DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-15
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations

SMDL #02-009

May 9, 2002

Dear State Medicaid Director:

This letter transmits two template applications specifically designed to promote family or individual independence and choices regarding the selection of long-term care supports and services provided in the home. The *Independence Plus:* A Demonstration Program for Family or Individual Directed Community Services Template applications, developed by the Centers for Medicaid and Medicaid Services (CMS), will assist states to create and fund such programs. While the templates are voluntary, the streamlined applications and approval process created by a standardized application will lessen the administrative burden on states and expedite the Federal review period.

The template applications further the goals contained in President Bush's *New Freedom Initiative* and advances CMS's commitment to continue creating a "culture of responsiveness." The intended purposes are specifically to:

- Delay institutional or other high cost out-of-home placement by strengthening supports to families or individuals and permit the individual who requires long-term supports and services to live in the family residence or their own home.
- Recognize the essential role of the family or individual in the planning and purchasing of health care supports and services by providing individuals or their families control over an agreed resource amount.
- Encourage cost effective decision-making to purchase necessary supports and services.
- Increase family or individual satisfaction through the promotion of self direction, control and choice - a major theme expressed during the *New Freedom Initiative* - National Listening Session.
- Facilitate the states' abilities to meet their legal obligations under the Americans with Disabilities Act (ADA) and the Supreme Court *Olmstead* decision.

Two templates are available allowing states to choose different design features to satisfy their unique programs. For states wishing to create programs which combine target populations or allow Medicaid beneficiaries to maintain direct control over the resources available to them, the §1115 Demonstration Template application is available. For other program designs, the 1915(c) Waiver version is more appropriate. A series of appendices are included in the 1915(c) Waiver version. Terms and conditions and an Excel spreadsheet to simplify the submission of data accompany the §1115 Demonstration version.

The CMS website (www.cms.hhs.gov/medicaid) offers copies of the template applications.

A notice will be published in the Federal Register on or around May 10, 2002.

We invite public comment. Such comments will help us improve the templates. After completion of the Paperwork Reduction Act review process, we will issue the final documents. States wishing to provide comments on the template applications may do so by directing an e-mail to:

Selfdirectionwaiver@cms.hhs.gov (for 1915(c) Waiver comments) or
Selfdirectiondemo@cms.hhs.gov (for §1115 Demonstration comments).

Sincerely,

/s/
Dennis G. Smith
Director

Enclosures

cc:

CMS Regional Administrators

CMS Associate Regional Administrators
for Medicaid and State Operations

Lee Partridge
Director, Health Policy Unit
American Public Human Services Association

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Matt Salo
Director of Health Legislation
National Governors Association

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Senior Director, Access Policy
Association of State and Territorial Health Officials

Jim Frogue
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American Legislative Exchange Council

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Independence Plus
A Demonstration Program for Family or Individual Directed Community Services Demonstration

§1115 of the Social Security Act

Created by:

Center for Medicaid and State Operations

NOTE: This document has not received OMB approval of the information collection pursuant to the Paperwork Reduction Act.

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Template for *Independence Plus*:
A Demonstration Program for Family or Individual Directed Community Services
§1115 Demonstration Proposal

Independence Plus
A Demonstration Program for Family or Individual Directed Community Services
1115 Demonstration Application

I. State Proposal Information

The State of _____ , Department of _____ proposes an 1115 Demonstration Proposal entitled _____, which will allow Medicaid eligibles to arrange and purchase their own personal care and related services.

The demonstration would operate for _____ years, beginning approximately _____.

II. General Description of the Program

The purpose of the program is to provide assistance for families with a member who requires long-term supports and services, or to individuals who require long-term supports and services, so that the individual may remain in the family residence or in their own home.

III. Assurances

The program design includes the following mandatory requirements (please check all to indicate assurance):

_____ The program is voluntary for all eligible participants.

_____ A Fiscal/Employer Agent will be available to all participants that choose or need one based on a skills test.

_____ The State will conduct an evaluation of the program and will cooperate with an independent evaluation contractor CMS may procure.

_____ The State will comply with public notice requirements as published in the Federal Register, Vol. 59, No. 186, dated September 29, 1994 (Document number 94 - 23960) and Centers for Medicare and Medicaid Services (CMS) requirements regarding Native American Tribe consultation.

IV. Waivers Requested

The following waivers are requested pursuant to the authority of Section 1115(a)(1) of the Social Security Act (Please check all applicable):

_____**Statewideness 1902(a)(1)**

To enable the State to operate the demonstration within an area that does not include all political subdivisions of the State.

_____ **Comparability 1902(a)(10)(B)**

To permit the state to offer demonstration participants benefits that are not equal in amount, duration, and scope to those offered to other Medicaid beneficiaries.

_____ **Income and Resource Rule 1902(a)(10)(C)(i)**

To permit the exclusion of payments received under the demonstration from the income and resource limits established under State and Federal law for Medicaid eligibility. Beneficiaries will also be permitted to Accu accumulate financial resources in a separate account for special (approved) purchases.

_____ **Provider Agreements 1902(a)(27)**

To permit the provision of care by individuals who have not executed a Provider Agreement with the State Medicaid agency.

_____ **Direct Payments to Providers 1902(a)(32)**

To permit payments to be made directly to beneficiaries or their representatives.

_____ **Payment Review 1902(a)(37)(B)**

To the extent that prepayment review may not be available for disbursements by individual beneficiaries to their caregivers/providers.

Section 1115(a)(2) authority of the Social Security Act is requested, for the following expenditures to be made by the State under the demonstration, (which are not otherwise included as expenditures under Section 1903) for the period of the demonstration to be regarded as expenditures under the State's Title XIX plan.

Note: Checking the appropriate box(es) will allow the State to claim Federal Financial Participation for expenditures that otherwise would not be eligible for Federal match.

_____ Expenditures for demonstration caregiver services provided by members of the demonstration participant's family to the participant.

_____ Expenditures to provide services that are not covered under the State Plan as demonstration services, i.e., to provide for training and fiscal/employer agent services as a part of the demonstration design.

_____ Expenditures for prepayment to demonstration participants for demonstration services prior to the delivery of those services.

V. STATE SPECIFIC ELEMENTS

Target Population(s)

All items that apply are checked:

Category	CHILDREN AGE RANGE		ADULTS AGE RANGE		AGED AGE RANGE
	From	To	From	To	From
AGED ONLY					
DISABLED (PHYSICAL)					
DISABLED (OTHER)					
BRAIN INJURY (ACQUIRED)					
BRAIN INJURY (TRAUMA)					
HIV/AIDS					
MEDICALLY FRAGILE					
TECHNOLOGY DEPENDENT					
AUTISM					
DEVELOPMENTAL DISABILITY					
MENTAL RETARDATION					
MENTAL ILLNESS					

Geographic Area

_____ Statewide

_____ One County or

_____ Regional (Please specify areas to be included)

_____

_____ Other (Please specify)

_____

Delivery System

Family members or legally responsible persons may qualify as providers?

_____ Yes _____ No

Beneficiaries will be permitted to invest resources in a special account for special (approved) purchases?

_____ Yes _____ No

Enrollment Cap
The limit on the number of enrollees is:_____

Services
The State requests that the following State Plan Services be included under this demonstration:

_____ Personal Care Services
_____ Durable Medical Equipment
_____ Home Health Services
_____ Non-Emergency Transportation
_____ Other

The State requests that the following Home and Community-Based Services, as set forth in 42 CFR 440.180, be included under this demonstration:

_____ Homemaker Services
_____ Home Health Aide Services
_____ Personal Care Services
_____ Adult Day Health Services
_____ Respite Care Services
_____ Enhanced Personal Care
_____ Transportation
_____ Supported Employment
_____ Other services requested by the State and approved by CMS as budget neutral and necessary to avoid institutionalization

The services available through this demonstration will all be self-directed support services, under the direction of the participant, family, or proxy, and will comply with all existing regulations unless waived.

VI. Budget Neutrality

_____ The attached budget shell relies on the model that the demonstration expenditures will not exceed what would have been incurred without the demonstration.

_____ The State assures that the aggregate cost of services provided herein will be no more than 100% of the cost to provide these services without the waiver. The plan of care and budget for plan of care will be developed in the demonstration exactly as they would have been developed without the waiver. Procedures for determining the amount, duration, and scope of Personal Care services are identical for Personal Care recipients, regardless of whether or not they are part of this voluntary demonstration program.

_____ The State estimates the cost of this program will be $_____ over its _____ year approval period.

VII. Additional Requirements

In addition to the above requirements, the State agrees to the Section 1115 *Independence Plus:* A Demonstration Program for Family or Individual Directed Community Services Special Terms and Conditions (STCs) of Approval, and agrees to prepare the Operational Protocol document as described in the Model STCs. During CMS's review and consideration of this demonstration request, using the Model STCs, the state will work with CMS to develop STCs that are specific to this request that will become part of the approval of demonstration authority.

_____ _____

Date Name of Authorizing Official, Typed

_____

Name of Authorizing Official, Signed

Independence Plus
A Demonstration Program for Family or Individual Directed Community Services

A DEMONSTRATION PROGRAM UNDER SECTION 1115

Model Special Terms and Conditions of Approval

CENTERS FOR MEDICARE AND MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: (11-W-00XXX/XX)

TITLE: *Independence Plus:* A Demonstration Program for Family or Individual Directed Community Services

AWARDEE: State & Department Name

The following are Special Terms and Conditions for the award of the *Independence Plus:* A Demonstration Program for Family or Individual Directed Community Services Medicaid Section §1115 Demonstration request submitted on _____. The Special Terms and Conditions are arranged in eight subject areas: General Program Requirements, General Reporting Requirements, Legislation, Assurances, Operational Protocol, General Financial Requirements, Monitoring Budget Neutrality, and a Summary Schedule of Reporting Items.

Letters, documents, reports, or other materials that are submitted for review or approval must be sent to the Centers for Medicare and Medicaid Services (CMS) Central Office Demonstration Project Officer and the State representative in the CMS Regional Office.

