# Medicaid Renewals

*What Your Family Needs to Know*

benefind
Assistance & Support Programs for Kentuckians

Medicaid benefits must be renewed every 12 months. We will try to renew your Medicaid automatically with little or no action required by you; this is called Passive Renewal. If we can't renew your Medicaid automatically, we will send you a form to complete; this is called Active Renewal.

## What is Passive Renewal?

- Passive Renewal renews your Medicaid without requiring you to do an interview or fill out a form.
- It happens when our system checks with other systems to see if we can verify your information.
- Passive Renewal starts on the first day of the month before your renewal month. In other words, if your renewal month is July, Passive Renewal begins June 1st.

## What Do I Need to Do?

- If we are able to verify all of your information, then there's nothing you have to do.
- If we can't verify everything, you will get a notice telling you what proof we need and the day it is due.
- Be sure to return any proof that we ask for before the due date on the notice or your Medicaid will stop.

## What is Active Renewal?

- Active Renewal means you have to take action to renew your Medicaid benefits.
- If you have to complete an Active Renewal you will get a form in the mail.
- The form is mailed around the first of the month before your renewal month and you should get it by the 10th.

## What Do I Need to Do?

- You can fill out the form and return it to us or you can renew your Medicaid online by logging on to your benefind account.
- If you use the form, you must fill out the whole form and sign it, then return it to us. You can mail it to us, drop it off at any DCBS office, or upload it to your benefind account at benefind.ky.gov.
- Be sure to return your Active Renewal form before the due date or your Medicaid will stop.

## Is There Anything Else I Need to Know?

- You don't have to call or go in to the DCBS office to interview for Medicaid renewal.
- Return the completed form or any proof as soon as you can. Waiting until the due date could cause a delay in the next month's Medicaid.
- If you have any questions you can call 1-855-306-8959.

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TO: Each Local Office

FROM: Jason C. Dunn, Director

DATE: June 27, 2017

SUBJECT: Changes to Medicaid Applications and Recertifications

Effective 07/01/2017 changes have been made to the recertification process and the requirements for applications made on the benefind Self Service Portal (SSP).

- Individuals may make an application for Non-MAGI Medicaid on the SSP and receive an eligibility determination in real time; the same as a MAGI Medicaid application. An interview will no longer be required for Medicaid applications initiated on the SSP. This includes regular Medicaid, long term care (LTC), Medicare Savings Program (MSP), etc.

- Non-MAGI Medicaid, including MSP will be passively or actively renewed using the same process that is currently in place for MAGI Medicaid. There will now be one process to recertify all Medicaid programs, regardless of the type of assistance (TOA). The passive renewal process begins July 1 for cases due recertification in August.

- Neither of these changes affect State Supplementation as it is not a Medicaid program. Applications and recertifications for State Supplementation, including those with a Medicaid TOA, must be completed by phone or face to face and a thorough interview is required.

- Beginning 7/1/2017, clients no longer have to give permission, or “opt-in”, for Worker Portal to call the federal hub for verification. Instead, they will be informed that we will gather information from state and federal sources and they will have to choose **No** to “opt-out” of this process. All Medicaid recipients will be passively renewed unless they have specifically opted out or do not meet all of the requirements for passive renewal.

**Applications Initiated on the SSP**

When individuals initiate and complete an application on the SSP, eligibility may be determined without worker intervention, unless verification is required. When eligibility runs, Worker Portal will determine if verification is needed based on the data entered on the SSP. If verification is required, a request for information (RFI) will be issued. If no verification is needed, the application may be approved or denied without further action. The case will no longer pend for an interview and the RFI requiring an interview will no longer be issued.

Currently, the SSP does not request information regarding all resources. Additional resource questions have been added to the Resource gatepost screen to include the most commonly reported resources. In addition, some existing resource screens have been updated with more detailed questions.

The following Resource screens will trigger when the appropriate question is answered on the Resource gatepost screen on the SSP. If verification is required for any information entered on the screens below, an RFI will be issued.

| | |
|---|---|
| Vehicle | Life Insurance and Burial Insurance |
| Real Estate Property | Annuity |
| Trusts | Liquid Resources |
| Pre-arranged Funeral Contracts | |

There are no screens on the SSP to capture details regarding the following resources. For these resources, an RFI is generated when someone answers 'Yes' to the related question on the Resource gatepost screen. The appropriate screens on Worker Portal must be completed when verification of one of these resource types is returned. If the documentation returned is not sufficient, another RFI should be issued to request whatever additional information is needed.

| | |
|---|---|
| Burial Funds | Promissory Note or Land Contracts |
| Life Estate | Lifetime Care Agreements |
| Partnership Qualified LTC Policy | Burial Plots |
| Life Settlement Contract | Other Resources |

In order to standardize the SSP application process, the following rules will be implemented in Worker Portal for all applications initiated on the SSP with reported resources:

- All **Verification** fields are defaulted to 'Client Statement'.
- The **Begin Date** field is defaulted to 3 months from the date the resource was entered.
- The date in all **Verified On** fields are defaulted to the date the application is submitted on the SSP.

**PLEASE NOTE:** Although applications initiated on the SSP no longer require an interview, applications made by phone or face to face still require a thorough interview.

**Recertifications**

Worker Portal will determine if MA cases meet the criteria to be passively renewed. If not, the case must be renewed using the active renewal process. Recipients may still complete a recertification by phone or in person if they choose, in which case an interview must be completed.

**What is a Passive Renewal?**

A passive renewal does not require an individual to interview, complete a form, or take any action to initiate recertification of their Medicaid benefits. The only action that may be required, is providing verification of income and/or resources, if required.

There are no changes to the passive renewal process for MAGI Medicaid. For Non-MAGI Medicaid, RFIs will be issued for any resources that require verification at recertification. If no resources require verification and MAGI income meets reasonable compatibility, the case will process and approve.

**Which Cases Will be Passively Renewed?**

When selecting cases for passive renewal, Worker Portal uses the following criteria:

- Individual has not explicitly opted-out of the passive renewal process.
- All income and resources in the case must meet the reverification requirements for passive renewal (unless it was verified within the last 90 days).
- ***Everyone*** on the case must meet the criteria for passive renewal. If any EDG does not meet passive renewal criteria, the whole case must be actively renewed.

