

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 441

[CMS-2337-P]

RIN 0938-AQ35

Medicaid Program; Community First Choice Option

AGENCY: Centers for Medicare & Medicaid Services (CMS),
HHS.

ACTION: Proposed rule.

SUMMARY: This proposed rule implements Section 2401 of the Affordable Care Act (ACA) which establishes a new State option to provide home and community-based attendant services and supports. These services and supports may be offered through the Community First Choice State plan option.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on [OFR--insert date 60 days after date of publication in the **Federal Register**].

ADDRESSES: In commenting, please refer to file code CMS-2337-P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (please choose only one of the ways listed):

1. Electronically. You may submit electronic comments on this regulation to <http://www.regulations.gov>. Follow the "Submit a comment" instructions.

2. By regular mail. You may mail written comments to the following address ONLY:

Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-2337-P,
P.O. Box 8016,
Baltimore, MD 21244-8016.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. By express or overnight mail. You may send written comments to the following address ONLY:

Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-2337-P,
Mail Stop C4-26-05,
7500 Security Boulevard,
Baltimore, MD 21244-1850.

4. By hand or courier. If you prefer, you may deliver (by hand or courier) your written comments before the close of the comment period to either of the following addresses:

a. For delivery in Washington, DC--

Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Room 445-G, Hubert H. Humphrey Building,
200 Independence Avenue, SW.,
Washington, DC 20201

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. For delivery in Baltimore, MD--

Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
7500 Security Boulevard,
Baltimore, MD 21244-1850.

If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786-7195 in advance to schedule your arrival with one of our staff members.

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

Submission of comments on paperwork requirements. You may submit comments on this document's paperwork requirements by following the instructions at the end of the "Collection of Information Requirements" section in this document.

For information on viewing public comments, see the beginning of the "SUPPLEMENTARY INFORMATION" section.

FOR FURTHER INFORMATION CONTACT:

Carrie Smith, (410) 786-4485.

SUPPLEMENTARY INFORMATION:

Submitting Comments: We welcome comments from the public on all issues set forth in this rule to assist us in fully considering issues and developing policies. You can assist us by referencing the file code CMS-2337-P and the specific "issue identifier" that precedes the section on which you choose to comment.

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web

site as soon as possible after they have been received:
<http://www.regulations.gov>. Follow the search instructions on that Web site to view public comments.

Comments received timely will also be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1-800-743-3951.

I. Background

A. Section 2401 of the Affordable Care Act

The Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148, enacted on March 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152, enacted March 30, 2010) (collectively referred to as the Affordable Care Act) established a new State plan option to provide home and community-based attendant services and supports. Section 2401 of the Affordable Care Act, entitled "Community First Choice Option," adds a new section 1915(k) of the Social Security Act (the Act) that allows States, at their option, to provide home and community-based attendant services and

supports under their State plan. This option, available October 1, 2011, allows States to receive a 6 percentage point increase in Federal matching payments for expenditures related to this option.

Under section 1915(k)(1) of the Act, States can provide home and community-based attendant services and supports for individuals who are eligible for medical assistance under the State plan whose income does not exceed 150 percent of the Federal Poverty Level or, if greater, the income level applicable for an individual who has been determined to require an institutional level of care to be eligible for nursing facility services under the State plan and 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 hospital, a nursing facility, an intermediate care facility for the mentally retarded, or an institution for mental diseases, the cost of which could be reimbursed under the State plan. The individual must choose to receive such home and community-based attendant services and supports, and the State must meet certain requirements set forth in section 1915(k)(1) of the Act. Section 1915(k)(1)(A) of the Act requires States electing this option to make available home and community-based attendant

services and supports to eligible individuals, under a person-centered service plan agreed to in writing by the individual, or his or her representative, that is based on a functional need assessment. This assessment will determine if the individual requires assistance with activities of daily living (ADLs), instrumental activities of daily living (IADLs), or health-related tasks. The services and supports must be provided by a qualified provider in a home or community setting under an agency-provider model, or through other methods for the provision of consumer controlled services and supports as referenced in section 1915(k)(6)(C) of the Act. Section 1915(k)(1)(B) of the Act requires that States make available additional services and supports including the acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish ADLs, IADLs, and health-related tasks, back-up systems or mechanisms to ensure continuity of services and supports and voluntary training on how to select, manage, and dismiss attendants.

Section 1915(k)(1)(C) of the Act prohibits States from providing services and supports excluded from section 1915(k) of the Act, including room and board costs for the individual, special education and related services provided under the Individuals with Disabilities Education Act

(Pub. L. 101-476, enacted on October 30, 1990) (IDEA) and vocational rehabilitation services provided under the Rehabilitation Act of 1973 (Pub. L. 93-112, enacted on September 26, 1973), assistive technology devices and services other than back-up systems or mechanisms to ensure continuity of services and supports, medical supplies and equipment, or home modifications. However, some, although not all, of these services can be covered by Medicaid under other authorities. Section 1915(k)(1)(D) of the Act sets forth services and supports permissible under section 1915(k) of the Act that States can provide, including expenditures for transition costs such as rent and utility deposits, first month's rent and utilities, bedding, basic kitchen supplies, and other necessities required for an individual to make the transition from a nursing facility, institution for mental diseases, or intermediate care facility for the mentally retarded to a community-based home setting where the individual resides. States can also provide for expenditures relating to a need identified in an individual's person-centered plan of services that increase independence or substitute for human assistance, to the extent that expenditures would otherwise be made for the human assistance.

Section 1915(k)(2) of the Act provides that States offering this option to eligible individuals during a fiscal year quarter occurring on or after October 1, 2011 will be eligible for a 6 percentage point increase in the Federal medical assistance percentage (FMAP) applicable to the State for amounts expended to provide services under section 1915(k) of the Act (hereinafter referred to as "section 1915(k) services").

Section 1915(k)(3) of the Act sets forth the requirements for a State plan amendment. States must develop and have in place a process to implement an amendment in collaboration with a Development and Implementation Council established by the State that includes a majority of members with disabilities, elderly individuals, and their representatives. States must also provide consumer controlled home and community-based attendant services and supports to individuals on a statewide basis, in a manner that provides such services and supports in the most integrated setting appropriate to the individual's needs, without regard to the individual's age, type or nature of disability, severity of disability, or the form of home and community-based attendant services and supports the individual requires in order to lead an independent life.

In addition, for expenditures during the first full fiscal year of implementation, States must maintain or exceed the level of State expenditures attributable to the preceding fiscal year for medical assistance provided under sections 1905(a), 1915, or 1115 of the Act, or otherwise provided to individuals with disabilities or elderly individuals. States must also establish and maintain a quality assurance system with respect to community-based attendant services and supports that includes standards for agency-based and other delivery models for training, appeals for denials and reconsideration procedures of an individual plan, and other factors as determined by the Secretary. The quality assurance system must incorporate feedback from individuals and their representatives, disability organizations, providers, families of disabled or elderly individuals, and members of the community, and maximize consumer independence and control. The quality assurance system must also monitor the health and well-being of each individual who receives section 1915(k) services and supports, including a process for the mandatory reporting, investigation, and resolution of allegations of neglect, abuse, or exploitation in connection with the provision of such services and supports. The State must also provide information about

the provisions of the quality assurance required to each individual receiving such services.

States must collect and report information for the purposes of approving the State plan amendment, providing Federal oversight, and conducting an evaluation, including data regarding how the State provides home and community-based attendant services and supports and other home and community-based services, the cost of such services and supports, and how the State provides individuals with disabilities who otherwise qualify for institutional care under the State plan or under a waiver the choice to receive home and community-based services in lieu of institutional care.

Section 1915(k)(4) of the Act requires that States ensure, regardless of the models used to provide attendant services and supports, such services and supports are to be provided in accordance with the requirements of the Fair Labor Standards Act of 1938 and applicable Federal and State laws regarding the withholding and payment of Federal and State income and payroll taxes; the provision of unemployment and workers compensation insurance; maintenance of general liability insurance; and occupational health and safety.

Section 1915(k) (5) of the Act sets forth the requirements that States provide data to the Secretary for an evaluation and Report to Congress on the provision of home and community-based attendant services and supports. States must provide information for each fiscal year for which attendant services and supports are provided, on the number of individuals estimated to receive section 1915(k) services and supports during the fiscal year; the number of individuals that received such services and supports during the preceding fiscal year; the specific number of individuals served by type of disability, age, gender, education level, and employment status; and whether the specific individuals have been previously served under any other home and community-based services program under the State plan or under a waiver.

B. Background of Home and Community-Based Attendant Services and Supports

The Community First Choice Option continues to move Medicaid toward expanding options to States and individuals for the provision of community-based long-term care services. Consistent with the decision of the United States Supreme Court in Olmstead v. L.C., 527 U.S. 581 (1999), this option will support States in their mission to develop or enhance a comprehensive system of long-term care

services and supports in the community that provide beneficiary choice and direction in the most integrated setting. Since the mid-1970s, States have had the option to offer personal care services under their Medicaid State plans. The option was originally provided at the Secretary's discretion, had a medical orientation and could only be provided in an individual's place of residence. Personal care services were mainly offered to assist individuals in activities of daily living, and, if incidental to the delivery of such services, could include other forms of assistance (for example, housekeeping or chores). In the 1980s, some States sought to broaden the scope of personal care services to include community settings for the provision of services to enable individuals to participate in normal life activities.

Through the Omnibus Budget Reconciliation Act of 1993 (Pub. L. 103-66, enacted on August 10, 1993) (OBRA 93), the Congress formally included personal care as a separate and specific optional service under the Federal Medicaid statute and gave States explicit authorization, under a new section 1905(a)(24) of the Act, to provide such services outside the individual's residence. This was implemented by final rule published in the September 11, 1997 **Federal Register** (62 FR 47896) that added a new section at §440.167

describing the option for States to provide a wide range of personal assistance both in an individual's residence and in the community. In 1999, we released additional guidance to clarify that personal care services may include ADLs and IADLs that all qualified relatives, with the exception of "legally responsible relatives", could be paid to provide personal care services and that States were permitted to offer the option of consumer-directed personal care services.

Additionally, the Omnibus Reconciliation Act of 1989 (Pub. L. 101-239, enacted on December 19, 1989) (OBRA 89), revised the Early Periodic Screening and Diagnosis and Treatment Benefit to include the requirement that all section 1905(a) services are mandatory for individuals under the age of 21 if determined to be medically necessary in accordance with section 1905(r) of the Act.

