Sec. 441.300 Basis and purpose.

Section 1915(c) of the Act permits States to offer, under a waiver of statutory requirements, an array of home and community-based services that an individual needs to avoid institutionalization. Those services are defined in Sec. 440.180 of this subchapter. This subpart describes what the Medicaid agency must do to obtain a waiver.

Sec. 441.301 Contents of request for a waiver.

(a) A request for a waiver under this section must consist of the following:
   (1) The assurances required by Sec. 441.302 and the supporting documentation required by Sec. 441.303.
   (2) When applicable, requests for waivers of the requirements of section 1902(a)(1), section 1902(a)(10)(B), or section 1902(a)(10)(C)(i)(III) of the Act, which concern respectively, statewide application of Medicaid, comparability of services, and income and resource rules applicable to medically needy individuals living in the community.
   (3) A statement explaining whether the agency will refuse to offer home or community-based services to any recipient if the agency can reasonably expect that the cost of the services would exceed the cost of an equivalent level of care provided in--
      (i) A hospital (as defined in Sec. 440.10 of this chapter);
      (ii) A NF (as defined in section 1919(a) of the Act); or
      (iii) An ICF/MR (as defined in Sec. 440.150 of this chapter), if applicable.
   (b) If the agency furnishes home and community-based services, as defined in Sec. 440.180 of this subchapter, under a waiver granted under this subpart, the waiver request must--
      (1) Provide that the services are furnished--
         (i) Under a written plan of care subject to approval by the Medicaid agency;
         (ii) Only to recipients who are not inpatients of a hospital, NF, or ICF/MR; and
      (iii) Only to recipients who the agency determines would, in the absence of these services, require the Medicaid covered level of care provided in--
         (A) A hospital (as defined in Sec. 440.10 of this chapter);
         (B) A NF (as defined in section 1919(a) of the Act); or
(C) An ICF/MR (as defined in Sec. 440.150 of this chapter);
(2) Describe the qualifications of the individual or individuals who will be responsible for developing the individual plan of care;
(3) Describe the group or groups of individuals to whom the services will be offered;
(4) Describe the services to be furnished so that each service is separately defined. Multiple services that are generally considered to be separate services may not be consolidated under a single definition.
Commonly accepted terms must be used to describe the service and definitions may not be open ended in scope. CMS will, however, allow combined service definitions (bundling) when this will permit more efficient delivery of services and not compromise either a recipient's access to or free choice of providers.
(5) Provide that the documentation requirements regarding individual evaluation, specified in Sec. 441.303(c), will be met; and
(6) Be limited to one of the following target groups or any subgroup thereof that the State may define:
   (i) Aged or disabled, or both.
   (ii) Mentally retarded or developmentally disabled, or both.
   (iii) Mentally ill.


Sec. 441.302  State assurances.

Unless the Medicaid agency provides the following satisfactory assurances to CMS, CMS will not grant a waiver under this subpart and may terminate a waiver already granted:
   (a) Health and Welfare--Assurance that necessary safeguards have been taken to protect the health and welfare of the recipients of the services. Those safeguards must include--
      (1) Adequate standards for all types of providers that provide services under the waiver;
      (2) Assurance that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver; and
      (3) Assurance that all facilities covered by section 1616(e) of the Act, in which home and community-based services will be provided, are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.
   (b) Financial accountability-- The agency will assure financial accountability for funds expended for home and community-based services, provide for an independent audit of its waiver program (except as CMS may otherwise specify for particular waivers), and it will maintain and make available to HHS, the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver, including reports of any independent audits conducted.
   (c) Evaluation of need. Assurance that the agency will provide for the following:
      (1) Initial evaluation. An evaluation of the need for the level of care provided in a hospital, a NF, or an ICF/MR when there is a reasonable indication that a recipient might need the services in the near future (that is, a month or less) unless he or she receives home or community-based services. For purposes of this section, "evaluation" means a review of an individual recipient's condition to determine--
         (i) If the recipient requires the level of care provided in a hospital as defined in Sec. 440.10 of this subchapter, a NF as defined in section 1919(a) of the Act, or an ICF/MR as defined by Sec. 440.150 of this subchapter; and
         (ii) That the recipient, but for the provision of waiver services, would otherwise be institutionalized in such a facility.
      (2) Periodic reevaluations. Reevaluations, at least annually, of each recipient receiving home or community-based services to determine if the recipient continues to need the level of care provided and would, but for the provision of waiver services, otherwise be institutionalized in one of the following institutions:
         (i) A hospital;
(ii) A NF; or
(iii) An ICF/MR.

