This is the third in a periodic series of special reports on federal policies governing the financing of services for mentally retarded and other handicapped persons. The general aim of these Federal Funding i Inquiry reports is to explore, in detail, the implications of new and emerging federal assis- tance *programs and policies as* they impact *on disabled citizens]*

December 1, 1981

THE MEDICAID HOME AND COMMUNITY-BASED CARE WAIVER AUTHORITY

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FOREWORD

Due to increasing resource constraints, many states are seeking more efficient and economical ways to organize and operate their human service programs. During 1981, the monumental task of accomplishing such cost-cutting reforms has been complicated by the efforts of the Reagan Administration to reduce the federal government's role in financing health, education, housing and social welfare programs.

Earlier this year, Congress, at the urging of the Reagan Administration, enacted a sweeping package of legislative and budgetary changes which mandate reductions in federal domestic expenditures totalling $130 billion over the next three years. This measure, called the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35), also delegates increased responsibility to the states, by authorizing a series of nine federal-state block grant programs and trimming eligibility and benefits under most major social entitlement programs, such as Social Security, Medicare, Medicaid, Food Stamps and unemployment compensation.

Generally, the enactment of the reconciliation legislation--combined with the President's subsequent call for further cuts in FY 1982, 1983 and 1984 spending--has created an era of uncertainty in state capitals and a sense of impending doom upon many service providers. However, in the midst of this gloomy fiscal outlook, there is one feature of P.L. 97-35 which potentially could be of assistance to states interested in developing more cost-effective methods of serving needy elderly and disabled persons--i.e., the so-called home and community-based care waiver authority.

Section 2176 of the 1981 Reconciliation Act adds a new provision to Title XIX of the Social Security Act (Section 1915(c)), granting the Secretary of Health and Human Services authority to waive existing statutory requirements in order to permit states to finance through the federal-state Medicaid program non-institutional services for elderly and disabled persons who otherwise would require care in Title XlX-certified institutions. The principal purpose of this report is to offer state mental retardation officials and other interested parties a practical guide to federal policies governing the new home and community-based care waiver authority and to explain the steps necessary to prepare a sound waiver request.

The report explores the meaning and applications of Section 1915(c) in terms of: (a) its basic, underlying rationale and legislative history; (b) statutory and regulatory conditions

for approval of a state's waiver request; (c) beneficiary eligibility criteria; (d) definitions of reimbursable services; and (e) other statutory and regulatory requirements (see Chapters I-V). A copy of the actual provisions of Section 1915(c) and the implementing regulations, published by the Department of Health and Human Services on October 1, 1981, are included in the appendices (see Appendices A and B).

Suggested issues that state officials might consider in drafting a request for a Section 1915 (c) waiver are raided in each of the substantive chapters (see Chapters II-V). Chapter VI contains two hypothetical examples of waiver requests. These sample cases were developed primarily to illustrate the many factors a state must consider in calculating the comparative average per capita costs of providing long term care services, as required under HHS regulations. A draft version of this chapter was informally reviewed by the staff of HCFA's Bureau of Program Policy and subsequently revised to take their comments into account. However,, readers should recognize that the authors are solely responsible for the contents of this, as well as other, chapters of the report.

Finally, the closing chapter analyzes the result of a preliminary survey of state mental retardation directors, conducted by the NASMRPD staff. The aim of this survey was to determine the number of states planning to submit Section 1915 (c) waiver requests, the extent to which services to mentally retarded and other developmentally disabled clients will be included in such requests, and the types of services which each state plans to provide under its waiver program.

This publication represents the third in the Association's special Federal Funding Inquiry series. The general aim of these reports is to explore, in detail, new and emerging federal assistance programs and policies as they impact on disabled citizens. Previous issues in the 1981 series include: Status of the Reagan Budget Proposals: An Interim Analysis of the Implications for Developmentally Disabled Citizens (June, 1981); and Congressional Action on the Reagan Budget Proposals (August, 1981).*

The manuscript for this report was prepared by the undersigned, with considerable help from Stephanie Mensh and Karen Percy of the Association's staff. It is our fervent hope that responsible state officials will find the report's contents of assistance as they undertake the task of preparing home and community-based care waiver requests.

Robert M. Gettings
Executive Director

December 1, 1981

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* Copies available upon request, by writing NASMRPD, 2001 Jeff Davis Highway, Arlington, Virginia 22202 ($5.00 per copy; $4.00 for orders of 10 or more copies). All orders totalling $15.00 or less must be prepaid.

Chapter I

BASIC RATIONALE UNDERLYING THE WAIVER AUTHORITY

A. The Dilemma of Long Term Care Services

In recent years federal and state policy makers have expressed growing concern about the burgeoning public costs of providing long term care services to elderly and disabled citizens. Several converging forces have led many astute observers to predict that services to chronically disabled persons will soon emerge as a public policy crisis of epic proportions. Among these forces are:

- the rapid growth in the percentage of the total population over 65 years of age. In 1900, three million Americans were in the 6 5-3nd-over age group, or about four percent of the total population. By 1980, 25 million people were 6 5 and older, or 11 percent of the total population. And, by the year 20 30, demographers predict 34 million people—or one in every eight Americans—will be 65 or older. The growth rate among the so-called "old-old" population (i.e., over 80) is expected to be even more precipitous—more than doubling over the next fifty years.[1] These figures would be of only passing academic interest, except that past studies and surveys have demonstrated a consistent correlation between age and the incidence of physical and mental disabilities; thus, the already escalating demand for long term care services can be expected to continue, and even accelerate, in the decades ahead.

« alterations in family structures have led to increased reliance on formal service organizations to provide long term services. The increased divorce rate, the declining birth rate, the growing number of married women in the work force, the growth in single parent households, the escalating number of four and even five generation families have combined to undermine society's past reliance on the nuclear family as the exclusive caregiver for elderly and disabled relatives. Given these trends combined with the inexorable demographic realities discussed above, it now appears certain that the percentage of elderly and disabled citizens who are reliant on formal service networks will continue to grow in the years ahead.

National Conference of Social Welfare, Long Term Care: In Search of Solutions (NCSW: Washington, D.C., 1981).

- the spiraling increase in the cost of providing long term care, combined with growing reliance on government to pay for such servcies. Total nursing home expenditures rose from $1.3 billion in 1965 to nearly $17.9 billion in 1979. Of this amount, government (primarily through the federal-state Medicaid program) paid for 56.7 percent of the cost, while private payments made up 4 3.2 percent of total outlays. The growing dependence on government aid is illustrated by the fact that, while the total cost of nursing home services rose by 280 percent between 1970 and 1979, public expenditures, over this same period, increased by 34 3 percent. Assuming the continuation of current policies, it has been estimated that total nursing home costs will reach $76 billion by the year 1990.[3]

- the overreliance on institutions as a mechanism for delivering long term ca""e services to elderly and* disabled persons. The Congressional Budget Office has estimated that over 90 percent of all public dollars expended on long term care services are obligated for nursing home care;[4] and yet, there are at least as many persons outside of nursing homes who require extensive assistance in basic daily living skills (some would suggest two or three times as many) as currently reside in nursing homes.[2] Another frequently cited benchmark of the "institutional bias" built into government assistance programs is that less than one percent of all Medicaid payments are obligated for home health services, even though Medicaid dollars make up over 87 percent of all public expenditures for long term care services.

Despite the growing recognition of the nature and the scope of the problems posed by long term care services for the elderly and disabled, public policymakers have been reluctant, thus far, to take any concerted action to solve these problems. Two primary reasons can be cited for this inaction. First, the potential public costs of a reasonably comprehensive reform strategy, by most estimates, would be astronomical.

U.S. Department of Health and Human Services, Health Care Financing Administration, Long Term Care: Background and Future Directions (HHS: Washington, D.C.), January, 1981.

Op. cit., National Conference of Social Welfare.

4 U.S. Congress, Congressional Budget Office, Long Term Care for the Elderly and Disabled (U.S. Government Printing Office: Washington, D.C.), February, 1977.

For example, in a study conducted in 1976, the Congressional Budget Office estimated that, if the government were to underwrite a system of long term care insurance and eliminate financial need as a basis for eligibility (i.e., use the same social insurance principle underlying the Social Security system), total public costs for such services would balloon from $5.8 billion in FY 1975 to between $28 to $50 billion by FY 1985. Furthermore, the study concluded that even relatively modest, incremental liberalizations in existing government benefits would add billions of dollars to federal and state costs. When you add such mind-boggling fiscal projections to the other, more immediate pressures on the public purse—most notably deferred military outlays, the chronic double-digit inflation in the acute health care sector and continuing instability in the Social Security trust funds--it is not surprising that long term care reform generally has been assigned a lower priority in Washington.

Second, despite numerous studies over the past few years, there is little firm basis for predicting how present and potential consumers of long term care services (and their responsible relatives) might respond to new government initiatives in this area. Given estimates that up to seventy percent of long term services are currently provided through the family and other informal caregivers, government officials worry that expanded public benefits--especially in the form of home-based services--might have the effect of inducing more families to relinquish their role as caregiver in favor of publicly-funded services. They point to the experience of adding home health benefits under Medicare and Medicaid in the early 1970's—a move which, in retrospective, seems to have done little to dampen the demand for nursing home placements, but, rather, has made public funding available to a new segment of the LTC population. Furthermore, the studies of consumer behavior which have been completed have led HCFA officials to conclude that "...broader coverage of in-home and community-based benefits would largely go to a new population rather than substituting for more expensive nursing home care".6 Of course, this does not mean that such expanded coverage is a socially undesirable policy direction, simply that any rationale for such action must take into account a more complex set of cost and benefit variables than sometimes is suggested by advocates of home and community-based services.

[5]Op. cit., U.S. Congress, Congressional Budget Office.

[6]U.S. Department of Health and Human Services, Health Care Financing Administration, Long Term Care: Background and Future Directions (HHS: Washington, D.C.), January, 1981.

B. The Relationship of Mental Retardation Services to the Overall Long Term Care Crisis

Mentally retarded and other persons who are appropriately identified as developmentally disabled* should be viewed as an identifiable sub-set of the overall target population in need of long term care services. As such, they have many similarities to other segments of the LTC population, including the need for an individually tailored package of health and social services of indefinite duration.

Yet, despite notable efforts in recent years to bridge the overlapping service networks which address the needs of distinctive LTC subpopulations and build a framework for a national long term care policy, policymakers in Washington and state capitals have tended to treat the term "long term care" as though it were synonomous with care services for frail elderly persons. Considering the fact that most recent disability surveys have reported that well over half of all Americans with severe, chronic disabilities are 55 years of age or older, it is not surprising that long term care should be so closely

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* For purposes of this discussion, the term "developmental disability" will be used as that term is defined in Section 102 (7) of the federal Developmental Disabilities Assistance and Bill of Rights Act—i.e., "...a severe and chronic disability of a person which—(A) is attributable to a mental or physical impairment or combination of mental and physical impairments; (B) is manifested before the person attains age twenty-two; (C) is likely to continue indefinitely; (D) results in substantial functional limitations in three or more of the following areas of major life activity: (i) self-care, (ii) receptive and expressive language, (iii) learning, (iv) mobility, (v) self-direction, (vi) capacity for independent living, and (vii) economic self-sufficiency; and (E) reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated."

The reader should be aware of the fact that a significant proportion of persons afflicted with etiological conditions associated with the term developemntal disability (i.e., mental retardation, cerebral palsy, epilepsy, autism, etc.) have relatively mild forms of the disability and, thus, do not meet the criteria outlined in the definition above. The focus of this paper is on that portion of the population (variously estimated at between 2 and 3 million children and adults) who do meet the statutory definition and, thus, are in need of long term care services of various types.

identified with the elderly. Furthermore, to the extent that the functional needs of elderly and non-elderly disabled persons are similar, the practical implications of age variations, in terms of shaping public policy, may be slight.

In the real world, however, there are significant differences, as well as similarities, between various subgroups within the overall LTC population. For example, developmentally disabled persons differ from the frail elderly in the following significant ways:

- the developmentally disabled individual generally requires an array of services over his or her entire lifespan, in contrast to just during adult hood or, in the case of the elderly, during the waning years of life;

- the developmentally disabled person needs a changing constellation of services during different stages of his or her life, in contrast to the elderly person or an individual disabled during adulthood, who typically requires a gradually increasing intensity of care;

- due to the early onset of disability, the developmentally disabled individual is much less likely than elderly or other chronically disabled persons to have residual life skills which help to compensate for his or her impairments;

- programs for the developmentally disabled generally are oriented toward habilitation, growth and acquisi tion of skills, in contrast to rehabilitation or prevention of deterioration; and

- specialized services early in life, such as infant stimulation, education, corrective surgery/therapy and pre-vocational and vocational training, are vital to developmentally disabled persons, in con trast to elderly and chronically disabled individuals who need medical care and social-recreational ser vices primarily later in life.

Each of these differences carries with it significant implications for how services should be organized and delivered. An effective national long term care policy—as it is reflected in federal and state laws—must be sufficiently flexible to allow state and local administrators and service providers to take these differences into account 'in meeting the service needs of this particular segment of the LTC population.

C. Recent Long Term Care Legislation in Congress

Over the past ten years, literally hundreds of bills have been introduced in Congress to modify various aspects of federal law governing long term care for the elderly and disabled. The principal intent of many of these measures was to liberalize home health benefits for elderly persons. Others proposed more sweeping reforms of Medicare, Medicaid, social services, SSI and housing policy, usually with the aim of encouraging disabled elderly individuals to live at home or in other non-medical, sheltered care settings.

This is not the appropriate place to analyze the contents of relevant long term care legislation that has been introduced and considered by Congress over the past ten years. Suffice to say, for present purposes, that: (1) the basic thrust of most such bills was to assist in preventing the placement of needy, disabled persons in nursing homes and other institutional settings, wherever possible; and (2) with rare exceptions, the target population for such legislation was limited to frail elderly individuals. The reasons cited for the proposed changes in federal policy generally involved either the potential cost-savings associated with home care and other forms of non-institutional services or the humanistic and programmatic benefits of allowing people to live independently, outside a 24-hour care setting.

D. Consideration of Long Term Care Policy in the Context of the 1981 Reconciliation Bill

The efforts of President Reagan to control the growth in federal health care outlays, as part of his overall plan to restrict federal domestic expenditures, formed the general policical context in which long term care policies were considered during the first session of the 97th Congress. The new Administration's plans for limiting future Medicare and Medicaid expenditures were first announced by the President in a televised address to the Nation on February 18, 1981. Later, the White House provided detailed proposals in its March 10 budget revision and in a draft bill submitted to Congress on May 18.

1. The Reagan Plan. The Administration's draft bill, entitled "The Health Care Financing Admendments of 1981", proposed the following basic changes in federal policy: (a) restricting future Medicaid outlays by imposing a ceiling, or cap, on federal expenditures, effective July 1, 1981 (i.e., limited in FY 1982 to five percent above estimated FY 1981 outlays and by a cost-of-living deflator thereafter); (b) granting the states increased flexibility in determining how to utilize federal Title XIX dollars; and (c) authorizing several cost saving changes in the Medicare program.

One aspect of the Administration's plan to allow the states greater flexibility included a provision to permit states to cover certain non-medical services for Title XlX-eligible individuals who otherwise would require institutional care in a Medicaid-certified facility. Under this proposal, the Secretary of Health and Human Services would have been empowered to define the types of "personal care services" reimbursable under Title XIX, if a state elected to include optional coverage for such services in its Medicaid plan. The only statutory restrictions on the Secretary authority, as proposed, was that such payments could not include the cost of room and board and would have to be made pursuant to an individualized plan of care.

The intent of this provision was to encourage states to develop less costly non-institutional living and programming alternatives to large institutions for poor mentally retarded, mentally ill and elderly clients. The actual language of the draft bill did not define the precise range of services that would be reimbursable, but, instead, left this decision to the discretion of the Secretary, However, correspondence between HHS and OMB officials during the develop- ment of the Administration's legislative package made it clear that this provision was designed to permit states the option of funding such services as case management, sheltered living, and other habilitative and rehabilitative services, when it could be shown that such arrangements would be less costly than placing clients in Title XlX-certified institutions.

The important point to keep in raind is that the proposal to allow Title XIX reimbursement for non-institutional services was included in the Administration's bill, not because OMB and HHS officials believed that home and/or community-based services are more humane and effective, but primary as a mechanism to help states curb future increases in Medicaid costs. It is also critical to recognize that this provision was closely tied to the Administration's proposal to cap federal Medicaid outlays, since if a ceiling were imposed on federal Title XIX expenditures, the onus of any future cost overruns due to the coverage of non-institutional services would rest squarely with the states.

2. Senate Action. Even before the Administration's bill was forwarded to Congress, the Senate Finance Committee had completed its mark-up of amendments to programs under its jurisdiction, for inclusion in the omnibus

reconciliation bill (S. 1377). In the area of Medicaid policy, the Republican-controlled Committee generally followed the Administration's recommendations, with some modifications. More specifically, the Committee agreed to impose a cap on federal Medicaid outlays in FY 1982, although it set a somewhat more generous inflation factor (i.e., 9% instead of 5%) for FY 1982. To offset the dollar savings lost as a result of the higher inflation factor, Committee members proposed that the federal matching floor be lowered from 5 0 percent to 40 percent, thus reducing the dollar entitlements of twelve states and the District of Columbia.

The Finance Committee also agreed to the Administration's proposal allowing states the option of receiving federal reimbursement for "personal care services". However, rather than delegating authority to the Secretary to approve such services as an additional, optional element of a state's Medicaid plan (as proposed by the Administration), the Committee's bill would have empowered the Secretary to approve waivers permitting states to include such an optional service in its plan.

In addition to the exclusion against payments for room and board and the requirement for individual plans, the Finance Committee made approval of a waiver conditional upon the submittal of satisfactory assurances that necessary safeguards would be taken by the state to protect the health and welfare of Medicaid clients participating in such non-institutional services. The specific types of services reimbursable under the rubric of "personal care and other services" also were enumerated in the Committee's bill, including case management, supervised living, home services, rehabilitation, and "any other non-medical services (other than room and board) approved by the Secretary, which are provided pursuant to a plan of care to an individual who is mentally ill, mentally retarded, or otherwise at risk of being institutionalized..."

The explicit recognition in the Senate's bill that states would be entitled to claim federal financial participation for non-medical services provided to non-elderly, Medicaid recipients (including mentally ill and mentally retarded persons), who were at-risk of institutionalization,marked an important departure in the Congressional debate over federal long term care policy, although this possibility was certainly implicit in the discussions leading up to the development of the Administration's bill. As noted earlier, most past attempts to authorize Medicaid reimbursement for non-institutional services had focused exclusively on services to eligible elderly clients.

House Action. While the Senate Finance Committee reached a consensus on its version of the Medicaid reconciliation amendments in early May, the counterpart unit in the House—the Committee on Energy and Commerce—eventually reached an impasse, after weeks of internal debate. The deadlock was finally broken when the House Budget Committee agreed to floor votes on both the minority and majority versions of the Committee's reconciliation amendments. As a result of some complex parlimentary maneuvering, the Republican leadership eventually decided not to bring the minority substitute package up for a vote and, therefore, the majority amendments eventually prevailed.

In the area of Medicaid, the differences between the package of amendments supported by the Committee's Democratic majority and the alternative backed by the Republican minority (plus several conservative Democrats) was quite striking. The most significant difference was that the Democratic version rejected the Administration-proposed cap on federal Medicaid payments, substituting in its place a series of .across-the-board reductions in federal Title XIX payments to the states; by contrast, the Republican version included a cap on future Medicaid outlays.

The Medicaid amendments eventually built into the House-passed version of the reconciliation measure (H.R. 3982) also included a modified version of a bill to authorize Medicaid payments for certain home and community-based services. This provision of H.R. 3982 was based on a bill initially introduced by Representatives Henry Waxman (D-CA) and Claude Pepper (D-FL) in 1979. Under the provisions of the modified Waxman-Pepper language, states would have been permitted to cover home and community-based care under their Medicaid program (as an optional service), if they prepared and received HHS approval for a community care plan. Under the plan, states would have been required to provide comprehensive, individualized assessments of all persons eligible or applying for Medicaid coverage in skilled nursing and intermediate care facilities. The purpose of this plan was to determine whether recipients needed a level of care comparable to that provided in a SNF or an ICF setting. After October 1, 1982, states would have to provide assurances that no elderly or disabled

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* For additional details, see Congressional Action on the Reagan Budget Proposals (see full citation on p. v.)

person would be admitted to a SNF, ICF or ICF/MR facility unless such a comprehensive assessment had been completed.

In addition, under the House bill, states with approved community care plans would have been permitted to bill Medicaid for the following types of services: nursing care, home health aides, personal care, medical supplies and equipment, physical and occupational therapy, speech pathology and audiology, homemaker services, adult day care, respite care, case management and such other services as would assist elderly and handicapped persons to remain in the community. The House Committee on Energy and Commerce made clear in its accompanying report that it intended the term "adult day services" to encompass habilitative services for mentally retarded and other developmentally disabled persons.

Like the Senate bill, the House passed version of H.R. 3982 would have required that individual care plans be developed for each recipient of Medicaid-funded home and community care services. The House language, however, added several provisos not included in the Senate measure, including requirements that: (a) potential recipients of non-institutional services be informed of the feasible service alternatives and given a choice between institutional and community-based care modalities; (b) states be required to establish minimum and maximum reimbursement rates for home and community-based services; (c) states be obligated to submit information on the operation of Medicaid-reimbursable, non-institutional services, in accordance with a uniform data collection plan promulgated by HHS; (d) the Secretary be permitted to approve, upon the request of a state, a one time, three year waiver of the statutory provision that all Medicaid services be provided on a statewide basis; and (e) state expenditures for institutional and non-institutional services under its community care plan not exceed the amount the state otherwise would have expended on all long term care services through its Medicaid program.

Although the House Committee's stated rationale for authorizing Medicaid payments for home and community-based services evidenced a genuine concern about the undesirable social consequences of unnecessary or premature institutionalization, the potential cost savings associated with such non-institutional services were also a motivating factor. Once the Committee's majority members agreed not to impose a cap on Medicaid expenditures, they had to find alternative methods of

achieving the $1 billion savings target mandated under the reconciliation instructions in the First Concurrent Budget Resolution for FY 1982.* The main device for achieving this objective was the across-the-board payment reductions mentioned above (3% in FY 1982; 2% in FY 1983 and 1% in FY 1984). But a variety of other changes also were made in Medicaid policy, with the intent of helping states control the escalating costs of Medicaid services. The inclusion of the home and community-based care option was one of these changes.

4. Conference Committee Action. The final, compromise version of the home and community-based care provision, hammered out by a joint House-Senate conference committee in late July, represents a blending of the language of the House and Senate-passed versions of the reconciliation bill. This final language is contained in the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35), as signed into law by President Reagan on August 13.

