

Federal Medicaid Waivers

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- **Federal Authority**

- Social Security Act

- 42 U.S. Code Chapter 7 – Social Security

- Subchapter XVI – Supplemental Security Income for Aged, Blind, and Disabled § 1381 – 1385
 - Subchapter XVIII – Health Insurance for the Aged and Disabled (Medicare) § 1395 – 1395III
 - Subchapter XIX – Grants to States for Medical Assistance Programs (The Medicaid Act) § 1396 – 1396w-8

- States Medicaid programs are subject to requirements in 42 USC 1396a(a) -State Plan, if States chooses to participate in Medicaid

- Joint Federal/State funded (42 USC 1396a(a)(2)); federal match depends on state's per capita income (Federal Medical Assistance Percentage (FMAP) not less than 50%)
 - Fair hearing rights (42 U.S.C. 1396a(a)(3))
 - Single State agency to administer program (42 U.S.C. 1396a(a)(5))
 - “Reasonable promptness” for applications (42 U.S.C. 1396a(a)(8))
 - Mandatory eligible groups (42 U.S.C. 1396a(a)(10)(A)(i))
 - Optional eligible groups (42 U.S.C. 1396a(a)(10)(A)(ii))

- State Plan is implemented through state statute and administrative regulation

- **Types of Medicaid Waivers**

- Research and Demonstration Waiver

- §1115 Medicaid Demonstration Waiver

- States can develop experimental, pilot, or demonstration projects that are approved by the Health and Human Services Secretary that will likely promote the objective of Medicaid (provide medical assistance to low-income individuals), such as expanding eligibility, delivery system reforms payment experiments
 - Program Waivers
 - §1915(b) Waiver
 - Waivers to promote cost-effectiveness and efficiency
 - Allows use of Managed Care Organizations
 - §1915(c) Waiver
 - Home and Community Based Services (HCBS) waivers for states without HCBS in their state plans
 - Waivers respecting medical assistance requirement in State plan; scope, etc.; “habilitation services” defined; imposition of certain regulatory limits prohibited; computation of expenditures for certain disabled patients; coordinated services; substitution of participants
- **§1115 [42 U.S.C. 1315] Medicaid Demonstration Waiver**
 - Waives certain federal requirements, but cannot waive federal-state fund matching system or fair hearing rights
 - The Secretary may waive requirements under section 1902 such as statewideness (1902(a)(1)); property and efficient administration (1902(a)(4)); comparability of

services (1902(a)(10)(B)-€); payment of services outside the State(1902(a)(16)); freedom of choice of providers ((1902(a)(23));

- Sec. 1115(a)(1) – the Secretary may waive compliance with any of the requirements of section 2, 402, 454, 1002, 1402, 1602, or 1902, as the case may be, to the extent and for the period he finds necessary to enable such State or States to carry out such project.
- 42 U.S.C. 1315(a)(1) – the Secretary may waive compliance with any of the requirements of section 302, 602, 654, 1202, 1352, 1382, or 1396a of this title, as the case may be, to the extent and for the period he finds necessary to enable such State or States to carry out such project
- Common 1115 Waivers Include:
 - Statewideness – Sec. 1902(a)(1)
 - “[P]rovide that it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them;”
 - Comparability of Services – Sec. 1902(a)(10)(B)
 - [T]hat the medical assistance made available to any individual described in subparagraph (A)—
 - (i) shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual, and

- (ii) shall not be less in amount, duration, or scope than the medical assistance made available to individuals not described in subparagraph (A);
- Freedom of Choice of Providers Sec. 1902(a)(23)
 - [P]rovide that (A) any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services, and (B) an enrollment of an individual eligible for medical assistance in a primary care case-management system (described in section 1915(b)(1)), a 5ermissi managed care organization, or a similar entity shall not restrict the choice of the qualified person from whom the individual may receive services under section 1905(a)(4)(C), except as provided in subsection (g), in section 1915, and in section 1932(a), except that this paragraph shall not apply in the case of Puerto Rico, the Virgin Islands, and Guam, and except that nothing in this paragraph shall be construed as requiring a State to provide medical assistance for such services furnished by a person or entity convicted of a felony under

Federal or State law for an offense which the State agency determines is inconsistent with the best interests of beneficiaries under the State plan or by a provider or supplier to which a moratorium under subsection (kk)(4) is applied during the period of the moratorium;

- The Secretary may approve the use of federal Medicaid funds on generally impermissible expenditures.
 - Sec. 1903 outlines the payments to states that are federally matched, allowable sources of non-federal share of expenditures, and managed care requirements
 - Sec. 1115(a)(2)(A) costs of such project which would not otherwise be included as expenditures under section 3, 455, 1003, 1403, 1603, or 1903, as the case may be, and which are not included as part of the costs of projects under section 1110, shall, to the extent and for the period prescribed by the Secretary, be regarded as expenditures under the State plan or plans approved under such title, or for administration of such State plan or plans, as may be appropriate, and (B) costs of such project which would not otherwise be a permissible use of funds under part A of title IV and which are not included as part of the costs of projects under section 1110, shall to the extent and for the period prescribed by the Secretary, be regarded as a permissible use of funds under such part.
 - 42 U.S.C. 1315(a)(2)(A) costs of such project which would not otherwise be included as expenditures under section 303, 655, 1203, 1353, 1383, or

