SMA can and do perform assessments of an individual's needs to determine if the individual meets the institutional level of care required for the waiver, and may also gather and collect other information that is then shared with the SMA/government agency for their review and consideration. As noted in the instructions and technical guide for HCBS waivers:

> *"Other entities (e.g., case management providers) may be responsible for performing assessments, gathering the information that is necessary to make this determination and submitting this information to the state for the level of care waiver eligibility determination".*

For individuals in the 42 CFR § 435.217 special home and community-based services waiver eligibility group, the assessment of an individual's needs, when performed by an entity other than the SMA or SMA-delegated government agency should not be confused with the financial eligibility assessment/evaluation that the SMA or government agency performs in order to make Medicaid eligibility determinations. For individuals in the 42 CFR § 435.217 special home and community-based services waiver eligibility group, it would not comport with the regulation at 42 CFR § 431.10 for agencies besides the SMA or government agency to make any Medicaid eligibility decisions.

In this PRA package, the change to the waiver instructions and technical guide are to clarify that 42 CFR § 431.10 only applies to waivers that include the 42 CFR § 435.217 special home and community-based services waiver eligibility group. This is because an individual who is eligible for the waiver through this particular Medicaid eligibility group is also eligible for Medicaid through this same group. Based on public comments, CMS is making revisions to our proposed edits to the instructions and technical guide for the waiver application to clarify the role of the SMA or other governmental entity in determining financial Medicaid eligibility for individuals who are eligible for Medicaid via the 42 CFR § 435.217 special home and community-based services waiver eligibility group, when the waiver includes this group.

Action Taken: CMS will revise the proposed edits to Appendix A-7 of the instructions and technical guide for the waiver application to clarify that while the SMA or government agency delegated by the SMA is required to conduct Medicaid eligibility determinations in accordance

with 42 CFR § 431.10, waiver level of care assessments may be conducted by contractors or local/non-state entities, when certain protections apply. Specifically, the following language has been added: "Thus, eligibility determinations for the group described in 42 CFR § 435.217 (which includes a level-of-care assessment, 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 assessment tool. States should ensure that any use of an assessment 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". Clarifying language has been inserted throughout Appendix A.

CMS will also update Appendix B-6-b of the waiver application and the instructions and technical guide for the waiver application to specify that waiver level of care determinations may be made directly by the SMA or another entity under contract with the SMA. In addition, given that 42 CFR § 431.10 applies to Medicaid eligibility determinations overall, and that Appendix B-6-b is specific to waiver level of care determinations, CMS will remove references to 42 CFR § 431.10 in Appendix B-6-b of the instructions and technical guide for the waiver application. In addition, CMS will not retain previous edits to add references to 42 CFR § 435.217 in this section. Instead, to promote transparency in the state's level of care determination process, CMS will revise the review criteria in this section to add: "The agency that performs evaluations and reevaluations of level of care is described sufficiently in the waiver application".

Comment Summary

One commenter urged CMS to require that states inform applicants of all HCBS that are available to them under the freedom of choice requirements at 42 CFR § 441.302(d). They suggested the following amended language for Appendix B-7: technical guidance: "…The procedures should include ensuring that the individual (or the individual's legal representative) exercises an informed choice, including being informed of all HCBS services the individual may access as an alternative to institutional care". CMS review criteria: "The procedures described ensure that individuals are provided information about all waiver services available to them as an alternative to institutional care".

CMS Response: We appreciate the input. CMS is not prepared to make any additional changes to Appendix B-7 of the technical guide at this time; however, CMS will consider these suggestions when revising the HCBS technical guide in the future.

Action Taken: No changes were made to the waiver application or instructions as a result of this comment.

Comment Summary

One commenter expressed interest in using telehealth for 50-60 day visits and conducting an in-home visit yearly for recertifications unless there is a change in the waiver participant's condition. The commenter said that this would serve the same purpose as in-home visits and allow a safer work environment as well as minimizing risk to the direct care worker by not having travel and be on the roads as much.

Another commenter expressed support for the use of remote/telehealth delivery of waiver services, stating that in the right setting for the right person it can increase independence, autonomy, and community integration.

Other commenters were pleased to see additional guidance on telehealth/remote delivery of services included in the proposed changes to the technical guide and application. These commenters recommended that CMS adopt consistent language to describe delivery of services through telehealth. They also requested for CMS to specify that telehealth delivery of waiver extended state plan services is already permitted without additional language in waivers.

CMS Response: Thank you for these comments and support for telehealth delivery of home and community-based waiver services. The term used in the application and the instructions and technical guide for 1915(c) HCBS waiver is "remote/telehealth delivery of waiver services"; however, states have the flexibility to use alternate terms, such as "virtual delivery of services". During the COVID-19 Public Health Emergency, there was a great increase in services being delivered remotely/via telehealth. Many states are including a telehealth delivery option to ensure individual access to home and community-based services in a manner that also ensures individual autonomy and the health and welfare. States have flexibility to decide whether 1915(c) waiver services can safely and effectively be delivered remotely/via telehealth. In addition, states have broad flexibility in designing the parameters of remote/telehealth service delivery in a manner that respects individual privacy, supports the individual, and facilitates community integration. If a state is planning to allow for any waiver services to be delivered remotely/via telehealth, the state is asked to include specific information in the waiver application. For 1915(c) waiver services that only extend the amount and/or duration of specific services already approved in the state plan, states are not required to include additional language regarding these extended state plan services being delivered via telehealth.