Section 2176 of P.L. 97-35 adds a new Section 1915(c) to Title XIX of the Social Security Act (see Appendix A for the actual statutory language), authorizing the Secretary of HHS to waive federal requirements necessary to enable states to cover, under their Medicaid plans, personal care and other services (excluding room and board costs) for individuals who, without such services, would require institutional care in a Title XlX-certified facility. In order to qualify for such a waiver, a state must:

« *determine that eligible individuals would otherwise require care in a Title XlX-aertified skilled nursing or intermediate care facility.* In an explanatory statement accompanying the bill, the conferees made it clear that such a determination must involve more than a physician certification of eligibility for nursing home care; all related medical and non-medical factors bearing on the individual's need for institutionalization must be taken into account.

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* For further details see Status of the Reagan Budget Proposals An Interim Analysis of the Implications for Developmentally Disabled Citizens (for a full citation see p. v).

- *establish that -it is reasonable to furnish eligible individuals with such alternative services, in accordance with an individualized, written plan of care.* **The conferees** stressed that the selection of the most appropriate long term care service option should be based on an evaluation of the individual's needs, as well as the individual's own preference, rather than short-term cost considerations.

- *provide for the development of individual$_3$ written care plans on each person receiving alternative services covered by the waiver. determine that the alternative services provided to such Medicaid-eligible persons does not result in average per capita expenditures in excess of those which would have been incurred if the affected individuals were institutionalized.* In addition to the cost of ICF or SNF care, the conferees noted, a state should include in its calculations the cost of any additional physician visits, hospitalization, prescription drugs, etc. which are separately billed to Medicaid.

In requesting a waiver, a state may include the following types of alternative services for Title XIX-eligible persons who are at-risk of institutionalization: case management services, homemaker/home health aide services, personal care services, adult day health, habilitation services, respite care and "...such other services requested by the State as the Secretary may approve." Traditional health and medical services also may be furnished on behalf of such individuals, including nursing care, medical supplies and equipment, physical and occupational therapy and speech pathology and audiology.

A state is permitted, under the terms of the new waiver provision, to establish limits on the amount, scope and duration of services rendered to eligible individuals. However, in order to provide an appropriate mix of services tailored to the individual needs of participating clients, the conferees pointed out, "...it might be inadvisable to set definitive limits on each service, since the written plan of care delineates the number and frequency of services... The conferees also noted that "...the State may establish a per capita ceiling on the total cost of each client's care."

The Secretary may approve a waiver under this new section of the Act for an initial period of three years and, upon request of the state, extend the waiver for additional three year periods, unless he finds that the state has not lived up to its assurances.

The other substantive differences between the House and Senate versions of the community care amendments were resolved in the following manner:

- As noted above, the House bill would have prohibited the Secretary from approving community care coverage unless a state provided assurances that such services would not result in increased aggregate. expenditures for long term care ser vices. The conference substitute specifies that the average per diem cost of community-based care to partici- pating clients may not exceed the cost of providing institutional care to these same individuals.

- The House bill, unlike the Senate ver sion, would have permitted the Secretary to include room and board as an allowable cost under its community care plan. The conference substitute follows the Senate language by excluding room and board as a reimbursable element of service.

- The conference substitute includes a Senate amendment which stipulates that the Secre tary can grant a community care waiver only if a state provides assurances that necessary steps have been taken to safeguard the health and welfare of participating clients. The states also must agree to maintain and make available to the Secretary appropriate financial records documenting the cost of rendering such services.

- The House bill would have required that federal reimbursement for ICF and SNF services be withdrawn, effective October 1, 1982, on be half of all individuals who had not received a comprehensive assessment of their need for long term institutional care prior to admis- sion, except in urgent circumstances specified by the Secretary. The conferees dropped this provision from the final bill.

- The conference language includes a House provision which allows the Secretary to grant a waiver of the statewideness require- ment, in approving a community care waiver. No statutory limitation, however, was placed on the length of time such a waiver could be in effect.

E. Administrative Implementation

Less than two months after the omnibus reconciliation bill was signed into law the Department of Health and Human Services, through its Health Care Financing Administration, issued interim final regulations implementing the new home and community-based care waiver authority. Departmental officials decided to forego the usual process of promulgating proposed rules in this instance, since the applicable section of the law was immediately effective and,therefore, further delays in issuing final regulations "...would be contrary to the public interest."

Thus, the regulations, as published in the Federal Register on October 1, have an immediate effective date. However, the preamble to the October 1 rules (see Appendix B) does indicate that the Department will consider any comments on these regulations that are mailed prior to December 30, 1981 and, if necessary, revisions will be made at a later date.

HCFA officials emphasized, in the preamble to the rules, that states will be given broad latitude in defining services and establishing standards and eligibility criteria under the new home and community-based care waiver program. The agency's general aim in preparing these rules was to "...give the states the maximum opportunity for innovation in furnishing non-institutional services... with a minimum of Federal regulations." The rules, therefore, attempt to provide basic parameters, instead of detailed service delivery requirements, as has been the Department's practice in the past. The acceptability of a state's waiver request will be evaluated by HCFA officials using "...the statutory requirements rather than against a detailed additional set of Federal guidelines or criteria."

HCFA has promised to provide states with technical assistance in both the formulation of the waiver application and the development of new community services; but, federal officials stress that all choices regarding the types and extent of non-institutional services, as well as the manner in which they are organized and delivered, will be left to the discretion of the requesting state.

The following four chapters of this report will review the detailed requirements governing home and community-based waiver requests, as reflected in Section 1915 (c) of the Act and HHS's implementing regulations. Chapter II will

outline the basic assurances a state must provide to qualify for a waiver. Chapter III will discuss the general and specific conditions under which a state may treat clients as eligible for non-institutional services under a waiver, while Chapter IV will elaborate on the types of non-institutional services potentially reimbursable under this authority. Finally, other features of the waiver process will be considered in Chapter V, including the format and contents of a state's waiver request, HCFA's review process, and subsequent federal monitoring of the state's compliance with its waiver assurances.

Chapter II

CONDITIONS FOR APPROVAL OF A WAIVER

In order to qualify for a home and community-based care waiver, a state must submit an application to HCFA that meets the statutory requirements of Section 1915 (c). As indicated in the preceding chapter, the October 1 rules implementing this new waiver authority generally restate the requirements enumerated in the statute, with some elaboration on the Department's understanding of Congressional intent, but few additional specifications regarding how such provisions are to be carried out.

The main prerequisites for approval of a state's waiver request are incorporated in a series of six statutory assurances which each participating state must provide to the satisfaction of the Secretary. These assurances, contained in Section 1915(c)(2) of the Act, include:

- *the provision of safeguards to protect the health and welfare of clients, including adequate standards governing provider participation;*

  procedures and processes to assure financial accountability for funds expended on non-institutional services provided under the waiver;

- *provisions for evaluating the service needs of all Medicaid eligible recipients who may qualify for non-institutional services offered under the state 's waiver program to determine if they otherwise are likely to require care in a Title XIX-ceriified skilled nursing or intermediate care facility;*

- *procedures for offering recipients (or their representatives) a choice between institutional and non-institutional services, if they are found eligible for home and community-based services;*

- *evidence that average per capita expenditures under the waiver will not exceed average per capita expenditures if the waiver were not granted; and*

- *the provision of information and data on the impact of the waiver, including the types, amount and cost of services provided and the health and welfare of the recipients.*

A. Health and Welfare Safeguards

In the preamble to the October 1 regulations, HCFA officials explained that the federal rules do not attempt to define the safeguards required to protect the health and welfare of participants in Title XlX-funded, non-institutional services or prescribe how such safeguards are to be developed. Instead, in keeping with the general philosophy of the Reagan Administration, HCFA took the position that it is the state's responsibility to specify which safeguards are necessary, to define them, specify how they will be developed and implemented, and explain how they satisfy the statutory requirement. However, the law does mandate that the state have "...adequate standards for provider participation..." (Section 1915(c)(2)(A)). In addition, if a state has licensure or certification requirements governing any service covered by the waiver, or providers of such services, it must assure HCFA that these state standards will be met.

In framing measures to protect the health, and welfare of beneficiaries participating in non-institutional services provided under the waiver, state officials must decide:

1. *What types of safeguards will be provided?* In states which plan to include under their waiver programs day-time residential and support services which are currently funded through non-Medicaid sources, it is quite possible that existing operating standards or certification procedures include adequate safeguards or can be modified to accomplish this purpose. Similarly, a state may have methods of monitoring the quality of services rendered through such programs which can be adopted, as is, or modified in order to satisfy this Section 1915(c) requirement.

2. *What specific standards governing provider partici pation will be instituted?* If the state's request contemplates the provision of several distinct types of Title XlX-reimbursable, non-institutional services (e.g., daytime habilitative services, case management, respite care, etc.), then the state's written proposal should indicate whether uniform or differential participation criteria will be applied to various types of services and/or classes of providers.

3. *What existing state licensure/certification standards will apply to services provided under the waiver and any individuals /agencies furnishing such services?* For example, should a state have licensing standards governing the provision of daytime habilitative services (including minimum requirements for agency

licensure) and contemplate, under its waiver request, seeking Medicaid reimbursement for such specialized services to Title XlX-eligible retarded beneficiaries, then it must assure HCFA, in its written proposal, that such standards will be met by all licensed provider agencies.

4. *How will the state's proposed measures to protect the health and welfare of benefioiari.es be operationalized?* **Whether the health and welfare requirements** a **state intends to implement are incorporated in licensing standards, certification criteria or other administrative procedures, it will be necessary to indicate the process through which such standards/criteria will be monitored to insure provider compliance. In other words, state officials will have to spell out. the monitoring and enforcement process that will be used. Again, a state might elect to apply existing processes and procedures, assuming they offer** adequate **assurance of provider compliance.**

B. Financial Accountability

The state also must assure HCFA that it will maintain, and require providers to maintain, financial accountability for funds expended under the waiver. It is the state's responsibility to inform the Department how it will meet this requirement, as well as how it will assure that there is an audit trail by which all state and federal funds can be traced.

Among the questions a state must consider **in** designing **procedures for maintaining accountability of funds are:**

1. *What steps will be taken to assure adequate and. timely financial reporting by both state agencies and licensed/ certified private providers of non-institutional ser vices under the waiver?* **Procedures for reporting and monitoring fund expenditures must be outlined in sufficient detail to convince HCFA officials that there will be adequate financial control exercised by the state and a clear audit trail.**

2. *Bow will the state insure that average per capita data on the various types of non-institutional services furnished under the waiver are maintained and made available to HHS* ***and*** *GAO?* **States with approved waiver programs will be required to supply such comparative cost data to the Department (as well as GAO auditors) and, therefore, must specify in their initial proposal how such data will be collected, analyzed and reported.**

C. Individual Assessments

Under the provisions of Section 1915 (c) (2) (B) of the Act, participating states are required to evaluate each potential recipient's need for SNF, ICF or ICF/MR level of care before certifying the individual as eligible to participate in non-institutional services offered under its waiver program. If the potential recipient currently resides in a Title XIX long term care facility and his/her continued need for this level of care has been recertified in accordance with Section 1903(g) of the Act, no further assessment of need is required, unless the state chooses to do so. If, however, the potential applicant is not currently residing in a Title XIX long term care facility, his or her eligibility for non-institutional services under the waiver hinges on a determination that without such services the beneficiary in question would require care in a SNF, ICF or ICF/MR facility. In completing such evaluations the state must use the SNF and ICF level of care criteria contained in 42 CFR 440.40 and 440.150, respectively. At the option of the state, other medical and non-medical factors also may be considered, if the state regards them as relevant to reaching its determination concerning the service needs of potential beneficiaries .

As part of its waiver request, a state must: (1) include a copy of the written assessment instrument that will be used; (2) describe how assessments will be performed; and (3) specify who has responsibility for conducting such assessments. In addition to describing the party or parties responsible for performing the individualized assessments, the state must outline the criteria that it will use to evaluate and reevaluate the recipients' need for SNF/ICF-level services and specify when such evaluations and reevaluations will be conducted. In addition, HCFA requires that the state maintain written documentation of all such evaluations and reevaluations, either directly or through provider agencies.

In developing procedures for evaluating the eligibility of potential recipients of non-institutional services under its waiver program, a state will have to consider:

1. *What objective criteria and procedures wilt be used to determine whether potential recipients of non-institutional services would require care in a SNF$_3$ ICF or ICF/MR facility, if such non-institutional services were not available to them?* Perhaps the most critical element of a state's waiver pro-posal is the criteria and orocess for determining whether a potential recipient of home and community-based services would require institutionalization in

the absence of such services. Obviously, it is often difficult to predict, on the basis of a client's health or developmental status, family history, etc., who would require institutionalization if community services were unavailable. Yet, the state must set forth in its proposal a credible set of criteria for making such judgements, as well as an objective process for applying these criteria.

2. *How and by whom will such individual evaluations be conducted and what assessment instrument will be used?* In one form or another, many state mental retardation agencies already use interdisciplinary assessment teams to determine the eligibility of retarded clients for admission to state-operated and state supported day and residential services. Where such teams exist, their functions might be expanded and/or modified to include the determination of recipient eligibility for non-institutional services under the waiver. In the state's waiver request, the qualifications of persons conducting such assessments must be spelled out and a copy of the current or pro posed assessment instrument must be attached.

3. *What steps will be taken to assure that proper records of client assessments and reassessments are maintained and made available for review by HHS and GAO officials?* The state need not maintain such records itself, but it must have policies to assure that they are maintained by licensed providers and made accessible to state, HHS and GAO officials, upon request.

D. Informing Beneficiaries of Service Options

Beneficiaries determined to be likely to require SNF/ICF-level of care must be informed of the feasible alternatives and given a choice as to which type of service--i.e., institutional or non-institutional--they wish to receive. This requirement, however, need not apply to beneficiaries for whom there is a reasonable expectation that the cost of home and community-based services will be more than the cost of SNF or ICF-level care, if the state has indicated that such individuals will be excluded from non-institutional coverage under its waiver program. The state must explain in its waiver request how this requirement will be met. Under the federal regulations, however, the state will not be obligated to document that each beneficiary or his/her representative has been informed of the choices available to them.

State officials must consider the following questions in deciding how to carry out its obligations to inform beneficiaries of feasible long term care service options, in both institutional and non-institutional settings:

1. How *when and by whom will beneficiaries (or their-parents/guardian) be informed of their right to choose between available institutional and non-institutional service options.* Some states already have statutory or regulatory requirements that a retarded client and/or his parents/guardian (or other legally responsible relatives) must partici pate in the preparation of the individual program plan. In such instances, it may make logical sense to link such beneficiary choices to the IPP process. States where no such legal requirement exists, none theless, may want to consider offering the benefi ciary (or his parents/guardian) a choice of available services as part of the individual program planning process, as described in its waiver proposal.

2. *How will the state fulfill this requirement in the case of clients without a responsible parent or legal guardian, who either have been adjudicated incompetent or whose mental impairments raise serious doubts regarding their capacity to understand the choices and exercise informed consent?* Presumably, in most states, there will be a significant number of retarded clients who fall into this category and, therefore, state officials will have to develop plans for obtaining the informed consent of such clients (or their representative) before placing them in a non-institutional service program under the waiver.

3. *What steps will be taken to assure that beneficiaries who are not offered the choice of home or community-based services are permitted to request a fair hearing, in accordance with the provisions of 42 CFR Part 431₃ Subpart E?* Unless the reason for the denial is that the group of which the beneficiary is a part is not included in the scope of the state's waiver program, a state must provide a fair hearing to any beneficiary or applicant who has been denied home or community-based services, upon request.

E. Average Per Capita Expenditures

The state, in its waiver request, must provide assurances that average per capita expenditures under the waiver, as reasonably estimated by the state, will not exceed average per capita expenditure without the waiver. Under federal regulations, the term "average per capita expenditures" is defined as aggregate Medicaid payment for all long-term care services furnished by the state, taking into account the utilization of each type of service, divided by the number of beneficiaries expected to receive such services. These estimates must cover each fiscal year during the three year waiver period.

In its waiver application, a state must furnish HCFA with detailed information and data on anticipated per capita expenditures, both with and without the requested waiver*; it also must describe how these estimates were developed and the factors employed *in* deriving them. More spec fically, the state must base it calculations of comparative average per capita cost, using the following mathematical equation set forth in the regulations:

$$\frac{(A \times B) + \{C \times D)}{F + H} \qquad \frac{(F \times G) + (H \times I)}{F + H}$$

Where:

A = the estimated number of beneficiaries who would receive the level of care provided in a SNF, ICF or ICF/MR under the

B = the estimated Medicaid payment per eligible user of such institutional care under A.

C - the estimated number of beneficiaries who would receive home and community-based services under the waiver or other non-institutional alternative services included under the state's Medic-aid plan

D = the estimated Medicaid payment per eligible user of such home and community-based services under C

F = the estimated number of beneficiaries who would likely receive the level of care provided in a ICF or ICF/MR in the absence of a waiver^

G = the estimated Medicaid payment per eligible user of such institutional care under F.

H = the estimated number of beneficiaries who would receive any of the non-institutional, long-term care services otherwise provided under the state's Medicaid plan as an alternative to institutional care, in the absence of a waiver.

I = the estimated Medicaid payment per eligible user of the non-institutional services referred to in H

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* Note that a state is not required to include cost estimates for acute health care services paid for through Medicaid on behalf of participants in services provided under the waiver, since HCFA has indicated that the inclusion of such estimates "...would simply make the calculations more burdensome."

Chapter VI illustrates the use of this formula for estimating average per capita expenditures through the application of two hypothetical case examples (see pp. 39-60).

In calculating whether average per capita expenditures *under the waiver* are less than or greater than comparable expenditures *without a waiver,* state officials must take into consideration some of the following questions:

1. *Assuming that Title XIX reimbursement IS available for home and community-based services d.efined in the state's waiver proposal, what will be the impact on the aggregate number of residents served in Medicaid-certified long term care facilities (i.e., SNFs, ICFs and ICF/MRs) over the three year period of the waiver?* Theoretically, the availability of Medicaid payments for such non-institutional services should dampen demand for admission to Title XlX-certified institutions. However, depending on a variety of factors (e.g., past deinstitutionalization efforts, availability of community service providers, etc.), the specific effects in any given state may vary from slowing the rate of increase in the number of Medicaid-certified LTC beds to a significant decline in the number of such beds. As suggested by the hypothetical case examples in Chapter VI, the antici pated impact of the waiver on the number of certified institutional beds will be a major determinent of the scope of non-institutional services a state is able to cover under its waiver program.

2. *Conversely, assuming that a waiver is NOT approved, what will be the impact on the aggregate number of residents served in Medicaid-certified long term care beds over the next three years?* At least on a comparative basis, one would anticipate increased demand for Medicaid-certified beds, if Title XIX reimbursement is not available for home and community-based services. However, the actual rate of increase will be influenced by many factors. For example, a state which suffers sharp reductions in support for existing non-institutional community services (due to cuts in state purchase-of-care dollars and/or reductions in federal Title XX allotments) might reasonably project a more precipitous increase in demand for Title XlX-certified institutional beds than another state which faces less severe budgetary pressures (i.e., all other factors being equal). Again, as illustrated in Chapter VI, a state's estimates of growth in its institutionalized popula-tion (i.e., in SNFs, ICFs and ICF/MRs) in the absence of a waiver will have a major bearing on the scope of Title XIX-funded, non-institutional services it will be able to offer under its waiver program.

F. Annual Impact Report

The state must give assurances that it will provide HCFA, annually, with information on the impact of the waiver, as it affects the types and amount of services provided under the state plan and the health and welfare of beneficiaries. Such information must be consistent with a data collection plan HCFA will promulgate at a later date.

In order to meet its obligation to furnish HCFA with annual information on the impact of its waiver program, a state will have to determine:

1. *What procedures and processes must be established to 'insure the collection of information required by HCFA on the health and welfare of beneficiaries participating in non-institutional services offered under the waiver and the actual per capita costs of furnishing such services?* **Until HCFA issues its** data collection plan, it will not be possible for participating states to develop their own, internal procedures. Nonetheless, in offering the required assurances, a state should consider the general processes and procedures that will be employed to collect, store and analyze the necessary data.

2. *What obligations will be placed on direct providers of non-institutional services under the waiver to insure that necessary service, cost and client devel opmental data are collected and how will this data be aggregated and reported to the federal governmeyit?* Obviously, it is important that eligible providers of non-institutional services have a clear understanding of their reporting obligations from the onset of the program, especially if they have not been held to the same level of accountability in the past.

* * * * *

It should be clear from the discussion above that responsible state officials will have to take numerous factors into account in responding to the statutory assurances required under Section 1915(c)• The aim of this chapter has been to outline some of the issues a state must consider in formulating its response to these assurances.

Chapter III

RECIPIENT ELIGIBILITY

Participation in non-institutional services provided under a state's home and community-based waiver program is premised on a dual test of eligibility. First, a potential recipient of such services must meet the state's economic means test for Medicaid eligibility. And, second, the state must determine, through an objective assessment of the client's needs, that he or she would require placement in an SNF, ICF or ICF/MR facility if such Title XlX-reimbursable, non-institutional services were unavailable.

A. Financial Eligibility

Under current Title XIX regulations, states are permitted to establish special, higher income and resource standards governing the Medicaid eligibility of institutionalized recipients than apply to individuals living at home or in other non-medical settings (42 CFR 435.231). A state's institutional income eligibility level, however, may not exceed 300 percent of the federal SSI community-based payment standard (42 CFR 435.722 and 435.1005). Since the present federal SSI payment level for an individual is $264.70 per month (and $397.00 for a couple), this means that a state may set a monthly income standard of up to $794.10 for institutionalized adults (or $1191.00 for an eligible couple), after disregarding any income not countable in determining eligibility for SSI or optional state supplementary payments.

Most states have elected to take advantage of this option to set higher income standards for institutional residents However, in so doing, they have created a disincentive to placing such clients back into community settings, since they lose Medicaid eligibility as soon as they are discharged from the institution. In order to address this problem, the new regulations (42 CFR 435.232) permit states to use the higher institutional income eligibility standard for aged, blind and disabled persons in the community who: (a) are not eligible for SSI or state supplemental payments because of their income; (b)' have incomes below the institutional eligibility standards specified in the state's Medicaid plan; (c) would be eligible for Medicaid benefits if institutionalized; and (d) will receive home and community-based services under the waiver.

Low income elderly persons, whose limited income from Social Security, private pensions and/or earnings push them over the basic SSI means test, are expected to be

the principal beneficiaries of this regulatory change. But, some disabled individuals also may be affected— especially adults disabled later in life and developmentally disabled children living with their natural families, when the family does not meet the state's AFDC means test, but, nonetheless, has limited income and resources. [N.B., in most instances, developmentally disabled adults will be categorically eligible for SSI benefits, since, by federal law, the income and resources of their family is not "deemed" to be available to them.]