1396b of this title, as the case may be, and which are not included as part of the costs of projects under section 1310 of this title, shall, to the extent and for the period prescribed by the Secretary, be regarded as expenditures under the State plan or plans approved under such subchapter, or for administration of such State plan or plans, as may be appropriate, and (B) costs of such project which would not otherwise be a permissible use of funds under part A of subchapter IV and which are not included as part of the costs of projects under section 1310 of this title, shall to the extent and for the period prescribed by the Secretary, be regarded as a permissible use of funds under such part.

- Budget Neutrality Required for 1115 Waivers
 - Federal spending would be equal to that without the demonstration project
 - Budget neutrality is not defined under federal statute or regulations but has been in practice for numerous years
 - CMS must approve spending of budget neutrality savings, included in the agreed terms and conditions, to fund federal share of costs not otherwise allowed
 - CMS provides instructions for calculating budget neutrality. Most recent guidance provided in SMD #24-003 dated August 22, 2024.
 - Budget neutrality test that results in limits on federal Medicaid funding the state may receive over the course of the demonstration project period known as that budget neutrality expenditure limit set forth in the terms and conditions

- Applies to demonstration projects under Section 1115(a)(1) and 1115(a)(2)(A).
- Budget neutrality is monitored throughout the demonstration period and a final determination is made by CMS at the conclusion of the approval period.
 - If the state exceeds budget neutrality expenditure limit at the end of the period it must return the excess funds to CMS
 - Monitoring template on CMS website
- Affordable Health Care Act (Sec. 10201(i)) instituted changes to Section 1115 regarding transparency, public input, and evaluation by adding sub section (d) and. (Sec. 1115(d) and 42 U.S.C. 1315(d))
 - 42 C.F.R. pt. 431, subpt. G added to implement requirements under ACA
 - State public notice process (42 C.F.R. §431.408) requires a minimum 30-day public notice and comment period regarding the application for §1115 Waiver application or extension to comprise:
 - Comprehensive description of the application/extension with “sufficient level of detail to ensure meaningful input.” See 42 C.F.R. §431.408(a)(1)(i).
 - Location/website where copies of the application are available for review and comment
 - Postal address/website where written comments may be submitted by the public and the 30-day time period when comments will be accepted

- Location, date, and time of at least two (2) public hearings on separate dates by the State to seek public input on the application at least 20 days prior to the submission of the application.
- Requirements for the contents of the application and extensions can be found at 42 C.F.R. §431.412. These requirements include documentation of the public process conducted by the state, the issues raised by the public comments, and how the state considered these issues in development of the final application.
- Federal public notice process (42 C.F.R. §431.416)
 - Within 15 days of receipt of application (new or extension) CMS will the State a notice of receipt that will include the start date for the 30-day federal comment period. CMS will also publish the notice receipt, complete application with supporting information submitted by the State, proposed effective date of demonstration waiver, and addresses (mail/email) for submission of comments. To its website within the same 15-day timeframe.
 - CMS will provide continued public disclosure by publishing on its website status updates and listings issues raised during public notice process
 - CMS must publish the written comments online (primary or alternative website) and review and consider all comments

by deadline; written response by CMS to public comments will not be provided.

- CMS cannot make a final decision on the application until 45 days after the notice of receipt. However, 42 C.F.R. §431.416(g) provides exceptions to the federal public notice process and CMS may “expedite a decision on a proposed demonstration or demonstration extension request that addresses a natural disaster, public health emergency, or other sudden emergency threats to human lives.”
- Monitoring, Compliance, and Evaluation
 - Implementation
 - The terms and conditions agreed to between the Secretary and the State to implement the demonstration project require the State to conduct period reviews of the implementation, CMS to review documented complaints of the State’s failure to comply with the agreed terms and conditions and the implementation of the waiver, and CMS will promptly share complaints with the State that CMS has received and provide notice of any monitoring or compliance issues.
 - States must hold public forum within 6 months of implementation date and annually thereafter to

solicit comments on the progress of the demonstration project

- Terminations/Suspensions
 - Secretary may terminate or suspend the demonstration project at any time in whole or part whenever the Secretary has determined the State “materially failed to comply with the terms of the demonstration project.” See 42 C.F.R. §431.420(d) (1)
 - Secretary may withdraw waiver/expenditure authorities on finding the project “is not likely to achieve the statutory purposes.” See 42 C.F.R. §431.420(d) (2)
- Evaluation 42 C.F.R. §431.424
 - States must publicly publish their approved evaluation strategy for the demonstration project within 30 days CMS approval.
 - Evaluation plan must include the demonstration hypotheses, the data that will be utilized and baseline value, data collection methods, isolation of the effect of the project from outside factors through use of control or comparison groups, proposed date of final

report, and any other information significant to the State's research.