Action Taken: CMS will add to the instructions and technical guide for HCBS waivers in Appendix C-3 the clarification that "telehealth" refers to a general service modality, and that states may use other terms to reflect the use of telehealth in their HCBS waivers.

Comment Summary

Several commenters stated their appreciation for the evolution of policy regarding electronic/remote monitoring of HCBS to provide states with greater flexibility to offer remote monitoring as a component of an existing service or as a standalone service. These commenters requested CMS clarify the extent to which it will approve adding remote monitoring as a component of an existing waiver service.

One commenter organization agreed with the considerations added to the instructions and technical guide for HCBS waivers, and stated that when remote monitoring is used in place of staff for budgetary reasons or as a cost-savings measure it can quickly become very restrictive, violate privacy, and become equivalent to unnecessary seclusion. This commenter recommended some additional protections including remote monitoring must: be a choice of the individual and not a compelled choice due to budgetary constraints (noting that it is likely cheaper than in-person services for many services); not restrict the ability of the individual to come and go from their own home, including through the use of aversive alarms or triggering police presence to the property; not pressure individuals to allow the use of remote monitoring in place of paid staff; and, noting that remote services may lead to increased isolation, be weighed against the impact on health and safety, safety, and community integration before authorization. This commenter

also stated the importance of protections around privacy for the individual, and that there also needs to be privacy in other aspects of an individual's life, such as the right to visitors, and in the information and data generated by remote services. They also pointed out that remote monitoring data could potentially be used by the state, managed care companies, or other parties to analyze services of a subset of a population and apply conclusions broadly, such as to limit services, and stated that data from remote monitoring should not be allowed to be used or sold.

CMS Response: CMS appreciates these comments regarding remote monitoring, also referred to as electronic monitoring. CMS purposefully does not include in the instructions and technical guide for HCBS waivers limits to the types of services to which states may propose to add remote monitoring. If states choose to add remote monitoring to a waiver, they have the flexibility to decide which services it would best enhance for the purpose of increasing the independence of waiver participants. As noted in the policy added to the instructions and technical guide for HCBS waivers, states need to demonstrate in the waiver service definition that the remote monitoring and/or device/technology will significantly enable the individual to live, work or meaningfully participate in the community with less reliance on paid staff supervision or assistance. We agree with the comments and note that there is already language in the revised instructions and technical guide for HCBS waivers to indicate that remote monitoring must not take the place of staff monitoring and includes protections such as policies and practices to ensure individual privacy, avoid isolation of the individual, and ensure full consent to the use of remote monitoring prior to use. The use of remote monitoring must also be documented in the individual's person-centered service plan. As CMS evaluates each state's request for remote monitoring on a case-by-case basis, we will continue to look for these state assurances and information and also consider the commenters' suggestions for additional protections in our reviews and in future versions of this guidance.

Action Taken: No changes were made to the waiver application or instructions as a result of these comments.

Comment Summary

One commenter asked what services are considered similar services with regards to the services provided by legally responsible individuals. They also asked where non-personal care services are accounted for in waivers.

CMS Response: In the context of this item under Appendix C-2-d in the 1915(c) HCBS waiver application, personal care or similar services mean: (a) personal care (assistance with activities of daily living (ADLs) or instrumental activities of daily living (IADLs)) whether furnished in the home or the community and however titled by the state in the waiver (e.g., personal assistance, attendant care, etc.) and (b) closely related services such as home health aide, homemaker, chore, and companion services. This explanation is provided in the instructions and technical guide for HCBS waivers.

Provision of services other than personal care or similar services by relatives and/or legal guardians is addressed under item Appendix C-2-e in the 1915(c) HCBS waiver application, as well as the instructions and technical guide.

Action Taken: No changes were made to the waiver application or instructions as a result of this comment.

Comment Summary

CMS previously included in the HCBS waiver instruction and technical guide that states recognizing legally responsible individuals as providers should include the following safeguard: "Determining that the provision of personal care or similar services by a legally responsible individual is in the best interests of the waiver participant". Many commenters expressed concern that CMS is now removing this safeguard and have requested for CMS to add it back.

Some commenters asked CMS to replace, rather than remove, this language, with an affirmation that additional safeguards are important to ensure individual autonomy, choice, and program integrity. These commenters recommended the addition of language that references or echoes safeguard requirements in the 1915(i) State Plan HCBS authority at 42 CFR § 441.735: "The State must have policies describing the process for authorization; the extent of decision-making authorized; and safeguards to ensure that the representative uses substituted judgment on behalf of the individual".