If a state elects to establish a higher income eligibility standard for Title XlX-reimbursable home and community-based services under its waiver program (in accordance with the provisions of 42 CFR 435.232), it must require all recipients with income and resources above the categorical eligibility standard to share in the cost of providing such services, according to a fee schedule established by the state Medicaid agency. For purposes of determining the amount to be deducted from a state's payment for home and community-based services, in such instances, the regulations divide the states into two categories—i.e., those which provide Medicaid to all SSI beneficiaries (or to all SSI beneficiaries plus recipients of state supplemental benefits) and those with more restrictive Medicaid eligibility requirements than SSI (42 CFR 435.726 and 435.735, respectively). In both cases, the method for calculating the maximum amount allowed for maintainance expenses (i.e., in determining the benefi- clary's share of service costs) parallels the existing requirements governing institutional services (42 CFR 435.725 and 435.733, respectively).

In developing its waiver proposal, a state must consider the following questions related to the financial eligibility of potential recipients of home and community-based services :

1, *Should higher- income eligibility criteria be established for recipients of home and community-based services under the proposed waiver program, as permitted under Section 435.232 of HHS regulations?* In most states, the answer to this question will be influenced by the income eligibility level established for institutionalized persons under the state's existing Medicaid plan, the range of services to be covered, and the type of waiver proposal the state is planning to submit (i.e., a waiver request limited to eligible developmentally disabled clients versus an "umbrella" request for all eligible aged, blind and disabled recipients). If a state, for example, has not established higher income eligibility standards for institutionalized beneficiaries, it may not do so for recipients of

home and community-based services (unless it simultaneously sets higher standards for institutionalized persons as well). Similarly, a state which intends to focus its Title XIX-reimbursable community-based services primarily on developmentally disabled adults, may decide against seeking a higher income standard for recipients of services under its waiver program, since most substantially disabled adults who are likely to qualify for such services are already SSI recipients and, thus, categorically eligible for Medicaid benefits. Finally, all other factors being equal, a state which plans to submit an "umbrella" waiver proposal for the aged, blind and disabled probably will find it more advantageous to set a higher income standard for recipients, than a state which plans to limit its proposed services to eligible developmentally disabled beneficiaries. Elderly persons simply are more likely to have income from other sources which disqualify them for SSI benefits.

2. *Assuming that a states does elect to establish higher income eligibility standards for home and community-based services under its waiver program, what type of fee schedule should be developed, in accordance with the provisions of 42 CFR 435.726 or 435.735?* As indicated above, a state must establish a fee-schedule or cost-sharing arrangement for home and community-based services, if it elects to extend eligibility to persons who would not otherwise meet the SSI eligibility test while living at home or in an alternative (non-medical) community setting. In developing such a schedule, state officials may disregard a reasonable amount of the beneficiary's income to cover basic maintenance, provided they stay within the limits set by Section 435.726 (for states covering all SSI beneficiaries) or 435.735 (for states with more restrictive requirements than SSI).

B. Service Needs

In addition to the income/resource test, a potential recipient will be considered eligible for home and community-based services under a Section 1915 (c) waiver only after the state has determined, through an individualized assessment of the person's long term care needs, that he or she would be likely to require care in a SNF, ICF or ICF/MR facility in the absence of the proposed non-institutional services. As explained in Chapter II, a state must specify in its waiver proposal the objective criteria that will be used in making such determinations, the process through which individualized assessment will be conducted and the qualifications of personnel involved (see pp. 19-20).

One other eligibility issue which state officials must consider is whether certain, otherwise qualified recipients will be treated as ineligible for home and community-based services under the state's waiver program because similar long term care services offered by SNF, ICF and ICF/MR facilities would be less costly to provide. If a state elects to refuse such services to any recipient, it must be prepared to defend this decision on the grounds that it is reasonable to anticipate that the cost of home or community-based services for such individuals would exceed the cost of the level of care provided in a SNF, ICF or ICF/MR facility. The rationale underlying this provision is that the states should not be forced to provide services to a Medicaid recipient at home or in another community-based setting when such services could be provided as effectively and at less cost in a Title XlX-certified institution.

C. Plan of Care

IN accordance with Section 1915 (c) (1) of the Act, any home or community-based service provided to an eligible recipient must be furnished in accordance with the terms of an individualized, written plan of care. HHS regulations grant participating states broad discretion in designing such plans of care and prescribing who is responsible for developing them. HCFA officials indicated that they expect the plan of care to specify the medical and other services the recipient will receive, their frequency, and the type of provider who will be furnishing them. Plans of care are subject to the state's approval, in accordance with a process established by state officials. However, the state's waiver request must include a description of the qualifications of the individual(s) who will be responsible for developing the plans of care (see Chapter II for a discussion of issues to be considered by state officials in developing a waiver request, pp. 19-20).

Chapter IV

REIMBURSABLE SERVICES

Section 1915 (c) (4) (B) of the Act allows a state to cover the following types of services under its home and community-based care waiver program:

- case management
- homemaker services
- home health aides
- personal care
- adult day health services
- habilitation services
- respite care
- "such other services... as the Secretary may approve."

The statute, however,does not contain specific definitions of the above terms. Furthermore, in line with the Department's basic philosophy of giving the states maximum flexibility to design and implement their own waiver programs, HHS officials elected not to include service definitions in the October 1 regulations. Instead, the states are required to define the services they elect to cover in their waiver requests.

Despite the lack of precise statutory and regulatory definitions of reimbursable services, the legislative history of Section 1915 (c) offers some insights into how Congress expects these terms to be interpreted. The explanations contained in the report of the House Energy and Commerce Committee (H. Rept. 97-158), the conference report on the legislation (H. Rept. 97-208) and the preamble to HHS's October 1 regulations are summarized below.

A. Case Management

The House Committee's report, as well as the conference report, describes case management as a system "...under which responsibility for locating, coordinating and monitoring long term care services in behalf of a recipient rests with a defined person or agency." It also makes clear the case manager should "...be responsible for locating available sources of help from within the family and the community, so that the burden of care will not be exclusively borne by formal health and social agencies" (p. 321-322, H. Rept. 97-158).

B. Homemaker Services

The conference committee's report indicates that Congress intends the term "homemaker services" to be used in the same manner as it is currently used under Title XX of the

Social Security Act. The preamble to the October 1 rules goes on to specify that such services consist of "...general household activities (meal preparation and routine household care) provided by a trained homemaker when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for himself or others in the home." (p. 48533, Federal Register, October 1, 1981.)

C. Home Health Aides

The term "home health aide services", the House report explains, is currently defined in the Medicaid manual. It "...typically includes the performance of simple procedures such as the extension of therapy services, personal care, ambulation and exercise, household services essential to health care at home, assistance with medications that are ordinarily self-administered, reporting changes in the patient's condition and needs and completing appropriate records." (pp. 48534, Federal Register', October 1, 1981.)

D. Personal Care

The term "personal care" also has been a Medicaid-reirabursable service for a number of years and, as such, is defined in existing regulations (42 CFR 440.170(f)). For purposes of the waiver program, HCFA has the same understanding of the term—i.e., services furnished to a recipient in his or her home that are prescribed by a physician in accordance with the recipient's plan of treatment and provided by an individual who is: (a) qualified; (b) supervised by a registered nurse; and (c) not a member of the recipient's family. Thus, a state may choose to furnish home health aides and personal care services under its existing state plan, without seeking a home and community-based care waiver; or they may seek a waiver to provide such services in a manner that departs from the established regulatory definitions.

For example, let us assume that a state is desirous of seeking reimbursement for personal care services rendered to eligible developmentally disabled clients residing in specialized foster family homes, but responsible officials believed that it would be less costly and more effective to place caregivers under the supervision of a Qualified Mental Retardation Professional, rather than a registered nurse. Then, it might be advisable to seek reimbursement for personal care under its waiver program, by including in its request to HHS a full explanation of how such services would be defined, organized and delivered.

E. Adult Day Health Services

The House Committee's report describes adult day health services as encompassing "...both health and social services needed to insure the optimal functioning of the client..." It also makes clear that such services may include "habilitation services suitable for the care of the mentally retarded and the developmentally disabled" (p. 321, H. Rept. 97-158). The preamble to HHS's implementing regulations go on to suggest that "...such care should be furnished for four or more hours per day on a regularly scheduled basis, for one or more days a week in an outpatient setting" (p. 48534, Federal Register, October 1, 1981).

The Department also indicates that, despite the general statutory prohibition against covering room and board costs under a Section 1915 (c) waiver, states may claim ' Medicaid reimbursement for meals served as part of a qualified adult day health program. In explaining its reasons for reaching this conclusion, the Department points out that the House-Senate conferees indicated it was their intent that the term be interpreted in the same manner as it is currently used under the Title XX social services program. Federal Title XX policy has long considered meals as a reimbursable cost of providing an adult day health service.

F. Habilitation Services

The conference committee on the reconciliation bill indicated that habilitation services include "...both health and social services needed to insure optimal functioning of the mentally retarded and the developmentally disabled" (p. 966, H. Rept. 97-208).

G. Respite Care

The conference report describes respite care as short term assistance provided to individuals unable to care for themselves due to the temporary absence (or need for relief) of those persons normally furnishing such care. It goes on to indicate that these services may be furnished in the client's home or in an alternative facility approved by the state, such as a foster home, a hospital, a nursing home or a community residential facility.

Since Section 1915(c)(4)(B) specifically allows states to cover respite care services under its waiver program, HHS has "...concluded that Congress intend [ed] to create an exception to the general statutory prohibition against [covering] room and board..." as a Medicaid-reimbursable expense (p. 48534, Federal Register, October 1, 1981). Therefore, the Department's regulations permit a state to claim reimbursement for respite care services under

its waiver program, including any room and board expenditures resulting from the provision of such services outside a private residence.

H. Other Services

In addition to the named services specified above, the statute permits a state to request coverage of other services under its waiver program. These services may include, but are not necessarily limited to, nursing care, medical equipment and supplies, physical and occupational therapy, speech pathology and audiology, and minor adaptations to the home. However, a state must demonstrate, to the satisfaction of the Secretary, that such services will be a cost-effective element of its waiver program (i.e., their cost will not raise per capita expenditures for home and community-based care to more than the comparable cost of institutional care), describe the services in detail and provide HCFA with assurances that the services are necessary to avoid institutionalization.

In framing a waiver request, state officials must take the following questions into account:

1. *What services should he included under the state's Section 1915 (c) waiver program?* The decision regarding the types and range of reimbursable services to offer under the state's waiver program will be influenced by a number of factors, including the state's fundamental programmatic objectives, perceived priority service gaps (especially those most likely to influence future demand for institu tional services), the per capita costs of delivering such services (compared to available institutional service options) and the real or potential availability of ser vice providers. Thus, for example, other factors being equal, a state which plans a significant reduction in its Medicaid-certified institutional population will probably have a more favorable per capita expenditure ratio than a state which anticipates no reduction in its combined SNF, ICF and ICF/MR population; therefore, the former state will be in a more advantageous position to include additional non-institutional services in its waiver pro gram (see Chapter VI for an illustration of this point). Similarly, if state officials view the availability of daytime habilitative services as an essential prerequisite to institutional avoidance, then it makes sense to give higher priority to this service in shaping the state's waiver program, than other possible service options.

2. *Should the state choose to use generic or specialized descriptors of the services that will he provided to eligihle development ally disabled clients under its*

waiver program? To a large extent, the way services are defined will be affected by the type of waiver proposal a state plans to submit. Thus, for example, if a state is developing a waiver request which is limited to eligible MR/DD clients, it may make sense to cover adult activity services for severely/multiply-handicapped persons under the rubric of "habilitation services" (rather than "adult day health services"), since, presumably, the more circumscribed description will: (a) be less subject to later audit exceptions (i.e., on the grounds that operational components of the service do not coincide with the general purposes of a health-related service); and (b) minimize pressure to open such services to other groups of elderly and disabled persons in need of various types of daytime programming.

On the other hand, if a state plans to submit an "umbrella" waiver request, covering non-institutional services to ail eligible aged, blind and disabled persons, then it usually will make sense to employ a service descriptor that is sufficiently broad to encompass services to varying sub-populations. In this case, for example, it may be advantageous to use the term "adult day health services" to cover the various types of health and social service programs that will be available to aged, blind and disabled clients who are at-risk of institutionalization. However, in defining the service and describing the standards that providers will be expected to meet, a state should permit differentation between the programs available to specialized sub-groups of the at-risk population, where the service needs of such groups so dictate. For example, in a day health service for frail elderly clients it may be appropriate to require more rigorous nursing surveillance and supervision than would be the case in a similar day program for younger developmentally disabled or chronically mentally ill persons. By contrast, standards for develop-mentally-oriented programming in a day training setting for non-elderly, developmentally disabled or chronically mentally ill clients might be more demanding than in a similar program for the frail elderly. A state's service descriptors and standards should allow for such accommodations, even when the state elects to provide similar waiver services under a common title.

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The aim of this chapter has been to outline the service choices available to a state and suggest some of the factors which should be taken into account in deciding which services to include in a state's Section 1915 (c) waiver program. Clearly, the selection of the services to be provided is one of the most critical choices state officials must make. Therefore, great care should be exercised in the selection and description of non-institutional services reimbursable under the waiver, as well as the manner in which they will be delivered and monitored.

Chapter V

OTHER FEATURES OF THE WAIVER PROCESS

HHS regulations do not contain detailed specifications regarding the format and contents of a state's waiver request. But, they do require a state to include certain specified information and supportive documentation. The purpose of this chapter is to review the mandated elements of a state's waiver request, the types of waivers that may be requested, and the review and post-approval monitoring processes that will be employed by the Health Care Financing Administration.

A. Contents and Format

In keeping with HHS's basic decision to grant the states broad discretion in formulating their waiver programs, the October 1 regulations place relatively few constraints on the organization and contents of a state's waiver request, provided it includes the following informational elements:

* A description of the services the state is planning to offer under its waiver program and assurances that such services will be provided only to eligible beneficiaries.

- A description of now the state will comply with the statutory requirement that all services provided under its waiver program are furnished in accordance with written, individualized care plans. In addition to outlining the process by which such plans will be developed and approved, a state must list the qualifications of individuals who will be responsible for preparing such care plans.

- The six assurances discussed in Chapter II.

- Supportive documentation describing: (1) the health and welfare safeguards the state will institute; (2) the records and information that will be maintained to assure the financial accountability of Medicaid funds; (3) the agency's plan for evaluating and reevaluating the eligibility of potential recipients, including how and by whom these evaluations will be conducted (including a copy of the client evaluation instrument to be used and an indication of the written records to be maintained); (5) the agency's estimates of per capita expenditures for institutional and non-institutional services (based on projected utilization rates and costs), both with and without the requested waiver, using the formula specified in Section 441.303(d) of HHS's regulations (see Chapter II for details).

A state may organize the above information in any manner it sees fit and include such other information and data in its waiver proposal as it feels is necessary to describe the methods and procedures to be used in delivering the specified non-institutional services.

B. Types and Duration of Waivers

As emphasized throughout this report, the basic purpose of a Section 1915 (c) waiver is to permit a state to provide home and community-based services, not otherwise reimbursable under a federal-state Medicaid plan, to Title XlX-eligible elderly and/or disabled persons who would require, care in a SNF, ICF or ICF/MR facility if such non-institutional services were unavailable to them.

Initially, such waiver requests will be approved for a three year period and they may be extended for additional three year periods, if the state so requests and HCFA finds that, the state has complied with the terms of the initial waiver. Should HCFA determine that a state is not meeting the assurances contained in its waiver request or any other applicable waiver requirements, the state will be notified of these findings and given an opportunity to rebut them at a hearing. The waiver may be terminated if HCFA officials determine, after the hearing, that the state is not in compliance. The preamble to the October 1 rules makes it clear that excessive costs (i.e., actual per capita expenditures under the waiver which exceed estimated, comparable costs without the waiver) will be considered grounds for terminating a state's waiver.

If a state wishes to voluntarily terminate its waiver before the completion of the three-year period, it must submit a written request to HCFA stating its intent at least 30 days before the action is taken. Whether HCFA or the state terminates the waiver, the state must notify beneficiaries receiving services under the waiver 30 days before ending services. The state, however, is not required to offer beneficiaries a hearing when a waiver is terminated.

States also may elect to restrict certain services to specified categories of eligible clients in limited geographic locations, instead of across the entire state. If a state wishes to target services in this manner (e.g., as part of a pilot project), it must apply for a waiver of Medicaid provisions requiring that services be made available to all needy Medicaid beneficiaries statewide. Such targeting may involve either geographic restrictions on the availability of services (in which case a waiver of Section 1902(a)(1) should be requested), limitations on the target population eligible for services (in which case a waiver of Section 1902(a)(10) should be sought), or both. HCFA officials suggest that states planning to submit a target population-specific waiver request (i.e., one in which

service eligibility will be limited to one segment of the elderly or disabled population at risk of institutionalization) ask that the so-called comparability requirements of the statute (Section 1902(a) (10)) be waived for purposes of its home and community-based services program.

Finally, if a state intends to deny non-institutional services to certain otherwise eligible beneficiaries on the grounds that it can reasonably be expected that such services would cost more than comparable services provided in a SNF, ICF or ICF/MR facility, the state must explain in its waiver request how such determinations will be made and implemented. In other words, a state must be able to demonstrate that it has reasonable procedures for determining which specific clients are likely to be more costly to care for in a home or community-based setting than in an institution.

C. HCFA's Review and Monitoring Procedures

When HCFA officials receive a state's waiver request, they will review its contents against the specifications contained in the statute and the Department's implementing regulations to determine whether the request is approvable. For example, the reasonableness of the state's per capita expenditure estimates will be examined, as will the process of evaluating and reevaluating whether a beneficiary needs the level of care provided in a SNF or ICF facility.

If ECFA finds the request inadequate, unrealistic, or not cost-effective, it will return it to the state for more or better information. If the additional information supplied by the state fails to resolve the inadequacies of the initial proposal, HCFA will deny the state's waiver request. State waiver requests will be reviewed jointly by HCFA regional and central office personnel. As of this writing, the exact distribution of review responsibility between the central office and the regions has not been finalized.

From the date of submittal of a waiver request, by law, HCFA has ninety (90) days in which to approve it, disapprove it or request additional information from the state. If additional information is requested, HCFA then has ninety (90) days from the receipt of such information to approve or disapprove the request. If federal officials fail to take action within the specified timeframe, the request will be considered approved (Section 1915(f)).

HCFA has promised to furnish states with technical assistance on the development of waiver proposals and on estimating per capita expenditures, upon request. Such assistance , according to the preamble to the October 1 regulations, might range from furnishing information on successful case management models to advice on the types of waivers and plan changes to request.

Once a Section 1915(c) waiver is approved, HCFA officials are required to monitor a state's implementation of its home and community-based services program to assure that all statutory and regulatory assurances and other requirements are met. To assist in this process, participating states are obligated to furnish HCFA, annually, with information on the impact of their waiver program, including data on the types and amount of services furnished under the state's Medicaid plan and the health status and general welfare of beneficiaries receiving such non-institutional services. This data must be consistant with a uniform data collection plan currently being developed by HCFA officials.

In preparing a waiver request, there are a number of critical questions state officials must answer, including:

1. *Should the state submit a single, integrated waiver request., embracing all Medicaid recipients who are at-risk of insti tutionalization in a long term care facility_, or elect to develop separate proposals for identifiable subgroups within the overall, Title XIX-eligible LTC population?* No doubt, there will be advantages and disadvantages associated with each approach. For example, in most states it probably will take somewhat longer to develop a sound, well-conceived waiver proposal for all elidible recipients, due to the difficulties involved in preparing common service definitions, procedures and processes bridging the varied service systems currently responsible for meeting the needs of frail elderly, mentally ill, developmentally disabled and physically handicapped persons who may qualify for waiver services. Also, single disability waiver requests offer a state greater flexibility in molding non-institutional services to the unique needs of the population.

   On the other hand, the submittal of separate waiver proposals could foster a lack of interaction between service systems and, ultimately, inequities in the types and quality of non-institutional services available to various subgroups within the LTC population. In the long run, such differences will be difficult to rationalize, on either programmatic or political grounds. Furthermore, a single, integrated proposal may be seen as more advantageous to the state's broader fiscal and programmatic interests.

2. *What specialized waivers should a state request?* To a significant extent, the types of waivers a state requests (i.e., other than basic permission to claim Medicaid reimbursement for specified non-institutional services) will be dictated by the state's programmatic objectives. If, for example, a state intends to seek Title XIX reimbursement under the waiver for existing services across the state provided to eligible aged, blind and/or disabled recipients,

then it should not be necessary to request a waiver of the "statewideness" requirement (Section 1902(a)(1)). However, there may be merit to asking for a statewideness waiver, if state officials are desirous of testing out a new type of service, which is not generally available across the state and can be more effectively evaluated through a small-scaled demonstration project.

As noted above, any state which intends to limit available services to a designated segment of eligible beneficiaries in need of long term care should request a waiver of the "comparability" requirements (Section 1902(a) (10)). Thus, for example, if a state plans to submit a waiver under which non-institutional services will be focused exclusively on eligible mentally retarded and other developmentally disabled clients, it should ask that the comparability requirements of Section 1902(a)(10) of the Act be waived. Such a waiver, if it is approved by HCFA, will allow the state to furnish such services to MR/DD clients without violating the general Medicaid principle that services must be equally available to all eligible beneficiaries who require them. While it might be argued that a frail elderly person is unlikely to benefit from a service program specifically designed for the developmentally disabled, HCFA officials nonetheless suggest that a "comparability" waiver be requested in such instances to avoid any later ambiguities.

3. *To whom should a state submit its completed waiver request?* Waiver requests should be submitted to the HHS regional director or his/her designee. Even though central office personnel plan to play an active role in reviewing the initial round of Section 1915 (c) waiver requests, state officials should work through responsible personnel in the regional HHS office.

   The central office staff of HCFA's Bureau of Program Policy has met with regional office representatives to discuss their responsibilities for reviewing waiver applications and providing technical assistance. Written instructions will be issued in the near future, according to HCFA/BPP officials.

Chapter VI

HYPOTHETICAL EXAMPLES OF A WAIVER REQUEST

A. Introduction

Officials in both State A and State B are desirous of analyzing the feasibility of submitting a Section 1915 (c) waiver request in order to expand home and community-based service options for its mentally retarded citizens who otherwise would require placement in Title XlX-certified long term care facilities. In both states, necessary data on client needs and service costs have been assembled to complete an analysis of average per capita expenditures for the level of care provided in SNF, ICF or ICF/MR facilities, with and without a waiver, as required under Section 441.302(e) and 441.303(d) of HHS's interim final regulations. The purpose, of this analysis is to illustrate the methods used by responsible officials in State A and State B to determine whether the planned expansion in Title XIX support for home and community-based services is permissible under the terms of EHS regulations.