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I. GENERAL PROGRAM REQUIREMENTS

1. **Extension or Phase-out Plan.** The State will discuss demonstration extension plans with CMS at least 18 months prior to demonstration expiration, and requests for extensions are due to CMS no later than 12 months prior to the expiration of the demonstration. If the State does not request an extension, it must submit a phase-out plan, which includes provisions for cessation of enrollment, to CMS no later than 12 months prior to the expiration of the demonstration. The phase-out plan will be submitted for CMS to review and consider for approval.

2. **Cooperation with Federal Evaluators.** The State will fully cooperate with Federal evaluators and their contractor's efforts to conduct an independent Federally funded evaluation of the demonstration program.

3. **CMS Right to Suspend or Preclude the Demonstration During Implementation.** The CMS may suspend or preclude State demonstration implementation and/or service provision to demonstration enrollees whenever it determines that the State has materially failed to comply with the Special Terms and Conditions or other terms of the project, and/or if the implementation of the project does not further the goals of the Medicaid program.

4. **CMS Right to Terminate or Suspend the Demonstration During Operation.** During demonstration operation, CMS may suspend or terminate any project in whole or in part at any time before the date of expiration, whenever it determines that the State has materially failed to comply with any of the terms of the project. The CMS will promptly notify the State in writing of the determination and the reasons for the suspension or termination, together with the effective date. The State waives none of its rights to challenge CMS' finding that the State materially failed to comply. The CMS reserves the right to withhold approval for the demonstration project or withdraw such approval at any time, if it determines that granting or continuing the demonstration project would no longer be in the public interest. If the demonstration project is terminated by action of CMS, CMS will be liable for only normal closeout costs. The State will submit a phase-out plan for CMS to review and consider for approval.

5. **State Right to Terminate or Suspend Demonstration.** The State may suspend or terminate this demonstration in whole or in part at any time before the date of expiration. The State will promptly notify CMS in writing of the reasons for suspension or termination, together with the effective date. If the demonstration project is terminated by the State, CMS will be liable for only normal closeout costs. The State will submit a phase-out plan for CMS to review and consider for approval.

II. GENERAL REPORTING REQUIREMENTS

(Attachment C provides a summary of the frequency of required reporting items.)

6. **Monthly Progress Calls.** Before and up to three months after implementation, CMS and the State will hold monthly calls to discuss demonstration progress and the State will respond to questions from CMS regarding any issues.

7. **Quarterly & Annual Progress Reports.** The State will submit quarterly progress reports that are due 60 days after the end of each quarter. The fourth quarterly report of every calendar year will include an overview of the past year as well as the last quarter, and will serve as the annual progress report. CMS reserves the right to request the annual report in draft. The reports must address, at a minimum:
   - A discussion of events occurring during the quarter (including enrollment numbers, lessons learned, and a summary of expenditures);
   - Notable accomplishments, including findings from Quality Assurance, beneficiary survey and evaluation activities; and
   - Problems/issues that were identified and how they were solved.

8. **Final Report.** At the end of the demonstration, the State will submit a draft final report to CMS for review and comments. The final report with CMS' comments is due no later than 180 days after the termination of the project.

III. LEGISLATION

9. **Changes in the Enforcement of Laws, Regulations, and Policy Statements.** All requirements of the Medicaid program expressed in laws, regulations, and policy statements, not expressly waived or identified as not applicable in the award letter (of which these Special Terms and Conditions are part), will apply to the demonstration. To the extent that changes in the enforcement of such laws, regulations, and policy statements would have affected State spending in the absence of the demonstration in ways not explicitly anticipated in this agreement, CMS will incorporate such effects into a modified budget limit for the Demonstration. The modified budget limit would be effective upon enforcement of the law, regulation, or policy statement.

   If the law, regulation, or policy statement cannot be linked specifically with program components that are or are not affected by the demonstration (e.g., all disallowances involving provider taxes or donations), the effect of enforcement on the State's budget limit will be proportional to the size of the demonstration in comparison to the State's entire Medicaid program (as measured in aggregate medical assistance payments).

10. Changes in Federal Law Affecting Medicaid Expenditures. The State must, within the time frame specified in law, come into compliance with any changes in Federal law affecting the Medicaid program that occur after the demonstration award date. To the extent that a change in Federal law, which does not exempt State Section 1115 Demonstrations, would affect State Medicaid spending in the absence of the demonstration, CMS will incorporate such changes into a modified budget limit for the demonstration. The modified budget limit will be effective upon implementation of the change in Federal law, as specified in law.

If the new law cannot be linked specifically with program components that are or are not affected by the demonstration (e.g., laws affecting sources of Medicaid funding), the State must submit its methodology to CMS for complying with the change in law. If the methodology were consistent with Federal law and in accordance with Federal projections of the budgetary effects of the new law in the State, CMS would approve the methodology. Should CMS and the State, working in good faith to ensure State flexibility, fail to develop within 90 days a methodology to revise the without waiver baseline that is consistent with Federal law and in accordance with Federal budgetary projections, a reduction in Federal payments will be made according to the method applied in non-demonstration states.

11. Amending the Demonstration. The State may submit for CMS consideration a request for an amendment to the demonstration to request exemption from changes in law occurring after the demonstration award date. The cost to the Federal Government of such an amendment must be offset to ensure that total projected expenditures under a modified demonstration do not exceed projected expenditures in the absence of the demonstration (assuming full compliance with the change in law).

IV. ASSURANCES

Acceptance of the Special Terms and Conditions of Approval constitutes the State's assurance that the following will be met:

12. Assurances included in Application. All assurances checked in the *Independence Plus:* A Demonstration Program for Family or Individual Directed Community Services State Proposal Information by this reference become included as items in these Special Terms and Conditions of Approval, and will be fulfilled as part of the Special Terms and Conditions of Approval.

13. Preparation and Approval of Operational Protocol. The State will prepare an Operational Protocol Document, which represents all policies and operating procedures applicable to this demonstration, and will submit the Operational Protocol to CMS for approval prior to implementation. The State acknowledges that CMS reserves the right not to approve an Operational Protocol in the event that it does not comply with the Special Terms and Conditions of Approval. *Requirements and required contents of the Operational Protocol are outlined in* Section V *of these Special Terms and Conditions.*

14. Adequacy of Infrastructure. This demonstration will provide adequate resources to support participants in directing their own care. The support assures, but is not limited to, participant's compliance with laws pertaining to employer responsibilities, provision for back-up attendants as needs arise, and the performance of background checks on employees and guidance to participants on the results of checks. Adequate resources for implementation, monitoring activities, and compliance to the terms and conditions of approval of the demonstration will be provided by the State.

15. Assistance of a Proxy. This demonstration is designed to assist individuals who are capable of directing their own care. Individuals not capable of directing their own care will not be deliberately excluded from participating in the demonstration. Specifically, persons who require the assistance of others for care planning, or for whom authorization for care must be obtained from a proxy (e.g., a parent or legal guardian/representative) will not be excluded from program participation.

16. Supplant Services. Cash payments provided under this demonstration program do not supplant informal care services that have routinely and previously been available to project participants. Such ongoing informal care services will be identified as a part of each participant's care plan.

17. Contract Approval. The Fiscal Intermediary (FI) contract(s) will be reviewed and approved by CMS prior to the State's requesting Federal financial payments for expenditures incurred under the contract(s).

V. OPERATIONAL PROTOCOL

18. Operational Protocol Timelines and Requirements. The Operational Protocol will be submitted to CMS no later than 90 days prior to program implementation. The CMS will respond within 60 days of receipt of the protocol regarding any issues or areas for which clarification is needed in order to fulfill the terms and conditions of approval, those issues being necessary to approve the Operational Protocol.

The FFP is not available for Medical Assistance Payments prior to CMS approval of the Operational Protocol. The FFP is available for post-approval project development and implementation, and compliance with Special Terms and Conditions.

Subsequent changes to the demonstration program and the Operational Protocol that are the result of major changes in policy or operating procedures, including changes to cost-sharing amounts or subsidy amounts, including adjustments for inflation, must be submitted for review by CMS. The State must submit a request to CMS for these changes no later than 90 days prior to the date of implementation of the change(s).

19. Required Contents of Operational Protocol:

a. Organization and Structural Administration. A description of the organizational and structural administration that will be in place to implement, monitor, and operate the demonstration, and the tasks each organizational component will perform.

b. Reporting Items. A description of the content and frequency of each of the reporting items as listed in Section II and Attachments A and C of this document.

c. Benefits. Descriptions or listings of:

- procedures for determining the plan of care;
- methodology for establishing the budget for the plan of care;
- how purchasing plans are developed;
- procedures and mechanisms to be used to review and adjust payments for the plan of care;
- services which will be cashed out; and
- Alternative Health Related Services which may be approved for participants, as well as procedures for amending the list of services.

d. Outreach/Marketing/Education. A description of the State's outreach, marketing, education, and staff training strategy. NOTE: *All marketing materials must be reviewed and approved by CMS prior to use.* Include in the description:

- information that will be communicated to enrollees, participating providers, and State outreach/education/intake staff (such as social services workers and caseworkers);
- types of media to be used;
- specific geographical areas to be targeted;
- locations where such information will be disseminated;
- staff training schedules, schedules for State forums or seminars to educate the public; and
- the availability of bilingual materials/interpretation services and services for individuals with special needs. Include a description of how eligibles will be informed of cost sharing responsibilities.

e. Eligibility/Enrollment. A description of the population of individuals eligible for the demonstration (and eligibility exclusions) and population phase-in and the following:

- eligibility determination;
- annual redetermination;
- intake, enrollment, and disenrollment;
- procedures for determining the existence and scope of a demonstration applicant's existing third party liability;

- the State agency that will be responsible for each of the above processes; and
- a comparison of the number of new individuals accessing Medicaid-funded community based services to the numbers of individuals accessing Medicaid-funded community-based services without the demonstration.

f. Enrollment Ceiling. Description of the enrollment ceiling. This description shall include the process for amending the enrollment ceiling.

