1915(c) Home and Community Based Services (HCBS) Waiver Application and Technical Guide Paperwork Reduction Act (PRA) Response to Public Comments

July 2024

Comment: Two organizations support the new revisions made in response to their comments submitted to CMS in Fall, 2023. They indicated that they appreciated CMS' decision to repost the 1915(c) HCBS waiver application and the 1915(c) HCBS Waiver Instructions & Technical Guide for public comment in response to feedback from state partners and stakeholders, and believe this collaboration sets a strong foundation for continued partnership on implementation of the proposed Ensuring Access to Medicaid Services rule and other upcoming HCBS initiatives.

CMS Response: Thank you for the feedback. We agree that collaboration with state partners and stakeholders is important, and we look forward to continued collaboration.

Action Taken: No changes were made to the 1915(c) HCBS waiver application or instructions as a result of this comment.

Comment: Two organizations requested that CMS provide clear guidance to states regarding implementation of the updated 1915(c) HCBS waiver application template. The organizations asked whether amendments submitted after the proposed revisions are effective must incorporate changes necessary to align with the updated application and guide, or whether these changes can be added through renewals. They expressed that these operational details will be essential for states to understand, as many are planning to submit amendments in the near future and will need time to make any alterations and to obtain public comments on any new language. Likewise, a state commenter requested that the changes be effective January 1, 2025, rather than immediately upon publication. This state noted that they have a lengthy waiver renewal process that includes review and approval by the state legislature, and this process is already well underway for a renewal effective January 1, 2025. They are concerned that incorporating the proposed changes will delay this process and the submission of their waiver renewal application. They stated that delaying the effective date of the application will allow states to respond thoughtfully to the prompts and provide time to implement any required changes.

CMS Response: We agree that it is important for CMS to provide clear guidance to states regarding the implementation of the updated 1915(c) HCBS waiver application template and updated 1915(c) HCBS Waiver Instructions & Technical Guide. The changes in the waiver application template will be effective once it is incorporated into the Waiver Management System (WMS). At that time, there will be an e-mail notification to all WMS users. We note that states are already incorporating many of the changes in waiver actions prior to CMS approval. Most of the proposed changes pertain to CMS policy that has evolved to make improvements and additions that align with current trends and practices to comply with statutory and regulatory requirements. For example, states have already been incorporating into waiver submissions the information that CMS has newly added to the waiver application regarding remote/telehealth delivery of services.

It is CMS' expectation that states will incorporate the necessary changes at the time an amendment is submitted that changes sections affected by this update, or at the time of renewal, whichever comes first following the go-live date of the updates in WMS. This date is to be determined and CMS will alert states of the date as soon as possible to ensure there is adequate lead time for states. States submitting renewal

and new waiver applications will need to complete the new sections of the waiver application, and such actions should be in alignment with the revised Version 3.7 of the 1915(c) HCBS Waiver Instructions & Technical Guide. As states amend waivers already approved in WMS, they will be expected to update the sections that they are amending in order to align with the 1915(c) HCBS waiver application and the 1915(c) HCBS Waiver instructions and Technical Guide. States that have already started drafting waiver applications in the WMS prior to when these changes become effective may be prompted by WMS to complete new sections prior to submission to CMS. States can reach out to CMS at any time for technical assistance during this transition process. CMS will work with states to make this transition as seamless as possible for states.

Action Taken: No changes were made to the 1915(c) HCBS waiver application or instructions as a result of these comments.

Comment: Two organizations noted appreciation of CMS's response to their comments regarding navigability of the Waiver Management System (WMS) and accessibility of the 1915(c) HCBS waiver application template. In particular, they appreciated efforts to increase the character limits in WMS. They re-stated their previous comment suggesting the ability to make it easier to enter and view information in WMS, including the ability to add bullets, use italics and add tables and charts. They encouraged CMS to continue efforts to make the waiver application process more accessible, efficient and reliable.

CMS Response: We appreciate the positive feedback and note that we will continue our efforts to improve the usability of WMS.

Action Taken: No changes were made to the 1915(c) HCBS waiver application or instructions as a result of these comments.