B. Guiding Assumptions

In both the case of State A and State B the following assumptions apply:

- Under existing state law, every mentally retarded client served through a program operated or supported by the state office of mental retardation—including all home and community-based service programs that would be included under the state's waiver request—is required to have an individualized program plan which meets minimum specifications set forth in state law and regulation. State officials are prepared to describe the existing IPP process, as it affects mentally retarded clients, including the required specifications of such plans, the qualifications of individuals developing IPPs and related approval procedures. The assumption is that the state's existing IPP process will comply fully with the requirements of Section 441.301 (b) of HHS regulations.

- State officials are prepared to give written assurances that necessary safeguards have been taken to protect the health and welfare of all Medicaid beneficiaries receiving services under the proposed waiver. In addition, the State's proposal will define all appli-

cable safeguards, specify how they will be developed and implemented, as well as how they satisfy the statutory requirements of Section 1915(c).

- State officials are prepared to give assurances that there will be adequate financial accountability for all funds expended for services under the pro posed waiver, by both the state and responsible provider agencies. In particular, the state's proposal will outline the applicable procedures to assure accountability of funds, including provisions for a clear audit trail.

- State officials have developed an objective process for evaluating a Medicaid beneficiary's need for the level of care provided in a SNF, ICF or ICF/MR facility. The state is prepared to give HHS assur ance that this assessment process will be used to determine the needs of all Medicaid recipients who may require services provided under the proposed waiver. Furthermore, the state will include in its waiver request a copy of the written assessment-instrument (s) to be used, a description of the manner in which such evaluations and reevaluations will be conducted and documented, including an indication of the qualifications of personnel responsible for con ducting such assessments. State officials do not believe that the individual assessment process they are prepared to describe in the state's waiver pro posal will constitute a barrier to HHS approval.

* Since the state's waiver request will be restricted to specialized non-institutional services for Title XlX-eligible mentally retarded persons, state officials will include in their proposal a request that the present statutory prohibition against differentiating in the amount, scope and duration of services to any selected Medicaid sub-group, contained in Section 1902(a)(10) of the Act, be waived.

- The state's waiver request will provide assurances that Medicaid beneficiaries who are not given the choice of receiving home or community-based services as an alternative to SNF, ICF or ICF/MR services will be permitted to request a fair hearing, in accordance with the provisions of 42 CFR Part 431, Subpart E.

- State officials are prepared to provide assurances that all beneficiaries (or their representatives) determined to be in need of SNF, ICF or ICF/MR level of care will be informed of the feasible alternatives and given a choice regarding the types of services (i.e., institutional vs. non-institutional) they wish

to receive. The state's waiver request will spell out how this requirement will be met.

* The state is prepared to give assurances that it will furnish HHS officials with such information as the Department may require on the impact of the waiver in regard to the types and amount of services provided and the health and welfare of beneficiaries. This information will be presented in a format con-sistant with HCFA's approved data collection plan.

• The state's waiver request will include specific, operational definitions of each non-institutional service which will be made available to eligible recipients under the proposed home and community-based services waiver. In the case of State A and State B, such services will be limited to those explicitly mentioned in Section 1915 (c) of the Act and be defined in a manner compatible with Congressional and regula-tory statements of intent. As a consequence, state officials feel confident that these definitions will not constitute a barrier to approval of the waiver requests.

* Neither state currently covers non-institutional long term care services for the mentally retarded under its Medicaid program (i.e., Title XIX payments on behalf of retarded Medicaid recipients are limited to acute health/medical care and institutional forms of long term care).

In summary, both State A and State B appear to meet all appli-cable pre-conditions to qualifying for a Section 1915 (c) waiver, with the possible, exception of the requirement that average per capita Medicaid expenditures after the waiver not exceed comparable average costs without the waiver. The remainder of this chapter sets forth contrasting sets of service data/cost assumptions reflecting the differing situations facing State A and State B and then attempts to calculate, using the mathematical formula contained in Section 441.303(d) of HHS's regulations, whether either or both of the states can qualify for a waiver.

C. State A

1. Service Data Assumptions. State A's primary motivation for seeking a Section 1915 (c) waiver is to accelerate the rate at which mentally retarded persons are placed out of inappropriate institutional settings. The following para-graphs describe the state's current situation and the pro-jected impact of the proposed waiver, should it be approved.

a. Institutional Services. State A presently provides institutional services to mentally retarded persons in three types of Medicaid-certified long term care facilities: state institutions for the retarded, small ICF/MR-certified community residences and general skilled and intermediate care facilities.

- *State Institutions*. The total population in the state's seven public residential facilities for the mentally retarded has dropped from over 7,800 in 1970 to 4,310 on June 30, 1981. However, net-placements have declined sharply over the past: eighteen months, primarily because the state lacks a sufficient number of community residential and daytime programming alternatives for the severely retarded, multi-handicapped residents who remain to be placed. Client assessment data on the present resident population in state-operated facilities indicates that 870, or slightly over 20 percent, could benefit from placement in the community, if appropriate residential and daytime services were available.

  All existing beds in the seven public residential facilities for the mentally retarded (total rated bed capactiy of 4,350) are certified as eligible for ICF/MR reimbursement. However, despite the fact that the state has expended in excess of $6 0 million over the past four years on capital renovation projects designed to bring such facilities into compliance with federal environmental and life safety requirements, there remains a total of 300 beds, spread over five campuses, which have more than four residents to a bedroom. The state's current plans of correction for these facilities project that these units will be phased out of use by July, 1982, as a result of population reductions. The state's capability of achieving this goal, however, is currently in doubt due to the recent drop in the net monthly placement rate.

- *Community ICF/MR Facilities*. Currently, the state has eight ICF/MR-certified community residences, serving a total of 56 residents. Long range plans call for establishing 60 additional facilities of this type, capable of serving 420 severely retarded clients. Approximately 300 of these additional residents will be transferred from state institutions or private SNF and ICF general facilities, while the remainder will be admitted directly from the community (i.e., in order to avoid placement in more restrictive residential settings, such as state institutions and general SNF/ICF facilities). State officials hope to open twenty such residences during the current fiscal

year, serving a total of 140 additional residents. One of the major obstacles to accomplishing this goal is the lack of adequate community support services, especially daytime habilitative services (see discussion below). In order to insure that the state meets its July, 19 8 2 population reduction goal in public ICF/MR facilities, state officials plan to give priority to placing current institutional residents in newly established community ICF/MR facilities during FY 1982.

- *General SNF and ICE Facilities*. A recent statewide study found that there are approximately 650 retarded individuals residing in Title XlX-certified skilled nursing and general intermediate care facilities (300 in SNF's and 350 in ICF's), at least half of whom require a living/programming setting in which they can receive "active treatment", geared to their developmental needs.* Preliminary estimates indicate that 125 of these SNF/ICF residents could benefit from placement in a state-operated residential facility, while the remaining 200 would be candidates for transfer to community residences—if a sufficient number of appropriate facilities were available.

  As fully certified beds in state-operated facilities become available, state officials plan to transfer retarded residents in private SNF and ICF-general facilities to such state institutions. Such placements, however, will be contingent on a determination by an interdisciplinary team that the habilitative services appropriate to the client's assessed needs cannot be effectively provided in a less restrictive residential environment. State officials estimate that approximately 12 5 SNF and ICF general residents will be transferred to state-operated ICF/MR centers over a three year period.

b. Non-Institutional Services. Based on past experience with community placement programs for the mentally retarded, state officials recognize that it will be necessary to adopt a dual strategy—actively developing alternative community-based residential and support programs, on the one hand, while simultaneously taking steps to prevent future placements in institutional settings, whenever possible. After extensive study, state mental retardation and Medicaid officials have jointly concluded that over the next three years the state should plan to reduce the current population in the state's seven residential institutions by a total of 500 residents and reduce the number

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* The remaining residents are either in need of the constant medical/nursing supervision and care offered by a skilled nursing facility or are elderly retarded individuals whose needs are similar to those of other geriatric clients in general ICF facilities.

of inappropriately placed nursing home residents by 200. In order to achieve this goal, state officials calculate that it will be necessary to request a Section 1915 (c) waiver authorizing the provision of the following types of non-institutional services to retarded clients who would otherwise require care in an ICF/MR-certified setting:

* *Specialized Foster Family Cave.* The state's existing specialized foster family placement program will be expanded to serve an additional 170 severely retarded, multi-handicapped children, 120 of whom will be transferred from existing state institutions and SNF/ICF facilities. An estimated 50 clients will be placed in such facilities during the current fiscal year (i.e., 40 from state institutions and 10 from the community). In order to encourage foster families to assume responsibility for difficult-to-place retarded children, the state will certify such providers as vendors of personal care servcies under Title XIX and pay them a special monthly rate, calculated on the basis of specialized care service units specified as needed in the client's individual program plan. No portion of the special Title XIX payment will be used to cover the cost of room and board for such clients.

  In order to insure appropriate supervision of the foster families rendering such personal care services, the state will request that the current regulatory requirement (under 42 CFR 440.170(f)) for nursing supervision be waived and replaced with a stipulation that such services be monitored by a qualified mental retardation professional (see discussion of case management services below).

• *Habilitative Services in Non-Mediaal Group Homes.* The state will institute a special habilitative payment rate for the provision of designated services to mentally retarded clients residing in non-medical group homes. This special rate will be an add-on to the facility's basic payment (consisting of the resident's SSI entitlement and a state supplemental payment). Only homes serving eligible residents will be qualified to receive such special Title XIX payments and then only to the extent that they render specified services to such residents. A client's eligibility to have such special Title XIX payments made on his or her behalf will be based on a determination that: (a) the resident is Medicaid eligible and requires the type, range and intensity of services offered by the facility; (b) in the absence of the specialized habilitative services covered under the Title XIX payment the resident would require placement in a Title XlX-certified institution;

and (c) the average per diem cost of serving such residents in a group home setting is less than the comparable cost of care in other settings appropriate to their needs. The amount of the Title XIX payment made on behalf of any eligible resident will be adjusted according to the types and frequency of services the facility is obligated to provide, in accordance with the resident's needs as reflected in his/her individual program plan. No portion of the special Title XIX payment will be used to cover the cost of room and board for such clients.

State officials estimate that a total of 400 additional residents would benefit from a group home; environment, if such special Title XIX payments could be made on their behalf. Of this number 100 currently reside either in state institutions or other Title XlX-certified settings, while the remainder live in non-medical settings of various kinds. Current estimates; are that space for 80 such clients could be created in group homes during the current fiscal year—2 0 of whom would be transferred from state institutions (and/or general SNF/ICF facilities) and the remainder from non-medical settings.

- *Daytime Habilitative Services*. In order to accomodate the expanded number of severely and profoundly retarded, multi-handicapped clients scheduled, for placement in a community living environment and, at the same time, reduce pressure for institutional placements among similar clients who are currently living with their families or in other non-medical settings, the state plans to certify selected community agencies as vendors of Title XlX-reimbursable daytime habilitative services for the mentally retarded. Only Medicaid-eligible clients who are certified by an interdisciplinary assessment team as needing such services will be eligible to participate. A client's need for Title XlX-reimbursable daytime habilitative services will be based on a determination that he or she: (a) meets all eligibility requirements for placement in an ICF/MR-certified setting; (b) needs an intensive regimen of daytime habilitative services geared to assisting him/her in acquiring basic self-help and social coping skills; (c) such services can be rendered to the client more effectively and at less cost in a day habilitation program than in an ICF/MR-certified facility.

  State officials estimate that a total of 400 program slots will be required during the current fiscal year in Title XlX-reimbursed day habilitation centers across the state. By the end of the three year period, the number of Medicaid-reimbursed clients in such settings is expected to increase to 1,150. During the initial

year of the program, priority will be given to placing formerly institutionalized adults into such day habilitative programs. It is estimated that a total of 300 former state institutional or SNF/ICF residents will be served in such day habilitation centers by the end of the first year, while the remainder will have resided in non-medical settings.

- *In-Home Support/Training Services*. State officials plan to expand an existing state-supported pilot program which offers training and in-home support services to parents caring for severely impaired, developmentally disabled children. This expansion will be financed, in part, by matching existing state dollars with federal Title XIX reimbursements, in the case of families who meet the state's Medicaid financial eligibility test and are caring for eligible developmentally disabled children within their homes. No portion of this special Title XIX payment, however, will be used to cover the cost of room and board for such clients.

  It is estimated that approximately 15 percent of families currently participating in the pilot program are either Medicaid eligible or would qualify for eligibility under the state's present means test. The total number of families assisted through this in-home support program will be increased from 100 last year, to 200 by the end of the current fiscal year and 350 by the end of the three year period. In approximately 15 percent of all cases (i.e., where the family meets the state Medicaid means test), a portion of the costs of providing such in-home services will be matched by Title XIX payments.

  The basic aim of the program will be to reduce demand for costly out-of-home placement in Title XlX-certified and other long term care facilities. However, state officials estimate that by the end of the fiscal year ten families with children currently residing in Title XlX-certified facilities can be convinced to take their children back home, if such in-home support services are made available to them.

- *Respite Care.* As another method of encouraging natural and adoptive families to maintain their severely retarded, multi-handicapped offspring at home, whenever possible, state officials plan to expand existing respite care services. Under the state's current program, such services are provided to an estimated 250 clients (100 adults and 150 children) annually, with a limit of fifteen (15) days of respite per annum available to each participating client/family. The state plans to expand the number of participating clients this year

to 200 adults and 225 children and increase the maximum family allowance to 25 days, by seeking (under a Section 1915(c) waiver) Medicaid reimbursement for the cost of furnishing respite care services to all eligible adult clients, over 18 years of age, and children in Medicaid-eligible families (i.e., an estimated 15 percent of all eligible families). By 1984, state officials estimate that 300 adult clients and 400 children will be recipients of respite care services, of whom 360 will be eligible for Title XIX reimbursement under the state's Section 1915(c) waiver program.

- *Case Management*. In order to insure proper synchronization among the daytime, residential and support services rendered to the increased number of Title XIX-eligible retarded clients living in the community, state officials plan to seek reimbursement for case management services provided to Title XlX-eligible retarded clients who are participating in non-institutional services funded through Medicaid. The cost of such services will be pro-rated among eligible and non-eligible clients in a client coordinator's caseload, with only those costs reasonably associated with the provision of case management services rendered to Title XIX, LTG clients billed to Medicaid,

  State officials estimate that by the end of the current fiscal year, reimbursement for case management services will be sought on behalf of some 400 Title XlX-eligible long term care clients living in the community and receiving Medicaid financed non-institutional services. This number will grow to 1,150 by the end of the three year period.

Finally, state officials estimate that if none of the above steps are taken, the total number of residents in Title XlX-certified institutions will increase at an average rate of five percent per year over the three year period. This calculation is based on an analysis of admission trends in public and private ICF/MR, SNF and ICF facilities over the past three years, a study of the current waiting list for placement in state institutions, and an anticipated increase in demand for all types of out-of-home care due to federal and state reductions in support for social and habilitative services (especially Title XX funding cuts). If state officials are correct, failure to act would lead to a growth in the number of ICF/MR eligible residents in state facilities (to 4,526 by September 30, 1982 and 4,990 by September 30, 1984). Similarly, the number of retarded residents in SNF's could be expected to increase to 315 by the end of FY 1981-82 and 331 by FY 1983-84, while the number of ICF-general residents would rise to 368 and 404, respectively, over this same period.

At present, State A lacks sufficient certified bed capacity in its state-operated mental retardation facilities to accommodate the anticipated expansion in the population, should its Section 1915(c) waiver request not be approved. However, vacant units in two state mental hospitals could be converted—with only minor capital renovations—to serve the expected overflow population, if such action proves necessary. State officials view this option as a much less desirable course of action, both in terms of programmatic and fiscal considerations; but they also recognize the importance of having a viable backup strategy.

2. Cost Estimates. Based on past experience, officials in State A estimate that the average per diem costs incurred in providing Medicaid-reimbursable services to mentally retarded person will be:

   a. State-operated ICF/MR facilities: $85.00 per day, per resident in FY 1981-82, increasing by 10 percent per annum in both FY 1982-83 and FY 1983-84.

   b. Privately operated skilled nursing facilities (only those caring for retarded residents): $45.00 per day, per resident, increasing by 10 percent in both FY 1982-83 and FY 1983-84.

   c. Privately operated intermediate care facilities (other than ICF/MR[1]s, caring for mentally retarded residents): $42.00 per day, per resident, increasing by 10 percent in both FY 1982-83 and FY 1983-84.

   d. ICF/MR-certified community residences: $65.00 per day, per resident in FY 1981-82, increasing by 10 percent, per annum in both FY 1982-83 and FY 1983-84.

   e. Specialized foster family care (Title XIX personal care payments only): $10.00 per day, per resident in FY 1981-82, increasing by 10 percent, per annum in both FY 1982-83 and FY 1983-84.

   f. Non-medical group homes (Title XIX habilitative pay ments only): $12.50 per day, per eligible resident, increasing by 10 percent, per annum in both FY 1982-83 and FY 1983-84.

   g. In-home services to families (Title XIX payment rate only): an average of $2,700 per annum, per family in FY 1981-82, remaining stable over the three year period.

   h. Respite care (Title XIX reimbursable services only): an average of $675 per client, per annum in FY 1981-82, increasing by 10 percent in both FY 1982-83 and FY 1983-84.

i. Case management (Title XIX reimbursable services only): an average of $575 per client, per annum in FY 1981-82, increasing by 10 percent in both FY 1982-83 and FY 1983-84.

All assumptions concerning average per capita costs and levels of utilization in State A, both with and without the proposed waiver, are summarized in the following table

Summary of Hypothetical Data on Section 1915(c) Waiver Request of State A

9/30/82	ICF/MR		ICF/MR COMMUNITY				ICF/GENERAL	
	W/W +	WO/Wi	W/W	WO/W	W/W	WO/W	W/W	WO/W
	4,100	4,526	196		**300**	300	350	350
Aver, Per			476		150	315	175	**368**
			$23,725		516,425	$16,425	$15,330	$15,330
		$37,540	$28,707	$28,707	**$19,874**	$19,&74		

9/30/84	RESPITE CARE*		CASE MANAGEMENT SERVICES*		GROUP HOME NON-MED.*		SPECIALIZED FOSTER FAM. HOMES*		IN-HOME SUPPORT SERVICES*	
	W/W	WO/W	W/W	WO/W	W/W	WO/W	W/W	WO/W	W/W	WO/W
	234	-0-	400	-o-	30	-o-	50	-o-	:o	-0-
	360		1,150		400	-o-	170	-0-	53	-o-
Aver. Per Annum 9/30/82	**675**	—		—	$4,563		$3,650	—	$2,700	--
Aver. **Per** 9/30/84	**817**	—	69 6		$5,521		$4,417	—	$2,700	—

* Title XlX-reimbursable costs only. + W/W—with waiver. ++ WO/W—without waiver.

Average Per Diem Cost Comparisons. Applying the mathematical formula contained in Section 441.303(d) of HHS's interim final regulations, it is possible to calculate whether State A qualifies for a home and community -based care waiver under the terms of Section 441.302 (e) of the same rules {i.e., the average per capita fiscal year expenditures under the waiver may not exceed the average per capita expenditures for the level of care provided in a SNF, ICF or ICF/MR that would have been incurred had the waiver not been granted}.* The formula reads as follows:

$$\frac{}{F+H}$$

Where:

A = the estimated number of beneficiaries who would receive the level of care provided in art SKF, ICF or ICF/MR under the waiver-

B = the estimated Medicaid payment per eligible Medicaid user of such institutional care.

IMPORTANT NOTE: The calculations below are limited to the first year of the proposed three year waiver period. Therefore, it would be necessary to repeat the same procedures for the second and third year in order to determine definitively whether State A or State B qualifies for a waiver. To avoid repetition the latter calculations are not included in this paper. However, it seems fairly apparent, given all the data assumptions, that the outcome of such calculations for years 2 and 3 would be the same as in year 1.

In addition, readers should note that the cost and service utilization estimates used in this paper assume that all Title XlX-reimbursed non-institutional services under the waiver will be fully operational throughout the first year of the waiver period. This assumption was made in order to simplify the mathematics involved. Actually, one would expect that such programs would be phased in over the course of the first year and, thus, Medicaid reimbursements for such non-institutional services would be less than suggested in this paper. While the use of annualized figures will affect the degree of Medicaid savings which can be anticipated during the first year of the waiver period (i.e., as measured in comparative average per capita expenditures), it should have no impact on whether a state qualifies for a Section 1915(c) waiver under the per capita cost criteria of the regulations.

C = the estimated number of beneficiaries who would receive home and community-based services under the waiver or other non-institutional alternative services included under the State plan.

D = the estimated Title XIX payment per eligible Medicaid user of such home and community-based services.

F = the estimated number of beneficiaries who would likely receive the level of care provided in an SNF, ICF or ICF/MR in the absence of the waiver.

G = the estimated Medicaid payment per eligible Medicaid user of such institutional care.

H = the estimated number of beneficiaries who would receive any of the non-institutional, long-term care services otherwise provided under the state plan as an alternative to institutional care.

I - the estimated Medicaid payment per eligible Medicaid user of the non-institutional services referred to in H.

a. Estimated number of SNF, ICF and ICF/MR beneficiaries under the waiver times the estimated Medicaid payment per recipient (AxB).

- Estimated number of ICF/MR eligible residents in state-operated facilities by September 30, 1982 (4,310-300) = 4,010.
- Estimated annual Medicaid reimbursement rate per resident in state-operated ICF/MR facilities ($85 x 365) = $31,025.
- Estimated number of Medicaid-eligible residents in SNF facilities as of September 30, 1982 = 300.
- Estimated annual Medicaid reimbursement rate per resident in SNFs ($45 x 365) = $16,425.
- Estimated number of Medicaid-eligible residents in ICF-general facilities, as of September 30, 1982 = 350.
- Estimated annual Medicaid reimbursement rate per resi dent in ICF-general facilities ($42 x 365) = $15,330.
- Estimated number of Medicaid-eligible residents in ICF/MR-certified community residences, as of September 30, 1982 = 196.
- Estimated annual Medicaid reimbursement rate per resi dent in ICF/MR-certified community residences ($65 x 365) = $23,725.

