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PART 430—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

■ 1. The authority citation for part 430 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

■ 2. Section 430.25 is amended by revising paragraphs (h)(2) to read as follows:

§ 430.25 Waivers of State plan requirements.

* * * * *

(h) * * *

(2) *Duration of waivers.* (i) *Home and community-based services under section 1915(c) of the Act.*

(A) The initial waiver is for a period of 3 years and may be renewed thereafter for periods of 5 years.

(B) For waivers that include individuals who are dually eligible for Medicare and Medicaid, 5-year initial approval periods may be granted at the discretion of the Secretary for waivers meeting all necessary programmatic, financial and quality requirements, and in a manner consistent with the interests of beneficiaries and the objectives of the Medicaid program.

(ii) *Waivers under section 1915(b) of the Act.*

(A) The initial waiver is for a period of 2 years and may be renewed for additional periods of up to 2 years as determined by the Administrator.

(B) For waivers that include individuals who are dually eligible for Medicare and Medicaid, 5-year initial and renewal approval periods may be granted at the discretion of the Secretary for waivers meeting all necessary programmatic, financial and quality requirements, and in a manner consistent with the interests of beneficiaries and the objectives of the Medicaid program.

(iii) *Waivers under section 1916 of the Act.* The initial waiver is for a period of 2 years and may be renewed for additional periods of up to 2 years as determined by the Administrator.

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PART 431—STATE ORGANIZATION AND GENERAL ADMINISTRATION

■ 3. The authority citation for part 431 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

■ 4. Section 431.54 is amended by adding new paragraphs (a)(3) and (h) to read as follows:

§ 431.54 Exceptions to certain State plan requirements .

(a) * * *

(3) Section 1915(i) of the Act provides that a State may provide, as medical assistance, home and community-based services under an approved State plan amendment that meets certain requirements, without regard to the requirements of sections 1902(a)(10)(B) and 1902(a)(10)(C)(i)(III) of the Act, with respect to such services.

* * * * *

(h) *State plan home and community-based services.* The requirements of § 440.240 of this chapter related to comparability of services do not apply with respect to State plan home and community-based services defined in § 440.182 of this chapter.

PART 435—ELIGIBILITY IN THE STATES, DISTRICT OF COLUMBIA, THE NORTHERN MARIANA ISLANDS, AND AMERICAN SAMOA

■ 5. The authority citation for part 435 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

■ 6. Section 435.219 is added to subpart C under the undesignated center heading ‘‘Options for Coverage of Families and Children and the Aged, Blind, and Disabled’’ to read as follows:

§ 435.219 Individuals receiving State plan home and community-based services.

If the agency provides State plan home and community-based services to individuals described in section 1915(i)(1), the agency, under its State plan, may, in addition, provide Medicaid to individuals in the community who are described in one or both of paragraphs (a) or (b) of this section.

(a) Individuals who—

(1) Are not otherwise eligible for Medicaid;

(2) Have income that does not exceed 150 percent of the Federal poverty line (FPL);

(3) Meet the needs-based criteria under § 441.715 of this chapter; and

(4) Will receive State plan home and community-based services as defined in § 440.182 of this chapter.

(b) Individuals who—

(1) Would be determined eligible by

the agency under an existing waiver or demonstration project under sections 1915(c), 1915(d), 1915(e) or 1115 of the Act, but are not required to receive services under such waivers or demonstration projects;
(2) Have income that does not exceed 300 percent of the Supplemental Security Income Federal Benefit Rate (SSI/FBR); and
(3) Will receive State plan home and community-based services as defined in § 440.182 of this chapter.
(c) For purposes of determining eligibility under paragraph (a) of this section, the agency may not take into account an individual's resources and must use income standards that are reasonable, consistent with the objectives of the Medicaid program, simple to administer, and in the best interests of the beneficiary. Income methodologies may include use of existing income methodologies, such as the SSI program rules. However, subject to the Secretary's approval, the agency may use other income methodologies that meet the requirements of this paragraph.

PART 436—ELIGIBILITY IN GUAM, PUERTO RICO AND THE VIRGIN ISLANDS

■ 7. The authority citation for part 436 continues to read as follows:
Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).
■ 8. Section 436.219 is added to read as follows:
§ 436.219 Individuals receiving State plan home and community-based services.
If the agency provides State plan home and community-based services to individuals described in section 1915(i)(1) of the Act, the agency, under its State plan, may, in addition, provide Medicaid to of individuals in the community who are described in one or both of paragraphs (a) or (b) of this section.
(a) Individuals who—
(1) Are not otherwise eligible for Medicaid;
(2) Have income that does not exceed 150 percent of the Federal poverty line (FPL);
(3) Meet the needs-based criteria under § 441.715 of this chapter; and
(4) Will receive State plan home and community-based services as defined in § 440.182 of this chapter.
(b) Individuals who—
(1) Would be determined eligible by the agency under an existing waiver or demonstration project under sections 1915(c), 1915(d), 1915(e) or 1115 of the Act, but are not required to receive services under such waivers or demonstration projects;
(2) Have income that does not exceed 300 percent of the Supplemental Security Income Federal Benefit Rate (SSI/FBR); and
(3) Will receive State plan home and community-based services as defined in § 440.182 of this chapter.
(c) For purposes of determining eligibility under paragraph (a) of this section, the agency may not take into account an individual's resources and must use income standards that are reasonable, consistent with the objectives of the Medicaid program, simple to administer, and in the best interests of the beneficiary. Income methodologies may include use of existing income methodologies, such as the rules of the OAA, AB, APTD or AABD programs. However, subject to the Secretary's approval, the agency may use other income methodologies that meet the requirements of this paragraph.

PART 440—SERVICES: GENERAL PROVISIONS

■ 9. The authority citation for part 440 continues to read as follows:
Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).
■ 10. Section 440.1 is amended by adding the new statutory basis 1915(i) in sequential order to read as follows:
§ 440.1 Basis and purpose.
* * * * *
1915(i) Home and community-based services furnished under a State plan to elderly and disabled individuals.
■ 11. Section 440.180 is amended by revising the section heading to read as follows:
§ 440.180 Home and community-based waiver services.
* * * * *
■ 12. Section 440.182 is added to read as follows:
§ 440.182 State plan home and community-based services.
(a) *Definition.* State plan home and community-based services (HCBS) benefit means the services listed in paragraph (c) of this section when provided under the State's plan (rather than through an HCBS waiver program) for individuals described in paragraph (b) of this section.