Comment: Two organizations stated appreciation of the revisions CMS made to Appendix A-7 of the 1915(c) HCBS Waiver Instructions & Technical Guide to clarify that the Medicaid eligibility determination requirements in accordance with 42 CFR § 431.10 apply to the home and community-based eligibility group described at 42 CFR § 435.217, since level of care (LOC) evaluation is a factor in determining Medicaid eligibility. They also appreciated that CMS provided clarification and examples of the administrative functions that non-governmental entities can provide to support the eligibility determination process. These commenters encouraged CMS to make an additional minor revision, both for consistency with the LOC evaluation terminology in Appendix A-7 and Appendix B-6 sections of the 1915(c) HCBS Waiver Instructions & Technical Guide and to further clarify the distinction between Medicaid eligibility and waiver LOC determination for the 42 CFR § 435.217 eligibility group. Specifically, they proposed to amend the paragraph in Appendix A-7 that indicates:

"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".

And proposed for that sentence to instead read as follows: "Thus, all components of the eligibility determination process for the group described in 42 CFR § 435.217 (which includes a level-of-care evaluation, because meeting a 1915(c) level of care is a factor in determining Medicaid eligibility for the group) must comply with 42 CFR § 431.10".

CMS Response: CMS is not able to revise the paragraph as proposed by the commenter because the revisions would make the statement inaccurate. The regulations at 42 CFR § 431.10 only apply to Medicaid eligibility determinations and not the LOC eligibility evaluation that is required under Section 1915(c) of the Social Security Act. It is not a requirement that the entities responsible for the LOC evaluation as described under 42 CFR § 441.302(c) be in alignment with 42 CFR § 431.10; this entity can be an entity that is not the State Medicaid Agency (SMA) or a government agency delegated by the SMA.

However, we note that CMS is replacing the word "assessment" to "evaluation" in all language referencing the level of care assessment (evaluation) in order to be in alignment with the language at 42 CFR § 441.302(c) when referring to this function/activity.

Action Taken: CMS is replacing the word "assessment" to "evaluation" in all language referencing the level of care assessment (evaluation) in order to be in alignment with the language at 42 CFR § 441.302(c) when referring to this function/activity.

Comment: One organization suggested that a checkbox be added to the list of Medicaid eligibility groups in Appendix B-4-b for a state to choose the expansion population. The commenter noted that several states do not identify this group in their waivers and expressed that this option should be clearer through the inclusion of a check box so that states will be prompted to consider that population.

CMS Response: The checklist in Appendix B-4-b is intended to provide a non-exhaustive list of eligibility groups which are frequently included in 1915(c) waiver coverage. While individuals eligible for state plan Medicaid coverage under the adult expansion group may meet specific waiver needs-based and targeting criteria, the group is not included in 1915(c) waiver coverage by states with the same frequency as other groups currently included in the checklist, most of which use disability as a factor of eligibility. States that wish to include the adult expansion group in 1915(c) waiver coverage may continue to do so by listing the group in the "other specified groups" text box included after the checklist.

Action Taken: No action was taken as a result of this comment.

Comment: Two organizations noted that the practice of paying legally responsible individuals (LRIs) to provide supports has expanded in recent years, both as a response to growing workforce shortages and as an emergency response to the COVID-19 pandemic. They expressed understanding of the potential for this practice to increase the pool of direct care workers. They also stated that while LRIs are often best positioned to provide successful supports to an individual receiving HCBS, the practice comes with complexities that, if not carefully managed, can lead to increased isolation, loss of autonomy, and even increased risk of abuse or other threats to the health and welfare of individuals receiving services. Given the importance of this option as a tool to expand available supports and improve outcomes, they stated appreciation of CMS' attention to this section of the 1915(c) HCBS Waiver Instructions & Technical Guide, in particular reaffirming requirements associated with health and welfare, person-centered service planning, and community integration in the context of LRI service provision.

These commenters also expressed strong support of the addition of criteria for states to describe policies to determine that the provision of services by a LRI is in the best interest of the waiver participant and the addition of criteria for states to have processes to ensure that LRIs who have decision-making authority over the selection of waiver service providers use substituted judgement on behalf of the individual. They

state that these additional requirements will assist with establishing effective safeguards that ensure the health, welfare, and rights, of waiver participants.

CMS Response: We agree with these comments and believe that this revised section balances facilitating the provision of services an individual has been authorized to receive and ensuring the health and welfare requirements of HCBS waiver programs continue to be met.

Action Taken: No changes were made to the 1915(c) HCBS waiver application or instructions as a result of these comments.