(d) Alternatives--Assurance that when a recipient is determined to be likely to require the level of care provided in a hospital, NF, or ICF/MR, the recipient or his or her legal representative will be--
(1) Informed of any feasible alternatives available under the waiver; and
(2) Given the choice of either institutional or home and community-based services.

(e) Average per capita expenditures. Assurance that the average per capita fiscal year expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made in the fiscal year for the level of care provided in a hospital, NF, or ICF/MR under the State plan had the waiver not been granted.
(1) These expenditures must be reasonably estimated and documented by the agency.
(2) The estimate must be on an annual basis and must cover each year of the waiver period.

(f) Actual total expenditures. Assurance that the agency's actual total expenditures for home and community-based and other Medicaid services under the waiver and its claim for FFP in expenditures for the services provided to recipients under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred by the State's Medicaid program for these individuals, absent the waiver, in--
(1) A hospital;
(2) A NF; or
(3) An ICF/MR.

(g) Institutionalization absent waiver. Assurance that, absent the waiver, recipients in the waiver would receive the appropriate type of Medicaid-funded institutional care (hospital, NF, or ICF/MR) that they require.

(h) Reporting. Assurance that annually, the agency will provide CMS with information on the waiver's impact. The information must be consistent with a data collection plan designed by CMS and must address the waiver's impact on--
(1) The type, amount, and cost of services provided under the State plan; and
(2) The health and welfare of recipients.

(i) Habilitation services. Assurance that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver, are--
(1) Not otherwise available to the individual through a local educational agency under section 602 (16) and (17) of the Education of the Handicapped Act (20 U.S.C. 1401 (16 and 17)) or as services under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730); and
(2) Furnished as part of expanded habilitation services, if the State has requested and received CMS's approval under a waiver or an amendment to a waiver.

(j) Day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services for individuals with chronic mental illness. Assurance that FFP will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are--
(1) Age 22 to 64;
(2) Age 65 and older and the State has not included the optional Medicaid benefit cited in Sec. 440.140; or
(3) Age 21 and under and the State has not included the optional Medicaid benefit cited in Sec. 440.160.


Sec. 441.303 Supporting documentation required.
The agency must furnish CMS with sufficient information to support the assurances required by Sec. 441.302. Except as CMS may otherwise specify for particular waivers, the information must consist of the following:

(a) A description of the safeguards necessary to protect the health and welfare of recipients. This information must include a copy of the standards established by the State for facilities that are covered by section 1616(e) of the Act.

(b) A description of the records and information that will be maintained to support financial accountability.

(c) A description of the agency's plan for the evaluation and reevaluation of recipients, including--
   (1) A description of who will make these evaluations and how they will be made;
   (2) A copy of the evaluation form to be used; and if it differs from the form used in placing recipients in hospitals, NFs, or ICFs/MR, a description of how and why it differs and an assurance that the outcome of the new evaluation form is reliable, valid, and fully comparable to the form used for hospital, NF, or ICF/MR placement;
   (3) The agency's procedure to ensure the maintenance of written documentation on all evaluations and reevaluations; and
   (4) The agency's procedure to ensure reevaluations of need at regular intervals.

(d) 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 services or home and community-based services.

(e) An explanation of 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 (included in Sec. 435.217 of this chapter).

(f) An explanation with supporting documentation satisfactory to CMS of how the agency estimated the average per capita expenditures for services.

(1) The annual average per capita expenditure estimate of the cost of home and community-based and other Medicaid services under the waiver must not exceed the estimated annual average per capita expenditures of the cost of services in the absence of a waiver. The estimates are to be based on the following equation:

\[ D + D' \leq G + G' \]

The symbol `\[\leq\]` means that the result of the left side of the equation must be less than or equal to the result of the right side of the equation.

\[ D = \text{the estimated annual average per capita Medicaid cost for home and community-based services for individuals in the waiver program.} \]

\[ D' = \text{the estimated annual average per capita Medicaid cost for all other services provided to individuals in the waiver program.} \]

\[ G = \text{the estimated annual average per capita Medicaid cost for hospital, NF, or ICF/MR care that would be incurred for individuals served in the waiver, were the waiver not granted.} \]

\[ G' = \text{the estimated annual average per capita Medicaid costs for all services other than those included in factor G for individuals served in the waiver, were the waiver not granted.} \]

(2) For purposes of the equation, the prime factors include the average per capita cost for all State plan services and expanded EPSDT services provided that are not accounted for in other formula values.

(3) In making estimates of average per capita expenditures for a waiver that applies only to individuals with a particular illness (for example, acquired immune deficiency syndrome) or condition (for example, chronic mental illness) who are inpatients in or who would require the level of care provided in hospitals as defined by Sec. 440.10, NFs as defined in section 1919(a) of the Act, or ICFs/MR, the agency may
determine the average per capita expenditures for these individuals absent the waiver without including expenditures for other individuals in the affected hospitals, NFs, or ICFs/MR.