One commenter stated that removal of this language is understandable since the assessment should focus on whether the decision to pay a family caregiver reflects the choice of the individual, and that the term "best interest" could be determined by someone other than the participant. This commenter recommended replacing this language with alternative language about ensuring the informed choice of the individual from among an array of available providers.

Many commenters also expressed concern with and asked CMS to remove language in the HCBS waiver instruction and technical guide for states to include a process to guard against self-referral when a legally responsible individual has decision-making authority over the selection of waiver service providers. One commenter asked CMS to define "self-referral". Another commenter agreed that while there should be protections against self-referral, there also need to be policies in place that do not allow those protections to discriminate against certain structures of family-makeup, such as single parent households.

CMS Response: CMS proposed to remove the safeguard that would require states to ensure that the provision of personal care or similar services by a legally responsible individual is in the best interests of the participant to be more specific about what the state is safeguarding, which is ensuring that the state has a process in place to guard against self-referral when the legally responsible individual has decision-making authority over the selection of providers of waiver services. We note that the safeguard regarding prevention of self-referral was not newly added as it has already been included in the CMS technical guidance in the instructions and in the technical guide. However, to be transparent, with this PRA package we also added it to the instructions in the waiver application and to the CMS review criteria in the instructions and technical guide. This safeguard has historically been included in the CMS technical guidance to avoid problems that may arise when legally responsible individuals who have decision-making authority over the selection of waiver service providers can also provide those waiver services. This is not unlike the safeguards that are required when the only willing and qualified individuals who can perform assessments and develop service plans also provide HCBS to the same waiver participant. We believe that this is an important protection and is consistent with the provider self-referral issue inherent in the conflict of interest regulations at 42 CFR § 441.301(c)(1)(vi).

In response to these comments, we will reinstate the language that previously indicated that state policies should include safeguards for determining that the provision of personal care or similar services by a legally responsible individual is in the best interests of the waiver participant. We

will also add to the language that state processes to guard against self-referral should ensure that legally responsible individuals who have decision-making authority over the selection of waiver service providers use substituted judgment on behalf of the individual. We define "substituted judgment" as making decisions based on an understanding of what the individual would want.

We note that the language from Section 1915(i) regulations that commenters suggested be applied to 1915(c) pertains to the definition of the representative for the waiver participant, who might not be a legally responsible individual for the waiver participant. Appendix C-2-d of the waiver pertains to state policies when they permit waiver service providers to be legally responsible individuals. CMS does not define who can be legally responsible for the individual and refers to state law or regulations regarding the definitions of such individuals.

We believe the edits to this section strike the right balance between facilitating the provision of services an individual has been authorized to receive, and ensuring the components of HCBS waiver programs continue to be met.

Action Taken: CMS will reinsert the following statement back into the instructions and technical guide for HCBS waivers:

> "Determining that the provision of personal care or similar services by a legally responsible individual is in the best interests of the waiver participant".

We will also reinsert this into the waiver application. We will also add to the waiver application and to the instructions and technical guide for the waiver application a requirement that state processes ensure that legally responsible individuals who have decision-making authority over the selection of waiver service providers use substituted judgment on behalf of the individual.

In addition, with regard to the other items in this section that CMS did not change with this PRA package (i.e., limiting the amount of services that a legally responsible individual may furnish, and addressing other foreseeable risks), we will change "should include additional safeguards" to "may choose to specify limitations". CMS will also update this section in the instructions and technical guide to note that states may need to revisit such limitations if they are unable to meet the waiver assurance that services are delivered in accordance with the service plan, including in the type, scope, amount, duration, and frequency specified in the service plan.

In both the technical guide and the waiver application, CMS also made edits to align the instructions with the review criteria.

Finally, CMS will reiterate the requirement that waiver participants must have informed choice of providers for personal care or similar services in accordance with Appendix D-1-f of the waiver application, and that all other required statutory and regulatory components of 1915(c) waivers must continue to be met including, but not limited to, adherence to person-centered service planning, health and welfare oversight, and ensuring community integration consistent with the home and community-based settings regulations.

Comment Summary

Many commenters requested that CMS remove the "care cap" of 40 hours per week that would apply to the provision of personal care or similar services by a legally responsible individual.

CMS Response: CMS notes that the 40 hour week limit on the number of hours a legally responsible individual could be reimbursed for service delivery is only an example for states and was not newly added with this PRA renewal. This language was included as an example of a

limitation that states might put into place to cap the amount of services that legally responsible individuals may furnish, in order to take into account the amount of services that a legally responsible individual would ordinarily provide. States are not required to put such a limitation in their waiver. States may also wish to establish limits to the amount of services in which legally responsible individuals are paid for the provision of waiver services to account for overtime factors per Department of Labor regulations.