Furthermore, before 1981, the Medicaid program provided limited coverage for long-term care services in non-institutional, community-based settings. Medicaid's eligibility criteria and other factors made institutional care much more accessible than care in the community.

Medicaid home and community-based services (HCBS) were established in 1981 as an alternative to care provided in Medicaid institutions, by permitting States to waive

certain Medicaid requirements upon approval by the Secretary. Section 1915(c) of the Act was added to title XIX by the Omnibus Budget Reconciliation Act of 1981 (Pub. L. 97-35, enacted on August 13, 1981) (OBRA 81). Programs of HCBS under section 1915(c) of the Act are known as "waiver programs", or simply "waivers" due to the authority to waive certain Medicaid requirements.

Since 1981, the section 1915(c) HCBS waiver program has afforded States considerable latitude in designing services to meet the needs of people who would otherwise require institutional care. In 2010, approximately 315 approved HCBS waivers under section 1915(c) of the Act serve nearly 1 million elderly and disabled individuals in their homes or alternative residential community settings. States have used HCBS waiver programs to provide numerous services designed to foster independence; assist eligible individuals in integrating into their communities; and promote self-direction, personal choice, and control over services and providers. The addition of section 1915(i) of the Act in 2005 affords some of the same flexibility and service coverage through the State plan without a waiver.

The section 1915(k) benefit does not diminish the State's ability to provide any of the existing Medicaid home and community-based services. States opting to offer

the Community First Choice Option under section 1915(k) of the Act can continue to provide the full array of home and community-based services under section 1915(c) waivers, section 1115 demonstration programs, mandatory State plan home health benefits, and the State plan personal care services benefit. Community First Choice provides States the option to offer a broad service package that includes assistance with ADLs, IADLs, and health-related tasks, while also incorporating transition costs and supports that increase independence or substitute for human assistance.

Another important aspect to this background is the passage of the Americans with Disabilities Act of 1990 (Pub. L. 101-336, enacted July 26, 1990) (ADA), and the Olmstead v. L.C., U.S. Supreme Court decision. In particular, Title II of the ADA prohibits discrimination on the basis of disability by State and local governments and requires these entities to administer their services and programs, in the most integrated setting appropriate to the needs of qualified individuals with disabilities. In applying the most integrated setting mandate, the U.S. Supreme Court ruled in Olmstead that unnecessary institutionalization of individuals with disabilities constitute discrimination under the ADA. Under Olmstead, States may not deny a qualified individual with a

disability a community placement when: (1) community placement is appropriate; (2) the community placement is not opposed by the individual with a disability; and (3) the community placement can be reasonably accommodated.

As self-direction is a key component to Community First Choice, this service delivery model is another important aspect to the background of this provision. Two national pilot projects demonstrated the success of self-directed care. During the 1990's, the Robert Wood Johnson Foundation funded these projects which evolved into Medicaid funded programs under section 1915(c) of the Act and the "Cash and Counseling" national section 1115 demonstration programs. Evaluations were conducted in both of these national projects. Results in both projects were similar - persons directing their personal care experienced fewer unnecessary institutional placements, experienced higher levels of satisfaction, had fewer unmet needs, experienced higher continuity of care because of less worker turnover, and maximized the efficient use of community services and supports. The Deficit Reduction Act of 2005 (Pub. L. 109-171, enacted on February 8, 2006) (DRA), established section 1915(j) of the Act which provided a State plan option for States to utilize this

self-direction service delivery model without needing the authority of a Section 1115 demonstration.

II. Provisions of the Proposed Regulations

In the following discussion, we refer to particular home and community-based attendant services and supports offered under section 1915(k) of the Act as Community First Choice services and supports. We refer to the "Community First Choice Option" when describing the collective requirements of section 1915(k) of the Act for the State plan option.

A. Eligibility (§441.510)

Section 1915(k)(1) of the Act requires that in order to receive services under the Community First Choice Option, individuals must be eligible for Medicaid under an eligibility group covered by the State plan. This section does not create a new eligibility group. Individuals who are not eligible for Medicaid under a group covered under the State Medicaid plan are not eligible for the State plan Community First Choice Option, even if they otherwise meet the requirements for the option. Individuals eligible under the State Medicaid plan whose income does not exceed 150 percent of the Federal Poverty Level (FPL) are eligible for the Community First Choice Option without requiring a determination of institutional level of care. In

determining whether the 150 percent of the FPL requirement is met, the regular rules for determining income eligibility for the individual's eligibility group under the State plan apply, including any income disregards used by the State for that group under section 1902(r)(2) of the Act.

Individuals eligible under the State Medicaid plan whose income is greater than 150 percent of the FPL are eligible for the Community First Choice Option if it has been determined such individuals need the level of care required under the State Medicaid plan for coverage of nursing facility services. The State must determine that but for the provision of the home and community-based attendant services and supports, the individual would require the level of care provided in a hospital, a nursing facility, intermediate care facility for the mentally retarded or an institution for mental diseases, the cost of which would be reimbursed under the State plan. For example, section 1902(a)(10)(A)(ii)(XIII) of the Act defines an optional eligibility group known as working disabled. The income standard for this group is 250 percent of the FPL. An individual in this eligibility group with income that does not exceed 150 percent of the FPL would be eligible for CFC services without a level of

care determination. An individual in the same eligibility group with income that exceeds 150 percent of the FPL would need to have a Level of care determination to be eligible for CFC services. Additionally, individuals who are eligible for Medicaid under the special home and community-based waiver eligibility group defined at section 1902(a)(10)(A)(ii)(VI) of the Act, for example, the special income level group for institutionalized individuals, could be eligible to receive CFC services. These individuals would have to receive at least 1 section 1915(c) home and community-based waiver service per month. We propose to implement this eligibility requirement at §441.510.

As the need for a level of care determination is directly related to an individual's income level in section 1915(k)(1) of the Act, we propose to require an annual verification of income for all individuals receiving services under the section 1915(k) State plan option. We propose to implement this requirement at §441.510.

B. Statewideness (§441.515)

Section 1915(k)(3)(B) of the Act requires that a State that chooses to provide the Community First Choice Option do so for individuals on a statewide basis, in a manner that provides such services and supports in the most integrated setting appropriate to the individual's needs,

and without regard to the individual's age, type or nature of disability, severity of disability, or the form of home and community-based attendant services and supports that the individual requires in order to lead an independent life. We propose at §441.515 to adopt this statutory language as our definition.

C. Required Services (§441.520)

Section 1915(k)(1)(B) of the Act provides detailed requirements for the services and supports included in the Community First Choice Option. Therefore at §441.520, we propose the following services must be available under the Community First Choice option:

- Assistance with ADLs, IADLs, and health related tasks through hands-on assistance, supervision or cueing.
- The acquisition, maintenance and enhancement of skills necessary for the individual to accomplish ADLs, IADLs, and health-related tasks.
- Back-up systems or mechanisms to ensure continuity of services and supports.
- Voluntary training on how to select, manage, and dismiss attendants.

With regard to back up systems or mechanisms to ensure continuity of services and supports, we propose at §441.505 that such devices may include personal emergency response

systems, pagers, or any other appropriate mobile electronic device that may be used to ensure continuity of services and supports.

The Community First Choice Option requires the utilization of a person-centered planning process. A key component of the Community First Choice option is to allow individuals to self direct the provision of services and supports. Individuals must have the authority to hire, fire, and train attendants to provide services tailored to the individuals' needs. Therefore, we propose at §441.520(a)(6) to require States to develop and provide a training program for individuals (or representative) on how to select, manage and dismiss attendants. Consistent with the philosophy of self-direction, this training must be voluntary, and may not be a mandatory requirement for the individual to receive services under this option.

Section 1915(k)(1)(D) of the Act provides that States may allow an individual to purchase permissible services and supports. We propose to implement this option at §441.520(b). At a minimum, permissible services and supports include expenditures for transition costs such as rent and utility deposits, first month's rent and utilities, bedding, basic kitchen supplies, and other necessities required for an individual to transition from a

nursing facility, institution for mental disease, or intermediate care facility for the mentally retarded to a community-based home setting where the individual resides. We believe that the primary focus of Community First Choice is to remove barriers that prevent individuals from returning to the community or remaining in the community, thus avoiding unnecessary or premature institutionalization. Section 1915(k)(1)(D)(ii) of the Act permits States to make expenditures available for individuals to acquire items that increase independence or substitute for human assistance, to the extent that the expenditures would otherwise be made for the human assistance and are related to a need identified in an individual's person-centered plan. Based on our experience with the Cash and Counseling Demonstrations, and authorities under sections 1915(j) and 1915(c) of the Act, we know that many individuals do avail themselves of and benefit from this option and use this flexibility to purchase items that allow them greater independence, such as non-medical transportation services, or that substitute for human assistance, such as a microwave oven. We propose at §441.520(b)(2), when individuals utilize this option that items purchased must relate to a need identified in the service plan.

Based on our experience with Cash and Counseling, we found that some States limited participants' purchases to a list of allowable items for which no prior approval was necessary. Still, other States required prior approval for all items, while others provided a list of allowable items and required prior approval for other items not on the list. Each permissible purchase was determined based on an identified goal in an individual's service plan. Each State developed procedures that governed how participants could save an amount of their monthly budget and how and at what intervals the State would recoup funds that were not spent according to the purchase plan. The Community First Choice Option differs from Cash and Counseling and the section 1915(j) State plan Option in that an individual is not required to save an amount in a budget to purchase items that increase independence or substitute for human assistance. Therefore, in Community First Choice Option these purchases are permissible for inclusion in the service plan and service budget if applicable. CMS believes that permissible purchases will be a particularly useful tool for States to promote community integration.

D. Excluded Services (§441.525)

In §441.525, consistent with the provisions of section 1915(k) of the Act, we propose the following services are excluded from the Community First Choice Option:

- Room and board costs (except with respect to the transition costs identified above).
- Special education and related services provided under the IDEA.
- Vocational rehabilitation services provided under the Rehabilitations Act of 1973.
- Assistive technology devices and assistive technology services other than those defined in §441.520(a)(5).
- Medical supplies and equipment.
- Home modifications.

The exclusion of room and board costs is consistent with section 1905(a) of the Act, which limits Medicaid coverage of room and board to an inpatient setting only. The goal of the Community First Choice option is to provide attendant and support services in the community, as such, services provided in an inpatient setting are excluded from coverage. While attendant services and supports may be provided in a residential setting in the community, only the costs of the services and supports, not the room and board costs of the residential setting, will be covered.