(4) In making estimates of average per capita expenditures for a separate waiver program that applies only to individuals identified through the preadmission screening annual resident review (PASARR) process who are developmentally disabled, inpatients of a NF, and require the level of care provided in an ICF/MR as determined by the State on the basis of an evaluation under Sec. 441.303(c), the agency may determine the average per capita expenditures that would have been made in a fiscal year for those individuals based on the average per capita expenditures for inpatients in an ICF/MR. When submitting estimates of institutional costs without the waiver, the agency may use the average per capita costs of ICF/MR care even though the deinstitutionalized developmentally disabled were inpatients of NFs.

(5) For persons diverted rather than deinstitutionalized, the State's evaluation process required by Sec. 441.303(c) must provide for a more detailed description of their evaluation and screening procedures for recipients to ensure that waiver services will be limited to persons who would otherwise receive the level of care provided in a hospital, NF, or ICF/MR, as applicable.

(6) The State must indicate the number of unduplicated beneficiaries to which it intends to provide waiver services in each year of its program. This number will constitute a limit on the size of the waiver program unless the State requests and the Secretary approves a greater number of waiver participants in a waiver amendment.

(7) In determining the average per capita expenditures that would have been made in a waiver year, for waiver estimates that apply to persons with mental retardation or related conditions, the agency may include costs of Medicaid residents in ICFs/MR that have been terminated on or after November 5, 1990.

(8) In submitting estimates for waivers that include personal caregivers as a waiver service, the agency may include a portion of the rent and food attributed to the unrelated personal caregiver who resides in the home or residence of the recipient covered under the waiver. The agency must submit to CMS for review and approval the method it uses to apportion the costs of rent and food. The method must be explained fully to CMS. A personal caregiver provides a waiver service to meet the recipient's physical, social, or emotional needs (as opposed to services not directly related to the care of the recipient; that is, housekeeping or chore services). FFP for live-in caregivers is not available if the recipient lives in the caregiver's home or in a residence that is owned or leased by the caregiver.

(9) In submitting estimates for waivers that apply to individuals with mental retardation or a related condition, the agency may adjust its estimate of average per capita expenditures to include increases in expenditures for ICF/MR care resulting from implementation of a PASARR program for making determinations for individuals with mental retardation or related conditions on or after January 1, 1989.

(10) For a State that has CMS approval to bundle waiver services, the State must continue to compute separately the costs and utilization of the component services that make up the bundled service to support the final cost and utilization of the bundled service that will be used in the cost-neutrality formula.

(g) The State, at its option, may provide for an independent assessment of its waiver that evaluates the quality of care provided, access to care, and cost-neutrality. The results of the assessment should be submitted to CMS at least 90 days prior to the expiration date of the approved waiver-period and cover the first 24 or 48 months of the waiver. If a State chooses to provide for an independent assessment, FFP is available for the costs attributable to the independent assessment.

(h) For States offering habilitation services that include prevocational, educational, or supported employment services, or a combination of these services, consistent with the provisions of Sec. 440.180(c) of this chapter, an explanation of why these services are not available as special education and related services under sections 602 (16) and (17) of the Education of the Handicapped Act (20 U.S.C. 1401 (16 and 17)) or as services under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. section 730);

(i) For States offering home and community-based services for individuals diagnosed as chronically mentally ill, an explanation of why these individuals would not be placed in an institution for mental diseases (IMD) absent the waiver, and the age group of these individuals.
Sec. 441.304 Duration of a waiver.

(a) The effective date for a new waiver of Medicaid requirements to provide home and community-based services approved under this subpart is established by CMS prospectively on or after the date of approval and after consultation with the State agency. The initial approved waiver continues for a 3-year period from the effective date. If the agency requests it, the waiver may be extended for additional periods unless--

(1) CMS's review of the prior waiver period shows that the assurances required by Sec. 441.302 were not met; and

(2) CMS is not satisfied with the assurances and documentation provided by the State in regard to the extension period.

(b) CMS will determine whether a request for extension of an existing waiver is actually an extension request or a request for a new waiver. If a State submits an extension request that would add a new group to the existing group of recipients covered under the waiver (as defined under Sec. 441.301(b)(6)), CMS will consider it to be two requests: One as an extension request for the existing group, and the other as a new waiver request for the new group. Waivers may be extended for additional 5-year periods.

(c) CMS may grant a State an extension of its existing waiver for up to 90 days to permit the State to document more fully the satisfaction of statutory and regulatory requirements needed to approve a new waiver request. CMS will consider this option when it requests additional information on a new waiver request submitted by a State to extend its existing waiver or when CMS disapproves a State's request for extension.

