authorized by the above-cited provisions of law. A copy of the General Counsel's certification will be posted for public inspection at the Corporation's headquarters, located at 750 First Street, NE., Washington, D.C. 20002, in its three reception areas, and will otherwise be available upon request.

OPEN SESSION:

1. Approval of Agenda.
2. Approval of Minutes of May 17, 1992 Meeting
3. Consideration of the Office of the Inspector General's Proposed Guidelines for the Corporation Annual Financial Audit.
4. Consideration of the Office of the Inspector General's Investigative Reporting Process.

CLOSED SESSION:

5. Approval of Minutes of May 17, 1992 Executive Session.
6. Consideration of Report on Current Investigations of the Office of the Inspector General.

OPEN SESSION: (Resumed)

7. Consideration of Motion to Adjourn Meeting.

CONTACT PERSON FOR INFORMATION: Patricia D. Batie, Executive Office, (202) 336–8896.

Date Issued: June 26, 1992.

Patricia D. Batie,

Corporate Secretary.

[FR Doc. 92–15484 Filed 6–26–92; 2:58 pm]

BILLING CODE 7050–01–M

LEGAL SERVICES CORPORATION BOARD OF DIRECTORS

Operations and Regulations Committee Meeting; Notice

TIME AND DATE: A meeting of the Board of Directors Operations and Regulations Committee will be held on July 13, 1992. The meeting will commence at 3:00 p.m.

PLACE: Drake University, The Neal and Bea Smith Law Center, 2400 University Avenue, The Law Library, Des Moines, Iowa 50311, (515) 271–3851.

STATUS OF MEETING: Open.

MATTERS TO BE CONSIDERED:

OPEN SESSION:

1. Approval of Agenda.
2. Approval of Minutes of May 18, 1992 Meeting.
3. Consideration of Report By Staff Regarding Competition Demonstration Projects.

CONTACT PERSON FOR INFORMATION: Patricia Batie, Executive Office, (202) 336–8896.

Date issued: June 26, 1992.

Patricia D. Batie,

Corporate Secretary.

[FR Doc. 92–15485 Filed 6–26–92; 2:58 pm]

BILLING CODE 7050–01–M

NATIONAL TRANSPORTATION SAFETY BOARD:

TIME AND DATE: 9:30 a.m., Wednesday, July 8, 1992.

PLACE: NTSB Board Room, 5th Floor, 490 L'Enfant Plaza, SW., Washington, D.C. 20594.

STATUS: Open.

MATTERS TO BE CONSIDERED:

5795—Aircraft Accident Summary Report: Controlled Flight Into Terrain, Bruno's, Inc., Beechjet, N25BR, Rome, Georgia, December 11, 1991

5788—Amendment to Memorandum of Agreement Between FAA and NTSB for Postaccident/Postincident Review of Airman and Air Traffic Controller Medical Records

NEWS MEDIA CONTACT: (202) 382–0660.

FOR MORE INFORMATION CONTACT: Bea Hardesty; (202) 382–6525.

Dated: June 26, 1992.

Ray Smith,

Alternate Federal Register Liaison Officer.

[FR Doc. 92–15472 Filed 6–26–92; 2:07 pm]

BILLING CODE 7533–01–M

NUCLEAR REGULATORY COMMISSION

DATE: Weeks of June 29, July 6, 13, and 20, 1992.

PLACE: Commissioners' Conference Room, 11555 Rockville Pike, Rockville, Maryland.

STATUS: Open and Closed.

MATTERS TO BE CONSIDERED:

Week of June 29

Thursday, July 2

9:30 a.m.
Periodic Briefing on Operating Reactors and Fuel Facilities (Public Meeting)

11:30 a.m.
Affirmation/Discussion and Vote (Public Meeting)
a. Commission Response to Motion to Modify or Quash Subpoenas in the Matter of Houston Lighting and Power Company (South Texas, Units 1 and 2) (Tentative)

Week of July 6—Tentative

Wednesday, July 8

11:30 a.m.
Affirmation/Discussion and Vote (Public Meeting) (if needed)

Week of July 13—Tentative

Tuesday, July 14

11:30 a.m.
Affirmation/Discussion and Vote (Public Meeting) (if needed)

Week of July 20—Tentative

Monday, July 20

11:30 a.m.
Affirmation/Discussion and Vote (Public Meeting) (if needed)

Note: Affirmation sessions are initially scheduled and announced to the public on a time-reserved basis. Supplementary notice is provided in accordance with the Sunshine Act as specific items are identified and added to the meeting agenda. If there is no specific subject listed for affirmation, this means that no item has as yet been identified as requiring any Commission vote on this date.

To Verify the Status of Meeting Call (Recording)—(301) 504–1292.

CONTACT PERSON FOR MORE INFORMATION: William Hill (301) 504–1661.

Dated: June 25, 1992.

William M. Hill, Jr.,

Office of the Secretary.

[FR Doc. 92–15476 Filed 6–26–92; 2:09 pm]

BILLING CODE 7590–01–M

Corrections

Federal Register
Vol. 57, No. 126
Tuesday, June 30, 1992

This section of the FEDERAL REGISTER contains editorial corrections of previously published Presidential, Rule, Proposed Rule, and Notice documents. These corrections are prepared by the Office of the Federal Register. Agency prepared corrections are issued as signed documents and appear in the appropriate document categories elsewhere in the issue.

DEPARTMENT OF COMMERCE

Foreign-Trade Zones Board

[Docket 10-92]

Foreign-Trade Zone 77-Memphis, TN; Application for Expansion for Subzone 77A Sharp Television, Microwave Oven and Computer Plant, Memphis, TN

Correction

In notice document 92-10107 appearing on page 18467 in the issue of Thursday, April 30, 1992, make the following corrections:

1. On page 18467, in the second column, in the fourth full paragraph, in the sixth line following "is" insert "June 30, 1992."; and in the eighth line following "15-day period" insert "July 8, 1992.

BILLING CODE 1505-01-D

DEPARTMENT OF EDUCATION

Demonstration Projects for the Integration of Vocational and Academic Learning Program (Model Tech-Prep Education Projects)

Correction

In notice document 92-12144 beginning on page 22118, in the issue of Tuesday, May 26, make the following corrections:

1. On page 22122, in the second column, under **REQUIRED ACTIVITIES**, in the second line "may" should read "any".

2. On the same page, in the third column, in the fourth paragraph designated (d), in the first line "on" should read "no".

BILLING CODE 1505-01-D

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket Nos. ER92-618-000, et al.]

Interstate Power Co. et al.; Electric Rate, Small Power Production, and Interlocking Directorate Filings

Correction

In notice document 92-14668 beginning on page 27966 in the issue of Tuesday, June 23, 1992 make the following corrections:

1. On page 27967, in the third column, under "**12. Florida Power & Light Co.**", the next line should read "[Docket No. ER92-635-000]".

2. On page 27968, in the first column, under "**15. Florida Power & Light Co.**", the next line should read "[Docket No. ER92-633-000]".

BILLING CODE 1505-01-D

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

21 CFR Parts 5, 20, 100, 101, 105, and 130

[Docket No. 92N-0198]

Nutrition Labeling; Small Business Exemption Public Forums

Correction

In proposed rule document 92-10732 beginning on page 19410 in the issue of Wednesday, May 6, 1992 make the following corrections:

On page 19411, in the third column, in the last paragraph, in the third line, "request a" should read "request to" and in the sixth line, "Inspector" should read "Inspection".

BILLING CODE 1505-01-D

DEPARTMENT OF LABOR

Occupational Safety and Health Administration

29 CFR Part 1926

[Docket No. H-033-d]

Occupational Exposure to Asbestos, Tremolite, Anthophyllite and Actinolite

Correction

In rule document 92-12903 beginning on page 24310 in the issue of Monday, June 8, 1992, make the following correction:

On page 24331, in the second column, in amendatory instruction 5e. to § 1926.58, in the second line from the bottom, "(m)(2)(ii)(B)" should read "(n)(2)(ii)(B)".

BILLING CODE 1505-01-D

SECURITIES AND EXCHANGE COMMISSION

17 CFR Parts 230 and 240

[Release Nos. 33-6932; 34-30577; IC-18651]

RIN 3235-AD54

Blank Check Offerings

Correction

In rule document 92-9605 beginning on page 18037 in the issue of Tuesday, April 28, 1992, make the following corrections:

1. On page 18038, in the third column, in the second paragraph, in the fifth line from the bottom, "as" should read "at".

2. On page 18040, in the second column, in heading designation 2., "and" should read "an".

BILLING CODE 1505-01-D

SECURITIES AND EXCHANGE COMMISSION

[Securities Exchange Act of 1934 Release No. 30609]

Order Temporarily Exempting Broker-Dealers From Section 15(g)(2) of the Securities Exchange Act of 1934

Correction

In notice document 92-9603 appearing on page 18050 in the issue of Tuesday, April 28, 1992, the docket number should read as set forth above.

BILLING CODE 1505-01-D

DEPARTMENT OF TRANSPORATION

Coast Guard

33 CFR Part 117

[CGD5-92-001]

Drawbridge Operation Regulations; Beaufort Channel, Beaufort, NC

Correction

In rule document 92-4368 beginning on page 6677 in the issue of Thursday, February 27, 1992, in the first column, under **EFFECTIVE DATES** "March 30, 1997." should read "March 30, 1992."

BILLING CODE 1505-01-D

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Parts 25, 121, and 135

[Docket No. 26530, Amdt. Nos. 25-76, 121-228 and 135-43]

RIN 2120-AC46

Improved Access to Type III Exits

Correction

In rule document 92-10306 beginning on page 19220 in the issue of Monday, May 4, 1992, make the following corrections:

1. On page 19220:

a. In the first column, under **SUMMARY**, in the seventh line, "results" should read "result".

b. In the 3d column, in the 23d line, "different" was misspelled.

2. On page 19227, in the third column, in the second full paragraph, in the first line, before "configuration" insert "a".

3. On page 19231, in the first column, in the first paragraph, in the fourth line, "Type JII" should read "Type III".

4. On page 19237, in the second column, in the first full paragraph, in the second line, "researchers" was misspelled.

§ 25.813 [Corrected]

5. On page 19244:

a. In the second column, in § 25.813(a), beginning in the fifth line from the bottom, "two more more" should read "two or more".

b. In the same column, in § 25.813(c)(1), in the second line, after "nearest" insert "aisle".

c. In the third column, in § 25.813(c)(2)(i), in the fourth line, after "must" insert "not".

§ 121.310 [Corrected]

6. On page 19245:

a. In the first column, in § 121.310(f)(3)(ii), in the last line, "certified" should read "certificated".

b. In the same column, in § 121.310(f)(3)(iv), in the ninth line, "compliance" was misspelled.

c. In the same column, after the last line of § 121.310(f)(3)(v), there should be five stars.

§ 135.178 [Corrected]

d. In the second column, in § 135.178(b)(1), in the last line, "location" should read "locating".

e. In the third column, in § 135.178(c)(1), in the second line, "location" should read "locating".

BILLING CODE 1505-01-D

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. 90-NM-167-AD]

Airworthiness Directives; McDonnell Douglas Model DC-10 Series Airplanes

Correction

In proposed rule document 92-13503 beginning on page 24395 in the issue of Tuesday, June 9, 1992 make the following correction:

§ 39.13 [Corrected]

On page 24401, in the first column, in § 39.13(f)(2), in the first line, after "have" insert "not".

BILLING CODE 1505-01-D

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. 91-NM-274-AD]

Airworthiness Directives; Boeing Model 737 Series Airplanes

Correction

In proposed rule document 92-6255 beginning on page 9392 in the issue of Wednesday, March 18, 1992, make the following corrections:

§ 39.13 [Corrected]

On page 9394:

a. In the first column, in § 39.13(g)(1), in the third line, after "must" insert "be" and in the same line, "inspect" should read "inspected".

b. In the same column, in the same paragraph, in the sixth line, after "replaced" insert "with protruding head solid fasteners with" and remove "until".

c. In the same column, in § 39.13(g)(2), in the second line, "but" should read "must". And in the third line, "fastnerships" should read "fasteners".

BILLING CODE 1505-01-D

federal register

Tuesday
June 30, 1992

Part II

Department of Labor

Employment and Training Administration

Unemployment Insurance Performance Measurement Project; Unemployment Insurance Program Letter No. 30–92; Notice

DEPARTMENT OF LABOR

Employment and Training Administration

Unemployment Insurance Performance Measurement Project; Unemployment Insurance Program Letter No. 30-92

This Unemployment Insurance Program Letter transmits to the States performance measures which the Unemployment Insurance Service proposes to field test in up to six State Employment Security Agencies. The intent of the revised measures is to strengthen the oversight of the Federal-State Unemployment Compensation program thereby promoting improved services.

Public comment is solicited with regard to the operational feasibility of implementing these measures as well as how the measures can be used for management improvement purposes. Comments should be sent to Mary Ann Wyrsch, Director, Unemployment Insurance Service, room S-4231, 200 Constitution Ave. NW., Washington, DC 20210. Comments will be accepted through August 15, 1992.

No decisions have been made at this time concerning the nation-wide implementation of the proposed performance measures. The Department will make these decisions after evaluating the results of the field test, and in consultation with stakeholders in the UI system.

For further information contact William Coyne or Sally Ehrle on (202) 535-0623.

Signed at Washington, DC, on June 18, 1992.

Roberts T. Jones,

Assistant Secretary of Labor.

Classification: UI/PMR Project
Correspondence Symbol: TEU.

Dated: June 11, 1992.

Directive: Unemployment Insurance Program Letter No. 30-92.
To: All State Employment Security Agencies.
From: Donald J. Kulick, Administrator for Regional Management.
Subject: Status of Unemployment Insurance (UI) Program Performance Measurement Review (PMR) Project.

Rescissions: None.

Expiration Date: September 30, 1993.

1. Purpose

a. To convey decisions reached by the UI system based on UI National Office, Regional and State participation on the PMR project, including performance measures to be field tested.

b. To obtain comments on the feasibility of obtaining data for the proposed measures and their potential use for encouraging program improvement.

c. To obtain from States expressions of interest in serving as a field test site.

2. References

Federal Register Notice No. 54 FR 2238; Unemployment Insurance Program Letter (UIPL) No. 10-89; UIPL No. 13-91.

3. Project Status

The PMR project began in the latter part of 1988. Its purpose is to examine, evaluate and improve the mechanisms for performance measurement in the UIS oversight of State Employment Security Agency (SESA) UI Programs.

From 1988-1991, work was directed to oversight system design. This phase involved: (1) Identifying legal responsibilities that could require performance measurement; (2) identifying alternative performance measures for basic UI service areas, including benefit payments, adjudications, appeals and benefit payment control; (3) selecting measures to be tested based on criticality, potential State agency management and Federal oversight use and cost, among other factors; (4) determining how data will be obtained and stored; and (5) preparing a preliminary field test design for revised measures. The next phase of the project is the field test of selected measures which is described below.

4. Field Test

The field test to be conducted in up to six States, will provide information about the operational feasibility of data collection as well as the need for and use of collected data. In preparation for the test, measures will be refined and a final field test design prepared.

The measures selected for field testing build on and strengthen the Quality Appraisal process. The attachment to this UIPL provides further background on the project, the current status, and the performance measures selected for the field test.

Information on the field test and the application process for serving as a field test State will be provided to each Regional Office which will in turn share this information with States. Selection criteria will be applied by a National Office panel to SESA applications received through the Regional offices. The selection criteria are as follows:

a. Geographic representation;

b. Claims workload (we expect to select States with various workload levels);

c. States selected should have a level of automation adequate to support the additional requirements of the field test including the availability of staff to program and retrieve needed information; and

d. Commitment by SESA management.

5. Action Required

SESA Administrators are invited to:

a. Provide copies of this UIPL and Attachments to appropriate staff for comment on: (1) the feasibility of obtaining data for the proposed measures, and (2) the potential use of the measures for program improvement purposes;

b. Forward comments to the appropriate Regional Office by August 15, 1992. Comments will be taken into consideration in field test planning; and

c. Inform the appropriate Regional Office of potential interest in serving as a field test State. Additional information on the field test will be available shortly, including information on funding, ADP assumptions for the field test and field test processes and time schedules.

6. Inquiries

Direct any questions to the appropriate Regional Office.

7. Attachment

Performance Measurement Review Phase I, Project Design.

[Attachment to UIPL No. 30-92]

Performance Measurement Review (PMR) Phase I, Project Design

I. Background

The PMR project was initiated in 1988 to examine, evaluate, and improve the mechanisms for performance measurement in UIS oversight of State Unemployment Insurance (UI) programs. The project envisioned three stages. The first stage, a design stage, defined performance measures to be field tested. Subsequent stages are field testing of the proposed performance measures to determine value and operational feasibility and finally, nationwide implementation of measures.

A. Project Objectives

The specific objectives of the PMR project are to:

1. Review the Secretary of Labor's legal responsibilities for the UI program and to ensure they are identified and monitored;

2. Identify gaps and overlaps which now exist in assessing SESA performance and recommend solutions;

3. Identify and justify alternative methods of evaluating SESAs' UI performance;

4. Examine and establish new methods of measuring performance and

determine, where appropriate, what constitutes a minimum level of performance;

5. Examine linkages between components of the UI oversight program; and

6. Develop and recommend a comprehensive oversight system integrating findings and results of the components of the overall UI program.

B. Project Criteria

The following criteria have been used during the process of decisionmaking in order to come up with measures that are directed toward improved performance of the system:

1. Criticality—Fulfilling the Secretary's essential legal oversight responsibilities.

2. Management-Oriented—Capable of providing timely detection of performance problems that can serve as the basis for management action. The measures should, therefore, relate to operations and be useful to managers to improve performance. This criterion relates closely to the criterion of continuous improvement espoused by Total Quality Management.

3. Operationally Feasible—Capable of operating within cost and resource constraints and can be obtained as a byproduct of operations in the SESAs.

4. Customer-Oriented—Defining and measuring quality service to claimants and employers.

5. Outcome Focused—Failing to achieve a desired level of performance, such as timely payments, should trigger a more thorough analysis of detailed data and/or review of the administrative processes employed by a SESA.

6. Quantitatively Based—Measures are objective and free from discretionary judgment as much as possible.

7. Statistically Valid—Employing sampling methods which provide confidence in the results.

C. Development of Measures

Following the initial performance period of the PMR project (see UIPL No. 13–91), Macro International, Inc., was selected to provide contractor support to the PMR project in the fall of 1990. As technical advisors to the contractor, twenty-one SESA representatives served as State Experts or Service Area Specialists in the area of benefits, adjudications, appeals and benefit payment control. In addition, a Federal Steering Committee was established composed of a representative from each of the 10 Federal Regions as well as National Office experts in the areas of Federal legislation, Regional Office operations, Benefit Quality Control, appeals, nonmonetary determinations and benefit payment control. Subsequently, several meetings of the PMR Steering Committee, the State Expert Panel and State Service Area Specialists were held. These meetings involved the review and development of performance measures including reaction to contractor-developed materials and proposals. In addition, discussion sessions were held across the country in order to obtain Regional and State perspectives on changes needed in the Quality Appraisal system.

The process which resulted in the selection of measures for the field test began with a review of statutory requirements in order to determine gaps in the measurement process. The process then involved soliciting State suggestions on needed changes, brainstorming and refining alternatives and finally selecting the final measures for testing.

D. State Participation

The State Employment Security Agencies (SESAs) have contributed significantly to the results of this process during Phase I, the design stage. Recommendations received from SESAs in response to UIPL No. 10–89, dated January 4, 1989, were considered as the work progressed. SESA representatives, from most States, attended meetings in the fall of 1990 on ways the current Quality Appraisal (an existing performance measurement system) could be modified. Finally, twenty-one SESA experts and service area specialists served on a contractor panel at UIS' request to provide and react to proposals.

E. Accomplishments

Work to meet the objectives of the PMR project is well underway. The legal responsibilities of the Secretary for the UI program have been identified. Several gaps (and some overlaps) have been identified regarding SESA performance and solutions to these gaps are proposed in the measures. Alternative methods of evaluating SESA's UI performance have been developed and examined, particularly in the service areas of benefits, adjudication and lower authority appeals. Also, the examination of the linkages between components of the UI oversight program has begun.

The following contractor reports have been submitted by the contractor and accepted by the Department of Labor: (1) A Recommended Alternatives Report (June 1991) and (2) a Selected Alternatives Report (November 1991).

II. Status

A. The Design Stage

• The development of measures to be field tested—is largely complete. This stage will be followed by a field test of selected alternative measures.

• The measures listed in this UIPL are still subject to comment. Comments received from within the Federal-State UI partnership on the proposed measures will be considered to identify changes, if any, needed in the measures to be tested.

B. Field Test

• The field test will include up to six States and will run for 15 months to secure 12 months of performance data concerned with timeliness and selected quality data. The data collected during the first 3 months will be used to ensure that the procedures are in place. The schedule will allow data collection over a full 12-month cycle.

In addition to the collection of performance data, field test States will collect information on costs and potential uses of the data for State management purposes.

One of the participating States will also serve as host State. The host State will secure an evaluation contract with an independent research contractor who will design, monitor and evaluate the field test and provide specified logistical support.

• The objectives of the field test are to: (1) Evaluate the usefulness of the revised measures in evaluating State performance; (2) determine that the needed information can be obtained in an efficient manner; (3) determine changes in the revised measures, if needed; (4) devise a method for data validation; and (5) provide a basis for establishing an approach to the development of benchmarks of minimum performance, if deemed appropriate.

• Plans call for Cooperative Agreements to be signed with the States selected to field test by September 30, 1992.

• As stated in the objectives above, data gathered during the field test will be used to determine if changes are needed in the measures before the final performance measures are agreed upon and implementation begins.

C. Implementation

Finally, there will be a phased-in period for implementation of revised performance measures (dates yet to be determined).

III. UIS Executive Decisions, Phase I, the Design Stage

Decisions reached (see Section IV) can be described as incremental change within a modified Quality Appraisal system. That is, certain changes in the system will be tested to determine the improvements that might be achieved through use of these measures.

The selected alternative measures will achieve one or more of the following objectives: (a) Overcome a gap in the oversight system; (b) provide timely information to Federal and State management which can foster continuous improvement; (c) strengthen the statistical validity of the performance data; (d) direct the UIsystem toward better customer service by a focus on outcomes while retaining some process information to identify the source of problems; and (e) strengthen or change existing scoring instruments (review guides) based on current experience.

A. General Direction

A goal of the Department of Labor and the Unemployment Insurance Service is the establishment of an integrated, rationalized and comprehensive oversight system, that will not only serve the Secretary's responsibilities for oversight, but will also assist States to continuously improve the way they operate.

This system will integrate the current Benefits Quality Control and Quality Appraisal systems, as well as the planned Revenue Quality Control program. Optimally, this integrated system will also result in revised report requirements, which eliminate duplication, and also contain reports validation features, which assure the quality of data used for oversight and for decisions on continuous improvement.

Resource constraints and the magnitude of the tasks involved prevent the UIS from implementing such a system in a single step. Instead, UIS will utilize a building block approach, which will address a particular aspect of change or modifications required in the oversight system. The changes proposed for certain Quality Appraisal measures represent one of these changes. Other components of the oversight system, which will be addressed in the next year or two are:

1. Benefits Quality Control will be examined to determine if any modification in design is warranted. The review will weigh experience to date, the need for assessing the accuracy of other claims (e.g., denials), and resource constraints;

2. Revenue Quality Control, currently not part of the PMR process, will produce a set of measures to evaluate State UI tax operations—thus, PMR has concentrated on the benefit payment process, rather than on the tax collection process;

3. Cash Management will establish minimum satisfactory levels of performance to be subsequently incorporated;

4. Higher Authority appeals quality measures will be addressed in subsequent timeframes due to several considerations including effective administration of selected measures. Field testing will be delayed until a method is developed to effectively administer them;

5. Benefit Payment Control and Program Reviews (UCX, UCFE, EB, DUA, TRA, Interstate) will be examined in the future and incorporated, when ready; and

6. The Workload Validation process will be evaluated in conjunction with reports validation concepts arising from reviews of required reports and from the Revenue Quality Control effort. A revised workload/reports validation system to support all UIS oversight systems will be developed.