The IDEA ensures every child with a disability has available a free appropriate public education that includes special education and related services. When services are identified in an Individualized Education Program (IEP) or an Individualized Family Service Plan (IFSP), Medicaid will only pay for services determined to be medically necessary. Therefore, at §441.525, we propose that services related to education only are excluded from this section.

The Rehabilitation Act of 1973 provides for direct services to people with disabilities which help them to become qualified for employment. Vocational services are those that teach specific skills required by an individual to perform tasks associated with performing a job. Therefore, at §441.525, we propose the general prohibition established by section 1915(k) of the Act excluding vocational rehabilitation services provided under the Rehabilitation Act of 1973.

We also propose at §441.525 that Community First Choice would not include services furnished through another benefit or section under the Act. Per section 1915(k)(1)(C) of that Act, we propose at §441.525 the exclusion of the following services: Assistive technology (other than what is described in §441.520(a)(5); Medical supplies and equipment; and home modifications.

The statute specifically excludes assistive technology devices and assistive technology services (other than back-up systems or mechanisms), medical equipment and home modifications. However, the statute does not define such items and furthermore, the statute provides that the excluded services and supports are "subject to subparagraph (D)" which defines permissible services and supports to include expenditures relating to a need identified in an individual's person-centered plan of services that increase independence or substitute for human assistance. In general, the terms "assistive technology devices" and "assistive technology services" may be broadly interpreted to include items and services necessary for an individual to make the transition from an institution to a community-based setting, or that increase independence or substitute for human assistance. In addition, some medical equipment and environmental adaptations may make the provision of human assistance feasible when it would not otherwise be provided. These types of items could be covered under sections 1915(k)(1)(D)(i) and (ii) of the Act. For example, eating and cooking utensils can be fitted with oversized handles for easier gripping. These "assistive devices" can enable an individual with limited hand function to continue to prepare meals for himself for

herself. Further examples would include items such as bedside controls for lights and other appliances to increase the ability of mobility impaired individuals to control the lighting, temperature or other conditions of their home without getting out of bed. Wheelchair lifts and stair-climbs can provide an individual with full access and mobility throughout a multi-level home. Other self-direction programs have permitted the inclusion of certain items that could be broadly defined as assistive technology, medical equipment, and home modifications. To ensure that items or services that could be covered under sections 1915(k)(1)(D)(i) or (ii) of the Act are not excluded, we interpret the provision to prohibit service plans from identifying assistive technology or services, medical equipment or home modifications as the only needed service in an individual's plan of services or supports. Therefore, we are proposing that in Community First Choice some items or services that could be classified as assistive technology devices or services, medical equipment or home modifications may be covered, but only when based on a specific need in the person-centered service plan, when used in conjunction with other home and community-based attendant services. We invite comment on this proposal. We further propose to allow States to determine

at what point the amount of funds to purchase such devices and adaptations places them in the statutorily excluded categories. We also invite comments on this proposal.

E. Setting (§441.530)

Section 1915(k)(1)(A)(ii) of the Act provides that a home and community-based setting does not include a nursing facility, institution for mental diseases, or an intermediate care facility for the mentally retarded. We propose at §441.530 to adopt this statutory language in our regulations.

In the June 22, 2009 **Federal Register** (74 FR 29453), we published the Home and Community-Based Services (HCBS) Waivers Advance Notice of Proposed Rulemaking (ANPRM) to seek public input on strategies to define home and community with regard to waivers under section 1915(c) of the Act. We recognize the important role that Medicaid plays in States' efforts to ensure compliance with the ADA and the Olmstead v. L.C., 527 U.S. 581 (1999) U.S. Supreme Court decision. In the Olmstead decision, the Court affirmed a State's obligation to serve individuals in the most integrated setting appropriate to their needs. The Court held that the unjustified institutional isolation of people with disabilities is a form of unlawful discrimination under the ADA. We seek to assist States'

objective to meet these ADA and Olmstead obligations. However, a State's Olmstead obligations under the ADA and section 504 of the Rehabilitation Act are not defined by, or limited to, the scope or requirements of the Medicaid program and nothing in this regulation should be construed as limiting a State's obligation to comply with the integration requirements under the ADA or section 504 of the Rehabilitation Act.

Notwithstanding our continuing efforts to gain stakeholder input on the nature of HCBS settings, we are proposing to clarify that certain settings are clearly outside of what would be considered home and community-based because they are not integrated into the community. Section 1915(k)(1)(A)(ii) of the Act provides that services must be provided in a home or community setting, which excludes nursing facilities, institutions for mental diseases, and intermediate care facilities for the mentally retarded. However, there may be instances in which individuals reside in alternative or subsidiary residential settings on the grounds of or located adjacent to such institutional facilities, which are not licensed as institutions for the purpose of Medicaid reimbursement or under State licensing rules. We are proposing to clarify that home and community settings may not include a building

that is also a publicly or privately operated facility which provide inpatient institutional treatment or custodial care; or in a building on the grounds of, or immediately adjacent to, a public institution or disability-specific housing complex, designed expressly around an individual's diagnosis that is geographically segregated from the larger community, as determined by the Secretary. To maintain consistency across the Medicaid program, we anticipate adopting this same clarification for services provided under section 1915(c) of the Act and other authorities permitting coverage of home and community-based services under Medicaid.

F. Assessment of Need (§441.535)

Section 1915(k)(1)(A)(i) of the Act requires that States conduct an assessment of individuals' functional need on which to base the person-centered service plan. We propose to implement this requirement at §441.535. An assessment of an individual's needs, strengths, and preferences is crucial because it forms the basis for the identification of the needed services and supports that will be authorized in the individual's subsequent person-centered service plan. The assessment should include a determination of whether there are any persons available to support the individual, including family

members. These persons may be able to provide unpaid personal assistance, or fulfill the more formal roles such as acting in the capacity of a paid provider of attendant services or as an individual's representative. We propose to require in §441.535 that the assessment include a face-to-face meeting with the individual ("individual" meaning in this context, if applicable, the individual and the individual's authorized representative when appropriate).

For consistency among Medicaid program benefits and in keeping with our decisions for implementation of the Self-directed Personal Assistance Services State plan Option under section 1915(j) of the Act, we do not prescribe the assessment tool to be used by States, but we expect that the assessment will include a standardized set of data elements, key system functionality, and workflow that will be sufficiently comprehensive to support the determination that an individual would require attendant care services and supports under the Community First Choice State Option and the development of the individual's subsequent service plan and budget. We propose at §441.535(a), as in section 1915(j) of the Act, that the assessment include information about an individual's health condition, personal goals and preferences for the provision

of services, identified functional limitations, age, school participation status, employment, household, and other factors that are relevant to the authorization and provision of services, and support the finding for need of home and community-based attendant services and supports and development of the service plan and budget. We are currently working to determine universal core elements to include in a standard assessment for consistency across programs. As these elements are identified, it is expected States will incorporate these elements in the assessment of need to be used for Community First Choice. We invite comments on the elements that should be included in this list.

Finally, in §441.535(c), we propose to require that the assessment of need is conducted at least every 12 months and as needed when the individual's needs and circumstances change significantly, or as requested by an individual or their representative, in order to revise the service plan.

G. Service Plan (§441.540)

Section 1915(k)(1)(A)(i) of the Act require a person-centered approach to establishing a service plan, based on an assessment of need, developed in collaboration with an individual ("individual" meaning in this context, if

applicable, the individual and the individual's authorized representative) choosing to receive home and community-based attendant services and supports under the Community First Choice State Option. In §441.540, we propose to require that based on the assessment of need specified in §441.535, the State must develop (or approve, if the Plan is developed by others) a written service plan, in collaboration with the individual (including, for purposes of this paragraph, the individual and the individual's authorized representative if applicable). The service plan must be created using a person-centered and directed planning process.

For clarification and consistency among programs, our expectation regarding person-centered services and supports is that the plan reflects what is important to the individual and important for his or her health and welfare. The person-centered approach is a process, directed by the individual with long-term support needs, or by another person important in the life of the individual who the individual has freely chosen to direct this process, intended to identify the strengths, capacities, preferences, needs, and desired outcomes of the individual. The person-centered process includes the opportunity for

the individual to choose others to serve as important contributors to the planning process.

These participants in the person-centered planning process enable and assist the individual to identify and access a personalized mix of paid and non-paid services. This process and the resulting service plan will assist the individual in achieving personally defined outcomes in the most integrated community setting in a manner that reflects what is both important for the individual to meet identified support needs and what is important to the individual to ensure delivery of services in a manner that reflects personal preferences and choices and assures health and welfare. The individual identifies planning goals to achieve these personal outcomes in collaboration with those that the individual has identified. The identified personally-defined outcomes, preferred methods for achieving them and the training supports, therapies, treatments, and other services the individual needs to achieve those outcomes become part of the written services and support plan, also known as plan of care.

Based on our experience with States' self-direction waivers and demonstrations, we are aware that States have historically implemented the person-centered planning process differently. Based on the above clarification of

person-centered planning and to promote consistency among programs, we propose to require, at §441.540(a), a person-centered planning process. We propose that the person-centered planning process would:

- Include people chosen by the individual;
- Provide necessary support to ensure that the individual has a meaningful role in directing the process;
- Occur at times and locations of convenience to the individual;
- Reflect cultural considerations of the individual;
- Include strategies for solving conflict or disagreement within the process, including clear guidelines for the management of conflict of interest concerns among planning participants;
- Include opportunities for periodic and ongoing plan updates as needed or requested by the individual; and
- Offer choices to the individual regarding the services and supports they receive and from whom.

We propose at §441.540(b) that the plan resulting from this process must reflect the services that are important for the individual to meet individual services and support needs as assessed through a person-centered functional assessment, as well as what is important to the person with regard to preferences for the delivery of such supports.

Commensurate with the level of need of the individual, the plan must reflect the individual's strengths and preferences, as well as clinical and support needs (for example, as identified through a person-centered functional assessment). The plan should include individually identified goals, which may include goals and preferences related to relationships, community participation, employment, income and savings, health care and wellness, education, and others.

