

(ii) CMS continues to apply the APEL in § 441.354 of this subpart, but the limit is prorated according to the number of days in the fiscal year during which waiver services were offered. The limit expires concurrently with the termination of home and community-based services under the waiver.

EFFECTIVE DATE NOTE: At 57 FR 29156, June 30, 1992, § 441.356 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.

§ 441.357 Hearing procedures for waiver denials.

The procedures specified in § 430.18 of this subchapter apply to State requests for hearings on denials, renewals, or amendments of waivers for home and community-based services for individuals age 65 or older.

§ 441.360 Limits on Federal financial participation (FFP).

FFP for home and community-based services listed in § 440.181 of this subchapter is not available in expenditures for the following:

(a) Services furnished in a facility subject to the health and welfare requirements described in § 441.352(a) during any period in which the facility is found not to be in compliance with the applicable State requirements described in that section.

(b) The cost of room and board except when furnished as part of respite care services in a facility, approved by the State, that is not a private residence. For purposes of this subpart, “board” means three meals a day or any other full nutritional regimen. “Board” does not include meals, which do not comprise a full nutritional regimen, furnished as part of adult day health services.

(c) The portion of the cost of room and board attributed to unrelated, live-in personal caregivers when the waiver recipient lives in the caregiver’s home or a residence owned or leased by the provider of the Medicaid services (the caregiver).

(d) Services that are not included in the approved State plan and not approved as waiver services by CMS.

(e) Services furnished to recipients who are ineligible under the terms of the approved waiver.

(f) Services furnished by a provider when either the services or the provider do not meet the standards that are set by the State and included in the approved waiver.

(g) Services furnished to a recipient by his or her spouse.

§ 441.365 Periodic evaluation, assessment, and review.

(a) *Purpose.* This section prescribes requirements for periodic evaluation, assessment, and review of the care and services furnished to individuals receiving home and community-based waiver services under this subpart.

(b) *Evaluation and assessment review team.* (1) A review team, as described in paragraphs (b)(2) and (c) of this section, must periodically evaluate and assess the care and services furnished to recipients under this subpart. The review team must be created by the State agency directly, or (through inter-agency agreement) by other departments of State government (such as the Department of Health or the Agency on Aging).

(2) Each review team must consist of at least one physician or registered nurse, and at least one other individual with health and social service credentials who the State believes is qualified to properly evaluate and assess the care and services provided under the waiver. If there is no physician on the review team, the Medicaid agency must ensure that a physician is available to provide consultation to the review team.

(3) For waiver services furnished to individuals who have been found to be likely to require the level of care furnished in a NF that is also an IMD, each review team must have a psychiatrist or physician and other appropriate mental health or social service personnel who are knowledgeable about geriatric mental illness.

(c) *Financial interests and employment of review team members.* (1) No member of a review team may have a financial interest in or be employed by any entity that furnishes care and services under the waiver to a recipient whose care is under review.