B. Selected Measures

This section lists timeliness and quality measures recommended for field test. Additional field test information is listed in Appendices 1–3.

1. *Timeliness measures.* Timeliness measurement is important to the UI System to ensure that the "payment when due" provision (section 303(a)(1) of the Social Security Act is met.

The measures selected fill in gaps in the current system. Transactions which are currently excluded from performance measurement will be included. For example, in the area of first payments, all first payments will be measured rather than only those first payments for a week of total unemployment. In adjudication the measurement goes beyond the four issues currently defined for workload purposes to include all adjudications. Other measures will examine certain aspects of the program not currently covered, such as continued claim payments, redeterminations, and implementation of adjudications and appeals decisions.

All timeliness measures will be based on universe data rather than on samples. The results will therefore be more accurate, more comprehensive in scope, and, by the use of automation, more cost effective. The distribution for each timeliness measure (except for decision implementation) will be drawn from automated records and reported monthly by the States. The timely availability of data for analysis is expected to facilitate oversight and the goal of continuous improvement. Finally, where applicable, the universe of cases measured for timeliness is the frame for the selection of a sample used to measure the adjudication; lower authority appeals; and CWC transfer, billing and reimbursement quality. The following defines the timeliness measures selected by the UI service for field testing. (See Appendix 1.)

a. First Payment Timeliness (Initial Claims). The length of time from the end of the first (earliest) compensable week in the benefit year to the date the payment is issued is measured. This includes all payments, e.g., total, part-total and partial. Currently, the measurement is restricted to the first payment issued for a week of total unemployment.

b. Continued Claim Payment Timeliness. The length of time from the end of each week paid (whether total or partial) to the date the check was issued. This measure includes all weeks paid subsequent to the first week compensated in the benefit year. This is a new measure.

c. Adjudication Timeliness. The length of time to adjudicate all statutory issues which have the potential to adversely affect claimant benefit rights. Currently, the performance is measured by a sample of 125 additional claims and weeks claimed issues which excludes new claims issues. This definition is expanded to include all claims issues.

d. Adjudication Implementation Timeliness. The length of time between the date that the adjudication decision is issued and the date the outcome is applied to the claim record. This is a new measure to determine the length of time it takes to implement the determination outcome to the claim record and to ensure the obligation under the *Java* decision to pay benefits as soon as administratively feasible following the determination that eligibility is met. This information will be collected in the field test from the sample of decisions measured for quality.

e. Adjudication Redetermination Timeliness. Two measures are being tested: (1) Time lapse between the end of the week affected by the redetermination and the date that the redetermination was issued; and (2) time lapse between the date the redetermination was requested and the date the redetermination is issued. These are new measures which gather

universe information on the impact of redeterminations on time lapse.

f. Lower Authority Appeals Timeliness. The length of time between the date that the request for hearing is filed and the date the decision is issued. No change from the current measure.

g. Lower Authority Decision Implementation Timeliness. The length of time between the date that the decision is issued and the date the outcome is applied to the claim record. This is a new measure to determine compliance with the obligation to implement an administrative decision promptly. This information will be collected during the field test from the sample measured for quality.

h. Higher Authority Appeals Timeliness. The length of time between the date the request for a Higher Authority appeal is filed and the date that the decision is issued. No change from the current measure.

i. Combined Wage Claims—Wage Transfer Timeliness. The length of time between the date that the transfer request is received and the date that the data which completes the transfer are sent to the paying State. No change from the current measure.

j. Combined Wage Claims—Billing Timeliness. The length of time from the end of the calendar quarter to the date that reimbursement requests (billings) were mailed to the transferring States. Universe data obtained from the paying State's CWC records will be measured rather than a sample as is currently done.

k. Combined Wage Claims—Reimbursement Timeliness. The length of time from the date that the transferring State receives the reimbursement request to the date that payment is mailed to the paying State. Universe data will be used rather than a sample as is currently done.

2. Quality measures. The quality measures proposed for field testing are: (1) Adjudications Quality, (2) Lower Authority Appeals Quality and (3) Combined Wage Claim Quality. A measure of the quality of Higher Appeals was considered, but not selected for field testing due to the need to do further work on the measure itself, as well as on the implementation of the measure.

a. Adjudication quality. The measure for adjudication would build on and improve the current Quality Performance Index (QPI) measurement system. The definition of adjudication quality is the assessment of the likelihood that a State is adequately adjudicating a preset percentage of all issues.

The proposed adjudications measurement review system is intended to improve the current system, as follows: First, it broadens the range of adjudication decisions reviewed beyond the 4 categories currently reviewed to the universe of decisions measured for time lapse. Sixty cases per State would be selected at random from all decisions issued during the immediately preceding quarter. Second, the scoring system would continue to provide information for each of the key factors of quality but would move from a numeric system to an easier to understand pass/fail system. Further, all evaluation criteria would be given equal weight which increases the importance of the adequacy of the written determination. A revised adjudication format is provided in Appendix 2.

b. Lower Authority Appeals Quality. The measure for Lower Authority Appeals Quality also builds on the current Quality Appraisal measure while making certain improvements.

Lower Authority Appeals Quality is defined as: (1) The numerical assessment of the quality of the hearing, and (2) whether due process was provided. Both measures will be field tested. A concern with the current scoring system is that it is possible for a case that does not provide due process to obtain a passing score.

The proposed Lower Authority appeals measurement would provide two measures of performance. First, a case cannot be rated as adequate (providing a fair and impartial hearing) unless all of the due process elements pass. Second, changes have been made to improve the current appeals quality assessment instrument. These changes, recommended by SESA Appeals staff in Region X and reviewed by the contractor's State Expert Panel and Service Area Experts, have been accepted by UIS. The instrument will be scored: (1) Numerically to measure the quality of the hearing and (2) pass/fail for measuring "due process". The revised instrument and scoring sheet is located in Appendix 3.

A random sample of twenty appeals decisions will be selected and analyzed each quarter. The sample frame will include both single and two-party appeals. Withdrawals, dismissals and no-shows (where one party does not appear) will be excluded from the sample frame.

c. Combined Wage Claim (CWC) Quality. This performance indicator also builds on the current Quality Appraisal experience. The measures of CWC will assess the accuracy of wages transferred, billing of charges, and reimbursement by participating States. We anticipate that quality will be assessed during the field test based on a randomly selected quarterly sample of twenty for each type of transaction.

3. Scoring consistency/Rereview. The PMR recommendations significantly strengthen the existing Quality Appraisal quality measurement process by ensuring consistency in scoring between SESAs within a Region and between Regions. In the area of adjudications, the Regional Office will review a subsample of the individual cases as scored by the SESAs to ensure consistency in scoring between SESAs within the Region. In turn, the National Office will review a subsample of the individual cases scored by each Regional Office to ensure scoring consistency between the Regional Offices.

For Lower Authority appeals quality, consistency is improved through: (1) Statistically valid random sampling at the SESA level, and (2) an annual review by UIS of a randomly selected subsample of SESA scored cases.

The Appendix material which follows contains measures to be tested and scoring information for adjudication and Lower Authority appeals. This information is included in the "Selected Alternatives Report" submitted to the Unemployment Insurance Service by Macro International Inc. on November 22, 1992.

Appendix 1. Selected Measures for Field Test
Appendix 2. Adjudication Scoring Format
Appendix 3. Lower Authority Appeals Evaluation Instrument and Scoring Sheet

Appendix 1—Selected Measures for Field Test

Measure: First Payment Timeliness (Initial Claims).

Definition: The length of time from the end of the first (earliest) compensable week in the benefit year to the date the payment is issued.

Includes all payments whether partial or total.

Excludes retroactive payment for compensable waiting period.

Data Source: Universe of first payments.

Computation: Start date: End of first compensable week.

End date: Date check was issued.

Reporting Intervals: 7, 14, 21, 28, 35, 42, 49, 56, 63, 70, 70+ Days.

Reporting Categories: Report separately for:

—Intrastate UI, UCFE, UCX, CWC.
—Interstate UI, UCFE, UCX, CWC.

Reporting Frequency: Monthly.

Measure: Continued Weeks Payment Timeliness.

Definition: The length of time from the end of the continued week claimed (whether total or partial) to the date the check is issued.

Applies to weeks paid subsequent to the first week compensated in the benefit year.

Data Source: Universe of continued weeks paid.

Computation: Start date: End of last week for which claim was filed.

End date: Date check was issued.

Reporting Intervals: 7, 14, 21, 28, 35, 42, 49, 56, 63, 70, 70+ Days.

Reporting Categories: Report separately for:

—Intrastate UI, UCFE, UCX, CWC.
—Interstate UI, UCFE, UCX, CWC.

Reporting Frequency: Monthly.

Measure: Adjudications Timeliness.

Definition: The length of time to adjudicate all statutory issues which have the potential to adversely affect claimant benefit rights.

Data Source: Universe of Adjudications.

Computation: Start date: Week ending date of first claimed week of unemployment affected by decision.

End date: Date determination decision is issued.

Reporting Intervals: 7, 14, 21, 28, 35, 42, 49, 56, 63, 70, 70+ Days.

Reporting Categories: Report separately for:

—Intrastate UI, UCFE, UCX, CWC—Seps & Nonseps.
—Interstate UI, UCFE, UCX, CWC—Seps & Nonseps.
—Multi-Claimant Labor Dispute.
—Multi-Claimant "Other".

Reporting Frequency: Monthly.

Notes: Applies to all adjudications.

Measure: Adjudication Implementation Timeliness.

Definition: The length of time from the date of determination to the date the outcome is applied to the claim record.

Data Source: Adjudication Quality sample.

Computation: Start date: Date determination issued.

End date: Date outcome applied to claim record.

Reporting Intervals: 0, 1, 2, 3, 4, 4+ Days.

Reporting Categories: Report separately for:

—Intrastate UI, UCFE, UCX, CWC—Seps & Nonseps.
—Interstate UI, UCFE, UCX, CWC—Seps & Nonseps.
—Multi-Claimant Labor Dispute.
—Multi-Claimant "Other".

Reporting Frequency: Quarterly.

Notes: Provides measurement to assess how prompt SESA is in updating claim record to either authorize or stop payment based on determination issued.

Measure: Adjudication Redetermination Timeliness.

Definition: The length of time to issue a redetermination of the initial adjudication.

Data Source: Universe of Redeterminations.

Computation: Start date: Date redetermination is requested.

Start date: Week ending date of first week affected by the redetermination.

End date: Date redetermination is issued.

Reporting Intervals: 7, 14, 21, 28, 35, 42, 49, 56, 63, 70, 70+ Days.

Reporting Categories: Report separately for:

—Intrastate UI, UCFE, UCX, CWC—Seps & Nonseps.
—Interstate UI, UCFE, UCX, CWC—Seps & Nonseps.
—Multi-Claimant Labor Dispute.
—Multi-Claimant "Other".

Reporting Frequency: Monthly.

Notes: Applies to all adjudications.

Two start dates employed: (1) Date redetermination requested, and (2) week ending date of first week affected by the redetermination.

Measure: Lower Authority Appeals Timeliness.

Definition: The length of time from the date the request for hearing is filed to the date the decision is issued.

Data Source: Universe of Lower Authority Appeals Decisions.

Computation: Start date: Date the appeal is filed.

End date: Date notice of final decision is issued.

Reporting Intervals: 30, 45, 60, 75, 90, 120, 120+ Days.

Reporting Categories: Report separately for:

—Intrastate UI, UCFE, UCX, CWC—Seps & Nonseps.
—Interstate UI, UCFE, UCX, CWC—Seps & Nonseps.
—Multi-Claimant Labor Dispute.
—Multi-Claimant "Other".

Reporting Frequency: Monthly.

Notes: Include remanded and reopened cases.

If a case is remanded from Higher Authority Appeals for a new hearing and decision by the Lower Authority, the clock starts on the date the case is remanded from the Higher Authority.

Measure: Lower Authority Decision Implementation Timeliness.

Definition: The length of time from the date the decision is issued to the date the outcome is applied to the claim record.

Data Source: Lower Authority Appeals Quality Sample.

Computation: Start date: Date decision is issued.

End date: Date outcome applied to claim record.

Reporting Intervals: 0, 1, 2, 3, 4, 4+ Days.

Reporting Categories: Report separately for:

—Intrastate UI, UCFE, UCX, CWC—Seps & Nonseps.
—Interstate UI, UCFE, UCX, CWC—Seps & Nonseps.
—Multi-Claimant Labor Dispute.
—Multi-Claimant "Other".

Reporting Frequency: Quarterly.

Notes: Provides measurement to assess how prompt SESA is in updating claim record to either authorize or stop payment based on decision issued.

Measure: Higher Authority Appeals Timeliness.

Definition: The length of time from the date the request for a Higher Authority appeal is filed to the date the decision is issued.

Data Source: Universe of Higher Authority Appeals Decisions.

Computation: Start date: Date the appeal is filed.

End date: Date notice of final decision is issued.

Reporting Intervals: 45, 60, 75, 90, 120, 150, 180, 210, 240, 270, 300, 330, 360, 360+ Days.

Reporting Categories: Report separately for:

—Intrastate UI, UCFE, UCX, CWC—Seps & Nonseps.
—Interstate UI, UCFE, UCX, CWC—Seps & Nonseps.
—Multi-Claimant Labor Dispute Separations.
—Multi-Claimant Nonseparations.

Reporting Frequency: Monthly.

Notes: Include remanded and reopened cases.

If a case is remanded to the Lower Authority for additional evidence and then case returned, the Higher Authority clock keeps running.

If a case is remanded to the Lower Authority for a new hearing and decision, the clock stops.

Measure: Combined Wage Claims—Wage Transfer Timeliness.

Definition: The length of time from the date that the transfer request is received to the date that the data which completes the transfer is sent to the paying State.

Data Source: Universe of transfers completed during the quarter from the transferring State's files.

Computation: Start date: Date the transfer request is received.

End date: Date that the data which completes the transfer is sent to the paying State.

Reporting Intervals: 3, 6, 10, 14, 21, 28, 35, 42, 49, 56, 63, 70, 70+ days.

Reporting Categories: Not Applicable (N/A).

Reporting Frequency: Quarterly.

Notes: Only change from existing measure, as reported on ETA 586, is an increase in the number of intervals.

Measure: Combined Wage Claims—Billing Timeliness.

Definition: The length of time from the end of the calendar quarter to the date that reimbursement requests (billings) were mailed to the transferring States.

Data Source: Universe of billings by the paying State for benefits paid during a given quarter.

Computation: Start date—End of calendar quarter.

End date—Date that reimbursement requests were mailed to transferring States.

Reporting Intervals: 14, 28, 42, 56, 56+ days.

Reporting Categories: N/A.

Reporting Frequency: Quarterly.

Measure: Combined Wage Claims—Reimbursement Timeliness.

Definition: The length of time from the date that the transferring State receives the reimbursement request to the date that payment is mailed to the paying State.

Data Source: Universe of reimbursements made by the transferring State.

Computation: Start date—Date the transferring State receives the reimbursement request.

End date—Date payment is mailed to the paying State.

Reporting Intervals: 14, 28, 42, 56, 56+ days.

Reporting Categories: N/A.

Reporting Frequency: Quarterly.

Measure: Adjudication Quality.

Definition: The assessment of the adequacy of adjudications.

Data Source: Sample from the adjudications timeliness universe.

Computation: Each case scored as Pass/Fail. Failure of one element causes case to fail.

Reporting Intervals: N/A.

Reporting Categories: Report separately for:

—Intrastate UI, UCFE, UCX, CWC—Separations and Nonseparations.
—Interstate UI, UCFE, UCX, CWC—Separations and Nonseparations.
—Multi-claimant Labor Dispute.
—Multi-claimant "Other".

Reporting Frequency: Quarterly.

Measure: Percent of cases scored Pass/Fail using the Lower Authority Appeals quality assessment instrument.

Definition: Assessment of the quality of the hearing and whether or not due process was provided.

Data Source: Sample of appeal decisions (single and two party) issued in a quarter. Excludes withdrawals and dismissals.

Computation: Scored pass/fail re: 8 due process elements. Numeric scoring of all elements.

Reporting Intervals: N/A.

Reporting Categories: Report separately for:

—Intrastate UC, UCFE, UCX, CWC—Seps & Nonseps.
—Intrastate UC, UCFE, VCX, CWC—Seps & Nonseps.
—Multi-claimant Labor Dispute.
—Multi-claimant "Other".

Reporting Frequency: Quarterly.

Measure: Combined Wage Claims—Quality of Wage Transfers.

Definition: Assessment of the propriety of the wages transferred by the transferring State.

Data Source: Sample of universe of wage transfers.

Computation: Percentage of transfers properly completed.

Reporting Intervals: N/A.

Reporting Frequency: Quarterly.

Notes: Propriety as defined by 20 CFR 616.9 (a) & (b).

Measure: Combined Wage Claims—Billing Quality.

Definition: Assessment of the propriety of the billing of charges by the paying State.

Data Source: Sample of universe of charges billed.

Computation: Percentage of charges properly billed.

Reporting Intervals: N/A.

Reporting Frequency: Quarterly.

Notes: Propriety as defined by 20 CFR 616.8(f).

Measure: Combined Wage Claims—Reimbursement Quality.

Definition: Assessment of the propriety of reimbursements by the transferring State.

Data Source: Sample of universe of reimbursements made by the transferring State.

Computation: Percentage of reimbursements properly made.

Reporting Intervals: N/A.

Reporting Frequency: Quarterly.

Notes: Propriety as defined by 20 CFR 616.9(c).

Appendix 2—Adjudications Quality

Note: This is a prototype of what an adjudications summary report might look like. Scoring instructions and a user guide must be developed before any review for adjudication quality can be undertaken.

BILLING CODE 4510-30-M

ADJUDICATION QUALITY -- **UIS PERFORMANCE MEASUREMENT**

STATE _____ Report code _____

Report Period: Calendar Year _____ Quarter ending _____

Case no	01	02	03	04	05	06	07	08	09	10
Local Office										
Decision Date										
Adjudicator										
Issue										
Reviewer										
WRITTEN DOCUMENTATION of FACTFINDING [pass of fail]										
claimant information										
employer information										
other information										
required rebuttals										
CLAIM DETERMINATION [pass or fail]										
clearly written and understandable.....										
Eligibility outcome correctly stated....										
Key eligibility facts are supported.....										
Decision reflects State policy.....										
Adequate appeal information.....										

Decision Implementation

Accurate? yes/no										
Time lapse? days										

Scoring Key for FACTFINDING & DETERMINATION :::P = Pass F = Fail
Scoring Key for Components::: NR = Element not required
IS = inadequate - unacceptable - insufficient - incomplete
IM = Missing - no attempt to obtain data was documented

BILLING CODE 4510-30-C

Appendix 3—Lower Authority Appeals Quality

Appeals Quality Package Criteria and Guidelines—Lower Authority—Hearing

1. Notice of Hearing (2)

Does the notice of hearing clearly identify the parties, the date, time and place of hearing and the issues to be addressed or was there an informed waiver?

Good (6)

The hearing notice clearly lists all parties to whom the hearing notice was mailed. It need not list the agency as a party. The date and time are clear and the place of hearing is adequately described. In case of a telephone hearing, the method of appearance is clearly explained, e.g., "Parties should call the toll free number above at least 15 minutes before the hearing to notify the Hearing Officer of the number to be called for hearing." No deduction will be made if the place of hearing is listed as "Employment Security Office, 1100 W 10, Jasper, MA." A room number or reference to hearings room is not necessary.

The issues must be sufficiently clear so as to allow the parties to adequately prepare for hearing, e.g., "Should claimant be disqualified from benefits because of his separation from work."

Fair (3)

The notice does not clearly identify parties or does not clearly state the issue, e.g., "Should the September 25, 19____ examiner's decision be affirmed?"

Unsatisfactory (0)

The notice of hearing does not identify the parties or does not state the issue so that the parties can understand it.

Reference Notes—Question 1

The intent of this question is to ensure that the parties have adequate notice of the hearing and opportunity to prepare for the hearing. The notice should state the other parties that have been given notice of the hearing and in case of a telephone hearing information should be given on how to appear.

A "Good" is given if the hearing notice covers all of the required information and does so in a way that can be understood by the parties.

A "Fair" rating is given if the notice gives the general date, time and place information but does either not list what parties have been given notice or does not clearly state the issue. Reference back to the decision appealed is not sufficient to meet the notice requirement.

This criterion will not be scored down in those situations where notice was given and there was subsequent waiver of notice and the hearing was held on issues other than those set forth on the notice. The same is true where, in emergency situations, a hearing may be held without written notice.

2. Pre-hearing/Pre-testimony Explanation (2)

At the start of the hearing, did the Hearing Officer clearly explain the procedures to be followed?

Good (6)

Before testimony was taken, the hearing office explained: (a) the purpose of the hearing, (b) the order of testimony, (c) the right to question witnesses, and (d) asked if any of the parties had any questions before proceeding with the hearing.

Fair (3)

The Hearing Officer explained two or more of the above.

Unsatisfactory (0)

The Hearing Officer did not explain two or more of the above.

Reference Notes—Question 2

This explanation and opportunity for questions may be included in the opening statement (Question 3).

The intent of this question is to ensure that the parties understand how the hearing will be conducted and the rights and opportunities they will have to participate in the hearing.

A "Good" score will be given if the Hearing Officer covers all of the elements set forth above. The elements shall be covered in the taped prehearing explanation or in a taped opening statement. The explanation must be clearly stated and delivered in an understandable manner. The "Fair" score will be given if the Hearing Officer covered two or more of the elements.

An "Unsatisfactory" score will be given if the Hearing Officer does not cover two or more of the elements or if the explanation is not tape recorded.

Rapid or "machine gun" opening statements should be scored down to fair or unsatisfactory based on its understandability or ability of the parties to assimilate the information being provided.

A concurrence that the explanation was done off the tape recorded portion of the hearing would result in an unsatisfactory score.

3. Opening Statement (2)

Did the opening statement set forth the identity of the parties and participants at the hearing, the date, the place of hearing, the Hearing Officer, the decision appealed, and the issues to be considered at the hearing?

Good (6)

Before taking testimony the Hearing Officer: (a) identified him or herself, (b) identified the persons present at the hearing, (c) stated the date and place of hearing (or that it was a telephone hearing), (d) identified the decision appealed and the issues that would be considered.

Fair (3)

The Hearing Officer did not do one of the above elements.

Unsatisfactory (0)

The Hearing Officer did not do two or more of the above elements.

Reference Notes—Question 3

The intent of this question is to ensure that the Hearing Officer clearly sets forth the administrative details and/or case history at the beginning of the hearing. An explanation of issues must be more than just a statement of the decision appealed, i.e., a brief explanation of the elements of the law, such as "to establish that the claimant was discharged for misconduct, the employer has to show * * *".

4. Exhibits (2)

Did the Hearing Officer handle exhibits correctly?

Good (6)

The Hearing Officer correctly handled exhibits in that s/he:

(a) Described and marked all exhibits.

(b) Allowed parties to review the exhibits and offer objections. When a party appears by telephone and a document is read into the record as a proposed exhibit, the party was allowed to offer objections to the document.

(c) Authenticated offered exhibits (to the extent possible) where questionable or challenged. Documents which are not "part of the agency file" may need proper foundation.

(d) Received all competent, relevant and reasonably available exhibits.

(e) Gave an explanation if s/he denied admission of any of the proposed exhibits.

(f) Ruled on the admissibility of any documents read into the record as proposed exhibits.

Fair (3)

The Hearing Officer received all competent, relevant and reasonably available exhibits and showed them to

the parties, but did not fully describe them or correctly mark them. The Hearing Officer provided the parties with an opportunity for questions and rebuttal as to their contents.

