

(i) Meet qualifications for nurses in advanced practice or general nurse practitioners as defined by the State; and

(ii) Have a family nurse practice limited to providing primary health care to individuals and families.

(d) *Payment for nurse practitioner services.* The Medicaid agency must reimburse nurse practitioners for their services in accordance with § 441.22(c) of this subchapter.

[60 FR 19861, Apr. 21, 1995]

§ 440.167 Personal care services.

Unless defined differently by a State agency for purposes of a waiver granted under part 441, subpart G of this chapter—

(a) *Personal care services* means services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are—

(1) Authorized for the individual by a physician in accordance with a plan of treatment or (at the option of the State) otherwise authorized for the individual in accordance with a service plan approved by the State;

(2) Provided by an individual who is qualified to provide such services and who is not a member of the individual's family; and

(3) Furnished in a home, and at the State's option, in another location.

(b) For purposes of this section, *family member* means a legally responsible relative.

[42 FR 47902, Sept. 11, 1997]

§ 440.168 Primary care case management services.

(a) Primary care case management services means case management related services that—

(1) Include location, coordination, and monitoring of primary health care services; and

(2) Are provided under a contract between the State and either of the following:

(i) A PCCM who is a physician or may, at State option, be a physician assistant, nurse practitioner, or certified nurse-midwife.

(ii) A physician group practice, or an entity that employs or arranges with physicians to furnish the services.

(b) Primary care case management services may be offered by the State—

(1) As a voluntary option under the State plan; or

(2) On a mandatory basis under section 1932 (a)(1) of the Act or under section 1915(b) or section 1115 waiver authority.

[67 FR 41115, June 14, 2002]

§ 440.170 Any other medical care or remedial care recognized under State law and specified by the Secretary.

(a) *Transportation.* (1) "Transportation" includes expenses for transportation and other related travel expenses determined to be necessary by the agency to secure medical examinations and treatment for a recipient.

(2) Transportation, as defined in this section, is furnished only by a provider to whom a direct vendor payment can appropriately be made by the agency. If other arrangements are made to assure transportation under § 431.53 of this subchapter, FFP is available as an administrative cost.

(3) "Travel expenses" include—

(i) The cost of transportation for the recipient by ambulance, taxicab, common carrier, or other appropriate means;

(ii) The cost of meals and lodging en route to and from medical care, and while receiving medical care; and

(iii) The cost of an attendant to accompany the recipient, if necessary, and the cost of the attendant's transportation, meals, lodging, and, if the attendant is not a member of the recipient's family, salary.

(b) *Services furnished in a religious nonmedical health care institution.* Services furnished in a religious nonmedical health care institution are services furnished in an institution that:

(1) Is an institution that is described in (c)(3) of section 501 of the Internal Revenue Code of 1986 and is exempt from taxes under section 501(a) of that section.

(2) Is lawfully operated under all applicable Federal, State, and local laws and regulations.

(3) Furnishes only nonmedical nursing items and services to patients who

choose to rely solely upon a religious method of healing and for whom the acceptance of medical health services would be inconsistent with their religious beliefs.

(4) Furnishes nonmedical items and services exclusively through nonmedical nursing personnel who are experienced in caring for the physical needs of nonmedical patients.

(5) Furnishes these nonmedical items and services to inpatients on a 24-hour basis.

(6) Does not furnish, on the basis of its religious beliefs, through its personnel or otherwise, medical items and services (including any medical screening, examination, diagnosis, prognosis, treatment, or the administration of drugs) for its patients.

(7) Is not owned by, is not under common ownership with, or does not have an ownership interest of 5 percent or more in, a provider of medical treatment or services and is not affiliated with a provider of medical treatment or services or with an individual who has an ownership interest of 5 percent or more in a provider of medical treatment or services. Permissible affiliations are described in paragraph (c) of this section.

(8) Has in effect a utilization review plan that meets the following criteria:

(i) Provides for the review of admissions to the institution, duration of stays, cases of continuous extended duration, and items and services furnished by the institution.

(ii) Requires that the reviews be made by a committee of the institution that included the individuals responsible for overall administration and for supervision of nursing personnel at the institution.

(iii) Provides that records be maintained of the meetings, decisions, and actions of the utilization review committee.

(iv) Meets other requirements as CMS finds necessary to establish an effective utilization review plan.

(9) Provides information CMS may require to implement section 1821 of the Act, including information relating to quality of care and coverage determinations.

(10) Meets other requirements as CMS finds necessary in the interest of

the health and safety of patients who receive services in the institution. These requirements are the conditions of participation found at part 403, subpart G of this chapter.