The plan should reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals and who provides them. The plan should reflect risk factors and measures in place to minimize them including back-up strategies when needed. The plan should be signed by all individuals and providers responsible for its implementation, should be understandable to the individual receiving services and the individuals important in supporting him or her, and should include a timeline for review. The plan should identify the individual or entity responsible for monitoring the plan and should be distributed to everyone involved (including the participant) in the plan. The plan should also be directly integrated into self-direction where individual budgets are used and should prevent the

provision of unnecessary or inappropriate care. We invite comment on the person-centered process and planning elements of this proposed rule.

We would also propose at §441.540(c) a minimum list of policies and procedures associated with service plan development that must be completed and included by the State. We believe these are necessary to ensure the proper administration and development of the service plan. Policies and procedures should ensure that the responsibilities for assessment of need and service plan development are identified, the planning process is timely, the participant's needs are assessed and services meet the needs. When determining the timeframe in which the planning process should occur, we expect States to establish guidelines that support a timeframe that responds to the needs of the individual, thus allowing access to needed services as quickly as possible. Additionally, the State must ensure the conflict of interest standards for assessment of need and service plan development apply to all individuals and entities, public or private. These standards at a minimum must ensure that the individuals and entities conducting the assessment of need and developing the service plan are not related by blood or marriage to the individual or to any paid caregiver of the individual,

financially responsible for the individual, empowered to make financial or health-related decisions on behalf of the individual, and would not benefit financially from the provision of assessed needs and services.

Section 1915(k)(1)(A)(i) of the Act requires that the service plan be agreed to in writing by the individual or, as appropriate, the individual's representative. We propose at §441.540(d) to require that the service plan must be finalized and agreed to in writing by the individual or, as appropriate, the individual's representative and that a copy of the plan must be provided to the individual.

Finally, in §441.540(e), we propose to require that the service plan be reviewed and revised upon reassessment of need at least every 12 months, when the individual's circumstances or needs change significantly and at the individual's request.

H. Service Models (§441.545)

Section 1915(k)(1)(A)(iii) of the Act requires that the Community First Choice Option be provided under an agency-provider model or other model. Section 1915(k)(6)(C)(ii) of the Act defines other models to mean methods, other than the agency-provider model, for the provision of consumer controlled services and supports.

The statute provides that such models may include vouchers, direct cash payments, or use of a fiscal agent to assist in obtaining services.

We propose at §441.545 that a State may choose one or more of the service delivery models defined in the statute. In §441.545(a) and (b), we have categorized these models into two main groups, the Agency Model and the Self-directed Model with Service Budget. We have elected the use of the term self-directed rather than consumer controlled to be consistent with terminology in other regulatory provisions that offer this type of service delivery model including sections 1915(i) and 1915(j) of the Act. In §441.545(a), we propose to reflect the statutory definition of the agency model as a service delivery method in which services and supports are provided by entities through a contract.

Based on our experience with self-directed programs, we are aware that States may choose to allow individuals to self-direct services under a traditional agency model or an "agency with choice" model, which utilizes a co-employment relationship between the individual and an agency. Under the traditional agency model, the individual retains hiring and firing authority of personal care attendants. The "agency with choice" utilizes a co-employment relationship

between the individual and the agency. We interpret the definition of "agency-provider model" in section 1915(k)(6)(C)(i) of the Act to include such delivery options as allowable under Community First Choice as the agency model.

In §441.545 (b)(1), (b)(2) and (b)(3), we propose to further define the categories within the Self-directed Model with Service Budget to include the models specified in the statute including financial management entity, direct cash, and vouchers. We have elected to use the term financial management entity rather than fiscal agent to be consistent with other regulatory provisions that offer this type of service delivery model.

In §441.545(b)(1), we propose to require that the financial management entity perform specific functions that include, but are not limited to, the following: collect and process timesheets of the individual's workers; process payroll, withholding, filing and payment of applicable Federal, State and local employment related taxes and insurance; maintain a separate account for each individual's budget; track and report disbursements and balances of individual's funds; process and pay invoices for services in the service plan; and provide to the individual periodic reports of expenditures and the status

of the approved service budget. We propose to adopt these functions to be consistent with section 1915(j) of the Act in which a self-directed service delivery model is also defined. We propose in §441.545(b)(1)(vii) that States may perform the functions of a financial management entity internally or use a vendor organization that has the capabilities to perform the required task in accordance with the applicable IRS requirements. Again, we propose this provision to be consistent with flexibility offered in section 1915(j) of the Act.

We propose in §441.545(b)(2) that the State have the option of disbursing cash prospectively to individuals self-directing their Community First Choice Option. This Direct Cash option is specified in section 1915(k)(6)(C)(ii) of the Act. To be consistent with the option under section 1915(j) of the Act, which also allows for the direct payment of cash, we further propose that if a State elects this option, it must meet the following requirements: ensure compliance with all applicable requirements of the Internal Revenue Service, including but not limited to, retaining required forms and payment of FICA, FUTA and State unemployment taxes; permit individuals, or their representatives as applicable, using the cash option to choose to use the financial management

entity for some or all of the functions; make available a financial management entity to an individual who has demonstrated, after additional counseling, information, training, or assistance that the individual cannot effectively manage the cash option described in this section. If the cash option is the only model offered by the State for Community First Choice, then the State may require an individual to utilize the financial management entity services under the cash option, but must provide the conditions under which this would be enforced after additional counseling, information, training or assistance are unsuccessful.

In §441.545(b)(3), we propose that the State also have the option of issuing vouchers as a self-directed service delivery model. We propose that if the State elects this option that it must ensure compliance with all applicable requirements of the Internal Revenue Service.

I. Additional Service Plan Requirements for Self-directed Model with Service Budget (§441.550)

Section 1915(k)(1)(A)(i) of the Act requires that the Community First Choice Option be provided through a person-centered plan of services and supports that is based on an assessment of functional need. While the general requirements of the service plan are proposed in §441.550,

to clarify our expectations for a service plan when the State elects the option of a Self-Directed Service Model with Service Budget and to be consistent with the self-directed service delivery model under section 1915(j) of the Act, we propose that the service plan convey authority to the individual to perform, at a minimum, specific tasks. In §441.550, we propose these tasks include the ability to recruit, hire (including specifying worker qualifications), fire, supervise, and manage workers in the provision of Community First Choice Option services and supports. We propose that the expectations for managing workers include determining worker duties, scheduling workers, training workers in assigned tasks, and evaluating workers' performance. In addition, we propose that the service plan describe the ability of the individual to determine the amount paid for a service, support, or item, as well as the ability to review and approve provider invoices. It is the approval of the service plan that authorizes the individual to undertake these activities as part of the self-directed service delivery model. The service plan must encompass both the general decision-making authority that an individual has and outline the individualized services and supports to address the individual's needs, abilities, preferences and choices. In our experience with self-

directed programs these components of the service plan have been critical elements in the implementation of successful programs. Therefore, we propose to adopt the same elements in this provision of self-directed services.

J. Support System (§441.555)

Based on our experience with self-direction programs, we are aware that the support system provided by the State is a critical element of the service delivery model. Therefore, to maintain consistency and to reflect our policy relating to self-direction, in §441.555 we propose the requirement that the State have in place a support system. While we do not prescribe the way States are to design their support system, in order to allow flexibility, based on our experience, we include in the proposed regulation a minimum list of activities for which individuals may need information, counseling, training, or assistance, but States may offer additional activities. Generally, the activities requiring support include participant rights information and how the self-directed model of service delivery operates.

K. Service Budget Requirements (§441.560)

While section 1915(k) of the Act does not specifically address the requirement for an individual to have authority over a budget, in §441.560 we have proposed specific

service budget requirements based on experience with the section 1915(j) self-directed service delivery model which utilizes the options of financial management entities and direct cash payments. The requirements of section 1915(j) of the Act were supported by the experience of section 1115 demonstrations and proven to be successful models for implementation of a self-directed service model with a service budget. The service budget amount is the cap on the amount of funds available to an individual with which to purchase self-directed Community First Choice Option services and supports. Therefore, in §441.560(a), we require that a service budget be developed and approved by the State and include specific items such as the specific dollar amount, how the individual is informed of the amount, and the procedures for how the individual may adjust the budget.

In §441.560(b), we propose that the budget methodology set forth by the State meet certain criteria such as being objective and evidence based, be applied consistently to individuals in the program, and be included in the State plan. In addition, we propose the budget methodology include calculations of the expected costs of Community First Choice Option services and supports if those services and supports were not self-directed. We recognize in

§441.560(b)(5) that States may place monetary or budgetary limits on self-directed Community First Choice Option services. Therefore, if a State does so, we would require that the State have a process in place that describes the limits and the basis for the limits, and any adjustments that will be allowed and the basis for the adjustments, such as an individual's health and welfare.

Additionally, we propose to require certain beneficiary safeguards in light of these possible limitations. First, we propose that States have procedures to adjust a budget when a reassessment indicates a change in a participant's medical condition, functional status, or living situation to ensure that the budget amount is appropriate to the individual's current needs. Second, we propose that States have a method of notifying participants of the amount of any limit that applies to an individual's Community First Choice Option services and supports. Finally, we propose that the budget not restrict access to other medically necessary care and services furnished under the State plan and approved by the State but not included in the budget. Based on our experience in other self-directed programs like those specified in section 1915(j) of the Act, these components of the budget and the

budget methodology are critical elements of a successful program. We invite comments on this approach.

L. Provider Qualifications (§441.565)

Section 1915(k)(1)(A)(iv)(III) of the Act requires that Community First Choice State Option services and supports be provided by individuals, including family members, who are qualified to provide such services. We reflect these requirements in the proposed regulation at §441.565. We propose in §441.565(a) to require that States provide assurance that necessary safeguards have been taken to protect the health and welfare of the enrollees in the Community First Choice State Option by provision of adequate standards for all types of providers of attendant services and supports under the option. States must define qualifications for providers of attendant services and supports under the agency model.

Self-direction is an integral component of the Community First Choice State Option. This is reflected in §441.565(b) through (d). To ensure that individuals maintain the ability to participate in and control the provision of Community First Choice Option attendant services and supports, we propose in §441.565(b) that individuals can choose any qualified provider, including family members, to provide such services. In §441.565(c),

we propose that individuals retain the right to train their workers in the specific areas of attendant services and supports needed by the individual and to perform the needed assistance in a manner that comports with participants' personal preferences, as well as their needs, which we believe is an important component of self-direction based on our experience with the self-direction waiver and demonstration programs. In this way, workers benefit from clear instructions about how to effectively and appropriately deliver the attendant services, and any potential dissatisfaction with the way services are being delivered can be averted. We further propose, at §441.565(d), that individuals retain the right to establish additional staff qualifications based on their needs and preferences. Again, we believe that the individual is in the best position to set forth the particular staff qualifications needed to meet the particular preferences of the individual. For example, if the individual communicates best using American Sign Language (ASL), the individual may require the worker to be able to communicate using ASL.