Action Taken: No changes were made to the waiver application or instructions as a result of these comments. However, as described above, updates have been made to this section in the instructions and technical guide to note that states may need to revisit such limitations if they are unable to meet the waiver assurance that services are delivered in accordance with the service plan, including in the type, scope, amount, duration, and frequency specified in the service plan. We believe the edits to this section strike the right balance between facilitating the provision of services an individual has been authorized to receive, and ensuring the components of HCBS waiver programs continue to be met.

Comment Summary

Many commenters raised concerns regarding new CMS review criteria language related to paying legally responsible individuals (LRIs) for service delivery. The commenters state that despite the vocal support of senior CMS leadership, the draft technical guidance for 1915(c) waivers continues to suggest hiring LRIs only as last resort caregivers and repeatedly reminds states that they can make it as difficult as possible for LRIs to be paid for their labor. Commenters strongly request the following language to be removed from Appendix C-2-d of the technical guide:

- States are not required to, but **may** also specify other limitations, such as specific circumstances under which legally responsible individuals may be paid providers. Such limitations could include the lack of other providers who are available to serve the participant during periods when the legally responsible individual would otherwise be absent. In any case, providing for payments to legally responsible individuals is a state option, not a federal requirement.
- State policies **should** include additional safeguards such as addressing other foreseeable risks that might attend the provision of services by legally responsible individuals.
- The waiver **must also specify any additional safeguards** the state implements when legally responsible individuals provide personal care or similar services.

CMS Response: We agree that one of outcomes of the pandemic was states' increased interest in allowing for legally responsible individuals of 1915(c) waiver participants to be waiver service providers and therefore, be paid for providing waiver services. This arrangement facilitated service continuity during a time of disruption and exacerbation of a direct service workforce shortage. States chose to include this flexibility temporarily in their 1915(c) Appendix Ks in response to the public health emergency, and some have opted to subsequently amend their 1915(c) waivers to make this flexibility permanent. It is not CMS' intent to make any changes that would create barriers for this state option. While we made minor changes to Appendix C-2-d, CMS policy has not changed; it is a state option, and not a federal requirement, to allow legally responsible individuals to provide services. If doing so, states need to be transparent in their waivers regarding any parameters that they set for such providers in their 1915(c) waiver programs. This is a state flexibility. CMS cannot require states to choose this option. The

historical and current intent of this language in this area of the instructions and technical guide has been to alleviate or mitigate state concerns that result in states not permitting legally responsible individuals to be paid waiver service providers. The CMS suggestions in the technical guide are some examples of parameters that some states have chosen to set to address their state concerns and thus enable them to implement this option. We believe in sharing these examples, more states have been more receptive to consider this option and have, therefore, not removed these examples.

Action Taken: No changes were made to the waiver application or instructions as a result of these comments. However, responses to earlier comments describe changes made to this section of the Technical Guide. We believe the edits to this section strike the right balance between facilitating the provision of services an individual has been authorized to receive, and ensuring the components of HCBS waiver programs continue to be met.

Comment Summary

Many commenters expressed support for allowing parents to be paid caregivers for their children. One commenter stated that as a person with a disability, it should be up to her if she wants her parents to be paid to provide care for her. Another commenter expressed support for allowing parents to be paid caregivers, but also suggested that financial support to deliver services should be given to parents in the form of block grants for providing this care.

CMS Response: We appreciate the input these commenters have provided regarding the challenges that parents of individuals with all types of disabilities face. It has been CMS long-standing policy to support the state option for legally responsible individuals to receive payment for the provision of waiver services. We agree that Medicaid free choice of provider requirements at section 1902(a)(23) of the Act continue to apply in the utilization of legally responsible individuals as paid providers. If an individual's parents are among other qualified waiver service providers who can provide the waiver services that an individual needs, the individual must be allowed to freely choose their provider during the person-centered service planning process and must not be required or compelled to receive their waiver services from their parents.

Section 1915(c) waiver services are not funded under a block grant(s) so the comment regarding block grants is not germane to the subject of the 1915(c) waiver application renewal.

Action Taken: No changes were made to the waiver application or instructions as a result of these comments. However, responses to earlier comments describe changes made to this section of the Technical Guide. We believe the edits to this section strike the right balance between facilitating the provision of services an individual has been authorized to receive, and ensuring the components of HCBS waiver programs continue to be met.

Comment Summary

Some commenters (national associations) suggested that we require states to describe strategies utilized to ensure that the provision of services by a legally responsible individual adheres to all regulatory provisions at 42 CFR §§ 441.301(c)(1) and (c)(4). They suggested emphasizing the requirement at 42 CFR § 441.301(c)(1)(vii): "The person-centered planning process: offers informed choices to the individual regarding the services and supports they receive and from whom".

CMS Response: We appreciate the input provided. We agree that language reminding states of the applicability of all regulatory requirements would be helpful.