Unsatisfactory (0)

The Hearing Officer (a) denied the introduction of exhibits without giving an appropriate reason(s) for such denial, or (b) did not show exhibits received to the other parties, or (c) failed to enter agency exhibits which were referred to in hearing or decision and which were competent, relevant and material.

Did not occur (6)

There were no exhibits tendered, marked or introduced, or no documents made reference to in statements or testimony that should have been marked or introduced.

Reference Notes—Question 4

The intent of this question is to ensure that the Hearing Officer builds as complete a record as possible including the utilization of all competent, relevant, and material exhibits that are available; that the exhibits are properly described, authenticated, marked and entered into the record, and that the parties are made aware of their contents and provided with the opportunity to object, explain or rebut. The requirements are the same for in-person and telephone hearings. Telephone hearing exhibits will be sent to each of the parties prior to the hearing and, if a party does not have all of the documents marked as exhibits, the matter may be continued to allow opportunity to review and object. (See Question 18)

In either an in-person or telephone hearing the parties should be offered the opportunity to see and review the documents or to be mailed the documents and offer post-hearing objections if provided for in the appeals process.

The exhibit should be described sufficiently to identify it for the record. It should be authenticated (to the extent possible) if it is suspect or challenged. It is not necessary to authenticate agency documents created or obtained in the claim processing, such as fact finding or separation reports. The hearings officer shall determine the weight given challenged agency documents.

The record should reflect that the parties had an opportunity to review the exhibits prior to their being received into evidence. The Hearing Officer may state "I have allowed the parties to read and review the documents that I have marked as exhibits" or ask the question of the parties, "Mr. Claimant, have you had the opportunity to read the letter I marked as Exhibit 1?" The record must affirmatively show that the parties were given the opportunity to examine the document.

The exhibit should be clearly marked with the exhibit number or identification. It should be received if competent and relevant if there are no objections, or after the objections have been ruled on.

The Hearing Officer should assume the responsibility to introduce on his/her own motion exhibits that are competent, relevant, and material to the issue but are not introduced by the parties. Common among these would be documents that are in agency files. It is important to realize that the Hearing Officer cannot consider in his/her decision-making process any document that was not properly entered.

Jurisdictional documents, such as the decision appealed, the request for hearing and the notice of hearing, need not be entered as exhibits because they are not really considered in the decision-making process. The score will not be reduced if the Hearing Officer marks or fails to mark them. If the jurisdictional documents are material to the disposition of the case, they must be entered as exhibits, such as the request for hearing when the issue is whether the request for hearing was timely filed.

5. Witnesses (2)

Were witnesses called, sworn and the evidence developed in logical order?

Good (6)

The order was reasonable and flexible depending on the circumstance of each case. Unless a fixed order was necessary, generally the party with the most knowledge proceeded first. For example: in voluntary quit issues, the claimant proceeded first; in misconduct issues, the employer proceeded first.

The Hearing Officer also generally avoided jumping back and forth between witnesses and issues. A brief question of the party not testifying to clarify an issue or to determine whether further foundation or explanation was necessary will not result in deduction.

Fair (3)

The Hearing Officer permitted the introduction of some testimony in illogical sequence, but did not substantially jeopardize the organization of the hearing and the presentation of evidence.

Unsatisfactory (0)

The Hearing Officer did not call witnesses or did not swear in witnesses or did not take evidence in logical order.

Did Not Occur (6)

The evidence was submitted without witnesses or sworn testimony.

Reference Notes—Question 5

The intent of this question is to move the hearing to a conclusion in a logical and orderly manner. Therefore, as a general rule, the party with the most information should be called to testify first. However, the Hearing Officer should be allowed to exercise reasonable discretion in directing the order which must be flexible and dependent upon the particular circumstances of each case.

If a State has a court ruling or some other authority which dictates the order of proof, then that ruling takes precedence and must be applied. The rating should be "Good" where it has been applied.

Witnesses must testify under oath or affirmation. In distinguishing between the "Good" and the "Fair" rating, the evaluator must decide whether the Hearing Officer exercised reasonable discretion in determining the order of proof. That decision generally should be based on who is most knowledgeable about the case. The order should produce an easy flow of information and fact finding without the Hearing Officer resorting to aimless jumping back and forth between witnesses.

The "Fair" rating should be scored where the Hearing Officer failed to meet the "Good" criteria in some instances, but in a manner which did not seriously affect the fact-finding process. However, for the most part the Hearing Officer adhered to a logical sequence of testimony.

For the "Unsatisfactory" rating, the Hearing Officer lacked sound judgment in the order of proof, thereby prolonging the hearing unnecessarily, failed to swear in a witness(s), or jumped back and forth between witnesses and/or issues.

6. Order of Testimony from Each Witness (3)

Was evidence from each witness developed in a logical order?

Good (3)

As each witness testified, the evidence was developed in a logical and orderly manner, although the Hearing Officer was flexible as required by the circumstances.

Fair (1)

The Hearing Officer permitted the introduction of some evidence in illogical sequence, but did not substantially jeopardize the

organization of the hearing and the presentation of evidence. The Hearing Officer generally completed one line of inquiry before moving on.

Unsatisfactory (0)

The Hearing Officer did not take the evidence in logical order and sequence.

Reference Notes—Question 6

The intent of this question is to move the testimony of each witness to a conclusion in a logical and orderly manner.

Witnesses must testify under oath or affirmation. In distinguishing between the "Good" and the "Fair" rating, the evaluator must decide whether the Hearing Officer exercised reasonable discretion in determining the order and sequence of the testimony. The order should produce an easy flow of information and fact finding without the Hearing Officer or the witness resorting to aimless jumping back and forth between areas of the testimony.

The "Fair" rating should be scored where the Hearing Officer failed to meet the "Good" criteria in some instances, but in a manner which did not seriously affect the fact-finding process.

For the "Unsatisfactory" rating, the Hearing Officer lacked sound judgment in allowing or directing the testimony, thereby prolonging the hearing unnecessarily, failed to swear in a witness(s), or jumped back and forth between elements of testimony with the witness.

7. Questions of own Witness (1 With Mid Range Score)

Did the Hearing Officer provide parties and representatives with a timely opportunity to question their *own* witnesses?

Good (9)

Where necessary, the Hearing Officer informed the parties that they or their representatives could question witnesses in the party's own behalf. Where necessary, he or she assisted such party or representatives in framing questions and cautioned them not to make statements or arguments.

Fair (3)

Although the Hearing Officer advised parties who were not represented by counsel that they could question their own witnesses, s/he failed to assist when appropriate, or they were not allowed to question their own witnesses in a timely manner.

Unsatisfactory (0): F

The Hearing Officer failed to provide parties the opportunity to question their own witnesses.

Did Not Occur (9)

The parties did not have witnesses to question or it was not necessary to inform them of this right, e.g., a party was represented by counsel or an experienced representative.

Reference Notes—Question 7

The intent of this question is to ensure that the Hearing Officer has provided the parties or their representatives the right to question their own witnesses in a timely manner as some parties may be unaware of this right.

It is also the responsibility of the Hearing Officer to provide the parties with whatever assistance they need to question witnesses in a timely and proper manner.

8. Clear Language (2)

Throughout the hearing, did the Hearing Officer use language that was clear and understandable, avoiding unnecessary legal phrases and technical language?

Good (6)

The Hearing Officer's language was clear and understandable in all but inconsequential instances. There was no unnecessary use of legal phrases or technical language.

Fair (3)

There were minor instances when the Hearing Officer's language was not clear and understandable or legal phrases or technical language was used. "Minor instances" would be confined to those that would not have a significant bearing on the outcome of the case.

Unsatisfactory (0)

The Hearing Officer's language was not clear and understandable in significant and critical areas or unnecessary legal phrases and technical language was used.

Reference Notes—Question 8

The intent of this question is to ensure that all language to participants is clear and understandable and not misinterpreted and that they are not confused by or not able to understand legal phrases or technical language.

References to form numbers and agency jargon should be avoided.

9. Single Point Questions (2)

Did each question of the Hearing Officer express only one point?

Good (6)

The Hearing Officer's questions expressed only one point and, if more than one point was expressed, it was corrected.

Fair (3)

Occasionally, the Hearing Officer asked a question with more than one point, but it did not interfere with the development of the testimony.

Unsatisfactory (0)

The Hearing Officer repeatedly asked questions containing two or more points and confused the witnesses.

Reference Notes—Question 9

Questions should express one point only so that neither the question nor the answer will be misunderstood. For example, a compound question such as "Was John Doe your supervisor and did he discharge you?" would be unlikely to produce a clear answer. Hearing officers should avoid compound questions and carefully tailor the questions to express one point only.

10. Clarification of Conclusionary Statements (2)

Did the Hearing Officer attempt to clarify conclusionary statements, opinions and ambiguous or unclear testimony?

Good (6)

When the witness responded with an opinion or conclusion, the Hearing Officer made a reasonable effort to develop the factual basis for the opinion or conclusion. When the testimony was not entirely clear or was ambiguous, the Hearing Officer questioned the witness(es) in a conscientious attempt to get specific, clear responses.

Fair (3)

The Hearing Officer asked some questions of witnesses, but did not make a reasonable effort to clear up relevant opinions, conclusions, ambiguities or unclear testimony.

Unsatisfactory (0)

The Hearing Officer's questioning of witnesses disregarded conclusionary statements, ambiguities or unclear testimony that was relevant, or dealt with them in an obviously inadequate manner.

Did Not Occur (6)

There were no conclusionary statements or opinions and the testimony was clear and unambiguous and did not need clarification.

Reference Notes—Question 10

The intent of this question is to ensure that the Hearing Officer fulfills his/her obligation to require lay witnesses to testify to evidentiary facts, as distinguished from conclusions. For example, if the witness says that the claimant was discharged for excessive absenteeism, this would be a conclusionary statement. The Hearing Officer would be responsible for getting the witness' testimony reflecting the factual basis for this conclusion.

All opinions expressed by lay witnesses should be subjected to thorough questioning to establish the facts used as a basis for the opinions whenever the statements are germane to the decision. Opinion evidence by expert witnesses is admissible to meet the necessity of providing to the Hearing Officer the aid of those especially qualified by education, background, experience, training and study to express an opinion on questions of facts relating to their particular skills, an example being a qualified employment service representative who testifies on labor market conditions.

However, it is important that the Hearing Officer establish, on the record, what the expert witness's background is and that they qualify as an expert.

The difference between "Good" and "Fair" is that the latter score is applied when the Hearing Officer occasionally overlooks clearing up ambiguities, conclusionary testimony, etc. An "Unsatisfactory" mark is given if the Hearing Officer accepted opinions or conclusions of the witnesses without asking the factual basis.

11. Confrontation (1)

Was there opportunity for confrontation of all opposing witnesses?

Good (9)

Each party had the opportunity to be present during the giving of all testimony affecting him/her and to confront all opposing witnesses (use of telephone hearings where all parties have the opportunity to participate and hear the witness(es) satisfies the confrontation requirement).

Fair (X)

Not applicable.

Unsatisfactory (0) F

The Hearing Officer denied the opportunity for confrontation.

Did Not Occur (9)

There were no opposing witnesses.

Reference Notes—Question 11

The intent of this question is to ensure fulfillment of the due process right to an opportunity to know all of the evidence presented by opposing parties.

Excluding witnesses does not conflict with the requirements of this question unless the witness happens to be an "interested party" (claimant or employer).

12. Cross-examination (1 With Mid Range Score)

Did the Hearing Officer afford a timely (before testimony from another witness) opportunity to cross-examine, properly control cross-examination, and provide appropriate assistance where necessary?

Good (9)

The Hearing Officer provided the parties their right to timely cross-examination of the opposing witnesses, provided assistance in framing questions as necessary, and limited it to permissible bounds. When the parties made statements instead of asking questions, the Hearing Officer assisted the party in forming the statement into a question unless it was very clear that the party had no questions but wanted to testify.

Fair (3)

The Hearing Officer informed the parties of their right to cross-examination, but either did not control it or did not provide assistance that was needed in framing questions or s/he stated in one sentence, "Do you want to ask questions or make a statement?" The Hearing Officer cut people off who were clearly making a statement without helping them form the statement into a question, provided it is clear the party wanted or needed to get additional information from the witness.

Unsatisfactory (0) F

The Hearing Officer failed to afford the parties their right to timely cross-examination or it is obvious the party did not know how to form questions and gave up out of frustration.

Did Not Occur (9)

There were no opposing witnesses.

Reference Notes—Question 12

The intent of this question is to ensure that all parties are afforded the right to cross-examine opposing witnesses.

Cross-examination is a fundamental right, and not a mere privilege. It is not diminished by reason of the fact that the parties are unrepresented by counsel. If an unrepresented party appears to be unable to comprehend the term, it is necessary to provide them with that right anyway, but it should be expressed in lay language, such as, "Do you want to ask Mr. Jones any questions about any of the testimony he just gave?" If an unrepresented party is incapable of cross-examining properly (for example, instead of asking questions s/he makes statements and seems unable to change), the Hearing Officer must assist by framing questions for the party.

The right to cross-examine should be offered immediately after the witness testifies, and it should not be delayed until all the witnesses for one side have concluded their direct testimony.

However, the right to cross-examination may be restricted, as for example, when it becomes unduly repetitious. Moreover, the cross-examiner should not be permitted to unduly harass, argue with or badger the witness.

The distinction between "Good" and "Fair" is that the latter score is given if the cross-examiner is permitted to harass the witness to a limited extent, or if the cross-examination is allowed to continue excessively, or if the Hearing Officer fails to provide meaningful assistance to lay persons.

An "Unsatisfactory" score is given if the Hearing Officer fails to provide cross-examination rights, *or* fails to provide them immediately after direct examination, *or* fails completely to keep the questioner from unduly and excessively badgering the witness, *or* the Hearing Officer lets a lay person flounder without giving assistance that is clearly needed.

13. Repetitive testimony (3)

Did the Hearing Officer control the undue extension or repetition of testimony so as to keep the hearing moving expeditiously?

Good (3)

The Hearing Officer diplomatically informed the witnesses that repetitious and prolonged testimony was not necessary and added nothing to the hearing. The Hearing Officer did not question witnesses excessively or permit undue repetition or extension of testimony by witnesses or duplication of witnesses, and testimony was limited to the issues.

Fair (1)

The Hearing Officer indulged in or allowed testimony that was repetitious, prolonged or irrelevant, but it did not burden the record and did not affect the final decision.

Unsatisfactory (0)

The Hearing Officer permitted persistent repetition of testimony, prolonged testimony, or permitted irrelevant testimony; the Hearing Officer repeatedly asked repetitious questions of the witness.

Reference Notes—Question 13

This criteria is intended to keep hearings moving along expeditiously. The Hearing Officer is bound not to belabor the witnesses with repetitious questions or remarks and to keep the witnesses from indulging in irrelevant, immaterial, and/or unduly repetitious testimony.

The score is based upon the extent that this type of testimony is permitted.

14. Leading Questions (2)

Did the Hearing Officer indulge in or permit improper leading questions on material issues on direct examination?

Good (6)

The Hearing Officer did not ask improper leading questions on material issues, nor did the Hearing Officer allow the parties to do so.

Fair (3)

The Hearing Officer asked or allowed improper leading questions, but they did not inhibit the fair presentation of the evidence.

Unsatisfactory (0)

The Hearing Officer and/or the parties asked improper leading questions which were material to the issues in the case.

Reference Notes—Question 14

The intent of this question is to ensure that the Hearing Officer did not ask or permit the asking of improper leading questions. A leading question is one which suggests the answer. There are exceptions to this principle. On direct examination, parties or their representatives should not ask leading questions unless it relates to matters such as the party's or witness's name, social security number, address, etc. This is all background information and, in order to expedite the hearing, leading questions are permissible. The Hearing Officer may ask leading questions on direct examination if necessary to develop the evidence so long as the questions do not inhibit the fair presentation of the facts. On direct examination, if leading questions are asked by others, the Hearing Officer should curtail them and/or tell the questioner that answers to such questions will be entitled to less weight in his consideration for the decision.

Another exception is that leading questions are permissible where the witness is hostile, biased, or unwilling to cooperate. In this situation, the Hearing Officer must decide if any one of these conditions exists and proceed accordingly.

Further, if it occurs that a witness cannot recall dates, names, places, times, etc., leading questions may be asked in order to jog his/her memory.

15. Control of Interruptions (2)

Did the Hearing Officer, in as tactful a manner as possible, effectively control interruption of testimony and/or disruptive individuals at the hearing and refrain from inappropriate interruptions himself/herself?

Good (6)

The Hearing Officer, in as tactful a manner as possible, effectively handled interruptions at the hearing and/or disruptive individuals and did not interrupt unnecessarily.

Fair (3)

The Hearing Officer allowed some interruptions that did not disrupt the hearing.

Unsatisfactory (0)

The Hearing Officer's interruptions were inappropriate or s/he did not effectively control disruptions or interruptions.

Did Not Occur (6)

There were no interruptions or disruptive individuals.

Reference Notes—Question 15

This question is intended to ensure that the Hearing Officer fulfills his/her obligation to prevent undue or improper interruptions in the testimony of the witnesses and/or control of disruptive individuals.

If possible, the Hearing Officer should have first made tactful attempts to prevent improper interruptions and to control disruptive individuals before resorting to more forceful means.

The scoring is based upon the degree or the extent that this is permitted to happen without correction by the Hearing Officer.

16. Off the Record (2)

Did the Hearing Officer effectively control "going off the record" and handle correctly on the record matters that occurred or were discussed off the record?

Good (6)

The Hearing Officer went off the record or granted an application to do so for good and sufficient purposes. The Hearing Officer allowed no one else to go off the record but himself/herself. On resuming the record, the Hearing Officer summarized the essentials of what took place and obtained the concurrence of the parties. On turning over the tape or putting in a new tape, the Hearing Officer stated s/he was going off the record to change tape and when returning to the record, stated that the tape had been replaced and that nothing relating to the hearing had transpired in the process (concurrence is necessary). If the tape ran out unexpectedly creating a gap in the record, the Hearing Officer repeated or asked the last speaker to repeat the missing portion of the statement. In these instances, concurrence of the witness and parties is required.

Fair (3)

The Hearing Officer allowed parties to go off the record without establishing good and sufficient cause, but the Hearing Officer did summarize for the record the off-the-record discussion.

Unsatisfactory (0)

The Hearing Officer went off the record and failed to summarize on the record what happened off the record or failed to repeat questions or testimony when the tape unexpectedly ran out or failed to get concurrence from the parties.

Did Not Occur (6)

The Hearing Officer did not go off the record for any reason.

Reference Notes—Question 16

The intent of this question is to build a record that is totally complete and without unexplained interruptions. Any interruption or break in the record must be covered by the Hearing Officer. The Hearing Officer may hear and grant a motion to go off the record from either of the parties.

A "Good" score is warranted when the Hearing Officer: (a) Goes off the record or grants an application to do so only for good and sufficient reasons; (b) allows no one to go off the record without his/her permission except when beyond his control, such as with machine failure; and (c) summarizes the off-the-record discussion and events and obtains the concurrence of the parties to the summary upon resuming the record.

A "Fair" score should be given if the Hearing Officer allows parties to go off the record without establishing good and sufficient reason for doing so.

An "Unsatisfactory" score should be given if the Hearing Officer went off the

record and failed to summarize on the record what happened while off the record or failed to get a concurrence of the parties if the record was summarized.

17. Interpreters (2)

Did the Hearing Officer utilize interpreters correctly?

Good (6)

When necessary, the Hearing Officer gave clear instructions to the interpreter as to how to interpret and administered a special interpreter's oath. When necessary, the Hearing Officer established on the record that the interpreter was fluent in both languages. The Hearing Officer must require that the interpretation be word for word to the extent possible as it was spoken in the foreign language.

Fair (3)

The Hearing Officer did not give clear instructions to the interpreter as necessary, but corrected the interpreter on errors committed.

Unsatisfactory (0)

The Hearing Officer (a) did not give an interpreter's oath, or (b) failed to take reasonable steps to ensure that the translation accurately reflected the testimony.

Did Not Occur (6)

An interpreter was not used.

Reference Notes—Question 17

The intent of this question is to ensure that the testimony is accurately interpreted. The interpretation should be word for word to the extent possible as it was spoken in the foreign language.

For example, if the interpreter says, "He said that * * *," the interpreter is not translating word for word; the interpreter should translate in the first person as the witness testifies.

A "Good" score is warranted if the Hearing Officer gave clear instructions to the interpreter as to how to interpret. A "Good" score should also be given for those hearings wherein a "qualified" interpreter was used and no instructions were necessary and in those States that give the instructions before going on the record. In addition to giving clear instructions when necessary, a special interpreter's oath is to be administered in order to receive a "Good" score.

A "Fair" score should be given if the Hearing Officer administered the special interpreter's oath but failed to give instructions to the interpreter when necessary; however, the Hearing Officer did correct the interpreter on errors committed thereby ensuring an accurate translation.

An "Unsatisfactory" score should be given if the Hearing Officer failed to administer the special interpreter's oath or failed to take reasonable steps to ensure that the translation accurately reflected the testimony.

18. Continuances (3)

After the hearing had begun did the Hearing Officer use good judgment as to continuances?

Good (3)

The Hearing Officer granted a necessary continuance when requested by either party or upon his/her own motion.

Fair (1)

The Hearing Officer granted a continuance where the need for such action was doubtful and not fully supported by the record.

Unsatisfactory (0)

The Hearing Officer granted a continuance for insufficient reasons or failed to order a continuance when necessary.

Did Not Occur (3)

A continuance was not requested or appropriate.

Reference Notes—Question 18

The intent of this question is to curtail unwarranted continuances that unreasonably delay the disposition of cases and to ensure that those necessary are granted. If new material matters develop in the course of a hearing, which a party is unprepared to meet and the element of surprise is present, it is necessary to order a continuance to afford an opportunity for preparation (unless the right to a further hearing is waived). If parties to a telephone hearing are not furnished copies of exhibits, a continuance may be necessary to allow opportunity to review and object to the documents. (See Question 4)

A "Good" score is warranted when the Hearing Officer granted a continuance only for good and sufficient reasons that were fully supported by the record.

A "Fair" score should be given if the Hearing Officer granted a continuance and the need for such action was doubtful.

An "Unsatisfactory" score should be given when the Hearing Officer granted a continuance for reasons that were insufficient and not supported by the record; or the Hearing Officer did not order a continuance when one was needed.

19. Closing Hearing (2)

Did the Hearing Officer properly conclude the hearing by ascertaining whether the parties had anything to add?

Good (6)

The Hearing Officer asked the parties at the end of the hearing if they had anything further to say.

Fair (3)

The Hearing Officer made a statement that the hearing was closed unless the parties stated that they had something further to say.

Unsatisfactory (0)

The Hearing Officer failed to ask this question at the conclusion of the hearing.

Reference Notes—Question 19

The intent of this question is to ensure that the parties have a full and ample opportunity to present all of the information pertinent to their case.

This question is important especially in those cases where the parties are not represented by counsel. Affording the parties an opportunity to state anything additional at the conclusion of the hearing aids all subsequent reviewers of a case in their consideration of allegations contending that a party to a case was not allowed to state everything they wanted to present. Any wording which the Hearing Officer chooses to use to accomplish this result is permissible. The question will not be scored down for curtailing repetitive or irrelevant statements.

The difference between the "Good" rating and the "Fair" rating is that by using the type of wording in the "Fair" category, the Hearing Officer may appear to be adopting a negative approach, and may possibly defeat the purpose and intent of the question by inviting a "no" response.

An "Unsatisfactory" score should be given when the Hearing Officer ends the hearing abruptly without affording the parties a final opportunity to make additional statements.

20. Hearing Within Scope of Issues (1)

Did the Hearing Officer conduct the hearing within the scope of the issues raised by the notice of hearing, and within the issues as finally developed at the hearing, giving proper notice of new issues?