(d) If CMS finds that an agency is not meeting one or more of the requirements for a waiver contained in this subpart, the agency is given a notice of CMS's findings and an opportunity for a hearing to rebut the findings. If CMS determines that the agency is not in compliance with this subpart after the notice and any hearing, CMS may terminate the waiver. For example, a State submits to CMS a waiver request for home and community-based services that includes an estimate of the expenditures that would be incurred if the services were provided to the covered individuals in a hospital, NF, or ICF/MR in the absence of the waiver. CMS approves the waiver. At the end of the waiver year, the State submits to CMS a report of its actual expenditures under the waiver. CMS finds that the actual expenditures under the waiver exceed 100 percent of the State's approved estimate of expenditures for these individuals in a hospital, NF, or ICF/MR in the absence of the waiver. CMS next requires the State to amend its estimates for subsequent waiver year(s). CMS then compares the revised estimates with the State's actual experience to determine if the revised estimates are reasonable. CMS may terminate the waiver if the revised estimates indicate that the waiver is not cost-neutral or that the revised estimates are unreasonable.

Sec. 441.305 Replacement of recipients in approved waiver programs.

(a) Regular waivers. A State's estimate of the number of individuals who may receive home and community-based services must include those who will replace recipients who leave the program for any reason. A State may replace recipients who leave the program due to death or loss of eligibility under the State plan without regard to any federally-imposed limit on utilization, but must maintain a record of recipients replaced on this basis.

(b) Model waivers. (1) The number of individuals who may receive home and community-based services under a model waiver may not exceed 200 recipients at any one time.

(2) The agency may replace any individuals who die or become ineligible for State plan services to maintain a count up to the number specified by the State and approved by CMS within the 200-maximum limit.
Sec. 441.306 Cooperative arrangements with the Maternal and Child Health program.

Whenever appropriate, the State agency administering the plan under Medicaid may enter into cooperative arrangements with the State agency responsible for administering a program for children with special health care needs under the Maternal and Child Health program (Title V of the Act) in order to ensure improved access to coordinated services to meet the children's needs.

Sec. 441.307 Notification of a waiver termination.

(a) If a State chooses to terminate its waiver before the initial 3-year period or 5-year renewal period expires, it must notify CMS in writing 30 days before terminating services to recipients.

(b) If CMS or the State terminates the waiver, the State must notify recipients of services under the waiver in accordance with Sec. 431.210 of this subchapter and notify them 30 days before terminating services.

Sec. 441.308 Hearings procedures for waiver terminations.

The procedures specified in subpart D of part 430 of this chapter are applicable to State requests for hearings on terminations.

Sec. 441.310 Limits on Federal financial participation (FFP).

(a) FFP for home and community-based services listed in Sec. 440.180 of this chapter is not available in expenditures for the following:

(1) Services provided in a facility subject to the health and welfare requirements described in Sec. 441.302(a) during any period in which the facility is found not to be in compliance with the applicable State standards described in that section.

(2) The cost of room and board except when provided as--

(i) Part of respite care services in a facility approved by the State that is not a private residence; or

(ii) For waivers that allow personal caregivers as providers of approved waiver services, a portion of the rent and food that may be reasonably attributed to the unrelated caregiver who resides in the same household with the waiver recipient. FFP for a live-in caregiver is not available if the recipient lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services (the caregiver). For purposes of this provision, "board" means 3 meals a day or any other full nutritional regimen and does not include meals provided as part of a program of adult day health services as long as the meals provided do not constitute a "full" nutritional regimen.

(3) Prevocational, educational, or supported employment services, or any combination of these services, as part of habilitation services that are--

(i) Provided in approved waivers that include a definition of "habilitation services" but which have not included prevocational, educational, and supported employment services in that definition; or
(ii) Otherwise available to the recipient under either special education and related services as defined in section 602(16) and (17) of the Education of the Handicapped Act (20 U.S.C. 1401(16) and (17)) or vocational rehabilitation services available to the individual through a program funded under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

(4) For waiver applications and renewals approved on or after October 21, 1986, home and community-based services provided to individuals aged 22 through 64 diagnosed as chronically mentally ill who would be placed in an institution for mental diseases. FFP is also not available for such services provided to individuals aged 65 and over and 21 and under as an alternative to institutionalization in an IMD if the State does not include the appropriate optional Medicaid benefits specified at Secs. 440.140 and 440.160 of this chapter in its State plan.

(b) FFP is available for expenditures for expanded habilitation services, as described in Sec. 440.180 of this chapter, if the services are included under a waiver or waiver amendment approved by CMS.