Action Taken: As a result of the comment, we are adding a new statement to the technical guidance under "Discussion: Items C-2-d and C-2-e" as follows:

> "Lastly, other regulatory provisions such 42 CFR §§ 441.301(c)(1) and (c)(4) regarding the person-centered planning process and HCBS settings criteria continue to apply, including the requirements at 42 CFR § 441.301(c)(1)(vii): "The person-centered planning process: offers informed choices to the individual regarding the services and supports they receive and from whom".

In addition, edits were made in C-2-e to align with edits made in C-2-d.

Comment Summary

One commenter requested that CMS require all states to pay a fair, decent, and livable wage to those caring for a loved one with a disability so they do not have to rely on the government to pay for this care or be forced into poverty.

CMS Response: CMS agrees that payments to providers need to be compliant with the statutory requirements of section 1902(a)(30)(A) of the Act, (i.e., "payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers…"). This is noted in the instructions and technical guide for the 1915(c) waiver application.

Action Taken: No changes were needed to the waiver application or instructions as a result of this comment.

Comment Summary

One commenter requested that CMS specify the HCBS that may be provided while a waiver recipient is in an acute care hospital stay and asked if nursing services covered under the waiver would be allowable during a hospital stay. In addition, the commenter requested that this flexibility also be available under the state plan.

CMS Response: Under section 3715 of the Coronavirus Aid, Relief, and Economic Security (CARES) Act, Congress added to the Social Security Act under section 1902(h)(1) a new provision that allows states to provide HCBS in acute care hospitals under certain conditions. It applies to 1915(c), 1915(i) state plan, 1915(j) state plan, 1915(k) state plan and Section 1115 demonstrations. For 1915(c) HCBS waivers, states have the flexibility to determine which services may be provided in acute care hospitals as long as the following conditions are met:

- States must describe what services would be provided by the HCBS provider or caregiver (for instance, habilitative services, such as cuing and assistance with communication with a non-verbal individual, or personal assistant services for implementation of behavior support plans);
- The services must be in addition to, and may not substitute the services that the acute care hospital is obligated to provide (such as medication administration);
- The services must be provided to meet the needs of the individual that are not met through the provision of hospital services and are not a substitute for services that the hospital is obligated to provide through its conditions of participation, under federal or state law, or under another applicable requirement;

- The services must be designed to ensure smooth transitions between acute care settings and home and community-based settings, and to preserve the individual's functional abilities; and
- The services must be identified in an individual's person-centered service plan.

Nursing services could be covered as HCBS provided during an acute hospital stay if those services meet the criteria above.

Action Taken: No changes were made to the waiver application or instructions as a result of this comment.

Comment Summary

One commenter requested that a crosswalk of services in current and proposed waivers be available for advocates and others to see. The commenter also requested the ability to compare waiver services offered by different states and would like to see crosswalks between all waivers.

CMS Response: The public input process allows advocates and others to see changes that a state is proposing to its waiver programs, including changes to waiver services that are substantive. States are required to obtain public input during the development of a waiver (or a waiver renewal or a waiver amendment with substantive changes) in accordance with 42 CFR § 441.304(f). The public input process must be described fully and be sufficient in light of the scope of the changes proposed, to ensure meaningful opportunities for input for individuals served or eligible to be served in the waiver. In addition, the state must provide at least a 30-day public notice and comment period, which must be completed prior to submission of the proposed change to CMS. Given that waivers can be amended at any time, and that waiver programs change frequently, crosswalks would become outdated very quickly. However, we note that approved section 1915(c) waivers, which include services offered in each waiver, are posted on the CMS Medicaid.gov site at https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html.

Action Taken: No changes were made to the waiver application or instructions as a result of this comment.

Comment Summary

Several commenters raised concerns about the deletion of the education core service definition from the technical guide. Commenters noted that states have used this service to cover tuition for adult education classes offered by a college, community college, technical school or university as defined in Sections 22 and 25 of the Individuals with Disabilities Education Act (IDEA), and other similar benefits, when they are not available under a program funded by IDEA or by the Office of Vocational Rehabilitation (OVR). They recommend that, if CMS does not accept the recommendation to retain the core service definition, we provide confirmation for states currently covering such services that the removal of the core service definition will not impact their ability to continue to offer the service as a part of their service package.

CMS Response: We appreciate the comment and want to clarify that we proposed to remove the core service definition for education from the instructions and technical guide for HCBS waivers because although cited as a coverable type of expanded habilitation service in 42 CFR § 440.180, the core service definition was associated with provisions in the IDEA and was not descriptive in what the Medicaid service entailed. Instead, we added the policy applicable to education services

to the existing description of children's education services which under Appendix C-3, item D of the instructions and technical guide for the HCBS waiver. We also updated the policy in Appendix C-3, item D to be more inclusive of what can be permitted. We nevertheless acknowledge that the removal of this service from the list of core services has led to confusion that the service was no longer permissible in the 1915(c) waiver. We would like to take this opportunity to note that states continue to have the flexibility to propose in their waivers services that are beyond those for which CMS provides a core service definition in the instructions and technical guide for HCBS waivers, including education services. Although removal of the core service definition for education services would not have precluded the state from including an education service in their waiver(s), CMS will maintain the education service in the list of core services, with some technical updates.