  Example: Gregg is receiving ADLT and Becky is receiving ABDM on the same case. During passive renewal case selection, Gregg's EDG met all requirements for passive renewal but Becky's EDG failed the criteria. Since Becky's EDG was flagged for active renewal, the entire case must be actively renewed.

**Reverification Requirements at Passive Renewal**

The following ***income*** **types require verification at recertification**, so cases with these types of income will not be passively renewed.

| | |
|---|---|
| Pension/Retirement Payments | Life Estate Interest Income |
| Other | Capital Gains |
| Worker's Compensation | Interest |
| Child Support (for Non-MAGI MA only) | Trust Income |
| Mineral Rights/Royalties | Consumer Directed Option (CDO) Payments |
| IRA Distribution (traditional) | Oil Leases |
| Dividends | Loans |
| Alimony/Spousal Support | Military Retirement |
| Unemployment Insurance Benefits | Friends or Family Contribution |
| Wages | Self-employment |

The following ***income*** **types do not require verification at recertification** so if these are the ONLY types of income in the case, the case may be passively renewed if it meets all other criteria.

| | |
|---|---|
| RSDI Payments | AmeriCorps |
| In-Kind Income | U. S. Refugee Program |
| VA Pension or Compensation | Insurance Settlement Payments |
| Black Lung | Lottery Payments |
| Railroad Retirement | Taxable State Tax Refund |
| Annuity Payments | LTC Insurance Payment (whether to the individual or NF) |
| Indemnity Policy | Reverse Mortgage Payments |

The following ***resource* types require verification at recertification** so cases with these types of resources will not be passively renewed.

| | |
|---|---|
| Whole Life Insurance | Mutual Fund |
| Direct Express Card | Individual Development Account (IDA) |
| Nursing Facility Resident Account | Oil Rights |
| Stocks | Mineral Rights |
| Reloadable Money Card | Other Liquid Assets |
| Modified Term Life | Other Investments |
| Bonds | Other |

The following ***resource* types do not require verification at recertification**, so if these are the ONLY types of resources in the case, other than liquid assets, the case may be passively renewed if it meets all other criteria.

| | |
|---|---|
| Vehicles (Transportation and Recreational) | Annuity |
| Non-home Real Property | Trust |
| Reverse Mortgage | Promissory Note |
| Term Life | Land Contract |
| Pre-Arranged Funeral Contract | Lifetime Care Agreement |
| Burial Reserves (Including Burial Plots) | Life Settlement Contract |
| Life Estate | Deferred Payment Loan Home Equity Line of Credit |

**What is an Active Renewal?**

If a case is not eligible for passive renewal, then the active renewal process is initiated. Form HBE-044, Renewal Form for Medical Coverage, and form KIP-2Q, Renewal Form for Medicare Savings Program, are obsoleted and the information captured on these forms has been consolidated into one form, EDB-087, Renewal Form for Medical Coverage. Renewal notices will be issued on a household level. One form must be completed for all members of the Medicaid household.

Form EDB-087 is issued on the first day of the month prior to the renewal month. Form EDB-087 is due by the last day of the renewal month. However, if the renewal is not entered on Worker Portal by the 15th of the renewal month, form EDB-088, Renewal Reminder Form for Medical Coverage, will be issued. If form EDB-087 or form EDB-088 is not returned, Medicaid will discontinue for failure to recertify.

Example: Fred's case is due for renewal in August. Form EDB-087 is issued on July 1st with a due date of August 31st. If Fred does not return form EDB-087 by August 15th (or if it is not entered timely) form EDB-088 will be issued the night of August 15th with a due date of August 31st.

When form EDB-087 or form EDB-088 is received, workers must update the case with all information reported. If workers have any questions regarding the responses on the form, they must contact the client to clarify reported information or resolve any discrepancies. When eligibility is run, Worker Portal hits State and Federal data hubs for MAGI income. If verification of income or resources is required, an RFI will be issued and the case will pend. If no RFI is issued, dispose the case. **Please note:** Individuals may choose to complete their active renewal, in person, by phone, or on the SSP instead of completing the active renewal form. Renewals completed in person or by phone require an interview.

## Which Cases will be Actively Renewed?

- 3 month Pass Through renewal cases.
- Cases where everyone on the case does not meet passive renewal criteria.
- Cases in change, intake, or reinstate mode will be actively renewed.
- Cases where the individual has specifically opted out of the passive renewal process.
- Cases with resources/income not meeting reverification requirements for passive renewal.

  Example: Marsha is receiving ADLT and has no income so Marsha's EDG meets all criteria for passive renewal. Jeffrey is receiving LTCM and has a pension. Since pensions must be verified at recertification, Jeffrey's income does not meet the reverification requirements. His EDG is not eligible for passive renewal, so the entire case must be actively renewed.

## End-dating or Removing Resources on the SSP

When an applicant or recipient tries to remove a resource on the SSP, a pop up box will appear to ask the applicant to select a reason for deleting the resource.

- If the individual changes the response from 'Yes' to 'No' for a resource listed on the Resource Gatepost screen on the SSP, then the verification source for that resource will be changed to 'Other' on Worker Portal, and an RFI will generate requesting verification.
- No changes can be made to responses on the Resource Gatepost screen, if the resource has no corresponding screen on the SSP. These changes must be reported to DCBS.

**MA-34 Declaration of Annuities Screen**

Effective July 1, 2017, workers no longer need to issue form MA 34, Declaration of Annuities, manually. A screen has been added to both Worker Portal and the SSP to capture disclosure of annuities and agreement to name the Department for Medicaid Services (DMS) as beneficiary. This screen will only be triggered for a Non-MAGI Medicaid application and will appear before the Sign and Submit page.

The applicant can choose 'Yes' or 'No' in response to the statement, *"I have disclosed any and all interest that I (applicant) and/or the community spouse may have in an annuity."* If the applicant chooses 'No', the case will deny for failure to disclose all assets. If 'Yes' is chosen, the 2 statements following the disclosure statement are enabled and the applicant must choose one.

Worker Portal will only capture one signature on the sign and submit page, which will be the signature for form MA-2, Medicaid Penalty Warning, form MA-34, and the application for benefits.

