2020 (old version)	2023 (new version)	Type of Change	Reason for Change	Burden Change
Attachment #2: Home and Community-Based Waiver Settings Transition Plan where states specified their process to bring the waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.	Removed this section (attachment)	Del	This section is no longer needed. States provide information regarding compliance with the settings requirements in Appendix C-5.	No
Appendix A-7 - Distribution of Waiver Operational and Administrative Functions. In the chart, item titled "Level of Care Evaluation"	In the chart, revised "Level of eare Evaluation" to "Level of care waiver eligibility evaluation"	Rev	Minor/technical edit.	No
Appendix A-7: Distribution of Waiver Operational and Administrative Functions	Added the following note - "In 1915(c) waivers that include the 42 CFR § 435.217 special home and community-based services waiver eligibility group, Medicaid eligibility determinations can only be performed by the 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 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	Add	To clarify that in 1915(c) waivers that include the 42 CFR § 435.217 special home and community-based services waiver eligibility group, Medicaid eligibility determinations can only be performed by the SMA or a government agency delegated by the SMA in accordance with 42 CFR § 431.10.	No.

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Appendix B-4: financial eligibility, low income families with children as provided in 1931 of the Act	Appendix B-4, updated financial eligibility. Appendix B-4-b, Medicaid Eligiblity Groups Served in the Waiver, removed the eligibility group "low income families with children as provided in 1931 of the Act." Added three groups: Parents and Other Caretaker Relatives (42 CFR 435.110), Pregnant Women (42 CFR 435.116), and Infants and Children under Age 19 (42 CFR 435.118).	Del, Add	After the enactment of the Affordable Care Act, the regulations were updated to separate out the populations that are covered under the "low income families with children as provided in §1931 of the Act", specifically the populations of Parents and Other Caretaker Relatives (42 CFR 435.110), Pregnant Women (42 CFR 435.116), and Infants and Children under Age 19 (42 CFR 435.118). These three groups describe more accurately the populations covered as "low income families with children as provided in §1931 of the Act."	No
Main Module 6. Additional Requirements Item F: "FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non- Medicaid), and bills other legally liable third party insurers. Alternatively,"	Removed this language.	Del	technical update	No
Appendix B-5: Post Eligibility Treatment of Income	Revised the end date throughout from 2019 to 2027 as well as adding "or other date as required by law." Also updated, corrected and clarified citations.	Rev	technical updates	No

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B-6-b: Responsibility for Performing Evaluations and Reevaluations	Revised the 3rd radio button to replace "government agency" with "entity."	Rev	To reflect that the option for this function to be performed by an entity under contract with the SMA. Note: As noted in the 1915(c) waiver instructions and technical guide, in 1915(c) waivers that include the 42 CFR § 435.217 special home and community-based services waiver eligibility group, Medicaid eligibility determinations can only be performed by the 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 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	No
Appendix C-1-c: Delivery of Case Management Services.	Added "and the requirements for their training on the HCBS settings regulation and person-centered plannng requirements" to the existing language. It now reads "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:"	Add	To align the application with 1915(c) HCBS regulation requirements.	Yes. Add 1 hour for the state to add the training requirements to the waiver application.

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Appendix C-1	Added new C-1-d: Remote/Telehealth Delivery of Waiver Services Remote delivery of services option	Add	States have the option to add the option for a waiver service to be delivered via telehealth. If a state chooses this option, the waiver application will reflect that this is an option to be transparent to the public, and include safeguards to ensure individual safety, privacy, and community integration.	Yes. Add 2 hours
C-2-b: Abuse Registry Screening	Added: "and (d) the process for ensuring continuity of care for a waiver participant whose service provider was added to the abuse registry."	Add	If the state maintains abuse registries, this addition is to ensure that states include in the waiver application their process for ensuring waiver participant continuity of care if their waiver service provider is added to a state registry.	Yes. Add 1 hour for states to describe the process in the waiver application.
C-2-d: Provision of Personal Care or Similar Services by Legally Responsible Individuals.	Added language to define extraordinary care as "exceeding the ordinary care that would be provided to a person without a disability or chronic illness of the same age." Also made some minor wording changes such as the removal of the words "and typically includes" and "spouse of a waiver participant."	Rev	Clarifies language to specify existing policy regarding legally responsible individuals providing waiver services and the definition of extraordinary care.	No
Appendix C-2-d & C-2-e	Added to the instructions: "When the relative/legal guardian has decision-making authority over the selection of providers of waiver services, specify the the state's process for ensuring that the legally responsible individual uses substituted judgement on behalf of the individual..." Also made other additions to align with the current CMS review criteria.	Add	To align with current exisiting policy.	Yes. Add 1 hour.
Appendix E: Participant Direction of Services	Removed independence plus designation.	Del	Technical Correction. This designation is not applicable and was removed in previous updates but missed in this section of the waiver application.	No