Thus, we can determine that A x B would equal the sum of

A		B
4,010	**x $31,G35 =**	**$124,411,025**
300	**x 16,425 =**	**4,927,500**
350	**x 15,330 -**	**5,365,500**
196	**x 23,725 =**	**4,650,100**
Total (A X B)	**-**	**$139,354,125**

b. Estimated number of beneficiaries receiving home and community-based, services under the waiver or other non-institutional services funded under the state Medicaid plan tiroes the estimated Medicaid cost of providing such services (C x *D).*

- **Estimated number of Title XlX-reimbursed clients served in specialized foster family homes by September 30, 1982 = 50.**

  Estimated average annual Medicaid reimbursement rate per resident in specialized foster family homes ($10 x 365) - 53,650.

  Estimated number of Title XlX-reimbursed clients served in non-medical group homes as of September 30, 1982 =80.

  Estimated average annual Medicaid reimbursement rate per resident in non-medical group homes ($12.50 x 365) = $4,563-

  Estimated number of Title XIX reimbursed clients served through in-home support/family training services to families as of September 30, 1982 = 30.

  Estimated average annual Medicaid reimbursement rate per recipient of in-home support/family training services = $2,700.

  Estimated number of Title XlX-reimbursed clients receiving respite care services as of September 30, 1982 = 234.

  Estimated average annual Medicaid reimbursement rate per recipient of respite care services = $6 75.

  Estimated number of Title XlX-reimbursed clients receiving case management services as of September 30, 1982 = 400.

  Estimated average annual Medicaid reimbursement rate per recipient of case management services = $575.

Thus, we can determine that C x D would equal the sum of:

C		D		
50		$3 ,650	= $	182,500
80	X	4 ,563	-	**365,040**
30	X	***2*** *r* **700**	**=**	**81,000**
23	X	675	=	**157,950**
40	X	575	=	**230,000**
			Total (C *x D)* = $1,016,490	

c. Estimated number of beneficiaries likely to receive SNF, **ICF or ICF/MR level of care in *the* absence of a waiver plus the estimated number of beneficiaries who would receive any of the non-institutional, long term care services otherwise provided under the state Medicaid plan as an alternative to institutional care (F + H}.**

- **Estimated number of beneficiaries. in state-operated ICF/MR's as of September 30*r* 1982 in the absence of a waiver = 4,526.**
- **Estimated number cf beneficiaries in small community-based ICF/MR's as of September 30, 1982 in the absence of a waiver = 56.**
- **Estimated number of beneficiaries in ICF~general facilities as of September 30, 1982 in the absence of a waiver - 36 8.**
- **Estimated number of beneficiaries in SNF's as of September 30, 19 3 2 in the absence of a waiver = 315.**
- **Estimated number of beneficiaries of Title XIX-reimbursed group home, foster family home, in-home support services, respite care and case management in the absence of a waiver = 0.**

Thus, we can determine that the sum of F + H equals:

			F	**H**
4.526	+ 0	**= 4**	**,526**	
56	**+ 0**		**56**	
350	**+ 0**		**350**	
300	**+ 0**	=	**300**	
Total	***F +*** **H)**	= 5	23	

Estimated number of beneficiaries likely to receive SNF/ ICF and ICF/MR level of care in the absence of waiver times the estimated Medicaid payment per eligible user of such institutional care (F x G) .

Since the estimates for F are identical to those shown in I-C-3 above, the product of F x G will equal the sum of:

	G	
4,526	x $31,035	= $140,419,150
56	x 23,725	= 1,323,600
368	x 15,330	= 5,641,440
315	x 16,425	= 5,173,375
Total (F x G)		= $152,563,065

e. Estimated number of beneficiaries who would receive non-institutional long term care services otherwise provided under the state Medicaid plan times the estimated Medicaid payment per eligible user of such services (H x I).

- Estimated number of beneficiaries of Title XIX-reimbursed group home, foster family home, in-home support services, respite care and case management in the absence, of a waiver = 0.

- Estimated Medicaid payment per eligible user of such non-institutional services = 0.

Thus, we can determine that H x I equals the sum of:

		I	
15	x	0	= 0
0	x	0	= 0
0		a	= 0
0		0	= 0

Total [H x I) =0

When we combine all of the above calculations in the regulatory formula, we find that:

$$\$139,354,125 + 1,016,490 \quad \$152,563,065 + 0$$
$$5232 \qquad - \qquad 5232$$

or $26,329 <

$29,159

In other words, State A's waiver request WOULD meet the minimum condition for approval, contained in Section 441.302(e) of HHS's regulations.

D. State B

Service Data Assumptions. In contrast to State A, State B has a relatively small, stable number of mentally retarded persons in public and private institutions. Several years ago, state officials made a major effort

to reduce the number of residents in the state's two public institutions and, as a result, the total population in these facilities was cut from 525 to 310. All beds in these state-operated facilities are presently certified for Medicaid reimbursement and state officials anticipate no substantial change in the resident population of either facility in the foreseeable future.

As part of the state's deinstitutionalization thrust during the late 1970's, a total of twelve, small community residences were developed and certified as ICF/MR providers. Presently, there facilities serve a total of 96 residents. There are no current plans to expand the number of community-based ICF/MR facilities. '-

State B has few retarded clients in either general ICF's or SNF's. According to state officials, there are only ten residents in SNF's and five in ICF's who have a primary or secondary diagnosis of mental retardation. The most recent level of care data suggests that these residents are appropriately placed.

The major dilemma facing State B at the present moment is that reductions in federal and state support for daytime habilitative services are likely to eliminate space for 200 of the 800 clients currently enrolled in such service programs. These sharp cutbacks are the result of a twenty percent reduction in federal Title XX social services aid—a major funding source for daytime habilitative services for the past ten years—combined with a five percent reduction in state purchase of care dollars, the other primary funding source for such centers.

Assessment data on the population served in day habili-tation centers across the state suggests that at least 300 clients meet the state's criteria for admission to an ICF/MR facility. Almost all of these clients are severely or profoundly retarded persons, between ages 19 and 55, who are enrolled in adult activities programs to assist them in acquiring basic self-help and social coping skills.. If the number of programming slots in these centers is reduced by 200, state officials expect that demand for out-of-home placements in Title XlX-certified facilities will increase next year by at least 110 residents over the current admission rate. However, due to the lack of bed capacity in appropriate facilities and the constraints on the state's Medicaid budget, there is no way in which the state can accommodate more than ten additional persons in ICF/MR-certified space.

Officials in State B, therefore, are interested in exploring whether it is possible, through a Section 1915(c) waiver, to certify selected day habilitation centers as vendors of Medicaid-reimbursable services on behalf of clients who meet ICF/MR level of care criteria and are otherwise eligible for Title XIX benefits. Their plan is to use the additional Title XIX reimbursements to replace revenues lost through Title XX and state purchase of care cutbacks, thereby avoiding a reduction in the current level of services offered through such centers and dampening demand for institutional placements.

2. Cost Estimates. Based on past experience, officials in State B estimate that the average per diem costs incurred in providing Medicaid-reimbursable services to eligible mentally retarded person will be:

   a. State-operated ICF/MR facilities: $78.00 per day, per resident in FY 1981-82, increasing by ten percent,per annum in both FY 1982-83 and FY 1983-84.

   b. ICF/MR-certified community residences: $62.00 per day, per resident in FY 1981-82, increasing by ten percent,per annum in both FY 1982-83 and FY 1983-84.

   c. Privately-operated skilled nursing facilities (only those serving mentally retarded clients) : $50.00 per day, per resident in FY 1981-82, increasing by ten percent,per annum in both FY 1982-83 and FY 1983-84.

   d. Privately-operated general intermediate care facilities (other than ICF/MR's, serving mentally retarded residents): $44.00 per day, per resident in FY 1981-82, increasing by ten percent, per annum in both FY 1982-83 and FY 1983-84.

   e. Daytime habilitative services (Title XIX payment rate only): $25.00 per day, per client in FY 1981-82, increasing by ten percent, per annum in both FY 1982-83 and FY 1983-84.

   All assumptions concerning average per capita costs and levels of utilization in State B, both with and without the proposed waiver, are summarized in the following table.

Summary of Hypothetical Data on Section 1915(c) Waiver Request of State B

	1CF/MR STATE		ICF/MR COMMUNITY		SNF	
	W/W +	WO/W++	W/W	WO/W	W/W	WO/W
	310	320	96		10	10
9/30/84	310	120	96		10	10
Average Per Annum Cost 9/30/82	,470	$2 ,470 8	522,630	522,630	$18, 25 0	25 0
Average Per Annum Cost	$3 ,449 4	,449	$27,382	527,382	$22, 09 2	$2

	ICF/GENERAL		DAY HABILITATIVE*	
	W/W	WO/W	W/W	WO/W
9/30/82	*5*		300	"0-
	5	5	300	-0-
9/30/84	$16,060	$16,060	$6,500	$6,500
Average Per Annum Cost 9/30/82	$19,433	519,433	$7,965	$7,865
Average Per Annum Cost 9/30/94				

* Title XlX-reimbursable costs only. + W/W—with waiver. ++ WO/W—without waiver.

Average Per Diem Cost Comparisons. Applying the mathematical formula contained in Section 441.303(d) of HHS's interim final regulations, it is possible to calculate whether State B qualifies for a home and community-based care waiver under the terms of Section 441.302 (e) of the rules [see formula in section C above}.*

a. Estimated, number of SNF, ICF and ICF/MR beneficiaries under the waiver times the estimated Medicaid payment per recipient (A x 5) .

A		B
310 x	$28,470 =	$ 8,825,700
96 x	22,630 =	2,172,480
10 x	18,250 =	132,500
5 x	16,060 =	80,300
Total	[A x B) =	$11,260,980

Estimated number of beneficiaries receiving; community-based services under the waiver or other non-institutional services funded under the state's Medicaid plan times the estimated Medicaid cost of providing such services (C x D). .....

C	
300 x $6,500	= $1,950,000
Total (C x D)	= $1,950",000

Estimated number of beneficiaries likely to receive SNF, f.CF and ICF/MR .level of care in. the absence of a would receive any of the non-institutional, long term care services otherwise provided under the state's" waiver plus the estimated number of Beneficiaries who provided under the state's plan as an alternative to institutional care (F + H} .

F		H		
320	+	0	=	320
96	H H	0	=	96
10	H +	0	=	**10**
5	+	0	=	5

Total (F+H)= 431

* See note concerning data assumptions on page 12,

d. Estimated number of beneficiaries likely to receive ICF and ICF/MR level of care in the absence of a waiver times the estimated Medicaid payment per eligible **user of such institutional care (F x *G)* .**

F	G	
320 x	$23,470	= S 9,110,400
96 x	22,630	= 2,172,480
10 x	18,250	= 132,500
5 x	16,060	= 30,300
Total (F x G)		= $11,545,680

Estimated number of beneficiaries who will receive non-Institutional long term care services otherwise provided under the state Medicaid plan times the **estimated Medicaid payment per eligible user of services (H x I).**
is provides

0 x 0 = 0

Total(H x I) - 0

When "we combine all of **the above calculations in the regulatory formula, we find that:**

$11,260,980 + $1,950,000 >, $11,545,680 + 0

431 ^ 431

or $30,652

> $26,788

In other words, State B's waiver request WOULD HOT meet the minimum condition for approval, contained in Section '441.302 (e) of HHS's regulations.

E. Conclusion

The aim of this paper has been to illustrate, through the use of two somewhat simplified hypothetical cases, the manner in which states can calculate the feasibility of various strategies for employing the new Medicaid home and community-base waiver authority, given the statutory prohibition against HHS approval of waivers where average per capita Medicaid expenditures under the waiver would exceed comparable expenditures if a waiver were not granted. Although each proposed approach will have to be evaluated on its own merits, as a general rule it seems clear (as shown in the above examples) that a state will have a difficult time demonstrating that its waiver request is approvable unless: (a) it plans to include in the population eligible for Title XlX-reimbursable non-institutional services a

significant number of current recipients of Medicaid-certified institutional services; and/or (b) it can offer convincing evidence that the number of residents in Title XlX-certified institutions will increase at a rate sufficient to offset the added federal costs of non-institutional services contemplated under its waiver request.

Even reasonably modest changes in a state's waiver proposal can alter the outcome of the comparative per capita cost equation. For example, if we assume that State B can document to the satisfaction of HCFA officials that, in the absense of a waiver, sixty-five percent (rather than 9%) of the increased demand for ICF/MR beds (or a total of 72 beds) would be met through the conversion of existing institutional space (possibly in vacant or underutilized areas of an acute care or mental hospital), then the state would qualify for a waiver and would be able to finance the desired restoration of daytime habilitative services through Title XIX payments.* Conversely, if we assume that State A projects a reduction in its aggregate public institutional population of 50, rather than 200, during the first year of the waiver and, in the absence of a waiver, a growth rate of two, instead of five, percent in its existing state institutional population (and no growth in the number of ICF-general and SNF residents), then the state would not be eligible for a waiver, since average per capita costs with the waiver would exceed comparable costs without the waiver.

It. is also important to remember that HCFA officials will review a state's performance under the waiver authority,, based on annual reports submitted by the state. Thus, even though a state may receive approval for a three year waiver, if it fails to fulfill its obligations, the waiver may be terminated by HCFA at any time. For example, let us assume that by the end of the initial year of the waiver-period, State A has been able to place a net total of only 35 retarded residents out of state-operated ICF/MR facilities (and none from general ICF's and SNF's), but has proceeded to qualify the number of retarded clients for Title XlX-reimbursed non-institutional services specified in its original waiver proposal (see Section C-l above). Under these circumstances, the state will be in danger of having its waiver terminated by HCFA (in accordance with Section 441.304(b) of the interim final regulations), on the grounds that average per capita costs under the waiver exceed comparative costs without the waiver.

By their very nature, all of the examples outlined in this paper are speculative and, thus, cannot serve as a substitute for the actual planning process which must take place in every applicant state. However, they do tend to illustrate the complex, multi-facited factors which must be taken into account in developing a sound, realistic waiver proposal.

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* Assuming, of course, that the state met all other prerequisites for approval of its waiver request.

Chapter VII

INITIAL REACTION OF STATE MENTAL RETARDATION AGENCIES

For a number of years, the National Association of State Mental Retardation Program Directors has advocated changes in legislative and administrative policies which would allow states to support community services for mentally retarded and other developmentally disabled persons through the Medicaid program. As a result, Association leaders were encouraged by Congress' action in authorizing home and community-based care waivers, under Section 2176 of the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35).

The inclusion of this new waiver authority in the reconciliation bill generated an immediate flurry of requests from state mental retardation officials for additional information. Therefore, the NASMRPD staff decided to conduct a state-by-state survey to determine the number of states which were planning to submit Section 1915 (c) waiver requests, as well as the basic thrust of such requests.

A. Survey Methodology

On October 8, 1981, a one page questionnaire was sent to all state mental retardation directors, along with an explanatory memorandum, a copy of HHS's October 1 regulations implementing the home and community-based care waiver authority, and a bulletin analyzing the contents of these regulations. In addition to asking if the state planned to submit a waiver request, the questionnaire elicited information on: (a) whether the state's waiver request would include non-institutional services for MR/DD clients; (b) the type of waiver request that would be submitted (i.e., single-purpose or combined); and (c) the types of non-institutional services for which reimbursement would be sought under the state's waiver proposal (see Appendix C for a copy of the questionnarie) . Respondents also were asked to supply the name of a contact person (see list in Appendix D) and indicate whether they would be interested in having one or more representatives attend a special half-day workshop on the waiver authority, if the Association's staff organized such a session.

A follow-up request was sent to all non-responding states on October 23. In addition, telephone calls were made to * a few states which were especially late in returning their survey questionnaires.

B. Survey Findings

Completed questionnaires were received from fifty one (51) jurisdictions, including forty-nine (49) states, the District of Columbia and Puerto Rico. Idaho was the only state which did not send in a response.

As indicated in Table A (see page 6 3), approximately half of the respondents (24) indicated that their state would be submitting a waiver request. Twenty additional respondents said a decision on this matter had not yet been made in their state. Officials from only five states told us that there were no plans to submit a Section 1915(c) waiver request at this time.

Of the forty-one (41) states either planning to submit waiver requests or contemplating doing so, thirty-one (31) reported that their state's request will include coverage of community-based services for MR/DD clients. The remaining ten (10) states indicated that a decision on this matter has not yet been reached.

At the time the survey was conducted, relatively few states had decided whether to submit a combined waiver request, involving services to all eligible Medicaid beneficiaries with long term care needs, or one or more separate requests, each of which would be limited to a particular sub-set of LTC clients (such as the frail elderly, the developmentally disabled or the chronically mentally ill) . Twenty-five (25) of the forty-one (41) states which responded to this question said that a decision had not yet been reached; nine (9) respondents indicated that their states would forward a combined waiver proposal, while seven (7) reported that single-purpose requests would be submitted.

Twenty-six (26) states provided a preliminary indication of the services that they expect to cover under their Section 1915(c) waiver programs. Fourteen (14) additional states indicated that no decision had been made regarding the types of non-institutional services which would be eligible for reimbursement.

Of those respondents supplying information on the types of services to be included, most (18 out of 26) felt their states would elect to cover five or more of the seven service categories specified in Section 1915(c)(4)(B) of the Act. The remaining eight states predicted that two to four of these non-institutional services would be provided under their state's waiver program.

Table A

SUMMARY OF MEDICAID COMMUNITY CARE WAIVER SURVEY

STATE	Plan to Submit a Waiver Request			Include Comm.-Based Services for MR/DD			Format			Services to be Included in Waiver Request								
	yes	no	no decis.	yes	no	no decis.	comb.	single	no decis.	case Mgmt.	Home-maker	Pers. Care	Adult Day Health	Habil.	Home Health Aide	Resp. Care	no decis.	Other
Alabama	X			X				X									X	
Alaska			X	X					X								X	
Arizona	n/a																	
Arkansas	X			X				X		X			X	X	X	X		
California	X			X			X			X		X	X	X		X		X
Colorado	X			X					X	X	X	X	X	X	X	X		
Connecticut			X			X			X								X	
Delaware	X			X					X	X	X			X		X		
District of Columbia		X																
Florida	X			X			X			X	X	X	X	X		X		
Georgia	X			X			X			X	X	X	X	X		X		
Hawaii	X			X					X	X	X		X		X	X		
Idaho	NO RESPONSE																	
Illinois	X			X					X	X			X			X		
Indiana			X			X			X								X	
Iowa			X			X			X								X	
Kansas	X			X			X			X	X	X	X	X	X	X		X
Kentucky			X	X					X	X		X	X	X		X		X
Louisiana	X			X			X				X		X	X				
Maine			X			X			X								X	
Maryland	X			X				X		X	X			X			X	
Massachusetts			X			X			X	X	X	X	X	X	X	X		
Michigan			X	X					X	X	X	X	X	X	X	X		X
Minnesota			X	X					X	X	X	X	X	X	X	X		X
Mississippi		X																
Missouri			X			X			X								X	
Montana	X			X				X		X	X		X	X	X	X		
Nebraska	X			X					X								X	
Nevada	X			X				X		X	X	X	X	X	X	X		
New Hampshire			X			X			X								X	
New Jersey	X			X					X								X	
New Mexico			X															
New York			X	X					X	X	X	X	X	X	X	X		
North Carolina	X			X					X								X	
North Dakota			X	X			X										X	
Ohio			X	X					X	X	X	X	X	X	X	X		X
Oklahoma			X															
Oregon	X			X				X		X			X	X		X		
Pennsylvania	X			X				X		X		X	X	X				
Puerto Rico		X																
Rhode Island	X					X			X	X		X	X	X	X	X		
South Carolina		X																
South Dakota	X			X					X	X		X		X				
Tennessee			X			X			X								X	
Texas			X	X					X	X		X	X	X		X		
Utah	X			X			X			X	X	X	X	X	X	X		
Vermont		X																
Virgin Islands	NO RESPONSE																	
Virginia			X															
Washington	X			X			X							X		X		
West Virginia			X			X			X								X	
Wisconsin	X			X			X			X	X	X	X	X	X	X		X
Wyoming		X																

The most frequently mentioned types of covered services were case management and habilitation (25 out of 26 responding states), followed closely by adult day health and respite care (23 out of 26 responding states). Personal care (18 states), homemaker services (17 states) and home health aides (14 states) were less frequently mentioned, but nonetheless were designated by a majority of the responding states.

Only seven (7) of the responding states indicated plans to request approval of services not listed in the Act. The only "other service" category to be listed more than once was "transportation", which was mentioned by two states. Additional services included in the "other" category were: occupational and physical therapy, speech and hearing, minor physical facility adaptations, meals on wheels, chore services and independent living skills.

Finally, the vast majority of the responding states expressed interest, in sending a representative to a special workshop on the home and community-based waiver authority. Thirty-eight state directors indicated that one or more representatives from their agency would attend such a workshop.

C. Implication of the Findings

Since the survey was conducted only a month and a half after the signing of the budget reconciliation bill and the week following publication of HHS"s implementing regulations, the views expressed by the respondents, no doubt, *are* subject to change. As state officials become more deeply immersed in the preparation of waiver proposals, they may find that their initial perspectives need to be tempered by the realities of developing an approvable waiver request. As a result, the number and types of waiver proposals ultimately submitted by the states might be quite different than they are envisioned at this early stage of the process.

Nonetheless, the fact that at least half the states--and possibly more—plan to submit waiver requests illustrates the significant level of interest among state mental retardation officials in finding more cost-effective methods of programming for mentally retarded and other developmentally disabled persons in non-institutional settings. Another indication of the high level of interest is the number of states willing to send representatives to a special workshop on the waiver authority, especially given the tight constraints many states have placed on out-of-state travel in recent months.

It is too early to predict the extent to which the Section 1915 (c) waiver authority will help to offset the institutional bias which has characterized Medicaid long term care policy over the past decade. However, the results of this brief state-by-state survey tend to indicate the state mental retardation officials are willing to cooperate in this effort.

As an organization representing such officials, NASMRPD plans to play a catalytic role in this process, by facilitating communication among states which are preparing waiver requests, seeking answers to inter-state policy questions from responsible HCFA officials, and generally monitoring the states' attempts to appropriately use the Section 1915(c) waiver authority. The issuance of the present report is viewed by Association leaders as an initial step in this direction.

APPENDICES

WAIVER TO PROVIDE HOME AND COMMUNITY-BASED SERVICES FOR CERTAIN INDIVIDUALS

SEC. 2176. Section 1915 of the Social Security Act (added by section 2175 of this subtitle) is amended—

(1) by inserting "(other than a waiver under subsection (c))" in subsection (c) after "No waiver under this section", and

(2) by redesignating subsections (c) and (d) as subsections (d) and (e), respectively, and by inserting after subsection (b) the following new subsection:

"(c)(l) The Secretary may by waiver provide that a State plan approved under this part may include as 'me dical assistance' under such plan home or community-based services (other than room and board) approved by the Secretary which are provided pursuant to a written plan of care to individuals with respect to whom there has been a determination that but for the provision of such services the individuals would require the level of care provided in a skilled nursing facility or intermediate care facility the cost of which could be reimbursed under the State plan.