(b) *State plan HCBS coverage.* State plan HCBS can be made available to individuals who—
(1) Are eligible under the State plan and have income, calculated using the otherwise applicable rules, including any less restrictive income disregards used by the State for that group under section 1902(r)(2) of the Act, that does not exceed 150 percent of the Federal Poverty Line (FPL); and
(2) In addition to the individuals described in paragraph (b)(1) of this section, to individuals based on the State's election of the eligibility groups described in § 435.219(b) or § 436.219(b) of this chapter.
(c) *Services.* The State plan HCBS benefit consists of one or more of the following services:
(1) Case management services.
(2) Homemaker services.
(3) Home health aide services.
(4) Personal care services.
(5) Adult day health services.
(6) Habilitation services, which include expanded habilitation services as specified in § 440.180(c).
(7) Respite care services.
(8) Subject to the conditions in § 440.180(d)(2), for individuals with chronic mental illness:
(i) Day treatment or other partial hospitalization services;
(ii) Psychosocial rehabilitation services;
(iii) Clinic services (whether or not furnished in a facility).
(9) Other services requested by the agency and approved by the Secretary as consistent with the purpose of the benefit.
(d) *Exclusion.* FFP is not available for the cost of room and board in State plan HCBS. The following HCBS costs are not considered room or board for purposes of this exclusion:
(1) The cost of temporary food and shelter provided as an integral part of respite care services in a facility approved by the State.
(2) Meals provided as an integral component of a program of adult day health services or another service and consistent with standard procedures in the State for such a program.
(3) A portion of the rent and food costs that may be reasonably attributed to an unrelated caregiver providing State plan HCBS who is residing in the same household with the recipient, but not if the recipient is living in the home of the caregiver or in a residence that is owned or leased by the caregiver.

PART 441—SERVICES: REQUIREMENTS AND LIMITS APPLICABLE TO SPECIFIC SERVICES

■ 13. The authority citation for part 441 continues to read as follows:
Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).
■ 14. Section 441.301 is amended by revising paragraphs (b)(1)(i) and (b)(6) and adding paragraph (c) to read as follows:

§ 441.301 Contents of request for a waiver.

* * * * *
(b) * * *
(1) * * *
(i) Under a written person-centered service plan (also called plan of care) that is based on a person-centered approach and is subject to approval by the Medicaid agency.
* * * * *
(6) Be limited to one or more of the following target groups or any subgroup thereof that the State may define:
(i) Aged or disabled, or both.
(ii) Individuals with Intellectual or Developmental Disabilities, or both.
(iii) Mentally ill.
(c) A waiver request under this subpart must include the following—
(1) *Person-Centered Planning Process.* The individual will lead the person-centered planning process where possible. The individual's representative should have a participatory role, as needed and as defined by the individual, unless State law confers decision-making authority to the legal representative. All references to individuals include the role of the individual's representative. In addition to being led by the individual receiving services and supports, the person-centered planning process:
(i) Includes people chosen by the individual.
(ii) Provides necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions.
(iii) Is timely and occurs at times and locations of convenience to the individual.
(iv) Reflects cultural considerations of the individual and is conducted by providing information in plain language

and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with § 435.905(b) of this chapter.
(v) Includes strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants.
(vi) Providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual must not provide case management or develop the person-centered service plan, except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS. In these cases, the State must devise conflict of interest protections including separation of entity and provider functions within provider entities, which must be approved by CMS. Individuals must be provided with a clear and accessible alternative dispute resolution process.
(vii) Offers informed choices to the individual regarding the services and supports they receive and from whom.
(viii) Includes a method for the individual to request updates to the plan as needed.
(ix) Records the alternative home and community-based settings that were considered by the individual.
(2) *The Person-Centered Service Plan.* The person-centered service plan must reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports. Commensurate with the level of need of the individual, and the scope of services and supports available under the State's 1915(c) HCBS waiver, the written plan must:
(i) Reflect that the setting in which the individual resides is chosen by the individual. The State must ensure that the setting chosen by the individual is integrated in, and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS.
(ii) Reflect the individual's strengths and preferences.
(iii) Reflect clinical and support needs as identified through an assessment of functional need.
(iv) Include individually identified goals and desired outcomes.
(v) Reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports. Natural supports are unpaid supports that are provided voluntarily to the individual in lieu of 1915(c) HCBS waiver services and supports.
(vi) Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed.
(vii) Be understandable to the individual receiving services and supports, and the individuals important in supporting him or her. At a minimum, for the written plan to be understandable, it must be written in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with § 435.905(b) of this chapter.
(viii) Identify the individual and/or entity responsible for monitoring the plan.
(ix) Be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation.
(x) Be distributed to the individual and other people involved in the plan.
(xi) Include those services, the purpose or control of which the individual elects to self-direct.
(xii) Prevent the provision of unnecessary or inappropriate services and supports.
(xiii) Document that any modification of the additional conditions, under paragraph (c)(4)(vi)(A) through (D) of this section, must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:
(A) Identify a specific and individualized assessed need.
(B) Document the positive

interventions and supports used prior to any modifications to the person-centered service plan.
(C) Document less intrusive methods of meeting the need that have been tried but did not work.
(D) Include a clear description of the condition that is directly proportionate to the specific assessed need.
(E) Include a regular collection and review of data to measure the ongoing effectiveness of the modification.
(F) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
(G) Include informed consent of the individual.
(H) Include an assurance that interventions and supports will cause no harm to the individual.
(3) *Review of the Person-Centered Service Plan.* The person-centered service plan must be reviewed, and revised upon reassessment of functional need as required by § 441.365(e), at least every 12 months, when the individual's circumstances or needs change significantly, or at the request of the individual.
(4) *Home and Community-Based Settings.* Home and community-based settings must have all of the following qualities, and such other qualities as the Secretary determines to be appropriate, based on the needs of the individual as indicated in their person-centered service plan:
(i) The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
(ii) The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.
(iii) Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.
(iv) Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.
(v) Facilitates individual choice regarding services and supports, and who provides them.
(vi) In a provider-owned or controlled residential setting, in addition to the qualities at § 441.301(c)(4)(i) through (v), the following additional conditions must be met:
(A) The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the State must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.
(B) Each individual has privacy in their sleeping or living unit:
(*1*) Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.
(*2*) Individuals sharing units have a choice of roommates in that setting.
(*3*) Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.
(C) Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time.
(D) Individuals are able to have visitors of their choosing at any time.
(E) The setting is physically accessible to the individual.
(F) Any modification of the additional conditions, under § 441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:
(*1*) Identify a specific and