Good (9)

The Hearing Officer conducted the hearing within the scope of the issues specifically raised by the notice of hearing and explained other issues that arose, as well as the right to a continuance to meet any new issues. If the Hearing Officer took up new issues, a knowledgeable waiver of notice was obtained before going to the merits. No deduction will be made for inquiry intended to assist in issue identification, in determining relevance, for impeachment or for credibility assessment.

Fair (X)

Not applicable—Do not use.

Unsatisfactory (0): F

The Hearing Officer did not conduct the hearing within the scope of the issues raised. The Hearing Officer did not identify new issues which arose and which were explored or, having identified and explored such issues, failed to explain the right to a continuance to meet them, or the necessity to waive notice in order to proceed with the new issue(s).

Reference Notes—Question 20

The intent of this question is to limit the hearing to the issue or issues set forth in the hearing notice or to obtain an informed waiver of notice before considering a new issue. The question will not be scored down if a party testifies or tries to testify about an issue not before the Hearing Officer. This is not a control of hearing question. If a new issue arises during the hearing, the Hearing Officer must inform the parties that there is a new issue which could affect entitlement to benefits and that it needs to be covered (State law will determine whether the Hearing Officer has jurisdiction or must remand). The parties must be advised of how resolving the issue would affect them, that they can proceed with the case or request a continuance to prepare for hearing on the new issue. If they elect to proceed, with no continuance, then their election to waive notice must be on the record.

21. Attitude (2)

Did the Hearing Officer create an atmosphere that allowed all parties and representatives to speak freely in an orderly manner as to the issues in the case and not interfere with the development of the case by gratuitous comments or observations.

Good (6)

The Hearing Officer made a reasonable effort to make the parties feel at ease in making statements and in developing their case and made no inappropriate comments.

Fair (3)

The Hearing Officer did not consistently make reasonable efforts to make all parties feel at ease in making statements and in developing their case and made some inappropriate comments, but this did not affect the outcome.

Unsatisfactory (0)

The Hearing Officer's attitude was antagonistic or indifferent (bored, uninterested) or s/he made gratuitous comments or observations.

Reference Notes—Question 21

The intent of this question is to ensure that the Hearing Officer makes an effort to place the parties at ease to the extent possible. It is important that parties feel that they had a fair hearing, as well as one be provided. The Hearing Officer must leave them with the impression that a fair decision will be reached.

The principal difference between the "Good" and the "Fair" score is the consistency and care of the Hearing Officer in endeavoring to make the parties feel at ease, and in providing assistance as needed. If the Hearing Officer's attitude was consistently antagonistic or indifferent, the question should be scored "Unsatisfactory."

22. Bias and Prejudice (1)

Did the Hearing Officer conduct the hearing in an impartial manner?

Good (9)

The Hearing Officer did not appear to demonstrate bias or prejudice toward any participant in the hearing. The intensity of questioning, type of questions asked, or the treatment of the participants, did not indicate bias or prejudice.

Fair (X)

Not applicable—Do not use.

Unsatisfactory (0): F

The Hearing Officer appeared to demonstrate bias or prejudice toward a participant, or the Hearing Officer's actions were reasonably perceived as doing so.

Reference Notes—Question 22

The intent of this question is to ensure that the Hearing Officer conducted the hearing in a fair and impartial manner. When it appears that the Hearing Officer treated a participant in a negative or demeaning manner because of the participant's career field, status, beliefs, appearance, age, sex, religious beliefs, or other protected civil rights, the question shall be scored unsatisfactory.

The Hearing Officer must control the hearing and ask hard questions and be persistent in clarifying or determining the truth of a statement. At times one party may require more assistance than the other. Maintaining control and asking questions does not excuse tyrannizing the party or witness. By the same token, offering assistance in a way that clearly is demeaning and disparaging would result in an unsatisfactory score.

23. Obtain Reasonably Available Evidence (1 With Mid Range Score)

Did the Hearing Officer attempt to obtain the reasonably available, competent evidence necessary to resolve the issues in the case?

Good (9)

The Hearing Officer obtained competent evidence, reasonably available and necessary to resolve the issues in the case.

Fair (3)

The Hearing Officer obtained most of the evidence necessary to resolve the issues of the case and the omissions were not prejudicial to the outcome of the case.

Unsatisfactory (0) F

The Hearing Officer did not make a sufficient record to render a decision, because s/he did not obtain sufficient, competent, available evidence to resolve the issues in the case.

Reference Notes—Question 23

The intent of this question is to ensure that the Hearing Officer functions as a fact-finder.

It is the responsibility of the Hearing Officer to develop all the evidence that is reasonably available and to make a decision according to the dictates of the State law. "Reasonably available" means that evidence or testimony which is available at hearing and which is critical to the issues to be decided.

In applying this criterion, consideration must be given to the adequacy of the Hearing Officer's development of the evidence on each issue: Was it sufficient to secure evidence that was necessary and reasonably available?

Decision

24. Issues Clearly Stated (3)

Were the statutory issues involved clearly and simply stated in the decision?

Good (3)

Early in the decision, a full statement was made, in simple language, of all the statutory issues in the case.

Fair (X)

Not applicable—Do not use.

Unsatisfactory (0)

The Hearing Officer either omitted to state all the issues, or did so in an involved way, or in a manner making them incomprehensible.

Reference Notes—Question 24

The intent of this question is to ensure that there is a clear understanding of what the decision concerns. The Hearing Officer should communicate the issues clearly and effectively to the interested parties and other readers. A further objective is to make sure that the reader knows early in the decision just what is being decided, and to establish the boundaries of the decision beyond which the Hearing Officer should not go without explanation and valid reason.

At the beginning of the decision, under the first heading of "issues," or included in the history of the case, or in the first paragraph, the issue or issues to be decided should be stated in simple terms for clear understanding and should include all the elements of the applicable provision(s). Such statement need not be in the precise language of the statute. For example, the decision may say, "The issue in this case is voluntarily leaving the most recent employment without good cause." Include the words "suitable," "most recent," or "good cause," or whatever is pertinent to the provision.

25. Findings Supported by Substantial Evidence (1)

Accepting the Hearing Officer's judgment of credibility, unless it is manifestly without basis, were the findings of fact supported by substantial evidence in the hearing record?

Good (9)

The findings of fact which were made were supported by substantial evidence.

Fair (X)

Not applicable—Do not use.

Unsatisfactory (0) F

The findings of fact which were made were not supported by substantial evidence.

Reference Notes—Question 25

The intent of this question is to ensure that the findings of fact are supported by evidence in the record and it is of sufficient quality (substantial evidence) and quantity (more than a mere scintilla) to support the findings.

In answering this question, it is not decided whether all the necessary findings of fact were made, but whether the findings of fact made by the Hearing Officer are supported by substantial evidence in the hearing record. See Question 26 for findings of fact.

Only evidence that is properly entered into the record and that which is officially/administratively noticed can be considered as a basis for the findings of fact.

The weight the Hearing Officer gives to the evidence, and, in the case of contradictory evidence or testimony, the Hearing Officer's judgment of credibility should be accepted unless it is entirely without basis or is clearly unreasonable.

There is no "Fair" score. Either the findings of fact which were made are supported by the evidence, or they are not. The distinction between "Good" and "Unsatisfactory" is whether or not the findings of fact are supported by substantial evidence. Substantial evidence has been defined as "such evidence, or such relevant or competent evidence, as a reasonable mind might accept as adequate to support a conclusion."

26. Findings of Fact (1 With Mid Range Score)

Did the Hearing Officer make findings of fact necessary to resolve the issues and support the conclusions of law in the case?

Good (9)

The decision contained all the necessary findings of fact. The form in which the findings were stated leaves no doubt that they were facts found by the Hearing Officer. The decision omitted recitation of the testimony in support of the findings of fact.

Fair (3)

The decision contained all the necessary findings of fact. However, there was some recitation of testimony.

Unsatisfactory (0) F

The decision did not contain the necessary findings of fact.

Reference Notes—Question 26

Findings of fact are sometimes referred to as evidentiary findings or primary facts. The intent of this question is to ensure that the findings of fact are complete and also expressed in the decision as findings. They should cover everything in issue and support the legal conclusion of the Hearing Officer, and they should be worded to show clearly that they are the findings of the Hearing Officer. If the finding is based on the taking of official or administrative notice, it should be so stated.

Findings of fact are the basis for the legal conclusions (ultimate facts) which are required by the statute that is being applied, and which are arrived at by a process of reasoning from the findings of fact. For example, if "quit" is the issue, the decision should contain findings of fact that the claimant left (and was not discharged), concerning the circumstances (to see whether the leaving was voluntary or involuntary), and as to the reason(s) for leaving (to determine the question of good cause). The conclusions that the claimant left his work and did so voluntarily and without good cause are the conclusions of law.

From a study of all the evidence, the Hearing Officer must determine what s/he concludes are the facts concerning what happened. This story of what happened should be told in logical (usually chronological) order and in positive terms which leave no doubt in the reader's mind what the Hearing Officer's findings of fact are.

The findings of fact must refer to all the elements of the issue. The findings must be expressed as findings; evidence should not be summarized; and the testimony should not be stated or quoted, except when testimony may be a finding of fact.

The Hearing Officer's findings of fact must be relevant, accurate, and complete since they are final (in most States) if supported by sufficient, competent evidence in the record. Under the circumstances, the review court must rely upon the decision for these findings. Therefore, they must be clearly stated in the decision as findings of the Hearing Officer (as distinguished from a summary of evidence).

A "Good" score is warranted if the decision contains all necessary findings of fact and does not cite testimony, and a "Fair" score is warranted when the decision cites some testimony although the findings of the Hearing Officer are apparent. "Unsatisfactory" is scored when the decision fails to contain all the necessary findings needed to resolve the issues.

27. Official Notice/Administrative Notice (2)

If the decision contained findings of fact which were the subject of official/administrative notice, were they clearly

and accurately identified and were the parties allowed to object?

Good (6)

The Hearing Officer clearly identified officially/administratively noted facts, and they were facts which could be officially noted.

Fair (X)

Not applicable—Do not use.

Unsatisfactory (0)

The Hearing Officer officially/administratively noted facts not subject to official notice or failed to state they were noted facts.

Did Not Occur (6)

No facts were officially/administratively noted.

Reference Notes—Question 27

The intent of this question is to ensure that if the Hearing Officer took official/administrative notice of a fact, it was a fact that could be officially/administratively noted, that it was clearly identified at hearing or in the decision as an officially/administratively-noted fact, and the parties had opportunity to object to the fact so noticed at hearing or before the decision became final.

Official/administrative notice may extend beyond those "judicially cognizable facts" to include "general, technical or scientific facts within the Hearing Officer's specialized knowledge" and may include "documents, records and forms retained within the agency files." Where officially/administratively-noted facts form a basis for the decision, they need to be identified and the parties given the opportunity to challenge them. A statement in the decision "objections to officially-noted facts must be made in writing within 10 days of the mailing date of this decision" is sufficient to meet this requirement.

28. Required Conclusions (2)

Did the decision contain the conclusions of law required to resolve the issue(s) in the case?

Good (6)

The decision did contain the necessary conclusions.

Fair (X)

Not applicable—Do not use.

Unsatisfactory (0)

The decision did not contain the necessary conclusions.

Reference Notes—Question 28

The intent of this question is to ensure that the Hearing Officer has indicated his/her final conclusion on each and all issues involved.

The conclusions of law (ultimate findings) refer to the final legal result of the case which grants or denies or modifies the relief requested by the appeal. Following the language of the statute, it tells the parties what will happen. The conclusion should be stated in clear, understandable terms, which are, nonetheless indicative of a firm, unwavering decision.

For example, in a simple absence misconduct issue, the specific provision in the law should be referred to by quoting it or by explaining it in simple terms with, when necessary, an explanation of a term such as "misconduct." The conclusion of law might be, "The claimant is disqualified since absence without notice constitutes misconduct connected with the work." This statement resolves the issue and should be supported by the Hearing Officer's findings that the claimant had been absent and had not given notice to his employer, with further appropriate details. The opinion would then continue with the rationale for the conclusion.

29. Logical Reasons (2)

Did the decision state reasons and rationale that were logical?

Good (6)

The reasons and rationale that were stated in the decision logically followed from the findings of fact to the conclusions of law. Extensive rationale was avoided which was not relevant to the specific case. Deduction will not be made for addressing specific legal or factual contentions raised by the parties and not given credence or weight.

Fair (3)

The reasoning was either not fully stated or was excessive, but understandable.

Unsatisfactory (0)

The reasoning and rationale used either were not stated or did not logically follow from the findings of fact to the conclusions of law.

Reference Notes—Question 29

The intent of this question is to ensure that the explanation of the decision is reasonably drawn from the findings of fact, is understandable, and adequately covers only the factors in the provision of the law relating to the issue.

The reasoning serves to bridge the gap between the findings of fact and the conclusions of law. It should explain why the facts led to the conclusions which were reached.

The facts should not be repeated as reasoning, nor should new facts be entered. The reasoning should be stated in concise, understandable terms without unnecessary elaboration, and without including reasoning for immaterial considerations. Even if the facts seem to be self-evident—seem to show obviously what the reasoning will be—the reason must be stated. This is the place to explain to the parties why their contentions were either accepted or rejected.

The Supreme Court has said in what is called "a simple but fundamental rule" that "the orderly functioning of the process of review requires that the grounds upon which the Administrative Agency acted be clearly disclosed and adequately sustained."

A "Fair" score requires that most of the reasoning be understandable, even though the language used may be redundant, and/or the reasoning is slightly incomplete. "Unsatisfactory" is where there is no attempt to provide reasons, or illogical reasons are used not connected or associated with the facts. For example, if the Hearing Officer merely states, "It is the opinion of the Hearing Officer that the claimant is unavailable."

30. Form and Style Organization (3)

Was the decision well organized as to form and style (not content)?

Good (3)

The decision was organized so that the issues in the case, the findings of fact, the rationale, the conclusions of law and the ruling were clearly set forth and could be easily understood by the parties.

Fair (1)

Although the various portions of the decision merged with one another, it was clear which statements were findings of fact and which were conclusions of law.

Unsatisfactory (0)

The decision was not organized and it was difficult to understand.

Reference Notes—Question 30

The intent of this question is to ensure that each segment of the decision is stated distinctly for the purposes of clarity, correct administrative adjudication procedures, and compliance with legal requirements. The decision also serves as a source of

information both within the agency and for the public.

This question refers to the outline or form of the decision and not to its content, which is covered in other questions.

The written decision is of the utmost importance. It is the culmination of the hearing process, and must be adequate for judicial review. The decision should consist of:

1. A statement of what the issue is.
2. The findings of fact or evidentiary findings.
3. The opinion, rationale, or reasons—based upon the facts as found and the statute involved.
4. The conclusion of law—based upon the findings of fact and reasons, and showing the final judgment of the Hearing Officer on the issue.
5. The ruling (final decision) or the action to be taken by the agency in accord with the decision.

Although some of these sections may be merged together by format, each should be distinguishable by its wording.

31. Decision States Legal Effect (3)

Did the "decision" portion contain a clear and correct statement of the legal effect of each issue covered?

Good (3)

Each issue in the proceeding was covered, treated as affirmed, reversed, or modified, and when there was a modification, the modification was stated. The Hearing Officer indicated clearly the administrative action to be taken.

Fair (1)

Each issue in the proceeding was covered, treated as affirmed, reversed, or modified and, when there was a modification, the modification was stated. However, the decision did not clearly show the administrative action to be taken.

Unsatisfactory (0)

The decision did not adequately cover the disposition of the issues.

Reference Notes—Question 31

The intent of this question is to ensure a decision style and fomat that informs the reader in a clear and effective manner the ruling of the Hearing Officer on all issues involved in the appeal.

A "Good" is scored when the decision shows the Hearing Officer's action on all issues involved, i.e., "affirmed," "reversed," or "modified" (as appropriate). If modified, it must clearly show the modification. Additionally, the decision taken as a whole shows the administrative action taken—for example, "benefits are denied from the week of (date) and the 7 weeks immediately following ending (date.)" (Or any wording chosen by the Hearing Officer that would clearly show the administrative action.)

A "Fair" rating is scored if the decision meets all of the requirements for "good" except that it fails to show clearly the administrative action taken if such be necessary.

A decision is "Unsatisfactory" if it fails to show the disposition of issues involved in the appeal.

33. Find Date and Further Appeal (3)

Did the decision clearly and understandably state the date that the decision would become final and the rights of further review or appeal?

Good (3)

The decision clearly states when the decision is final and that the party adversely affected may appeal. "This decision becomes final 20 days from the date of mailing" is sufficient if the date of mailing is clearly identified. "See the attached brochure for further appeal rights" is adequate to advise the parties that further appeal rights are available.

Fair (X)

Not applicable—Do not use.

Unsatisfactory (0)

The decision does not clearly set out when the decision becomes final or does not indicate that further appeal rights are available.

Reference Notes—Question 33

The intent of this question is to ensure that the parties understand when the decision becomes final and that the adversely affected party may appeal.

APPEALS QUALITY PACKAGE CRITERIA AND GUIDELINES—SUMMARY

New No.	Old No.	Old score	New score
		G-F-U-N	G-F-U-N
(1) Notice of hearing	( )	_-_-_-_	6-3-0-X
(2) Pre-hearing explanation	( )	_-_-_-_	6-3-0-X
(3) Opening statement	(1)	6-X-0-X	6-3-0-X
(4) Exhibits	(14)	6-3-0-6	6-3-0-6
(5) Witnesses (logical order)	(2)	6-4-0-6	6-3-0-6
(6) Witnesses (orderly inquiry)	( )	_-_-_-_	3-1-0-X
(7) Questions of own witnesses	(3)	6-4-0-6	9-3-0-9 _F
(8) Clear language	(4)	6-4-0-X	6-3-0-X
(9) Single point questions	(5)	4-2-0-X	6-3-0-X
(10) Clarify conclusions	(6)	9-6-0-9	6-3-0-6
(11) Confrontation	(7)	9-X-0-9	9-X-0-9 _F
(12) Cross-examination	(8)	6-4-0-6	9-3-0-9 _F
(13) Repetitive testimony	(9)	4-2-0-4	3-1-0-X
(14) Leading questions	(10)	6-4-0-6	6-3-0-X
(15) Control of interruptions	(12)	4-2-0-4	6-3-0-6
(16) Off the record	(13)	6-4-0-6	6-3-0-6
(17) Interpreters	(15)	6-4-0-6	6-3-0-6
(18) Continuances	(16)	4-2-0-4	3-1-0-3
(19) Closing hearing	(17)	4-2-0-X	6-3-0-X
(20) Hearing within scope acronyms at critical points	(18)	9-X-0-X	9-X-0-X _F

33. Final Date and Further Appeal (3)

Did the decision clearly and understandably state the date that the decision would become final and the rights of further review or appeal?

Good (3)

The decision clearly states when the decision is final and that the party adversely affected may appeal. "This

decision becomes final 20 days from the date of mailing" is sufficient if the date of mailing is clearly identified. "See the attached brochure for further appeal rights" is adequate to advise the parties that further appeal rights are available.

Fair (X)

Not applicable—Do not use.

Unsatisfactory (0)

The decision does not clearly set out when the decision becomes final or does not indicate that further appeal rights are available.

Reference Notes—Question 33

The intent of this question is to ensure that the parties understand when the decision becomes final and that the adversely affected party may appeal.

APPEALS QUALITY PACKAGE CRITERIA AND GUIDELINES—SUMMARY

New No.	Old No.	Old Score	New Score
		G-F-U-N	G-F-U-N
(1) Notice of hearing	( )	__-__-__-__	6-3-0-X
(2) Pre-hearing explanation	( )	__-__-__-__	6-3-0-X
(3) Opening statement	(1)	6-X-0-X	6-3-0-X
(4) Exhibits	(14)	6-3-0-6	6-3-0-6
(5) Witnesses (logical order)	(2)	6-4-0-6	6-3-0-6
(6) Witnesses (orderly inquiry)	( )	__-__-__-__	3-1-0-X
(7) Questions of own witnesses	(3)	6-4-0-6	9-3-0-9__F
(8) Clear language	(4)	6-4-0-X	6-3-0-X
(9) Single point questions	(5)	4-2-0-X	6-3-0-X
(10) Clarify conclusions	(6)	9-6-0-9	6-3-0-6
(11) Confrontation	(7)	9-X-0-9	9-3-0-9__F
(12) Cross-examination	(8)	6-4-0-6	9-3-0-9__F
(13) Repetitive testimony	(9)	4-2-0-4	3-1-0-X
(14) Leading questions	(10)	6-4-0-6	6-3-0-X
(15) Control of interruptions	(12)	4-2-0-4	6-3-0-6
(16) Off the record	(13)	6-4-0-6	6-3-0-6
(17) Interpreters	(15)	6-4-0-6	6-3-0-6
(18) Continuances	(16)	4-2-0-4	3-1-0-3
(19) Closing hearing	(17)	4-2-0-X	6-3-0-X
(20) Hearing within scope	(18)	9-X-0-X	9-X-0-X__F
		G-F-U-N	G-F-U-N
(21) Attitude	(11)	5-2-0-X	6-3-0-X
	(20)		
(22) Bias and prejudice	( )	__-__-__-__	9-X-0-X__F
(23) Obtain evidence	(21)	9-X-0-X	9-3-0-X__F
(24) Issues clear	(22)	4-X-0-X	3-X-0-X
(25) Substantial evidence for facts	(24)	9-X-0-X	9-X-0-X__F
(26) Findings of fact	(23)	9-6-0-X	9-3-0-X__F
(27) Official notice	( )	- - - -	6-X-0-6
		- - - -	
(28) Conclusions	(25)	6-X-0-X	6-X-0-X
(29) Reasons and rationale	(26)	6-3-0-X	6-3-0-X
(30) Decision organized	(27)	4-2-0-X	3-1-0-X
(31) Decision legal effect	(28)	4-2-0-X	3-1-0-X
(32) Decision understandable	(29)	6-4-0-X	6-3-0-X
(33) Finality and appeal	( )	__-__-__-__	3-X-0-X

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federal register

Tuesday
June 30, 1992

Part III

Department of Health and Human Services

Health Care Financing Administration

42 CFR Part 400, et al.

Medicaid Program; Home and Community-Based Services Waivers for Individuals Age 65 or Older; Interim Final Rule With Comment Period

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 400, 435, 436, 440, and 441

RIN 0938-AD55

[MB-019-IFC]

Medicaid Program; Home and Community-Based Services Waivers for Individuals Age 65 or Older

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Interim final rule with comment period.

SUMMARY: This interim final rule amends current Medicaid regulations to permit States to offer, under a Secretarial waiver, a wide array of home and community-based services to individuals age 65 or older who are determined, but for the provision of these services, to be likely to require the level of care furnished in a skilled nursing facility (SNF) or intermediate care facility (ICF) (nursing facility (NF) effective October 1, 1990). The rule allows Federal payment for these and other long term care services, up to an amount specified in section 1915(d)(5)(B) of the Social Security Act, subject to HCFA's approval of the States' requests for waivers and certain assurances made by the States. Once granted, waivers are in effect for 3 years, unless terminated by the State with notice to the Secretary, and are renewable for periods of 5 years. Periodic evaluation, assessment, and review of the care furnished under the waivers is required. This rule implements section 4102 of the Omnibus Budget Reconciliation Act of 1987, as modified by section 411(k) of the Medicare Catastrophic Coverage Act of 1988, section 8432 of the Technical and Miscellaneous Revenue Act of 1988, and section 4741(b) of the Omnibus Budget Reconciliation Act of 1990.

This rule is being issued in final and, for the most part, without a delay in the effective date for the reasons explained in section IV, "Waiver of Proposed Rulemaking and Delay in the Effective Date."

DATES: *Effective Date:* This interim final rule is effective on June 30, 1992 except for the following sections. Sections 441.351 through 441.353, 441.356, and 441.365 will be made effective only after review and approval by the Office of Management and Budget (OMB) in accordance with the Paperwork Reduction Act; notice of the effective date will be published in the **Federal Register**. Section 441.365 will be effective 90 days after OMB approval is announced in the **Federal Register**.