"(2) A waiver shall not be granted under this sub section unless the State provides assurances satisfactory to the Secretary that—

"(A) necessary safeguards (including adequate standards for provider participation) have been taken to protect the health and welfare of individuals provided services under th e waiver and to assure financial accountability for funds expended with respect to such services;

"(B) the State will provide, with respect to individuals who are entitled to medical assistance for skilled nursing facility or intermediate care facility services under the State plan and who may require such services, for an evaluation of the need for such services;

"(C) such individuals who are determined to be likely to require the level of care provided in a skilled nursing fa cility or intermediate care facility are informed of the feasible alterna - tives, if available under the waiver, at the choice of such individuals, to the provision of skilled nursing facility or inter - mediate care facility services;

"(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 the average per capita expenditure that the State reasonably esti - mates would have been made in th at fiscal year for expenditures under the State plan for such individuals if the waiver had not been granted; and

"(E) the State will provide to the Secretary annually, consist - ent with a data collection plan designed by the Secretary, information on the impact of the waiver granted under this subsection on the type and amount of medical assistance pro - vided under the State plan and on the health and welfare of recipients.

"(3) A waiver granted under this subsection may include
of the requirements of subsection (a)(1) (relating to statewide
42 USC 1396a. subsection (a)(10) of section 1902. A waiver under this subsec
be for an initial term of three years and, upon the request of
shall be extended for additional three-year periods unless th
tary determines that for the previous three-year period th
ances provided under paragraph (2) have not been met.

"(4) A waiver granted under this section may, consiste
paragraph (2)—

"(A) limit the individuals provided benefits under suc
to individuals with respect to whom the State has det
that there is a reasonable expectation that the am
medical assistance provided with respect to the individu
such waiver will not exceed the amount of such medic
ance provided for such individual if the waiver did not ap

"(B) provide medical assistance to individuals (to th
consistent with written plans of care, which are subjec
approval of the State) for case management services
maker/home health aide services and personal care s
adult day health services, habilitation services, respite c
such other services requested by the State as the Secret
approve.".

TIME LIMITATION FOR ACTION **ON** REQUESTS FOR PLAN AMEN
AND WAIVERS

SEC. 2177. (a) Section 1915 of the Social Security Act (a
section 2175 of this subtitle) is further amended by adding a
thereof the following new subsection:

"(f) A request to the Secretary from a State for a propos
plan or plan amendment or a waiver of a requirement of t
submitted by the State pursuant to a provision of this title
deemed granted unless the Secretary, within 90 days after th
its submission to the Secretary, either denies such request in
or informs the State agency in writing with respect to any a
information which is needed in order to make a final deter
with respect to the request. After the date the Secretary recei
additional information, the request shall be deemed grante
the Secretary, within 90 days of such date, denies such req

(b) The amendment made by this section shall become effe
da vs after the date of the enactment of this Act.

federal register

Thursday October
1, 1981

Part V

Department of Health and Human Services

Health Care Financing Administration

Medicaid Program; Home and Community-Based Services

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 431,435,440,441

Medicaid Program; Home and Community-Based Services AGENCY: Health Care Financing Administration (HCFA), HHS. ACTION: Interim final rule with comment period.

SUMMARY: This rule amends current Medicaid regulations to permit States to offer, under a Secretarial waiver, a wide array of home and community-based services that an individual may need in order to avoid institutionalization. Before enactment on August 13.1981, of the Omnibus Budget Reconciliation Act of 1981, little coverage under Medicaid was available for noninstitutional long-term care services. Conversely, institutional long-term care services represent a significant part of the budgets of State Medicaid programs.

These regulations, which implement section 2176 of Pub. L 97-35, allow Federal payment for these noninstitutional services, subject to HCFA's approval of the States' requests for waivers and to certain assurances made by the States. Once granted, waivers are in effect for 3 years and are renewable. On an annual basis, the States must report to HCFA on the impact and effectiveness of the program. EFFECTIVE DATES: October 1.1981. These regulations are being published in final for reasons described in the Supplementary Information, below. However, we will consider any written comments mailed by December 30,1981 and will revise the regulations if necessary.

Sections 441.300-441.305 of these regulations contain reporting requirements subject to the Paperwork Reduction Act (Pub. L. 96-511) that have not been approved by the Office of Management and Budget. The reporting is not required until the Office of Management and Budget approval has been obtained. HCFA will publish a notice in the Federal Register when approval has been obtained, indicating the effective date of the reporting. ADDRESS: Address comments in writing to: Administrator, Department of Health and Human Services, Health Care Financing Administration, P.O. Box 17076, Baltimore, Maryland 21235.

If you prefer, you may deliver your comments to Room 309-G Hubert H. Humphrey Building, 200 Independence Ave., S.W., Washington, D.C., or to Room 789, East High Rise Building, 6325 Security Boulevard, Baltimore, Maryland.

In commenting, please refer to BPP-182-FC. Agencies and organizations are requested to submit comments in duplicate.

Comments will be available for public inspection, beginning approximately two weeks after publication, in Room 309-G of the Department's office at 200 Independence Ave.. S.W - Washington, D.C. 20201 on Monday through Friday of each week from 8:30 a.m. to 5:00 pan. (202-245-7890).

Because of the large number of comments we receive, we cannot acknowledge or respond to them individually. However, if as a result of comments, we believe that changes are needed in these regulations, we will publish the changes in the Federal Register and respond to the comments in the preamble of that document.

FOR FURTHER INFORMATION, CONTACT: Robert Wren, (301) 594-9820.

SUPPLEMENTARY INFORMATION:

Background

Until Pub. L. 97-35, the Omnibus Budget Reconciliation Act, was signed on August 13,1981, the Medicaid program provided little coverage for long-term care services in a noninstitutional setting, but offered full or partial coverage for such care in an institution. Even though only approximately 6 percent of the elderly reside in an institution, more than 40 percent of Medicaid expenditures was for long-term institutional care in the most recent year for which data are available.

The House Report accompanying the House Omnibus Reconciliation Bill (H. Rept. 97-158, p. 316) notes that it has been estimated that a quarter of the current nursing home population do not need full-time, residential care. Many elderly, disabled and chronically ill persons live in institutions not for medical reasons, but because of the paucity of health and social services available to them in their homes or communities, and the individual's inability to pay for those services or to have them covered by Medicaid when they do exist.

Assessment procedures required under Medicaid to determine the need for institutional care for the elderly and disabled have not been adequate in preventing avoidable admissions. Most of the reviews occur after admission to the long-term care facility, when it is most difficult to discharge the resident back to the community. In addition, the reviews focus on medical conditions, primarily, and not on social and other factors that are often more critical in determining the most suitable placement.

Statutory Amendments

Section 2176 of Pub. L. 97-35 added new provisions to the Social Security Act to deal with the circumstances described above, by inserting a new subsection 1915(c). (Section 1915 itself was added by section 2175 of Pub. L. 97-35.) The subsection authorizes the Secretary of HHS to waive Medicaid statutory limitations in order to enable a State to cover a broad array of home and community-based services. All such services must be furnished under an individual written plan of care, and may only be furnished to persons who would otherwise require the level of care provided in a skilled nursing facility (SNF) or intermediate care facility (ICF) for which the cost could be reimbursed under the State plan. The law provides that the Secretary will not approve the State's request for a waiver unless the State provides satisfactory assurances to the Secretary that:

1. Necessary safeguards (including adequate standards for provider participation] have been taken to protect the health and welfare of beneficiaries provided services under the waiver and to assure financial accountability for funds spent for the services;

2. The State will provide for an evaluation of the need for the inpatient services for individuals who are entitled to and who may require the level of care provided in an SNF or ICF under the State plan;

3. Any individuals who are determined to be likely to require the level of care provided in a SNF or ICF are informed of the feasible alternatives available under the waiver, and are given the choice of the inpatient services or the alternative noninstitutional services;

4. The average per capita expenditure estimated by the State in any fiscal year for medical assistance provided to these individuals does not exceed the average per capita expenditure that the Slate reasonably estimates would have been made in that fiscal year for expenditures under the State plan for these individuals if the waiver had not been granted; and

5. The State will provide to the Secretary annually, consistent with a data collection plan designed by the Secretary, information on the impact of the waiver on the type and amount of medical assistance provided under the State plan and on the health and welfare of its beneficiaries.

Additionally, the law specifically provides that a waiver granted under section 1915(c) may include a waiver of the requirements of section 1902(a](l) and (10) of the Social Security Act Under section 1902(a)(l) of the Act, a State plan for medical assistance must be in effect throughout the State. Section 1902(a)(10), as amended by Pub. L. 97-35 of the Act, sets forth certain Medicaid eligibility and service coverage requirements. It requires the plan to provide that services available to the categorically needy beneficiary are not less in amount duration and scope than services available to the medically needy and are equal in amount duration and scope for all categorically needy beneficiaries.

Waivers granted under section 1915(c) of the Act shall be for an initial term of three years and, if requested by the State, shall be extended for additional three-year periods unless the Secretary determines that for the previous three-year period, the State did not meet the assurances discussed above (in (1) through (5)).

Section 1915(d), as added by section 2175 and redesignated as section 1915(e) by section 2176 of Pub. L. 97-35. provides that the Secretary shall monitor the implementation of the waivers granted to determine if the requirements of the waivers are being met After giving the State notice and an opportunity for a hearing, the Secretary shall terminate any waivers if noncompliance has occurred.

Under the waiver, the State may exclude those individuals for whom there is a reasonable expectation that home and community-based services would be more expensive than Medicaid services the individual would otherwise receive.

A waiver will allow a State to provide Medicaid to individuals for such services as case management, homemaker, home health aide, personal care, adult day health, habitation, and respite care, and other services requested by the State and approved by the Secretary. The services must be consistent with plans of care, which are subject to the State's approval.

Section 2177 of the Omnibus Budget Reconciliation Act of 1981 also amends the new section 1915 of the Social Security Act. It adds a new subsection (f) that affects subsection (c) as well as other parts of title XDC. Section 1915(f) provides that a request from a State for approval of a State plan amendment or waiver, including a waiver request under section 1915(c), shall be deemed granted unless the Secretary, within 90 days after the date of its submission to the Secretary, either denies the request in writing or informs the State in writing of any additional information needed to make the determination on the request The request will be deemed granted 90 days after the receipt of the additional information, unless the Secretary denies the request in writing within the 90 days.

Regulatory Provisions

The provisions of the new regulations parallel the statute with clarifying or implementing policy as discussed below. The new regulations add a new § 440.180. defining home or community-based services, to 42 CFR Part 440; and a new Subpart G to Part 441, specifying requirements for providing these services. They also add new $ § 435.232, 435.726, and 435.735 to the eligibility regulations, specifying new eligibility provisions that allow States to cover certain individuals who would otherwise be institutionalized. The regulations also make technical amendments to 5431.50, Statewideness; 440.1, the basis and purpose section of the regulations defining Medicaid services; S 440.170(f). Personal care services in a recipient's home; and § 440.250, limits on comparability of services.

The purpose of these regulations is to give the States the maximum opportunity for innovation in furnishing noninstitutional services to beneficiaries, with a minimum of Federal regulation. Basically, we will measure the States' proposals against the statutory requirements rather than against a detailed additional set of Federal guidelines or criteria. That is, we will require the State requesting a waiver to describe its proposal, to explain how it satisfies the statutory requirements of section 1915(c) and, with regard to some specific requirements, to make assurances that those requirements are met. However, we are not generally mandating how the States must establish or implement their community care programs.

Using our experience with demonstration projects, which tested an expanded range of noninstitutional services, we will be able to offer technical assistance to States interested in requesting waivers. We can provide the States with information, for example, on successful procedures and services for a case management system and home health aides. We can also provide assistance to States that they can use in developing their community care programs and, in requesting appropriate waivers and State plan changes.

Note.—References in this document to "the level of care provided in an ICF" include the level of care furnished to beneficiaries in **ICFs for the mentally retarded (ICF/MR) (42 CFR 44O.15O(c)).**

A. Definition of Services

The regulations provide that home or community-based services for which a waiver may be granted under this provision may consist of the following services (other than room and board):

1. Case management services.
2. Homemaker services.
3. Home health aide services.
4. Personal care services.
5. Adult day health services.
6. Habilitation services.
7. Respite care services.
8. Other services requested by the State and approved by the Secretary.

We are not going to try to define these terms in our regulation. Instead, we are requiring that the States define them in their waiver request The States thus have broad discretion in determining the nature of the services to be covered, subject to the budgetary restraints discussed below.

The following discussion of services is presented solely for the purpose of providing the States with suggestions on how they might begin developing a waiver proposal

1. *"Case management** is commonly understood to be a system under which responsibility for locating, coordinating and monitoring a group of services rests with a designated person or organization. It was Congress' view (H. Rept. 97-158, p. 321) that the case manager should be responsible for locating available sources of help from within the family and community so that the burden of care will not be exclusively borne by formal health and social agencies. Thus, an "informal network" of friends, relatives, churches, etc., can be used wherever feasible to strengthen the elderly or disabled person's ties with his or her own community.

2. *"Homemaker services"* is normally viewed as consisting of general household activities (meal preparation and routine household care) provided by a trained homemaker when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for himself or others in the home.

3. *"Home health aide services"* would typically include the performance of simple procedures such as the extension of therapy services, personal care, ambulation and exercise, household services essential to health care at home, assistance with medications that are ordinarily self-administered, reporting changes in the patient's condition and needs, and completing

appropriate records. (See 42 CFR 405.1227(a) and 440.70 for the Medicare and current Medicaid provisions on home health aides.)

4. *"Personal care services"* are presently defined for the Medicaid program in 42 CFR 440.170(0 as services furnished to a recipient in his or her home that are prescribed by a physician in accordance with the recipient's plan of treatment and provided by an individual who is—

(i) Qualified;

(ii) Supervised by a registered nurse; and

(iii) Not a member of the recipient's family.

States can furnish home health aide and personal care services under their State plan without seeking a waiver under section 1915{c}. However, they can also seek such a waiver to provide these services in a manner that departs from these definitions.

5. *"Adult day health services"* are discussed in the legislative history as encompassing "both health and social services needed to insure the optimal functioning of the client as well as habitation services suitable for the care of the mentally retarded and the developmentally disabled" (H. Rept 97-158, p. 321). In our view, such care should be furnished for four or more hours per day on a regularly scheduled basis, for one or more days a week in an outpatient setting. We also believe that meals provided as a part of these services could be covered. Although section 1915(c.)(l) has a general prohibition against the payment for room and board, the Conference Report (H. Rept. 97-208, p. 966) indicates that Congress was aware of the manner in which homemaker and adult day health services are provided under title XX. That statute contains a similar prohibition against payment for "room and board". The title XX regulations at 45 CFR 1396.1 define "board" as "three meals a day or any other full nutritional regimen". Under this definition, title XX now pays for individual meals provided as part of adult day health services. We are adopting the title XX approach. Accordingly, Federal financial participation (FFP) will be available for meals that are provided as a part o f adult day health services.

6. *"Habilitation services "* are typically health and social services needed to insure optimal functioning of the mentally retarded or persons with related conditions.

7. *"Respite care"*—The Conference Report (H. Rept. 97-208, p. 966) states that respite care is given to individuals unable to care for themselves and is provided on a short term basis to the individual because of the absence or need for relief of those persons normally providing the care. Respite care services may be provided in the individual's home or in a facility approved by the State such as a hospital nursing home, foster home or community residential facility. As noted above, section 1915(c)(l) of the Act precludes Federal payment for room and board when furnished as a home or community-based service. However, since the statute specifically authorizes the provision of respite care, and the Conference Report indicates that Congress intended that respite care include full-time, short-term institutional care, which always under the Medicaid program has included room and board, we have concluded that Congress intends to create an exception to the general statutory prohibition against room and board. Accordingly, Federal funds will be available for respite care provided tinder the waiver, including any room and board that may result from furnishing respite care outside a private residence. When respite care is furnished in a setting that charges a "per diem" rate, the room and board is considered part of the "per diem" rate.

8. *Other services*—The State may also request HCFA's approval to provide other home and community-based services not listed here. Such services may include, for example, but not be limited to, nursing care, medical equipment and supplies, physical and occupational therapy, speech pathology and audiology, and minor physical adaptations to the home. We will approve these services and others if the State demonstrates in its waiver request that they are cost-effective (i.e., their cost would not raise the cost of home and community-based care for the beneficiaries to whom they are provided to an amount greater than the cost of the level of care provided in an SNF or 1CF), describes the services in detail, and assures HCFA that the services are necessary to avoid institutionalization.

B. Content of Waiver Requests

Requests for waivers must contain—

(1) The information as described below in C;

(2) The assurances discussed below in D; and

(3) The required supporting information discussed below in E.

Section 1915(c) describes this provision as a waiver. We are implementing it in that fashion. Therefore, we are requiring that the State submit supporting explanation and documentation in the form of a waiver request. If the State does not intend to offer home and community-based services to all individuals who would otherwise likely require institutionalization, it must also include a request for a waiver of the requirements of either section 1902(a)(1 or (10) of the Social Security Act or both, if applicable. If the State intends not to offer the home or community -based services to beneficiaries on the basis that it can reasonably expect that the services would cost more than the services the beneficiaries would otherwise receive, the State must also explain in its waiver request how it will make and implement such determinations.

C Waiver Request Requirements

The waiver request must describe the services the State is offering under the waiver and who is eligible to receive them. It must also state that the services will only be furnished to those eligible beneficiaries who, but for the provision of the home and community-based services, would require the level of care provided in an ICF or SNF.

The request must indicate how the statutory requirements for a plan of care will be met. The services provided a beneficiary must be furnished under a plan of care that is written specifically for that beneficiary. The State has discretion in designing the plan of care process and prescribing who writes individual plans of care. Based on our experience and that of the States, we expect the plan of care to include the medical and other services to be given, their frequency, and the type of provider to furnish them. Plans of care are subject to the State's approval, and the State has the discretion to set up its own approval process. The waiver request must include a description of the qualifications of the individual or individuals who will be responsible for developing the individual plan of care.

D. State Assurances

Section 1915(c) of the Act explicitly requires that a waiver can be approved only if the State provides us with satisfactory assurances of the following:

1. *Safeguards*—The State must assure us that necessary safeguards have been taken to protect the health and welfare of the beneficiaries receiving the services. Under the statute, these safeguards must include adequate standards for provider participation. These regulations do not attempt to define these safeguards or to prescribe how they are to be developed. It is the State's responsibility to determine what the necessary safeguards are, to define them or specify how they will be developed and implemented, and to

explain how they satisfy the statute. If the State has licensure or certification requirements for any services (or for the individuals who furnish these services) provided under the waiver, it must assure HCFA that the standards in the licensure or certification requirements will be met.

The State must also assure us that it will maintain, and require providers of these services to maintain, financial accountability for funds expended with respect to these services. Again, it is the State's responsibility to inform us how it will meet this requirement and, in particular how it will assure that there is an audit trail for all State and Federal funds.

2. *Individual assessments*—Services under the waiver may be furnished only to an individual who, but for these services, would require the level of care provided in an SNF or ICF. This does not mean that the individual must be receiving the level of care provided in an SNF or ICF before receiving the noninstitutional services. It means, rather, that the individual, in the absence of the noninstitutional services, would require the level of care provided in an SNF or ICF. Thus, the state must assure us that, for each beneficiary encompassed by the waiver, it will provide an objective method for evaluating the beneficiary's need for the level of care provided in an SNF or ICF.

The new section requires the States to provide for an evaluation of the need for the level of care provided in an SNF or ICF with respect to all individuals who are entitled to medical assistance for these services and who may require these services. Section 1903(g) of the Act requires Fpecific recertification of the need for institutional care with respect to beneficiaries who are already inpatients. Accordingly, under the waiver, a State would not be required to perform any further evaluation of those inpatients, although it would, of course be free to do so. It would, however, be required to perform an evaluation for all beneficiaries or Medicaid applicants for whom there is a reasonable indication that they might need the level of care provided in an SNF or ICF in the near future. In making this evaluation, the level of care provided in an SNF or ICF, as defined at 42 CFR 140.40 and 440.150 respectively, must be used. Other factors, whether medical or not, may be employed as the State deems appropriate. The State, in its assurance, must include a copy of the written assessment instrument that will be used, must describe how those assessments will be made, and specify who has responsibility for doing them.

The waiver request would have to describe, for example, the party or parties responsible for the assessment, what factors they will use to evaluate and reevaluate the recipient's need for the level of care provided in an SNF or ICF, and when evaluations and revaluations will be made.

Our regulations require that the State maintain written documentation of all such evaluations and reevaluations. {The State need not keep the documentation itself but may arrange for the provider or for another person or agency to keep it.) The State must include in its waiver request an explanation of how it will satisfy this requirement. Congress clearly intended that these services would be made available only to individuals who had been determined to need inpatient SNF or ICF services in the absence of the alternative noninstitutional services. Therefore, we believe the maintenance of documentation is necessary to insure an audit trail and to enable us to determine whether only those individuals who would otherwise have required institutionalization were being provided these service?.

3. *Informing beneficiaries of choice.*— Beneficiaries determined to be likely to require an SNF or ICF level of care must be informed of the feasible alternatives and given a choice as to which type of services to receive. (This would not apply to beneficiaries for whom there is a reasonable expectation that the cost of home and community-based services would be more than the cost of SNF or ICF care, if the State indicates in its waiver request that it will exclude these individuals from coverage under the waiver. See discussion in B above.) The State must explain in its waiver request how this requirement will be met and assure us that it will be met. We are not, however, requiring that the State document that each beneficiary (or his or her representative) has been so informed. In the absence of information to the contrary, we will accept the State's assurance that it has been done.

The Congressional Conference Committee, in its report on this amendment (H. Rept. 97-208. p. 366) emphasized that, while it is expected that the existence of alternatives will encourage the acceptance of community care, the integrity of patient choice must be preserved. The determination of which long-term care options are feasible in a particular case should be based on the individual's needs, as determined by an evaluation, and not on short-term cost savings.

