



NATIONAL ASSOCIATION OF
STATE MENTAL RETARDATION
PROGRAM DIRECTORS, INC.

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BULLETIN NO. 81-77

October 7, 1981

HCFA IMPLEMENTS NEW MEDICAID AUTHORITY FOR
NON-INSTITUTIONAL LONG TERM CARE SERVICES

The Health Care Financing Administration recently issued interim final regulations (copy attached) governing procedures for states to provide home and community-based care services to aged and disabled Medicaid beneficiaries who otherwise would require institutional services in a skilled nursing, intermediate care, or intermediate care facility for the mentally retarded. The rules, published on October 1, implement statutory amendments to Title XIX that, for the first time, permit certain home and community-based care services--including adult day services, case management, and respite care--to be reimbursed under Medicaid. In order to provide these non-institutional services, states must apply to HCFA for a waiver of certain statutory requirements, and must assure that: (1) services will be provided under a written plan of care; (2) the health and safety of clients are protected; (3) the community-based services do not cost more, on an average per capita basis, than services provided to the individual in a SNF, ICF or ICF/MR; and (4) adequate records will be kept.

General Approach. HCFA emphasizes in the preamble to the October 1 regulations, that states will be given broad latitude in defining services and establishing standards and eligibility under the new community-care waiver program. The aim is to "...give the States the maximum opportunity for innovation in furnishing non-institutional services..., **with** a minimum of Federal regulations." The rules and guidelines will provide basic parameters instead of detailed service delivery requirements, as in the past. The acceptability of a state's waiver request will be evaluated by HCFA using "...the statutory requirements rather than against a detailed additional set of Federal guidelines or criteria." **HCFA will** provide states **with** technical assistance in both

the development of the waiver application and the development of new community services, but the choice as to types and extent of non-institutional services and the manner in which they are organized and delivered will be left to the discretion of the requesting state.

Services. The Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35) added a new Section 1915(a) to Title XIX of the Social Security Act, permitting HCFA to waive Medicaid requirements so that states may offer alternative community-based services (see Intelligence Report bulletin no. 81-62, dated August 7, 1981K). Such services may include: case management, home health services, homemaker services, personal care, adult day health services, habilitation services and respite care. The regulations do not define these terms, but instead instruct states to propose their own operational definitions in their waiver requests. The preamble to the regulations, however, offer the following insights into how Congress and HCFA officials interpret the above-listed terms:

- Case management. In the preamble to the October 1 rules, HCFA describes case management as a system under which responsibility for locating, coordinating and monitoring a group of services rests with a designated person or organization. Case managers are encouraged to tap into "informal networks" of friends, relatives, and churches, in addition to formal public and private agencies for services to the eligible clients.
- Homemaker services. HCFA said that these services are normally viewed as general household activities provided by a trained homemaker when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for himself or others in the home.
- Adult day health services. In the conference report on P.L. 97-35, adult day health services are said to encompass both health and social services needed to insure the optimal functioning of the client, as well as habilitation services suitable for the care of mentally retarded and developmentally disabled persons. HCFA added that such services should be furnished for four hours or more per day on a regularly scheduled basis, for one or more days per week on an outpatient basis.
- Habilitation services. These generally are health and social services needed to insure "optimal functioning" of MR/DD persons.

- Respite care. The conference report on P.L. 97-35 describes respite care as assistance given to individuals unable to care for themselves, which is provided on a short term basis because of the absence or need for relief of those persons normally providing care. Respite may be provided in the individual's home or in a facility approved by the state.
- Home health aide services. These services typically would include the performance of simple procedures, such as the extension of therapy services, personal care, ambulation and exercise, household services essential to health care at home, assistance with medications that are ordinarily self-administered, reporting changes in the patient's condition and needs, and completing appropriate records.
- Personal care services. These are defined as services furnished to a recipient in his/her home that are prescribed by a physician under the client's treatment plan and provided by a qualified individual (not a member of the client's family) under the supervision of a registered nurse.

Personal care services and home health aide services currently may be provided without a waiver of Medicaid requirements. However, a waiver may be required if states wish to furnish these services in a manner which departs from the existing definitions. Although Congress specifically excluded payment for room and board under the new waiver authority, HCFA said that there is some leeway to allow coverage for meals furnished as part of day health/habilitation services, and room and board that is part of respite care, as long as it is provided outside the recipient's private residence.