Action Taken: CMS reinserted the core service definition with some technical edits into the instructions and technical guide for HCBS waivers. We also updated the description of children's education services under Appendix C-3, item D, of the instructions and technical guide for the HCBS waiver.

Comment Summary

Several commenters were pleased to see the inclusion of a section titled "Assistance in Community Integration - Housing Supports" in the technical guide. They expressed appreciation of CMS' commitment to supporting states to provide housing-related supports and services that promote health and community integration, and the agency's recognition of the importance of addressing Social Determinants of Health (SDOH) for Medicaid beneficiaries.

CMS Response: CMS appreciates the comment and support regarding the CMS addition of a new core service definition for housing supports services in the instructions and technical guide for 1915(c) HCBS waivers.

Action Taken: No changes were made to the waiver application or instructions as a result of this comment.

Comment Summary

One commenter requested that, in order to be consistent with the core service definition of assisted living services, which includes language about being compliant with the HCBS settings requirements, we revise the core service definition for adult foster care services to include the statement: "Adult foster care is furnished to adults who receive these services in conjunction with residing in the home, which must meet the HCBS setting requirements".

CMS Response: At this time, CMS is not prepared to make any additional changes to these sections of the application or instructions and technical guide for 1915(c) HCBS waivers. However, CMS will thoughtfully consider these suggestions when revising the HCBS technical guide in the future.

Action Taken: No changes were made to the waiver application or instructions as a result of this comment.

Comment Summary

One commenter suggested that states not only be required in Appendix C-5 of the waiver application to attest to compliance with the lease/tenancy provisions in the HCBS settings rule

but for CMS to add examples of how the state can comply with the requirements. For instance, the commenter suggested that the state choose one of four options to demonstrate how the settings comply with the lease/tenancy requirements.

CMS Response: Based on the number of potential settings in a single waiver and the applicability of lease/tenancy agreements in each setting across populations and geographical locations within a state, we think that the suggestion may be too prescriptive, as more than one of the options may overlap another. For instance, the commenter suggested that the state attest that the landlord/tenant laws in a locality apply to the setting or that the state indicate that either a provider-developed agreement or a state developed agreement are in place for the individual. These options do not negate each other and may overlap.

Action Taken: No changes were made to the waiver application or instructions as a result of this comment.

Comment Summary

One commenter disagreed with the removal of language describing settings that isolate individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS.

CMS Response: We replaced this language in the instructions and technical guide for the 1915(c) waiver application with policy that was released in March 2019 (State Medicaid Director Letter # 19-001) that clarified the characteristics of settings that isolate. Although the commenter disagrees with the removal of the rescinded descriptions of settings that isolate, the examples subjected some setting types as a whole to heightened scrutiny review not by their individual characteristics but by their inclusion in a category of settings. This change aligns with current guidance.

Action Taken: No changes were made to the waiver application or instructions as a result of this comment.

Comment Summary

One commenter asked if CMS will require states that currently have an HCBS settings corrective action plan (CAP) to include a reference to the CAP in their waiver application.

CMS Response: The inclusion of a reference to the CAP is contingent upon the nature of the action (i.e., amendment or renewal) and the length of and progress toward implementation of the state's CAP. These decisions will be made on a case-by-case basis determined by the state and CMS.

Action Taken: No changes were made to the waiver application or instructions as a result of this comment.

Comment Summary

One commenter suggested that CMS revise the language in the instructions and technical guide for HCBS waivers to ensure care managers are competent on the HCBS settings requirements and person-centered plan development, stressing that inadequate knowledge among care managers can obstruct the delivery of person-centered care.

CMS Response: CMS agrees that it is important for those responsible for the person-centered service planning process to have training and competency in HCBS settings and person-centered

service plan development. Since we already added new language to the application and the instructions and technical guide for 1915(c) HCBS waivers to indicate that the qualifications of those responsible for service plan development should include training or competency requirements for the HCBS settings criteria and person-centered plan development, CMS has not incorporated any new changes as a result of this comment.

Action Taken: No additional changes were made to the waiver application or instructions as a result of this comment.

Comment Summary

One commenter requested that CMS add to the safeguards in Appendix D-1-b and D-2-b regarding mitigation of conflict of interest that may occur when an individual's provider performs service plan development. Specifically, they suggested adding a requirement for states to provide an oversight plan with participant feedback to the safeguard of direct oversight or periodic evaluation by a state agency.

CMS Response: At this time, CMS is not prepared to make any additional changes to these sections of the application or instructions and technical guide for 1915(c) HCBS waivers. However, CMS will consider these suggestions when revising these documents in the future.

Action Taken: No changes were made to the waiver application or instructions as a result of this comment.

Comment Summary

One commenter requested additional language to be added pertaining to person-centered service planning throughout Appendix D-1-d-i of the waiver application instructions and review criteria.

