

(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 § 440.140; or
- (3) Age 21 and under and the State has not included the optional Medicaid benefit cited in § 440.160.

[50 FR 10026, Mar. 13, 1985, as amended at 59 FR 37717, July 25, 1994; 65 FR 60107, Oct. 10, 2000]

§ 441.303 Supporting documentation required.

The agency must furnish CMS with sufficient information to support the assurances required by § 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;

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(3) The agency’s procedure to ensure the maintenance of written documentation on all evaluations and re-evaluations; 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 § 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 “≤” 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 = the estimated annual average per capita Medicaid cost for home and community-based services for individuals in the waiver program.

D’ = the estimated annual average per capita Medicaid cost for all other services provided to individuals in the waiver program.

G = 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’ = 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 or who would require the level of care provided in hospitals as defined by § 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 § 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 § 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 § 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.

[46 FR 48532, Oct. 1, 1981, as amended at 50 FR 10027, Mar. 13, 1985; 50 FR 25080, June 17, 1985; 59 FR 37718, July 25, 1994]

§ 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 § 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 § 441.301(b)(6)),