Comment: Regarding payment to LRIs being a state option, two organizations requested that CMS strengthen the CMS language about states considering the authorization of LRIs to ensure access to needed services by reminding states to establish safeguards to mitigate any risks associated with LRI service provision. They also suggested stating that in the event that LRI service provision leads to adverse outcomes such as increased isolation, loss of autonomy, or difficulty providing sufficient quality oversight, states should reconsider their approach to allowing payment to LRIs. They stated that adding this language would support fully informed state level discussion focused on both the benefits and the potential risks associated with this flexibility.

CMS Response: We believe the following language in Appendix C-2-d of the 1915(c) HCBS Waiver Instructions & Technical Guide is sufficient for addressing this comment, in that it reminds states of their obligations to monitor that all of the statutory and regulatory requirements of the 1915(c) waiver program are met:

> When legally responsible individuals are used to deliver services, all required statutory and regulatory components of 1915(c) waivers must continue to be met, including, but not limited to, an individual's free choice of providers, adherence to person-centered service planning, health and welfare oversight, and ensuring community integration consistent with the home and community-based settings regulations.

CMS will add similar language to Appendix C-2-e (regarding payment for waiver services provided by relatives/legal guardians) section of this document.

Action Taken: We have added the following language to the Appendix C-2-e section of the 1915(c) HCBS Waiver Instructions & Technical Guide:

> When relative/legal guardians deliver services, all required statutory and regulatory components of 1915(c) waivers must continue to be met, including, but not limited to, *an individual's free choice of providers*, adherence to person-centered service planning, health and welfare oversight, and ensuring community integration consistent with the home and community-based settings regulations.

Comment: One organization commented that since states have an obligation to ensure access to needed services, they should strongly consider payment to LRIs. They suggested removing the caveat of "when necessary" from the language in the 1915(c) HCBS Waiver Instructions & Technical Guide stating that even in a situation of abundant choice of providers, it may still be the best choice for an individual to include paid family caregivers in their array of service providers. They expressed that as with other waiver policies, the choice of the individual should be paramount and paid family caregivers should not only be considered a choice in case of provider shortages, but an option that is available consistently. The

commenters recommended that CMS specify that states should explain how individual choice of the enrollee is prioritized.

Also, while this organization agreed that the decision to use legal guardians as paid caregivers should be in the best interest of the individual, they expressed concern with how states may interpret this provision, in that states may choose to limit access to paid family caregivers. They noted that this particularly has an impact on smaller families with fewer choices of family caregivers or people to serve as legal guardian. These commenters therefore recommended that states ensure that an unbiased advocate or other individual that is conflict-free make decisions about the person's best interest and not the state's interest.

They note that these state policies may commonly require exemptions or reasonable accommodations to ensure a person continues to have access to the program and states should assure that those processes are available and afforded due process when the denial creates an adverse decision regarding services.

CMS Response: It has been long-standing CMS policy to support the state option for relatives, legal guardians, and/or LRIs to receive payment for the provision of most waiver services. We agree with the commenters' suggestion to remove the language "when necessary" from the statement in the 1915(c) HCBS Waiver Instructions & Technical Guide that they have referenced. We note however that states may opt to only permit payment for relatives, legal guardians, and/or LRIs in certain situations.

Medicaid free choice of provider requirements at section 1902(a)(23) of the Act continue to apply in the utilization of relatives, legal guardians, and/or LRIs as paid providers, and we believe the following language in the Appendix C-2-d section of the 1915(c) HCBS Waiver Instructions & Technical Guide reinforces this requirement. We will also add similar language to Appendix C-2-e section of this document:

> When legally responsible individuals deliver services, all required statutory and regulatory components of 1915(c) waivers must continue to be met, including, but not limited to, *an individual's free choice of providers*, adherence to person-centered service planning, health and welfare oversight, and ensuring community integration consistent with the home and community-based settings regulations.

We further note that, if relatives, legal guardians, and/or LRIs 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 such individuals. In addition, we note that states have discretion on whether they allow payment for relatives, legal guardians, and/or LRIs for delivery of waiver services and the circumstances under which that payment may be rendered. Foregoing this option or defining specific parameters for payment for LRI service provision does not conflict with the individual free choice of provider requirement because states have the flexibility to determine the types of providers needed to deliver waiver services.

Action Taken: We have removed "when necessary" from the following statement in the 1915(c) HCBS Waiver Instructions & Technical Guide:

> States are required to ensure individuals have access to needed services~~,~~ and ~~when necessary,~~ states should strongly consider the authorization of legally responsible individuals to meet the requirement of ensuring the delivery of needed services.

