

(4) The agency's procedure to assure reevaluations of need at regular intervals.

(5) The intervals at which reevaluations occur, which may be no less frequent than for institutionalized individuals at comparable levels of care.

(6) The procedures and criteria used for evaluation and reevaluation of waiver beneficiaries must be the same or more stringent than those used for individuals served in NFs.

(d) *Alternatives available.* A description of the agency's plan for informing eligible beneficiaries of the feasible alternatives available under the waiver and allowing beneficiaries to choose either institutional or home and community-based services must be submitted to CMS. A copy of the forms or documentation used by the agency to verify that this choice has been offered and that beneficiaries of waiver services, or their legal representatives, have been given the free choice of the providers of both waiver and State plan services must also be available for CMS review. The Medicaid agency must provide an opportunity for a fair hearing, under 42 CFR part 431, subpart E, to beneficiaries who are not given the choice of home or community-based services as an alternative to institutional care in a NF or who are denied the service(s) or the providers of their choice.

(e) *Post-eligibility of income.* An explanation of how the agency applies the applicable provisions regarding the post-eligibility treatment of income and resources of those individuals receiving home and community-based services who are eligible under a special income level (included in § 435.217 of this subchapter).

EFFECTIVE DATE NOTE: At 57 FR 29156, June 30, 1992, § 441.353 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.

§ 441.354 Aggregate projected expenditure limit (APEL).

(a) *Definitions.* For purposes of this section, the term *base year* means—

(1) Federal fiscal year (FFY) 1987 (that is, October 1, 1986 through September 30, 1987); or

(2) In the case of a State which did not report expenditures on the basis of age categories during FFY 1987, the base year means FFY 1989 (that is, October 1, 1988 through September 30, 1989).

(b) *General.* (1) The total amount expended by the State for medical assistance with respect to NF, home and community-based services under the waiver, home health services, personal care services, private duty nursing services, and services furnished under a waiver under subpart G of this part to individuals age 65 or older furnished as an alternative to care in an SNF or ICF (NF effective October 1, 1990), may not exceed the APEL calculated in accordance with paragraph (c) of this section.

(2) In applying for a waiver under this subpart, the agency must clearly identify the base year it intends to use.

(3) The State may make a preliminary calculation of the expenditure limit at the time of the waiver approval; however, CMS makes final calculations of the aggregate limit after base data have been verified and accepted.

(4) All base year and waiver year data are subject to final cost settlement within 2 years from the end of the base or waiver year involved.

(c) *Formula for calculating APEL.* Except as provided in paragraph (d) of this section, the formula for calculating the APEL follows:

$$\text{APEL} = P \times (1+Y) + V \times (1+Z), \text{ where}$$

P=The aggregate amount of the State's medical assistance under title XIX for SNF and ICF (NF effective October 1, 1990) services furnished to individuals who have reached age 65, defined as the total medical assistance payments (Federal and State) reported on line 6 of form CMS 64 (as adjusted) for SNF services, ICF-other services, and mental health facility services for the base year, multiplied by the ratio of expenditures for SNF and ICF-other services for the aged to total expenditures for these services as reported on form CMS 2082 for the base year.

Q=The market basket index for SNF and ICF (NF effective October 1, 1990) services for the waiver year involved, defined as the total SNF Input Price Index used in the Medicare program, identified as the third quarter data available from CMS's Office of National Cost Estimates in August preceding the start of the fiscal year.

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R=The SNF Input Price Index for the base year.

S=The number of residents in the State in the waiver year involved who have reached age 65, defined as the number of aged Medicare beneficiaries in the State, equal to the Mid-Period Enrollment in HI or SMI in that State on July 1 preceding the start of the fiscal year.

T=The number of aged Medicare beneficiaries in the State who are enrolled in either the HI or SMI programs in the base year, as defined in S, above.

U=The number of years beginning after the base year and ending on the last day of the waiver year involved.

V=The aggregate amount of the State's medical assistance under title XIX in the base year for home and community-based services for individuals who have reached age 65, defined as the total medical assistance payments (Federal and State) reported on line 6 of form CMS 64 (as adjusted) for home health, personal care, and home and community-based services waivers, which provide services as an alternative to care in a SNF or ICF (NF effective October 1, 1990), increased by an estimate (acceptable to CMS) of expenditures for private duty nursing services, multiplied by the ratio of expenditures for home health services for the aged to total expenditures for home health services, as reported on form CMS 2082, for the base year.

W=The market basket index for home and community-based services for the waiver year involved, defined as the Home Agency Input Price Index, used in the Medicare program identified as the third quarter data available from CMS's Office of National Cost Estimates in August preceding the start of the fiscal year.

X=The Home Health Agency Input Price Index for the base year.

Y=The greater of—
(U×.07), or (Q/R)-1+(S/T)-1+(U×.02).

Z=The greater of—
(U×.07), or (W/X)-1+(S/T)-1++(U×.02).

(d) *Amendment of the APEL.* The State may request amendment of its APEL to reflect an increase in the aggregate amount of medical assistance for NF services and for services included in the calculation of the APEL as required by paragraph (c) of this section when the increase is directly attributable to legislation enacted on or after December 22, 1987, which amends title XIX of the Act. Costs attributable to laws enacted before December 22, 1987 will not be considered. Because the APEL for each year of the waiver is computed separately from the APEL

for any other waiver year, a separate amendment must be submitted for each year in which the State chooses to raise its APEL. Documentation specific to the waiver year involved must be submitted to CMS.

§ 441.355 Duration, extension, and amendment of a waiver.

(a) *Effective dates and extension periods.* (1) The effective date for a waiver of Medicaid requirements to furnish home and community-based services to individuals age 65 or older under this subpart is established by CMS prospectively on the first day of the FFY following the date on which the waiver is approved.

(2) The initial waiver is approved for a 3-year period from the effective date. Subsequent renewals are approved for 5-year periods.

(3) If the agency requests it, the waiver may be extended for an additional 5-year period if CMS's review of the prior period shows that the assurances required by § 441.352 were met.

(4) The agency may request that waiver modifications be made effective retroactive to the first day of the waiver year in which the amendment is submitted, unless the amendment involves substantive change. Substantive changes may include, but are not limited to, addition of services under the waiver, a change in the qualifications of service providers, or a change in the eligible population.

(5) A request for an amendment that involves a substantive change is given a prospective effective date, but this date need not coincide with the start of the next FFY.

(b) *Extension or new waiver request.* CMS determines whether a request for extension of an existing waiver is actually an extension request, or a request for a new waiver. Generally, if a State's extension request proposes a substantive change in services furnished, eligible population, service area, statutory sections waived, or qualifications of service providers, CMS considers it a new waiver request.

(c) *Reconsideration of denial.* A determination of CMS to deny a request for a waiver (or for extension of a waiver) under this subpart may be reconsidered in accordance with § 441.357.