

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

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

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

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

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

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

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

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

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

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

(e) *Functions in support of self-direction.* When the State elects to offer

self-directed State plan HCBS, it must offer the following individualized supports to individuals receiving the services and their representatives:

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

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

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

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

(iii) Maintain separate accounts for each individual's budget and provide periodic reports of expenditures against budget in a manner understandable to the individual.

(3) Voluntary training on how to select, manage, and dismiss providers of State plan HCBS.

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

(a) *State plan HCBS administration*—(1) *State responsibilities.* The State must carry out the following responsibilities in administration of its State plan HCBS:

(i) *Number served.* The State will annually provide CMS with the projected number of individuals to be enrolled in the benefit and the actual number of unduplicated individuals enrolled in State plan HCBS in the previous year.

(ii) *Access to services.* The State must grant access to all State plan HCBS assessed to be needed in accordance with a service plan consistent with § 441.725, to individuals who have been determined to be eligible for the State plan HCBS benefit, subject to the following requirements:

(A) A State must determine that provided services meet medical necessity criteria.

(B) A State may limit access to services through targeting criteria established by § 441.710(e)(2).

(C) A State may not limit access to services based upon the income of eligible individuals, the cost of services, or the individual's location in the State.

(iii) *Appeals.* A State must provide individuals with advance notice of and the right to appeal terminations, suspensions, or reductions of Medicaid eligibility or covered services as described in part 431, subpart E.

(2) *Administration—(i) Option for presumptive payment.* (A) The State may provide for a period of presumptive payment, not to exceed 60 days, for Medicaid eligible individuals the State has reason to believe may be eligible for the State plan HCBS benefit. FFP is available for both services that meet the definition of medical assistance and necessary administrative expenditures for evaluation of eligibility for the State plan HCBS benefit under § 441.715(d) and assessment of need for specific HCBS under § 441.720(a), prior to an individual's receipt of State plan HCBS or determination of ineligibility for the benefit.

(B) If an individual the State has reason to believe may be eligible for the State plan HCBS benefit is evaluated and assessed under the presumptive payment option and found not to be eligible for the benefit, FFP is available for services that meet the definition of medical assistance and necessary administrative expenditures. The individual so determined will not be considered to have enrolled in the State plan HCBS benefit for purposes of determining the annual number of participants in the benefit.

(ii) *Option for phase-in of services and eligibility.* (A) In the event that a State elects to establish targeting criteria through § 441.710(e)(2), the State may limit the enrollment of individuals or the provision services to enrolled individuals based upon criteria described in a phase-in plan, subject to CMS approval. A State which elects to target the State plan HCBS benefit and to phase-in enrollment and/or services must submit a phase-in plan for approval by CMS that describes, at a minimum:

(1) The criteria used to limit enrollment or service delivery.

(2) The rationale for phasing-in services and/or eligibility.

(3) Timelines and benchmarks to ensure that the benefit is available statewide to all eligible individuals within the initial 5-year approval.

(B) If a State elects to phase-in the enrollment of individuals based on highest need, the phase-in plan must use the needs-based criteria described in § 441.715(a) to establish priority for enrollment. Such criteria must be based upon the assessed need of individuals, with higher-need individuals receiving services prior to individuals with lower assessed need.

(C) If a State elects to phase-in the provision of any services, the phase-in plan must include a description of the services that will not be available to all eligible individuals, the rationale for limiting the provision of services, and assurance that all individuals with access to a willing and qualified provider may receive services.

(D) The plan may not include a cap on the number of enrollees.

(E) The plan must include a timeline to assure that all eligible individuals receive all included services prior to the end of the first 5-year approval period, described in paragraph (a)(2)(vi) of this section.

(iii) *Reimbursement methodology.* The State plan amendment to provide State plan HCBS must contain a description of the reimbursement methodology for each covered service, in accordance with CMS sub-regulatory guidance. To the extent that the reimbursement methodologies for any self-directed services differ from those descriptions, the method for setting reimbursement methodology for the self-directed services must also be described.

(iv) *Operation.* The State plan amendment to provide State plan HCBS must contain a description of the State Medicaid agency line of authority for operating the State plan HCBS benefit, including distribution of functions to other entities.

(v) *Modifications.* The agency may request that modifications to the benefit be made effective retroactive to the first day of a fiscal year quarter, or another date after the first day of a fiscal year quarter, in which the amendment is submitted, unless the amendment involves substantive change. Substantive changes may include, but are not limited to, the following:

(A) Revisions to services available under the benefit including elimination or reduction in services, and changes in

the scope, amount and duration of the services.

(B) Changes in the qualifications of service providers, rate methodology, or the eligible population.

(1) *Request for Amendments.* A request for an amendment that involves a substantive change as determined by CMS—

(i) May only take effect on or after the date when the amendment is approved by CMS; and

(ii) Must be accompanied by information on how the State will ensure for transitions with minimal adverse impact on individuals impacted by the change.

(2) [Reserved]

(vi) *Periods of approval.* (A) If a State elects to establish targeting criteria through §441.710(e)(2)(i), the approval of the State Plan Amendment will be in effect for a period of 5 years from the effective date of the amendment. To renew State plan HCBS for an additional 5-year period, the State must provide a written request for renewal to CMS at least 180 days prior to the end of the approval period. CMS approval of a renewal request is contingent upon State adherence to Federal requirements and the state meeting its objectives with respect to quality improvement and beneficiary outcomes.

(B) If a State does not elect to establish targeting criteria through §441.710(e)(2)(i), the limitations on length of approval does not apply.

(b) *Quality improvement strategy: Program performance and quality of care.* States must develop and implement an HCBS quality improvement strategy that includes a continuous improvement process and measures of program performance and experience of care. The strategy must be proportionate to the scope of services in the State plan HCBS benefit and the number of individuals to be served. The State will make this information available to CMS at a frequency determined by the Secretary or upon request.

(1) *Quality Improvement Strategy.* The quality improvement strategy must include all of the following:

(i) Incorporate a continuous quality improvement process that includes monitoring, remediation, and quality improvement.

(ii) Be evidence-based, and include outcome measures for program performance, quality of care, and individual experience as determined by the Secretary.

(iii) Provide evidence of the establishment of sufficient infrastructure to implement the program effectively.

(iv) Measure individual outcomes associated with the receipt of HCBS, related to the implementation of goals included in the individual service plan.

(2) [Reserved]

## PART 442—STANDARDS FOR PAYMENT TO NURSING FACILITIES AND INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES

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### Subparts D–F [Reserved]

AUTHORITY: Sec. 1102 of the Social Security Act (42 U.S.C. 1302), unless otherwise noted.