As with other services under Medicaid, a beneficiary who is not given the choice of home or community-based services as an alternative to SNF or ICF services may request a fair hearing under 42 CFR Part 431, Subpart E, unless the reason for the denial is that the group of which the individual is a part is not included within the scope of the waiver (see 42 CFR 431J220(b)). Since a finding that home or community-based services are not feasible in a particular case constitutes a denial of services covered under a State's Medicaid plan, the Medicaid statute (section 1902(a)(3)) requires that applicants and beneficiaries be provided the procedural protections of the Medicaid administrative hearing process as described in 42 CFR Part 431. Subpart E. 4. *A verage per capita expenditures.*— Congress was concerned that the total of all medical assistance for services provided to individuals who would qualify for home or community-based care under the State plan not exceed, on an average per capita basis, the total expenditures that would be incurred for such individuals if home and community-based services were not available. Accordingly, the statute and these regulations provide that the State, in its waiver request must assure us that the average per capita expenditure under the waiver does not exceed the average per capita expenditure, as reasonably estimated by the State, that would have been made under the State plan had the waiver not been granted. Congress expected that this provision would assure that aggregate costs will not be greater than they would have been without these alternative services. (H. Rept. 97-208, p. 967)

Average per capita expenditures for services for this purpose means the aggregate Medicaid payment for all long-term care services furnished (taking into account the utilization of each type of service) divided by the number of beneficiaries expected to receive services. (We are excluding from these calculations services other than long-term care services, since they should be unaffected by the waiver, and their inclusion would simply make the calculations more burdensome.) These estimates must cover each fiscal year during the 3-year term of the waiver. To be granted approval by HCFA, the estimates must be reasonable, based on statistically sound and valid procedures, and verifiable. To develop the required assurances, the State will have to develop estimates of the costs and utilization for each type of service and an estimate of the total population that would likely receive these services. The estimated average per capita expenditures under the waiver is obtained by multiplying (A) the

estimated number of beneficiaries who would receive the level of care provided in an SNF or ICF under the waiver times (B) the estimated Medicaid payment per eligible Medicaid user of such care; and adding that figure to the product of (C) the estimated number of beneficiaries who would receive home and community-based services under the waiver or other noninstitutional alternative services included under the State plan times (D) the estimated Medicaid payment per eligible Medicaid user of such services. This figure is to be divided by (F) the estimated number of beneficiaries who would receive the level of care provided in an SNF or ICF under Medicaid in the absence of the waiver plus (H) the estimated number of beneficiaries who would receive any of the noninstitutional, long-term care services otherwise provided under the State plan as an alternative to institutional care.

To illustrate,

$\frac{(A \times B) + (C \times D)}{F + H}$ = the estimated average

pet capita expenditure under the waiver.

Note.—The product of Ax B would be calculated separately for SNF and ICF levels of care and then added. Similarly, the product of CxD would be calculated for each type of service covered under the waiver and then added. Thus, the numerator would be the sum of all these products—or the estimated aggregate cost for all long-term care services offered under the plan.

Next, the State will develop an estimate of average per capita expenditures that would result in the absence of a waiver. This estimate is obtained by multiplying (F) the estimated number of beneficiaries who would receive the level of care provided in an SNF or ICF in the absence of the waiver times (G) the estimated Medicaid payment per eligible Medicaid user of such care; and adding that figure to the product of (H) the estimated number of beneficiaries who would receive any of the noninstitutional, long-term care services otherwise provided under the State plan as an alternative to institutional care times (I) the estimated Medicaid payment per eligible Medicaid user of such noninstitutional services. This figure will be divided by the same denominator as before—namely. (F) the estimated number of beneficiaries who would receive the level of care provided in an SNF or ICF under Medicaid in the absence of the waiver plus (H) the estimated number of beneficiaries who would receive any of the noninstitutional. long-term care services otherwise provided under the State plan as an alternative to institutional care.

To illustrate.

$\frac{(F \times G) + (H \times I)}{F + H}$ = the estimated average per capita expenditures in the absence of a waiver.

In both of these computations the denominator (i.e., the estimated number of beneficiaries who would likely receive the level of care provided in an ICF or SNF under Medicaid in the absence of the waiver) must be the same number for like periods of time. In particular, if the State wishes to revis e its estimate of the denominator at some point after a waiver is approved (in order to adjust for an error in the estimate or for adding an unanticipated increase in the eligible population], that revision would be made in both calculations and the comparison would be re-examined to determine if the waiver is still cost effective.

In developing the estimates of utilization necessary to complete the above computations, the State must use actual data on nursing home cost and utilization and on cost and utilization of community-based services for the most recent year before the waiver takes effect. These figures would be adjusted by the State to reflect anticipated growth in the supply of nursing home beds, availability of community-based services and inflation. Similarly, the State's experience with utilization and cost of home and community-based services provided under title XIX, title XX and other programs should provide a useful basis for the necessary estimates.

The State, in its waiver request, must inform HCFA of what its per capita expenditures are, describe how these were estimated, and describe the factors it employed in deriving the estimates. HCFA will review these estimates very closely to determine if they are reasonable and based on statistically supportable assumptions. Further, HCFA will compare these estimates with data the State must furnish annually on its actual experience. In the event of a discrepancy between actual and estimated per capita expenditures, HCFA will ask the State to explain the basis for the difference or to adjust its estimates.

We will provide further guidance on how to develop estimating methodology and will provide technical assistance to States that request it.

5. *Annual report on impact*—The State must assure us that it will provide us annually with information on the impact of the waiver on the type and amount of services provided under the State plan and on the health and welfare of the beneficiaries. The data will have to be consistent with a data collection plan we are designing. We will provide further guidance to the States' on what data must be submitted and in what form. However, such data would include, but not be limited to, the State' actual per capita expenditures for services provided under the waiver.

D. Duration of Waiver

If we approve a waiver request, the waiver may continue for three years. The waiver may be extended for three-year periods thereafter if the State requests it, unless our review of the prior three-year period shows that the assurances the State offered were not met.

The development and implementation of a State home and community-based services program is a time-consuming and complex process, often requiring the coordination of several agencies and, sometimes, State legislative action. In recognition of this, Congress provided that the waiver would be for three-year periods of time. However, Congress also provided in the amendments for the Secretary to monitor implementation of the waivers to assure that the requirements for them are being met Thus, if HCFA finds that a given State is not meeting the assurances it made in it: waiver request or any of the other requirements for a waiver specified in this subpart, the State will be given a notice of these findings and an opportunity for a hearing to rebut the findings. If, after the proceedings, HCFA determines that the State is not in compliance, HCFA will terminate the waiver. Possible grounds for termination will include excessive costs.

If a State wants to terminate its waiver before the completion of the three-year period and no longer provide home and community-based services, it must submit a written request to HCFA showing its intent to terminate the waiver 30 days before terminating services.

Whether HCFA or the State terminates the waiver, the State must notify beneficiaries receiving services under the waiver in accordance with 42 CFR 431.210 and must notify them 30 days before ending services. The State does not have to offer a hearing to beneficiaries when a waiver is terminated.

E. HCFA's Review of Waiver Requests

When we receive a request for a waiver, we will review its contents against the regulations and the statute to determine whether the request meets our requirements. For example, we will review to see that per capita expenditure estimates are reasonable

and that the State has an adequate means for evaluating whether a beneficiary needs the level of care provided in an SNF or ICF. If we find the request inadequate, unrealistic, or not cost-effective, we will return the request for more or better information. If the additional information does not improve the request sufficiently, we will deny it

F. Eligibility of Beneficiaries

Under 42 CFR 435.231. it is possible for a beneficiary who would not be eligible for Medicaid while in the community to be eligible in an institution. The regulations permit States to set a special income standard that results in a higher institutional eligibility level for institutionalized beneficiaries than the community-based eligibility level. This level cannot exceed 300 percent of the Supplemental Security Income (SSI) community-based payment standard (42 CFR 435.722 and 435.1005). Most States have chosen this option and often the institutional level is significantly higher than the community level. The purpose of current regulations, which-recognize the high cost of institutional care, is to enable States, particularly those without spend down mechanisms, such as a medically needy program, to cover institutionalized individuals although their income exceeds the community-based level. However, a beneficiary may lose Medicaid eligibility if he or she leaves the institution and returns to the community. A lack of community-based supportive services and the eligibility effect of § 435.231 have combined to provide an incentive toward institutionalization.

Section 1915(c) of the Act has a target population consisting of beneficiaries who are or who would be eligible for Medicaid in an institutional setting. The statute is not explicit on how beneficiaries are to be determined eligible for new services under the waiver. However, we believe that Congress did not intend that there would be a smaller population eligible for Medicaid for home and community-based services than for institutional long-term care. In addition, the purpose of the law is to provide an incentive for beneficiaries to remain in the community by providing supportive care at home, rather than making it available to them only in an institution.

Under our regulations implementing the changes in Medicaid eligibility made by Pub. L. 97-35, "Medicaid Eligibility and Coverage Criteria", BPP-179-FG published in the Federal Register of September 30,1981, we decided to retain, at least for the time being, this and other optional categorically needy groups. To keep optional categorical coverage under 42 CFR 435.231 for the institutionalized only would deprive the program and the beneficiaries who are eligible for Medicaid only because they are institutionalized of the benefits of having care provided at home and in the community, and of the savings that Congress expected would accrue from the provision of less costly noninstitutional care. Therefore, we are adding new regulations, 42 CFR 435.232, to allow States to cover individuals who would be eligible for institutional services under 42 CFR 435.231 to be eligible for home and community-based services furnished under a waiver. The new regulations, § 435.232, will affect only the base of categorically-needy beneficiaries. Medically needy individuals may become eligible under provisions of other regulations.

These new regulations, § 435.232, are very similar to 5 435.231 and permit States to make eligible those categorically needy individuals in the community who—

(1) Are not eligible for SSI or a State supplement because of their income;

(2) Have income below a level specified in the plan under § 435.722;

(3) Would be eligible under J 435.231 if institutionalized: and

(4) Would require institutional care if not receiving home or community-based services authorized under the waiver.

The effect of the changes just discussed is to remove the bias in favor of institutionalization. Conversely, we do not wish to provide an inequitable incentive for those receiving noninstitutional services.

Since beneficiaries determined eligible under a special standard, such as § 435.231, have income in excess of their maintenance needs, it is reasonable to expect these beneficiaries to share in the cost of personal and medical care above a level of income protected for maintenance needs. Current regulations at 42 CFR 435.725 and 435.733 impose this requirement on beneficiaries who are Medicaid eligible under 431.231. Therefore, to insure equal treatment of institutionalized beneficiaries and beneficiaries receiving home and community-based services under the waiver, we will require beneficiaries who are eligible for home and community-based services under the waiver to share in the cost of the services. We believe that this requirement is supportable under the rationale of *Friedman* v. *Berger*, 547 F. 2d 724 (2d Cir., 1976). We are adding new § 435.726 and 435.735 to 42 CFR Part 435 for categorically needy beneficiaries. The sections are very similar to $ § 435.725 and 435.733, which lay out the requirements of post-eligibility treatment of income and resources of institutionalized beneficiaries. Section 435.726 deals with beneficiaries who reside in States that provide Medicaid to all SSI beneficiaries or to all SSI beneficiaries and to State supplement beneficiaries. Section 435.735 deals with beneficiaries residing in States with more restrictive requirements than SSI.

There are two major differences in the new sections: (1) there is no provision dealing with consideration of maintenance of the beneficiary's home while he or she is an inpatient; and (2) there is no provision specifying the amount that is to be deducted from a beneficiary's total income and protected for his or her use for personal needs. Instead, there will be a provision discussing a beneficiary's maintenance allowance, which will be deducted from the total income. We are requiring this amount to be based on a reasonable assessment of need but it must not (for beneficiaries subject to the provisions of § 435.726, applicable to States covering all SSI beneficiaries) exceed the highest of:

(a) The amount of the income standard used to determine eligibility for SSI for and individual living in his own home, if the agency provides Medicaid only to individuals receiving SSI;

(b) The amount of the highest income standard, in the appropriate category of age, blindness, or disability, used to determine eligibility for an optional State supplement for an individual in his or her own home, if the agency provides Medicaid to optional State supplement recipients under § 435.230; or

(c) The amount of the medically needy income standard for one person established under §5 435.811 and 435.814, if the agency provides Medicaid under the medically needy coverage option.

Our reasoning for setting these maximum levels (and those under § 435.735] for beneficiaries only is that they are the levels set under the present regulations at §§ 435.726{c}(2) and 435.733(c)(2) for maximum maintenance levels for spouses in the community. We assume that all other needs of beneficiaries under the waiver, which might otherwise require a higher income level to meet them, will be met by the supportive services furnished under the waiver.

In these regulations the allowances for a beneficiary with only a spouse at home and for a beneficiary with a family at home will be based on the same criteria that are used for beneficiaries

who are eligible for Medicaid because they are institutionalized.

A beneficiary with only a spouse will be allowed the reasonable amount for the beneficiary's maintenance, as determined above, plus a reasonable amount for maintenance of the spouse. The reasonable amount for the spouse will be based on the same criteria used to determine the allowance for the beneficiary.

The allowances for a beneficiary with a family will be the reasonable amount (as determined above) for the beneficiary, plus an additional amount for the maintenance needs of the family. The additional amount will:

(a) Be based on a reasonable assessment of the family's financial needs;

(b) Be adjusted for the number of family members living in the home; and

(c) Not exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's AFDC plan or the medically needy income standard established under 42 CFR Part 435, Subpart i for a family of the same size. See present S 435.725(c)(3).

The State must also deduct from the beneficiary's total income amounts for incurred medical expenses that are not subject to payment by a third party. These expenses include:

(a) Medicare and other health insurance premiums, deductibles, or coinsurance charges; and

(b) Necessary' medical or remedial care recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits the agency may establish on amounts of these expenses. See present S 435.725{c)(4).

For beneficiaries subject to the provisions of § 435.735 (applicable to States with more restrictive requirements than SSI), the amount the beneficiary needs for maintenance will be determined in the same manner as the maintenance needs of the spouse under existing regulations at § 435.733. The spouse's needs will be determined the same as in § 435.733, as will the family's needs. Amounts for incurred medical expenses, as in § 435.733. will be deducted from total income.

G. Technical Changes

We are revising 5 431.50, Statewide operation, to show that a State need not offer services under the new benefit to all beneficiaries in the State.

We ire revising § 440.1, the basis and purpose statement for existing regulations on services, to show the new statutory authority for services that can be furnished under the waiver.

We are amending $ 440.170(f) so that personal care services, when furnished under a waiver as home and community-based services, will not have to meet the definitions of these sections.

Finally, we are amending *1*440.250, regulations on comparability of services, to provide that if applicable under the waiver, services provided by the State need not be comparable for all individuals within a group.

Some sections of these regulations are affected by statutory provisions that are implemented by other regulations documents also being published at this time. It would be confusing to present the same section with different wording in different documents (by making, in each document only the particular changes called for by the statutory provisions implemented by that document). In order to avoid this problem, the sections affected by more than one provision are presented in each document with all the changes required by each of the provis ons of law that affect them. However, each of the changes is explained only once, in the preamble of the regulations document that implements the provision which requires that particular change.

Waiver of Proposed Rulemaking

Public Law 97-35 was enacted on August 13,1981, and section 2176 of that law became effective on that date. In order to have regulations in place as close as possible to the effective date of the law, we must publish these regulations in final form promptly. Because of this, and because we believe that the States and a substantial number of Medicaid recipients may benefit by these regulations, we believe that publication of a notice of proposed rulemaking would be contrary to the public interest We therefore find good cause to waive notice of proposed rulemaking and our normal 30-day delay in effective date. We will, however, consider any comments on this rule that are mailed by the date specified above in the "Dates" section and make any further changes that may be necessary. We will also respond to the comments when we make any further changes.

Impact Analyses

Executive Order 12291

The Secretary has determined that the proposed regulations do not meet the criteria for a "major rule", as defined by section l(b) of Executive Order 12291. That is, the proposed regulations will not—

• Have an annual effect on the economy of $100 million or more;

•Result in a major increase in costs or prices for consumers, any industries, any government agencies or any geographic regions; or

•Have significant adverse effects on competition, employment investment productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or import markets.

Congress estimated that this provision, as it appeared in H.R. 3962, would save $20 million in fiscal year 19821 Cost or savings estimates for the provision, as enacted, were not developed.

The costs or savings are a function of the balance between deinstitutionalization (some current residents of nursing homes could be returned to the community for less money) and new demand (some people who currently receive care from family and friends despite a medical need for nursing home care will become eligible for Medicaid outside the nursing home setting], and the number of States which choose to exercise this option. Because of these variables, we cannot estimate the cost of this program at this time. (However, Congress indicated (H. Rept 97-206. p. 967) that it expected the provisions concerning per capita costs to assure that aggregate costs will not be greater than they would have been without the home and community-based services.) Moreover, the purpose of the legislative amendment was to provide the States with sufficient flexibility to develop more economical alternatives to the high cost of long-term care institutional services. To the extent that this purpose is achieved, then the cost of providing the home and community-based services under the waiver will offset the cost of institutional care that would otherwise have been required. Further, by facilitating the use of other providers of care, more competition should be generated. Accordingly, we do not believe the criteria for a "major rule" will be met

Regulatory Flexibility Act

Section 604 of Public Law 96-354 (the Regulatory Flexibility Act of 1980) requires that each Federal agency prepare, and make available for public comment a regulatory flexibility analysis on certain regulations. The regulatory flexibility analysis is intended to explain what effect regulatory actions by agencies would have on small businesses and other small entities.

As defined by the Regulatory Flexibility Act, the term "small entities"

includes "small governmental jurisdictions". The latter term is defined as local governments (cities, counties, towns, townships, villages, school districts, or other special districts) with a population of less than fifty thousand persons.

As explained above, these regulations will permit States to offer an array of services to beneficiaries outside of an institutional setting. Although they directly affect States, the regulations could indirectly adversely affect providers of institutional services that are small enough to meet the definition of "small entity", since some individuals may choose a home or community-based service rather than an inpatient service. However, we do not believe the regulations will have a significant economic effect on a substantial number of small entities. These regulations will benefit some entities that were not able to participate previously as providers under Medicaid before because the services they provide are not covered under the Medicaid program. The regulations are intended to expand the universe of small providers and may benefit them economically. Although we do not know how many States will take advantage of the provisions of these regulations, we project that the total number of providers that benefit significantly will be small compared to total number of providers. (Many providers in a position to become Medicaid providers are already reimbursed under other programs for the same services.) Therefore, the Secretary certifies, under section 605(b) of the Regulatory Flexibility Act, that the regulations will not have a significant economic impact on a substantial number of small entities.

Reporting end Recordkeeping Requirements

The Department is required to submit to the Office of Management and Budget for review and approval, 42 CFR 441.301, 441.302. 441.303 and 441.304. which include reporting and recordkeeping requirements. These sections have been submitted to OMB. We will publish a notice in the Federal Register when approval has been obtained indicating the effective date of the reporting.

PART 431—STATE ORGANIZATION AND GENERAL ADMINISTRATION

42 CFR Part 431 is amended as follows:

The authority citation for Part 431 reads as follows:

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

2. Section 431.50 is amended by revising paragraphs (a) and (c) to read as follows:

{431.50 Statewide operation.

(a) *Basis and purpose.* This section implements section 1902(a)(l) of the Act which requires a State plan to be in effect throughout the State, and section 1915, which permits certain exceptions.
* * * * *

(c) *Exceptions.* The requirements of paragraph (b) of this section do not apply with respect to:

(1) Service offered by comprehensive health services organizations (see § 440.25O(g)) of this subchapter;

(2) Services offered by rural health clinics (see § 440.20(b)):

(3) Arrangements under $ 431.54(d) to purchase medical services or laboratory and x-ray services (as defined in § 440.30);

(4) Lock-in or lock-out restrictions under J 431.54(e) and (f); and

(5) Services offered under a waiver with respect to home and community based services (§ 440.180).

PART 435— ELIGIBILITY IN THE STATES AND DISTRICT OF COLUMBIA

42 CFR Part 435 is amended as follows:

1. The table of contents for Part 435 is amended by adding new §§ 435.232, 435.728 and 435.735 as follows:

Subpart C—Options for Coverage as Categorically Needy

Section

435.232 Individuals receiving home and community-based services who are eligible under a special income level.

Subpart H—Financial Requirements for the Categorically Needy

* * * * *

435.728 Post-eligibility treatment of income and resources of individuals receiving home and community-based services furnished under a waiver: Application of patient income to the cost of care.

* * * * *

435.735 Post-eligibility treatment of income and resources of individuals receiving home and community-based services furnished under a waiver: Application of patient income to the cost of care.

2. The authority citation for Part 435 reads as follows:

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

3. Section 435.3 is amended by adding a new statutory citation at the end of the existing text as set forth below.

{435.3 Basis

This part implements the following sections of the Act, which state eligibility requirements and standards:
* * * * *

1915(c) Home or community based services. -

4. A new 435.232 is added to read as follows:

$ 435.232 Individuals receiving horn* **and** community-based services who are eligible under a special income level.

(a) If the agency provides Medicaid under 435.231 to individuals in institutions who are eligible under a special income level, it may also cover aged, blind and disabled individuals in the community who—

(1) Because of their income, are not eligible for SSI or State upplements;

(2) Have income below a level specified in the plan under $ 435.722 (See § 435.1005 for limitations on FFP in Medicaid expenditures for individuals specified in this section);

(3) Would be eligible for Medicaid under § 435.231 if institutionalized; and

(4) Will receive home and community-based services under a waiver granted under Part 441, Subpart G, of this subchapter.

5. New § 435.726 and 435.735 are added to read as follows:

§ 435.726 Post-eligibility treatment of income and resources of individuals receiving home and community-based services furnished under a waiver Application of patient income to the cost of care.

(a) The agency must reduce its payment for home and community-based services provided to an individual specified in paragraph (b) of this section, by the amount that remains after deducting the amounts specified in paragraph (c) of this section from the individual's income.

(b) This section applies to individuals who are eligible for Medicaid under 5 435.232 and are receiving home and community-based services furnished under a waiver of Medicaid requirements under Part 441, Subpart G of this subchapter.

(c) In reducing its payment for home and community-based services, the agency must deduct the following amounts, in the following order, from the individual's total income (including amounts disregarded in determining eligibility):

(1) An amount for the maintenance needs of the individual. This amount must be based on a reasonable assessment of need but must not exceed the higher of—

(1) The amount of the income standard used to determine eligibility for SSI for an individual living in his own home, if the agency provides Medicaid only to individuals receiving SSI;

(ii) The amount of the highest income standard, in the appropriate category of age, blindness, or disability, used to determine eligibility for an optional State supplement for an individual in his own home, if the agency provides Medicaid to optional State supplement recipients under 435.230; or

(iii) The amount of the medically-needy income standard for one person established under S S 435.811 and 435.814. if the agency provides Medicaid under the medically needy coverage option.

(2) For an individual with only a spouse at home, an additional amount for the maintenance needs of the spouse. This amount must be based on a reasonable assessment of need but must not exceed the highest of—

(i) The amount of the income standard used to determine eligibility for SSI for an individual living in his own home, if the agency provides Medicaid only to individuals receiving SSI:

(ii] The amount of the highest income standard, in the appropriate category of age, blindness, or disability, used to determine eligibility for an optional State supplement for an individual in his own home, if the agency provides Medicaid to optional State supplement recipients under § 435-230; or

(iii) The amount of the medically needy income standard for one person established under §§ 435.811 and 435.814, if the agency provides Medicaid under the medically needy coverage option.

