

(1) The existing waiver remains in effect for a period of not less than 90 days after the date on which CMS denies the request, or, if the State seeks reconsideration in accordance with § 441.357, the date on which a final determination is made with respect to that review.

(2) CMS calculates an APEL for the period for which the waiver remains in effect, and this calculation is used to pro-rate the limit according to the number of days to which it applies.

§ 441.356 Waiver termination.

(a) *Termination by the State.* If a State chooses to terminate its waiver before an approved program is due to expire, the following conditions apply:

(1) The State must notify CMS in writing at least 30 days before terminating services to beneficiaries.

(2) The State must notify beneficiaries of services under the waiver at least 30 days before terminating services in accordance with § 431.210 of this chapter.

(3) CMS continues to apply the APEL described in § 441.354 through the end of the waiver year, but this limit is not applied in subsequent years.

(4) The State may not decrease the services available under the approved State plan to individuals age 65 or older by an amount that violates the comparability of service requirements set forth in § 440.240 of this chapter.

(b) *Termination by CMS.* (1) If CMS finds, during an approved waiver period, that an agency is not meeting one or more of the requirements for a waiver contained in this subpart, CMS notifies the agency in writing of its findings and grants an opportunity for a hearing in accordance with § 441.357. If CMS determines that the agency is not in compliance with this subpart after the notice and any hearing, CMS may terminate the waiver.

(2) If CMS terminates the waiver, the following conditions apply:

(i) The State must notify beneficiaries of services under the waiver at least 30 days before terminating services in accordance with § 431.210 of this chapter.

(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 beneficiary 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 beneficiaries who are ineligible under the terms of the approved waiver.

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(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 beneficiary 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 beneficiaries 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 beneficiary whose care is under review.

(2) No physician member of a review team may evaluate or assess the care

of a beneficiary for whom he or she is the attending physician.

(3) No individual who serves as case manager, caseworker, benefit authorizer, or any similar position, may serve as member of a review team that evaluates and assesses care furnished to a beneficiary with whom he or she has had a professional relationship.

(d) *Number and location of review teams.* A sufficient number of teams must be located within the State so that onsite inspections can be made at appropriate intervals at sites where waiver beneficiaries receive care and services.

(e) *Frequency of periodic evaluations and assessments.* Periodic evaluations and assessments must be conducted at least annually for each beneficiary under the waiver. The review team and the agency have the option to determine the frequency of further periodic evaluations and assessments, based on the quality of services and access to care being furnished under the waiver and the condition of patients receiving care and services.

(f) *Notification before inspection.* No provider of care and services under the waiver may be notified in advance of a periodic evaluation, assessment, and review. However, when a beneficiary receives services in his own home or the home of a relative, notification must be provided to the residents of the household at least 48 hours in advance. The beneficiary must have an opportunity to decline access to the home. If the beneficiary declines access to his or her own home, or the home of a relative, the review is limited solely to the review of the provider's records. If the beneficiary is incompetent, the head of the household has the authority to decline access to the home.

(g) *Personal contact with and observation of beneficiaries and review of records.*

(1) For beneficiaries of care and services under a waiver, the review team's evaluation and assessment must include—

(i) A review of each beneficiary's medical record, the evaluation and re-evaluation required by § 441.353(c), and the plan of care under which the waiver and other services are furnished; and