- Reporting 42 C.F.R. §431.428
 - State must submit annual reports to CMS that include:
 - Policy/administrative difficulties in operation; issues and/or complaints by beneficiaries of the health care delivery system; impact in providing insurance coverage to beneficiaries and uninsured; outcomes of care, quality of care, cost of care, and access to care; results of beneficiary surveys, grievances, and appeals; results of any audits, investigations, or lawsuits that impact the project; financial performance of project; status of progress in achieving demonstration evaluation criteria; State legislative developments that may impact project; results/impact of any project programmatic area that is unique to design or hypothesis of project; summary of annual post-award public forms (comments).

- Draft annual reports must be submitted no later than 90 days after the end of the demonstration year or as specific in the agreed terms and conditions.
 - Draft annual report must be published by the State within 30 days of submission to CMS
 - Final annual report must be submitted within 60 days of the receipt of comments from CMS
 - State must publish the approved final report with 30 days of approval
- §1115 Waiver Application Process
 - Draft Application
 - CMS preprint form
 - State 30-day public comment period and minimum 2 public hearings
 - Submit application to CMS
 - Federal 30-day public comment period
 - CMS review (Health and Human Services and Office of Management and Budget)
 - Budget neutrality required
 - Approval
 - Waivers are generally approved for a 5-year period with)
 - Implementation
 - Monitoring/Evaluation
 - Annual state reports and evaluations

- Amendments/Renewals
 - Extensions are generally approved for three (3) years and five (5) years when the beneficiary population includes those dually eligible in Medicare and Medicaid
- Extensions of 1115 Waivers
 - CMS has “fast track” process to extend demonstrations projects for states meeting the following criteria
 - (1) have had one full extension cycle of the demonstration without substantial programs changes; (2) in compliance with reporting deliverables, positive monitoring and evaluation results indicating objectives of project and Medicaid have been achieved; (3) not proposing major or complex changes; and (4) use streamlined extension application templates
 - Section 1115(a) Extensions
 - States with targeted or compressive demonstration projects may submit an attestation, streamlined extension template application, and if needed reline of term and conditions to outline changes to effectuate any requested program changes.
 - CMS reviews monitor and evaluation information to determine progress on meeting Medicaid objectives and a specific program component the state has requested to change
 - Fast track review offers five (5) year extension period
 - Example provided by CMS

- CMS successfully piloted this fast track process with the extension of a section 1115(a) demonstration in Colorado. The demonstration has been operating since 2002 and maintains federal funding for uninsured pregnant women with family incomes from 141 percent to 195 percent of the federal poverty level. Colorado submitted an extension application with no changes requested and showed positive outcomes in meeting the objectives of the demonstration. CMS' review focused on whether the demonstration had been operating successfully and that the demonstration would meet its future goals. CMS approved the demonstration extension for a 5-year period on July 24, 2015; completing federal review in 98 days.
- CMS does not offer fast track review for complex policy areas such as
 - Medicaid Expansion Programs with enhanced Federal Medical Assistance Percentage (FMAP);
 - Delivery system reform, financing, and payments arrangements that cannot be authorized under state plan authority, including delivery system reform incentive pools;
 - Designated State Health Programs;
 - Demonstrations with dual eligible Medicare and Medicaid populations;

- Establishing Home and Community-Based Services (HCBS), including those discussed in the 2014 HCBS final rule;
 - Enrollment caps and eligibility limitations;
 - Uncompensated care pools
- Section 1115(c) Extensions
 - Available to states with comprehensive demonstration projects proposing no program changes
 - Limited to three (3) year extension unless waiver qualifies for five years for dual eligible enrollees
 - States submit attestation, streamlined extension template application, and abbreviated set of supporting documents
 - CMS required to provide decision within six (6) months of submission by state; deemed granted if no response provided
- Section 1115(f) Extensions
 - States with 1115(c) extensions may submit 1115(f) extensions under an expedited process with proposed program changes
 - 120-day extension review period
 - Within 45 days after receipt of application CMS notifies the State of intent to review of the terms and conditions; failure to notify deemed approval of application

- Within 45 days after notification CMS informs State of proposed changes in terms and conditions; failure to provide deemed approval of application
 - During 30-day period following notification of proposed changes CMS And State negotiate revised terms and conditions
- Limited to three (3) year extension unless waiver qualifies for five years for dual eligible enrollees
- States submit attestation and streamlined extension template application
- **§1915(b) [42 U.S.C. 1396n(b)] Medicaid Waivers to promote cost-effectiveness and efficiency**
 - Purpose of this waiver is to utilized managed care delivery system to increase cost-effectiveness and efficiency in the delivery of health care
 - See §1915(b); 42 U.S.C. 1396n(b); and 42 CFR pt. 438
 - Typically used by states to waiver requirements for comparability, statewidenss, and freedom of choice to implement a managed care delivery system for Medicaid
 - Managed Care is a delivery system to provide health care and additional services through contractual arrangement between state Medicaid agencies and managed care organizations that accept a set number of enrollees per month payments (capitation) for services.
 - 42 C.F.R. 438.2 defines capitation payment as “a payment the State makes periodically to a contractor on behalf of each beneficiary

enrolled under a contract and based on the actuarially sound capitation rate for the provision of services under the State plan.