(3) For an individual with a family at home, an additional amount for the maintenance needs of the family. This amount must—

(i) Be based on a reasonable assessment of their financial need;

(ii) Be adjusted for the number of family members living in the home; and

(iii) Not exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's AFDC plan or the medically needy income standard established under subpart I of this part for a family of the same size.

(4) Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party including—

(i) Medicare and other health insurance premiums, deductibles, or coinsurance charges; and

(ii) Necessary medical or remedial care recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits the agency may establish on amounts of these expenses.

$435,735 Post-eligibility treatment of income and resources of individuals receiving home and community-based services furnished under a waiver: Application of patient income to the cost of

(a) The agency must reduce its payment for home and community-based services provided to an individual specified in paragraph (b) of this section, by the amount that remains after deducting the amounts specified in paragraph (c) of this section from the individual's income.

(b) This section applies to individuals who are eligible for Medicaid under § 435.232, and are eligible for home and community-based services furnished under a waiver of State plan requirements under Part 441, Subpart G of this subchapter.

(c) In reducing its payment for home and community-based services, the agency must deduct the following amounts, in the following order, from the individual's total income (including amounts disregarded in determining eligibility):

(1) An amount for the maintenance needs of the individual. This amount must be based on a reasonable assessment of need but must not exceed the higher of—

(1) The more restrictive income standard established under 435.121: or

(ii) The medically needed standard for an individual.

(2) For an individual with only a spouse at home, an additional amount for the maintenance needs of the spouse. This amount must be based on a reasonable assessment of need but must not exceed the higher of—

(i) The more restrictive income standard established under § 435.121; or

(ii) The medically needy standard for an individual.

(3) For an individual with a family at home, an additional amount for the maintenance needs of the family. This amount must—

(i) Be based on a reasonable assessment of their financial need;

(ii) Be adjusted for the number of family members living in the home; and

(iii) Not exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under subpart I of this part for a family of the same size.

(4) Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including—

(i) Medicare and other health insurance premiums, deductibles. coinsurance charges; and

(ii) Necessary medical or remed care recognized under State law b covered under the State's Medicaid plan, subject to reasonable limits agency may establish on amounts these expenses.

PART 440—SERVICES: GENERAL PROVISIONS

42 CFR Part 440 is amended as follows.

1. The authority citation for Part reads as follows:

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

2. Section 440.1 is revised to read as follows:

§ 440.1 Basis and purpose.

This subpart interprets section 1 of the Act which lists the services included in the term "medical assistance," sections 1905 (c), (d), and (1), which define some of those services, and section 1915(c), which as "medical assistance" certain homes and community-based services provided under waivers under that section 1 individuals who would otherwise require institutionalization. It also implements sec. 1902(a)(43) with to laboratory services (see also §§447.10 and 447.342).

3. Section 440.170 is amended by revising paragraph (f) as follows:

§440.170 Any other medical care provider remedial care recognized under State and specified by the Secretary.

. . .

(f) *Personal care services in a recipient's home.* Unless defined differently by a State agency for purposes of a waiver granted under 441, Subpart G of this chapter, "persons care services in a recipient's home means services prescribed by a physician in accordance with the recipient's plan of treatment and provided by an individual who is -

(1) Qualified to provide the service

(2) Supervised by a registered nurse

and

(3) Not a member of the recipient family.

4. Section 440.180 is added to read as follows:

§ 440.180 Home or community-base services.

(a) "Home or community-based

services" means services that are furnished under a waiver granted the provisions of Part 441, Subpart this subchapter. The services may

consist of any of the following services as defined by the agency (but not including room and board except as specifically provided for in paragraph (b) of this section]:

(1) Case management services;
(2) Homemaker services;
(3) Home health aide services;
(4) Personal care services;
(5) Adult day health services;
(6) Habilitation services;
(7) Respite care services;
(8) Other services requested by the Medicaid agency and approved by HCFA as cost-effective.

(b) FFP for home community-based services des cribed in paragraph (a) of this section is not available in expenditures for the cost of room and board except when provided as part of respite care in a facility approved by the State that is not a private residence. For purposes of this provision, "board" means three meals a day or any other full nutritional regimen and does not include meals provided as part of a program of adult day health services.

5. Section 440.250 is amended by adding new paragraphs (h) through (k) to read as allows:

§440.25C limits on comparability of

(ii) Ambulatory services for the medically needy (§ 440.220(b)) may be limited to—

(1} Individuals under age 18; and

(2) Individuals entitled to institutional services,

(i) Services provided under an exception to requirements allowed under § 431.54 may be limited as provided under that exception.

(j) If HCFA has approved a waiver of Medicaid requirements under § 431.55, services may be limited as provided by the waiver.

(k) If the agency has been granted a waiver of the requirements of § 440.240 (Comparability of services) in order to provide home or community-based services under § 440.180, the services provided under the waiver need not be comparable for all individuals within a group.

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

42 CFR Part 441 is amended as follows:

Subpart G, § § 441.300-441.305 is added to read as follows:

Subpart G—Home and Community Based Services: Waiver Requirements

Sec.
441.300 Basis and purpose.
441.301 Contents of request for a waiver.
441.302 State assurances.
441.303 Supporting documentation required.
441.304 Duration of waiver.
441.305 Notification of termination of a waiver.

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

Subpart G—Home and Community-Based Services: Waiver Requirements

§ 441.300 Basis and purpose.

Section 1915(c) of the Act permits States to offer, under a waiver of statutory requirements, an array of home and community-based services that an individual needs to avoid institutionalization. Those services are defined in $ 440.180 of this subchapter. This subpart describes what the Medicaid agency must do to obtain a waiver.

§ 441.301 Contents of request for a waiver.

(a) A request for a waiver under this section must consist of—

(1) The assurances required by § 441.302 and the supporting documentation required by § 441.303;

(2) When applicable, requests for waivers of the requirements of section 1902(a) (1) or (10) of the Act: and

(3) A statement as to whether the agency will refuse to offer home or community-based services to any recipient because it can reasonably expect that the cost of the home or community-based services furnished to that recipient would exceed the cost of the level of care provided in an SNF or ICF (or ICF/MR if applicable).

(b) If the agency furnishes home and community-based services, as defined in 440.180 of this subchapter, under a waiver granted under this subpart, the waiver request must:

(1) Provide that the services are furnished—

(1) Under a written plan of care subject to approval by the Medicaid agency;

(ii) Only to recipients who are not inpatients of a hospital, SNF, ICF, or ICF/MR, and who the agency determines would require the level of care provided in an SNF or ICF (or ICF/ MR, if applicable) under Medicaid (as defined in §§ 440.40 and 440.150) if not furnished these services;

(2) Describe the qualifications of the individual or individuals who will be responsible for developing the individual plan of care;

(3) Describe the group or groups of individuals to whom the services will be offered;

(4) Describe the services to be furnished; and

(5) Provide that the documentation requirements regarding individual evaluation, specified in § 44U03(c], will be met.

5 441.302 State assurances.

HCFA will not grant a waiver under this subpart unless the Medicaid agency provides satisfactory assurances to HCFA that:

(a) Necessary safeguards have been taken to protect the health and welfare of the recipients of the services. Those safeguards must include adequate standards for provider participation. If the State has licensure or certification requirements for any services or for any individuals furnishing services provided under the waiver, it must assure that the standards in the licensura or certification requirements will be met.

(b) The agency will assure financial accountability for funds expended for home and community-based services, and it will maintain and make available to HHS, the Comptroller General, or their designees, appropriate financial records documenting the cost of services provided under the waiver.

(c) The agency will provide for an evaluation of the need for home and community-based care for recipients who are entitled to the level of care provided in an SNF, ICF, or ICF/MR, as defined by 15 440.40 and 440.150 respectively, and for whom there is a reasonable indication that they might need such services in the near future.

(d) If a recipient is determined to be likely to require the level of care provided in an SNF. ICF, or ICF/MB; services, the recipient or his or her representative will be informed of the feasible alternatives, if any, available under the waiver, and permitted to choose among them.

(e) The average per capita fiscal year expenditures under the waiver will not exceed the average per capita expenditures for the level of care provided in an SNF, ICF, or ICF/MR under the State plan that would have been made in that fiscal year had the waiver not been granted. These expenditures must be reasonably estimated by the agency, and the estimates must cover each year of the waiver period.

(f) The agency will provide HCFA annually with information on the impact of the waiver on the type, amount and cost of services provided under the State plan and on the health and welfare of recipients. The information must be consistent with a data collection plan designed by HCFA.

5441.303 Supporting documentation required.

The agency must furnish HCFA with sufficient information to support the assurances required by § 441.302. The information must consist of the following, at a minimum:

(a) A description of the safeguards necessary to protect the health and welfare of recipients.

(b) A description of the records and information that will be maintained to support financial accountability.

(c) A description of the agency's plan for the evaluation and reevaluation of recipients, including a description of who will make these evaluations and how they will be made. The information must Include a copy of the evaluation instrument to be used and provide for the maintenance of written documentation of all evaluations and reevaluations.

(d) An explanation with supporting documentation of how the agency estimated the per capita expenditures for both institutional and noninstitutional services. This: information must include the estimated utilization rates and costs for institutional and noninstitutional services included in the plan.

(1) The average per capita expenditure estimate of the cost of all services, both institutional and noninstitutional, under the waiver must not exceed the average per capita expenditure of the cost of all services in the absence of a waiver. The estimates are to be based on the following equation:

$$\frac{(A \times B) + (C \times D)}{F+H} \leq \frac{(F \times G) + (H \times I)}{F+H}$$

where:

A = the estimated number of beneficiaries who would receive the level of care provided in an SNF, ICF. or ICF/MR under the waiver.

B = the estimated Medicaid payment per eligible Medicaid user of such institutional care.

C= the estimated number of beneficiaries who would receive home and community-based services under the waiver or other noninstitutional alternative services included under the State plan.

D = the estimated Medicaid payment per eligible Medicaid user of such home and community-based services.

F= the estimated number of beneficiaries who would likely receive the level of care provided in an SNF, ICF, or ICF/MR in the absence of the waiver.

G = the estimated Medicaid payment per eligible Medicaid user of such institutional care.

H = the estimated number of beneficiaries who would receive any of the noninstitutional, long-term care services otherwise provided under the State plan as an alternative to institutional care.

I=the estimated Medicaid payment per eligible Medicaid user of the noninstitutional services referred to in H.

$441,304 Duration of a waiver.

(a) Except as provided in paragraph (b) of this section, a waiver of State plan requirements to provide home or community-based services approved under this section will continue for a three-year period from the date of the approval. If the agency requests it, the waiver may be extended for three years after the initial three-year period, if HCFA's review of the prior three-year period shows that the assurances required by { 441.302 of this subpart were met.

(b) If HCFA finds that an agency is not meeting any of the requirements for a waiver contained in this subpart the agency will be given a notice of-HCFA's findings and an opportunity for a hearing to rebut the findings. If HCFA determines that the agency is not in compliance with this subpart after the notice and any hearing. HCFA will terminate the waiver.

§441.305 Notification of a waiver termination.

(a) If a State chooses to terminate its waiver before the three-year period is up, it must notify HCFA in writing 30 days before terminating services to recipients.

(b) If HCFA or the State terminates the waiver, the State must notify recipients of services under the waiver in accordance with 5 431.210 of this subchapter and notify them 30 days before terminating services.

(Catalog of Federal Domestic Assistance Program No. 11714. Medical Assistance Program)

Daied: September 16.1981.

Carolyne K. Davis,

Administrator. Health Care Financing Administration.

Approved: September 24.1961.

Richard S. Schweiker.

Secretary:

[FR Doc 81-28331 PHed 9-30-8L 8.45 am)

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5441.303 Supporting documentation required.

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(a) A description of the safeguards necessary to protect the health and welfare of recipients.

(b) A description of the records and information that will be maintained to support financial accountability.

(c) A description of the agency's plan for the evaluation and reevaluation of recipients, including a description of who will make these evaluations and how they will be made. The information must Include a copy of the evaluation instrument to be used and provide for the maintenance of written documentation of all evaluations and reevaluations.

(d) An explanation with supporting documentation of how the agency estimated the per capita expenditures for both institutional and noninstitutional services. This: information must include the estimated utilization rates and costs for institutional and noninstitutional services included in the plan.

(1) The average per capita expenditure estimate of the cost of all services, both institutional and noninstitutional, under the waiver must not exceed the average per capita expenditure of the cost of all services in the absence of a waiver. The estimates are to be based on the following equation:

$$\frac{A \times B + C \times D}{F + H} = \frac{F \times G + H \times I}{F + H}$$

where:

A = the estimated number of beneficiaries who would receive the level of care provided in an SNF, ICF. or ICF/MR under the waiver.

B = the estimated Medicaid payment per eligible Medicaid user of such institutional care.

C= the estimated number of beneficiaries who would receive home and community-based services under the waiver or other noninstitutional alternative services included under the State plan.

D = the estimated Medicaid payment per eligible Medicaid user of such home and community-based services.

F= the estimated number of beneficiaries who would likely receive the level of care provided in an SNF, ICF, or ICF/MR in the absence of the waiver.

G = the estimated Medicaid payment per eligible Medicaid user of such institutional care.

H = the estimated number of beneficiaries who would receive any of the noninstitutional, long-term care services otherwise provided under the State plan as an alternative to institutional care.

I=the estimated Medicaid payment per eligible Medicaid user of the noninstitutional services referred to in H.

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(b) If HCFA finds that an agency is not meeting any of the requirements for a waiver contained in this subpart the agency will be given a notice of-HCFA's findings and an opportunity for a hearing to rebut the findings. If HCFA determines that the agency is not in compliance with this subpart after the notice and any hearing. HCFA will terminate the waiver.

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(a) If a State chooses to terminate its waiver before the three-year period is up, it must notify HCFA in writing 30 days before terminating services to recipients.

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(Catalog of Federal Domestic Assistance Program No. 11714. Medical Assistance Program)

Daied: September 16.1981.

Carolyne K. Davis,

Administrator. Health Care Financing Administration.

Approved: September 24.1961.

Richard S. Schweiker. *Secretary:*

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Informational Contacts in State Mental Retardation Agencies Regarding Medicaid Home and Community Care Waivers

State	Contact Person
Alabama	Robert D. Sanders, Ph.D. Associate Commissioner for MR and Superintendent of Facilities Department of Mental Health P.O. Box 864 Tuscaloosa, AL 35402 (205) 556-5390
Alaska	Robert P. Gregovich, Ph.D. Program Administrator DD Section Department of Health and Social Services Pouch H-04 Juneau, AK 99 811 (907) 465-3372
Arizona	N/A
Arkansas	K. Ray Nelson, Ph.D. Commissioner MR/DD Services Department of Human Services Suite 400, Waldon Building 7th and Main Little Rock, AR 72201 (501) 371-3419
California	Ms. Ida Zodrow Department of Developmental Services, Health and Welfare Agency 1600 9th St., N.W., 2nd Floor Sacramento, CA 95814 (916) 445-6888
Colorado	Sharon O'Hara Director Division for DD Department of Institutions 3824 West Princeton Circle Denver, CO 802 36 (303) 761-5990
Connecticut	John Campion Department of Mental Retardation 342 N. Main Street West Hartford, CT 06117 (203) 236-2531

State	Contact Person
Delaware	J. Robert Timmons Delaware Division of Mental Retardation 44 9 N. duPont Highway Dover, DE 19901 (302) 736-4386
District of Columbia	George Smith Acting Administrator MR/DD Administration Department of Human Services Presidential Building Room 410 415 12th St., N.W. Washington, D.C. 20004 (202) 673-6904
Florida	Charles Kimber Director Developmental Services Program Office Department of Health and Rehabilitation Services 1311 Winewood Blvd. Building 5, Room 215 Tallahassee, FL 32301 (904) 488-4257
Georgia	Webb F. Spraetz Deputy Director MR Services Division of MH/MR Department of Human Resources 47 Trinity Ave., S.W. Atlanta, GA 303 34 (404) 656-6370
Hawaii	Lily Wang Executive Secretary State Planning and Advisory Council DD Programming ... Department of Health P.O. Box 3378 Honolulu, HI 96801 (808) 548-5994/8482/8483

State	Contact Person
Idaho	No Response
Illinois	Judy Redick Illinois Department of MH/DD 402 Stratton Office Building Springfield, IL 62706 (217) 782-7393
Indiana	Jack S. Collins Assistant Commissioner for MR/DD Department of Mental Health Five Indiana Square Indianapolis, IN 46204 (317) 232-7836
Iowa	Gary Gesaman Division of MH Resources Department of Social Services Hoover State Office Building Des Moines, IA 50319 (515) 281-5586
Kansas	R. Don Homer, Ph.D. Director of Mental Retardation 5th Floor State Office Building Topeka, KS 66 612 (913) 864-4950
Kentucky	Edward R. Skarnulis, Ph.D. Director Div. for Comm. Srvs. for MR Bureau for Health Services Department of Human Resources 275 East Main Frankfort, KY 40601 (502) 564-7700
Louisiana	Bill Coffey Office of Mental Retardation Department of Health and Human Resources 721 Government Street Room 308 Baton Rouge, LA 70802 (504) 342-6817
Maine	Robert Foster Bureau of Mental Retardation Department of MH and Corrections Statehouse, Room 400 Augusta, ME 04 330 (207) 289-2711

State	Contact Person
Maryland	Adrian Bergin MR/DD Administration Department of Health and Mental Hygiene 201 W. Preston Street Baltimore, MD 21201 (301) 383-3354
Massachusetts	Kathy Schwaninger Department of Mental Health 160 N. Washington Street Boston, MA 02114 (617) 727-5608
Michigan	Ben Censoni Administrator Program Development and Support Systems Department of Mental Health 6th Floor, Lewis Cass Building Lansing, MI 48926 (517) 373-2900
Minnesota	Ardo Wrobel Director Division of Retardation Services Department of Public Welfare. Centennial Office Building 5th Floor St. Paul, MN 55155 (612) 296-2160
Mississippi	Randy Hendrix Division of Mental Retardation Department of Mental Health 1100 Robert E. Lee Building Jackson, MS 39210 (601) 354-6692
Missouri	Gerold W. Stewart Division of MR/DD Department of Mental Health 2002 Missouri Blvd. P.O. Box 687 Jefferson City, MO 65101 (314) 751-4054
Montana	Ken Wahlstrand DD Division/SRS P.O. Box 4210 Helena, MT 59601 (406) 449-2995

State	Contact Person
Nebraska	Dave Evans Director Office of Mental Retardation Statehouse P.O. Box 94728 Lincoln, NE 68508 (402) 471-2165
Nevada	Dan Payne, Ph.D. Associate Administrator Division of MH/MR Department of Human Resources 1937 N. Carson Street, Suite 244 Capitol Mail Complex Carson City, NV 89710 (702) 885-5943
New Hampshire	Donald Shumway Acting Assistant Division Director for Community Developmental Services Health and Welfare Building Hazen Drive Concord, NH 03301 (603) 271-4711
New Jersey	Clarie Mahan Division of Mental Retardation Department of Human Services 222 S. Warren Street Capitol Place One Trenton, NJ 086 25 (609) 292-7354
New Mexico	Louis Landry DD Bureau HED-Behaviroal Health Services Division P.O. Box 968 Santa Fe, NM 87501 (505) 827-5271 Ext. 241
New York	David Picker Office of MR/DD 44 Holland Ave. Albany, NY 12229 (518) 474-3625
North Carolina	Paul Rasmussen Division of MH/MR Services Albemarle Building 325 N. Salisbury Street Raleigh, NC 27611 (919) 733-3654

State	Contact Person
North Dakota	Darvin Hirsch, Ph.D. Director Community MR/DD Programs Department of Health 909 Basic Ave. Bismarck, ND 585 05 (701) 224-2769
Ohio	Frank Bunk Programs Liaison Officer Department of MR/DD State Office Tower Room 1371 30 E. Broad St. Columbus, OH 4 3215 (614) 466-9950
Oklahoma	Lloyd E. Rader Director Department of Human Services P.O. Box 25325 Oklahoma City, OK 73125 (405) 521-3646
Oregon	Cindy Farber Program for MR/DD Mental Health Division Department of Human Resources 2570 Center Street, NE Salem, OR 97310 (503) 378-2429
Pennsylvania	Dave Smith Dept. of Public Welfare Room 302, Health and Welfare Building Harrisburg, PA 17120 (717) 787-3700
Puerto Rico	Irma Revilla de Ferrer Department of Social Services P.O. Box 11398 Santurce, PR 00910 (809) 765-2092
Rhode Island	Robert L. Carl, Jr., Ph.D. Associate Director Division of Retardation Department of MH/MR and Hospitals Aime J. Forand Building 6 00 New London Avenue Cranston, RI 02920 (401) 464- 3234

State	Contact Person
South Carolina	Charles D. Barnett, Ph.D. Commissioner Department of MR 2712 Middleburg Drive P.O. Box 4706 Columbia, SC 29240 (803) 758-3671
South Dakota	Thomas E. Scheinost Program Administrator Division of MH/MR Department of Social Services State Office Bldg., 3rd Floor Pierre, 5D 57501 (605) 773-3438
Tennessee	James G. Foshee, Ph.D. Assistant Commissioner for MR Department of MH/MR James K. Polk State Office Bldg. 505 Deaderick St. Nashville, TN 37219 (615) 741-3803
Texas	Spencer McClure Department of MH/MR Box 12668, Capitol Station Austin, TX 78711 (512) 465-4520
Utah	Paul S. Sagers, Ed.D. Director of DD/MR Division of Family Services Department of Social Services 150 West N. Temple, Suite 370 P.O. Box 2500 Salt Lake City, UT 84110
Vermont	Ronald Melzer, Ph.D. Director of MR Programs Department of Mental Health 10 3 S. Main Street Waterbury, VT 05676 (802) 241-2636
Virginia	Robert H. Shackelford, Jr. Department of MH/MR P.O. Box 1797 Richmond, VA 23214 (804) 786-3915

State	Contact Person
Virgin Islands	No Response
Washington	Patricia K. Wilkins Division of Developmental Disabilities Department of Social and Health Services P.O. Box 1788, OB-42C Olympia, WA 98532 (206) 753-3905
West Virginia	None listed
Wisconsin	Gerald Born Director Bureau of Developmental Disabilities Department of Health and Social Services 1 West Wilson St. Madison, WI 53702
Wyoming	Julie Robinson Institutions Coordinator Board of Charities and Reform Barrett Building Cheyenne, WY 82001 (307) 777-7405