(c) *Affiliations.* An affiliation is permissible for purposes of paragraph (b)(7) of this section if it is between one of the following:

(1) An individual serving as an uncompensated director, trustee, officer, or other member of the governing body of an RNHCI and a provider of medical treatment or services.

(2) An individual who is a director, trustee, officer, employee, or staff member of an RNHCI and another individual, with whom he or she has a family relationship, who is affiliated with (or has an ownership interest in) a provider of medical treatment or services.

(3) The RNHCI and an individual or entity furnishing goods or services as a vendor to both providers of medical treatment or services and RNHCIs.

(d) *Skilled nursing facility services for individuals under age 21.* “Skilled nursing facility services for individuals under 21” means those services specified in § 440.40 that are provided to recipients under 21 years of age.

(e) *Emergency hospital services.* “Emergency hospital services” means services that—

(1) Are necessary to prevent the death or serious impairment of the health of a recipient; and

(2) Because of the threat to the life or health of the recipient necessitate the use of the most accessible hospital available that is equipped to furnish the services, even if the hospital does not currently meet—

(i) The conditions for participation under Medicare; or

(ii) The definitions of inpatient or outpatient hospital services under §§ 440.10 and 440.20.

(f) [Reserved]

(g) *Critical access hospital (CAH).* (1) CAH services means services that (i) are furnished by a provider that meet the requirements for participation in Medicare as a CAH (see subpart F of part 485 of this chapter), and (ii) are of a type that would be paid for by Medicare when furnished to a Medicare beneficiary.

(2) Inpatient CAH services do not include nursing facility services furnished by a CAH with a swing-bed approval.

[43 FR 45224, Sept. 29, 1978, as amended at 45 FR 24889, Apr. 11, 1980; 46 FR 48540, Oct. 1, 1981; 58 FR 30671, May 26, 1993; 62 FR 46037, Aug. 29, 1997; 64 FR 67051, Nov. 30, 1999]

§ 440.180 Home or community-based services.

(a) *Description and requirements for services.* “Home or community-based services” means services, not otherwise furnished under the State’s Medicaid plan, that are furnished under a waiver granted under the provisions of part 441, subpart G of this chapter.

(1) These services may consist of any or all of the services listed in paragraph (b) of this section, as those services are defined by the agency and approved by CMS.

(2) The services must meet the standards specified in § 441.302(a) of this chapter concerning health and welfare assurances.

(3) The services are subject to the limits on FFP described in § 441.310 of this chapter.

(b) *Included services.* Home or community-based services may include the following services, as they are defined by the agency and approved by CMS:

- (1) Case management services.
- (2) Homemaker services.
- (3) Home health aide services.
- (4) Personal care services.
- (5) Adult day health services.
- (6) Habilitation services.
- (7) Respite care services.
- (8) Day treatment or other partial hospitalization services, psychosocial rehabilitation services and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness, subject to the conditions specified in paragraph (d) of this section.

(9) Other services requested by the agency and approved by CMS as cost effective and necessary to avoid institutionalization.

(c) *Expanded habilitation services, effective October 1, 1997—(1) General rule.* Expanded habilitation services are those services specified in paragraph (c)(2) of this section.

(2) *Services included.* The agency may include as expanded habilitation services the following services:

(i) Prevocational services, which means services that prepare an individual for paid or unpaid employment and that are not job-task oriented but are, instead, aimed at a generalized result. These services may include, for example, teaching an individual such concepts as compliance, attendance, task completion, problem solving and safety. Prevocational services are distinguishable from noncovered vocational services by the following criteria:

(A) The services are provided to persons who are not expected to be able to join the general work force or participate in a transitional sheltered workshop within one year (excluding supported employment programs).

(B) If the recipients are compensated, they are compensated at less than 50 percent of the minimum wage;

(C) The services include activities which are not primarily directed at teaching specific job skills but at underlying rehabilitative goals (for example, attention span, motor skills); and

(D) The services are reflected in a plan of care directed to rehabilitative rather than explicit employment objectives.

(ii) Educational services, which means special education and related services (as defined in sections 602(16) and (17) of the Education of the Handicapped Act) (20 U.S.C. 1401 (16 and 17)) to the extent they are not prohibited under paragraph (c)(3)(i) of this section.

(iii) Supported employment services, which facilitate paid employment, that are—

(A) Provided to persons for whom competitive employment at or above the minimum wage is unlikely and who, because of their disabilities, need intensive ongoing support to perform in a work setting;

(B) Conducted in a variety of settings, particularly worksites in which persons without disabilities are employed; and

(C) Defined as any combination of special supervisory services, training, transportation, and adaptive equipment that the State demonstrates are