g. Quality. Description of an overall quality assurance monitoring plan that includes, but not be limited to the following:

- quality indicators to be employed to monitor service delivery under the demonstration and the system to be put in place so that feedback from quality monitoring will be incorporated into the program;
- the mechanisms the State will utilize to assure that the care needs of vulnerable populations participating in this demonstration (i.e., the elderly and disabled) are satisfied, and that funds provided to these beneficiaries are used appropriately;
- the system the State will operate by which it receives, reviews and acts upon critical events or incidents, with a description of the critical events or incidents;
- case management staff for purposes of monitoring participant health and welfare;
- quality monitoring surveys to be conducted, and the monitoring and corrective action plans to be triggered by the surveys;
- plans to report survey results, service utilization, and general quality assurance findings to CMS as part of the quarterly and annual reports;
- procedures for assuring quality of care and participant safeguards;
- procedures for insuring against duplication of payment between the demonstration, fee for service and Home and Community-Based Services programs; and fraud control provisions and monitoring.

h. Education, Counseling, Fiscal/Employer Agent and Support Services. Descriptions of the following topics will be included:

- the State's relationships and arrangements with organizations providing enrollment/assessment, counseling, training, and fiscal/employer agent services;
- the procurement mechanism, standards, scope of work and payment process for the fiscal/employer agent;
- procedures for ensuring sufficient availability of fiscal/employer agent services for participants who do not pass the mandatory test on employer responsibilities;
- procedures for mandatory testing of participants related to fiscal and legal responsibilities and training opportunities and support services available for participants of the demonstration who require assistance with their fiscal and legal responsibilities; and
- the procedures for conducting participants background checks on potential providers and informing participants of the results of the criminal background checks.

i. Participant Protections: A description of the State procedures and processes to assure that protections are in place. The description will include the following:

- procedures to assure that families have the requisite information and/or tools to direct and manage their care, including but not limited to employer agent services such as training in managing the caregivers, assistance in locating caregivers, as well as completing and submitting paperwork associated with billing, payment and taxation;
- a viable system in place for assuring emergency back up and emergency response capability in the event those providers of services and supports essential to the individual's health and welfare are not available. While emergencies are defined and planned for on an individual basis, the State also has system procedures in place;
- procedures for how the State will work with families who expend their individualized budget in advance of the re-determination date to assure that services needed to avoid out-of-home placement and the continuation of the health and welfare of the individual are available;
- procedures for how decisions will be made regarding unexpended resources at the time of budget re-determination; and
- process by which the State makes available to participants, at no cost, provider qualification/background checks.

j. Evaluation Design. A description of the State's evaluation design. The description will include the following:

- discussion of the demonstration hypotheses that will be tested;
- outcome measures that will be included to evaluate the impact of the demonstration;
- what data will be utilized;
- methods of data collection;
- effects of the demonstration will be isolated from those other initiatives occurring in the State;
- any other information pertinent to the State's evaluative or formative research via the demonstration operations; and
- plans to include interim evaluation findings in the quarterly and annual progress reports (primary emphasis on reports of services being purchased and participant satisfaction.)

ATTACHMENT A

GENERAL FINANCIAL REQUIREMENTS

1. The State will provide quarterly expenditure reports using the Form CMS-64 to report total expenditures for services provided under the Medicaid program, including those provided through the demonstration under Section 1115 authority. The CMS will provide Federal Financial Participation (FFP) for allowable demonstration expenditures only as long as they do not exceed the pre-defined limits as specified in Attachment B (Monitoring Budget Neutrality for the demonstration).

2. a. In order to track expenditures under this demonstration, the State will report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in Section 2500 of the State Medicaid Manual. All expenditures subject to the budget neutrality cap will be reported on separate Forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the demonstration year in which services were rendered). For monitoring purposes, cost settlements must be recorded on Line 10.b, in lieu of Lines 9 or 10c. For any other cost settlements (i.e., those not attributable to this demonstration), the adjustments should be reported on lines 9 or 10.c, as instructed in the State Medicaid Manual. The term, "expenditures subject to the budget neutrality cap," is defined below in item 2.c.

b. For each demonstration year, a Form CMS-64.9 WAIVER and/or 64.9P WAIVER will be submitted reporting expenditures subject to the budget neutrality cap. All expenditures subject to the budget neutrality ceiling for demonstration eligibles must be reported. The sum of the expenditures, for all demonstration years reported during the quarter, will represent the expenditures subject to the budget neutrality cap (as defined in 2.c.).

c. For the purpose of this section, the term "expenditures subject to the budget neutrality cap" will include all Medicaid expenditures on behalf of demonstration participants, and those individuals eligible to participate (as described in number 3.c. and d. of this section) that are also receiving the services subject to the budget neutrality cap. The services subject to budget neutrality include the following categories as they appear on the CMS-64 WAIVER forms: Home Health Services; Home and Community-Based Services, Personal Care Services; Targeted Case Management; Hospice Benefits; and Other Care Services (to include the subsets of Non-Emergency Transportation, and Durable Medical Equipment). (THE ACTUAL SERVICES INCLUDED COULD VARY DEPENDING ON THE INFORMATION SUPPLIED BY THE STATE.)

d. Administrative costs will not be included in the budget neutrality limit, but the State must separately track and report additional administrative costs that are directly attributable to the demonstration.

e. All claims for expenditures subject to the budget neutrality cap (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the 1115 Demonstration on the Form CMS-64 in order to properly account for these expenditures in determining budget neutrality.

f. The procedures related to this reporting process, report content, and frequency must be discussed by the State in the Operational Protocol (see Section V.)

3. **a.** For the purpose of calculating the budget neutrality expenditure cap described in Attachment B, the State must provide to CMS on a quarterly basis the actual number of eligible member/months for the demonstration eligibles as defined below. This information should be provided to CMS in conjunction with the quarterly progress report referred to in number 10 of Section III. If a quarter overlaps the end of one demonstration year (DY) and the beginning of another, member/months pertaining to the first DY must be distinguished from those pertaining to the second. (Demonstration years are defined as the years beginning on the first day of the demonstration, or the anniversary of that day.) Procedures for reporting eligible member/months must be defined in the Operational Protocol (see Section V.).

b. The term, "eligible member/months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes three eligible member/months to the total. Two individuals who are eligible for 2 months each contribute two eligible member months to the total, for a total of four eligible member/months.

c. The *Independence Plus* Initiative Medicaid eligibility group (MEG) consists of persons residing in the geographic service areas under the demonstration who are using home health agency (HHA) services and for 12 months have utilized at least one service per month. (NOTE: TO BE MODIFIED AS NECESSARY TO ADDRESS EACH DEMONSTRATION'S ELIGIBILITY CRITERIA)

d. The term "demonstration eligibles" refers to persons who are eligible in the geographic areas of the demonstration and receiving services subject to the

budget neutrality cap, whether or not they are participants of the cashed out feature of the demonstration.

4. The standard Medicaid funding process will be used during the demonstration. The State must estimate matchable Medicaid expenditures on the quarterly Form CMS-37. As a supplement to the Form CMS-37, the State will provide updated estimates of expenditures subject to the budget neutrality cap as defined in 2c. of this Attachment. The CMS will make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. The CMS will reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the State for the quarter, and include the reconciling adjustment in the finalization of the grant award to the State.

5. The CMS will provide Federal Financial Participation (FFP) at the applicable Federal matching rate for the following, subject to the limits described in Attachment B:

a. Administrative costs, including those associated with the administration of the demonstration.

b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved State Plan.

c. Net medical assistance expenditures made under Section 1115 Demonstration authority, including those made in conjunction with the demonstration.

6. The State will certify State/local monies used as matching funds for the *Independence Plus* Initiative and will further certify that such funds will not be used as matching funds for any other Federal grant or contract, except as permitted by Federal law.

ATTACHMENT B

MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

The following describes the method by which budget neutrality will be assured under the demonstration. The demonstration will be subject to a limit on the amount of Federal Title XIX funding that the State may receive on selected Medicaid expenditures during the demonstration period. This limit will be determined using a per capita cost method. In this way, the State will be at risk for the per capita cost (as determined by the method described below) for Medicaid eligibles, but not at risk for the number of eligibles. By providing FFP for all eligibles, CMS will not place the State at risk for changing economic conditions. However, by placing the State at risk for the per capita costs of Medicaid eligibles, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration.

For the purpose of calculating the overall expenditure limit for the demonstration, separate budget estimates will be calculated for each year on a demonstration year (DY) basis. The annual estimates will then be added together to obtain an overall expenditure limit for the entire demonstration period. The Federal share of this estimate will represent the maximum amount of FFP that the State may receive during the 5-year period for the types of Medicaid expenditures described below. For each DY, the Federal share will be calculated using the FMAP rate(s) applicable to that year.

Projecting Service Expenditures

Each demonstration year budget estimate of Medicaid service expenditures will be calculated as the product of the trended monthly per person cost times the actual number of eligible/member months as reported to CMS by the State under the guidelines set forth in Attachment A number 3.a. The State Fiscal Year (SFY) 2000 base year cost is $31,966.46 (or $ 2,663.87 monthly per person cost) and the trended amounts by SFY are the following (THE NUMBERS PROVIDED ARE SAMPLES FOR PURPOSE OF ILLUSTRATION – THE ACTUAL AGREEMENT WOULD BE BASED ON INFORMATION PROVIDED BY THE STATE ON THE INCLUDED WORKSHEET):

State Fiscal Year	Trended Monthly Per Person Cost
SFY 2002	$ 2948.11
SFY 2003	$ 3101.41
SFY 2004	$ 3262.37
SFY 2005	$ 3432.01
SFY 2006	$ 3610.48
SFY 2007	$ 3798.23

Demonstration Years which do not align with State Fiscal Years or which fall beyond the range of years shown will be calculated using an annual trend rate of 5.2% or a monthly trend rate of .423336% (THE TREND RATE USED IS FOR THE PURPOSE OF

ILLUSTRATION – THE ACTUAL AGREEMENT WOULD BE BASED ON INFORMATION FROM THE STATE. THE TREND RATE WOULD BE THE LOWER OF THE STATE'S TREND OR THE TREND FROM THE PRESIDENTS BUDGET.)