We have added the following language to the Appendix C-2-e section of the 1915(c) HCBS Waiver Instructions & Technical Guide:

> When relative/legal guardians deliver services, all required statutory and regulatory components of 1915(c) waivers must continue to be met, including, but not limited to, *an individual's free choice of providers,* adherence to person-centered service planning, health and welfare oversight, and ensuring community integration consistent with the home and community-based settings regulations.

Comment: One organization requested for CMS to change "avoid institutionalization" in the language in the 1915(c) HCBS waiver application as well as the 1915(c) HCBS Waiver Instructions & Technical Guide to "prevent segregation from the community" or similar language. They asserted that this change in language will reflect that people have the right to not live in institutions and to live in the most integrated setting appropriate to their needs.

CMS Response: At this time, CMS is not prepared to make these additional changes. However, CMS will thoughtfully consider these suggestions when revising the 1915(c) HCBS Waiver Instructions & Technical Guide in the future.

Action Taken: No changes were made to the 1915(c) HCBS waiver application or instructions as a result of this comment.

Comment: One organization suggested that CMS add another example of extraordinary care to reflect supervision or "within arm's reach" services that are commonly an issue in service denial for children with disabilities who need additional supports that a child of a similar age would not typically receive on a day-to-day basis (e.g., hands-on-assistance, cueing, or close supervision of child while eating who at that age would typically eat independently or with limited reminders from across the room). The commenters explain that if the need for assistance with daily living skills is noted in a developmental assessment, they should have the presumption of qualifying as extraordinary care as they are typically then considered not within "normal" ranges.

CMS Response: The example provided by the commenter would align with the following language from the 1915(c) HCBS Waiver Instructions & Technical Guide. We do not believe it is necessary to add additional examples.

> By extraordinary, CMS simply means care exceeding the range of activities that a legally responsible individual would ordinarily perform in the household on behalf of a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant and avoid institutionalization. For example, support for activities of daily living such as bathing and dressing by a legally responsible individual to a teenage child enrolled in a waiver could constitute extraordinary care, as teenage children without a disability or chronic illness do not typically require such support.
>
> In the context of this item, personal care or similar services mean: (a) personal care (assistance with ADLs or 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.

Action Taken: No changes were made to the 1915(c) HCBS waiver application or instructions as a result of this comment.

Comment: Many commenters expressed gratitude to CMS for listening to the voices of hundreds of family care workers across the United States, and for making the following changes to the guide:

- Adding a suggestion that "states should strongly consider the authorization of LRIs" as care workers.

- Removing the suggestion that states consider LRIs only as a last resort when there is a "lack of other providers are available". They stated that this change will discourage states from implementing harmful "provider of last resort" policies.

- Adding the stipulation that states may need to reconsider the limitations they place on family care workers (such as limiting children to 40 hours of care) if the children's needs are not being met due to those limitations.

- Replacing the language regarding self-referral with the use of substituted judgement in provider selection.

One of these commenters stated that it is unfortunate families still face challenges given that flexibility to permit payment for LRIs is ultimately a state decision; however, they are thankful that the language in the 1915(c) HCBS Waiver Instructions & Technical Guide that encourages states to pursue the option if necessary to ensure access to needed services. Among these commenters, one noted that these updates will positively affect disabled individuals and their families across the nation. Another strongly recommended that the 40-hour rule limitations be removed if the child encountered abuse from the hands of someone that is not the parent/caregiver. Some others noted that LRIs are often the only caregivers keeping HCBS participants healthy and safe, that encouraging states to utilize LRIs will help bridge the workforce gap and ensure these participants remain healthy, and that these changes will benefit their families.

CMS Response: We appreciate all of the helpful feedback that has contributed to this section. We believe that this revised section strikes 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.

We note that the reference to a 40-hour week limit on the number of hours a legally responsible individual could be reimbursed for service delivery is only an example of a limitation that states might put into place to cap the amount of services that LRIs 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. We have noted in the 1915(c) HCBS Waiver Instructions & Technical Guide that states may need to revisit such limitations if they are unable to meet the waiver assurances, which include the waiver assurance to meet the health and welfare of the waiver participant.

Action Taken: No changes were made to the 1915(c) HCBS waiver application or instructions as a result of these comments.

Comment: One commenter requested for family caregivers to be paid, expressing that they give the best care, are the most dependable, and it keeps food on their tables.