The State makes the payment regardless of whether the particular beneficiary receives services during the period covered by the payment.”

- Capitation payments can only be made by State and retained by the Managed Care Organization (MCO) for Medicaid eligible enrollees
- CMS must review and approval all contracts, proposed final contracts must be submitted no later than 90 days prior to the effective date of contract. See 42 CFR 438.3
- Contracts are publicly available and should be reviewed
- Managed care programs may also be implemented under state plan authority §1932(a) and §1115 as a demonstration project waiver.
 - May also have concurrent §1915(b) and §1915(c) waivers such as Florida’s Long-Term Care Waiver
- Key differences between a managed care §1915(b) waiver program and managed care state plan are:
 - under §1915(b) states are able to require dual eligibles, American Indians, and children with special health care needs to enroll in a managed care delivery system; State must demonstrate the delivery system is cost-effective, efficient, and consistent with objectives of Medicaid; and approval is limited to 2 years

- Four types of waivers listed in §1915(b)
 - (1) Freedom of Choice - restricts enrollees from receiving services within the managed care network
 - (2) Enrollment Broker – use a central broker to assist enrollees in selecting plan
 - (3) Non-Medicaid Services - uses cost savings to provide additional services to beneficiaries that are not included in federal match funding
 - (4) Selective Contracting - restricts the provider from whom the Medicaid eligible may obtain services
- Cost Effectiveness Required
 - Spending is equal to or less than the cost of the same services without the waiver
 - Measurement is the projected estimate of the cost of the services provided without the waiver compared to the cost of services under the waiver program
 - States must demonstrate that the waiver is cost effective and efficient in the application and quarterly after implementation
- Enrollee Rights
 - State must ensure that MCO enrollees is guaranteed the rights outlined in 42 CFR 438.100(b)(2) and (3).
- Grievance and Appeals
 - All MCOs must have a grievance and appeal system in place

▪ Filing Requirements

- Enrollee may file a grievance or appeal with MCO. Enrollee may request a State Fair Hearing only after receiving notice that an adverse benefit determination was upheld or if MCO failed to adhere to notice and timing requirements.
 - 42 CFR 438.400 - Adverse benefit determination means, in the case of an MCO, PIHP, or PAHP, any of the following:(1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. (2) The reduction, suspension, or termination of a previously authorized service. (3) The denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a “clean claim” at § 447.45(b) of this chapter is not an adverse benefit determination. (4) The failure to provide services in a timely manner, as defined by the State. (5) The failure of an MCO, PIHP, or PAHP to act within the timeframes provided in § 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.(6) For a resident of a rural area with only one MCO, the denial of an enrollee's

request to exercise his or her right, under § 438.52(b)(2)(ii), to obtain services outside the network. (7) The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities

- Timing
 - Enrollee may file a grievance at any time
 - Enrollee has 60 calendar days from the date on the adverse benefit determination notice in which to file a request for an appeal to the managed care plan.
- Timely and adequate notice of an adverse benefit determination in writing
 - Notice must explain: determination made or intended to be made; reason for determination; right of enrollee to information; enrollee's right and procedures to request appeal and a fair hearing; circumstances to expedite appeal process; and enrollee's right to continuance of benefits
 - Review 42 CFR for specific time frames of notices
- General Requirements
 - MCOs must give beneficiaries any reasonable assistance in completing the forms and procedural steps.
 - Process for grievances must: acknowledge receipt of each grievance and appeal; ensure decision makers are qualified, do not have conflicts, and consider all information submitted by

beneficiary; oral inquiries seeking appeal are treated as an appeal; beneficiary has opportunity to present evidence and testimony and to make legal and factual arguments, provide beneficiary with a copy of their case file and other documents in connection with the appeal of the adverse benefit determination free of charge; and include enrollee, authorized representative or legal representative of deceased enrollee's estate.

- Resolution of Grievance

- MCO must resolve each grievance and provide notice to the beneficiary
- Timeframes
 - For standard resolution of a grievance and notice to the affected parties, the timeframe is established by the State but may not exceed 90 calendar days from the day the MCO, PIHP, or PAHP receives the grievance.
 - For standard resolution of an appeal and notice to the affected parties, the State must establish a timeframe that is no longer than 30 calendar days from the day the MCO, PIHP, or PAHP receives the appeal. This timeframe may be extended.
 - For expedited resolution of an appeal and notice to affected parties, the State must establish a timeframe that is no

longer than 72 hours after the MCO, PIHP, or PAHP receives the appeal. This timeframe may be extended.