M. State Assurances (§441.570)

Section 1915(k)(3)(C) of the Act requires that, for the first full fiscal year in which the State plan

amendment is implemented, the State must maintain or exceed the level of expenditures for services provided under sections 1905(a), section 1915, or section 1115 of the Act, or otherwise, to individuals with disabilities or elderly individuals attributable to the preceding fiscal year. We interpret this requirement to mean that, for the first 12 months the State chooses to offer this option in the State plan, the State's share of Medicaid expenditures for individuals with disabilities or elderly individuals must remain at the same level or be greater than expenditures from the previous year. We also interpret this requirement to be limited to personal care attendant services. We propose to implement this requirement at §441.570. States will need to identify the existing programs for individuals with disabilities and elderly individuals and the related expenditures to be monitored for this requirement and calculation. We will provide future guidance on the format of this reporting requirement.

Section 1915(k)(4) of the Act requires States that elect this option to comply with certain laws in the provision of the Community First Choice Option regardless of which service delivery model the State elects. Specifically, the statute requires that services and supports are provided in accordance with the Fair Labor

Standards Act of 1938 and applicable Federal and State laws regarding withholding and payment of Federal and State income and payroll taxes; provision of unemployment and workers compensations insurance; maintenance of general liability insurance; and occupational health and safety. We propose to include these assurances as specified in the statute at §441.570(b).

N. Development and Implementation Council (§441.575)

Under this State plan option, the statute requires a State to consult and collaborate with a Development and Implementation Council during the development and implementation of a State plan amendment under this subsection. Section 1915(k)(3)(A) of the Act requires that the council include a majority of members with disabilities, elderly individuals, and their representatives. We recognize that stakeholder input is an important piece of the Medicaid program and agree that this council will provide additional opportunities for stakeholder collaboration. We propose to set forth this requirement as defined by the statute at §441.575. We invite comment on how States can achieve robust stakeholder input including transparency in the selection process and the activities of the council.

O. Data Collection (§441.580)

Section 1915(k)(5)(B) of the Act requires that States provide CMS with information regarding the provision of home and community-based attendant services and supports under The Community First Choice Option for each fiscal year for which such services and supports are provided. The statute requires States to provide data including the number of individuals who are estimated to receive Community First Choice Option services and supports during the fiscal year, the number of individuals that have received such services and supports during the preceding fiscal year, the specific number of individuals served by type of disability, age, gender, education level and employment status, and whether the specific individuals have been previously served under any other home and community-based services program under the State plan or under a waiver. We propose to adopt these requirements as detailed in the statute at §441.580. We will provide future guidance on the format of this reporting requirement. Section 1915(k)(3)(E) of the Act requires States to collect and report information for the purposes of approving the State plan amendment, providing Federal oversight and conducting an evaluation of the provision of the Community First Choice State Option. The data collected through this requirement and the quality

assurance system will help determine how States are currently providing home and community-based services, the cost of those services, and whether States are currently offering individuals with disabilities who otherwise qualify for institutional care under Medicaid the choice to instead receive home and community-based services, as required by the U.S. Supreme Court in Olmstead v. L.C. (1999). We will provide future guidance on the format of this reporting requirement.

P. Quality Assurance System (§441.585)

We propose in §441.585 the requirements for the comprehensive continuous quality assurance system that the State must establish and maintain as set forth in section 1915(k)(3)(D) of the Act. The system must employ measures for program performance and quality of care, standards for delivery models, mechanisms for discovery and remediation, and quality improvements proportionate to the benefit and number of individuals served. The system must also include a quality improvement strategy that reflects the nature and scope of the benefit the State will provide. The statute also requires stakeholder input and feedback to be incorporated in the quality assurance system and for information regarding quality assurance to be provided to each individual receiving Community First Choice State

Option services. We propose to adopt these requirements in §441.585(a)(4) and §441.585(b). We will review the State's description of the quality assurance system and improvement plan when we review the State's Medicaid plan amendment electing the Community First Choice State Option.

In §441.585(a)(1), we propose to require States to have program performance measures, appropriate to the scope of the benefit, designed to assess the State's overall system for providing home and community-based attendant services and supports.

In §441.585(a)(2), we propose to require States to have quality of care measures that may be used to measure individual outcomes associated with the receipt of community-based attendant services and supports, such as function indicators and measures of individual satisfaction. These measures must be made available to CMS upon request and must include a process for the mandatory reporting, investigation, and resolution of allegations of neglect, abuse, or exploitation in connections with provision of Community First Choice services as well as quality indicators approved or prescribed by the Secretary.

In §441.585(a)(3), we propose to require States to have standards for agency-based and other delivery models

for training, appeals for denials and reconsideration procedures on an individual service plan.

Q. Increased Federal Financial Participation (§441.590)

Unlike similar programs such as those specified under sections 1915(c) and 1915(j) of the Act, section 1915(k) of the Act does not allow States to choose only specific categories or types of home and community-based attendant services and supports to be included in the overall service benefit. Recognizing the section 1915(k) option is a more robust service package, section 1915(k)(2) of the Act requires States to receive an increased FMAP of 6 percent for the provision of services under the Community First Choice Option effective October 1, 2011, or later under an approved State plan amendment. We propose to implement this requirement at §441.590.

III. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the

Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We are soliciting public comment on each of these issues for the following sections of this document that contain information collection requirements (ICRs):

A. ICRs Regarding Assessment of Need (§441.535)

Proposed §441.535 would require States to conduct face-to-face assessments of the individual's needs, strengths and preferences. Specifically, the face-to-face assessments may use one or more processes and techniques to obtain information about an individual, including but not limited to the information listed in proposed §441.535(a)(1) through (8). In addition to the initial face-to-face assessment, proposed §441.535 would require

States to conduct face-to-face assessments at least every 12 months as needed. The burden associated with this requirement would be the time required for a State to conduct a face-to-face assessment. We estimate that all States that elect this option will comply with this requirement. We further estimate that it will take each State 1 hour to perform a face-to-face assessment; however, we know that the number of assessments will vary according to the number of participants in each State under this State plan option. Because we cannot accurately quantify the number of assessments per State, we are soliciting public comment pertaining to the per State volume and will reevaluate this issue and the associated burden estimate in the final rule stage of rulemaking.

B. ICRs Regarding Service Plan (§441.540)

As stated in proposed §441.540(a), the State must develop a person-centered planning process resulting in a service plan, based on the assessment of need, in collaboration with the individual and the individual's authorized representative, if applicable. Proposed §441.540(b) lists the minimum components of a person-centered service plan, while proposed §441.540(c) lists the requirements of a service plan. Proposed §441.540(d) would require that a service plan must be agreed to in writing by

the individual or the individual's representative, if applicable. In addition, States must provide a copy of the plan to the individual.

The burden associated with the aforementioned requirements is the time and effort necessary for a State to both develop and finalize a written service plan for each individual. We estimate that it will take each State an average of 2 hours to develop and finalize a service plan. Because we cannot accurately quantify the number of service plans per State, we are soliciting public comment pertaining to the per State volume and will reevaluate this issue and the associated burden estimate in the final rule stage of rulemaking.

In addition to the burden associated with developing and finalizing service plans, proposed §441.540 also imposes a disclosure requirement. As part of the finalization process, States are required to give each individual a copy of the service plan. We estimate that it will take each State 30 minutes to produce and disseminate a copy of a finalized report to an individual. The total estimated burden associated with this disclosure requirement will vary according to the number of participants in each State under this State plan option. Because we cannot accurately quantify the number of plan

copies each State will need to distribute to the individuals in the State plan option, we are soliciting public comment pertaining to the number of plan copies distributed per State and will reevaluate this issue and the associated burden estimate in the final rule stage of rulemaking.

Proposed §441.540(e) would require States to review each service plan at least every 12 months. We estimate that it will take each State 1 hour to annually review and revise (upon reassessment of need or at the individual's request) a single written service plan. The total estimated burden associated with this requirement will vary according to the number of participants in each State under this State plan option. Because we cannot accurately quantify the number of plans each State will need to review annually, we are soliciting public comment pertaining to the number of plans each State must review annually and will reevaluate this issue and the associated burden estimate in the final rule stage of rulemaking.

C. ICRs Regarding Service Models (§441.545)

Proposed §441.545 would require State to choose one or more service delivery models by which to provide self-directed home and community-based attendant services and supports. Specifically, a State may choose one or more of

the models discussed in proposed §441.545(a) through (b). While we acknowledge that the service models discussed in proposed §441.545(a) through (b) contain information collection requirements, it is difficult for us to accurately quantify both the number of States that will avail themselves of these models and the time associated with the information collection requirements contained therein. As a result, because we are unable to estimate both the total number of participating States and the burden associated with these requirements, we are soliciting public comment pertaining to this burden and will reevaluate this issue in the final rule stage of rulemaking.

D. ICRs Regarding Support System (§441.555)

As stated in proposed §441.555, for the self-directed model with a service budget, States must provide or arrange for the provision of a support system. Proposed §441.555(a) would require a support system to appropriately assess and counsel an individual or the individual's representative, if applicable, before enrollment. Proposed §441.555(b) would require that the support system to provide appropriate information, counseling, training and assistance to ensure that an individual is able to manage the services and budgets. In addition, proposed

§441.555(b) would require that the information be communicated to the individual in a manner and language understandable by the individual.

The burden associated with proposed §441.555 would be the time and effort necessary for the State or the provider of the support system to meet the aforementioned disclosure requirements. We estimate that it will take each State 2 hours to provide or arrange for the provision of a support system that meets the necessary requirements. However, we cannot estimate the frequency with which a State will provide or arrange for the provision of support systems, as it will vary by State depending on the number of participants that are assessed to need this service. Because we cannot accurately quantify the frequency with which a State will provide or arrange for the provision of support systems, we are soliciting public comments on this issue and will reevaluate the associated burden estimate in the final rule stage of rulemaking.