individualized assessed need.
(*2*) Document the positive interventions and supports used prior to any modifications to the person-centered service plan.
(*3*) Document less intrusive methods of meeting the need that have been tried but did not work.
(*4*) Include a clear description of the condition that is directly proportionate to the specific assessed need.
(*5*) Include regular collection and review of data to measure the ongoing effectiveness of the modification.
(*6*) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
(*7*) Include the informed consent of the individual.
(*8*) Include an assurance that interventions and supports will cause no harm to the individual.
(5) *Settings that are not Home and Community-Based.* Home and community-based settings do not include the following:
(i) A nursing facility;
(ii) An institution for mental diseases;
(iii) An intermediate care facility for individuals with intellectual disabilities;
(iv) A hospital; or
(v) Any other locations that have qualities of an institutional setting, as determined by the Secretary. Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS will be presumed to be a setting that has the qualities of an institution unless the Secretary determines through heightened scrutiny, based on information presented by the State or other parties, that the setting does not have the qualities of an institution and that the setting does have the qualities of home and community-based settings.
(6) *Home and Community-Based Settings: Compliance and Transition:*
(i) States submitting new and initial waiver requests must provide assurances of compliance with the requirements of this section for home and community-based settings as of the effective date of the waiver.
(ii) CMS will require transition plans for existing section 1915(c) waivers and approved state plans providing home and community-based services under section 1915(i) to achieve compliance with this section, as follows:
(A) For each approved section 1915(c) HCBS waiver subject to renewal or submitted for amendment within one year after the effective date of this regulation, the State must submit a transition plan at the time of the waiver renewal or amendment request that sets forth the actions the State will take to bring the specific waiver into compliance with this section. The waiver approval will be contingent on the inclusion of the transition plan approved by CMS. The transition plan must include all elements required by the Secretary; and within one hundred and twenty days of the submission of the first waiver renewal or amendment request the State must submit a transition plan detailing how the State will operate all section 1915(c) HCBS waivers and any section 1915(i) State plan benefit in accordance with this section. The transition plan must include all elements including timelines and deliverables as approved by the Secretary.
(B) For States that do not have a section 1915(c) HCBS waiver or a section 1915(i) State plan benefit due for renewal or proposed for amendments within one year of the effective date of this regulation, the State must submit a transition plan detailing how the State will operate all section 1915(c) HCBS waivers and any section 1915(i) State plan benefit in accordance with this section. This plan must be submitted no later than one year after the effective date of this regulation. The transition plan must include all elements including timelines and deliverables as approved by the Secretary.
(iii) A State must provide at least a 30-day public notice and comment period regarding the transition plan(s) that the State intends to submit to CMS for review and consideration, as follows:
(A) The State must at a minimum provide two (2) statements of public notice and public input procedures.
(B) The State must ensure the full transition plan(s) is available to the public for public comment.
(C) The State must consider and modify the transition plan, as the State

deems appropriate, to account for public comment.
(iv) A State must submit to CMS, with the proposed transition plan:
(A) Evidence of the public notice required.
(B) A summary of the comments received during the public notice period, reasons why comments were not adopted, and any modifications to the transition plan based upon those comments.
(v) Upon approval by CMS, the State will begin implementation of the transition plans. The State's failure to submit an approvable transition plan as required by this section and/or to comply with the terms of the approved transition plan may result in compliance actions, including but not limited to deferral/disallowance of Federal Financial Participation.
■ 15. Section 441.302 is amended by adding paragraphs (a)(4) and (a)(5) to read as follows:

§ 441.302 State assurances.
* * * * *
(a) * * *
(4) Assurance that the State is able to meet the unique service needs of the individuals when the State elects to serve more than one target group under a single waiver, as specified in § 441.301(b)(6).
(i) On an annual basis the State will include in the quality section of the CMS–372 form (or any successor form designated by CMS) data that indicates the State continues to serve multiple target groups in the single waiver and that a single target group is not being prioritized to the detriment of other groups.
(5) Assurance that services are provided in home and community based settings, as specified in § 441.301(c)(4).
■ 16. Section 441.304 is amended by—
■ A. Revising the section heading as set forth below.
■ B. Redesignating paragraph (d) as new paragraph (g).
■ C. Adding new paragraphs (d), (e), and (f).
■ D. Revising newly designated paragraph (g).
The additions and revisions read as follows:

§ 441.304 Duration, extension, and amendment of a waiver.
* * * * *
(d) The agency may request that waiver modifications be made effective retroactive to the first day of a waiver year, or another date after the first day of a waiver year, in which the amendment is submitted, unless the amendment involves substantive changes as determined by CMS.
(1) Substantive changes include, but are not limited to, revisions to services available under the waiver including elimination or reduction of services, or reduction in the scope, amount, and duration of any service, a change in the qualifications of service providers, changes in rate methodology or a constriction in the eligible population.
(2) A request for an amendment that involves a substantive change as determined by CMS, may only take effect on or after the date when the amendment is approved by CMS, and must be accompanied by information on how the State has assured smooth transitions and minimal effect on individuals adversely impacted by the change.
(e) The agency must provide public notice of any significant proposed change in its methods and standards for setting payment rates for services in accordance with § 447.205 of this chapter.
(f) The agency must establish and use a public input process, for any changes in the services or operations of the waiver.
(1) This process must be described fully in the State's waiver application 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.
(2) This process must be completed at a minimum of 30 days prior to implementation of the proposed change or submission of the proposed change to CMS, whichever comes first.
(3) This process must be used for both existing waivers that have substantive changes proposed, either through the renewal or the amendment process, and new waivers.
(4) This process must include consultation with Federally-recognized Tribes, and in accordance with section 5006(e) of the American Recovery and Reinvestment Act of 2009 (Pub. L. 111–5), Indian health programs and Urban Indian Organizations.
(g)(1) If CMS finds that the Medicaid

agency is not meeting one or more of the requirements for a waiver contained in this subpart, the agency is given a notice of CMS' findings and an opportunity for a hearing to rebut the findings.
(2) If CMS determines that the agency is substantively out of compliance with this subpart after the notice and any hearing, CMS may employ strategies to ensure compliance as described in paragraph (g)(3) of this section or terminate the waiver.
(3)(i) Strategies to ensure compliance may include the imposition of a moratorium on waiver enrollments, other corrective strategies as appropriate to ensure the health and welfare of waiver participants, or the withholding of a portion of Federal payment for waiver services until such time that compliance is achieved, or other actions as determined by the Secretary as necessary to address non-compliance with 1915(c) of the Act, or termination. When a waiver is terminated, the State must comport with § 441.307.
(ii) CMS will provide states with a written notice of the impending strategies to ensure compliance for a waiver program. The notice of CMS' intent to utilize strategies to ensure compliance would include the nature of the noncompliance, the strategy to be employed, the effective date of the compliance strategy, the criteria for removing the compliance strategy and the opportunity for a hearing.
■ 17. Section 441.530 is added to read as follows:

§ 441.530 Home and Community-Based Setting.

