EFFECTIVE DATE NOTE: At 57 FR 29156, June 30, 1992, §441.351 was added. This section contains information collection and recordkeeping requirements and will not become effective until approval has been given by the Office of Management and Budget.

§441.352 State assurances.

Unless the Medicaid agency provides the following satisfactory assurances to CMS, CMS will not grant a waiver under this subpart and may terminate a waiver already granted.

(a) *Health and welfare.* The agency must assure that necessary safeguards have been taken to protect the health and welfare of the recipients of services by assuring that the following conditions are met:

(1) Adequate standards for all types of providers that furnish services under the waiver are met. (These standards must be reasonably related to the requirements of the waiver service to be furnished.)

(2) The standards of any State licensure or certification requirements are met for services or for individuals furnishing services under the waiver.

(3) All facilities covered by section 1616(e) of the Act, in which home and community-based services are furnished, are in compliance with applicable State standards that meet the requirements of 45 CFR part 1397 for board and care facilities.

(4) Physician reviews of prescribed psychotropic drugs (when prescribed for purposes of behavior control of waiver recipients) occur at least every 30 days.

(b) *Financial accountability.* The agency must assure financial accountability for funds expended for home and community-based services. The State must provide for an independent audit f its waiver program. The performance of a single financial audit, in accordance with the Single Audit Act of 1984 (Pub. L. 98–502, enacted on October 19, 1984), is deemed to satisfy the requirement for an independent audit. The agency must maintain and make available to HHS, the Comptroller General, or other designees, appropriate financial records documenting the cost of services furnished to individuals age 65 or older under the waiver and the State plan, including reports of any independent audits conducted.

(c) *Evaluation of need.* The agency must provide for an initial evaluation (and periodic reevaluations) of the need for the level of care furnished in a NF when there is a reasonable indication that individuals age 65 or older might need those services in the near future, but for the availability of home and community-based services. The procedures used to assess level of care for a potential waiver recipient must be at least as stringent as any existing State procedures applicable to individuals entering a NF. The qualifications of individuals performing the waiver assessment must be as high as those of individuals assessing the need for NF care, and the assessment instrument itself must be the same as any assessment instrument used to establish level of care of prospective inpatients in NFs. A periodic reevaluation of the level of care must be performed. The period of reevaluation of level of care cannot extend beyond 1 year.

(d) *Expenditures.* The agency must assure that the total amount expended by the State for medical assistance with respect to NF, home health, private duty nursing, personal care services, home and community-based services furnished under a section 1915(c) waiver granted under Subpart G of this part to individuals age 65 or older, and the home and community-based services approved and furnished under a section 1915(d) waiver for individuals age 65 or older during a waiver year will not exceed the APEL, calculated in accordance with §441.354.

(e) *Reporting.* The agency must assure that it will provide CMS annually with information on the waiver's impact. The information must be consistent with a reasonable data collection plan designed by CMS and must address the waiver's impact on—

(1) The type, amount, and cost of services furnished under the State plan; and

(2) The health and welfare of recipients of the services described in §440.181 of this chapter.

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