E. ICRs Regarding Service Budget Requirements (§441.560)

Proposed §441.560(a) would require, for the self-directed model with a service budget, that a service budget be developed and approved by the State based on the assessment of need and service plan. The budget must include all of the information listed in §441.560(a)

through (b). The burden associated with this requirement is the time and effort put forth by the State to develop a service budget. We estimate that it will take each State 3 hours to develop a service budget; however, the total number of budgets each State must prepare will depend on the number of individual's utilizing the self-directed model in each State. Because we are unable to estimate the total number of service budgets each State would be required to develop, we are soliciting public comments pertaining to this issue and will reevaluate the burden estimate in the final rule stage of rulemaking.

Proposed §441.560(c) would require States to have procedures in place that will provide safeguards to individuals when the budgeted services amount is insufficient to meet the individual's needs. The burden associated with this requirement is the time and effort it would take for a State to develop and maintain its procedures. We estimate that will take each State 16 hours to develop these procedures. Similarly, we estimate that all States that elect this State plan option will comply with this requirement. We believe this requirement imposes a one-time burden; therefore, we have not assigned any future burden to this requirement. We cannot estimate the total annual burden associated with this requirement

because it will vary by State. Because we cannot quantify the aforementioned burden, we are soliciting public comments pertaining to this issue and will reevaluate the burden estimate in the final rule stage of rulemaking.

Proposed §441.560(d) would require a State to have a method of notifying individuals of the amount of any limit that applies to an individual's Community First Choice Option services and supports. The burden associated with this requirement is the time and effort it would take for each State to develop and distribute a notice to each individual. We estimate that all States that elect this option must comply with this notification requirement. We further estimate it would take each State 15 minutes to develop and distribute a single notice. The total number of notices each State must distribute will vary depending on the number of individual's utilizing the self-directed model in each State. Therefore, we are unable to estimate the burden associated with this requirement. We are soliciting public comments pertaining to this issue and will reevaluate the burden estimate in the final rule stage of rulemaking.

F. ICRs Regarding Provider Qualifications (§441.565)

Proposed §441.565 would require States to provide assurances that necessary safeguards have been taken to

protect the health and welfare of enrollees in the Community First Choice State Option. In addition, the States must define in writing the adequate qualifications for providers in the agency model of Community First Choice services and supports. The burden associated with the aforementioned requirements is the time and effort necessary to develop system safeguards that include written adequacy qualifications for providers. We estimate that it will take each State 16 hours to comply with this requirement; however, the total estimated annual burden associated with these requirements will vary by State. We are unable to estimate the total number of written assurances that will be required; therefore, we are seeking public comment pertaining to this issue and will reevaluate the burden estimate in the final rule stage of rulemaking.

G. ICRs Regarding Data Collection (§441.580)

Proposed §441.580 would require a State to provide information regarding the provision of home and community-based attendant services and supports under the Community First Choice Option for each fiscal year for which such services are provided. Specifically, States must submit the information contained in proposed §441.580(a) through (f). We estimate that it will take each State 24 hours to submit the required information. We also estimate that all

States that elect this State plan option must comply with this requirement. The total estimated annual burden associated with this requirement is 24 hours at a cost of \$576 per State for the initial year.

H. ICRs Regarding Quality Assurance System (§441.585)

Proposed §441.585 would require each State to establish and maintain a comprehensive, continuous quality assurance system, detailed in the State plan amendment, that includes a quality improvement strategy and employs measures for program performance and quality of care, standards for delivery models, mechanisms for discovery and remediation, and quality improvements proportionate to the benefit and number of individuals served. Specifically, the quality assurance system must include but not be limited to the components listed in proposed §441.585(a) through (c). The burden associated with this requirement is the time and effort necessary for a State to develop and maintain a quality assurance system. We estimate that it will take 100 hours for each State to comply with the initial requirement to develop a quality assurance system. The total estimated annual burden associated with developing a quality assurance system is 100 hours per State, at a cost of \$2,400. Similarly, we estimate that each State will incur an annual burden of 16 hours to

review and maintain its quality assurance system. The total estimated annual burden associated with reviewing a quality assurance system is 16 hours at a cost of \$384 for each participating State.

If you comment on these information collection and recordkeeping requirements, please do either of the following:

1. Submit your comments electronically as specified in the ADDRESSES section of this proposed rule; or

2. Submit your comments to the Office of Information and Regulatory Affairs, Office of Management and Budget,

Attention: CMS Desk Officer, [CMS-2337-P]

Fax: (202) 395-6974; or

Email: OIRA_submission@omb.eop.gov

IV. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the "DATES" section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

V. Regulatory Impact Analysis

A. Statement of Need

This proposed rule implements section 2401 of the Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010. The Secretary is to establish a new State plan option to provide home and community-based attendant services and supports at a 6 percentage point increase in Federal matching payments for expenditures related to the provision of services under this option. Section 2401 of the Affordable Care Act, entitled "Community First Choice Option," adds a new section 1915(k) of the Act that allows States, at their option, to provide home and community-based attendant services and supports under their State plan beginning October 1, 2011.

B. Overall Impact

We have examined the impacts of this rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (February 2, 2011), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96-354), section 1102(b) of the Social Security Act, section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104-4), Executive Order 13132 on Federalism (August 4, 1999), and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects (\$100 million or more in any 1 year). The proposed rule is estimated to have an economic impact of approximately \$1,585,000,000 in the fiscal year beginning on October 1, 2011. Therefore, we estimate that this rulemaking is economically significant as measured by the \$100 million threshold, and hence also a major rule under the Congressional Review Act. Accordingly, we have prepared an RIA below that to the best of our ability presents the costs and benefits of the rulemaking.

The RFA requires agencies to analyze options for regulatory relief of small entities if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most hospitals and most other health care providers and suppliers are small entities,

either by being nonprofit organizations or by meeting the SBA definition of a small business and having revenues of less than \$7 million to \$34.5 million in any 1 year. (For details, see the Small Business Administration's Table of Size Standards at <http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=2465b064ba6965cc1fbd2eae60854b11&rgn=div8&view=text&node=13:1.0.1.1.16.1.266.9&idno=13>.) Individuals and States are not included in the definition of a small entity. We are not preparing an analysis for the RFA because we have determined, and the Secretary certifies, that this proposed rule would not have a significant impact on a substantial number of small entities.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a metropolitan statistical area and has fewer than 100 beds. We are not preparing an analysis for section 1102(b) of the Act because the Secretary has determined that this proposed

rule will not have a significant impact on the operations of a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of \$100 million in 1995 dollars, updated annually for inflation. In 2011, that threshold is approximately \$136 million. Because this rule does not mandate State participation in section 1915(k) of the Act, there is no obligation for the State to make any change to their Medicaid program. As a result, there is no mandate for the State. Therefore, we estimate this rule will not mandate expenditures in the threshold amount of \$136 million in any 1 year.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. As stated above, this proposed rule would not have a substantial effect on State and local governments.

C. Anticipated Effects

1. Overview

This proposed rule provides States with additional flexibility to finance home and community based services by establishing a new Community First Choice Option at an increased Federal financial participation for attendant services and supports. Because of this enhanced flexibility, and the fact that a majority of States may already provide attendant services and supports through optional medical assistance services in its Medicaid State plan, HCBS waiver programs or both, we anticipate that each State will likely compare and decide which vehicle provides greater benefits and stability to their overall Medicaid program. As such, at this time it is very difficult to accurately predict how many States will choose to adopt the Community First Choice (CFC) Option, and how a State's election to exercise this option will influence other parts of its Medicaid program. However, for purposes of this RIA, we assume a gradual growth in the number of States adopting this option, so that, by FY 2015, 25 percent of eligible persons who would want this coverage would reside in States that offer it.

2. Effects on Medicaid Recipients

We anticipate that a large number of Medicaid recipients will be affected. We believe the optional expansion of settings where attendant care services and

supports may be furnished at the increased Federal Medical Assistance Percentage (FMAP) will likely have significant positive effects on Medicaid recipients, particularly on their demand for these services. We anticipate that the provisions of the proposed rule will likely increase State and local accessibility to services that augment the quality of life for individuals through a person-centered plan of service and various quality assurances, all at a potentially lower per capita cost relative to alternative care-settings.

3. Effects on other Providers

We anticipate that this proposed rule will increase the demand for attendant care services and supports. We believe this effect will be beneficial to providers, particularly providers of attendant care services and supports. Additionally, if the increase in demand for such services is sufficient, the number of providers of such services may increase.

4. Effects on the Medicaid Program Expenditures

Table 1 provides estimates of the anticipated Medicaid program expenditures associated with furnishing attendant care services and supports. The estimates were made using various assumptions about increases in service utilization and costs, as well as assumptions about the induced

utilization that may result from the CFC option. We have taken into account the varying costs for those who have a need for an institutional level of care as opposed to those who do not. We have allowed for possible State incentives due to the increased FMAP rate, as well as for the possibility of savings due to beneficiaries being diverted from nursing facility use. Given these assumptions and based on prior program experience, our estimate is shown in Table 1. We estimate the following costs to the Medicaid program:

**TABLE 1: ATTENDANT CARE SERVICES AND SUPPORTS
Medicaid Cost Estimates (in millions)¹**

Services	FY 2011	FY 2012	FY 2013	FY 2014	FY2015
Federal Share	N/A	\$1075	\$1475	\$2425	\$3420
State Share	N/A	\$510	\$615	\$1085	\$1540
Total	N/A	\$1585	\$2090	\$3510	\$4960

5. Effects on States

Varying State definitions of personal care services and rules concerning who may furnish them make it difficult to estimate accurately the potential increases in expenditures for States that choose to adopt the CFC option under section 1915(k) of the Act. Therefore, in light of the provisions of this proposed rule, we welcome comments

¹ Figures are rounded to the nearest \$1 million and assume increased State participation per fiscal year.

about the number of States that are likely to participate in the CFC program.

D. Alternatives Considered

Section 2401 of the Affordable Care Act is the legislation that we are required to implement. Therefore we considered no other alternatives.

E. Accounting Statement

As required by OMB Circular A-4 (available at: <http://www.whitehouse.gov/sites/default/files/omb/assets/omb/circulars/a004/a-4.pdf>), we have prepared an accounting statement showing the classification of expenditures associated with the provisions of this rule and discussed earlier in the RIA. This statement, to the best of our ability, captures the anticipated distributional effects of section 1915(k) services offered by qualified providers in the Medicaid program.