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Appendix C-1-b: provision of case management to waiver participants	Added another item to list of items, health homes including a check-off box and instruction for state to complete item C-1-c.	Rev	This change was added to reflect when waiver case management is funded under a Medicaid health home authority. This was previously missing from the list of options.	No.
Appendix C-2 (new section)	Added a new section C-2-g, State Option to Provide HCBS in Acute Care Hospitals in accordance with Section 1902(h)(1) of the Act. If the state chooses this option the state can do so under the conditions required by regulation and specified under this item. By checking the boxes, the state assures that it will meet these conditions. A text box was also added to for states to specify the waiver HCBS that can be provided that are not duplicative of services available in the acute care hospital setting, how the HCBS will assist the individual in returning to the community. If there is any difference from the typically billed rate for these HCBS provided during a hospitalization, the state is reminded to include this information in Appendix I-2-a.	Add	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 the option to provide HCBS in acute care hospitals under certain conditions.	Yes. Add 3 hours.
Appendix C-5: Settings	Removed statewide transition plan (STP) language. Split existing text box into two. Added new check boxes for states to check to assure that they will meet/are meeting regulation requirements. and, when applicable, radio buttons (i.e., when a waiver includes provider-owned or controlled settings).	Rev.	Separated out the one large text box into two text boxes to ease the burden in reviewing and updating the information that states are required to submit. Added checkboxes to take the place of some of the information that states are currently required via text box, to reduce state burden in completing this information.	No additional burden/reduces burden. Estimate of reduced burden is 5 hours.

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Appendix D-1-a: Responsibility for Service Plan Development	Added language to the instruction, for states to include in the qualifications training or competency requirements for the HCBS settings criteria and person-centered plan development.	Add	Given the importance of the role of the person-centered service plan in HCBS provision, the qualifications for individuals responsible for service plan development should include the training or competency requirements for the HCBS settings criteria and person-centered plan development.	Yes. Add 1 hour.
Appendix D-1-b: Service Plan Development Safeguards	Added the following regulation language: 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 service plan development except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. Added the following language to the second radio button:"Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can develop the service plan" with a text box for the state to fill out if this is applicable. In addition, added the following which will include check off boxes. Also removed "is conducted in the best interest of the participant" and replaced this with the safeguards states are required to implement in order to mitigate the potential for conflict of interest in service plan development.	Rev	Clarifies the information that states were previously required to provide in one large text box into one smaller text box for one portion of the requirement and check boxes (statements of assurances) for the rest. Reduces state and federal burden.	No. It reduces state burden by an estimated 2 hours.
Appendix D-1-d	Specified the previous language as sub-section "i" in order to add a new subsection "ii" below this. Within sub-section "i", added "(h) how the participant engages in and/or directs the planning process."	Rev	This is a technical clarification and does not impose a new state requirement.	No.

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Appendix D-1-d (new subsection added)	Added new subsection "ii" with check boxes for states to select to assure they will meet the HCBS Settings Requirements for the Service Plan.	add	Adds a set of statements for which states are to check off boxes to assure compliance with HCBS waiver regulations.	Yes. Add 1 hour.
Appendix D-1-h: The service plan is subject to at least annual periodic review and update.	After "update" added "when the individual's circumstances or needs change significantly, or at the request of the individual"	rev	Additional language to specify more detail regarding when updates are required. Language aligns with current practice and 2014 final rule.	No.
Appendix D-2-a: Service Plan Implementation and Monitoring. "Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan, and participant health and welfare, (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed."	After (a), added "; and adherence to the HCBS settings requirements under 42 CFR § 441.301(c)(4)-(5);"	add	Technical clarification to language to align with current practice and 2014 final rule.	No.
Appendix D-2-b: Monitoring Safeguards	Added the following language: 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 of implementation of the service plan except, at the option of the state, when providers are given responsibility to perform this function because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. Added the following language to the second radio button:"Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can monitor service plan implementation" with a text box for the state to fill out if this is applicable. Also removed "is conducted in the best interest of the participant" and replaced this with the safeguards to mitigate the potential for conflict of interest that states are required to check off to attest to their implementation.	rev	Clarifies the information that states were previously required to provide in one large text box into one smaller text box for one portion of the requirement and check boxes (statements of assurances) for the rest. Reduces state and federal burden.	No. Reduces burden by 2 hours.

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Appendix D QIS sub assurance: "Service plans are updated/revised at least annually or when warranted by changes in waiver participant's needs."	Changed to "Service plans are updated/revised at least annually, when the individual's circumstances or needs change significantly, or at the request of the individual."	Rev	Revised to align the subassurance with current practice which follows 2014 quality SMDL and final regulations published in 2014.	No.
Appendix D QIS sub assurance: "Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by waiver services or through other means."	Added "and community integration" to this sub assurance.	Rev	CMS agreed with this edit suggested by a commenter to add the words "and community-integration" to this sub-assurance.	No.
Appendix G QIS sub assurance: "Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014."	This lanaguage was deleted.	Del	This language was deleted because it was out-of-date.	No.
Appendix I QIS: "(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.") and "(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)"	This language was deleted.	Del	This language was deleted because it was out-of-date.	No.
Quality and QIS (throughout the waiver application)	Added the following under Methods for Remediation/Fixing Individual Problems: "and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions."	Add	This is a technical clarification and does not impose a new state requirement.	No.