(a) States must make available attendant services and supports in a home and community-based setting consistent with both paragraphs (a)(1) and (a)(2) of this section.
(1) Home and community-based settings must have all of the following qualities, and such other qualities as the Secretary determines to be appropriate, based on the needs of the individual as indicated in their person-centered service plan:
(i) The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
(ii) The setting is selected by the individual from among setting options, including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.
(iii) Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.
(iv) Optimizes but does not regiment individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.
(v) Facilitates individual choice regarding services and supports, and who provides them.
(vi) In a provider-owned or controlled residential setting, in addition to the above qualities at paragraphs (a)(1)(i) through (v) of this section, the following additional conditions must be met:
(A) The unit or dwelling is a specific physical place that can be owned, rented or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord tenant law of the State, county, city or other designated entity. For settings in which landlord tenant laws do not apply, the State must ensure that a lease, residency agreement or other form of written agreement will be in place for each participant and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.
(B) Each individual has privacy in their sleeping or living unit:
(*1*) Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors as needed.
(*2*) Individuals sharing units have a choice of roommates in that setting.
(*3*) Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.
(C) Individuals have the freedom and support to control their own schedules

and activities, and have access to food at any time.
(D) Individuals are able to have visitors of their choosing at any time.
(E) The setting is physically accessible to the individual.
(F) Any modification of the additional conditions, under paragraphs (a)(1)(vi)(A) through (D) of this section, must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:
(*1*) Identify a specific and individualized assessed need.
(*2*) Document the positive interventions and supports used prior to any modifications to the person-centered service plan.
(*3*) Document less intrusive methods of meeting the need that have been tried but did not work.
(*4*) Include a clear description of the condition that is directly proportionate to the specific assessed need.
(*5*) Include regulation collection and review of data to measure the ongoing effectiveness of the modification.
(*6*) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
(*7*) Include the informed consent of the individual.
(*8*) Include an assurance that interventions and supports will cause no harm to the individual.
(2) Home and community-based settings do not include the following:
(i) A nursing facility;
(ii) An institution for mental diseases;
(iii) An intermediate care facility for individuals with intellectual disabilities;
(iv) A hospital providing long-term care services; or
(v) Any other locations that have qualities of an institutional setting, as determined by the Secretary. Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS will be presumed to be a setting that has the qualities of an institution unless the Secretary determines through heightened scrutiny, based on information presented by the State or other parties, that the setting does not have the qualities of an institution and that the setting does have the qualities of home and community-based settings.
(b) [Reserved]

■ 18. A new subpart M, consisting of § 441.700 through § 441.745, is added to part 441 to read as follows:

Subpart M—State Plan Home and Community-Based Services for Elderly and Disabled Individuals

Sec.

Subpart M—State Plan Home and Community-Based Services for the Elderly and Individuals with Disabilities

§ 441.700 Basis and purpose.

Section 1915(i) of the Act permits States to offer one or more home and community-based services (HCBS) under their State Medicaid plans to qualified individuals with disabilities or individuals who are elderly. Those services are listed in § 440.182 of this chapter, and are described by the State, including any limitations of the services. This optional benefit is known as the State plan HCBS benefit. This subpart describes what a State Medicaid plan must provide when the State elects to include the optional benefit, and defines State responsibilities.

§ 441.705 State plan requirements.

A State plan that provides section 1915(i) of the Act State plan home and community-based services must meet the requirements of this subpart.

§ 441.710 State plan home and community-based services under section 1915(i)(1) of the Act.

(a) Home and Community-Based Setting. States must make State plan HCBS available in a home and community-based setting consistent with both paragraphs (a)(1) and (a)(2) of this section.
(1) Home and community-based settings must have all of the following qualities, and such other qualities as the Secretary determines to be appropriate, based on the needs of the individual as indicated in their person-centered service plan:
(i) The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
(ii) The setting is selected by the individual from among setting options, including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person–centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.
(iii) Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.
(iv) Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.
(v) Facilitates individual choice regarding services and supports, and who provides them.
(vi) In a provider-owned or controlled residential setting, in addition to the above qualities at paragraphs (a)(1)(i) through (v) of this section, the following additional conditions must be met:
(A) The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the state, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the State must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law;
(B) Each individual has privacy in their sleeping or living unit:
(*1*) Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors;
(*2*) Individuals sharing units have a choice of roommates in that setting; and
(*3*) Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.
(C) Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time;
(D) Individuals are able to have visitors of their choosing at any time;
(E) The setting is physically accessible to the individual; and
(F) Any modification of the additional conditions, under paragraphs (a)(1)(vi)(A) through (D) of this section, must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:
(*1*) Identify a specific and individualized assessed need.
(*2*) Document the positive interventions and supports used prior to any modifications to the person-centered service plan.
(*3*) Document less intrusive methods of meeting the need that have been tried but did not work.
(*4*) Include a clear description of the condition that is directly proportionate to the specific assessed need.
(*5*) Include regular collection and review of data to measure the ongoing effectiveness of the modification.
(*6*) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
(*7*) Include the informed consent of the individual.
(*8*) Include an assurance that interventions and supports will cause no harm to the individual.
(2) Home and community-based