CMS Response: At this time, CMS is not prepared to make any additional changes to these sections of the application or instructions and technical guide for 1915(c) HCBS waivers. However, CMS will consider these suggestions when revising the HCBS waiver application and instructions and technical guide in the future.

Action Taken: No changes were made to the waiver application or instructions as a result of this comment.

Comment Summary

One commenter recommended adding language to Appendix B to specify that federal financial participation (FFP) is available prior to the date that the service plan is completed when there is a provisional service plan.

CMS Response: Appendix D-1-d-i of the instructions and technical guide for HCBS waivers specifies the state option to develop a temporary interim or provisional service plan, not to exceed 60 days, in order to initiate services in advance of the finalization of a full-service plan. FFP for 1915(c) waiver services must be in accordance with an approved service plan, including instances where states permit the option for temporary service plans. Therefore, this requested specification already exists.

Action Taken: No changes were made to the waiver application or instructions as a result of this comment.

Comment Summary

One commenter suggested that, given the complex needs of the recipient population, more robust technical guidance and review criteria are needed in Appendix D-1-f to ensure informed decision-making. They recommended the technical guidance be amended to read "To effectively exercise this right, participants must be provided information in an accessible manner, adhering to federal and state language access requirements, presented in plain language to increase understanding, and promote culturally competent care that aligns with recipient needs…Such information may be furnished as part of the service plan development process or by other means of personalized support…". In addition, they recommended that the CMS Review Criteria be revised to read as follows: "● Participants are provided on an ongoing basis with accessible information (in a manner consistent with their needs. This information must adhere to federal and state language access requirements, be presented in plain language, and promote culturally competent care that aligns with recipient needs) about choice of qualified providers and available service providers. ● States specify the personalized support available to participants to are supported in selecting their informed selection of providers".

CMS Response: CMS is not prepared to make any additional changes to Appendix D-1-f at this time; however, CMS will consider these suggestions when revising the instructions and technical guide for HCBS waivers in the future.

Action Taken: No changes were made to the waiver application or instructions as a result of this comment.

Comment Summary

One commenter submitted suggested edits revising and adding language to the technical guidance and review criteria under Appendix D-1-g regarding the process for making the service plan subject to the approval of the Medicaid agency. One suggested edit specifically suggested requiring states to review a representative sample of person-centered service plans.

CMS Response: As indicated in the existing Appendix D-1-g, the Medicaid agency retains responsibility for service plan approval and at a minimum must review at least a sample of person-centered service plans retrospectively or employ other methods that ensure that plans have been developed in accordance with applicable policies and procedures and plans ensure the health and welfare of waiver participants. CMS agrees with and added the commenter's proposed edits that add clarity to the requirements for the CMS review criteria.

Action Taken: CMS added the underlined new language to the CMS review criteria in Appendix D-1-g. We also added a statement to the technical guidance to convey that the state sample of service plans must be representative of the demographic makeup of the waiver population.

- The process described to review plans indicates that the Medicaid agency exercises oversight of service plans on a routine and periodic basis. *The waiver includes a review process to ensure a practice of person-centered service planning, in accordance with* § 441.301(c).
- If an in-depth review of a sample of service plans is conducted…*The state ensures that the sample of service plans is representative of the demographic makeup of the waiver population*.

Comment Summary
One commenter provided suggested wording to ensure waiver programs efficiently serve the needs of recipients. The wording included specific minimum requirements for collecting feedback from waiver participants and their representatives. The commenter also suggested adding clarifying language to one of the Appendix D sub assurances.

CMS Response: Requiring states to solicit feedback from participants on delivery of their waiver services and to collect from a representative sample of waiver participants is currently outside the scope of 1915(c) waiver regulations. Therefore, the wording suggestions that pertain to these topics are not accepted. Regarding suggested wording for one of the service plan sub assurances, CMS accepts the suggested edit to add "and community-integration".

Action Taken: CMS accepts the edit for one of the service plan sub assurances in Appendix D to specify: *Service plans address all participants' assessed needs (including health and safety risk factors) and personal and community integration goals, either by waiver services or through other means.*

Comment Summary
One commenter expressed concerns about allowing biannual reporting of HCBS measures that could delay uncovering health and welfare problems, in addition to being inconsistent with the annual Form 372 reporting requirements. The commenter requested to remove all language from the technical guide related to biannual reporting.

CMS Response: The technical guide does not include language about reporting every other year or allowing biannual reporting. Therefore, no action is required for this comment.

Action Taken: No changes were made to the waiver application or instructions as a result of this comment.

Comment Summary
One commentor encouraged CMS to shift toward increased public transparency in states' HCBS quality assurance reporting.

CMS Response: CMS will encourage states to share quality reports or otherwise engage with stakeholders regarding ongoing quality assurance within HCBS.

Action Taken: No changes were made to the waiver application or instructions as a result of this comment.