TABLE 2: Accounting Statement: Classification of Estimated Expenditure from FY 2011 to FY 2015 (in millions)

CATEGORY		
BENEFITS:	Qualitative: Provision of the CFC option will increase State and local accessibility to services that increase the quality of life for individuals through a person-centered plan of service and various quality assurances, and reduce the financial strain on States and Medicaid participants.	
COSTS	Administrative costs included in the Paperwork Reduction Act section of the preamble.	
TRANSFERS	PRIMARY ESTIMATE	
Federal Annualized Monetized (\$millions/year)	<u>3 percent Discount Rate</u>	<u>7 percent Discount Rate</u>
	\$1630.6	\$1568.6
From Whom to Whom?	Federal Government to Qualified Providers	
State Annualized Monetized (\$millions/year)		
	\$728.4	\$700.8
From Whom to Whom?	State Governments to Qualified Providers	

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

List of Subjects in 42 CFR Part 441

Aged, Family planning, Grant programs-health, Infants
and children, Medicaid, Penalties, Reporting and
recordkeeping requirements

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services proposes to amend 42 CFR Chapter IV as set forth below:

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

1. The authority citation for part 441 continues to read as follows:

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

2. Part 441 is amended by adding subpart K to read as follows:

Subpart K -- Home and Community-based Attendant Services and Supports State Plan Option (Community First Choice)
Sec.

- 441.500 Basis and scope.
- 441.505 Definitions.
- 441.510 Eligibility.
- 441.515 Statewideness.
- 441.520 Required services.
- 441.525 Excluded services.
- 441.530 Setting.
- 441.535 Assessment of need.
- 441.540 Person-centered service plan.
- 441.545 Service models.

441.550 Service plan requirements for self-directed model with service budget.

441.555 Support system.

441.560 Service budget requirements.

441.565 Provider qualifications.

441.570 State assurances.

441.575 Development and Implementation Council.

441.580 Data collection.

441.585 Quality assurance system.

441.590 Increased Federal financial participation.

Subpart K -- Home and Community-based Attendant Services and Supports State Plan Option (Community First Choice)

§441.500 Basis and Scope.

(a) Basis. This subpart implements section 1915(k) of the Act concerning the Community First Choice Option to provide home and community-based attendant services and supports through a State plan.

(b) Scope. The Community First Choice Option is designed to make available home and community-based attendant services and supports to eligible individuals, as needed, to assist in accomplishing activities of daily living (ADLs), instrumental activities of daily living

(IADLs), and health-related tasks through hands-on assistance, supervision, or cueing.

§441.505 Definitions.

As used in this subpart:

Activities of daily living (ADLs) means basic personal everyday activities including, but not limited to, tasks such as eating, toileting, grooming, dressing, bathing, and transferring.

Agency-provider model means, with respect to the provision of home and community-based attendant services and supports, a method of providing self-directed services and supports under which entities contract for the provision of these services and supports.

Backup systems and supports means electronic devices used to ensure continuity of services and supports. These items may include pagers, personal emergency response systems, and other mobile communication devices. Persons identified by an individual can also be included as backup supports.

Health-related tasks means specific tasks related to the needs of an individual, which can be delegated or assigned by licensed health-care professionals under State law to be performed by an attendant.

Individual's representative means a parent, family member, guardian, advocate, or other authorized representative of the individual.

Instrumental activities of daily living (IADLs) means activities related to living independently in the community, including but is not limited to, meal planning and preparation, managing finances, shopping for food, clothing, and other essential items, performing essential household chores, communicating by phone or other media, and traveling around and participating in the community.

Other models means methods, other than an agency-provider model, for the provision of self-directed services and supports. These models may include the provision of vouchers, direct cash payments, or use of a fiscal agent to assist in obtaining services.

Self-directed means a consumer controlled method of selecting and providing services and supports that allow the individual, or where appropriate, the individual's representative, maximum control of the home and community-based attendant services and supports, regardless of who acts as the employer of record.

§441.510 Eligibility.

To receive Community First Choice services under this section, an individual must meet the following requirements:

(a) Be eligible for medical assistance under the State plan.

(b) Have an income that meets one of the following thresholds as determined annually:

(1) Is equal to or less than 150 percent of the Federal poverty level (FPL).

(2) Is greater than 150 percent of the FPL, and is eligible for nursing facility services under the State plan and for whom it has been determined that in the absence of home and community-based attendant services and supports, the individual would otherwise require a Medicaid covered level of care furnished in a hospital, a nursing facility, an intermediate care facility for the mentally retarded or an institution for mental diseases.

(3) Qualifies for Medicaid assistance under the special home and community-based waiver eligibility group defined at section 1902(a)(10)(A)(ii)(VI) of the Act, and is receiving at least one home and community-based waiver service per month.

(c) In determining whether the 150 percent of the FPL requirement is met, States must apply the same income

disregards in accordance with section 1902(r)(2) of the Act as they do under their Medicaid State plan.

§441.515 Statewideness.

States must provide the Community First Choice Option to individuals:

(a) On a Statewide basis.

(b) In a manner that provides such services and supports in the most integrated setting appropriate to the individual's needs, and without regard to the individual's age, type or nature of disability, severity of disability, or the form of home and community-based attendant services.

(c) In a manner that provides the supports that the individual requires in order to lead an independent life.

§441.520 Required services.

(a) If a State elects to provide the Community First Choice Option, the State must provide all of the following services:

(1) Assistance with ADLs, IADLs, and health-related tasks through hands-on assistance, supervision, or cueing.

(2) Acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish ADLs, IADLs, and health related tasks.

(3) Back-up systems or mechanisms to ensure continuity of services and supports, as defined in §441.505 of this subpart.

(4) Voluntary training on how to select, manage, and dismiss attendants.

(b) The State may provide permissible services and supports which include the following:

(1) Expenditures for transition costs such as rent and utility deposits, first month's rent and utilities, bedding, basic kitchen supplies, and other necessities required for an individual to transition from a nursing facility, institution for mental diseases, or intermediate care facility for the mentally retarded to a community-based home setting where the individual resides.

(2) Expenditures relating to a need identified in an individual's person-centered plan of services that increase a participant's independence or substitute for human assistance, to the extent that expenditures would otherwise be made for the human assistance.

(3) The services and supports that are purchased must be linked to an assessed need or goal established in the individual's person-centered service plan.

§441.525 Excluded services.

The Community First Choice Option may not include the following:

(a) Room and board costs for the individual, except for allowable transition services described in §441.520(b)(1) of this subpart.

(b) Special education and related services provided under the Individuals with Disabilities Education Act that are related to education only, and vocational rehabilitation services provided under the Rehabilitation Act of 1973.

(c) Assistive devices and assistive technology services other than those defined in §441.520(a)(5) of this subpart or those that are based on a specific need identified in the service plan when used in conjunction with other home and community-based attendant services.

(d) Medical supplies and equipment.

(e) Home modifications.

§441.530 Setting.

States must make available attendant services and supports in a home or community setting, which do not include the following:

(a) A nursing facility.

(b) An institution for mental diseases.

(c) An intermediate care facility for the mentally retarded.

(d) Any settings located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment or custodial care.

(e) A building on the grounds of or immediately adjacent to, a public institution or disability-specific housing complex, designed expressly around an individual's diagnosis that is geographically segregated from the larger community, as determined by the Secretary.

§441.535 Assessment of need.

States must conduct a face-to-face assessment of the individual's needs, strengths, and preferences in accordance with the following:

(a) States may use one or more processes and techniques to obtain information about an individual including the following:

(1) Health condition.

(2) Personal goals and preferences for the provision of services.

(3) Functional limitations.

(4) Age.

(5) School.

(6) Employment.

(7) Household.

(8) Other factors that are relevant to the need for and authorization and provision of services.

(b) Assessment information supports the determination that an individual requires the Community First Choice Option and also supports the development of the person-centered service plan and, if applicable, service budget.

(c) The assessment of need must be conducted at least every 12 months, as needed when the individual's support needs or circumstances change significantly necessitating revisions to the service plan, or at the request of the individual, or the individual's representative, as applicable.

§441.540 Person-centered service plan.

(a) Person-centered planning process. The person-centered planning process must include the following criteria:

(1) Includes people chosen by the individual.

(2) Provides necessary support to ensure that the individual has a meaningful role in directing the process.

(3) Occurs at times and locations of convenience to the individual.

(4) Reflects cultural considerations of the individual.

(5) Includes strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants.

(6) Offers choices to the individual regarding the services and supports they receive and from whom.

(7) Includes a method for the individual to request updates to the plan.

(b) The person-centered plan. The person-centered plan must reflect the services that are important for the individual to meet individual services and support needs as assessed through a person-centered functional assessment, as well as what is important to the person with regard to preferences for the delivery of such supports. Commensurate with the level of need of the individual, the plan must include the following criteria:

(1) Reflect the individual's strengths and preferences.

(2) Reflect clinical and support needs as identified through a person-centered functional assessment.

(3) Include individually identified goals, which may include, as desired by the individual, items related to relationships, community participation, employment, income and savings, health care and wellness, education, and others.

(4) Reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals and the providers of those services and supports.

(5) Reflect risk factors and measures in place to minimize them, including back-up strategies when needed.

(6) Be signed by all individuals and providers responsible for its implementation.

(7) Be understandable to the individual receiving services and the individuals important in supporting him or her.

(8) Include a timeline for review.

(9) Identify the individual and/or entity responsible for monitoring the plan.

(10) Be distributed to everyone involved (including the participant) in the plan.

(11) Be directly integrated into self-direction where individual budgets are used.

(12) Prevent the provision of unnecessary or inappropriate care.

(c) Requirements of the plan. All of the State's applicable policies and procedures associated with the person-centered service plan development must be carried

out and must include, but are not limited to, the following policies and procedures:

(1) Ensure the responsibilities for assessment of need and service plan development are identified.

(2) Ensure the planning process is timely.

(3) Ensure the individual's needs are assessed and the services and supports meet the individual's needs.

(4) Establish conflict of interest standards for assessment of need and the service plan development process that apply to all individuals and entities, public or private. At a minimum, these standards must ensure that the individuals or entities involved in the person-centered assessment of need and service plan development process are not:

(i) Related by blood or marriage to the individual, or to any paid caregiver of the individual.

(ii) Financially responsible for the individual.

(iii) Empowered to make financial or health-related decisions on behalf of the individual.

(iv) Individuals who would benefit financially from the provision of assessed needs and services.

(d) Finalizing the person-centered service plan. The service plan must be finalized and agreed to in writing by the individual or, as appropriate, the individual's

representative and a copy of the plan must be provided to the individual.