settings do not include the following:
(i) A nursing facility.
(ii) An institution for mental diseases.
(iii) An intermediate care facility for individuals with intellectual disabilities.
(iv) A hospital.
(v) Any other locations that have qualities of an institutional setting, as determined by the Secretary. Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS will be presumed to be a setting that has the qualities of an institution unless the Secretary determines through heightened scrutiny, based on information presented by the State or other parties, that the setting does not have the qualities of an institution and that the setting does have the qualities of home and community-based settings.
(3) Compliance and transition:
(i) States submitting state plan amendments for new section 1915(i) of the Act benefits must provide assurances of compliance with the requirements of this section for home and community-based settings as of the effective date of the state plan amendment;
(ii) CMS will require transition plans for existing section 1915(c) waivers and approved state plans providing home and community-based services under section 1915(i) to achieve compliance with this section, as follows:
(A) For each approved section 1915(i) of the Act benefit subject to renewal or submitted for amendment within one year after the effective date of this regulation, the State must submit a transition plan at the time of the renewal or amendment request that sets forth the actions the State will take to bring the specific 1915(i) State plan benefit into compliance with this section. The approval will be contingent on the inclusion of the transition plan approved by CMS. The transition plan must include all elements required by the Secretary; and within one hundred and twenty days of the submission of the first renewal or amendment request the State must submit a transition plan detailing how the State will operate all section 1915(c) HCBS waivers and any section 1915(i) State plan benefit in accordance with this section. The transition plan must include all elements including timelines and deliverables as approved by the Secretary.
(B) For States that do not have a section 1915(c) waiver or a section 1915(i) State plan benefit due for renewal or proposed for amendments within one year of the effective date of this regulation, the State must submit a transition plan detailing how the State will operate all section 1915(c) waivers and any section 1915(i) State plan benefit in accordance with this section. This plan must be submitted no later than one year after the effective date of this regulation. The transition plan must include all elements including timelines and deliverables as approved by the Secretary.
(iii) A State must provide at least a 30-day public notice and comment period regarding the transition plan(s) that the State intends to submit to CMS for review and consideration, as follows:
(A) The State must at a minimum provide two (2) statements of public notice and public input procedures.
(B) The State must ensure the full transition plan(s) is available to the public for public comment.
(C) The State must consider and modify the transition plan, as the State deems appropriate, to account for public comment.
(iv) A State must submit to CMS, with the proposed transition plan:
(A) Evidence of the public notice required.
(B) A summary of the comments received during the public notice period, reasons why comments were not adopted, and any modifications to the transition plan based upon those comments.
(v) Upon approval by CMS, the State will begin implementation of the transition plans. The State's failure to submit an approvable transition plan as required by this section and/or to comply with the terms of the approved transition plan may result in compliance actions, including but not limited to deferral/disallowance of Federal Financial Participation.
(b) *Needs-Based Eligibility Requirement.* Meet needs-based criteria for eligibility for the State plan HCBS

benefit, as required in § 441.715(a).
(c) *Minimum State plan HCBS Requirement.* Be assessed to require at least one section 1915(i) home and community-based service at a frequency determined by the State, as required in § 441.720(a)(5).
(d) *Target Population.* Meet any applicable targeting criteria defined by the State under the authority of paragraph (e)(2) of this section.
(e) *Non-application.* The State may elect in the State plan amendment approved under this subpart not to apply the following requirements when determining eligibility:
(1) Section 1902(a)(10)(C)(i)(III) of the Act, pertaining to income and resource eligibility rules for the medically needy living in the community, but only for the purposes of providing State plan HCBS. (2) Section 1902(a)(10)(B) of the Act, pertaining to comparability of Medicaid services, but only for the purposes of providing section 1915(i) State plan HCBS. In the event that a State elects not to apply comparability requirements:
(i) The State must describe the group(s) receiving State plan HCBS, subject to the Secretary's approval. Targeting criteria cannot have the impact of limiting the pool of qualified providers from which an individual would receive services, or have the impact of requiring an individual to receive services from the same entity from which they purchase their housing. These groups must be defined on the basis of any combination of the following:
(A) Age.
(B) Diagnosis.
(C) Disability.
(D) Medicaid Eligibility Group.
(ii) The State may elect in the State plan amendment to limit the availability of specific services defined under the authority of § 440.182(c) of this chapter or to vary the amount, duration, or scope of those services, to one or more of the group(s) described in this paragraph.

§ 441.715 Needs-based criteria and evaluation.
(a) *Needs-based criteria.* The State must establish needs-based criteria for determining an individual's eligibility under the State plan for the HCBS benefit, and may establish needs-based criteria for each specific service. Needs-based criteria are factors used to determine an individual's requirements for support, and may include risk factors. The criteria are not characteristics that describe the individual or the individual's condition. A diagnosis is not a sufficient factor on which to base a determination of need. A criterion can be considered needs-based if it is a factor that can only be ascertained for a given person through an individualized evaluation of need.
(b) *More stringent institutional and waiver needs-based criteria.* The State plan HCBS benefit is available only if the State has in effect needs-based criteria (as defined in paragraph (a) of this section), for receipt of services in nursing facilities as defined in section 1919(a) of the Act, intermediate care facilities for individuals with intellectual disabilities as defined in § 440.150 of this chapter, and hospitals as defined in § 440.10 of this chapter for which the State has established long-term level of care (LOC) criteria, or waivers offering HCBS, and these needs-based criteria are more stringent than the needs-based criteria for the State plan HCBS benefit. If the State defines needs-based criteria for individual State plan home and community-based services, it may not have the effect of limiting who can benefit from the State plan HCBS in an unreasonable way, as determined by the Secretary.
(1) These more stringent criteria must meet the following requirements:
(i) Be included in the LOC determination process for each institutional service and waiver.
(ii) Be submitted for inspection by CMS with the State plan amendment that establishes the State Plan HCBS benefit.
(iii) Be in effect on or before the effective date of the State plan HCBS benefit.
(2) In the event that the State modifies institutional LOC criteria to meet the requirements under paragraph (b) or (c)(6) of this section that such criteria be more stringent than the State plan HCBS needs-based eligibility criteria, States may continue to receive FFP for individuals receiving institutional services or waiver HCBS under the LOC criteria previously in effect.
(c) *Adjustment authority.* The State may modify the needs-based criteria established under paragraph (a) of this section, without prior approval from the

Secretary, if the number of individuals enrolled in the State plan HCBS benefit exceeds the projected number submitted annually to CMS. The Secretary may approve a retroactive effective date for the State plan amendment modifying the criteria, as early as the day following the notification period required under paragraph (c)(1) of this section, if all of the following conditions are met:
(1) The State provides at least 60 days notice of the proposed modification to the Secretary, the public, and each individual enrolled in the State plan HCBS benefit.
(2) The State notice to the Secretary is submitted as an amendment to the State plan.
(3) The adjusted needs-based eligibility criteria for the State plan HCBS benefit are less stringent than needs-based institutional and waiver LOC criteria in effect after the adjustment.
(4) Individuals who were found eligible for the State plan HCBS benefit before modification of the needs-based criteria under this adjustment authority must remain eligible for the HCBS benefit until such time as:
(i) The individual no longer meets the needs-based criteria used for the initial determination of eligibility; or
(ii) The individual is no longer eligible for or enrolled in Medicaid or the HCBS benefit.
(5) Any changes in service due to the modification of needs-based criteria under this adjustment authority are treated as actions as defined in § 431.201 of this chapter and are subject to the requirements of part 431, subpart E of this chapter.
(6) In the event that the State also needs to modify institutional level of care criteria to meet the requirements under paragraph (b) of this section that such criteria be more stringent than the State plan HCBS needs-based eligibility criteria, the State may adjust the modified institutional LOC criteria under this adjustment authority. The adjusted institutional LOC criteria must be at least as stringent as those in effect before they were modified to meet the requirements in paragraph (b) of this section.
(d) *Independent evaluation and determination of eligibility.* Eligibility for the State plan HCBS benefit must be determined through an independent evaluation of each individual according to the requirements of this subpart. The independent evaluation complies with the following requirements:
(1) Is performed by an agent that is independent and qualified as defined in § 441.730.
(2) Applies the needs-based eligibility criteria that the State has established under paragraph (a) of this section, and the general eligibility requirements under § 435.219 and § 436.219 of this chapter.
(3) Includes consultation with the individual, and if applicable, the individual's representative as defined under § 441.735.
(4) Assesses the individual's support needs.
(5) Uses only current and accurate information from existing records, and obtains any additional information necessary to draw valid conclusions about the individual's support needs.
(6) Evaluations finding that an individual is not eligible for the State plan HCBS benefit are treated as actions defined in § 431.201 of this chapter and are subject to the requirements of part 431 subpart E of this chapter.
(e) *Periodic redetermination.* Independent reevaluations of each individual receiving the State plan HCBS benefit must be performed at least every 12 months, to determine whether the individual continues to meet eligibility requirements. Redeterminations must meet the requirements of paragraph (d) of this section.