CMS Response: We appreciate the commenter's input. It has been CMS' long-standing policy to support the state option for LRIs to receive payment for the provision of most waiver services.

Action Taken: No changes were made to the 1915(c) HCBS waiver application or instructions as a result of this comment.

Comment: One medical professional asked for CMS to replace "strongly consider legally responsible individuals" with "enforced as a first source to be caregivers for legally responsible adults". This commenter stated that after COVID subsided their state no longer allowed them to be their son's caregiver so they have to find a paycheck outside of their home and spend less time with their child who has a disability.

CMS Response: One of the outcomes of the pandemic was states' increased interest in allowing for LRIs of 1915(c) waiver participants to enroll as waiver service providers and receive payment 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) waiver programs in response to the public health emergency, and some have opted to subsequently amend their 1915(c) waivers to make this flexibility permanent. We note that it is a state option to allow LRIs to receive payment for 1915(c) waiver services. CMS cannot require states to choose this option. The language in this area of the 1915(c) HCBS Waiver Instructions & Technical Guide is intended to be helpful in mitigating state concerns that might result in states not permitting LRIs to be paid waiver service providers.

Action Taken: No changes were made to the 1915(c) HCBS waiver application or instructions as a result of this comment.

Comment: One commenter expressed concerns with the impact to waiver participants in permitting LRIs to be paid caregivers, expressing that this usually becomes the default and exclusive service provider option which can result in dependency and isolation. They stated that a network of other providers, counselors, and services outside the home, which would introduce the individual to new concepts, ideas, backgrounds, and thoughts, will be lost by a push to allow LRIs to be care providers. This commenter urged CMS to consider and provide future guidance on how to prevent institutionalization at home with the post-COVID "strong push" not only for LRIs but for telehealth/telemedicine delivery of services through a computer/phone/tablet screen to a person in their home. This commenter stated that the (over)use of social media and telecommunication devices is often cited in well-publicized studies as a driving factor in children and young adults feeling more isolated and lonely than ever. They stressed that CMS must ensure that there are limits on these flexibilities to avoid insulation and social isolation of individuals on 1915(c) waivers, indicating they could otherwise lead to undesirable outcomes such as a stagnation in development, interaction, independence, and engagement of waiver participants in the community; a lack of innovation, training, oversight, and collaboration in ongoing care; substandard care & services that result in declining health outcomes; and abuse and neglect.

CMS Response: CMS agrees that if LRIs, as well as relatives/legal guardians, are included with a network of 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 LRIs. We believe that the updated language in the 1915(c) HCBS waiver application and the 1915(c) HCBS Waiver Instructions & Technical Guide sufficiently emphasizes that all required statutory and regulatory components of 1915(c) waivers must continue to be met, including, but not limited to, an

individual's free choice of providers, adherence to person-centered service planning, health and welfare oversight, and ensuring community integration.

CMS agrees with the importance for state use of a remote/telehealth delivery option for waiver services to facilitate individual access to home and community-based services in a safe and effective manner as well as ensure individual autonomy and community integration. In the updated 3.7 version of the 1915(c) HCBS waiver application, and the corresponding 1915(c) HCBS Instructions & Technical Guide, CMS included instructions for states to specify in the waiver application how they will ensure that remote/telehealth service delivery will be implemented in a manner that respects individual privacy, supports the individual, ensures individual health and safety, and facilitates community integration.

Action Taken: No changes were made to the 1915(c) HCBS waiver application or instructions as a result of these comments.

Comment: One commenter asked CMS to keep the updated (March 2024) revisions that allow parents of Medicaid- eligible minors to be paid caregivers for their children, stating that this option is critical for their community.

CMS Response: We appreciate the commenter's input. It has been CMS' long-standing policy to support the state option for LRIs to receive payment for the provision of most waiver services.

Action Taken: No changes were made to the 1915(c) HCBS waiver application or instructions as a result of this comment.

Comment: One commenter requested further guidance on how "substituted judgment" does not simply support the LRI's personal interests. They ask for guidelines, including examples, on when substituted judgment can be overridden. They note that some LRIs have shared their opinions of Appendix C-2-d in the framework of their own preferences which are not based on person-centered principles: (1) citing financial incentives; (2) avoiding "others coming into their homes"; (3) generally stating that "no one knows better than a parent"; and/or (4) refusing to educate others on how they interact, communicate, etc. The commenter states that this is only made worse when services are self-directed and individuals cannot self-direct their own services, such as minors or those with intellectual disabilities, and a LRI says that they are the only caregiver for this person without having ever tried anything else. They noted that CMS, in the last update, called this "self-referral" but has now backtracked in the most recent revisions and the commenter called the idea of "substituted judgment" a reversion to the past.