Using the trend rates to produce non-Federal fiscal year PMPM cost estimates
Because the beginning and the end of the demonstration are unlikely to coincide with either the Federal or State fiscal year, the following methodology will be used to produce DY estimates of PMPM cost. Using the monthly equivalent growth rate of .423336%, the appropriate number of monthly trend factors will be used to convert SFY 2000 base year PMPM costs to PMPM costs for the first DY. After the first DY, the annual trend factor of 5.2% will be used to trend forward from one year to the next. (This procedure is described more fully in the sample calculations presented below.)

Sample Calculations
First Demonstration Year:
As an example, assume that the base year (SFY ended 6/30/2000) per capita cost for the enrolled population is $1,000, and the first year of a demonstration (DY 2001) beginning January 1, 2001, and ends December 31, 2001. DY 2001 is 18 months in time beyond SFY 2000; therefore, the monthly trend factor must be applied to trend SFY 2000 cost forward to DY 2001. Applying the monthly trend factor to bring the base year estimate forward to DY 2001 results in PMPM cost of $1079. ($1079 = $1000 x 1.00423336^{18})

Second and Subsequent Demonstration Years:
Since DY 2002 is 12 months beyond DY 2001, 12 months of growth factor are needed. Applying the 5.2 percent growth factor to the estimated DY 2001 PMPM cost of $1079 gives a DY 2002 PMPM cost of $1135.

Impermissible DSH, Taxes or Donations
The CMS reserves the right to adjust the budget neutrality ceiling to be consistent with enforcement of impermissible provider payments, health care related taxes, new Federal statutes, or policy interpretations implemented through letters, memoranda or regulations. The CMS reserves the right to make adjustments to the budget neutrality cap if any health care related tax that was in effect during the base year, or provider related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of 1903(w) of the Social Security Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

How the Limit will be Applied
The limit calculated above will apply to actual expenditures for long-term care services, as reported by the State under Attachment A. If at the end of the demonstration period the budget neutrality provision has been exceeded, the excess Federal funds will be returned to CMS. There will be no new limit placed on the FFP that the State can claim for expenditures for recipients and program categories not listed. If the demonstration is

terminated prior to the 5-year period, the budget neutrality test will be based on the time period through the termination date.

Expenditure Review

The CMS shall enforce budget neutrality over the life of the demonstration, rather than on an annual basis. However, no later than 6 months after the end of each demonstration year, CMS will calculate an annual expenditure target for the completed year. This amount will be compared with the actual FFP claimed by the State under budget neutrality. Using the schedule below as a guide, if the State exceeds the cumulative target, they must submit a corrective action plan to CMS for approval. The State will subsequently implement the approved program.

Year	Cumulative target definition	Percentage
Year 1	Year 1 budget estimate plus	8 percent
Year 2	Years 1 and 2 combined budget estimate plus	3 percent
Year 3	Years 1 through 3 combined budget estimate plus	1 percent
Year 4	Years 1 through 4 combined budget estimate plus	0.5 percent
Year 5	Years 1 through 5 combined budget estimate plus	0 percent

ATTACHMENT C

SUMMARY SCHEDULE OF REPORTING ITEMS

Item	Timeframe for Item	Frequency of Item
Monthly Conference Calls	Prior to demonstration implementation and Post-implementation.	Monthly progress calls with CMS and the State.
Operational Protocol	Due to CMS 90 days prior to implementation, CMS comments 30 days prior to implementation, and State completion/CMS approval prior to implementation.	One Operational Protocol. Changes to the Operational Protocol must be submitted and approved by CMS.
Quarterly/Annual Progress Reports	Due to CMS 60 days after the end of a quarter.	One quarterly report per Federal Fiscal Year quarter during operation of the demonstration; the report for the fourth quarter of each year will serve as the annual progress report.
Final Report	Due to CMS 180 days after the end of the demonstration.	One final report.

Independence Plus
A Demonstration Program for Family or Individual Directed Community Services Waiver
§ 1915 (c) of the Social Security Act

Created by:

Center for Medicaid and State Operations

NOTE: This document has not yet received OMB approval of the information collection pursuant to the Paperwork Reduction Act.

Table of Contents

Template for *Independence Plus:* A Demonstration Program for Family or Individual Directed Community Services 1915(c) Waiver Application

I. State Proposal Information

The State of _____ requests approval of a Medicaid Home and Community-Based Services (HCBS) Waiver under the authority of Section 1915(c) of the Social Security Act. The program, to be entitled: _____ will allow Medicaid beneficiaries to arrange and purchase family and individual supports and related services as described below. The proposed effective date of this waiver program is _____. Initial waivers are approved for three years. Renewal waivers are extended for five years.

Line of Authority for Waiver Operation: (**Note**: The State Medicaid Agency is ultimately accountable for the operation of the program, but may allow daily operations to be managed by another entity of State government.) Check one:

_____ The waiver will be operated directly by the _____ Unit of the State Medicaid Agency/Single State Agency.

_____ Operational management and responsibilities of the waiver will be carried out by _____ (another State Agency) and will be subject to an explicit interagency agreement that ensures for accountability and effective management for all requirements and assurances under this waiver. The single State Agency will retain the responsibilities of issuing policies, rules and regulations concerning this waiver. A copy of the interagency agreement setting forth the specific agency responsibilities and authorities is attached and is made pursuant to Section 1902(a) of the Act and 42 regulations at 42 CFR 431.10 which stipulates the roles and responsibilities of the single State Agency.

II. General Description of Program

The purpose of the program is to provide assistance for families with a member who requires long-term supports and services, or to individuals who require long-term supports and services, so that the individual may remain in the family residence or in their own home. Eligibility will be limited to those individuals who require long-term supports at a level typically provided in an institution, as specified in this application.

resources will be identified through an established methodology, open for public inspection, for determining an individual budget that would be based upon actual service utilization data.

fiscal integrity and include participant protections that will be effective and family-friendly. (Additional information, specific to the State administration is included in Appendix A.)

III. Assurances

The State provides the following assurances to CMS:

Health & Welfare - Necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. Those safeguards are described in **Appendix B** and include:

A. Adequate standards for all types of providers that furnish services under the waiver;
B. Assurance that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements will be met on the date that the services are furnished; and
C. Assurance that all facilities covered by Section 1616(e) of the Social Security Act, in which Home and Community-Based Services will be provided, are in compliance with applicable State standards for board and care facilities.

Check one:

_____ Home and Community-Based Services will not be provided in facilities covered by Section 1616(e) of the Social Security Act.

_____ A list of facilities covered by 1616(e) of the Social Security Act, in which HCBS are furnished, and a copy of the standards applicable to each type of facility identified above are also maintained by the Medicaid Agency. These facilities will be used for the limited purpose of:_____
(Note: For example, respite care only when other services are unavailable.)

Financial Accountability - The State will maintain the financial integrity of the HCBS Waiver program. The State will assure financial accountability for funds expended for Home and Community-Based Services, provide for an independent audit of its waiver program, and will maintain and make available to HHS, the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver, including reports of any independent audits conducted. **See Appendix G-3**.

Evaluation of Need - The State will provide for an evaluation (and periodic reevaluations, at least annually) of the individuals' need for an institutional level of care, when there is a reasonable indication that individuals might need such services in the near future (one month or

less) but for the availability of Home and Community-Based Services. The requirements for such evaluations and reevaluations are detailed in **Appendix D**.

Choice of Alternatives - When an individual is determined to require a level of care provided in a NF, hospital, or ICF/MR, the individual or his or her legal representative will be:

A. Informed of any feasible alternatives under the waiver; and
B. Given the choice of either institutional or Home and Community-Based Services.

The State will provide an opportunity for a fair hearing under 42 CFR Part 431, subpart E, to persons who are not given the choice of home or community-based services as an alternative to institutional care, or whose services are denied, suspended, reduced or terminated.

Average per capita expenditures - The average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures for the level(s) of care, for which this waiver is an alternative, under the State plan that would have been made in that fiscal year had the waiver not been granted. Cost neutrality is demonstrated in **Appendix G**.

Actual total expenditures - The State's actual total expenditures for Home and Community-Based Services and other Medicaid services under the waiver and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred by the State's Medicaid program for these individuals in the institutional setting(s) for which this waiver is an alternative in the absence of the waiver. Cost neutrality is demonstrated in **Appendix G**.

Services absent the waiver - Absent the waiver, participants would receive the services appropriate to the level of care typically provided in institutional settings available through the State plan.

Reporting - The agency will provide CMS annually with information on the impact of the waiver on the type, amount and cost of services provided under the waiver and on the health and welfare of the persons served through the waiver. The information will be consistent with a data collection plan designed by CMS. Reporting is described in **Appendix F-2**

IV. Waivers Requested

Statewideness: The State requests a waiver of the "Statewideness" requirements set forth in Section 1902(a)(1) of the Act.

_____ No. Services will be available Statewide.
_____ Yes. Waiver services will be furnished only to individuals in the following geographic areas or political subdivisions of the State (Specify):

_____

_____

Comparability: The State requests a waiver of the requirements contained in Section 1902(a)(10)(B) of the Act, to provide services to individuals served on the waiver that are not otherwise available to other individuals under the approved Medicaid State plan.

Income and Resources: The State requests a waiver of 1902(a)(10)(C)(i)(III) of the Social Security Act in order to use institutional income and resource rules for the medically needy.

_____ Yes _____ No _____ N/A

V. State Specific Elements

A. Levels Of Care: This waiver is requested to provide Home and Community-Based Services (HCBS) to individuals who, but for the provision of such services, would require the following levels (s) of care, the cost of which could be reimbursed under the approved Medicaid State plan: (check all that apply)

_____ Hospital
_____ Nursing Facility
_____ ICF/MR

B. Target Population: A waiver of Section 1902(a)(10)(B) of the Act is requested to limit Home and Community-Based Services waiver services to select groups of individuals who would be otherwise eligible for waiver services. The target groups are indicated below:

1. Target group per 42 CFR 441.301(b)(6) – Check all disability and age categories that apply. (**Note:** Current regulations governing 1915(c) waivers do not allow persons under age 65 with mental retardation or developmental disability – and no concurrent physical disability – to be served in a waiver that serves persons with physical disabilities only. Combining populations under the 1115 Demonstration authority is allowable.)