- Timeframe may be extended for up to 14 calendar days if the beneficiary requests extension or MCO documents need for additional information and how delay is in the beneficiary's interest
- MCO must make reasonable efforts to give beneficiary prompt oral notice of delay; give written notice of reason for the extension to beneficiary; and resolve the appeal expeditiously

- Fair Hearing

- Enrollee may request a State fair hearing only after receiving notice that the MCO, PIHP, or PAHP is upholding the adverse benefit determination or if the MCO, PIHP, or PAHP fails to adhere to the notice and timing requirements in § 438.408, the enrollee is deemed to have exhausted the MCO's appeals process. The enrollee may initiate a State fair hearing.
- The enrollee must have no less than 90 calendar days and no more than 120 calendar days from the date of the MCO's notice of resolution to request a State fair hearing.

- Recordkeeping

- States must require MCOs to maintain records of all grievances and review the information as part of ongoing monitoring procedures and be available upon request by CMS.
- Records must include: general description of the reason for grievance/appeal; date received; date of each review/review meeting; resolution; date of resolution; and name of beneficiary
- Continuation of Benefits
 - MCO must continue the enrollee's benefits if all of the following occur:
 - The enrollee files the request for an appeal timely; appeal involves the termination, suspension, or reduction of previously authorized services; services were ordered by an authorized provider; period covered by the original authorization has not expired; and enrollee timely files for continuation of benefits
 - Timely filed means on or before the later of the following: (i) Within 10 calendar days of the MCO sending the notice of adverse benefit determination (ii) The intended effective date of the MCO's proposed adverse benefit determination.
 - Duration
 - If continued or reinstated by MCO, benefits must be continued until one of following occurs:

- The enrollee withdraws the appeal or request for state fair hearing
 - The enrollee fails to request a state fair hearing and continuation of benefits within 10 calendar days after the MCO sends the notice of an adverse resolution to the enrollee's appeal.
 - A State fair hearing office issues a hearing decision adverse to the enrollee.
- If allowed under MCO's contract, the MCO can recover the cost of services furnished to the enrollee while the appeal and state fair hearing was pending, to the extent that they were furnished solely under the continuation of benefits request and the final decisions was adverse to the enrollee (upholding the adverse benefit determination)
- Effectuation of reversed appeal resolutions.
 - If the MCO or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO must authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires but no later than 72 hours from the date it receives notice reversing the determination.
 - If the MCO or the State fair hearing officer reverses a decision to deny authorization of services, and the enrollee received the

disputed services while the appeal was pending, the MCO or the State must pay for those services, in accordance with State policy and regulations.

- Waiver Application Process

- Preprinted form must be used for initial requests, amendments, and renewals
- Application Includes
 - Program Overview
 - States must describe how Federally-recognized tribes in the State are aware of and have had the opportunity to comment on this waiver proposal (required)
 - Program Description, Wavier Services, Statutory Authority, Delivery Systems, Restriction on Freedom of Choice, and Populations Affect and/or Excluded
 - Access, Provider Capacity, and Utilization Standards
 - Timely Access to Contracted Services, Provider Capacity to Supply Sufficient Contracted Providers, Utilization Standards Specific to Selective Contracting Program
 - Quality
 - Quality Standards and Contract Monitoring
 - Coordination and Continuity-of-Care Standards
 - Program Operations

- How beneficiaries will get information about selective contracting program and processes in place for individuals with special needs
- Cost-Effectiveness and Efficiency
 - Projected waiver expenditures for waiver period (two - five years)
 - Pre-waiver costs, projected waiver costs and difference
 - CMS has 90 days from submission of application to make decisions unless CMS requests additional information in writing Section 1915(f)(2)
 - New 90-day time period begins upon submission of additional information by State
- Annual Reporting
 - State must submit a Medicaid managed care quality rating system report in a form and manner determined by CMS. See 42 CFR 438.535
- **§1915(c) [42 U.S.C. 1396n(c)] Medicaid Waivers for Home and Community Based Services**
 - Goal of 1915(c) Waivers is to provide an array of services sufficient to allow the enrollee to avoid or delay institutionalization
 - See Section 1915(c); 42 U.S.C. 1396n(c); and 42 CFR pt. 441 subpt. G
 - Section 1915(c) allows states to obtain waiver of statewideness (§1902(a)(1), comparability (§1902(a)(10)(B)), and income/resources rules (§1902(a)(10)(C)(i)(III)) to provide home and community-based services to

individuals who without such services would require services in an institutional setting

- Waiver of income and resources rules
 - Exclusion of community spouse's income and allows states to use spousal impoverishment rules in determining eligibility for applicant spouse
 - State can establish eligibility criteria for HCBS Waiver as long as it is no more restrictive than SSI rules for single applicant
 - §1902(a)(10)(C)(i)(III) the single standard to be employed in determining income and resource eligibility for all such groups, and the methodology to be employed in determining such eligibility, which shall be no more restrictive than the methodology which would be employed under the supplemental security income program in the case of groups consisting of aged, blind, or disabled individuals in a State in which such program is in effect, and which shall be no more restrictive than the methodology which would be employed under the appropriate State plan (described in subparagraph (A)(i)) to which such group is most closely categorically related in the case of other groups;
- Number of enrollees in HCBS can be capped by the State and the creation of a waitlist for services. See §1915(c)(4)(A).
 - State's estimated number of enrollees must include those that will replace beneficiaries who leave the waiver, die, or lose eligibility.