CMS Response: In response to previous comments, CMS added language that state policies should ensure that LRIs who have decision-making authority over the selection of waiver service providers use substituted judgment on behalf of the individual and defined "substituted judgment" as making decisions based on an understanding of what the individual would want.

While we agree that the state should have policies in place to address exceptions for using substituted judgement, CMS does not wish to be prescribe these state policies.

Action Taken: No changes were made to the 1915(c) HCBS waiver application or instructions as a result of this comment.

Comment: Two organizations indicated that they were pleased to see additional language in the Telehealth/Remote Supports delivery of waiver services section referencing that "'Telehealth' refers to a general service modality, and states may use other terms to reflect the use of telehealth in their HCBS waivers". They noted that this additional language allowing states to continue to use other terms to reflect the use of telehealth aligns with the way states have used such terms in waiver submissions that have already been approved by CMS.

CMS Response: Thank you for the positive feedback.

Action Taken: No changes were made to the 1915(c) HCBS waiver application or instructions as a result of this comment.

Comment: Two organizations indicated that they were pleased to see CMS retain the core service definition for education services within the 1915(c) HCBS Waiver & Technical Guide, noting that states will be able to continue to use this service to cover tuition for adult education classes offered by a college, community college, technical school or university (institution of postsecondary education) 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 available for funding by the Office of Vocational Rehabilitation (OVR).

CMS Response: The core service definition for education services in the 1915(c) HCBS Waiver Instructions & Technical Guide specifies that this service consists of special education and related services as defined in the Individuals with Disabilities Education Improvement Act (IDEA) of 2004, 34 CFR § 300.5 (20 U.S.C. 1401 et seq.), to the extent to which they are not available under a program funded by IDEA and documentation is maintained in the file of each individual receiving this service that the service is not otherwise available under section 110 of the Rehabilitation Act of 1973 or the IDEA.

Action Taken: No changes were made to the 1915(c) HCBS waiver application or instructions as a result of this comment.

Comment: Two organizations commented that beginning with 2011 guidance, CMS has increasingly made explicit the role that prevocational services should play as a time-limited part of preparing an individual for employment. They indicated that state approaches to supporting employment outcomes through HCBS have benefited from these policy clarifications, and stated concerns that the following proposed revisions may be interpreted as a softening of the direct connection between prevocational services and employment: "Individuals receiving prevocational services ~~must~~ are expected to have employment related goals in their person-centered plan" "The general habilitation goals ~~must~~ may be designed to support employment goals". They suggest retaining the original language and, if CMS intends a shift in expectations related to prevocational services, they suggest adding clarifying language. However, they urged CMS to maintain the expectation that prevocational services are time-limited and designed to lead to employment.

CMS Response: Current statutes and regulations do not address a requirement that employment-related goals be documented in the person-centered plan in accordance with delivery of prevocational services, or requiring states to ensure that habilitation goals are designed to support employment goals. For this reason, CMS will retain the current language, however we will strengthen the definition of prevocational services by stating the following (new language in bold):

"42 CFR § 440.180(c)(2)(i) defines prevocational services as services that prepare an individual for paid or unpaid employment that are not job-task oriented but are, instead, aimed at a generalized result. To ensure this requirement is met, individuals receiving prevocational services are expected to have employment related goals in their person-centered plan".

Action Taken: CMS will retain the current language while adding additional clarifying language, stated above.

Comment: Commenters expressed general support of the updates that incorporates the language of the HCBS settings regulations into the 1915(c) HCBS waiver application.

CMS Response: Thank you for your positive feedback.

Action Taken: No changes were made to the 1915(c) HCBS waiver application or instructions as a result of these comments.