§ 441.720 Independent assessment.
(a) *Requirements.* For each individual determined to be eligible for the State plan HCBS benefit, the State must provide for an independent assessment of needs, which may include the results of a standardized functional needs assessment, in order to establish a service plan. In applying the requirements of section 1915(i)(1)(F) of the Act, the State must:
(1) Perform a face-to-face assessment of the individual by an agent who is independent and qualified as defined in § 441.730, and with a person-centered process that meets the requirements of § 441.725(a) and is guided by best practice and research on effective strategies that result in improved health and quality of life outcomes.
(i) For the purposes of this section, a face-to-face assessment may include

assessments performed by telemedicine, or other information technology medium, if the following conditions are met:
(A) The agent performing the assessment is independent and qualified as defined in § 441.730 and meets the provider qualifications defined by the State, including any additional qualifications or training requirements for the operation of required information technology.
(B) The individual receives appropriate support during the assessment, including the use of any necessary on-site support-staff.
(C) The individual provides informed consent for this type of assessment.
(ii) [Reserved]
(2) Conduct the assessment in consultation with the individual, and if applicable, the individual's authorized representative, and include the opportunity for the individual to identify other persons to be consulted, such as, but not limited to, the individual's spouse, family, guardian, and treating and consulting health and support professionals responsible for the individual's care.
(3) Examine the individual's relevant history including the findings from the independent evaluation of eligibility, medical records, an objective evaluation of functional ability, and any other records or information needed to develop the person-centered service plan as required in § 441.725.
(4) Include in the assessment the individual's physical, cognitive, and behavioral health care and support needs, strengths and preferences, available service and housing options, and if unpaid caregivers will be relied upon to implement any elements of the person-centered service plan, a caregiver assessment.
(5) For each service, apply the State's additional needs-based criteria (if any) that the individual may require. Individuals are considered enrolled in the State plan HCBS benefit only if they meet the eligibility and needs-based criteria for the benefit, and are also assessed to require and receive at least one home and community-based service offered under the State plan for medical assistance.
(6) Include in the assessment, if the State offers individuals the option to self-direct a State plan home and community-based service or services, any information needed for the self-directed portion of the service plan, as required in § 441.740(b), including the ability of the individual (with and without supports) to exercise budget or employer authority.
(7) Include in the assessment, for individuals receiving habilitation services, documentation that no Medicaid services are provided which would otherwise be available to the individual, specifically including but not limited to services available to the individual through a program funded under section 110 of the Rehabilitation Act of 1973, or the Individuals with Disabilities Education Improvement Act of 2004.
(8) Include in the assessment and subsequent service plan, for individuals receiving Secretary approved services under the authority of § 440.182 of this chapter, documentation that no State plan HCBS are provided which would otherwise be available to the individual through other Medicaid services or other Federally funded programs.
(9) Include in the assessment and subsequent service plan, for individuals receiving HCBS through a waiver approved under § 441.300, documentation that HCBS provided through the State plan and waiver are not duplicative.
(10) Coordinate the assessment and subsequent service plan with any other assessment or service plan required for services through a waiver authorized under section 1115 or section 1915 of the Social Security Act.
(b) *Reassessments.* The independent assessment of need must be conducted at least every 12 months and as needed when the individual's support needs or circumstances change significantly, in order to revise the service plan.

§ 441.725 Person-centered service plan.
(a) *Person-centered planning process.* Based on the independent assessment required in § 441.720, the State must develop (or approve, if the plan is developed by others) a written service plan jointly with the individual (including, for purposes of this paragraph, the individual and the individual's authorized representative if applicable). The person-centered planning process is driven by the individual. The process:
(1) Includes people chosen by the individual.

(2) Provides necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions.
(3) Is timely and occurs at times and locations of convenience to the individual.
(4) Reflects cultural considerations of the individual and is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with § 435.905(b) of this chapter.
(5) Includes strategies for solving conflict or disagreement within the process, including clear conflict of interest guidelines for all planning participants.
(6) Offers choices to the individual regarding the services and supports the individual receives and from whom.
(7) Includes a method for the individual to request updates to the plan, as needed.
(8) Records the alternative home and community-based settings that were considered by the individual.
(b) The person-centered service plan. The person-centered service plan must reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports. Commensurate with the level of need of the individual, and the scope of services and supports available under the State plan HCBS benefit, the written plan must:
(1) Reflect that the setting in which the individual resides is chosen by the individual. The State must ensure that the setting chosen by the individual is integrated in, and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS.
(2) Reflect the individual's strengths and preferences. (3) Reflect clinical and support needs as identified through an assessment of functional need.
(4) Include individually identified goals and desired outcomes.
(5) Reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports. Natural supports are unpaid supports that are provided voluntarily to the individual in lieu of State plan HCBS.
(6) Reflect risk factors and measures in place to minimize them, including individualized backup plans and strategies when needed.
(7) Be understandable to the individual receiving services and supports, and the individuals important in supporting him or her. At a minimum, for the written plan to be understandable, it must be written in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with § 435.905(b) of this chapter.
(8) Identify the individual and/or entity responsible for monitoring the plan.
(9) Be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation.
(10) Be distributed to the individual and other people involved in the plan.
(11) Include those services, the purchase or control of which the individual elects to self-direct, meeting the requirements of § 441.740.
(12) Prevent the provision of unnecessary or inappropriate services and supports.
(13) Document that any modification of the additional conditions, under § 441.710(a)(1)(vi)(A) through (D) of this chapter, must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:
(i) Identify a specific and individualized assessed need.
(ii) Document the positive interventions and supports used prior to any modifications to the person-centered service plan.
(iii) Document less intrusive methods of meeting the need that have been tried but did not work.
(iv) Include a clear description of the condition that is directly proportionate

to the specific assessed need.
(v) Include a regular collection and review of data to measure the ongoing effectiveness of the modification.
(vi) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
(vii) Include informed consent of the individual; and
(viii) Include an assurance that the interventions and supports will cause no harm to the individual.
(c) Reviewing the person-centered service plan. The person-centered service plan must be reviewed, and revised upon reassessment of functional need as required in § 441.720, at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual.