Applicability Date: For States with section 1915(d) waivers currently in effect, the aggregate projected expenditure limit (APEL), computed and applied in accordance with § 441.354, for the waiver year that coincides with Federal fiscal year (FFY) 1990, and each succeeding waiver year will be determined as if the regulations had been published on October 1, 1989.

Comment Date: Written comments will be considered if we receive them at the appropriate address, as provided below, by 5 p.m. on August 31, 1992.

ADDRESSES: Mail written comments to the following address: Health Care Financing Administration, Department of Health and Human Services, Attention: MB-019-IFC, P.O. Box 26676, Baltimore, Maryland 21207.

If you prefer, you may deliver your written comments to one of the following addresses:

Room 309-G, Hubert H. Humphrey Building, 200 Independence Ave., SW., Washington, DC 20201, or

Room 132, East High Rise Building, 6325 Security Boulevard, Baltimore, Maryland 21207.

Due to staffing and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

In commenting, please refer to file code MB-019-IFC. Comments received timely will be available for public inspection as they are received, generally beginning approximately three weeks after publication of a document, in Room 309-G of the Department's offices at 200 Independence Ave., SW., Washington, DC, on Monday through Friday of each week from 8:30 a.m. to 5 p.m. (phone: (202) 245-7890). If comments concern information collection or recordkeeping requirements, please address a copy of comments to: Laura Oliven, HCFA Desk Officer, Office of Information and Regulatory Affairs, room 3002, New Executive Office Building, Washington, DC 20503.

Copies: To order copies of the **Federal Register** containing this document, send your request to: Superintendent of Documents, U.S. Government Printing Office, ATTN: New Order, P.O. Box 371954, Pittsburgh, PA 15250-7954.

Specify the date of the issue requested and enclose a check or money order payable to the Superintendent of Documents, or enclose your Visa or Master Card number and expiration date. Credit card orders can also be placed by calling the order desk at (202) 783-3238 or by faxing to (202) 512-2250. The cost for each copy is $1.50. In addition, you may view and photocopy the **Federal Register** document at most libraries designated as U.S. Government Depository Libraries and at many other public and academic libraries throughout the country that receive the **Federal Register**. The order desk operator will be able to tell you the location of the U.S. Government Depositories.

FOR FURTHER INFORMATION CONTACT:

Ingrid Osborne (301) 966-4461—Post eligibility treatment of income.

Robert Wardwell (301) 966-5659—All other issues.

SUPPLEMENTARY INFORMATION:

I. Background

Until the Omnibus Budget Reconciliation Act of 1981 (Pub. L. 97-35) was enacted on August 13, 1981, the Medicaid program (title XIX of the Social Security Act (the Act)) provided little coverage for long term care services in a noninstitutional setting. Many elderly, disabled, and chronically ill persons were living in institutions not for medical reasons, but because of the scarcity of health and social services available to them in their homes and communities. Further, even when the necessary services were available outside the institution, individuals were sometimes unable to pay for them, and the services were not covered by Medicaid.

Public Law 97-35 added section 1915 to the Act, which authorized the Secretary to waive Medicaid statutory requirements in order to establish two specific types of waiver programs: freedom of choice waivers under section 1915(b) of the Act; and home and community-based services waivers under section 1915(c) of the Act. This latter type of waiver allows State Medicaid agencies to furnish services not otherwise available under Medicaid to individuals who, absent these services, would otherwise be institutionalized in a hospital, nursing facility (NF), or intermediate care facility for the mentally retarded (ICF/MR).

II. Legislation

Section 4102 of the Omnibus Budget Reconciliation Act of 1987 (Pub. L. 100-203, enacted on December 22, 1987) amended section 1915 of the Act by redesignating section 1915(d) of the Act as section 1915(h) and by adding a new category of waiver under section 1915(d). Entitled "Home and Community-Based Services for the Elderly," this section establishes an

entirely new waiver program, separate and distinct from the other types of waivers available under section 1915 of the Act. Under section 1915(d) of the Act, State Medicaid agencies may request the authority to furnish home and community-based services to individuals age 65 or older who are determined to be likely to require the level of care furnished in a NF if the home and community-based services are not available. The Secretary may waive Medicaid comparability and Statewideness requirements and certain financial eligibility requirements (relating to income and resources) applicable in the community to enable State Medicaid programs to provide for these home and community-based services. The law specifies the services that may be furnished under the waiver.

In return for this waiver, the State must limit its expenditures for home and community-based waiver services, along with NF, home health, personal care and private duty nursing services for individuals in this age category, within an amount determined by principles specified in the statute. The Secretary is required to promulgate indices for projecting increases in institutional and noninstitutional long term care cost, as well as State-specific projections of increases in the number of residents over age 65. Upon promulgation, the maximum amount for which Federal financial participation (FFP) would be available under these waivers would be determined based on State expenditures in a base year, modified by the greater of (1) The sum of the percentages yielded by these indices, or (2) 7 percent computed annually.

Public Law 100–203 mandated promulgation of a method for projecting increases in the number of residents over age 75. Section 411(k)(3)(A)(i) of Public Law 100–360 replaced the first reference to the number "75" in section 1915(d)(5)(B)(iii)(III) of the Act with "65", but left "75" in the sentence following the correction. We believe that the failure to correct the second reference to "75" was merely an oversight, and that Congress intended to correct it in the second instance as well, since the 1915(d) waiver program is designed for individuals age 65 or older. However, as required by the statute, we have developed a method for determining both indices. We will use the same method described below to project both the number of individuals who have attained the age of 65 and those who have attained the age of 75 for each year of a State's waiver program.

A waiver granted under the authority of section 1915(d) of the Act will be in effect for a period of 3 years (unless terminated by the State with notice to the Secretary). At the request of the State, a waiver may be renewed for additional periods of 5 years, if certain assurances, specified in the statute, have been met by the State. The State must assure that adequate safeguards (including adequate standards for provider participation) are taken to protect the health and welfare of individuals served under the waiver and that financial accountability is provided for funds expended for the services.

Section 1915(d)(5) of the Act, as established by section 4102(a)(1)(B) of Public Law 100–203, was modified by section 411(k)(3)(A)(i) of the Medicare Catastrophic Coverage Act of 1988 (Pub. L. 100–360, enacted on July 1, 1988); by section 8432 of the Technical and Miscellaneous Revenue Act of 1988 (Pub. L. 100–647, enacted on November 10, 1988); and by section 4741(b) of the Omnibus Budget Reconciliation Act of 1990 (Pub. L. 100–508, enacted on November 6, 1990). These three laws made minor technical and editorial changes.

Section 4211 of Public Law 100–203 eliminated the distinction between skilled nursing facilities (SNFs) and intermediate care facilities (ICFs) under Medicaid, combining the two levels into a single category of NF. However, conforming changes were not made to section 4102 of Public Law 100–203, which added the section 1915(d) waiver program. Therefore, we believe that the omission of the conforming changes was merely an oversight. Consistent with this statutory change, we have referred to NFs throughout this preamble and regulations text except when citing the statute.

III. Provisions of this Interim Final Rule

We are making the following revisions to the home and community-based services regulations in 42 CFR parts 400, 435, 436 and 440, and adding a new subpart H in 42 CFR part 441, Home and Community-Based Services Waivers for Individuals Age 65 or Older. We believe these changes will make our regulations consistent with section 1915(d) of the Act, as added by Public Law 100–203 and modified by Public Law 100–360, Public Law 100–647, and Public Law 101–508.

A. Definition of "Nursing Facility"

In § 400.203, which defines terms specific to Medicaid, we are adding the definition for "nursing facility" (NF), which, effective October 1, 1990, means an SNF or an ICF participating in Medicaid.

B. Recipient Eligibility for Waiver Services, and Post-Eligibility Treatment of Income

Section 4102 of Public Law 100–203 makes those portions dealing with recipient eligibility for waiver services under the section 1915(d) waiver program conform to similar waiver provisions under section 1915(c) of the Act. Therefore, we are modifying those regulations currently applicable to waivers under section 1915(c) of the Act to apply them to waivers under section 1915(d) of the Act as well, with respect to (1) individuals only eligible for Medicaid when receiving care in an institutional setting (due to spousal income and resource "deeming" requirements), (2) individuals eligible under a special income limit (up to 300 percent of SSI), and (3) individuals receiving waiver services and governed by rules for post-eligibility treatment of income.

The enactment of section 1915(d) of the Act did not alter a State's option to apply for or administer waivers under section 1915(c) of the Act. We will continue to apply existing rules to the 1915(c) waiver program. States with a section 1915(d) waiver may continue to request waivers under section 1915(c) of the Act for individuals who have attained the age of 65. However, when a State has a section 1915(d) waiver concurrently in effect, the State's expenditures for services furnished to individuals age 65 or older under a section 1915(c) waiver must be included in the application of the expenditure limit under section 1915(d)(5)(B) of the Act. This is described more fully below.

We are amending the following regulations to include section 1915(d) of the Act, which sets forth coverage requirements for home and community-based services for individuals age 65 or older, among those sections of the Act that mandate requirements and standards for the Medicaid program:

- Section 435.3, which sets forth sections of the Act and public laws that mandate Medicaid eligibility requirements and standards for the United States, District of Columbia, the Northern Mariana Islands, and American Samoa.
- Section 436.2, which sets forth sections of the Act and public laws that mandate eligibility requirements and standards for Guam, Puerto Rico, and the Virgin Islands.
- Section 440.1, which specifies the statutory basis and describes the

services included in the term "medical assistance."

We are revising § 435.217, which states the eligibility requirements for those individuals receiving home and community-based services under Medicaid in the United States, District of Columbia, the Northern Mariana Islands, and American Samoa. We are also revising § 436.217, which states the eligibility requirements for those receiving home and community-based services under Medicaid in Guam, Puerto Rico, and the Virgin Islands. These regulations will extend Medicaid eligibility for home and community-based services to individuals age 65 or older, as specified in section 1915(d) of the Act.

We are revising §§ 435.726 and 435.735 regarding post-eligibility treatment of income and resources of individuals receiving home and community-based services furnished under a waiver to apply to individuals age 65 or older. Section 1915(d)(3) of the Act provides that the maximum amount of any individual's income which may be disregarded for any month is equal to the amount that may be allowed for that purpose under a section 1915(c) home and community-based services waiver. Therefore, we are incorporating all policies and procedures relative to post-eligibility determinations of the amount by which a Medicaid agency must reduce its payment for the cost of care, currently under section 1915(c) waivers, into waivers under section 1915(d) of the Act.

C. Services and Their Definitions

We are adding § 440.181 to include those home and community-based services specified in section 1915(d)(4) of the Act. Section 1915(d)(4) of the Act lists seven categories of home and community-based services that a State may provide: Case management services, homemaker services, home health aide services, personal care services, adult day health services, respite care, and other medical and social services that can contribute to the health and well-being of individuals and their ability to reside in a community-based care setting.

For purposes of waivers granted under section 1915(d) of the Act, we are suggesting the following service definitions. States are free to choose and define those services that they will provide under a waiver unless the services are otherwise defined by the Medicaid statute. However, each service (and service definition) must be approved by HCFA in order to be eligible for FFP.

1. Case Management Services

Section 1915(g)(1) of the Act gives States the authority to provide case management services to specific groups of individuals. Case management services are defined in section 1915(g)(2) of the Act as follows: "* * * services which will assist individuals eligible under the plan in gaining access to needed medical, social, educational and other services." A State may adopt this definition of case management services and apply relevant policies pertaining to case management under the State plan to home and community-based waivers for individuals age 65 or older under section 1915(d) of the Act.

2. Homemaker Services

Homemaker services are not defined in the Medicaid statute. However, in the preamble to the interim final rule, published October 1, 1981 (46 FR 48532), which expanded Medicaid coverage to include home and community-based services under section 1915(d) of the Act, homemaker services were described as consisting of general household activities (for example, meal preparation and routine household care) furnished by a trained homemaker when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for himself or herself in the home. We believe this definition is also applicable to homemaker services furnished to individuals age 65 or older under section 1915(d) waivers as well.

3. Home Health Aide Services

We also believe that the definition of home health aide services that was incorporated in the preamble to the October 1, 1981 interim final rule, governing the home and community-based waiver program under section 1915(c) of the Act, is appropriate to the section 1915(d) waiver program. This definition describes home health aide services as the performance of simple procedures such as the extension of therapy services, personal care, ambulation and exercise, household services essential to health care at home, assistance with administering medications that are ordinarily self-administered, reporting changes in the patient's condition and needs, and completing appropriate records.

4. Personal Care Services

Personal care services are defined in § 440.170(f) as those services in a recipient's home that are prescribed by a physician in accordance with a plan of treatment and are furnished by an individual who is: (1) qualified to furnish the services; (2) supervised by a registered nurse; and (3) not a member of the recipient's family.

Under a section 1915(d) waiver, States may elect to allow personal care services to be furnished to an eligible individual by a member of the recipient's family other than a spouse. Under no circumstances may Medicaid payment be made for any services (including personal care) that are furnished to a recipient by his or her spouse. A State opting to make payment for personal care services furnished by the recipient's immediate family other than a spouse must identify this option in its waiver request, and set forth the conditions under which it will do so. Accordingly, a State must have in place a mechanism to ensure that Medicaid does not make payment for services for which there is otherwise no obligation to pay, or for services that would be furnished regardless of whether payments are made.

We will also require an assurance that family members other than a spouse who furnish personal care services under the waiver must meet standards that are comparable to those required of providers who furnish these services and who are unrelated to the recipient.

Personal care services furnished under a section 1915(d) waiver need not be limited to services provided in the home. States have the flexibility to provide these services in other non-institutional settings when the need for personal care is specified in a recipient's written plan of care.

5. Adult Day Health Services

Adult day health services may be defined as services furnished for 4 or more hours per day on a regularly scheduled basis, for 1 or more days per week, in an outpatient setting, encompassing both health and social services needed to ensure the optimal functioning of the recipient. The health component of adult day health services may include physical, occupational, and speech therapies included in the recipient's written plan of care, as well as nursing oversight and necessary personal care. The service also provides an opportunity for socialization and recreational activities appropriate to the functional levels of the recipient with adaptations to compensate for any physical or mental impairments. Activities that are merely diversional in nature and unrelated to specific goals in the written plan of care will not be covered. Consistent with our policy under section 1915(c) waivers, a full nutritional regimen (three meals per day) is not covered.

6. Respite Care Services

Respite care services are generally defined as services furnished to an individual who is unable to care for himself or herself, on a temporary or short-term basis, and necessitated by the absence or need for relief of the customary caretaker. These services may take place in the home or in an out-of-home setting. Consistent with our definition of respite care services provided for under section 1915(c) waivers, FFP will be available for respite care room and board only when these services occur in a facility, approved by the State, which is not a private residence.

Although Public Law 101–508 precludes Federally mandated service limits for respite care, we are concerned that an excessive duration of respite care services furnished to an individual may indicate deficiencies in the written plan of care and reflect insufficient amounts of other forms of care necessary to maintain the health and welfare of the recipient. Therefore, we encourage States to monitor the provision of this service to maintain the noninstitutional focus of the program.

7. Other Medical and Social Services

States may also request the authority to provide other medical and social services that can contribute to the health and well-being of individuals and their ability to reside in a community-based setting. States wishing to provide for other services must identify and define each service, and describe how it will contribute to the individual's health and well-being, as well as to his or her ability to reside in the community.

States may also request the authority to provide services already available through their State plans, but in expanded amount, duration, or scope. In so doing, the State must identify any new service limits applicable to these services that are available to waiver-eligible individuals. The State also must reference the qualifications of providers of the services in both the State plan and the waiver. Any services furnished in excess of the limits provided for in the State plan are considered waiver services. They must be attributed to the waiver by including their costs in the aggregate projected expenditure limit (APEL).

Section 1915(d)(5)(C)(iii) of the Act excludes ICF/MR services from this waiver program. In addition, the types of waiver services that the statute allows do not include habilitation or the "active treatment" type of services that are required at the ICF/MR level of care. Thus, the range of services available under a section 1915(d) waiver is not sufficient to meet the health and welfare needs of this group. States wishing to provide for home and community-based services to individuals who would otherwise be institutionalized in an ICF/MR, regardless of the age of the recipients, must necessarily apply for waivers under section 1915(c) of the Act.

The clear intent of section 1915(d) of the Act is to enable States to provide for sufficient services to individuals in a home or community-based setting that prevent them from placement in an institutional-type setting. However, when these community-based services are furnished in a large institutional environment (for example, a 200-bed personal care home), which is not certified as a NF, we question whether the services are in conformance with one of the intents of the statute which is to provide service in a noninstitutional setting. We, therefore, request public comment on whether to define "home and community-based services" to exclude services provided by residential and institutional entities that furnish care and services to more than a specified number of individuals.

D. Waiver of Comparability

We are revising § 440.250(k), which sets forth the limits on comparability of services, to specify that home and community-based services waivers granted under section 1915(d) of the Act must be limited to individuals age 65 or older, and that the home and community-based services provided under § 440.181 need not be comparable for all individuals within a group.

E. Waiver Requirements

We are adding a new subpart H to part 441, which states the requirements and limits applicable to specific services under the Medicaid program. Subpart H sets forth the requirements for the State Medicaid agency to obtain a Secretarial waiver to provide for a wide array of home and community-based services to individuals age 65 or older who are determined, but for the provision of these services, to be likely to require the level of care furnished in a NF.

1. Basis and Purpose

We are adding a new § 441.350 to set forth the basis and purpose of the subpart. This section explains that the subpart will set forth the waiver of statutory requirements that permits States to offer home and community-based services not otherwise available under Medicaid to individuals age 65 or older in exchange for a limit on expenditures for certain services furnished to individuals in this age category.

2. Contents of a Waiver Request

We are adding a new § 441.351 to describe the requirements for the contents of a waiver request.

a. *Required signatures.* Each request for a waiver under section 1915(d) of the Act must be signed by the Governor, the Director of the Medicaid agency or the Director of the larger State agency of which the Medicaid agency is a component, or an official of the single State Medicaid agency to whom the authority has been delegated. Because this type of waiver deals only with the Medicaid program, a request from any other agency of State government, such as an Agency on Aging, will not be accepted. We expect that the request will include the title of the individual who has requested the waiver, and will indicate the name, address and telephone number of an individual within the Medicaid agency to whom any questions about the request may be posed. Because inclusion of the title of the individual requesting the waiver and the name of the contact person in the Medicaid agency is not statutorily mandated, we are not including them as requirements in the regulations text. However, in the interest of convenience and in expediting the review process, we suggest that this information be made available to HCFA.

b. *Assurances and Supporting Documentation.* The request must contain the assurances required by § 441.352, and the supporting documentation required by § 441.353, described below. A complete description of the State's procedures to ensure recipient health and welfare must be included with each waiver request.

c. *Statement for sections of the Act.* Section 1915(d)(3) of the Act allows States to request waivers of three sections of the Medicaid law: Section 1902(a)(1) of the Act, regarding Statewide availability of services; section 1902(a)(10)(B) of the Act, relating to comparability of services; and section 1902(a)(10)(C)(i)(III) of the Act, pertaining to income and resource rules applicable in the community. We will require States to clearly indicate whether or not they are requesting a waiver of one or all of these sections. States may request a waiver of any one of the sections cited above.

Section 1902(a)(1) of the Act requires that services furnished under the State plan be available on a Statewide basis. However, under section 1915(d) waivers, the home and community-based services

made available in excess of those otherwise furnished under the State plan may be restricted to specific geographic areas within a State. If a State requests the authority to waive section 1902(a)(1) of the Act, the State must specify the geographic areas or political subdivisions in which the home and community-based services furnished under the waiver will be offered. Waivers of Statewideness may be used only in regard to the provision of home and community-based waiver services not otherwise available under the State plan. They may not be used to restrict the provision of services otherwise available under the State plan (for example, inpatient hospital services, physicians' services, home health services) so that these services would be available in lesser amount, duration, or scope to individuals age 65 or older than to individuals less than 65 years of age.

Section 1902(a)(10)(B) of the Act provides that the amount, duration, and scope of services made available to one individual within a group not be less than that made available to any other individual within that group, and that the medical assistance made available to the medically needy not be less than that made available to the categorically needy. However, section 1915(d) of the Act provides that a State may make home and community-based services available to certain individuals who are age 65 or older. Therefore, if a State wishes to provide for home and community-based services not otherwise available under the State plan under a section 1915(d) waiver, that State must request a waiver of section 1902(a)(10)(B) of the Act. This will allow the provision of these services to individuals age 65 or older who are otherwise likely to require the level of care furnished in a NF, without making these services available to the Medicaid population at large. Since the clear intent of the statute is to allow States to provide for services not otherwise available under the Medicaid State plan, waiver of section 1902(a)(10)(B) of the Act may not be used to furnish fewer services or services lesser in amount, duration, or scope to the target population than would be available to individuals less than 65 years of age or to individuals age 65 years or older who are not included in the group eligible for waiver services.

Section 1915(d)(3) of the Act also allows a State to request waiver of section 1902(a)(10)(C)(i)(III) of the Act to allow the application of institutional deeming rules, rather than community deeming rules, to medically needy individuals under the waiver. (The application of institutional deeming rules means that income and resources are generally not deemed to the recipient from the spouse, thus making an individual eligible for Medicaid who might not otherwise qualify, based on the income and resources of the spouse.) This in turn allows States to cover under the waiver, medically needy individuals who are not eligible for waiver services under the usual community deeming rules, but who are eligible under institutional rules. This waiver of deeming rules may be applied only to individuals who receive home and community-based waiver services. This waiver of deeming rules is not applicable to individuals age 65 or older who reside in a community-based setting, but do not require or receive waiver services to maintain community residence status.

d. *Identification of Services.* In requesting a waiver under this subsection, the State must identify all services available to individuals under the approved State plan. If there are any limitations on these services, these should be set forth as well. The State must identify and describe each service specified in § 440.181 to be furnished under the waiver, and any additional home and community-based service that it intends to furnish. If the State intends to provide for additional services not specified in the statute, the State must explain how each additional service will contribute to the health and well-being of the recipients and to their ability to reside in a community-based setting.

e. *Recipients Served.* In accordance with section 1915(d)(2)(B) of the Act, the request must indicate that home and community-based services will be made available only to those Medicaid recipients who are age 65 or older, and who are determined by the State to be likely to require the level of care in a NF, the cost for which will be borne by Medicaid. (The term NF does not include services furnished in an ICF for the mentally retarded.)

To prevent duplication of services, FFP will not be available for section 1915(d) waiver services furnished to individuals while they are inpatients of a hospital, NF, or ICF/MR. A State requesting a waiver under section 1915(d) of the Act must assure that FFP will not be claimed for services in these settings.

f. *Plan of Care.* Section 1915(d)(1) of the Act provides that waiver services be furnished under a written plan of care. We will require that a written plan of care based on an assessment of the individual's health and welfare needs be developed by a qualified individual for each recipient under the waiver. A plan of care must describe the services to be furnished, their frequency, and the type of provider who will furnish them. The qualifications of an individual responsible for the development of a plan of care, a description of the process by which a plan of care is developed, and a copy of the plan of care format must be included with each State's waiver application. FFP will not be available for services furnished before the development of a written plan of care.