States may request approval to provide other home or community-based services not listed above, if they: (1) describe the services in detail; (2) can demonstrate that these services would not raise the cost of services to more than the cost of institutional-based services; and (3) assure HCFA that the services are necessary to avoid institutionalization.

Eligibility. Under current Medicaid regulations states are allowed to establish special standards that result in higher income eligibility requirements for institutionalized clients than for recipients of community services. The institutional income eligibility level may not exceed 300 percent of the federal SSI payment standard. Most states have elected to take advantage of this option by setting higher income standards for institutional residents. However, in so doing, they have created a disincentive to placing such clients back into community settings, since clients lose Medicaid eligibility as soon as they are discharged from the institution.

In order to address this problem, the new regulations permit states to use the higher institutional income eligibility standard for aged, blind and disabled persons in the community who: (a) are not eligible for SSI or state supplemental payments because of their income; (b) have incomes below the institutional eligibility standards specified in the state Medicaid plan; (c) would be eligible for Medicaid benefits if institutionalized; and (d) will receive home and community-based services under the waiver. Low income elderly persons, who do not meet the SSI means test, are expected to be the primary beneficiaries of this regulatory change, but some disabled individual also may be affected.

Waiver of Statewideness and Comparability. In providing services under the Section 1915(a) waiver, states may elect to restrict certain services to specified categories of eligible clients in limited geographic areas, instead of across the state. If states wish to so concentrate their services, then they must apply for waivers of Medicaid provisions requiring that all services must be made available to all medically or categorically needy Medicaid beneficiaries in the state (waiver of Sections 1902 (a) (1) and/or 1902 (a) (10)).

In addition, states are allowed, under the 1915(c) waiver, to furnish community-based services only to those eligible beneficiaries for whom community care would be less costly than institutional care, if they document how such a determination will be made.

Application for Waiver The October 1 rules generally restate the requirements for submitting a waiver proposal enumerated in the statute, with little elaboration. Waivers are granted for three year periods and are renewable. HCFA must respond in writing or approve the waiver request within 90 days of state submittal. The regional offices and the central HCFA office will share in the responsibility of reviewing and approving waiver applications. State Medical Assistance Plans do not need to be amended in order to furnish services under a Section 1915 (c) waiver.

States must provide HCFA with assurances that:

- there are safeguards for the health and welfare of clients, including adequate state-determined standards for provider participation. If states have licensing or certification requirements for existing services, these must be met;
- there must be financial accountability for funds expended;
- the state must agree to evaluate the need for home and community-based care services among all recipients entitled to institutional care, and for whom there is reasonable indication that they might need such care in the near future;

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States will be expected to provide a clear "audit trail" for HCFA review, and to keep down costs. A number of states already have indicated to the NASMRPD staff that they plan to develop and submit waiver requests to provide home and community based services to their mentally retarded/ Medicaid-eligible population.

NASMRPD Contact:
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SM: md

Attachment

Federal Register

Thursday October
1, 1981

Part V

Department of Health and Human Services

Health Care Financing
Administration

Medicaid Program; Home and
Community-Based Services

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration
42 CFR Parts 431, 435, 440, 441

Medicaid Program; Home and Community-Based Services

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Interim final rule with comment period.

SUMMARY: This rule amends current Medicaid regulations to permit States to offer, under a Secretarial waiver, a wide array of home and community-based services that an individual may need in order to avoid institutionalization. Before enactment on August 13, 1981, of the Omnibus Budget Reconciliation Act of 1981, little coverage under Medicaid was available for noninstitutional long-term care services. Conversely, institutional long-term care services represent a significant part of the budgets of State Medicaid programs.

These regulations, which implement section 2176 of Pub. L. 97-35, allow Federal payment for these noninstitutional services, subject to HCFA's approval of the States' requests for waivers and to certain assurances made by the States. Once granted, waivers are in effect for 3 years and are renewable. On an annual basis, the States must report to HCFA on the impact and effectiveness of the program. **EFFECTIVE DATES:** October 1, 1981. These regulations are being published in final, for reasons described in the Supplementary Information, below. However, we will consider any written comments mailed by December 30, 1981 and will revise the regulations if necessary.