§ 441.730 Provider qualifications.
(a) *Requirements.* The State must provide assurances that necessary safeguards have been taken to protect the health and welfare of enrollees in State plan HCBS, and must define in writing standards for providers (both agencies and individuals) of HCBS and for agents conducting individualized independent evaluation, independent assessment, and service plan development.
(b) *Conflict of interest standards.* The State must define conflict of interest standards that ensure the independence of individual and agency agents who conduct (whether as a service or an administrative activity) the independent evaluation of eligibility for State plan HCBS, who are responsible for the independent assessment of need for HCBS, or who are responsible for the development of the service plan. The conflict of interest standards apply to all individuals and entities, public or private. At a minimum, these agents must not be any of the following:
(1) Related by blood or marriage to the individual, or to any paid caregiver of the individual.
(2) Financially responsible for the individual.
(3) Empowered to make financial or health-related decisions on behalf of the individual.
(4) Holding financial interest, as defined in § 411.354 of this chapter, in any entity that is paid to provide care for the individual.
(5) Providers of State plan HCBS for the individual, or those who have an interest in or are employed by a provider of State plan HCBS for the individual, except when the State demonstrates that the only willing and qualified agent to perform independent assessments and develop person-centered service plans in a geographic area also provides HCBS, and the State devises conflict of interest protections including separation of agent and provider functions within provider entities, which are described in the State plan for medical assistance and approved by the Secretary, and individuals are provided with a clear and accessible alternative dispute resolution process.
(c) *Training.* Qualifications for agents performing independent assessments and plans of care must include training in assessment of individuals whose physical, cognitive, or mental conditions trigger a potential need for home and community-based services and supports, and current knowledge of available resources, service options, providers, and best practices to improve health and quality of life outcomes.

§ 441.735 Definition of individual's representative.
In this subpart, the term *individual's representative* means, with respect to an individual being evaluated for, assessed regarding, or receiving State plan HCBS, the following:
(a) The individual's legal guardian or other person who is authorized under State law to represent the individual for the purpose of making decisions related to the person's care or well-being. In instances where state law confers decision-making authority to the individual representative, the individual will lead the service planning process to the extent possible.
(b) Any other person who is authorized under § 435.923 of this chapter, or under the policy of the State Medicaid Agency to represent the individual, including but not limited to, a parent, a family member, or an advocate for the individual.
(c) When the State authorizes representatives in accordance with paragraph (b) of this section, 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. State policies must address exceptions to using substituted judgment when the individual's wishes cannot be ascertained or when the individual's wishes would result in substantial harm to the individual. States may not refuse the authorized representative that the individual chooses, unless in the process of applying the requirements for authorization, the State discovers and can document evidence that the representative is not acting in accordance with these policies or cannot perform the required functions. States must continue to meet the requirements regarding the person-centered planning process at § 441.725 of this chapter.

§ 441.740 Self-directed services.

(a) *State option.* The State may choose to offer an election for self-directing HCBS. The term ''self-directed'' means, with respect to State plan HCBS listed in § 440.182 of this chapter, services that are planned and purchased under the direction and control of the individual, including the amount, duration, scope, provider, and location of the HCBS. For purposes of this paragraph, individual means the individual and, if applicable, the individual's representative as defined in § 441.735.

(b) *Service plan requirement.* Based on the independent assessment required in § 441.720, the State develops a service plan jointly with the individual as required in § 441.725. If the individual chooses to direct some or all HCBS, the service plan must meet the following additional requirements:

(1) Specify the State plan HCBS that the individual will be responsible for directing.

(2) Identify the methods by which the individual will plan, direct or control services, including whether the individual will exercise authority over the employment of service providers and/or authority over expenditures from the individualized budget.

(3) Include appropriate risk management techniques that explicitly recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assure the appropriateness of this plan based upon the resources and support needs of the individual.

(4) Describe the process for facilitating voluntary and involuntary transition from self-direction including any circumstances under which transition out of self-direction is involuntary. There must be state procedures to ensure the continuity of services during the transition from self-direction to other service delivery methods.

(5) Specify the financial management supports, as required in paragraph (e) of this section, to be provided.

(c) *Employer authority.* If the person-centered service plan includes authority to select, manage, or dismiss providers of the State plan HCBS, the person-centered service plan must specify the authority to be exercised by the individual, any limits to the authority, and specify parties responsible for functions outside the authority the individual exercises.

(d) *Budget authority.* If the person-centered service plan includes an individualized budget (which identifies the dollar value of the services and supports under the control and direction of the individual), the person-centered service plan must meet the following requirements:

(1) Describe the method for calculating the dollar values in the budget, based on reliable costs and service utilization.

(2) Define a process for making adjustments in dollar values to reflect changes in an individual's assessment and service plan.

(3) Provide a procedure to evaluate expenditures under the budget.

(4) Not result in payment for medical assistance to the individual.

(e) *Functions in support of self-direction.* When the State elects to offer self-directed State plan HCBS, it must offer the following individualized supports to individuals receiving the services and their representatives:

(1) Information and assistance consistent with sound principles and practice of self-direction.

(2) Financial management supports to meet the following requirements:

(i) Manage Federal, State, and local employment tax, labor, worker's compensation, insurance, and other requirements that apply when the individual functions as the employer of service providers.

(ii) Make financial transactions on behalf of the individual when the individual has personal budget

authority.
(iii) Maintain separate accounts for each individual's budget and provide periodic reports of expenditures against budget in a manner understandable to the individual.
(3) Voluntary training on how to select, manage, and dismiss providers of State plan HCBS.

§ 441.745 State plan HCBS administration: State responsibilities and quality improvement.