To ensure that a plan of care is adequate to meet the needs of a recipient, as well as to ensure that the Medicaid agency is able to keep an ongoing account of projected expenditures, we will require that a written plan of care be approved by the Medicaid agency. In States in which an umbrella agency (that is, the larger State agency of which the Medicaid agency is a component) is designated as the Medicaid single State agency, plans of care must be approved by that subcomponent of the agency that actually administers the Medicaid program. This requirement ensures that approval is made by someone who has a working knowledge and a close involvement with the Medicaid program. We consider this requirement met, however, when an employee of the Medicaid agency prepares a plan of care and authorizes its implementation.

g. *Medicaid Agency Review.* The agency's request must contain an assurance that the agency will maintain and exercise its authority to review, at a minimum, a valid statistical sample of each month's plans of care. When the services in a plan do not comport with the stated disabilities and needs of the recipient, we will require that the agency implement immediate corrective action procedures to ensure that the needs of the recipient are adequately addressed.

h. *Groups Served.* The waiver request must include a description of the group or groups of individuals to whom the services will be offered.

i. *Assurance Regarding Amount Expended.* In accordance with section 1915(d)(5)(A) of the Act, the State must provide an assurance that the total amount expended by the State under the plan for individuals age 65 or older during a waiver year for medical assistance with regard to NF, home health, private duty nursing, personal care, and home and community-based services described in §§ 440.180 and 440.181 and furnished as an alternative to NF care will not exceed the APEL defined in § 441.354.

3. Required State Assurances

In order to comply with the requirements contained in section 1915(d)(2) of the Act, we are adding a new § 441.352 to require States to make the following assurances, as part of a waiver application.

a. *Health and Welfare.* Section 1915(d)(2)(A) of the Act requires States to assure that necessary safeguards have been taken to protect the health and welfare of the recipients of services. States must assure that—(i) adequate standards for all types of providers that furnish services under the waiver are met; (ii) the standards of any State licensure or certification requirements are met for services or for individuals furnishing services under the waiver; (iii) all facilities covered by section 1616(e) of the Act, in which home and community-based services are furnished, are in compliance with applicable State standards that meet the requirements of 45 CFR part 1397 for board and care facilities; and (iv) a physician will review the need for continuance of any psychotropic drugs prescribed for purposes of behavior control, at least every 30 days. (Note: This requirement is supported by the requirement set forth at section 1919(c)(1)(D) of the Act for nursing home reform.)

b. *Financial Accountability.* The State must assure financial accountability for funds expended for home and community-based services. The State must provide for an independent audit of its waiver program (except as HCFA may otherwise specify for particular waivers), and maintain and make available to HHS, the Comptroller General, or other designees, appropriate financial records documenting the cost of services furnished under the waiver, including reports of any independent audits conducted. The performance of a single financial audit in accordance with the Single Audit Act of 1984 (Pub. L. 98–502, enacted on October 19, 1984) is deemed to satisfy the requirement for an independent audit.

c. *Evaluation of Need.* Under section 1915(d) of the Act, waiver services are limited to individuals age 65 or older who have been determined, but for the provision of these services, to be likely to require the level of care furnished in a NF, the cost for which can be paid under the State plan. Therefore, when submitting a waiver request, the State must assure that it will provide for an evaluation (and periodic reevaluations) of the need for the level of care furnished in a NF, when there is a reasonable indication that individuals are likely to require these services in the near future, but for the availability of home and community-based services. We will require that States provide for an initial evaluation of level of care before the provision of home and community-based services under a waiver. To ensure the consistent application of level of care criteria, we also will require that the procedures and criteria used to assess level of care for potential waiver recipients be at least as stringent as any existing State procedures applicable to individuals entering a NF. We considered requiring States to include a health professional (that is, a physician or registered nurse) on the team which determines level of care. We considered this option because we anticipated that recipients under this program would have a level-of-care need that could only be properly evaluated by a health care professional. Instead, we are requesting public comment on this issue.

To ensure that an individual continues to meet one of the required levels of care specified in the statute, we further mandate a periodic reevaluation of the level of care. However, in no case can the period of reevaluation of level of care extend beyond 1 year.

d. *Expenditures.* The agency must assure that the total amount expended by the State for medical assistance with respect to NF, home health, private duty nursing, personal care services, home and community-based services furnished under a section 1915(c) waiver granted under subpart G of part 441 to individuals age 65 or older, and the home and community-based services approved and furnished under this section 1915(d) waiver for individuals age 65 or older during a waiver year will not exceed the APEL.

e. *Reporting.* Consistent with section 1915(d)(2)(C) of the Act, each State that requests a waiver under section 1915(d) of the Act must assure that it will furnish specific information to the Secretary annually, consistent with a reasonable data collection plan that will be developed by HCFA. This information must include data on the impact of the waiver on the type, amount, and cost of medical assistance provided for under the State plan, and on the health and welfare of the recipients. Reporting on the "cost" of medical assistance, although not statutorily required, is essential to determine whether the State may have exceeded the APEL on services for which FFP is available.

14. Supporting Documentation Required

We are adding a new § 441.353 to describe the supporting documentation required under the waiver.

a. *Health and Welfare.* As previously discussed, we are requiring the State to assure that adequate standards exist for each provider of services under the waiver, and that all provider standards will be met.

Section 441.353(a) requires that copies of provider qualifications or standards for each service to be offered under the waiver be included as part of the State's waiver request. These qualifications or standards must be reasonably related to the skills required for delivery of the waiver services. The State must also describe the administrative oversight mechanisms it will use to ensure quality of care. FFP will not be available for services furnished by providers or in facilities that do not meet the standards set forth in the waiver request.

b. *Financial Accountability.* In § 441.353(b), we are requiring the State to describe the records and information that will be maintained by the agency and by providers of services to support financial accountability, and to provide information regarding how the State will meet the requirement for financial accountability. We are also requiring an explanation of how the State will assure that there is an audit trail (that is, supporting records) for State and Federal funds expended for section 1915(d) home and community-based waiver services. In addition, States with an approved Medicaid Management Information System (MMIS) must use this system to process individual claims data and thus account for funds expended for services under the waiver. We are specifically requesting public comment on this provision, as well as any suggestions for alternative systems that would improve the accounting for funds expended for waiver services.

c. *Evaluation and Reevaluation of Recipients' Level of Care.* Under § 441.353(c), we are requiring the State agency to provide a description of the agency's plan for all evaluations and reevaluations of the level of care required by recipients under the waiver. This plan must include a description of the qualifications of the individuals who will make these evaluations and the criteria under which the evaluation will be judged. A copy of the written assessment instruments (forms and criteria that will be used in the level of care determinations) and the agency's procedure to assure the maintenance of written documentation on all evaluations and reevaluations and copies of the forms to be used must be included with the waiver request. In accordance with regulations at 45 CFR part 74, written documentation of all evaluations and reevaluations must be

maintained for a minimum period of 3 years. The request must also include an indication of when the initial evaluation will be performed, the frequency of reevaluations, and the procedures and criteria used for evaluation and reevaluation of waiver recipients, which must be the same or more stringent (at the State's option) than those used for individuals served in NFs.

d. Alternatives to Institutional Care. Section 1915(d)(2)(C) of the Act provides that individuals determined to be likely to require the level of care furnished in a NF be informed of feasible alternatives to institutional care if alternatives are available under a waiver and be allowed to choose among them. Therefore, we are requiring at § 441.353(d) that when a recipient is determined to meet the level of care criteria for NF care, the State must inform the recipient or his or her legal representative of any feasible alternatives under the waiver and be given the choice of either institutional or home and community-based services. A description of the agency's plan for informing eligible recipients of these alternative services must be submitted to HCFA. A State requesting a waiver must provide for HCFA review a copy of the forms that will be used to document recipient freedom of choice.

We are also requiring that the State must permit the recipient to choose among providers of both waiver and State plan services. An individual's election to receive home and community-based services under a waiver does not relieve the State from the requirements of section 1902(a)(23) of the Act, regarding free choice of providers. Therefore, a waiver recipient must be permitted free choice of all qualified providers of each service for which he or she is eligible (whether the service is provided under the State plan or the waiver), and the State must allow any person or entity, qualified to furnish a service (under the State plan or the waiver), who elects to furnish that service, to become a Medicaid provider of that service. The Medicaid agency must provide an opportunity for a fair hearing, under 42 CFR part 431, subpart E, to recipients who are not given the choice of home or community-based services as an alternative to institutional care in a NF or who are denied the service(s) or the provider(s) of their choice.

To provide individuals with the choice between institutional and home and community-based services, both types of care must actually be available in the State, or the "choice" becomes meaningless. The statute recognizes that home and community-based services of the type required by a particular individual may not be available. It therefore specifies that the State need only present this option "if available under the waiver." This exception is not made for the provision of institutional care. We have considered requiring a State requesting a waiver under section 1915(d) of the Act to provide evidence of sufficient capability of serving individuals in an institution (who may qualify for and elect institutional services). This evidence would include data pertaining to the number of individuals on waiting lists for institutional care, and the length of time between application and admission to NF care. We have decided against this requirement at the present time. However, we specifically request public comment on the issue of the necessity of the maintenance of adequate institutional capacity in the presence of a waiver to serve the number of individuals, including persons under age 65, who may reasonably be expected to qualify for and choose institutional care.

e. Post-Eligibility Treatment of Income. We are requiring at § 441.353(e) that the State must explain how the agency will apply the applicable provisions regarding the post-eligibility treatment of income and resources of those individuals receiving home and community-based services who are eligible under a special income level.

5. Aggregate Projected Expenditure Limit

We are adding a new § 441.354 to describe the aggregate projected expenditure limit (APEL). To ensure that FFP is properly claimed for waiver and other State plan services included in the statutory expenditure limit, we will require each State to include in its waiver request a description of the methodology to be used to maintain appropriate documentation of service expenditures. To receive payment for waiver services under section 1915(d) of the Act, we will require that claims be documented as they are for any other Medicaid service. This documentation will typically include the date of service; name of recipient; name and Medicaid identification number of the provider agency and person furnishing the service; nature, extent, or units of service furnished; and the place of service. The use of other documentation, such as time studies, random moment studies, or cost allocation plans, will not be considered sufficient as a basis for claiming FFP at the service match rate.

Section 1915(d)(5)(A) of the Act requires that if a State has a waiver approved under this subsection, the total amount expended for medical assistance with respect to NF services, and home and community-based services for individuals age 65 or older during a waiver year may not exceed an amount determined by a formula set forth in the statute. This amount is determined by inflating the State's expenditures for these services during a base year by a fixed percentage or by certain demographic and market basket indices. For States that have reported these expenditures on the basis of age, the statute sets the base year as "the most recent year (ending before the date of enactment of this subsection) for which actual final expenditures under this title have been reported to, and accepted by, the Secretary." Since Public Law 100–203 was enacted on December 22, 1987, the "most recent year" ending before enactment was Federal fiscal year (FFY) 1987 (that is, October 1, 1986 through September 30, 1987). States that did not report expenditures on the basis of age categories must use as their base year FFY 1989 (that is, October 1, 1988 through September 30, 1989).

To maintain consistency between base years and waiver reporting years, we will require all waivers under section 1915(d) of the Act to begin and end on the same dates as a FFY. In addition, to prevent the confusion that would inevitably arise if a waiver were to be approved with an effective date that has already passed, we will require that all waivers under this section be approved with prospective implementation dates.

For States with section 1915(d) waivers currently in effect, the APEL for the waiver year that coincides with FFY 1990, and each succeeding waiver year will be determined as if the regulations had been published on October 1, 1989. The decision to retroactively apply the maximum limit afforded by the computation of the APEL, rather than to make it effective upon issuance of the regulation, is discretionary. We do not believe it is equitable to financially disadvantage any State participating in this program because of a delay in publishing the regulation. We believe it is not in the best interest of the program to restrict States where an approved section 1915(d) waiver is in operation to annual funding increases of 7 percent instead of a higher limit that could be afforded under this regulation.

We will treat the effective dates for amendments to approved waivers under section 1915(d) of the Act differently from the effective dates for initial waivers. A State wishing to amend an approved waiver under section 1915(d)

of the Act may request that the waiver modifications be made effective retroactive to the first day of the waiver year in which the amendment is submitted, except when the amendment includes a substantive change in the program, for example, when additional services under the waiver are added, or changes are made in the qualifications of service providers. Approval of a retroactive effective date for amendments to approved waivers will remain discretionary with HCFA. Amendments that propose substantive changes, for example, those that change the target population eligible to receive waiver services, add additional services, or change the qualifications of the service providers, will only be given prospective effective dates; however, these dates need not coincide with the start of the next FFY. However, consideration will be given to a State's preference in this regard.

States are not required to furnish each service listed in section 1915(d)(5)(A) of the Act, unless the service is made available under the State plan to equivalent eligibility groups of individuals under age 65. Similarly, section 1915(c) waiver services furnished to individuals who would otherwise require care in an ICF/MR or hospital will not be included in the expenditure limit. However, section 1915(c) waiver services furnished to individuals age 65 or older who would otherwise require care in a NF (including a NF which qualifies as an IMD when the State plan provides for services to individuals age 65 or older who are in an IMD) must be included in the expenditure ceiling.

Section 1915(d)(5)(B) of the Act prescribes a methodology by which the aggregate expenditure limit is to be calculated. This limit is to be projected as the sum of:

(a) The aggregate amount of the State's medical assistance under title XIX for NF services furnished to individuals who have attained the age of 65 for the base year increased by a percentage which is equal to the lesser of 7 percent times the number of years (rounded to the nearest quarter of a year) beginning after the base year and ending at the end of the waiver year involved, or the sum of—

(i) The percentage increase (based on an appropriate market basket index representing the costs of elements of these services) between the beginning of the base year and the beginning of the waiver year involved, plus

(ii) The percentage increase in the number of residents in the State who have reached age 65, between the beginning of the base year and the beginning of the waiver year involved, plus

(iii) 2 percent for each year (rounded to the nearest quarter of a year) beginning after the base year and ending at the end of the waiver year.

(b) The aggregate amount of the State's medical assistance under title XIX for home and community based services for individuals who have reached age 65 for the base year increased by a percentage that is equal to the lesser of 7 percent times the number of years (rounded to the nearest quarter of a year) beginning after the base year and ending at the end of the waiver year involved or the sum of—

(i) The percentage increase (based on an appropriate market basket index representing the costs of elements of these services) between the beginning of the base year and the beginning of the waiver year involved, plus

(ii) The percentage increase in the number of residents in the State who have reached age 65, between the beginning of the base year and the beginning of the waiver year involved, plus

(iii) 2 percent for each year (rounded to the nearest quarter of a year) beginning after the base year and ending at the end of the waiver year.

On the date on which final regulations become effective, any reference to "the lesser of 7 percent" will be deemed to be a reference to "the greater of 7 percent," in accordance with section 1915(d)(5)(B) of the Act.

The statute requires that the expenditure limit be calculated using data from a base year. We believe that the best source of Medicaid expenditure data is Form HCFA 64. This is the form each State must use to claim FFP. The form identifies the major categories of Medicaid expenditures, but does not identify expenditures by age category. Therefore, we will adjust the appropriate categories of expenditures reported on Form HCFA 64 by a ratio of expenditures for that category of service as reported on Form HCFA 2082 for the same year. (Form HCFA 2082 is an annual statistical reporting form that captures cost and utilization data for Medicaid services, based on the date of payment for the services.) We will calculate this ratio as the total amount reported on Form HCFA 2082 that the State has expended for specific service categories for individuals age 65 or older, divided by the total expenditures reported by the State for that service for the entire Medicaid population. States will be able to calculate initial projections based on data they submit to HCFA. HCFA will calculate final projections after all final adjustments have been made for the fiscal (base) year.

To calculate the market basket index for NF services furnished to individuals age 65 or older, we will use the SNF Input Price Index used in the Medicare program. The index to be used is identified as the third quarter data available from HCFA's Office of National Cost Estimates in August preceding the start of the fiscal year. We believe this is in keeping with Congressional intent to meld the SNF and ICF levels of care into a single category of "nursing facility" as evidenced by section 4211 of Public Law 100–203, which became effective on October 1, 1990.

To calculate the percentage increase in the number of residents in the State who have reached the age of 65, we will use the number of aged Medicare beneficiaries in the State, equal to the Mid-Period Enrollment in the Hospital Insurance (HI) or Supplementary Medical Insurance (SMI) programs in that State for July 1 preceding the start of the fiscal year. We have chosen the July 1 date because it represents the latest date for which data would be available prior to the inception of a waiver year (which would start on October 1). Thus, for example, the number of aged Medicare beneficiaries for fiscal year 1991 would be determined as of July 1, 1990.

Section 1915(d)(5)(B)(iii) of the Act requires the Secretary to develop a method for projecting, on a State-specific basis, the percentage increase in the number of residents in each State who are over 75 years of age for any period. We will use the same HI and SMI data to calculate these increases as are used to calculate the number of individuals who have attained the age of 65. Readers should note, however, that although the number of individuals who are over age 75 will be calculated, these data will not be reflected in the computation of the APEL, because the statute specifies that only data pertaining to individuals age 65 or older be used in this computation.

We are unable to identify a common market basket for home health care, personal care services, private duty nursing services, and services furnished under a home and community-based services waiver. Since these types of services, when furnished to a similar population (that is, individuals age 65 or older), tend to include the same core elements and include services furnished by individuals with similar occupations, we will use as a market basket index the Home Health Agency Input Price Index used in the Medicare program and

published periodically in the **Federal Register.**

To establish the aggregate amount of the State's medical assistance under a State's Medicaid program for home and community-based services (defined by the statute to include home health care, personal care services, private duty nursing services, and services furnished under a home and community-based services waiver), furnished to individuals 65 years of age or older during the base year, we will adjust the amount reported by the State on Form HCFA 64 for the base year period for home health services by the ratio of expenditures for home health services for the aged to total expenditures for home health services, as reported on Form HCFA 2082 for the same period. On these forms, the category of "home health services" is intended to include expenditures for home health care, personal care, and home and community-based services. States may report expenditures for private duty nursing services either in the category of "home health" or in the generic category of "other" services. Therefore, States that report private duty nursing expenditures in the "other" category should notify us of this fact at the time the waiver is submitted, and include an estimate of the amount of Medicaid expenditures for this service to be included in the base year calculations of the expenditure limit projections.

We recognize that many of these data will not be available at the time of expenditure. Therefore, we expect States to make their best estimates based on available data, with a retrospective accounting and adjustment occurring when all the data become known.

To calculate the projected expenditure limit for each year of a State's waiver, we are incorporating the following formula into the regulations:

$APEL = P \times (1+Y) + V \times (1+Z)$, where

P = The aggregate amount of the State's medical assistance under title XIX for SNF and ICF (NF effective October 1, 1990) services furnished to individuals who have reached the age of 65, defined as the total medical assistance payments (Federal and State) reported on line 6 of Form HCFA 64 (as adjusted) for SNF services, ICF-other services, and mental health facility services for the base year, multiplied by the ratio of expenditures for SNF and ICF-other services for the aged to total expenditures for these services as reported on Form HCFA 2082 for the base year.

Q = The market basket index for SNF and ICF (NF effective October 1, 1990) services for the waiver year involved, defined as the total SNF Input Price Index used in the Medicare program, identified as the third quarter data available from HCFA's Office of National Cost Estimates in August preceding the start of the fiscal year.

R = The SNF Input Price Index for the base year.

S = The number of residents in the State in the waiver year involved who have reached age 65, defined as the number of aged Medicare beneficiaries in the State, equal to the Mid-Period Enrollment in HI or SMI in that State on July 1 preceding the start of the fiscal year.

T = The number of aged Medicare beneficiaries in the State who are enrolled in either the HI or SMI programs in the base year, as defined in S, above.

U = The number of years beginning after the base year and ending on the last day of the waiver year involved.

V = The aggregate amount of the State's medical assistance under title XIX in the base year for home and community-based services for individuals who have reached age 65, defined as the total medical assistance payments (Federal and State) reported on line 6 of Form HCFA 64 (as adjusted) for home health, personal care and home and community-based services waivers, which provide care as an alternative to SNF or ICF (NF effective October 1, 1990) services, increased by an estimate (acceptable to HCFA) of expenditures for private duty nursing services, multiplied by the ratio of expenditures for home health services for the aged to total expenditures for home health services, as reported on Form HCFA 2082, for the base year.

W = The market basket index for home and community-based services for the waiver year involved, defined as the Home Health Agency Input Price Index, used in the Medicare program, identified as the third quarter data available from HCFA's Office of National Cost Estimates in August preceding the start of the fiscal year.

X = The Home Health Agency Input Price Index for the base year.

Y = The greater of—
$(U \times .07)$, or $(Q/R) - 1 + (S/T) - 1 + (U \times .02)$.

Z = The greater of—
$(U \times .07)$, or $(W/X) - 1 + (S/T) - 1 + (U \times .02)$.

Under this methodology, the expenditure limitation will be the greater of the amount calculated under this formula, or 7 percent times the number of years beginning after the base year and ending at the end of the waiver year. A separate calculation will be made for each year of the waiver.

FFP is available in expenditures for NF, home health, personal care, private duty nursing services furnished to individuals age 65 or older, and home and community-based waiver services furnished to individuals age 65 or older under section 1915(d) and services furnished under a section 1915(c) waiver to individuals age 65 or older as an alternative to care in an NF up to the APEL, calculated in accordance with the formula above. Should a State exceed the APEL, it may no longer claim FFP for these services for this population for the remainder of the FFY. However, the State may not diminish or refuse to furnish services included in its Medicaid plan for these individuals, when FFP is no longer available, because the State has exceeded the APEL. The Budget Committee of the House of Representatives (H.R. Report No. 391, 100th Cong., 1st Sess., 573 (1987)) explained.

> The Committee emphasizes that elderly Medicaid-eligible individuals receiving or applying for either nursing home or home and community-based services in a State with such a waiver continue to be likely to require services covered under the State plan, even if the State has exceeded its projected amount in a given waiver year and loses its claim to Federal matching payments for any additional costs incurred. The State's cost overrun would not extinguish the beneficiaries' entitlement. If a State's actual expenditures exceed its projected expenditures for a given waiver year, it will have to absorb the entire excess cost of providing the benefits to which elderly individuals eligible for Medicaid are entitled.

Section 411(k)(3) of Public Law 100–360 added a requirement that the Secretary develop (by not later than October 1, 1989) a method for projecting, on a State-specific basis, the percentage increase in the number of residents in each State who are over 65 years of age for any period. As with the State-specific calculation of the increase in the number of individuals who are age 65 or older, we propose to use data from the Medicare HI and SMI files, which are maintained in HCFA. Because these data are already on file for use in the Medicare program, there will be no additional burden on States to assist in the collection of these statistics.

We are implementing section 1915(d)(5)(B)(iv) of the Act by permitting States to amend their approved waivers to raise their APELs to account for increased costs (see § 441.354(d)). To be considered, these increased costs must be the result of implementation of legislative changes to the Medicaid laws enacted on or after December 22, 1987.

Costs attributable to laws enacted before December 22, 1987 will not be considered. Because the APEL for each year of the waiver is computed separately from the APEL for any other waiver year, a separate amendment must be submitted for each year in which the State chooses to request an increase in its APEL. Documentation

specific to the waiver year involved must be submitted.

6. Duration of a Waiver

We are adding a new § 441.355, which describes the duration of a waiver.

Because each APEL will be in effect for a 1-year period, we believe it is important to establish consistency between waiver years and FFYs. Therefore, we are establishing the effective date of a section 1915(d) waiver prospectively, to begin on the first day of the FFY following the date of approval. Subject to termination by the State and upon notice to the Secretary, the waiver will be in effect for 3 years, and, upon request, may be extended for an additional 5-year period, provided the assurances required by § 441.352 are met. Waivers may be extended for additional 5-year periods upon receipt of the State's request, and approval by HCFA.

The agency may request that the waiver modifications be made effective retroactive to the first day of the waiver year in which the amendment is submitted, except when the amendment would make substantive changes. Substantive changes may include but are not limited to addition of services under the waiver, a change in the qualifications of service providers, or a change in the eligible population. This type of amendment request will be given a prospective effective date, but this date need not coincide with the start of the next FFY.

HCFA will determine whether a request for an extension of a waiver is an extension request (applicable for a period of 5 years), or is actually a request for a new waiver that would be in effect for a period of 3 years. If the extension request proposes a substantive change in services furnished, eligible population, service area, statutory sections waived, or qualifications of service providers, it will be considered a new waiver request.