Category	**CHILDREN AGE RANGE**		**ADULTS AGE RANGE**		**AGED AGE RANGE**
	From	**To**	**From**	**To**	**From**
Aged only					
Disabled (Physical)					
Disabled (Other)					
Brain Injury (Acquired)					
Brain Injury (Trauma)					
HIV/AIDS					

Medically Fragile					
Technology Dependent					
Autism					
Developmental Disability					
Mental Retardation					
Mental Illness					

2. States have the discretion to further define these target groups. If the State wishes to further define, please describe below:

_____
_____
_____
_____

3. The State selects the following option regarding individual cost limits:

_____ A. No otherwise eligible individual will be denied services or enrollment in the waiver solely because the cost of the individual's Home and Community-Based Services exceeds the average institutional Medicaid payment for the applicable level of care.

_____ B. Otherwise eligible individuals may be denied home or community-based services if the agency reasonably expects that the cost of the Home and Community-Based Services would exceed the cost of an equivalent and applicable level of institutional care, pursuant to 42 CFR 441.301(a)(3). The State selects the following method to calculate these costs:

_____ Individualized Computation. The Medicaid cost of the individual's service plan is compared to the cost of serving *this particular individual* in the institutional setting.

_____ **Mathematical Average.** The Medicaid cost of the individual's service plan will be compared to the state's average per capita cost of applicable institutional care at _____ 100% of the institutional average or a level higher than 100% (_____%). Further, the limit will be calculated on the basis of:

_____ 1) Level of care

_____ **2) Diagnosis or condition**

C. Medicaid Eligibility: All eligibility groups included under this waiver are covered in the State plan. The State will apply all applicable FFP limits under the plan.

1. ***Eligibility Criteria***: Specify whether your State uses the eligibility criteria used by the Supplemental Security Income (SSI) program or whether it uses more restrictive eligibility criteria than those of the SSI program for aged, blind, and disabled individuals: (check one):

   ____ SSI Criteria or 1634 State. The State uses SSI criteria.

   ____ 209(b) State. The State uses more restrictive eligibility criteria for aged blind, and disabled individuals than the criteria used under the SSI program.

2. ***Eligibility Groups Served*:** Individuals receiving services under this waiver are eligible for Medicaid under the following eligibility groups: (check one):

   a. _____All eligibility groups covered in the State plan are included under this waiver.
   b. _____Only the following groups covered under the State plan are included under this waiver. (Check all that apply)

   1. _____ Low-income families with children as described in Section 1931 of the Social Security Act
   2. _____ SSI Recipients
   3. _____Aged, blind or disabled who are eligible under 42 CFR 435.121
   4. _____ Medically needy (A waiver of Section 1902(a)(10)(C)(i)(III) of the Social Security Act is requested to use institutional income and resource rules for the medically needy.)
   5. _____ All other optional and mandatory groups under the plan except for those individuals who would be eligible for Medicaid only if they were in an institution).
   6. _____ Individuals who <u>would</u> be eligible for Medicaid only if they were in an institution
   7. _____ Individuals who would only be eligible for Medicaid, without spend down income, if they were living in a hospital, NF or ICF/MR. (Check one)
      _____ All Individuals
      _____ Limited to:
      A special income level equal to:
      _____300% of the SSI Federal Benefit Rate (FBR), <u>OR</u>
      _____ %, a percentage lower than 300% of FBR, <u>OR</u>
      $____, a specific amount that is lower than 300% of FBR
      _____ Aged blind and disabled who meet requirements that are more restrictive than those in the SSI program

(Please explain:_____
_____
_____ Medically needy without spend down
_____ Other: _____

3. Spousal Impoverishment Protection: Spousal impoverishment rules may be used for determining eligibility for the special Home and Community-Based Waiver eligibility group at 42 CFR 435.217 for individuals who have a spouse residing in the community. Further, these rules may apply to the post-eligibility treatment of income.

The State will use spousal impoverishment rules for determining income:
____ Yes ____ No

The State will use spousal impoverishment rules for the post-eligibility treatment of income:
_____ Yes _____ No

D. Services: The State requests that the following Home and Community-Based Services, as set forth in 42 CFR 440.180, be included under this waiver (Check all that apply here and define in **Appendix B**): (**NOTE:** All services must meet applicable regulatory standards and CMS policy guidance. Refer to **Appendix B** for new self-directed service descriptions.)

Check all that apply:

Service	Family or Individual Directed Method	Provider or Other Service Delivery Method
Case Management		
Homemaker Services		
Home Health Aide Services		
Personal Care Services (may include Attendant Care)		
Adult Day Health Services		
Habilitation Services		
Respite Services		
Supports Brokerage Services/Functions (Required)		
Fiscal/Employer Agent Services/Functions (Required)		
Other (Describe in Appendix B)		

VI. Cost neutrality

The State has provided the supporting information/data to demonstrate cost neutrality in **Appendix G**.

VII. Additional Requirements

A. Plan Of Care: A written plan of care will be developed for each individual under this waiver utilizing a family or person-centered planning process that reflects the needs and preferences of the individual and their family. The State's procedures governing the plan of care and the utilization of family or person-centered planning are included in **Appendix E**.

(**Note**: Family or person-centered planning is a process, directed by the family or the individual with long-term care needs, intended to identify the strengths, capacities, preferences, needs and desired outcomes of the individual. The family or individual directs the family or person-centered planning process. The process includes participants freely chosen by the family or individual who are able to serve as important contributors. The family or person-centered planning process enables and assists the individual to identify and access a personalized mix of paid and non-paid services and supports that will assist him/her to achieve personally-defined outcomes in the most inclusive community setting. The individual identifies planning goals to achieve these personal outcomes in collaboration with those that the individual has identified, including medical and professional staff. The identified personally-defined outcomes and the training, supports, therapies, treatments and/or other services the individual is to receive to achieve those outcomes become a part of the plan of care.)

All services will be furnished pursuant to a written plan of care.

This plan of care will describe the services and supports (regardless of funding source) to be furnished, their projected frequency, and the type of provider who will furnish each.

The plan of care will address how potential emergency needs of the individual will be met.

The plan of care will be subject to the approval of the Medicaid Agency.

FFP will not be claimed for waiver services furnished prior to the development of the plan of care or services that are not included in the individual written plan of care.

B. Individual Budgets:

(**NOTE:** Individual budgets include the value of the waiver services available to the family or individual to support the individual's plan of care. Only waiver services as defined by the State are included in the individual budget. This amount of money designated in the budget is established by a methodology determined by the State and the amount is agreed upon with the family or individual.)

Check one:

_____ The State has established a uniform methodology by which all individual budgets in the State will be calculated. The methodology is described in **Appendix H**. (**Note**: Minimum requirements of the methodology are that the budget is built upon actual service utilization and cost data, the methodology is described to the individual and their family, the methodology is open for inspection by authorized public entities including, but not limited to CMS, and there is a process for re-determination.)

_____ The State has established a minimum set of criteria and an approval process for methodologies developed by subcontractors, counties or other entities with which the State has contracted for the day-to-day operation of the waiver. The criteria by which individual budget methodologies will be reviewed and the approval process is described in **Appendix H**. (**Note**: Minimum requirements of the methodology are that the budget is built upon actual service utilization and cost data, the methodology is described to the individual and their family, the methodology is open for inspection by authorized public entities including, but not limited to, CMS, and there is a process for re-determination. Although the Medicaid Agency may contract with another agency or organization for the daily operation of the waiver program, it must retain the authority to issue policies, rules and regulations related to the waiver.)

C. Provider Selection: Families and individuals will have flexibility to select qualified providers of their choosing within the criteria established by the State. The criteria are described in **Appendix B.**

D. Plan Of Care Management: Families and individuals will have the ability to direct the services and supports identified in the plan of care within the resources available in the established individual budget. Families will have maximum possible flexibility in the utilization of resources delineated in the plan of care and individual budget. The State's description of how families may flexibly use resources while the State continues to assure health and welfare is described in **Appendix E**.

(Note: As determined by the state, families and individuals may have the ability to move resources among and between all or some of the services contained in the plan of care without a formal plan of care revision. Families or individuals might have full discretion

to manage all of the plan or only parts of it. For example, the family or individual might manage the homemaker services, but not the habilitation services.)

E. Participant Protections: The State assures that each of the protections below is in place and described in **Appendix I**.

The State has procedures to assure that families have the requisite information and/or tools to participant in a family or person-centered planning approach and to direct and manage their care as outlined in the individual plan of care. The State will make available and provide services such as assistance in locating and selecting qualified workers, training in managing workers, completing and submitting paperwork associated with billing, payment and taxation. Supports Brokerage and Fiscal/Employer Agent Services/Functions are required and should be provided by one or more entities. The services and the provider qualifications are described in **Appendix B**.

Upon family or individual request, the State makes available, at no cost, provider qualification checks, including criminal background checks. (Note: Provider qualifications for each service are described in **Appendix B**.)

The State has procedures to promote family and individual preferences and selections and these are appropriately balanced with accepted standards of practice. This balance requires deference to the individual whenever possible. Procedures will include individual risk management planning (e.g., risk agreements or informed consent contracts) to ensure that family or individual decisions are honored.

The State has a viable system in place for assuring emergency back-up and/or emergency response capability in the event those providers of services and supports essential to the individual's health and welfare are not available. While emergencies are defined and planned for on an individual basis, the State also has system procedures in place.

The State has procedures for how it will work with families or individuals and their fiscal/employer agents (if applicable) to monitor the ongoing expenditure of the individual budget.