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Overview Applications Plans & Programs Messages Assisters Settings

Application 200054996

90% Complete

- Start Application
- Household Member Information
- Financial Information
- Additional Medical Assistance Questions
- Authorized Representative Information
- Review and Submit
- Post Application Submission

Enter and Confirm Application | Review and Accept Eligibility | Select and Manage Plans | Submit Application

MA - 34 Declaration of Annuities

- The Deficit Reduction Act (DRA) of 2005 changed the Medicaid eligibility rules regarding annuities for nursing home and waiver applicants. All annuities owned by an applicant or the applicant's spouse must be disclosed at application/recertification.
- Annuities purchased on or after February 8, 2006, must name the Department for Medicaid Services (DMS) as beneficiary in the appropriate position. The community spouse and/or minor/disabled children shall be named prior to DMS. This includes any annuities belonging to the applicant's spouse. Annuities purchased by a third party, with third party assets, are not required to name DMS as beneficiary.
- DMS will only recoup an amount equal to the claims paid on the institutionalized individual; any excess will be available to a secondary beneficiary or the estate of the annuitant.
- Failure to comply will result in the annuity being treated as a transfer of resources for less than fair market value and could result in an ineligibility period.
- I have disclosed any and all interest that I (applicant) and/or the community spouse may have in an annuity.

* --Select--

( ) I have agreed to name DMS as beneficiary, in the appropriate position, on all appropriate annuities.

( ) I have refused to name DMS as beneficiary on my annuities and understand that in doing so I may be subject to an ineligibility period.

- I am signing this form in agreement that I have disclosed any annuities for me and/or my spouse. Refusal to sign will result in no eligibility for Medicaid. If I have agreed to name DMS as beneficiary, I understand that a new beneficiary page must be presented prior to my approval for nursing home or waiver vendor payment.

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If you have questions, please contact the Division of Family Support through your Regional Office.

JCD/PW/LS

NATIONAL HEALTH LAW PROGRAM

# Q & A
# Relatives as Paid Providers[1]

Prepared By: Elizabeth Edwards
Date: December 5, 2014

Q: Our state allows some parents to be compensated for providing Medicaid services in certain programs, but will not pay parents to provide other services. Can the state restrict parents as paid providers in this way?

A: Yes, states may choose when to permit relatives or legally responsible individuals to be paid for providing Medicaid services. There is some variation in the rules regarding different home and community based services (HCBS) and there are separate limitations for other Medicaid State plan services. For HCBS programs, the approved waiver or State plan document should describe the criteria for paying relatives as providers.

## Background

State policies on the provision of HCBS services by relatives varies both across states and by program and population served.[2] Almost all states allow relatives to provide paid care in certain programs, but only 21 states pay a parent who is also a guardian and even fewer, six, pay parents of minor children.[3] Although HCBS services often allow

[1]This document was prepared with the support of The Atlantic Philanthropies, a limited life foundation dedicated to bringing about lasting changes in the lives of disadvantaged and vulnerable people, and with a grant from the Training Advocacy Support Center (TASC), which is sponsored by the Administration on Intellectual and Developmental Disabilities (AIDD), the Substance Abuse and Mental Health Services Administration (SAMHSA), the Rehabilitation Services Administration (RSA), the Social Security Administration (SSA), and the Health Resources Services Administration (HRSA). TASC is a division of the National Disabilities Rights Network (NDRN).

[2] Robert J. Necome, et al., *Allowing Spouses to Be Paid Personal Care Providers*, 52(4) THE GERONTOLOGIST 517-530, (2012), *available at* http://www.medscape.com/viewarticle/767749.

[3] Robin E. Cooper, NASDDDS, Paying Relatives Providing Supports: Practices, Issues, Lessons Learned (Aug. 2010), http://www.reinventingquality.org/docs/rcooper10.pdf (citing survey conducted by NASDDS as reported in Cooper, *Caring Families, Families Giving Care:*

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relative providers, especially in self-directed options, State plan personal care services clearly prohibit payment for services by a family member, defined as a legally responsible person.[4] State policies also differ on whether there are restrictions on the provider living with the individual being served, qualifications of the relative provider, application processes to serve as relative provider, etc.

State officials are sometimes reluctant to pay relatives as providers of care. They cite the existing responsibility for children and spouses, fear that substituting paid care for unpaid family care will increase costs, overreliance on a limited number of individuals as both paid supports and unpaid natural supports, burnout of caregivers, conflicts of interest, and isolation from the larger community if care is only provided by family members. But, studies have shown that those who receive paid supports from family members reported higher satisfaction with paid care and had either better or no worse outcomes on self-reported quality measures.[5] Moreover, positive effects of respite may not occur if individuals or their family members do not trust others to provide quality care.[6] Paid family caregivers have also been associated with neutral or positive outcomes, such as fewer hospital admissions and fewer institutional placements.[7]

Paying legally responsible relatives is explicitly an option, not a requirement, for states in most HCBS programs.[8] The following is an overview of the federal program requirements. However, because state policy choices on this topic vary it is important to check the approved waiver and state plan documents for additional information about a state's policies regarding whether and when to allow paid family.

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*Using Medicaid to Pay Relatives Providing Supports to Family Members*, NASDDDS (June 2010)).

[4] 42 U.S.C. § 1396d(a)(24)(B) ("not a member of the individual's family"); 42 C.F.R. § 440.167 (personal care services are not provided by a member of the individual's family and for purposes of this section, family member means a legally responsible relative). This prohibition is based on the presumption that legally responsible individuals may not be paid for supports that they are ordinarily obligated to provide. CMS, STATE MEDICAID MANUAL § 4442.3.B.1.

[5] Newcome, *supra* note 2; A.E. Benjamin and Ruth E. Matthias, *Comparing Consumer- and Agency-Directed Models: California's In-Home Supportive Services Program*, 24(3) GENERATIONS 85-87 (2000), *available at* http://laborcenter.berkeley.edu/homecare/pdf/benjamin_01.pdf.

[6] Newcome, *supra* note 2.

[7] *Id*.

[8] CMS, APPLICATION FOR A § 1915(C) HOME AND COMMUNITY-BASED WAIVER: INSTRUCTIONS, TECHNICAL GUIDE AND REVIEW CRITERIA1915(C) TECHNICAL GUIDE 119 (Jan. 2008), http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Downloads/Technical-Guidance.pdf [hereinafter 1915(C) TECHNICAL GUIDE].

