

§ 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)), 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.

[50 FR 10028, Mar. 13, 1985; 50 FR 25080, June 17, 1985, as amended at 59 FR 37719, July 25, 1994]

§ 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.

[59 FR 37719, July 25, 1994]

§ 441.306 Cooperative arrangements with the Maternal and Child Health program.

Whenever appropriate, the State agency administering the plan under

§ 441.307

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.

[59 FR 37720, July 25, 1994]

§ 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 § 431.210 of this subchapter and notify them 30 days before terminating services.

[46 FR 48541, Oct. 1, 1981. Redesignated at 59 FR 37719, July 25, 1994, as amended at 65 FR 60107, Oct. 10, 2000]

§ 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.

[50 FR 10028, Mar. 13, 1985. Redesignated at 59 FR 37720, July 25, 1994]

§ 441.310 Limits on Federal financial participation (FFP).

(a) FFP for home and community-based services listed in § 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 § 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

42 CFR Ch. IV (10–1–06 Edition)

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 §§ 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 of this chapter, if the services are included under a waiver or waiver amendment approved by CMS.

[59 FR 37720, July 25, 1994, as amended at 65 FR 60107, Oct. 10, 2000]