

### 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