## 1915(c) Waivers[9]

In 1915(c) HCBS waivers, states have the option of allowing waiver services to be provided by individuals who are related to the participant, including legal guardians. The State must make a separate choice regarding whether it will allow the provision of State Plan personal care services (PCS) or similar services by a legally responsible relative.[10] PCS or waiver services can only be provided by a qualified individual who is not a legally responsible relative, except in specific extraordinary circumstances.[11] For the purpose of waiver services, a legally responsible person is defined as "spouses or parent of minor children, when the services are those that these persons are already legally obligated to provide."[12]

A person may have a relative or friend who is not legally responsible provide State Plan PCS if:

- the relative or friend meets the qualifications for providers of care,
- there are strict controls to assure that payment made to the relative or friend as providers only in return for specific services rendered, and
- the provision of care by the relative or friend is adequately justified, such as because there is a lack of other qualified providers in remote areas.[13]

In limited circumstances, a legally responsible relative may provide "extraordinary services requiring specialized skills (e.g., skilled nursing, physical therapy) which such people are not already legally obligated to provide."[14] Extraordinary care means, "care exceeding the range of activities that a legally responsible individual would ordinarily perform in the household on behalf of a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant and avoid institutionalization."[15] If a state allows for the provision of paid services by a legally responsible relative, it must specify:

- the types of legally responsible individuals who may be paid and what services they may provide,

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[9] 1915(d) waivers, although rarely used, do not allow the participant's spouse to provide services. 42 C.F.R. § 441.360(g).
[10] 42 U.S.C. 1396n(c); 42 C.F.R. § 441.310(a)(2)(ii); 1915(C) TECHNICAL GUIDE, *supra* note 8, at 116. In a waiver application, item C-2-e asks about general waiver services and C-2-d is a much narrower question regarding personal services.
[11] CMS, STATE MEDICAID MANUAL § 4442.3.B.1.
[12] CMS, STATE MEDICAID MANUAL §4442.3.B.1.
[13] *Id.* at B.2.
[14] *Id.*
[15] 1915(C) TECHNICAL GUIDE, *supra* note 8, at 119

- the applicable state policies that describe the circumstances when payment is authorized, including how the state distinguishes extraordinary from ordinary care,[16]
- how the State ensures that the provision of services by the legally responsible individual is in the best interest of the participant, and
- the controls that are used to ensure that payments are made only for services rendered.[17]

When a state provides for payment to legally responsible individuals for extraordinary care, it must monitor the services. The State must also have safeguards, such as limiting the amount of paid services that a legally responsible individual may furnish so as to take into account the amount of care that they would ordinarily provide; implementing payment review procedures; and addressing other foreseeable risks from such provision of services and any effect payment to the legally responsible person may have on the participant's eligibility.[18] The guidance regarding safeguards for relatives and/or legal guardians that are not legally responsible or are not providing personal care is slightly different, but not substantially so.[19]

It is in the state's discretion whether to allow the provision of services by family members and to specify the circumstances under which payment is permitted. These conditions are usually specified in the waiver document. The could include the lack of other providers available to serve the individual, that the specific needs of the individual can only be met by the legally responsible individual, etc. In addition to these conditions, the person must always meet the provider qualifications that apply to a service.[20]

**1915(i) State Plan Option**

A state may choose to allow relatives, legally responsible individuals, and legal guardians to provide 1915(i) services. The standards or protections used are very similar to those for 1915(c) waivers.[21] A state must provide assurances that it has policies regarding the payment to qualified persons furnishing State plan HCBS who are relatives of the individual.

There must be additional policies and control if the State makes payment to qualified legally responsible individuals or legal guardians who provide State Plan HCBS. These policies are substantially similar to 1915(c) in that the State must specify:

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[16] *Id.*
[17] *Id.* at 118.
[18] *Id.* at 119.
[19] *Id.* at 121-122.
[20] *Id.* at 118.
[21] The services allowed in a 1915(i) references those in 1915(c). 42 U.S.C. 1396n(i)(1). CMS seems to apply the 1915(c) standards about family providers to 1915(i).

- who may be paid to provide State plan HCBS;
- the specific State plan HCBS that can be provided;
- how the State ensures that the provision of services by such persons is in the best interest of the individual;
- the State's strategies for ongoing monitoring of services provided by such persons;
- the controls to ensure that payments are made only for services rendered; and
- if legally responsible individuals may provide person care or similar services, the policies to determine and ensure that the services are extraordinary.[22]

**1915(j) Self-Directed Personal Assistant Services**

In self-directed personal assistance services (PAS), participants set their own provider qualifications, train their PAS providers, and determine how much they pay for a service, support, or item.[23] States may choose to allow people enrolled in a PAS to hire legally liable relatives, which are defined as "persons who have a duty under the provisions of State law to care for another person" and may include that parent (biological or adoptive) of a minor child, or the guardian of the minor child who must provide care to the child, legally-assigned caretaker relatives, and a spouse.[24] It is up to the States to determine what other relationships they include in their definition of legally responsible relatives.[25]

If a person is acting as a participant's representative to direct the provision of self-directed PAS, that person may not act as a provider of self-directed PAS to the participant.[26] In a PAS program, the supports broker or consultant is supposed to provide sufficient assistance in dealing with service issues and CMS declined to require additional safeguards, relying on the financial management service entities to report irregularities and the oversight and monitoring activities of the State Medicaid agency.[27]

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[22] This language is in the 1915(i) preprint under the Services section. *See, e.g.,* Indiana's 1915(i) for Behavioral and Primary Healthcare Coordination Services (SPA 13-013) (May 30, 2014) (state plan page 146), http://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/IN/IN-13-013.pdf

[23] CMS, Self-Directed Personal Assistance Services 1915(j), http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/self-directed-personal-assistant-services-1915-j.html [last visited Nov. 13, 2014].

[24] 42 U.S.C. 1396n(j)(B)(i); 42 C.F.R. § 441.450(c).

[25] Self-Directed Personal Assistance Services Program State Plan Option (Cash and Counseling), 73 Fed. Reg. 57854, 57859 (Oct. 3, 2008) (to be codified at 42 C.F.R. pt. 441).

[26] 42 C.F.R. § 441.480.

[27] Self-Directed Personal Assistance Services Program State Plan Option, 73 Fed. Reg. at 57869.