- Model waivers limited to 200 beneficiaries at a time
- Enrollees must be determined to need a level of care provided in a hospital, nursing facility, or intermediate care facility (ICF) which would be reimbursed under the state plan (institutional level of care)
- Cost Neutrality required
 - §1915(c)(2)(D) under such waiver the average per capita expenditure estimated by the State in any fiscal year for medical assistance provided with respect to such individuals does not exceed 100 percent of the average per capita expenditure that the State reasonably estimates would have been made in that fiscal year for expenditures under the State plan for such individuals if the waiver had not been granted
 - Expenditures must be reasonably estimated and documented
 - Estimates must be on annual basis for each year of the waiver period
- Services under HCBS Waiver may include:
 - Case management; homemaker (chores/light housekeeping); home health aid; personal care; adult day programs; habilitation services; respite care; supported employment; day treatment or partial hospitalization for individual with chronic mental illness; educational services; prevocational services; other services approved by CMS “as cost effective and necessary to avoid institutionalization.” 42 CFR 440.180
 - Room and board are excluded except when part of respite care services in a facility approved by State that is not a private residence or waiver that “allow personal caregivers as providers of approved waiver services, a

portion of the rent and food that may be reasonably attributed to the unrelated caregiver who resides in the same household with the waiver beneficiary.” 42 CFR 441.310(a)(2)(ii)

- Written Person-Centered Plan

- Planning process for the person-centered plan should include:

- The individual (beneficiary), individual’s authorized representative, those the individual has chose to include, and the case manager qualified to develop an individual care plan. If case manager is same as HCBS provider the State must have conflict of interest protections approved by CMS.
 - “Individuals must be provided with a clear and accessible alternative dispute resolution process.” 42 CFR 441.301(c)(1)(vi)
 - Time at date/time/locate convenience for individual
 - Process should be directed by the individual and the individual should be provided with information and support to ensure the individual directs the process and allows them to make an informed choice.
 - Offers informed choices regarding services and supports and from whom.
 - Cultural considerations, plain language, and in a manner accessible to individual.

- Provides clear conflict-of-interest guidelines and strategies for resolving conflict during planning
- Provide individual with process to request update to plan as needed
- Record of alternative settings that were considered during planning
- Person-Centered Service Plan
 - 42 CFR 441.301(c)(3) Plan must reflect services and supports that are important to the individual to meet the needs identified through an assessment of functional needs... 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:
 - Residential setting chosen by individual that is fully integrated and supports full access to the community;
 - Individual's strength and preferences;
 - Clinical and support needs identified in functional needs assessment;
 - Individual's goals and desired outcomes;
 - Paid and unpaid services and supports to achieve goals and provider of 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."
 - Risk factors and methods to minimize them

- Understandable written plan to the individual and natural supports
 - Identify individual/entity that will monitor plan
 - Finalized and agreed to with informed consent in writing and signed by individual/authorized representative and provider
 - Distributed to individual and those involved in plan
 - Self-directed services included
 - Prevent inclusion of unnecessary or inappropriate services and supports; and
 - Document that any modification of the additional conditions, under paragraph 42 CFR 441.301(c)(4)(vi)(A)-(D)
- Review of Person-Centered Plan
 - Plans must be reviewed and revised: at least every 12 months; significant change in needs or circumstances of individual; or at the individual's request
 - State are required to complete reassessment of functional needs assessment and review and revise person-centered service plan based on reassessment at least every 12 months for no less than 90% of one-year continuous enrollees

- Compliance with this standard begins three years after 7/9/24
- Home and Community Based Services Settings Rule
 - Detailed set of rules adopted to prevent placement of HCBS Waiver enrollees into institutional-like settings. See 42 CF 431.301(c)(4)-(6).
 - HCBS Settings must have all the following qualities:
 - Integrated in and supports full access of individuals to the greater community;
 - Selected by the individual. “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;”
 - Ensures rights to privacy, dignity, and respect, and freedom from coercion and restraint;
 - Enhances individual initiative, autonomy, and independence in making life choices (ADLs, IADLS, physical and social environment);
 - Facilitates individual choice regarding services and supports, and who provides them; and
 - Provider owned settings have additional requirements under 42 CFR 441.301(c)(4)(vi).
 - Settings that are not considered HCBS

- Nursing facility, mental health facility, intermediate care facility (ICF), hospital, and any other locations that have qualities of an institutional setting, as determined by the Secretary
 - 42 CFR 441.301(c)(5)(v) - 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.
- Compliance and Transition
 - State assurance on initial application of compliance with HCBS settings requirements
 - CMS requires transition plans to bring states into compliance with HCBS settings rule; timeframe for transition plans was based on renewal date and effective date of regulation.
 - 30-day public notice and comment period at the State level for proposed transition plans