The State has procedures for how it will handle those instances where this ongoing monitoring has failed to prevent the expenditure of the individual budget in advance of the re-determination date to assure that services needed to avoid out-of-home placement and the health and welfare of the individual are available.

The State has procedures for how decisions will be made regarding unexpended resources at the time of budget re-determination.

F. Quality Assurance & Improvement:

The State, through an organized quality assurance program, will provide appropriate oversight and monitoring of its HCBS Waiver program to ensure that each of the

assurances contained in this application is met and to continually improve the operation of the program. The program will involve families or individuals in the process of assessing and improving quality. Details of this process are found in **Appendix F** of this request. The State further assures that all problems identified by this monitoring will be addressed in an appropriate and timely manner, consistent with their severity and nature and will contain an incident management system to address critical events.

G. Contact Person: The State Medicaid Agency Representative that CMS may contact with questions regarding the waiver request is:

Name:

Title:

Agency:

Address:

Telephone:

E-mail:

H. Authorizing Signature: This document, together with Appendices A through I, and all attachments, constitutes the State's request for a *Independence Plus:* A Demonstration Program for Family or Individual Directed Community Services Home and Community-Based Services Waiver under Section 1915(c) of the Social Security Act. The State affirms that it will abide by all conditions set forth in the waiver (including Appendices and Attachments), and certifies that any modifications to the waiver request will be submitted in writing by the State Medicaid Agency. Upon approval by CMS, this waiver request will serve as the State's authority to provide Home and Community-Based Services to the target group under its Medicaid plan. Any proposed changes to the approved waiver will be formally requested by the State in the form of waiver amendments.

The State assures that all material referenced in this waiver application (including standards, licensure and certification requirements) will be kept on file at the Medicaid Agency.

(**Note:** The request must be signed by the Governor, Single State Agency or Medicaid Director, or a person within the State Medicaid Agency with the authority to sign on behalf of the State.)

Signature:
Print Name:
Title:
Date:

APPENDIX A – DESCRIPTION OF THE WAIVER PROGRAM

(**Note:** The state must provide a narrative description of the waiver program beyond the general description above. This includes the intended purposes of the waiver.)

APPENDIX B - SERVICE DEFINITIONS, STANDARDS AND PROVIDER QUALIFICATIONS

A. SERVICE DEFINITIONS, STANDARDS & PROVIDER QUALIFICATIONS CHARTS

For each service that was checked under State Specific Elements/Services of the template, the following chart must be completed. Each chart provides the State's service definition, outlines the provider qualifications and standards, and the service delivery method that govern the provision of each service under the waiver.

Provider qualifications would be expected to vary by the type of service being provided or managed. For those services for which there is a uniform State license or certification requirement, the legal citation is provided. For State defined standards other than those governed by State law, the standards are attached. Either the family or individual and the State Agency may manage some services. For example, the family or individual might have self-directed support services which include personal care type arrangements. The State may also have personal care services provided by an agency. The provider requirements might be different under these two arrangements. However, the differences must be explained.

For those services that are available in the State plan, the description must include those aspects of the service that go beyond the State plan coverage. (**Note:** For example, if personal care services are included in the State plan, personal care services provided under the scope of the waiver must differ in amount, scope, supervision arrangements or provider type **or** be utilized only when the state plan coverage is exhausted.)

The State has the authority to request that the Secretary approve "other" services identified by the State as cost neutral and appropriate to avoid institutionalization. Each "other" service defined by the State must be separately identified and defined and include the provider qualifications.

Service/Function Definitions Not Described Elsewhere:

> ***Supports Brokerage:*** Service/function that assists participating families and individuals to make informed decisions about what will work best for them, are consistent with their needs and reflect their individual circumstances. Serving as the agent of the family or participant, the service is available to assist in identifying immediate and long-term needs, developing options to meet those needs and accessing identified supports and services. A family or person-centered planning approach is used. Supports Brokerage offers practical skills training to enable families and individuals to remain independent. Examples of skills training include providing information on recruiting and hiring personal care workers, managing personal care workers and providing information on effective communication and problem-solving. The service/function provides sufficient information to assure that participants and their families understand the responsibilities involved with self direction and assist in the development of an effective back-up and emergency plan. States may elect to fulfill the requirement

of this service/function using a self-directed case manager or creating a distinct service. States may elect to fulfill this required service/function either as a service cost or an administration cost, but must clearly identify which method will be used. The services/functions included in Supports Brokerage are mandatory requirements of the template.

Fiscal/Employer Agent: Service/function that assists the family or individual to manage and distribute funds contained in the individual budget including, but not limited to, the facilitation of the employment of service workers by the family or individual, including Federal, state, and local tax withholding/payments, unemployment compensation fees, wage settlements, fiscal accounting and expenditure reports, etc. States may elect to fulfill this required service/function either as a service cost or an administration cost, but must clearly identify which method will be used. This service/function, regardless of provider or method, must be delivered under a family or person-centered planning process and is a requirement of the template.

Other Services: Services appropriate to ensure the health and welfare of individual participants and, in conjunction with other services, serve as an alternative to institutionalization.

Service Title	
Service Definition	
Provider Requirements	
State License	
Certification	
Other Requirements or Standards	
Describe Service Delivery Method (Agency or Self-directed)	

B. ASSURANCES THAT REQUIREMENTS ARE MET

1. The State assures that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services provided under the waiver.

2. The State assures that each service furnished under the waiver is cost-effective (compared to the cost of institutional care) and necessary to prevent institutionalization. Cost effectiveness is demonstrated in Appendix G.

C. FREEDOM OF CHOICE

The State assures that each individual found eligible for the waiver will be given free choice of all qualified providers of each service included in his or her written plan of care.

APPENDIX C – INTENTIONALLY LEFT BLANK

APPENDIX D - ENTRANCE PROCEDURES AND REQUIREMENTS

APPENDIX D-1

a. QUALIFICATIONS OF INDIVIDUALS PERFORMING INITIAL EVALUATION

Persons performing initial evaluations of level of care for waiver applicants will have the following educational/professional qualifications:

b. PROCESS FOR LEVEL OF CARE DETERMINATION

The following describes the process for evaluating and screening waiver applicants to determine level of care:

c. CONSISTENCY WITH INSTITUTIONAL LEVEL OF CARE
The State will use the following methods to ensure that level of care determinations used for the waiver program are consistent with those made for institutional care under the State plan:

APPENDIX D-2

a. REEVALUATIONS OF LEVEL OF CARE

Reevaluations of the level of care required by the individual will take place (at least annually) according to the following schedule:

b. QUALIFICATIONS OF PERSONS PERFORMING REEVALUATIONS

Persons performing reevaluations of level of care will have the following qualifications:

c. PROCEDURES TO ENSURE TIMELY REEVALUATIONS

The State will employ the following procedures to ensure timely reevaluations of level of care:

APPENDIX D-3

a. MAINTENANCE OF RECORDS

1. Records of evaluations and reevaluations of level of care will be maintained in the following location(s):

2. Written documentation of all evaluations and reevaluations will be maintained as described in this Appendix for a minimum period of 3 years.

b. COPIES OF FORMS AND CRITERIA FOR EVALUATION / ASSESSMENT

A copy of the written assessment instrument(s) to be used in the evaluation and reevaluation of an individual's need for a level of care indicated in item 2 of this request is attached to this Appendix. If this instrument differs from the form used to evaluate or assess institutional level of care, a description of how and why it differs and an assurance that the outcome of the determination is reliable, valid, and fully comparable is attached.

APPENDIX D-4

a. FREEDOM OF CHOICE AND FAIR HEARING

1. When an individual is determined to be likely to require a level of care provided in an institutional setting, the individual or his or her legal representative will be:

   a. informed of any feasible alternatives under the waiver; and

   b. given the choice of either institutional or Home and Community-Based services.

PROCESS: The following describes the agency's procedure(s) for informing eligible individuals of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services:

2. The agency will provide an opportunity for a fair hearing under 42 CFR Part 431, subpart E, to individuals who are not given the choice of home or community-based services as an alternative to the institutional care or who are denied the service(s) of their choice, or the provider(s) of their choice.

PROCESS: The following describes the process for informing eligible individuals of their right to request a fair hearing under 42 CFR Part 431, Subpart E:

b. FREEDOM OF CHOICE DOCUMENTATION

1. A copy of the form(s) used to document freedom of choice and to offer a fair hearing is attached to this Appendix.

2. Copies of free choice documentation are maintained in the following location(s): _____.

APPENDIX E - PLAN OF CARE

APPENDIX E-1 - PLAN OF CARE DEVELOPMENT/MAINTENANCE

1. The attached policy and procedures define and guide the family or person-centered planning process and assure that families are integrally involved in the plan development and that the plan of care reflects their preferences, choices, and desired outcomes.

2. The following individuals are responsible for the preparation of the plans of care: _____.

3. Copies of written plans of care will be maintained for a minimum period of 3 years in the following location(s):

4. The plan of care is the fundamental tool by which the State will ensure the health and welfare of the individuals served under this waiver. As such, it will be subject to periodic review and update. These reviews will take place to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the individual's disability, and responsive to the individual's needs and preferences. The minimum schedule under which these reviews will occur is:

5. If the State uses a standardized plan of care document, a copy of this form should be submitted.

APPENDIX E-2 – MEDICAID AGENCY APPROVAL

The following is a description of the process by which the plan of care is made subject to the approval of the Medicaid Agency.

APPENDIX E-3 – PLAN OF CARE MANAGEMENT

The following is a description of process and parameters within which families or individuals have flexibility to utilize resources identified within the plan of care and the individual budget that do not necessitate a formal revision to the plan of care. In addition, the State's infrastructure to support families or individuals in directing and managing their plan of care is described here.