## 1915(k) Community First Choice Option

Community First Choice (CFC) options allow for paid relative caregivers, but if a person is acting as an individual's legal representative, that person may not also be a paid caregiver of an individual receiving services and supports.[28] For purposes of the CFC option, a legal representative may be a parent, family member, guardian, advocate, or other person authorized by the individual to serve as a representative in connection with the provision of CFC services and supports.[29] If the person is in a self-directed program, the individual has the right to hire "family members, or any other individual[]…provided they meet the qualifications to provide the services and supports established by the individual, including additional training."[30]

CMS interprets the statute to require states to allow individuals in self-directed models to hire family members qualified to provide any service on the person-centered plan, but recognized that States have the option of only offering the agency-provider model. While CMS expects that the agency-provider model should allow an individual to exercise maximum control over who provides services to them, CMS cannot mandate agencies to employ individuals' family members for the purpose of providing CFC services.[31] However, it is strongly encouraged.[32] However, a person cannot be a person's individual representative and their provider.[33]

## State Plan Personal Care Services

States call personal care services (PCS) a variety of names, including personal attendant services, personal assistance services, or attendant care services. State plan PCS can only be provided by a qualified individual "who is not a member of the individuals' family."[34] The regulation further defines a family member as "a legally responsible relative."[35] Generally, legally responsible relative refers to spouses of recipients and parents of minor recipients, including stepparents who are legally

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[28] 42 C.F.R. § 441.505.
[29] *Id.*
[30] 42 C.F.R. § 42 C.F.R. § 441.565(c). This follows the intent of the statute that the supports in a CFC program be "provided by an individual who is qualified to provide such services, including family members (as defined by the Secretary)." 42 U.S.C. 1396n(k)(1)(A)(iv)(III).
[31] Community First Choice Option, 77 Fed. Reg. 26828, 26879-80 (May 7, 2012) (to be codified at 42 C.F.R. pt.441).
[32] *Id.*
[33] For an example of a state policy on how to address this conflict, see Oregon, http://www.dhs.state.or.us/policy/spd/transmit/ar/2013/ar13085.pdf. Oregon transitioned its 1915(c) waiver into a 1915(k) state plan option and had to adjust the policies because of the 1915(k) rules.
[34] 42 U.S.C. § 1396d(a)(24); 42 C.F.R. § 440.167(a)(2).
[35] 42 C.F.R. § 440.167(b).

responsible for minor children.[36] Legally responsible individual does not usually include the parent of an adult beneficiary, including a parent who may also be a legal guardian, or other types of relatives. However, the definition of legally responsible relative will vary, depending on the responsibilities imposed under State law or under custody or guardianship arrangements.[37] States can also further restrict which family members can qualify as providers through the way they define "family members" for purposes of PCS.[38] Therefore, the family members who may be allowed to be a qualified provider for state plan PCS may be different based on the state and the individual's own situation.

**Case Law**

Limited case law exists on the question of relative providers. In *Calenzo v. Shah*, a participant in one of the State's self-directed waiver options contested the denial of his stepfather providing paid support services. [39] In *Calenzo* the state regulation did not allow payment for personal care services by a spouse, parent, son, son-in-law, daughter, or daughter-in-law and the Department had refused to allow the adult individual's step-father to be a paid provider, saying that step-parents were supposed to be included in the term "parent". The Department argued that such a reading would be consistent with the federal regulations and statute. The court found that the lack of ambiguity in the language of the state regulations and the detailed list of relationships, including the failure to include stepparents, did not give fair notice and the denial lacked a rational basis, thus the denial should be overturned. The court said that if the state regulations were inconsistent with federal, then the solution was to amend the regulation, not read into the regulation a term that is clearly not there.[40]

In *Peers v. Harvey*[41], Mr. Peers' sister was providing State plan personal care services to her adult brother. When their mother had to go to the hospital and could not provide the care she was providing to Mr. Peers, the sister asked for additional hours to cover the additional services. During this request, the Department realized that the sister was being paid to provide care, in violation of their state statute and the federal regulations at the time. Mr. Peers' filed suit to continue to allow his sister to provide services, saying

[36] Coverage of Personal Care Services, 62 Fed. Reg. 47896, 47899 (Sept. 11, 1997) (to be codified at 42 C.F.R. pt. 440); State Medicaid Manual, 4480.D. This definition is identical to that for HCBS waiver services. If stepparents are not legally responsible for the recipient in some States, they could provide PCS under this definition, but States can further restrict which family members can qualify as providers by extending the definition to apply to individuals other than those legally responsible for the recipient.
[37] CMS, STATE MEDICAID MANUAL §4480.D.
[38] Coverage of Personal Care Services, 62 Fed. Reg. at 47899.
[39] 112 A.D.3d 709, 976 N.Y.S.2d 555 (App. Div. 2013).
[40] *Id.*
[41] No. A-97-592, 1998 WL 800963 (Neb. Ct. App.).

that he may suffer harm if she does not provide services and that they may not be able to find a provider at the wages offered. They argued estoppel and laches and that the state should have to request a waiver. The court found none of these arguments persuasive. [42]

## Conclusion

The shortage of qualified providers in most states means that it is often difficult for all individuals to find the necessary providers. Many individuals rely on paid family members for the reliable, effective provision of supports. These difficulties may increase with the wage and hour rules on overtime requirements for home care workers that will soon go into effect.[43] Although the difficulty in finding providers may increase reliance on paid family support, there should be a sufficient network of non-family providers for the services. In addition, states cannot supplant needed paid services with natural, unpaid support unless those supports are provided voluntarily in lieu of an attendant.[44] Although states can set up policies for when a family member may provide services, any changes to provider policies should always consider the effect on access to providers. State policies regarding family providers are evolving and it is important to maintain focus on what the individual needs, maintaining sufficient providers to meet those needs reliably and how best to support a person's community living.

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[42] *Id.*

[43] U.S. Dep't of Labor, Fact Sheet #79F: Paid Family or Household Members in Certain Medicaid-Funded and Certain Other Publicly Funded Programs Offering Home Care Services under the Fair Labor Standards Act (FLSA) (June 2014), http://www.dol.gov/whd/regs/compliance/whdfs79f.htm. The rule goes into effect January 1, 2015, but the Department has announced a time-limited non-enforcement policy for six months and a subsequent six months during which the Department will exercise prosecutorial discretion, taking into consideration good faith efforts at compliance. U.S. Dep't of Labor, http://social.dol.gov/blog/an-announcement-concerning-the-home-care-final-rule/.