- State required to submit proof public notice and summary of comments received, reasons why comments were not adopted, and any modifications to plan based on comments.
- Grievance
 - States must have a system for beneficiaries to file a grievance related to the State's or provider's performance of activities under 42 CFR 441.301(c)(1)-(6).
 - Grievance is defined as an expression of dissatisfaction or complaint related to the State's or a provider's performance of the activities described in paragraphs (c)(1) through (6) of this section, regardless of whether remedial action is requested.
 - Compliance required two years after 7/9/24
 - General Requirements
 - The beneficiary/authorized representative may file a grievance at any time. Another individual or entity may file on behalf of, assist, and represent the beneficiary with written consent. Providers are not permitted to file a grievance.
 - State must have written grievance policies and procedures; provide assistance to beneficiaries to access and use grievance system; ensure punitive or retaliatory action is not threatened or taken; accept grievances and requests for extension of timeframes; provide beneficiary with notices and information; review resolution with which the beneficiary is dissatisfied; and provide

information about grievance system to all providers and subcontractors approved to deliver services.

- Process for grievances must: allow either oral or written grievance to be filed; acknowledge receipt of each grievance; ensure decision makers are qualified, do not have conflicts, and consider all information submitted by beneficiary; beneficiary has opportunity to present evidence and testimony and to make legal and factual arguments, provide beneficiary with a copy of their case file free of charge and “sufficiently in advance of the resolution timeframe”; and provide beneficiaries language services free of charge..

▪ Resolution of Grievance

- State must resolve each grievance and provide notice to the beneficiary
- Timeframe not exceed 90 calendar days from the date the State receives the grievance
- Timeframe may be extended for up to 14 calendar days by the State if the beneficiary requests extension or State documents need for additional information and how delay is in the beneficiary’s interest
 - State must make reasonable efforts to give beneficiary prompt oral notice of delay; give written notice of reason for the extension to beneficiary; and resolve the grievance expeditiously

- Recordkeeping
 - States must maintain records of all grievances and review the information as part of ongoing monitoring procedures and be available upon request by CMS.
 - Records must include: general description of the reason for grievance; date received; date of each review/review meeting; resolution; date of resolution; and name of beneficiary.
- Application for Waiver
 - CMS preprinted form recommended but not required
 - Applications are extensive (hundreds of pages)
 - 42 CFR 443.301 outlines the content requirements for waiver requests including State assurances described in §441.302, supporting documents required by §441.303, specific waivers requested, cost neutrality, services provide through person-centered service plan, eligibility, number of enrollees (cap on enrollment), service areas, etc.
 - State Assurances must include: safeguards to protect health and welfare of beneficiaries; financial accountability; evaluation of level of care need of beneficiary (initial and periodic); alternatives of care under waiver (institutional or home and community-based services); average per capita expenditures; actual total expenditures; Institutionalization absent waiver; reporting to CMS of waiver's impact; habilitation services correctly furnished; day

treatment/partial hospitalization services are correctly furnished;
and HCBS payment adequacy to ensure sufficient direct care staff;

CMS has 90 days from submission of application to make decisions unless
CMS requests additional information in writing Section 1915(f)(2)

- New 90-day time period begins upon submission of additional information by State
- Approval for three years (five years for programs that include dually eligibility beneficiaries). Extensions are generally for five years.
 - Public notice is required if “any significant” proposed changes to the State’s methods and standards for setting payment rates for services
- Reporting
 - Compliance Reporting
 - Incident management system every 24 months, CMS may reduce frequency up to once every 60 months
 - Critical incidents, as defined in 42 CFR 441.302(a)(6)(i)(A), in the form and manner, and at a time, specified by CMS
 - Person-Centered Planning annual report
 - Annually the State will provide CMS with information on the waiver's impact on the type, amount, and cost of services provided under the State plan, in the form and manner, and at a time, specified by CMS

- Compliance begins 3 years after 7/9/24; managed care delivery system compliance begins the first rating period for contracts with the MCO, PIHP, or PAHP beginning on or after the date that is 3 years after July 9, 2024.
- Home and Community-Based Services Quality Measure Set
 - Home and Community-Based Services Quality Measure Set are required to be used by States with section 1915(c) waiver programs to promote public transparency related to the administration of Medicaid-covered HCBS
 - States must report every other year on all measures in the Home and Community-Based Services Quality Measure Set that are identified by the Secretary pursuant to 42 CFR 441.312(d)(1)(ii)
 - Compliance begins 4 years after 7/9/24; managed care delivery system compliance begins the first rating period for contracts with the MCO, PIHP, or PAHP beginning on or after the date that is 4 years after July 9, 2024.
- Access Reporting Annually
 - Waiting Lists
 - Description of how State maintains waiting list including if the State screens individuals on waitlist for eligibility, if the State periodically rescreens individuals on waitlist for eligibility, and the frequency of rescreening.
 - Number of people on the waitlist