Comment Summary
Three comments pertaining to waiver rate methodology were submitted jointly from over 160 community-based providers, state associations of community-based providers, and one state advocacy organization. The commenters requested that CMS consider limitless page and character amounts under Appendix I-2-a of the 1915(c) waiver application and require states to publish within each waiver application each specific waiver service rate, details of a state's last rate review, a schedule of future rate reviews, rate models, and a description of how a state will respond to new statute, regulation, and/or policy that has significant fiscal impact to service delivery.

CMS Response: CMS is not prepared to make any additional changes to Appendix I-2-a of the 1915(c) waiver application at this time; however, CMS will consider these suggestions when revising the application and instructions and technical guide for HCBS waivers in the future.

Action Taken: No changes were made to the waiver application or instructions as a result of this comment.

Comment Summary

One commenter requested the implementation of a flexible 372 reporting format, allowing flexibility in the frequency of reporting for some measures, consideration of the additional costs that states will incur to assure compliance, and alignment of reporting requirements to the final Medicaid access rule.

CMS Response: The annual CMS-372(S) report is required to meet state assurances described in 42 CFR § 441.302. In 1915(c) waivers approved by CMS, states include performance measures and other attestations indicating how the required quality assurances will be met. The online form will have pre-populated information including specific performance measures, frequency of data collection, aggregation and analysis, and the sampling approach that is approved in the applicable section 1915(c) waiver. The online form will have flexibility allowing states to indicate that data are not due/available and the reasons why. When the Medicaid access rule is finalized and an approved section 1915(c) waiver includes changes to the quality assurances and performance measures, the changes will also be reflected in the corresponding CMS-372(S) report's pre-populated online form.

Action Taken: No changes were made to the waiver application or instructions as a result of this comment.

Comment Summary

Some commenters requested CMS to create accessible Word versions of the waiver application template and technical guide that states can share with the public to track changes that are being proposed in waiver amendments and renewals. They also asked for updates to include plain language to afford all stakeholders the ability to read and understand the materials effectively. They note that health literacy is a key goal of the U.S. Department of Health and Human Services' (HHS) Healthy People 2030, that improving access to information that people need to make informed decisions about their health is an important part of achieving this goal, and that increasing accessibility of waiver documents would align with proposed transparency and accessibility requirements in recently proposed regulations.

CMS Response: We appreciate these comments. Currently, a template of the 1915(c) HCBS waiver application that states use to submit waiver applications in the waiver management system (WMS) is available to the general public in a portable document format (pdf) at https://wms-mmdl.cms.gov/WMS/faces/portal.jsp.

The instructions and technical guide for the waiver application is also available in pdf on this website. We believe pdf to be a versatile file format used to present and exchange documents, that also preserves the integrity of the original file format. CMS seeks to make all documents accessible to the public and will consider these comments in future updates.

Action Taken: No changes were made to the waiver application or instructions as a result of this comment.

Comment Summary
One commenter expressed concerns regarding the amount of time it takes to enter a waiver program and asked for better ways for processes to be streamlined so that individuals can receive care in the community.

CMS Response: This comment is outside of the scope of the changes in this publication for renewal of the 1915(c) waiver application and technical guide. We suggest that the commenter contact their State Medicaid Agency with these concerns. We note that federal statute and regulations permit states to limit the number of individuals who can be served under a 1915(c) waiver.

Action Taken: No changes were made to the waiver application or instructions as a result of these comments.

Comment Summary
Some commenters expressed states' concerns regarding the waiver management system (WMS). They report that the system is cumbersome to navigate and that technical issues have caused complications to waiver submissions, review, and approval processes. States have reported losing information that they enter into the waiver application. In addition, the commenters indicated that states would like the character limits to be increased to make data entry easier. They also recommended changes to the system that would make it easier to enter and view/review information (i.e., ability to add bullets, use italics, and add tables and charts).

CMS Response: We appreciate the feedback regarding WMS. We understand the importance of having a user-friendly system that is also efficient. We are looking into the possibility of increasing the character limits and will specifically look to see if character limits can be increased for performance measures as well as other sections of the waiver application. In addition, we have discussed the possibility of other changes in the system to make it easier to enter and view/review information.

Action Taken: At this time, no changes were made to the waiver application or instructions as a result of this comment. CMS will continue to work on possible upgrades to WMS.

Comment Summary
Some commenters expressed disappointment by the lack of engagement to develop the proposed changes and emphasized the importance of soliciting input from states to determine where clarification is needed, as well as to understand the impact proposed changes will have on states' HCBS waiver programs. Other commenters requested CMS consider their comments and engage in future collaboration as CMS and states prepare for implementation of the proposed Ensuring Access to Medicaid Services rule and other upcoming regulatory changes.

CMS Response: We appreciate the comment and agree that engagement with the associations and states as well as all stakeholders is important. The request for public comments was solicited with the Paperwork Reduction Act publication for extension of the 1915(c) waiver application. We are considering all comments and look forward to collaboration for future updates with the public on various items.

Action Taken: No changes were made to the waiver application or instructions as a result of these comments.