[44] *See, e.g.,* 42 C.F.R. § 441.540; *see also Jensen v. Missouri Dep't of Health & Senior Servs.*, 186 S.W.3d 857 (Mo. Ct. App. 2006) (holding state requirements regarding unmet need and undue hardship conflict with federal law because they consider family resources of adult recipients). In Jensen, the court determined that the State's waiver requirement regarding unmet need and undue hardship conflicted with federal law to the extent that they considered family resources of the adult recipient. Ms. Jensen had been receiving aide hours provided by her mother seven days a week. These hours were cut to five days a week on the basis that she had not document that it would not be an "undue hardship" for her parents to meet her needs on the additional two days. The assessment of Ms. Jensen indicated an unmet need for seven days per week, but because the evaluator determined that the family would meet her needs if a paid assistant were not available, the Department only authorized five days of paid assistance. *Id.*

# Application for a �1915(c) Home and Community-Based Services Waiver

## PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in �1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver�s target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

# Request for a Renewal to a �1915(c) Home and Community-Based Services Waiver

## 1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:

The Home and Community Based Services Waiver was AMENDED less than a year ago to include the following changes.

# Application for a �1915(c) Home and Community-Based Services Waiver

## 1. Request Information (1 of 3)

**A.** The State of **Kentucky** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of �1915(c) of the Social Security Act (the Act).

**B. Program Title** (*optional - this title will be used to locate this waiver in the finder*):

Home and Community Based Waiver

**C. Type of Request: renewal**

**Requested Approval Period:***(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **3 years** ● **5 years**

**Original Base Waiver Number: KY.0144**
**Waiver Number:KY.0144.R06.00**
**Draft ID: KY.001.06.00**

**D. Type of Waiver** *(select only one)*:

Regular Waiver

**E. Proposed Effective Date:** *(mm/dd/yy)*

08/01/15

**Approved Effective Date: 08/01/15**

## 1. Request Information (2 of 3)

**F. Level(s) of Care.** This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (*check each that applies*):

☐ **Hospital**

Select applicable level of care

Case managers employed by a qualified provider shall have:

## Appendix C: Participant Services

### C-2: General Service Specifications (1 of 3)

**a. Criminal History and/or Background Investigations.** Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- **No. Criminal history and/or background investigations are not required.**
- **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

All employees of enrolled waiver providers and representatives and employees of members participating in the Participant Directed Services Option are required to submit to a state criminal background check. DAIL will conduct

**b. Abuse Registry Screening.** Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

- **No. The State does not conduct abuse registry screening.**
- **Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

All employees of the waiver providers and employees of the Participant Directed Services Option non-medical waiver services are required to submit to screening through a State-maintained abuse registry. DMS or DAIL conduct

## Appendix C: Participant Services

### C-2: General Service Specifications (2 of 3)

**c. Services in Facilities Subject to §1616(e) of the Social Security Act.** *Select one:*

- **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**
- **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

## Appendix C: Participant Services

### C-2: General Service Specifications (3 of 3)

**d. Provision of Personal Care or Similar Services by Legally Responsible Individuals.** A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

- **No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- **Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

This service is available only through participant directed opportunities and only in specified extraordinary

e. **Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.** Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

- **The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- **The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

Under no circumstances may a legal guardian or an immediate family member provide traditional waiver services. Immediate family member is defined according to KRS 205.8451 as: a parent, grandparent, spouse, child, stepchild,

- **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

- **Other policy.**

Specify:

f. **Open Enrollment of Providers.** Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Provider enrollment is continuous and open to any individual or entity that meets provider qualifications. A potential provider may make application by contacting provider enrollment through a toll free number, completing the application

## Appendix C: Participant Services

### Quality Improvement: Qualified Providers

*As a distinct component of the State�s quality improvement strategy, provide information in the following fields to detail the State�s methods for discovery and remediation.*

a. **Methods for Discovery: Qualified Providers**

***The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.***

## Discussion: Items C-2-d and C-2-e

Items C-2-d and C-2-e address similar topics but are distinct. Both concern state policies regarding payment for the provision of waiver services by individuals who are related to the participant (and, in the case of Item C-2-e, a legal guardian of a participant). However, the scope of Item C-2-d is narrow. It solely concerns payment for the provision of *personal care or similar services by legally responsible individuals* (e.g., a parent of minor child or a spouse). The instructions for Item C-2-d below define "personal care or similar services."

Item C-2-e addresses state policies regarding the payment for the provision of *any type of waiver service* by a relative or legal guardian, including the provision of services other than personal care by legally responsible individuals (keeping in mind that the provision of personal care or similar services by such persons has been addressed in Item C-2-d). In this item, a state specifies whether it permits payments to relatives or legal guardians for waiver services and, if so, any conditions or limitations that the state places on such payments. For example, a state may decide to make payments to relatives or legal guardians only in certain circumstances, for limited periods of time, or permit payment to be made only to specified types of relatives (e.g., relatives who do not reside in the same household as the participant).

It is up to the state to decide whether to provide for either type of payment and, when such payments are made, to specify the circumstances when they are permitted. In the Appendix C-3 service specification template, there are check-offs as to whether the state allows for the provision of a service by a legally responsible individual and/or a relative/legal guardian. The conditions on payment specified in Items C-2-d and C-2-e apply to these check-offs. For example, if a state provides in Item C-2-e that a relative may furnish waiver transportation services only when there is no other provider available, then that that condition applies when "relative/legal guardian" is checked as a potential provider of the transportation service in Appendix C-3.

Whenever a legally responsible individual or relative/legal guardian is paid for the provision of a waiver service, the person must meet the provider qualifications that apply to a service and there must be a properly-executed provider agreement. In addition, other requirements such as the proper documentation and monitoring of the provision of services also apply.

## Item C-2-d: Provision of Personal Care or Similar Services by Legally Responsible Individuals

### Instructions

Select whether the waiver provides for *extraordinary care* payments to legally responsible individuals for the provision of personal care or similar services. If so, specify: (a) the types of legally responsible individual(s) who may be paid to furnish such services and the services they may provide; (b) applicable state policies that specify the circumstances when payment may be authorized for extraordinary care by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are used to ensure that payments are made only for services rendered.

