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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 prior to April 7, 1986;

(ii) 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;

(iii) Provided to recipients who were never institutionalized in a Medicaid certified NF, or ICF/MR; or

(iv) 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 §§ 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 § 440.180, if the services are included under a waiver or waiver amendment approved by HCFA on or after April 7, 1986.

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42 CFR Ch. IV (10-1-99 Edition)

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

SOURCE: 57 FR 29156, June 30, 1992, unless otherwise noted.

§ 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