If HCFA denies a request for a waiver, or for an extension of a waiver, the statute provides that the determination may be reconsidered in accordance with § 441.357. In the case of a denial of a request for an extension (renewal) of an existing waiver, the waiver will remain in effect for at least 90 days after the date of the denial. If the State seeks reconsideration of the denial, the waiver will remain in effect for a period of at least 90 days after the date on which a final determination is made. HCFA will calculate an APEL for the period for which the waiver remains in effect, and will pro-rate the limit according to the number of days to which it applies.

7. Waiver Termination

We are adding a new § 441.356 that addresses waiver termination. Section 1915(d)(3) of the Act specifies that a State may terminate a waiver at any time, after notice to the Secretary. Section 441.305(a) requires the State agency to notify us in writing at least 30 days before a State's termination of a home and community-based services waiver under section 1915(c) of the Act. The provisions of § 441.305(b), which now apply to section 1915(c) waivers, will also be applicable to section 1915(d) waivers. In addition to requiring at least 30 days notice to recipients before terminating waiver services, the provisions of § 441.305(b) require that the notice follow the requirements concerning content specified in § 431.210 as well.

Although a State may terminate its waiver at any time after a 30-day prior written notification to HCFA and the waiver recipients, the termination will have the effect of eliminating the availability of home and community-based services furnished under the waiver. The State's termination of a waiver will not end the use of the APEL for the current FFY under which the State plan services included in the limit must be provided. When the State chooses to terminate its waiver program, the knowledge that the APEL will continue to be applied should deter the State from allowing its APEL to be reached, for example, within the first few months of the waiver year based on an expectation that unlimited FFP will follow.

In support of this provision, the Budget Committee of the House of Representatives (H. R. Report No. 391, 100th Cong., 1st Sess., 573, (1987)) states:

> to assure budget neutrality, the Committee amendment specifies that even if a State terminates its participation during the course of a waiver year, it would remain subject to the limit on Federal matching payments determined by the projected amount for that year.

Therefore, we will require a State that has terminated its waiver under section 1915(d) of the Act to continue to make all services in its approved State plan available to individuals age 65 or older in the same amount, duration, and scope as to similarly situated individuals who have not yet reached age 65.

HCFA will terminate a waiver when a State has violated the assurances made as a condition of waiver approval, as well as when the State is found to be operating the program in a fashion that jeopardizes the health and welfare of the recipients of the services, or the integrity of the Federal funds.

If we find that an agency is not meeting the terms of the waiver, we will notify the agency in writing of our findings and its right to a hearing. If, after the notice and hearing, we determine that the agency is not in compliance, HCFA may terminate the waiver.

Should we decide to terminate a waiver, we will apply the APEL in a pro-rated fashion, to expire concurrently with the termination of home and community-based services under the waiver. We believe it would be unfair to continue to apply the APEL to the State plan services that will continue to be provided, when it was not the choice of the State to terminate the waiver program. This is because the basis for the calculation of the APEL (that is, the availability of waiver services) would no longer apply to the State in question. When HCFA chooses to terminate a waiver program because a State has not operated its waiver program properly, continuance of the APEL would financially burden the State. This financial burden is based on the higher costs incurred for NF services in place of the costs incurred for home and community-based services.

If we terminate a waiver, the State must notify recipients of services under the waiver 30 days before terminating services. This requirement is based on § 441.30 (a) and (b), which is the implementing regulation for the 1915(c) waiver program designed to permit clients to prepare alternatives to waiver services.

8. Hearings Procedures

We are adding a new § 441.357 to cover hearings procedures for these waiver terminations. Section 1915(d)(6) of the Act provides that a determination by the Secretary to deny a request for a waiver or an extension of a waiver under section 1915(d) of the Act will be subject to review to the extent provided under section 1116(b) of the Act. Section 441.357 sets forth the procedures for administrative and judicial review of the Secretary's determination of a State plan's conformity to the requirements of the statute. Regulations for hearings and appeals under section 1116(b) of the Act are found at § 430.18. Section 441.357 will cross refer to the existing requirements at § 430.18. We will apply these regulations to denied requests for waivers under section 1915(d) of the Act, along with denied requests for amendment or renewal of these waivers.

Section 1915(d)(6)(B) of the Act provides that, if the Secretary denies a request for extension or renewal of a State's waiver, and the State appeals the

denial, FFP will continue to be available for the later of: 90 days after the date on which the Secretary denied the extension or renewal request, or if the State seeks review of the denial, the date on which the final determination is made based on that review. This provision does not apply to denial of initial waiver requests, or requests for amendment of existing waivers, nor does it apply in situations when the Secretary, after notice and opportunity for appeal, has terminated a waiver.

Section 1915(f) of the Act mandates that HCFA monitor the implementation of all section 1915 waivers to assure that the requirements for the waivers are being met. This section further mandates that the Secretary will, after notice and opportunity for a hearing, terminate a waiver when he finds noncompliance has occurred. Section 441.306 currently applies to hearings procedures for terminations of home and community-based services waivers granted under section 1915(c) of the Act. We are applying the provisions of § 441.306 to terminations of waivers under section 1915(d) of the Act as well. Therefore, the procedures for administrative review of action on State plan material specified at § 430.18 will apply to State requests for hearings on terminations of waivers granted under section 1915(d) of the Act.

9. Limits on Federal Financial Participation

We are adding a new § 441.360 to provide limits on FFP for home and community-based services listed in § 440.181. To assure that the State Medicaid agency meets the waiver's health and welfare standards described in § 441.352(a), we will provide that FFP is not available when the services are furnished in a facility during a period in which the facility is not in compliance with applicable State standards described in that section. In keeping with our policy governing waivers approved under section 1915(c) of the Act, we are providing that FFP is not available for the cost of room and board, except when furnished as part of respite care services in a facility, approved by the State, that is not a private residence. For purposes of the 1915(d) waiver program, "board" means three meals a day or any other full nutritional regimen and does not include meals furnished as part of adult day health services, which do not comprise a full nutritional regimen.

For those waivers that contain personal caregivers as a waiver service, we are specifying that States may include a portion of the room and board attributed to the unrelated personal caregiver who resides in the same household with the waiver recipient. The method of apportioning the costs of room and board will be determined by the State but will be subject to review and approval by HCFA. The methodology used must be explained fully to receive HCFA's approval. FFP for live-in caregivers is not available in situations in which the recipient lives in the caregiver's home or in a residence owned or leased by the provider of Medicaid services (the caregiver).

We are further prohibiting FFP for the following activities: Services not included in the approved State plan and not approved as waiver services by HCFA; services furnished to recipients who are ineligible under the terms of the approved waiver; services furnished by a provider when either the services or the provider fail to meet the standards set by the State and included in the approved waiver; and services furnished to a recipient by his or her spouse.

To prevent duplication of services and as discussed earlier, we are prohibiting FFP for waiver services furnished to individuals while they are inpatients of a hospital, NF, or ICF/MR (see § 441.351(e)(2)). We will require that a State requesting a waiver under section 1915(d) of the Act assure that FFP will not be claimed for these services.

10. Periodic Evaluation, Assessment, and Review

A major emphasis of the section 1915(d) waiver program is the concern for the health and welfare of the recipients of services. A waiver may not be granted unless the State has satisfied the Secretary that necessary safeguards have been taken to protect the health and welfare of the recipients, and should the Secretary determine that these assurances have not been met, he is prohibited from renewing the waiver. Because the APEL constitutes a limit on FFP, we are concerned that there may be an incentive to inappropriately ration necessary care to remain within budgetary restraints. Accordingly, we have made a strong commitment to quality care by proposing periodic evaluation, assessment, and review to counter any financial disincentives to furnish needed services.

To assure quality of services and access to care under this waiver program and to standardize the methodology by which it will be enforced, we will require that a mechanism be established that will evaluate and assess the quality, access, and adequacy of care for individuals under the waiver on an ongoing basis. We will require that the agency either directly, or (through interagency agreement) by other departments of State government (such as the Department of Health or the Agency on Aging), create an evaluation and assessment review team, which will have the responsibility of monitoring, on an ongoing basis, the quality, access, and adequacy of care furnished to Medicaid eligible individuals receiving care under the waiver.

We are adding § 441.365 to provide for periodic evaluation, assessment, and review of the care furnished to recipients of waiver services under part 441, subpart H. We believe these changes will conform the regulations to the health and welfare requirements included in section 1915(d) of the Act.

To ensure that high quality standards for health care are maintained, § 441.365(b) requires a review team to periodically evaluate and assess the care and services furnished to recipients under the waiver provisions of part 441, subpart H. We specify that each review team must consist of a physician or registered nurse, and at least one other individual with appropriate health and social service credentials. If there is no physician on the review team, the Medicaid agency must ensure that a physician is available for consultation. For waiver services furnished to individuals who have been determined to be likely to require the level of care furnished in a NF that is also an IMD, we will require each review team to have a psychiatrist or physician who is knowledgeable about geriatric mental illness and other appropriate mental health or social service personnel with knowledge in the same field.

At § 441.365(c), we specify restrictions on the financial interests and employment of review team members. We specify that no member of the review team may have a financial interest in, or be employed by, any entity that furnishes services to the recipients whose care is under review. We will further require that no member of a review team may evaluate or assess the care of a recipient for whom he or she is a provider. We will also prohibit any individual who serves as case manager, caseworker, benefit authorizer, or in any similar position, from serving as member of a review team that evaluates and assesses care furnished to a recipient with whom he or she has had a professional relationship.

Section 441.365(d) requires a sufficient number of review teams located within the State so that onsite inspections can be made at appropriate intervals at sites where waiver recipients receive care and services.

Section 441.365(e) requires the review team and the Medicaid agency to

conduct evaluations and assessments for each recipient under the waiver at least annually. The review team and the agency may choose to conduct evaluations and assessments more frequently than annually based on the quality of care and services being furnished under the waiver and the condition of patients receiving care and services under the waiver.

Section 441.365(f) prohibits notification to a provider in advance of a periodic evaluation, assessment, and review. However, when services are provided in the recipient's own home or the home of a relative, at least 48 hours advance notice must be provided, and the recipient must have the opportunity to decline the visit. This exception is to protect the privacy of the recipient and the recipient's family. If the recipient declines access to his or her own home or the home of a relative, the review is limited solely to the review of the provider's records. If the recipient is incompetent, the head of the household has the authority to decline access to the home.

Section 441.365(g) requires the review team's evaluation and assessment to include a review of each recipient's medical record, the evaluation and reevaluation required by § 441.353(c), and the plan of care under which the waiver and other services are furnished. If these records are inadequate or incomplete, the review team must complete its evaluation and assessment through personal contact and observation of the recipient. The review team may personally contact and observe any recipient of waiver services whose care the team evaluates and assesses. The review team may also consult with both formal and informal caregivers when the recipient's records are inadequate or incomplete and when any apparent discrepancy exists between services required by the recipient and services furnished under the waiver.

Section 441.365(h) requires the review team to determine whether the services included in the plan of care and furnished to the recipient, are adequate to meet the health and welfare needs of each recipient under the waiver. The review team must determine whether the services included in the plan of care have been furnished to the recipient as planned. The team must also determine if it is necessary and in the interest of the recipient to continue receiving services through the waiver program, and if it is feasible to meet the recipient's health and welfare needs through the waiver program.

Section 441.365(i) establishes the basis for a review team to determine the adequacy of services to ensure the protection of the health and welfare of waiver recipients. The review team may consider whether the medical record, the determination of level of care, and the plan of care are consistent, and whether all ordered services have been furnished and properly recorded. Additionally, the team must consider whether physician review of prescribed psychotropic medications, when prescribed for behavior control, has occurred at least every 30 days. Another consideration of the review team is whether tests or observations of each recipient indicated by his or her medical record are made at appropriate times and properly recorded.

Other information the review team may examine includes whether progress notes entered in the record by formal and informal caregivers are made as required and appear to be consistent with the observed condition of the recipient. The review team also determines whether reevaluations of the recipient's level of care have occurred at least as frequently as would be required if that individual were served in a NF.

When observation of the recipient is necessary (requirements for the necessity of observation are set forth in new § 441.365(g)(3)), the review team must, at a minimum, weigh the following factors in determining whether the recipient receives adequate care and services: cleanliness of the recipient; absence of bedsores; and absence of signs of malnutrition or dehydration.

Furthermore, the review team may examine whether the recipient needs any service that is not included in the plan of care, or if included, is not being furnished by formal or informal caregivers under the waiver or through arrangements with another public or private source of assistance. Finally, the review team may determine whether the recipient requires continued home and community-based services to avoid the likelihood of placement in a nursing facility.

Section 441.365(j) requires that the review team submit the results of its periodic evaluations, assessments and reviews to the Medicaid agency within a reasonable period of time, not to exceed one month, after the completion of its review of each recipient's care. This section also requires that the team immediately notify the agency when it discovers conditions that may constitute a threat to the life or health of a recipient.

Section 441.365(k) requires that the Medicaid agency establish and adhere to procedures for taking appropriate action in response to the findings reported by the review teams. These procedures must provide for immediate response to any team's finding that the life or health of a recipient may be jeopardized.

IV. Regulatory Impact Statement

A. Executive Order 12291

Executive Order 12291 (E.O. 12291) requires us to prepare and publish a regulatory impact analysis for any interim final rule that meets one of the E.O. criteria for a "major rule"; that is, that would be likely to result in—

- An annual effect on the economy of $100 million or more;
- A major increase in costs or prices for consumers, individual industries, Federal, State, or local government agencies, or geographic regions; or
- Significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export markets.

Section 4102 of Public Law 100–203, effective January 1, 1988, as amended by section 411(k) of Public Law 100–360 and by section 8432 of Public Law 100–647, amended section 1915 of the Act. These changes redesignated section 1915(d) of the Act as section 1915(h) and added a new category of waiver under section 1915(d) entitled "Home and Community-Based Services for the Elderly."

Under section 1915(d) of the Act, State Medicaid agencies may request the authority to provide home and community-based services to individuals age 65 and older who are determined to be likely to require the level of care furnished in a NF if the home and community-based services are not provided. Section 440.181 of this rule, which implements section 1915(d)(4) of the Act, includes those home and community-based services that a State may provide under a section 1915(d) waiver.

In return for this waiver, States must limit expenditures for these services, along with NF, home health, personal care, and private duty nursing services as well as any services provided under a section 1915(c) waiver to individuals age 65 and older. A waiver under section 1915(c) of the Act allows State Medicaid agencies to provide for services not otherwise available under Medicaid to individuals who, absent these services, would otherwise be institutionalized in a hospital, NF, or ICF/MR.

To date, only one State has applied for and received a waiver under section 1915(d) of the Act. We do not have data that will assist in predicting the number

of States planning to request waivers in accordance with these rules. Because the waivers must contain costs within the APEL, this interim final rule does not meet the $100 million criterion nor do we believe that it meets the other E.O. 12291 criteria. Therefore, this rule is not a major rule under E.O. 12291, and a regulatory impact analysis is not required.

B. Regulatory Flexibility Act

We generally prepare a regulatory flexibility analysis that is consistent with the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 through 612) unless the Secretary certifies that a final rule will not have a significant economic impact on a substantial number of small entities. For purposes of the RFA, States and individuals are not considered small entities.

In addition, section 1102(b) of the Act requires the Secretary to prepare a regulatory impact analysis if a final rule may have a significant impact on the operations of a substantial number of small rural hospitals. Such an analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital which is located outside of a Metropolitan Statistical Area and has fewer than 50 beds.

We have determined, and the Secretary certifies that this interim final rule will not result in a significant economic impact on a substantial number of small entities and will not have a significant economic impact on the operations of a substantial number of small rural hospitals. Therefore, we are not preparing analyses for either the RFA or section 1102(b) of the Act.

V. Waiver of Notice of Proposed Rulemaking and Delay in the Effective Date

We ordinarily publish a general notice of proposed rulemaking in the **Federal Register**, and invite prior public comment on the proposed rule. The rule includes a reference to the legal authority under which it is proposed, and the terms and substance of the proposed rule or a description of the subjects and issues involved. However, this procedure can be waived when an agency finds good cause that a notice-and-comment procedure is impracticable, unnecessary, or contrary to the public interest, and incorporates a statement of the finding and its reasons in the rule issued.

Public Law 100–203, enacted on December 22, 1987 (as modified by Public Law 100–360, enacted on July 1, 1988; and Public Law 100–647, enacted on November 10, 1988; and Public Law 101–508, enacted on November 6, 1990) amended the Act to add a waiver for the provision of home and community-based services for individuals age 65 or older. In order to have regulations in place as close as possible to the effective date of the law, we must publish these regulations in interim final form promptly. For this reason, and because we believe that the States and a substantial number of Medicaid recipients may benefit by these regulations, we believe that publication of a notice of proposed rulemaking and delay in the effective date would be contrary to the public interest. We therefore find good cause to waive notice of proposed rulemaking and our normal 30-day delay in the effective date. We will, however, consider any comments on this interim final rule that are mailed by the date specified above in the "**DATES**" section and make any further changes that may be necessary when the rule is published in final. At that time, we will also respond to the public comments received.

VI. Other Required Information

A. Paperwork Burden

Final interim regulations at §§ 441.351, 441.352, 441.353, 441.356, and 441.365 contain information collection and recordkeeping requirements that are subject to review by the Office of Management and Budget (OMB) under the Paperwork Reduction Act of 1980 (44 U.S.C. 3501 et seq.). This regulation amends current Medicaid regulations to permit States to offer, under a Secretarial waiver, a wide array of home and community-based services to individuals age 65 or older who are determined, but for the provision of these services, to likely require the level of care furnished in a NF. The information collection requirements concern the preparation of the waiver request and report on the operation of the approved waiver program. The respondents who will provide the information include the State Medicaid agencies.

The overall public reporting burden for this collection of information is estimated to be 63,806 hours as shown in the following tables:

	Hours
Response and Reporting Burden (Annualized for Three States):	
Sections 441.351, 441.352, and 441.353 (Preparation of waiver request)	200
Sections 441.352 and 441.365 (Cost reporting)	60
Section 441.356 (Termination requests)	(1)
Total hours for response and reporting burden	260
Recordkeeping Burden (Annualized for Three States):	
Section 441.365 (Recording and managing recipient information)	63,546
Recordkeeping burden	63,546
Total burden	63,806

[1] Negligible.

A notice will be published in the **Federal Register** after approval is obtained. Organizations and individuals desiring to submit comments on the information collection and recordkeeping requirements should direct them to the OMB official whose name appears in the "**ADDRESSES**" section of this preamble.

B. Public Comment Period

Because of the large number of items of correspondence we normally receive on a regulation, we are not able to acknowledge or respond to them individually. However, we will consider all comments that we receive by the date and time specified in the "**DATES**" section of this preamble, and when we proceed with a subsequent final rule, we will respond to the comments in the preamble of that rule.

List of Subjects

42 CFR Part 400

Grant programs-health, Health facilities, Health maintenance organizations (HMO), Medicaid, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 435

Aid to Families with Dependent Children, Grant programs-health, Medicaid, Reporting and recordkeeping requirements, Supplemental Security Income (SSI), Wages.

42 CFR Part 436

Aid to Families with Dependent Children, Grant programs-health, Guam, Medicaid, Puerto Rico, Supplemental Security Income (SSI), Virgin Islands.

42 CFR Part 440

Grant programs-health, Medicaid.

42 CFR Part 441

Family planning, Grant programs-health, Infants and children, Medicaid, Penalties, Prescription drugs, Reporting and recordkeeping requirements.

42 CFR chapter IV is amended as set forth below:

CHAPTER IV—HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES

PART 400—INTRODUCTION; DEFINITIONS

A. Part 400 is amended as follows:

1. The authority citation for part 400 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh) and 44 U.S.C. chapter 35.

§ 400.203 [Amended]

2. In § 400.203, the definition for "nursing facility" (NF) is added in alphabetical order as follows:

* * * * *

Nursing facility (NF), effective October 1, 1990, means an SNF or an ICF participating in the Medicaid program.

* * * * *

PART 435—ELIGIBILITY IN THE STATES, DISTRICT OF COLUMBIA, THE NORTHERN MARIANA ISLANDS, AND AMERICAN SAMOA

B. Part 435 is amended as follows:

1. The authority citation for part 435 continues to read as follows:

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

Subpart A—Introduction, Definitions, and General Provisions

2. In § 435.3(a), the introductory paragraph is revised and reference to section 1915(d) of the Act is added following the entry for section 1915(c) of the Act to read as follows:

§ 435.3 Basis.

(a) This part implements the following sections of the Act and public laws that mandate eligibility requirements and standards:

* * * * *

1915(d) Home or community-based services for individuals age 65 or older.

* * * * *

Subpart C—Options for Coverage as Categorically Needy

3. Section 435.217 is revised as follows:

§ 435.217 Individuals receiving home and community-based services.

The agency may provide Medicaid to any group or groups of individuals in the community who meet the following requirements:

(a) The group would be eligible for Medicaid if institutionalized.

(b) In the absence of home and community-based services under a waiver granted under part 441—

(1) Subpart G of this subchapter, the group would otherwise require the level of care furnished in a hospital, NF, or an ICF/MR; or

(2) Subpart H of this subchapter, the group would otherwise require the level of care furnished in an NF and are age 65 or older.

(c) The group receives the waivered services.

Subpart H—Financial Requirements for the Categorically Needy

4. In § 435.726, paragraph (b) is revised to read as follows:

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

* * * * *

(b) This section applies to individuals who are eligible for Medicaid under § 435.217 and are receiving home and community-based services furnished under a waiver of Medicaid requirements specified in part 441, subpart G or H of this subchapter.

* * * * *

5. In § 435.735, paragraph (b) is revised to read as follows:

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

* * * * *

(b) This section applies to individuals who are eligible for Medicaid under § 435.217, and are eligible for home and community-based services furnished under a waiver of State plan requirements specified in part 441, subpart G or H of this subchapter.

* * * * *

PART 436—ELIGIBILITY IN GUAM, PUERTO RICO, AND THE VIRGIN ISLANDS

C. Part 436 is amended as follows:

1. The authority citation for part 436 continues to read as follows:

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

Subpart A—General Provisions and Definitions

2. In § 436.2, the introductory paragraph is revised and reference to section 1915(d) of the Act is added following the entry for section 1915(c) of the Act to read as follows:

§ 436.2 Basis.

This part implements the following sections of the Act and public laws that mandate requirements and standards for eligibility:

* * * * *

1915(d) Home and community-based services for individuals age 65 or older.

* * * * *

3. Section 436.217 is revised to read as follows:

§ 436.217 Individuals receiving home and community-based services.

The agency may provide Medicaid to any group or groups of individuals in the community who meet the following requirements:

(a) The group would be eligible for Medicaid if institutionalized.

(b) In the absence of home and community-based services under a waiver granted under part 441—

(1) Subpart G of this subchapter, the group would otherwise require the level of care furnished in a hospital, NF, or an ICF/MR; or

(2) Subpart H of this subchapter, the group would otherwise require the level of care furnished in an NF and are age 65 or older.

(c) The group receives the waivered services.

PART 440—SERVICES: GENERAL PROVISIONS

D. Part 440 is amended as follows:

1. The authority citation for part 440 continues to read as follows:

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

2. Section 440.1 is revised to read as follows:

§ 440.1 Basis and purpose.

This subpart interprets and implements the following sections of the Act:

1902(a)(43) Laboratory services. (See also §§ 447.10 and 447.342 for related provisions on laboratory services.)

1905(a) Services included in the term "medical assistance."

1905 (c), (d), (f) through (i), (l), and (m) Definitions of institutions and services that are included in the term "medical assistance."

1913 "Swing-bed" services. (See §§ 447.280 and 482.66 of this chapter for related provisions on "swing-bed" services.)

1915(c) Home and community-based services listed as "medical assistance" and furnished under waivers under that section to individuals who would otherwise require the

level of care furnished in a hospital, NF, or ICF/MR.

1915(d) Home and community-based services listed as "medical assistance" and furnished under waivers under that section to individuals age 65 or older who would otherwise require the level of care furnished in a NF.

3. Section 440.181 is added to Subpart A to read as follows:

§ 440.181 Home and community-based services for individuals age 65 or older.