### Technical Guidance

CMS policy is that payments for personal care or similar services delivered by *legally responsible individuals* (as defined in state law but typically the parent of a minor child or a spouse) are not eligible for Federal financial participation. Legally responsible individuals do not include the parent of an adult beneficiary (including a parent who also may be a legal

guardian) or other types of relatives, except as provided in state law). 42 CFR §440.167 prohibits FFP for payments to legally responsible individuals for the provision of State plan personal care services. This prohibition is based on the presumption that legally responsible individuals may not be paid for supports that they are ordinarily obligated to provide. See also Section 4442.3.B.1 of the *State Medicaid Manual.*

Through an HCBS waiver, a state may elect to make payment for personal care or similar services that are rendered by legally responsible individuals when such services are deemed extraordinary care so long as the state specifies satisfactory criteria for authorizing such payments. The criteria must include how the state will distinguish extraordinary from ordinary care. By extraordinary, CMS means care exceeding the range of activities that a legally responsible individual would ordinarily perform in the household on behalf of a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant and avoid institutionalization.

States are not required to, but may also specify other limitations, such as specific circumstances under which legally responsible individuals may be paid providers. Such limitations could include the lack of other providers who are available to serve the participant during periods when the legally responsible individual would otherwise be absent from the home and, thereby, must remain in the home to care for the participant or when the specific needs of the participant can only be met by a legally responsible individual. **In any case, providing for payments to legally responsible individuals is a state option, not a Federal requirement.**

In the context of this item, personal care or similar services mean: (a) personal care (assistance with ADLs or IADLs) whether furnished in the home or the community and however titled by the state in the waiver (e.g., personal assistance, attendant care, etc.) and (b) closely related services such as home health aide, homemaker, chore and companion services.

When a state provides for the payment to legally responsible individuals for extraordinary care, the service must meet all the waiver criteria required when delivered by a customary provider, as well as satisfy some additional protections. The legally responsible individual must meet the provider qualifications (as specified in Appendix C-3) that the state has established for the personal care or similar services for which payment may be made, and the state must conduct monitoring of such services as provided in Appendix D-2, including the required documentation and assurance that the services are delivered in accordance with the service plan. In addition, such arrangements require the proper execution of a provider agreement. State policies should include additional safeguards such as:

- Determining that the provision of personal care or similar services by a legally responsible individual is in the best interests of the waiver participant. A state should consider establishing safeguards when the legally responsible individual has decision-making authority over the selection of providers of waiver services to guard against self-referral.
- Limiting the amount of services that a legally responsible individual may furnish. For example, a state may decide to limit the amount to no more than 40 hours in a week and thereby take into account the amount of care that a legally responsible individual ordinarily would provide. When there is such a limitation, it should be reflected in the limitations section of the service specification in Appendix C-3.
- Implementing payment review procedures to ensure that the services for which payment is made have been rendered in accordance with the service plan and the conditions that the state has placed on the provision of such services.
- Addressing other foreseeable risks that might attend the provision of services by legally

responsible individuals.

In addition, states should be aware that unless the waiver uses institutional eligibility rules that disregard the family income of a child waiver participant, paying a legally responsible relative may affect the child's eligibility for Medicaid.

To summarize, when a state provides for payment to legally responsible individuals for the provision of personal care or similar services, the services will be equivalent to services supplied by other types of providers, with some additional protections. The waiver must specify:

- Whether payment is made to the parent(s) of minor children, spouses, or both or other (as defined by state law);
- The waiver personal care or similar services for which payment will be made;
- How the state distinguishes extraordinary care from ordinary care and any limitations of the circumstances under which payment will be authorized;
- Limitations on the amount of services for which payment will be made;
- How it is established that the provision of personal care or similar services by a legally responsible individual is in the best interests of the participant; and,
- How it is determined that payments are made for services rendered.

### CMS Review Criteria

When the waiver provides for the payment for personal care or similar services to legally responsible individuals for extraordinary care, the waiver specifies:

- The types of legally responsible individuals to whom payment may be made;
- The waiver personal care or similar services for which payment may be made;
- The method for determining that the amount of personal care or similar services provided by legally responsible individual is "extraordinary care," exceeding the ordinary care that would be provided to a person without a disability of the same age;
- Limitations on the amount of personal care or similar services for which payment may be made;
- How it is established that the provision of personal care or similar services by a legally responsible individual is in the best interests of the participant; and,
- The procedures that are used to ensure that payments are made for services rendered.

## Item C-2-e: State Policies Concerning Payment for Waiver Services Furnished by Relatives/ Legal Guardians

### Instructions

**This item concerns state policies regarding payment for waiver services rendered by relatives and/or legal guardians that do not fall within the scope of Item C-2-d.** Select whether the state makes payments to relatives or legal guardians for any waiver service (besides personal care or a similar service furnished by a legally responsible individual as described in C-2-d). If the state makes payments to relatives and/or legal guardians for waiver services, select one of the next three choices and provide the additional information under the selected choice.

### Technical Guidance

At the option of the state, waiver services may be provided by a relative and/or legal guardian of the participant. When responding to this item, keep in mind that Item C-2-d addresses

# Application for a §1915(c) Home and Community-Based Waiver [Version 3.5, Includes Changes Implemented through November 2014]

# Instructions, Technical Guide and Review Criteria

## Release Date: January 2015

Disabled and Elderly Health Programs Group
Center for Medicaid and State Operations
Centers for Medicare & Medicaid Services
Department of Health and Human Services

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## Discussion: Items C-2-d and C-2-e

Items C-2-d and C-2-e address similar topics but are distinct. Both concern state policies regarding payment for the provision of waiver services by individuals who are related to the participant (and, in the case of Item C-2-e, a legal guardian of a participant). However, the scope of Item C-2-d is narrow. It solely concerns payment for the provision of *personal care or similar services by legally responsible individuals* (e.g., a parent of minor child or a spouse). The instructions for Item C-2-d below define "personal care or similar services."

Item C-2-e addresses state policies regarding the payment for the provision of *any type of waiver service* by a relative or legal guardian, including the provision of services other than personal care by legally responsible individuals (keeping in mind that the provision of personal care or similar services by such persons has been addressed in Item C-2-d). In this item, a state specifies whether it permits payments to relatives or legal guardians for waiver services and, if so, any conditions or limitations that the state places on such payments. For example, a state may decide to make payments to relatives or legal guardians only in certain circumstances, for limited periods of time, or permit payment to be made only to specified types of relatives (e.g., relatives who do not reside in the same household as the participant).