- Average amount of time on waitlist for individuals newly enrolled in past 12 months
- Access to homemaker, home health aide, personal care, and habilitation services.
 - Average amount of time from when homemaker services, home health aide services, personal care services, and habilitation services initially approved for individuals newly receiving services in past 12 months
 - Percent of authorized hours for homemaker services, home health aide services, personal care services, and habilitation services provided within past 12 months.
- Compliance begins 3 years after 7/9/24; managed care delivery system compliance begins the first rating period for contracts with the MCO, PIHP, or PAHP beginning on or after the date that is 3 years after July 9, 2024.
- Payment Adequacy Reporting Annually
 - States must report percentage of total payments (not including excluded costs) for furnishing homemaker services, home health aide services, personal care, and habilitation services, that is spent on compensation for direct care workers
 - Exclude payments provided under self-directed
 - Compliance begins 4 years after 7/9/24; managed care delivery system compliance begins the first rating period for contracts with

the MCO, PIHP, or PAHP beginning on or after the date that is 4 years after July 9, 2024.

- Medicaid Enrollee Rights
 - Constitutional Due Process
 - Goldberg v. Kelly, 397 U.S. 254 (1970)
 - Procedural due process applies to welfare benefits. Pre-termination evidentiary hearing is necessary to provide due process. Benefit recipients must be provided timely and adequate notice detailing reasons for termination and opportunity to defend by confronting adverse witnesses and present arguments and evidence before an impartial decisionmaker.
 - Notice
 - 42 CFR 431.210 - Notice required under 42 CFR 431.206 (c)(2), (c)(3), or (c)(4) must contain (a) A statement of what action the agency, skilled nursing facility, or nursing facility intends to take and the effective date of such action; (b) A clear statement of the specific reasons supporting the intended action; (c) The specific regulations that support, or the change in Federal or State law that requires, the action; (d) An explanation of (1) The individual's right to request a local evidentiary hearing if one is available, or a State agency hearing; or (2) In cases of an action based on a change in law, the circumstances under which a hearing will be granted; and (e) An explanation of the circumstances under which Medicaid is continued if a hearing is requested.

- State or local agency must send notice at least 10 days before date of action except as permitted under 42 CFR 431.213 (death, voluntary withdrawal, etc) and 431.214 (probable fraud).
- Fair Hearing
 - Hearing is required as outlined 42 CFR 431.220
 - 42 CFR 431.220(b) The agency need not grant a hearing if the sole issue is a Federal or State law requiring an automatic change adversely affecting some or all beneficiaries.
 - Request for Fair Hearing
 - Agency must establish procedures to allow individual and authorized representative to submit hearing requests, including a request for an expedited fair hearing, via website, telephone, mail, in person, and common electronic means.
 - Agency cannot interfere or limit an applicant's or beneficiary's freedom to make a request for a hearing. Agency can assist with submitting and processing request.
 - Agency allow reasonable time, not to exceed 90 days from date of notice of action is mailed, to request a hearing.
 - Continuation of Benefits
 - 42 CFR 431.230 - beneficiary requests a hearing before the date of action, the agency may not terminate or reduce services until a decision is rendered after the hearing unless (1) It is determined at the hearing that the sole issue is one of Federal or State law or

policy; and (2) The agency promptly informs the beneficiary in writing that services are to be terminated or reduced pending the hearing decision.

- Agency may recover costs of continued services if agency action is upheld by hearing decisions.

- Hearing Decisions

- Review 42 CFR 431.244 for detailed description of hearing decision requirements.

- Corrective Action

- The agency must promptly make corrective payments, retroactive to the date an incorrect action was taken, and, if appropriate, provide for admission or readmission of an individual to a facility if hearing decision is favorable to the applicant or beneficiary; or agency decides in the applicant's or beneficiary's favor before the hearing. See 42 CFR 431.246

- Federal Rights

- Provisions of the Medicaid Act have been determined to be enforceable as individual civil rights under 42 U.S.C. §1983 (Civil Action for Deprivation of Rights). See *Gonzaga Univ. v. Doe*, 536 U.S. 273 (2002) and *Blessing v. Freestone*, 520 U.S. 329 (1997).

- Enrollees be provided medical assistance with reasonable promptness. 42 USC 1396a(a)(8); 42 CFR 435.930(a).
 - Enrollees be provided a fair hearing. 42 USC 1396a(a)(3);

- That services to children meet the requirements of Early & Periodic Screening, Diagnosis and Treatment (EPSDT). 42 USC 1396a(a)(43)
- Americans with Disabilities Act 42 USC 12132
 - Olmstead v. LC, 527 U.S. 582 (1999), Supreme Court decision found that unnecessary institutionalization of persons with disabilities was a violation of the Americans with Disabilities Act of 1990. States must provide services in the “most integrated setting appropriate to the needs of qualified individuals with disabilities.” 28 CFR 35.130(d)