APPENDIX F – QUALITY ASSURANCE AND IMPROVEMENT

APPENDIX F-1 - QUALITY ASSURANCE & IMPROVEMENT PROGRAM

A description of the State's quality assurance and improvement program is attached. This description includes State policies and procedures which describe the:

1) frequency of quality assurance activities;
2) domains/dimensions/assurances that will be monitored (e.g., access, person-centered service planning, provider capacity and capabilities, participant safeguards, participant rights, participant outcomes and satisfaction, etc.);
3) process of discovery (including sampling methodologies and whether or not information is collected from interviews with families/individuals in their community residences);
4) identification of the persons responsible for conducting quality assurance activities and their qualifications (including how families and individuals will be involved in the process of assessing and improving quality);
5) provisions for periodically reviewing and revising its quality assurance policies and procedures when necessary;
6) provisions for assuring that all problems identified by the discovery process will be addressed in an appropriate and timely manner, consistent with the severity and nature of deficiencies and
7) system to receive, review and act upon critical events or incidents.

APPENDIX F-2 ANNUAL REPORTS

A summary of the results of the State's monitoring of recipient health and welfare and the continuous improvement of waiver program operations will be submitted annually, as part of the CMS approved reporting forms/process.

APPENDIX G – FINANCIAL DOCUMENTATION

APPENDIX G-1
COMPOSITE OVERVIEW AND DEMONSTRATION OF
COST NEUTRALITY FORMULA

LEVEL OF CARE: _____

Definitions:

(NOTE: A separate chart should be filled out for every level of care in the waiver program. The State should also include a chart reflecting the weighted average of the combined levels of care offered in the program.)

Factor D Estimated annual average per capita Medicaid cost for Home and Community-Based Services for individuals in the waiver program.

Factor D' Estimated annual average per capita Medicaid cost for all other services provided to individuals in the waiver program

Factor G Estimated annual average per capita Medicaid cost for hospital, NF, or ICF/MR care that would be incurred for individuals served in the waiver, were the waiver not granted.

Factor G' Estimated annual average per capita Medicaid costs for all services other than those included in Factor G for individuals served in the waiver, were the waiver not granted.

Col. 1 Year	**Col. 2 Factor D**	**Col. 3 Factor D'**	**Col. 4 Total: D+D'**	**Col. 5 Factor G**	**Col. 6 Factor G'**	**Col. 7 Total: G+G ?**	**Col. 8 Difference (subtract column 4 from column 7)**
1							
2							
3							
4							
5							

If states elect to consider Supports Brokerage and/or Fiscal/Employer Agent Services/Functions administratively rather than as wavier services, these costs and the methodology used to calculate the costs must be identified.

Service	Estimated Costs	Methodology Description
Supports Brokerage		
Fiscal/Employer Agent		

APPENDIX G-2 - DERIVATION OF ESTIMATES

NUMBER OF UNDUPLICATED INDIVIDUALS SERVED

YEAR	UNDUPLICATED INDIVIDUALS	EXPLANATION of ESTIMATE of NUMBER of UNDUPLICATED INDIVIDUALS SERVED:
1		
2		
3		
4		
5		

FACTOR D: AVERAGE COST OF WAIVER SERVICES

Waiver Service (Add row for each service)	# Users	Avg. Units/User	Avg. Cost/Unit	Total Cost
1				
2				
3				
4				
5				
GRAND TOTAL:				
TOTAL ESTIMATED UNDUPLICATED RECIPIENTS:				
FACTOR D (Divide total by number of recipients)				

PROJECTED AVERAGE LENGTH OF STAY IN WAIVER PROGRAM:

_____

Please provide a narrative description and supporting documentation for the derivation of the following factors:

FACTOR D DERIVATION:

FACTOR D' DERIVATION:

FACTOR G DERIVATION:

FACTOR G' DERIVATION:

Appendix G-3 METHOD OF PAYMENTS (check one):

____ Payments for all waiver and State plan services will be made through an approved Medicaid Management Information System (MMIS).

____ Payments for some, but not all, waiver and State plan services will be made through an approved MMIS. A description of the process by which the State will make payments and maintain an audit trail is attached to this Appendix.

_____ Payment for waiver services will not be made through an approved MMIS. A description of the process by which the State will make payments and maintain an audit trail is attached to this Appendix.

Appendix G-4 – INDIVIDUAL BUDGET PROJECTIONS OF RESOURCES WITHIN THE EXCLUSIVE CONTROL OF THE FAMILY OR THE INDIVIDUAL. (This information is required, but will not be used in the calculations of cost neutrality.)

Please estimate the proportion of families or persons who will have annual individual budget amounts in the following ranges:

Budget Range	Proportion of Participants
$1 – 5,000	
$5001 – 10,000	
$10,000 – 15,000	
$15,001 – 20,000	
$20,001 – 25,000	
$25,001 – 50,000	

$50,000 – 75000	
$75,001 – 100,000	
$100,000 and above	
	100%

APPENDIX H – INDIVIDUAL BUDGETS

The following describes in detail EITHER:

The State's uniform methodology for the calculation of individual budgets, OR

The criteria and approval process for entities with which the State has contracted for day-to-day operations of the program.

This description addresses the minimum requirements that the methodology utilize actual service utilization and cost data, how the methodology is explained to the family or individual, the re-determination process, and how the methodology is open to public inspection.

APPENDIX I – PARTICIPANT PROTECTIONS

The State procedures and processes to assure that each of the following protections is in place are described below.

The State has procedures to assure that families and individuals have the requisite information and/or tools to participate in a family or person-centered planning approach and to direct and manage their care as outlined in the individual plan of care. The State will make available and provide services such as assistance in locating and selecting qualified workers, training in managing the workers, completing and submitting paperwork associated with billing, payment and taxation. Such functions are mandatory under the template and should be provided by one or more entities. The services and the provider qualifications are described in Appendix B.

Upon family or individual request, the State makes available at no cost, provider qualification checks, including criminal background checks.

The State has procedures to promote family or individual preferences and selections and these are appropriately balanced with accepted standards of practice. This balance requires deference to the individual whenever possible. Procedures will include individual risk management planning (e.g., risk agreements or informed consent contracts) to ensure that family or individual decisions are honored.

The State has a viable system in place for assuring emergency back up and/or emergency response capability in the event those providers of services and supports essential to the individual's health and welfare are not available. While emergencies are defined and planned for on an individual basis, the State also has system procedures in place.

The State has procedures for how it will work with families and their employer agents (if applicable) to monitor the ongoing expenditures of the individual budgets.

The State has procedures for how it will handle those instances where this ongoing monitoring has failed to prevent the expenditure of the individual budget in advance of the re-determination date to assure that services needed to avoid out-of-home placement and the health and welfare of the individual are available.

The State has procedures for how decisions will be made regarding unexpended resources at the time of budget re-determination.

The State has a viable system by which it receives, reviews and acts upon critical events or incidents (states must describe critical events or incidents). This system

may include an existing process (e.g. child or adult protective services). This system must be part of the Quality Assurance and Improvement Program.

Independence Plus: A Demonstration Program for Family or Individual Directed Community Services

This initiative expedites the ability of states to offer families with a member who requires long-term supports and services, or individuals who require long-term supports and services, greater opportunities to take charge of their own health and direct their own services. Families and individuals will exercise greater choice, control and responsibility for their services within cost neutral standards. Two template versions will be available to enable states to tailor the program to their preferences; the §1115 Demonstration Template and the 1915(c) Waiver Template. These templates further the interests of the administration, states and beneficiaries. The program builds on the experience and research from a number of pioneer states that have pre-tested these concepts.

The Goals of the Templates

1. The templates will assist states to develop programs that will permit individuals needing long-term supports and services to obtain assistance while living with their family or in their own home. This will be accomplished by:

- Recognizing the essential role of the family or individual in the planning and purchasing of health care supports and services by providing family or individual control over an agreed resource amount.
- Increasing family and individual satisfaction through the promotion of personal control and choice - a major theme expressed during the *New Freedom Initiative* - National Listening Session.
- Encouraging cost effective decision-making in the purchase of supports and services.
- Allowing eligible families and individuals to receive a cash allowance (in the §1115 Demonstration) or individual budget (in the 1915(c) Waiver) to obtain personal assistant services and related supports.
- Promoting solutions to the problem of worker availability.
- Providing fiscal/employer agent and supports brokerage services to support and sustain families or individuals as they direct their own services.
- Delaying or avoiding institutional or other high cost out-of-home placement by strengthening supports to families or individuals.

2. The templates will provide states the tools, resources and guidance to create effective programs and continue the CMS commitment to create a "culture of responsiveness" by:

- Assisting states with meeting their legal obligations under the Americans with Disabilities Act (ADA) and the Supreme Court *Olmstead* decision.
- Providing flexibility for states seeking to increase the opportunities afforded families and individuals in deciding how best to enlist or sustain home and community services.
- Incorporating the essential elements of self direction such as person-centered planning, individual budgets, participant protections and quality assurance and improvements.
- Providing states with streamlined and standardized application formats to reduce the administrative burden for preparing proposal submissions and to reduce the Federal review period.

Features of the Templates

- Electronic format for easier submission.
- Database platform to enable electronic tracking, sorting, querying and analyzing.
- Structured series of check boxes to facilitate completion.
- Pop-up instructions imbedded in the check boxes offering completion instructions.
- Technical Guide for developing the 1915(c) Waiver or the §1115 Demonstration applications.
- Additional features of the §1115 Demonstration include simplified/streamlined budget neutrality model and sample terms and conditions.

Independence Plus

A Demonstration Program for Family or Individual Directed Community Services Initiatives

SECTION 1915(c) WAIVER AND §1115 DEMONSTRATION TEMPLATES

QUESTIONS AND ANSWERS

Intent of the Programs

Q1. *Why has CMS developed these program initiatives?*

These initiatives assist states to achieve the goals established in President Bush's *New Freedom Initiative*. The President's initiative is intended "… to ensure that all Americans have the opportunity to live close to their families and friends, to live more independently, to engage in productive employment and to promote community life." - President George W. Bush, Executive Order 13217.

The recognition of the strengths, preferences and desired outcomes of families of persons with disabilities and persons with disabilities themselves is essential in the development and delivery of effective and meaningful services. By allowing individuals with disabilities, or their families, to direct the design and delivery of their own health care, they will experience higher levels of satisfaction, avoid unnecessary institutionalization and use resources more effectively.