It is up to the state to decide whether to provide for either type of payment and, when such payments are made, to specify the circumstances when they are permitted. In the Appendix C-3 service specification template, there are check-offs as to whether the state allows for the provision of a service by a legally responsible individual and/or a relative/legal guardian. The conditions on payment specified in Items C-2-d and C-2-e apply to these check-offs. For example, if a state provides in Item C-2-e that a relative may furnish waiver transportation services only when there is no other provider available, then that that condition applies when "relative/legal guardian" is checked as a potential provider of the transportation service in Appendix C-3.

Whenever a legally responsible individual or relative/legal guardian is paid for the provision of a waiver service, the person must meet the provider qualifications that apply to a service and there must be a properly-executed provider agreement. In addition, other requirements such as the proper documentation and monitoring of the provision of services also apply.

## Item C-2-d: Provision of Personal Care or Similar Services by Legally Responsible Individuals

### Instructions

Select whether the waiver provides for *extraordinary care* payments to legally responsible individuals for the provision of personal care or similar services. If so, specify: (a) the types of legally responsible individual(s) who may be paid to furnish such services and the services they may provide; (b) applicable state policies that specify the circumstances when payment may be authorized for extraordinary care by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are used to ensure that payments are made only for services rendered.

### Technical Guidance

CMS policy is that payments for personal care or similar services delivered by *legally responsible individuals* (as defined in state law but typically the parent of a minor child or a spouse) are not eligible for Federal financial participation. Legally responsible individuals do not include the parent of an adult beneficiary (including a parent who also may be a legal

guardian) or other types of relatives, except as provided in state law). 42 CFR §440.167 prohibits FFP for payments to legally responsible individuals for the provision of State plan personal care services. This prohibition is based on the presumption that legally responsible individuals may not be paid for supports that they are ordinarily obligated to provide. See also Section 4442.3.B.1 of the *State Medicaid Manual.*

Through an HCBS waiver, a state may elect to make payment for personal care or similar services that are rendered by legally responsible individuals when such services are deemed extraordinary care so long as the state specifies satisfactory criteria for authorizing such payments. The criteria must include how the state will distinguish extraordinary from ordinary care. By extraordinary, CMS means care exceeding the range of activities that a legally responsible individual would ordinarily perform in the household on behalf of a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant and avoid institutionalization.

States are not required to, but may also specify other limitations, such as specific circumstances under which legally responsible individuals may be paid providers. Such limitations could include the lack of other providers who are available to serve the participant during periods when the legally responsible individual would otherwise be absent from the home and, thereby, must remain in the home to care for the participant or when the specific needs of the participant can only be met by a legally responsible individual. **In any case, providing for payments to legally responsible individuals is a state option, not a Federal requirement.**

In the context of this item, personal care or similar services mean: (a) personal care (assistance with ADLs or IADLs) whether furnished in the home or the community and however titled by the state in the waiver (e.g., personal assistance, attendant care, etc.) and (b) closely related services such as home health aide, homemaker, chore and companion services.

When a state provides for the payment to legally responsible individuals for extraordinary care, the service must meet all the waiver criteria required when delivered by a customary provider, as well as satisfy some additional protections. The legally responsible individual must meet the provider qualifications (as specified in Appendix C-3) that the state has established for the personal care or similar services for which payment may be made, and the state must conduct monitoring of such services as provided in Appendix D-2, including the required documentation and assurance that the services are delivered in accordance with the service plan. In addition, such arrangements require the proper execution of a provider agreement. State policies should include additional safeguards such as:

- Determining that the provision of personal care or similar services by a legally responsible individual is in the best interests of the waiver participant. A state should consider establishing safeguards when the legally responsible individual has decision-making authority over the selection of providers of waiver services to guard against self-referral.
- Limiting the amount of services that a legally responsible individual may furnish. For example, a state may decide to limit the amount to no more than 40 hours in a week and thereby take into account the amount of care that a legally responsible individual ordinarily would provide. When there is such a limitation, it should be reflected in the limitations section of the service specification in Appendix C-3.
- Implementing payment review procedures to ensure that the services for which payment is made have been rendered in accordance with the service plan and the conditions that the state has placed on the provision of such services.
- Addressing other foreseeable risks that might attend the provision of services by legally

responsible individuals.

In addition, states should be aware that unless the waiver uses institutional eligibility rules that disregard the family income of a child waiver participant, paying a legally responsible relative may affect the child's eligibility for Medicaid.

To summarize, when a state provides for payment to legally responsible individuals for the provision of personal care or similar services, the services will be equivalent to services supplied by other types of providers, with some additional protections. The waiver must specify:

- Whether payment is made to the parent(s) of minor children, spouses, or both or other (as defined by state law);
- The waiver personal care or similar services for which payment will be made;
- How the state distinguishes extraordinary care from ordinary care and any limitations of the circumstances under which payment will be authorized;
- Limitations on the amount of services for which payment will be made;
- How it is established that the provision of personal care or similar services by a legally responsible individual is in the best interests of the participant; and,
- How it is determined that payments are made for services rendered.

**CMS Review Criteria**

When the waiver provides for the payment for personal care or similar services to legally responsible individuals for extraordinary care, the waiver specifies:

- The types of legally responsible individuals to whom payment may be made;
- The waiver personal care or similar services for which payment may be made;
- The method for determining that the amount of personal care or similar services provided by legally responsible individual is "extraordinary care," exceeding the ordinary care that would be provided to a person without a disability of the same age;
- Limitations on the amount of personal care or similar services for which payment may be made;
- How it is established that the provision of personal care or similar services by a legally responsible individual is in the best interests of the participant; and,
- The procedures that are used to ensure that payments are made for services rendered.

## Item C-2-e: State Policies Concerning Payment for Waiver Services Furnished by Relatives/ Legal Guardians

### Instructions

**This item concerns state policies regarding payment for waiver services rendered by relatives and/or legal guardians that do not fall within the scope of Item C-2-d.** Select whether the state makes payments to relatives or legal guardians for any waiver service (besides personal care or a similar service furnished by a legally responsible individual as described in C-2-d). If the state makes payments to relatives and/or legal guardians for waiver services, select one of the next three choices and provide the additional information under the selected choice.

### Technical Guidance

At the option of the state, waiver services may be provided by a relative and/or legal guardian of the participant. When responding to this item, keep in mind that Item C-2-d addresses