$441.353 Supporting documentation required.

The agency must furnish CMS 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 CMS. 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 CMS 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).

Effective Date Note: At 57 FR 29156, June 30, 1992, §441.353 was added. This section contains information collection and record-keeping requirements and will not become effective until approval has been given by the Office of Management and Budget.

$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, CMS 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:

\[
\text{APEL} = P \times (1+Y) + V \times (1+Z),
\]

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 age 65, defined as the total medical assistance payments (Federal and State) reported on line 6 of form CMS 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 CMS 2082 for the base year.
- \(V\) = The aggregate amount of the State’s medical assistance for NF and ICF other services to individuals who have reached age 65, defined as the total medical assistance payments (Federal and State) reported on line 6 of form CMS 64 (as adjusted) for NF services, ICF-other services, and mental health facility services, multiplied by the ratio 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 CMS 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 third quarter data available from CMS’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.
- \(W\) = 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 CMS 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 CMS) 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 CMS 2082, for the base year.
- \(U\) = The Home Health Agency Input Price Index for the base year.
- \(Y\) = The greater of:
  - \((U \times 0.07)\), or \((Q/R) - 1 + (S/T) - 1 + (U \times 0.02)\).
- \(Z\) = The greater of:
  - \((U \times 0.07)\), or \((W/X) - 1 + (S/T) - 1 + (U \times 0.02)\).

(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 CMS.

§ 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 CMS 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 CMS'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. CMS 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, CMS considers it a new waiver request.

(c) Reconsideration of denial. A determination of CMS 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 CMS 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 CMS 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) CMS 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 CMS 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) CMS 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 CMS. (1) If CMS 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, CMS notifies the agency in writing of its findings and grants an opportunity for a hearing in accordance with §441.357. If CMS determines that the agency is not in compliance with this subpart after the notice and any hearing, CMS may terminate the waiver.

(2) If CMS terminates the waiver, the following conditions apply:

(1) 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.