(e) Reviewing the person-centered service plan. The service plan must be reviewed, and revised upon reassessment of need, at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual or the individual's representative, as applicable.

§441.545 Service models.

A State may choose one or more of the following as the service delivery model to provide self-directed home and community-based attendant services and supports:

(a) Agency model. (1) The agency model is a delivery method in which the services and supports are provided by entities under a contract.

(2) Under the agency model for the Community First Choice option, individuals maintain the ability to hire and fire the providers of their choice for the services identified in their person-centered service plan.

(b) Self-directed model with service budget. A self-directed model with a service budget is one in which the individual has both a service plan and service budget based on the person-centered assessment of need.

(1) Financial management entity. States must make available financial management services to all individuals with a service budget. The financial management entity performs functions including, but not limited to, the following services:

(i) Collect and process timesheets of the individual's workers.

(ii) Process payroll, withholding, filing, and payment of applicable Federal, State and local employment related taxes and insurance.

(iii) Maintain a separate account for each individual's budget.

(iv) Track and report disbursements and balances of each individual's funds.

(v) Process and pay invoices for services in the service plan.

(vi) Provide individual periodic reports of expenditures and the status of the approved service budget.

(vii) States may perform the functions of a financial management entity internally or use a vendor organization that has the capabilities to perform the required tasks in accordance with applicable IRS requirements.

(2) Direct cash. States may disburse cash prospectively to individuals self-directing their Community

First Choice Option services and supports and must meet the following requirements:

(i) Ensure compliance with all applicable requirements of the Internal Revenue Service, including but not limited to, retaining required forms and payment of FICA, FUTA and State unemployment taxes.

(ii) Permit individuals, or their representatives as applicable, using the cash option to choose to use the financial management entity for some or all of the functions described in paragraph (b)(1)(ii) of this section.

(iii) Make available a financial management entity to an individual who has demonstrated, after additional counseling, information, training, or assistance that the individual cannot effectively manage the cash option described in this section.

(iv) If the cash option is the only model offered by the State for Community First Choice, the State may require an individual to use the financial management entity services under the cash option, but must provide the individual with the conditions under which this option would be enforced.

(3) Vouchers. (i) States have the option to issue vouchers to individuals who self-direct their Community First Choice Option services and supports.

(ii) States that choose to offer the vouchers must ensure compliance with all applicable requirements of the Internal Revenue Service.

§441.550 Service plan requirements for self-directed model with service budget.

An approved self-directed service plan conveys authority to the individual to perform, at a minimum, the following tasks:

(a) Recruit and hire workers to provide self-directed services, including specifying worker qualifications.

(b) Fire workers.

(c) Supervise workers in the provision of Community First Choice Option services and supports.

(d) Manage workers in the provision of Community First Choice Option services and supports, which includes the following functions:

(1) Determining worker duties.

(2) Scheduling workers.

(3) Training workers in assigned tasks.

(4) Evaluating workers performance.

(e) Determining the amount paid for a service, support, or item.

(f) Reviewing and approving provider invoices.

§441.555 Support system.

For the self-directed model with a service budget, States must provide, or arrange for the provision of, a support system that meets all of the following conditions:

(a) Appropriately assesses and counsels an individual, or the individual's representative, if applicable, before enrollment.

(b) Provides appropriate information, counseling, training, and assistance to ensure that an individual is able to manage the services and budgets.

(1) This information must be communicated to the individual in a manner and language understandable by the individual.

(2) The support activities must include at least the following:

(i) Person-centered planning and how it is applied.

(ii) Range and scope of individual choices and options.

(iii) Process for changing the person-centered service plan and service budget.

(iv) Grievance process.

(v) Risks and responsibilities of self-direction.

(vi) The ability to freely choose from available home and community-based attendant providers.

(vii) Individual rights.

(viii) Reassessment and review schedules.

(ix) Defining goals, needs, and preferences.

(x) Identifying and accessing services, supports, and resources.

(xi) Development of risk management agreements.

(xii) Development of a personalized backup plan.

(xiii) Recognizing and reporting critical events.

(xiv) Information about an advocate or advocacy systems available in the State and how an individual, or individual's representative, if applicable, can access the advocate or advocacy systems.

§441.560 Service budget requirements.

(a) For the self-directed model with a service budget, a service budget must be developed and approved by the State based on the assessment of need and service plan and must include all of the following requirements:

(1) The specific dollar amount an individual may use for Community First Choice Option services and supports.

(2) The procedures for informing an individual of the amount of the service budget before the service plan is finalized.

(3) The procedures for how an individual may adjust the budget including the following:

(i) The procedure for an individual to freely change the budget.

(ii) The circumstances, if any, that may require prior approval by the State before a budget adjustment is made.

(4) The circumstances, if any, that may require a change in the service plan.

(5) The procedures that govern the determination of transition costs and expenditures, relating to a need in the service plan, that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance.

(6) The procedures for an individual to request a fair hearing under §441.300 of this part if an individual's request for a budget adjustment is denied or the amount of the budget is reduced.

(b) The budget methodology set forth by the State to determine an individual's service budget amount must meet all of the following criteria:

(1) The State's method of determining the budget allocation is objective and evidence based utilizing valid, reliable cost data.

(2) Be applied consistently to individuals.

(3) Be included in the State plan.

(4) Includes a calculation of the expected cost of Community First Choice Option services and supports, if those services and supports are not self-directed.

(5) The State has a process in place that describes the following:

(i) Any limits it places on Community First Choice Option services and supports, and the basis for the limits.

(ii) Any adjustments that are allowed and the basis for the adjustments.

(c) The State must have procedures in place that will provide safeguards to individuals when the budgeted service amount is insufficient to meet the individual's needs.

(d) The State must have a method of notifying individuals of the amount of any limit that applies to an individual's Community First Choice Option services and supports.

(e) The budget may not restrict access to other medically necessary care and services furnished under the

State plan and approved by the State but which are not included in the budget.

(f) The State must have a procedure to adjust a budget when a reassessment indicates a change in an individual's medical condition, functional status, or living situation.

§441.565 Provider qualifications.

(a) The State must provide assurances that necessary safeguards have been taken to protect the health and welfare of enrollees in the Community First Choice State Option, and must define in writing adequate qualifications for providers in the agency model of Community First Choice services and supports.

(b) An individual has the option to permit family members, or any other individuals, to provide Community First Choice attendant services and supports identified in the service plan provided they meet the qualifications to provide the services and supports.

(c) An individual retains the right to train workers in the specific areas of attendant care needed by the individual and to perform the needed assistance in a manner that comports with the individual's personal, cultural, or religious preferences.

(d) An individual retains the right to establish additional staff qualifications based on the individual's needs and preferences.

§441.570 State assurances.

A State must assure the following requirements are met:

(a) For the first full fiscal year in which the State Plan amendment is implemented, a State must maintain, or exceed, the level of expenditures for services provided under sections 1115, 1905(a), and 1915, of the Act, or otherwise to individuals with disabilities or elderly individuals attributable to the preceding fiscal year.

(b) All applicable provisions of the Fair Labor Standards Act of 1938.

(c) All applicable provisions of Federal and State laws regarding the following:

(1) Withholding and payment of Federal and State income and payroll taxes.

(2) The provision of unemployment and workers compensation insurance.

(3) Maintenance of general liability insurance.

(4) Occupational health and safety

§441.575 Development and Implementation Council.

(a) States must establish a Development and Implementation Council primarily comprised primarily of individuals with disabilities, elderly individuals, and their representatives.

(b) States must consult and collaborate with the Council when developing and implementing a State plan amendment to provide home and community-based attendant services and supports.

§441.580 Data collection.

A State must provide the following information regarding the provision of home and community-based attendant services and supports under the Community First Choice Option for each fiscal year for which the services and supports are provided:

(a) The number of individuals who are estimated to receive the Community First Choice under this State plan option during the fiscal year.

(b) The number of individuals that received the services and supports during the preceding fiscal year.

(c) The number of individuals served broken down by type of disability, age, gender, education level, and employment status.

(d) The specific number of individuals who have been previously served under sections 1115, 1915(c) and (i) of the Act, or the personal care State plan option.

(e) Data regarding how the State provides the Community First Choice State option and other home and community-based services.

(f) The cost of providing Community First Choice State option and other home and community-based services and supports.

(g) Data regarding how the State provides individuals with disabilities who otherwise qualify for institutional care under the State plan or under a waiver the choice to receive home and community-based services in lieu of institutional care.

§441.585 Quality assurance system.

States must establish and maintain a comprehensive, continuous quality assurance system, detailed in the State plan amendment, that includes a quality improvement strategy and employs measures for program performance and quality of care, standards for delivery models, mechanisms for discovery and remediation, and quality improvements proportionate to the benefit and number of individuals served.

(a) Details of the quality assurance system. Details of the quality assurance system must include the following:

(1) Program performance measures. The States' quality assurance system must be designed to measure and provide evidence of program performance related to the following:

(i) Health and welfare.

(ii) Provider qualifications.

(iii) Choice of institution or community.

(iv) Choice of services, supports and providers

(v) Cost of services and supports.

(2) Quality of care measures. The State's quality assurance system must be designed to measure individual outcomes associated with the receipt of community-based attendant services and supports, particularly with respect to the health and welfare of recipients of this service. These measures must be made available to CMS upon request and must include a process for the mandatory reporting, investigation, and resolution of allegations of neglect, abuse, or exploitation in connection with the provision of community based attendant services and supports, as well as quality indicators approved or prescribed by the Secretary.

(3) Standards for delivery models. The States' quality assurance system must include standards for agency-based and other delivery models for training, appeals for

denials and reconsideration procedures on an individual service plan.

(4) Choice and control. The quality assurance system will employ methods that maximize consumer independence and control and will provide information about the provisions of quality improvement and assurance to each individual receiving such services and supports.

(b) Stakeholder feedback. The State must elicit and incorporate feedback from key stakeholders to improve the quality of the community-based attendant services and supports benefit.

(c) Collection and evaluation. The State must collect and report on monitoring, remediation, and quality improvements related to information defined in the State's quality improvement strategy.

§441.590 Increased Federal financial participation.

Beginning October 1, 2011, the FMAP applicable to the State will be increased by 6 percentage points, for the provision of the Community First Choice Option home and community-based attendant services, under an approved State plan amendment.

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Donald M. Berwick,
Administrator,
Centers for Medicare & Medicaid
Services

Approved: January 31, 2011.

Kathleen Sebelius,
Secretary,
Department of Health and Human
Services

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