The above represents some of the reasons that many state officials representing the elderly and persons with disabilities have encouraged CMS to explore options related to "self direction". For example, a recent survey of State Medicaid Directors, Mental Retardation/Developmental Disabilities Administrators and Vocational Rehabilitation Administrators indicated that 69% of the responding administrators were interested in advancing self-directed programs for persons with disabilities and 64% supported self-directed programs for older persons. State officials expressed concern that complex Medicaid laws present barriers to promote this service delivery method and that the Federal government should simplify the process for approving applications for states to establish or amend Home and Community-Based Services (HCBS) and other waiver programs.

The programs will:

- Delay institutional or other high cost out-of-home placement by strengthening supports to families or individuals, permitting the individual with a disability to live in their family's or own home.
- Recognize the essential role of the family or individual in the planning and purchasing of health care services and supports by providing control over an agreed upon resource amount.
- Facilitate cost effective decision-making in the purchase of supports and services.
- Increase family and individual satisfaction by facilitating control and choice, concepts voiced by many persons participating in a National Listening Session - *New Freedom Initiative.*
- Facilitate the states' abilities to meet legal obligations under the Americans with Disabilities Act (ADA) and the Supreme Court *Olmstead* decision.

Q2. ***Why are two different templates*** *provided (1915(c) and §1115)?*

Sections 1115 and 1915(c) of the Social Security Act provide states two options to establish family or individual directed community supports, however, the §1115 Demonstration option provides optimum flexibility. The §1115 Demonstration Template must be used if the State wishes to:

- Establish a program serving multiple populations, such as person with mental retardation and person with physical disabilities or
- Establish a program making cash directly available to demonstration participants or
- Cover an eligible population other than those who meet an institutional level of care.

	Section 1115 Demonstration Authority	**1915(c) HCBS Waiver Authority**
Level of Care	Any Level of Care	People Meeting Institutional Level of Care
Services Which May be Self-directed	State Plan Services	HCBS Waiver Services Only
Cash	Participant May or May Not Manage the Cash Directly	Participant Uses Fiscal/Employer Agent and Does Not Manage Cash Directly

Q3. *What is* ***new or innovative*** *about this initiative?*

This initiative provides guidance and assistance to states wishing to implement programs to support the self direction of services and supports by persons with disabilities and their families.

Q4*.* *What is meant by* ***"self direction"****?*

Self direction refers to a service delivery system whereby families, elderly persons or persons with disabilities have high levels of direct involvement, control and choice in

identifying, accessing and managing the services they obtain to meet their personal assistance and other health related needs.

Q5. *Has DHHS permitted or **approved** this type of service delivery system **previously**?*

Yes. The National Cash and Counseling Demonstration and Evaluation Project, co-sponsored by DHHS and the Robert Wood Johnson Foundation (RWJF), operates in the states of Arkansas, Florida and New Jersey under the authority of Section 1115 of the Social Security Act. This demonstration uses an experimental approach to randomize enrollees into a treatment or a control group. Treatment group participants are elderly and younger Medicaid beneficiaries with significant long-term functional disabilities with family caregivers serving as representatives, if necessary. Participants of the Project "self-direct" their own home and community personal assistance services and supports utilizing a cash allowance to purchase services or items needed to meet their personal care needs. An equal number of recipients are randomized into the Control Group. These individuals, while preferring to receive the cash allowance, remain in the traditional service delivery program. The evaluation compares the level of satisfaction, utilization and expenditures between the two groups. Similarly, a number of pioneer states are developing "self-determination" programs under the 1915(c) authority and are allowing individuals to manage their services. These initiatives and their related experiences have been instrumental in the design of the templates.

Q6. *How does this initiative differ from the existing **Cash and Counseling** Demonstration and Evaluation Programs?*

The two new templates are similar to the Cash and Counseling Demonstration and Evaluation Program but include some refinements based on the experiences of the participating states and states' developing "self-determination" models. Each incorporates direct family or individual involvement as an essential element of the program design. The new templates, however, do not require participant assignment into a treatment or control group.

Q7. *Do the templates cover **individuals who are currently institutionalized** and wish to move into the community and enroll in a demonstration program?*

Yes, the templates may be used to assist persons living in institutions to return to the community. The individuals must, however, be returning to their own home or the home of their families.

Relationship to State Program Initiatives

Q8. *How will these templates **help states**?*

CMS developed these templates to further efforts toward building a **culture of responsiveness** by creating an application that reduces the state administrative burden for submission and the Federal review period. Specific features of the templates include:

- Electronic format for easier submission.

- Structured series of check boxes to be completed.
- Database platform for the electronic submission to enable electronic tracking, sorting, querying, and analyzing of each application (to be developed by mid-2002).
- Technical Guide to develop the application or the Operations Protocol.
- For the §1115 Demonstration Template, the following is added:
    - Pop-up instructions imbedded in the check boxes on how to complete each question.
    - Simplified budget neutrality models.
    - Sample set of assurances or terms and conditions specific to self direction.

Q9. ***Can a state already do*** *what is proposed under these templates?*

Yes. However, states and their partnering organizations have often been confused by the existing array of choices and requirements. It has also been unclear to states as to how self direction can fit within traditional waiver or demonstration frameworks. These templates and the related material will provide guidance and administrative simplification. In addition, states would not be required to randomly assign individuals into experimental groups (treatment and control), but must allow individuals to participate in alternate research strategies.

Q10. *Are states required to provide* ***matching funds****?*

Yes. This initiative is part of Medicaid and must comply with basic Medicaid requirements. In terms of payment, the state makes payments for services then the Federal Government matches those expenditures according to the state's Federal Medicaid assistance payment rate.

Q11. **How should a state proceed if it wishes to** amend an existing 1915(c) Waiver or §1115 Demonstration **to incorporate one of the elements of self direction (e.g., Fiscal/Employer Agent, Individual Budget or Supports Brokerage)?**

States wishing to add one of the new self-directed components prior to the renewal period should contact CMS to discuss the anticipated changes. To understand fully the proposed modifications, CMS staff may request submission of a written concept paper. The decision will then be made to identify the most appropriate method by which the state will submit the changes and the required documentation. Options may include (a) converting to the new template or (b) amending an existing wavier to incorporate essential elements of the self-directed approach.

Q12. *If a state wishes to* ***renew an existing 1915(c) Waiver or a §1115 Demonstration*** *to include one of the elements of self direction or wishes to renew an existing wavier that includes a self direction component, should the template be used?*

Yes. Either the 1915(c) Waiver or the §1115 Demonstration Template must be used to renew an existing waiver or demonstration if the state wishes to add one of the self-directed components or has, in the past, offered a self-directed waiver service.

Accountability

Q13. *How does the Independence Plus Initiative assure state* ***fiscal accountability****?*

Use of the *Independence Plus* §1115 Demonstration or the 1915(c) Waiver application will maintain state fiscal responsibility by continuing to require states to meet statutory or regulatory requirements. Budget neutrality policy for the §1115 Demonstration limits Federal expenditures so that they do not exceed the levels that would have been realized had there been no demonstration. The similar requirement for the 1915(c) version is cost neutrality, which requires Federal funding to be no more than the institutional costs that would have been incurred for waiver participants. In addition, states must ensure the availability of fiscal/employer agent services and options for supports brokerage for the individual.

Q14. *How does the Independence Plus initiative assure for the* ***health and welfare*** *of the individual with the disability?*

Use of the §1115 Demonstration or the 1915(c) Waiver Templates require states to design and implement a quality assurance or improvement program and to implement procedures related to participant protections.

As part of the template application process states will be required to develop procedures to assure that families have the requisite information and/or tools to participant in a family or person-centered planning approach and to direct and manage their care as outlined in the individual plan of care. The state should make available and provide services such as assistance in locating and selecting qualified workers, training in managing workers, completing and submitting paperwork associated with billing, payment and taxation. Supports Brokerage and Fiscal/Employer Services/Functions are required and should be provided by one or more entities.

Upon family or individual request, the state will make available, at no cost, provider qualification checks, including criminal background checks.

The state will have procedures to promote family and individual preferences and selections and these will be appropriately balanced with accepted standards of practice. This balance requires deference to the individual whenever possible. Procedures will include individual risk management planning (e.g., risk agreements or informed consent contracts) to ensure that family or individual decisions are honored.

The state will have a viable system in place for assuring emergency back-up and/or emergency response capability in the event those providers of services and supports essential to the individual's health and welfare are not available. While emergencies are defined and planned for on an individual basis, the state also will have system procedures in place.

The state will have procedures for how it will work with families or individuals and their fiscal/employer agents (if applicable) to monitor the ongoing expenditures of the individual budget.

The state will have procedures for how it will handle those instances where ongoing monitoring has failed to prevent the expenditure of the individual budget in advance of the re-determination date to assure that services needed to avoid out-of-home placement and the health and welfare of the individual are available.

The state will have procedures for how decisions will be made regarding unexpended resources at the time of budget re-determination.

The state, through an organized quality assessment program, will provide appropriate oversight and monitoring of its HCBS Waiver Program to ensure that each of the assurances contained in the application is met and to continually improve the operation of the program. The program will involve families or individuals in the process of assessing and improving quality. The state will assure that all problems identified by this monitoring will be addressed in an appropriate and timely manner, consistent with their severity and nature and will contain an incident management system to address critical events.

Q15. *Will the* ***states be limited in the size*** *of the enrollment under one or both templates?*

Yes. Existing regulations for the 1915(c) Waivers require states to indicate the number of unduplicated beneficiaries to which it intends to provide waiver services in each year of its program. This number in the application will constitute a limit on the size of the waiver program. Future state requests to increase the limit would require a waiver amendment.

States must include their proposed limits in the §1115 Demonstration Template application for discussion with CMS staff. Again, future state requests to increase the limit will require a demonstration amendment. The state will also be asked to submit the results of an independent evaluation demonstrating that the program has remained within budget and cost neutrality parameters and the program's ability to adequately address the health, welfare, and satisfaction of the participants.