Comment: One organization noted that while they do not disagree that waiver enrollees should be informed of the choice of available providers as required in Section D-1-f, the expectation is that states should note any lack of alternative providers in the person centered plan and a plan of action developed with timelines and action items to be carried out by the service coordinator or similar position to work towards meeting the obligations of a choice of provider. They indicated that they often see individuals rely on family caregivers as a last resort and are concerned that states will interpret this language not to ensure there is actual choice or provider, but to simply record that a list of providers was made available even if none of those providers were available or suitable to meet the individual's service needs. They expressed that the failure of the state to ensure choice of available providers should be noted when that is the situation, as should steps that will be taken to remedy the problem. They further state that as part of the obligations to ensure services are available with reasonable promptness and the health and welfare of waiver enrollees, states should clearly record when services are not available or there is no choice of provider, and to make a plan to resolve the lack of provider issue. They note that the plan must not include decreasing service authorizations to match what is available, as opposed to what is needed.

CMS Response: CMS is not proposing at this time any changes to Appendix D-1-f of the 1915(c) HCBS waiver application or the corresponding 1915(c) HCBS Waiver Instructions & Technical Guide.

While states are not required to specify in the person-centered service plan when services or service providers are not available, the state is still responsible to ensure the health and welfare of the individual and to explore all service provider options with the individual, which includes unpaid and natural supports as a first option prior to paid providers. While there is not a requirement for states to document in the person-centered service plan the services and/or providers that are unavailable, CMS expects for efforts to obtain those services to be evident through both the individual person-centered planning process and the state's on-going monitoring to identify and resolve issues on a systemic level as part of the quality improvement process.

Action Taken: No changes were made to the 1915(c) HCBS waiver application or instructions as a result of this comment.

Comment: One organization expressed support of the language requiring the sample of service plans to be representative of the demographic makeup of the waiver population and asked that this representative sample go beyond demographic makeup and include representation of managed care plans, if relevant, as well as providers, and setting types.

CMS Response: Thank you for your comment. We previously updated the language to ensure the sample of service plans to be reviewed represents the population served in the waiver. States may employ other methods to satisfy the requirement that service plans are subject to the approval of the Medicaid Agency, but they must describe the methods used and how they meet the applicable requirements.

Action Taken: No changes were made to the 1915(c) HCBS waiver application or instructions as a result of this comment.

Comment: One organization expressed support with the updated assurances regarding service plans and recommended that more assurances be added to this section regarding the person-centered policies and monitoring. They stated appreciation of the change to reflect that service plans should be revised when the individual requests it or their circumstances or needs change. They indicated concern about how a state will interpret the term "significantly". While recognizing that this language is directly from the regulation, they requested for language in the 1915(c) HCBS Waiver Instructions & Technical Guide be more descriptive about revising a plan when services, service providers, restrictions, or other plan factors have changed, noting that service plans are often not being fulfilled or do not reflect current circumstances of an individual.

CMS Response: Thank you for your comment. CMS previously updated the person-centered service plan assurance with the language from the authorizing regulation at 42 CFR § 441.301(c)(3) to provide additional description of the type of change necessary to require a service plan revision.

Action Taken: No changes were made to the 1915(c) HCBS waiver application or instructions as a result of this comment.

Comment: Through one comment submitted by a provider organization, many commenters expressed understanding that CMS is not prepared to make additional changes to Appendix I-2-a of the 1915(c) HCBS waiver application at this time, but urged CMS to consider additional measures to guide states in ensuring reimbursement rates are transparent, regularly reviewed, and sufficient to ensure access to home and community-based services. These commenters recommended a higher degree of oversight and assistance to ensuring rate determination methods are sufficient.

CMS Response: With the recent release and publication of the Ensuring Access to Medicaid Services Final Rule, 42 CFR § 447.203(b)(1), CMS created a new requirement for payment rate transparency of fee-for-service (FFS) rates to promote greater consistency in rate publication across states. Beginning July 1, 2026, states will be required to publish all Medicaid FFS fee schedule payment rates made to providers delivering Medicaid services to Medicaid beneficiaries through an FFS delivery system on a website that is accessible to the general public and organized in a way the public can readily determine applicable rates for services. Additionally, 42 CFR §§ 447.203(b)(2) and (3) requires states to publish the average hourly rate paid to direct care workers delivering personal care, home health aide, homemaker and habilitation services and publish the disclosure every two years. The goal of these two provisions is to provide greater insight into how Medicaid payment levels affect access to care. CMS intends to revise

the 1915(c) HCBS waiver application as well as the 1915(c) HCBS Waiver Instructions & Technical Guide to incorporate requirements of the Access Final Rule in the future as needed.

Action Taken: No changes were made to the 1915(c) HCBS waiver application or instructions as a result of this comment.