(a) *Description of services.*—Home and community-based services for individuals age 65 or older means services, not otherwise furnished under the State's Medicaid plan, or services already furnished under the State's Medicaid plan but in expanded amount, duration, or scope, which are furnished to individuals age 65 or older under a waiver granted under the provisions of part 441, subpart H of this subchapter. Except as provided in § 441.310, the services may consist of any of the services listed in paragraph (b) of this section that are requested by the State, approved by HCFA, and furnished to eligible recipients. Service definitions for each service in paragraph (b) of this section must be approved by HCFA.

(b) *Included services.* (1) Case management services.

(2) Homemaker services.

(3) Home health aide services.

(4) Personal care services.

(5) Adult day health services.

(6) Respite care services.

(7) Other medical and social services requested by the Medicaid agency and approved by HCFA, which will contribute to the health and well-being of individuals and their ability to reside in a community-based care setting.

4. In § 440.250, paragraph (k) is revised to read as follows:

§ 440.250 Limits on comparability of services.

* * * * *

(k) If the agency has been granted a waiver of the requirements of § 440.240 (Comparability of services) in order to provide for home or community-based services under §§ 440.180 or 440.181, the services provided under the waiver need not be comparable for all individuals within a group.

* * * * *

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

E. Part 441 is amended as follows:

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

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

2. A new subpart H is added to read as follows:

Subpart H—Home and Community-Based Services Waivers for Individuals Age 65 or Older: Waiver Requirements

Secs.

Subpart H—Home and Community-Based Services Waivers for Individuals Age 65 or Older: Waiver Requirements

§ 441.350 Basis and purpose.

Section 1915(d) of the Act permits States to offer, under a waiver of statutory requirements, home and community-based services not otherwise available under Medicaid to individuals age 65 or older, in exchange for accepting an aggregate limit on the amount of expenditures for which they claim FFP for certain services furnished to these individuals. The home and community-based services that may be furnished are listed in § 440.181 of this subchapter. This subpart describes the procedures the Medicaid agency must follow to request a waiver.

§ 441.351 Contents of a request for a waiver.

A request for a waiver under this section must meet the following requirements:

(a) *Required signatures.* The request must be signed by the Governor, the Director of the Medicaid agency or the Director of the larger State agency of which the Medicaid agency is a component or any official of the Medicaid agency to whom this authority has been delegated. A request from any other agency of State government will not be accepted.

(b) *Assurances and supporting documentation.* The request must provide the assurances required by § 441.352 of this part and the supporting documentation required by § 441.353.

(c) *Statement for sections of the Act.* The request must provide a statement as to whether waiver of section 1902(a)(1), 1902(a)(10)(B), or 1902(a)(10)(C)(i)(III) of the Act is requested. If the State requests a waiver of section 1902(a)(1) of the Act, the waiver must clearly specify the geographic areas or political subdivisions in which the services will be offered. The State must indicate whether it is requesting a waiver of one or all of these sections. The State may request a waiver of any one of the sections cited above.

(d) *Identification of services.* The request must identify all services available under the approved State plan, which are also included in the APEL and which are identified under § 440.181, and any limitations that the State has imposed on the provision of any service. The request must also identify and describe each service specified in § 440.181 of this subchapter to be furnished under the waiver, and any additional services to be furnished under the authority of § 440.181(b)(7). Descriptions of additional services must explain how each additional service included under § 440.181(b)(7) will contribute to the health and well-being of the recipients and to their ability to reside in a community-based setting.

(e) *Recipients served.* The request must provide that the home and community-based services described in § 440.181 of this subchapter, are furnished only to individuals who—

(1) Are age 65 or older;

(2) Are not inpatients of a hospital, NF, or ICF/MR; and

(3) The agency determines would be likely to require the care furnished in a NF under Medicaid.

(f) *Plan of care.* The request must provide that the home and community-based services described in § 440.181 of this subchapter, are furnished under a written plan of care based on an assessment of the individual's health and welfare needs and developed by qualified individuals for each recipient under the waiver. The qualifications of the individual or individuals who will be responsible for developing the individual plan of care must be described. Each plan of care must contain, at a minimum, the medical and other services to be provided, their frequency, and the type of provider to furnish them. Plans of care must be subject to the approval of the Medicaid agency.

(g) *Medicaid agency review.* The request must assure that the State agency maintain and exercise its authority to review (at a minimum) a valid statistical sample of each month's plans of care. When the services in a plan do not comport with the stated disabilities and needs of the recipient, the agency must implement immediate corrective action procedures to ensure that the needs of the recipient are adequately addressed.

(h) *Groups served.* The request must describe the group or groups of individuals to whom the services will be offered.

(i) *Assurances regarding amount expended.* The request must assure that the total amount expended by the State under the plan for individuals age 65 or older during a waiver year for medical assistance with respect to NF, home health, private duty nursing, personal care, and home and community-based services described in §§ 440.180 and 440.181 of this subchapter and furnished as an alternative to NF care will not exceed the aggregate projected expenditure limit (APEL) defined in § 441.354.

§ 441.352 State assurances.

Unless the Medicaid agency provides the following satisfactory assurances to HCFA, HCFA will not grant a waiver under this subpart and may terminate a waiver already granted.

(a) *Health and welfare.* The agency must assure that necessary safeguards have been taken to protect the health and welfare of the recipients of services by assuring that the following conditions are met:

(1) Adequate standards for all types of providers that furnish services under the waiver are met. (These standards must be reasonably related to the requirements of the waiver service to be furnished.)

(2) The standards of any State licensure or certification requirements are met for services or for individuals furnishing services under the waiver.

(3) All facilities covered by section 1616(e) of the Act, in which home and community-based services are furnished, are in compliance with applicable State standards that meet the requirements of 45 CFR part 1397 for board and care facilities.

(4) Physician reviews of prescribed psychotropic drugs (when prescribed for purposes of behavior control of waiver recipients) occur at least every 30 days.

(b) *Financial accountability.* The agency must assure financial accountability for funds expended for home and community-based services. The State must provide for an independent audit of its waiver program. The performance of a single financial audit, in accordance with the Single Audit Act of 1984 (Pub. L. 98–502, enacted on October 19, 1984), is deemed to satisfy the requirement for an independent audit. The agency must maintain and make available to HHS, the Comptroller General, or other designees, appropriate financial records documenting the cost of services furnished to individuals age 65 or older under the waiver and the State plan, including reports of any independent audits conducted.

(c) *Evaluation of need.* The agency must provide for an initial evaluation (and periodic reevaluations) of the need for the level of care furnished in a NF when there is a reasonable indication that individuals age 65 or older might need those services in the near future, but for the availability of home and community-based services. The procedures used to assess level of care for a potential waiver recipient must be at least as stringent as any existing State procedures applicable to individuals entering a NF. The qualifications of individuals performing the waiver assessment must be as high as those of individuals assessing the need for NF care, and the assessment instrument itself must be the same as any assessment instrument used to establish level of care of prospective inpatients in NFs. A periodic reevaluation of the level of care must be performed. The period of reevaluation of level of care cannot extend beyond 1 year.

(d) *Expenditures.* The agency must assure that the total amount expended by the State for medical assistance with respect to NF, home health, private duty nursing, personal care services, home and community-based services furnished under a section 1915(c) waiver granted under Subpart G of this part to individuals age 65 or older, and the home and community-based services approved and furnished under a section 1915(d) waiver for individuals age 65 or older during a waiver year will not exceed the APEL, calculated in accordance with § 441.354.

(e) *Reporting.* The agency must assure that it will provide HCFA annually with information on the waiver's impact. The information must be consistent with a reasonable data collection plan designed by HCFA and must address the waiver's impact on—

(1) The type, amount, and cost of services furnished under the State plan; and

(2) The health and welfare of recipients of the services described in § 440.181 of this chapter.

§ 441.353 Supporting documentation required.

The agency must furnish HCFA with sufficient information to support the assurances required under § 441.352, in order to meet the requirement that the assurances are satisfactory. At a minimum, this information must consist of the following:

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

This information must include:

(1) A copy of the standards established by the State for facilities (in which services will be furnished) that are covered by section 1616(e) of the Act.

(2) The minimum educational or professional qualifications of the providers of the services.

(3) A description of the administrative oversight mechanisms established by the State to ensure quality of care.

(b) *Records.* A description of the records and information that are maintained by the agency and by providers of services to support financial accountability, information regarding how the State meets the requirement for financial accountability, and an explanation of how the State assures that there is an audit trail for State and Federal funds expended for section 1915(d) home and community-based waiver services. If the State has an approved Medicaid Management Information System (MMIS), this system must be used to process individual claims data and account for funds expended for services furnished under the waiver.

(c) *Evaluation and reevaluation of recipients.* A description of the agency's plan for the evaluation and reevaluation of recipients' level of care, including the following:

(1) A description of who makes these evaluations and how they are made.

(2) A copy of the evaluation instrument.

(3) The agency's procedure to assure the maintenance of written documentation on all evaluations and reevaluations and copies of the forms. In accordance with regulations at 45 CFR part 74, written documentation of all evaluations and reevaluations must be maintained for a minimum period of 3 years.

(4) The agency's procedure to assure reevaluations of need at regular intervals.

(5) The intervals at which reevaluations occur, which may be no less frequent than for institutionalized individuals at comparable levels of care.

(6) The procedures and criteria used for evaluation and reevaluation of waiver recipients must be the same or more stringent than those used for individuals served in NFs.

(d) *Alternatives available.* A description of the agency's plan for informing eligible recipients of the feasible alternatives available under the waiver and allowing recipients to

choose either institutional or home and community-based services must be submitted to HCFA. A copy of the forms or documentation used by the agency to verify that this choice has been offered and that recipients of waiver services, or their legal representatives, have been given the free choice of the providers of both waiver and State plan services must also be available for HCFA review. The Medicaid agency must provide an opportunity for a fair hearing, under 42 CFR part 431, subpart E, to recipients who are not given the choice of home or community-based services as an alternative to institutional care in a NF or who are denied the service(s) or the providers of their choice.

(e) *Post-eligibility of income.* An explanation of how the agency applies the applicable provisions regarding the post-eligibility treatment of income and resources of those individuals receiving home and community-based services who are eligible under a special income level (included in § 435.217 of this subchapter).

§ 441.354 Aggregate projected expenditure limit (APEL).

(a) *Definitions.* For purposes of this section, the term "base year" means—

(1) Federal fiscal year (FFY) 1987 (that is, October 1, 1986 through September 30, 1987); or

(2) In the case of a State which did not report expenditures on the basis of age categories during FFY 1987, the base year means FFY 1989 (that is, October 1, 1988 through September 30, 1989).

(b) *General.* (1) The total amount expended by the State for medical assistance with respect to NF, home and community-based services under the waiver, home health services, personal care services, private duty nursing services, and services furnished under a waiver under subpart G of this part to individuals age 65 or older furnished as an alternative to care in an SNF or ICF (NF effective October 1, 1990), may not exceed the APEL calculated in accordance with paragraph (c) of this section.

(2) In applying for a waiver under this subpart, the agency must clearly identify the base year it intends to use.

(3) The State may make a preliminary calculation of the expenditure limit at the time of the waiver approval; however, HCFA makes final calculations of the aggregate limit after base data have been verified and accepted.

(4) All base year and waiver year data are subject to final cost settlement within 2 years from the end of the base or waiver year involved.

(c) *Formula for calculating APEL.* Except as provided in paragraph (d) of this section, the formula for calculating the APEL follows:

APEL = P × (1+Y) + V × (1+Z), where

P = The aggregate amount of the State's medical assistance under title XIX for SNF and ICF (NF effective October 1, 1990) services furnished to individuals who have reached age 65, defined as the total medical assistance payments (Federal and State) reported on line 6 of form HCFA 64 (as adjusted) for SNF services, ICF-other services, and mental health facility services for the base year, multiplied by the ratio of expenditures for SNF and ICF-other services for the aged to total expenditures for these services as reported on form HCFA 2082 for the base year.

Q = The market basket index for SNF and ICF (NF effective October 1, 1990) services for the waiver year involved, defined as the total SNF Input Price Index used in the Medicare program, identified as the third quarter data available from HCFA's Office of National Cost Estimates in August preceding the start of the fiscal year.

R = The SNF Input Price Index for the base year.

S = The number of residents in the State in the waiver year involved who have reached age 65, defined as the number of aged Medicare beneficiaries in the State, equal to the Mid-Period Enrollment in HI or SMI in that State on July 1 preceding the start of the fiscal year.

T = The number of aged Medicare beneficiaries in the State who are enrolled in either the HI or SMI programs in the base year, as defined in S, above.

U = The number of years beginning after the base year and ending on the last day of the waiver year involved.

V = The aggregate amount of the State's medical assistance under title XIX in the base year for home and community-based services for individuals who have reached age 65, defined as the total medical assistance payments (Federal and State) reported on line 6 of form HCFA 64 (as adjusted) for home health, personal care, and home and community-based services waivers, which provide services as an alternative to care in a SNF or ICF (NF effective October 1, 1990), increased by an estimate (acceptable to HCFA) of expenditures for private duty nursing services, multiplied by the ratio of expenditures for home health services for the aged to total expenditures for home health services, as reported on form HCFA 2082, for the base year.

W = The market basket index for home and community-based services for the waiver year involved, defined as the Home Agency Input Price Index, used in the Medicare program identified as the third quarter data available from HCFA's Office of National Cost Estimates in August preceding the start of the fiscal year.

X = The Home Health Agency Input Price Index for the base year.

Y = The greater of—
(U×.07), or (Q/R)-1+(S/T)-1+(U×.02).

Z = The greater of—
(U×.07), or (W/X)-1+(S/T)-1+(U×.02).

(d) *Amendment of the APEL.* The State may request amendment of its APEL to reflect an increase in the aggregate amount of medical assistance for NF services and for services included in the calculation of the APEL as required by paragraph (c) of this section when the increase is directly attributable to legislation enacted on or after December 22, 1987, which amends title XIX of the Act. Costs attributable to laws enacted before December 22, 1987 will not be considered. Because the APEL for each year of the waiver is computed separately from the APEL for any other waiver year, a separate amendment must be submitted for each year in which the State chooses to raise its APEL. Documentation specific to the waiver year involved must be submitted to HCFA.

§ 441.355 Duration, extension, and amendment of a waiver.

(a) *Effective dates and extension periods.* (1) The effective date for a waiver of Medicaid requirements to furnish home and community-based services to individuals age 65 or older under this subpart is established by HCFA prospectively on the first day of the FFY following the date on which the waiver is approved.

(2) The initial waiver is approved for a 3-year period from the effective date. Subsequent renewals are approved for 5-year periods.

(3) If the agency requests it, the waiver may be extended for an additional 5-year period if HCFA's review of the prior period shows that the assurances required by § 441.352 were met.

(4) The agency may request that waiver modifications be made effective retroactive to the first day of the waiver year in which the amendment is submitted, unless the amendment involves substantive change. Substantive changes may include, but are not limited to, addition of services under the waiver, a change in the qualifications of service providers, or a change in the eligible population.

(5) A request for an amendment that involves a substantive change is given a prospective effective date, but this date need not coincide with the start of the next FFY.

(b) *Extension or new waiver request.* HCFA determines whether a request for extension of an existing waiver is

actually an extension request, or a request for a new waiver. Generally, if a State's extension request proposes a substantive change in services furnished, eligible population, service area, statutory sections waived, or qualifications of service providers, HCFA considers it a new waiver request.

(c) *Reconsideration of denial.* A determination of HCFA to deny a request for a waiver (or for extension of a waiver) under this subpart may be reconsidered in accordance with § 441.357.

(d) *Existing waiver effectiveness after denial.* If HCFA denies a request for an extension of an existing waiver under this subpart:

(1) The existing waiver remains in effect for a period of not less than 90 days after the date on which HCFA denies the request, or, if the State seeks reconsideration in accordance with § 441.357, the date on which a final determination is made with respect to that review.

(2) HCFA calculates an APEL for the period for which the waiver remains in effect, and this calculation is used to pro-rate the limit according to the number of days to which it applies.

§ 441.356 Waiver termination.

(a) *Termination by the State.* If a State chooses to terminate its waiver before an approved program is due to expire, the following conditions apply:

(1) The State must notify HCFA in writing at least 30 days before terminating services to recipients.

(2) The State must notify recipients of services under the waiver at least 30 days before terminating services in accordance with § 431.210 of this chapter.

(3) HCFA continues to apply the APEL described in § 441.354 through the end of the waiver year, but this limit is not applied in subsequent years.

(4) The State may not decrease the services available under the approved State plan to individuals age 65 or older by an amount that violates the comparability of service requirements set forth in § 440.240 of this chapter.

(b) *Termination by HCFA.* (1) If HCFA finds, during an approved waiver period, that an agency is not meeting one or more of the requirements for a waiver contained in this subpart, HCFA notifies the agency in writing of its findings and grants an opportunity for a hearing in accordance with § 441.357. If HCFA determines that the agency is not in compliance with this subpart after the notice and any hearing, HCFA may terminate the waiver.

(2) If HCFA terminates the waiver, the following conditions apply:

(i) The State must notify recipients of services under the waiver at least 30 days before terminating services in accordance with § 431.210 of this chapter.

(ii) HCFA continues to apply the APEL in § 441.354 of this subpart, but the limit is prorated according to the number of days in the fiscal year during which waiver services were offered. The limit expires concurrently with the termination of home and community-based services under the waiver.

§ 441.357 Hearing procedures for waiver denials.

The procedures specified in § 430.18 of this subchapter apply to State requests for hearings on denials, renewals, or amendments of waivers for home and community-based services for individuals age 65 or older.

§ 441.360 Limits on Federal financial participation (FFP).

FFP for home and community-based services listed in § 440.181 of this subchapter is not available in expenditures for the following:

(a) Services furnished in a facility subject to the health and welfare requirements described in § 441.352(a) during any period in which the facility is found not to be in compliance with the applicable State requirements described in that section.

(b) The cost of room and board except when furnished as part of respite care services in a facility, approved by the State, that is not a private residence. For purposes of this subpart, "board" means three meals a day or any other full nutritional regimen. "Board" does not include meals, which do not comprise a full nutritional regimen, furnished as part of adult day health services.

(c) The portion of the cost of room and board attributed to unrelated, live-in personal caregivers when the waiver recipient lives in the caregiver's home or a residence owned or leased by the provider of the Medicaid services (the caregiver).

(d) Services that are not included in the approved State plan and not approved as waiver services by HCFA.

(e) Services furnished to recipients who are ineligible under the terms of the approved waiver.

(f) Services furnished by a provider when either the services or the provider do not meet the standards that are set by the State and included in the approved waiver.

(g) Services furnished to a recipient by his or her spouse.

§ 441.365 Periodic evaluation, assessment, and review.

(a) *Purpose.* This section prescribes requirements for periodic evaluation, assessment, and review of the care and services furnished to individuals receiving home and community-based waiver services under this subpart.

(b) *Evaluation and assessment review team.* (1) A review team, as described in paragraphs (b)(2) and (c) of this section, must periodically evaluate and assess the care and services furnished to recipients under this subpart. The review team must be created by the State agency directly, or (through interagency agreement) by other departments of State government (such as the Department of Health or the Agency on Aging).

(2) Each review team must consist of at least one physician or registered nurse, and at least one other individual with health and social service credentials who the State believes is qualified to properly evaluate and assess the care and services provided under the waiver. If there is no physician on the review team, the Medicaid agency must ensure that a physician is available to provide consultation to the review team.

(3) For waiver services furnished to individuals who have been found to be likely to require the level of care furnished in a NF that is also an IMD, each review team must have a psychiatrist or physician and other appropriate mental health or social service personnel who are knowledgeable about geriatric mental illness.

(c) *Financial interests and employment of review team members.* (1) No member of a review team may have a financial interest in or be employed by any entity that furnishes care and services under the waiver to a recipient whose care is under review.

(2) No physician member of a review team may evaluate or assess the care of a recipient for whom he or she is the attending physician.

(3) No individual who serves as case manager, caseworker, benefit authorizer, or any similar position, may serve as member of a review team that evaluates and assesses care furnished to a recipient with whom he or she has had a professional relationship.

(d) *Number and location of review teams.* A sufficient number of teams must be located within the State so that onsite inspections can be made at appropriate intervals at sites where waiver recipients receive care and services.

(e) *Frequency of periodic evaluations and assessments.* Periodic evaluations and assessments must be conducted at least annually for each recipient under the waiver. The review team and the agency have the option to determine the frequency of further periodic evaluations and assessments, based on the quality of services and access to care being furnished under the waiver and the condition of patients receiving care and services.

(f) *Notification before inspection.* No provider of care and services under the waiver may be notified in advance of a periodic evaluation, assessment, and review. However, when a recipient receives services in his own home or the home of a relative, notification must be provided to the residents of the household at least 48 hours in advance. The recipient must have an opportunity to decline access to the home. If the recipient declines access to his or her own home, or the home of a relative, the review is limited solely to the review of the provider's records. If the recipient is incompetent, the head of the household has the authority to decline access to the home.

(g) *Personal contact with and observation of recipients and review of records.* (1) For recipients of care and services under a waiver, the review team's evaluation and assessment must include—

(i) A review of each recipient's medical record, the evaluation and reevaluation required by § 441.353(c), and the plan of care under which the waiver and other services are furnished; and

(ii) If the records described in paragraph (g)(1)(i) of this section are inadequate or incomplete, personal contact and observation of each recipient.

(2) The review team may personally contact and observe any recipient whose care the team evaluates and assesses.

(3) The review team may consult with both formal and informal caregivers when the recipient's records are inadequate or incomplete and when any apparent discrepancy exists between services required by the recipient and services furnished under the waiver.

(h) *Determinations by the review team.* The review team must determine in its evaluation and assessment whether—

(1) The services included in the plan of care are adequate to meet the health and welfare needs of each recipient;

(2) The services included in the plan of care have been furnished to the recipient as planned;

(3) It is necessary and in the interest of the recipient to continue receiving services through the waiver program; and

(4) It is feasible to meet the recipient's health and welfare needs through the waiver program.

(i) *Other information considered by review team.* When making determinations, under paragraph (h) of this section, for each recipient, the review team must consider the following information and may consider other information as it deems necessary:

(1) Whether the medical record, the determination of level of care, and the plan of care are consistent, and whether all ordered services have been furnished and properly recorded.

(2) Whether physician review of prescribed psychotropic medications (when required for behavior control) has occurred at least every 30 days.

(3) Whether tests or observations of each recipient indicated by his or her medical record are made at appropriate times and properly recorded.

(4) Whether progress notes entered in the record by formal and informal caregivers are made as required and appear to be consistent with the observed condition of the recipient.

(5) Whether reevaluations of the recipient's level of care have occurred at least as frequently as would be required if that individual were served in a NF.

(6) Whether the recipient receives adequate care and services, based, at a minimum, on the following when observations are necessary (the requirements for the necessity of observations are set forth in new § 441.365(g)(3)):

(i) Cleanliness.

(ii) Absence of bedsores.

(iii) Absence of signs of malnutrition or dehydration.

(7) Whether the recipient needs any service that is not included in the plan of care, or if included, is not being furnished by formal or informal caregivers under the waiver or through arrangements with another public or private source of assistance.

(8) Determination as to whether continued home and community-based services are required by the recipient to avoid the likelihood of placement in a NF.

(j) *Submission of review team's results.* The review team must submit to the Medicaid agency the results of its periodic evaluation, assessment and review of the care of the recipient:

(1) Within 1 month of the completion of the review.

(2) Immediately upon its determination that conditions exist that may constitute a threat to the life or health of a recipient.

(k) *Agency's action.* The Medicaid agency must establish and adhere to procedures for taking appropriate action in response to the findings reported by the review team. These procedures must provide for immediate response to any finding that the life or health of a recipient may be jeopardized.

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Gail R. Wilensky,

Administration, Health Care Financing Administration.

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Louis W. Sullivan,

Secretary.

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