(a) *State plan HCBS administration.*
(1) *State responsibilities.* The State must carry out the following responsibilities in administration of its State plan HCBS:
(i) *Number served.* The State will annually provide CMS with the projected number of individuals to be enrolled in the benefit and the actual number of unduplicated individuals enrolled in State plan HCBS in the previous year.
(ii) *Access to services.* The State must grant access to all State plan HCBS assessed to be needed in accordance with a service plan consistent with § 441.725, to individuals who have been determined to be eligible for the State plan HCBS benefit, subject to the following requirements:
(A) A State must determine that provided services meet medical necessity criteria.
(B) A State may limit access to services through targeting criteria established by § 441.710(e)(2).
(C) A State may not limit access to services based upon the income of eligible individuals, the cost of services, or the individual's location in the State.
(iii) *Appeals.* A State must provide individuals with advance notice of and the right to appeal terminations, suspensions, or reductions of Medicaid eligibility or covered services as described in part 431, subpart E.
(2) *Administration.*
(i) *Option for presumptive payment.*
(A) The State may provide for a period of presumptive payment, not to exceed 60 days, for Medicaid eligible individuals the State has reason to believe may be eligible for the State plan HCBS benefit. FFP is available for both services that meet the definition of medical assistance and necessary administrative expenditures for evaluation of eligibility for the State plan HCBS benefit under § 441.715(d) and assessment of need for specific HCBS under § 441.720(a), prior to an individual's receipt of State plan HCBS or determination of ineligibility for the benefit.
(B) If an individual the State has reason to believe may be eligible for the State plan HCBS benefit is evaluated and assessed under the presumptive payment option and found not to be eligible for the benefit, FFP is available for services that meet the definition of medical assistance and necessary administrative expenditures. The individual so determined will not be considered to have enrolled in the State plan HCBS benefit for purposes of determining the annual number of participants in the benefit.
(ii) *Option for Phase-in of Services and Eligibility*
(A) In the event that a State elects to establish targeting criteria through § 441.710(e)(2), the State may limit the enrollment of individuals or the provision services to enrolled individuals based upon criteria described in a phase-in plan, subject to CMS approval. A State which elects to target the State plan HCBS benefit and to phase-in enrollment and/or services must submit a phase-in plan for approval by CMS that describes, at a minimum:
(*1*) The criteria used to limit enrollment or service delivery.
(*2*) The rationale for phasing-in services and/or eligibility.
(*3*) Timelines and benchmarks to ensure that the benefit is available statewide to all eligible individuals within the initial 5-year approval.
(B) If a State elects to phase-in the enrollment of individuals based on highest need, the phase-in plan must use the needs-based criteria described in § 441.715(a) to establish priority for enrollment. Such criteria must be based upon the assessed need of individuals, with higher-need individuals receiving services prior to individuals with lower assessed need.
(C) If a State elects to phase-in the provision of any services, the phase-in plan must include a description of the services that will not be available to all eligible individuals, the rationale for limiting the provision of services, and assurance that all individuals with access to a willing and qualified provider may receive services.
(D) The plan may not include a cap on the number of enrollees.

(E) The plan must include a timeline to assure that all eligible individuals receive all included services prior to the end of the first 5-year approval period, described in paragraph (a)(2)(vi) of this section.
(iii) *Reimbursement methodology.* The State plan amendment to provide State plan HCBS must contain a description of the reimbursement methodology for each covered service, in accordance with CMS sub-regulatory guidance. To the extent that the reimbursement methodologies for any self-directed services differ from those descriptions, the method for setting reimbursement methodology for the self-directed services must also be described.
(iv) *Operation.* The State plan amendment to provide State plan HCBS must contain a description of the State Medicaid agency line of authority for operating the State plan HCBS benefit, including distribution of functions to other entities.
(v) *Modifications.* The agency may request that modifications to the benefit be made effective retroactive to the first day of a fiscal year quarter, or another date after the first day of a fiscal year quarter, in which the amendment is submitted, unless the amendment involves substantive change. Substantive changes may include, but are not limited to, the following:
(A) Revisions to services available under the benefit including elimination or reduction in services, and changes in the scope, amount and duration of the services.
(B) Changes in the qualifications of service providers, rate methodology, or the eligible population.
(*1*) *Request for Amendments.* A request for an amendment that involves a substantive change as determined by CMS—
(*i*) May only take effect on or after the date when the amendment is approved by CMS; and
(*ii*) Must be accompanied by information on how the State will ensure for transitions with minimal adverse impact on individuals impacted by the change.
(*2*) [Reserved]
(vi) *Periods of approval.*
(A) If a State elects to establish targeting criteria through § 441.710(e)(2)(i), the approval of the State Plan Amendment will be in effect for a period of 5 years from the effective date of the amendment. To renew State plan HCBS for an additional 5-year period, the State must provide a written request for renewal to CMS at least 180 days prior to the end of the approval period. CMS approval of a renewal request is contingent upon State adherence to Federal requirements and the state meeting its objectives with respect to quality improvement and beneficiary outcomes.
(B) If a State does not elect to establish targeting criteria through § 441.710(e)(2)(i), the limitations on length of approval does not apply.
(b) *Quality improvement strategy: Program performance and quality of care.* States must develop and implement an HCBS quality improvement strategy that includes a continuous improvement process and measures of program performance and experience of care. The strategy must be proportionate to the scope of services in the State plan HCBS benefit and the number of individuals to be served. The State will make this information available to CMS at a frequency determined by the Secretary or upon request.
(1) *Quality Improvement Strategy.* The quality improvement strategy must include all of the following:
(i) Incorporate a continuous quality improvement process that includes monitoring, remediation, and quality improvement.
(ii) Be evidence-based, and include outcome measures for program performance, quality of care, and individual experience as determined by the Secretary.
(iii) Provide evidence of the establishment of sufficient infrastructure to implement the program effectively.
(iv) Measure individual outcomes associated with the receipt of HCBS, related to the implementation of goals included in the individual service plan.
(2) [Reserved]

PART 447—PAYMENTS FOR SERVICES

■ 19. The authority citation for part 447 continues to read as follows:
Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).
■ 20. Section 447.10 is amended by adding new paragraph (g)(4) to read as follows:

§ 447.10 Prohibition against reassignment of provider claims.

* * * * *

(g) * * *

(4) In the case of a class of practitioners for which the Medicaid program is the primary source of service revenue, payment may be made to a third party on behalf of the individual practitioner for benefits such as health insurance, skills training and other benefits customary for employees.

* * * * *

Authority: (Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program)

Dated: September 18, 2013.

Marilyn Tavenner,

Administrator, Centers for Medicare & Medicaid Services.

Approved: December 9, 2013.

Kathleen Sebelius,

Secretary, Department of Health and Human Services.

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