Sections 441.300-441.305 of these regulations contain reporting requirements subject to the Paperwork Reduction Act (Pub. L. 96-511) that have not been approved by the Office of Management and Budget. The reporting is not required until the Office of Management and Budget approval has been obtained. HCFA will publish a notice in the Federal Register when approval has been obtained, indicating the effective date of the reporting.

ADDRESS: Address comments in writing to: Administrator, Department of Health and Human Services, Health Care Financing Administration, P.O. Box 17076, Baltimore, Maryland 21235.

If you prefer, you may deliver your comments to Room 309-G Hubert H. Humphrey Building, 200 Independence Ave., S.W., Washington, D.C., or to Room 799, East High Rise Building, 6325

Security Boulevard, Baltimore, Maryland.

In commenting, please refer to BPP-182-FC. Agencies and organizations are requested to submit comments in duplicate.

Comments will be available for public inspection, beginning approximately two weeks after publication, in Room 309-G of the Department's office at 200 Independence Ave., S.W., Washington, D.C. 20201 on Monday through Friday of each week from 8:30 a.m. to 5:00 p.m. (202-245-7890).

Because of the large number of comments we receive, we cannot acknowledge or respond to them individually. However, if as a result of comments, we believe that changes are needed in these regulations, we will publish the changes in the Federal Register and respond to the comments in the preamble of that document.

FOR FURTHER INFORMATION, CONTACT: Robert Wren, (301) 594-9820.

SUPPLEMENTARY INFORMATION:

Background

Until Pub. L. 97-35, the Omnibus Budget Reconciliation Act, was signed on August 13, 1981, the Medicaid program provided little coverage for long-term care services in a noninstitutional setting, but offered full or partial coverage for such care in an institution. Even though only approximately 8 percent of the elderly reside in an institution, more than 40 percent of Medicaid expenditures was for long-term institutional care in the most recent year for which data are available.

The House Report accompanying the House Omnibus Reconciliation Bill (H. Rept. 97-158, p. 316) notes that it has been estimated that a quarter of the current nursing home population do not need full-time, residential care. Many elderly, disabled and chronically ill persons live in institutions not for medical reasons, but because of the paucity of health and social services available to them in their homes or communities, and the individual's inability to pay for those services or to have them covered by Medicaid when they do exist.

Assessment procedures required under Medicaid to determine the need for institutional care for the elderly and disabled have not been adequate in preventing avoidable admissions. Most of the reviews occur after admission to the long-term care facility, when it is most difficult to discharge the resident back to the community. In addition, the reviews focus on medical conditions, primarily, and not on social and other

factors that are often more critical in determining the most suitable placement.

Statutory Amendments

Section 2176 of Pub. L. 97-35 added new provisions to the Social Security Act to deal with the circumstances described above, by inserting a new subsection 1915(c). (Section 1915 itself was added by section 2175 of Pub. L. 97-35.) The subsection authorizes the Secretary of HHS to waive Medicaid statutory limitations in order to enable a State to cover a broad array of home and community-based services. All such services must be furnished under an individual written plan of care, and may only be furnished to persons who would otherwise require the level of care provided in a skilled nursing facility (SNF) or intermediate care facility (ICF) for which the cost could be reimbursed under the State plan. The law provides that the Secretary will not approve the State's request for a waiver unless the State provides satisfactory assurances to the Secretary that:

1. Necessary safeguards (including adequate standards for provider participation) have been taken to protect the health and welfare of beneficiaries provided services under the waiver and to assure financial accountability for funds spent for the services;
2. The State will provide for an evaluation of the need for the inpatient services for individuals who are entitled to and who may require the level of care provided in an SNF or ICF under the State plan;
3. Any individuals who are determined to be likely to require the level of care provided in a SNF or ICF are informed of the feasible alternatives available under the waiver, and are given the choice of the inpatient services or the alternative noninstitutional services;
4. The average per capita expenditure estimated by the State in any fiscal year for medical assistance provided to these individuals does not exceed the average per capita expenditure that the State reasonably estimates would have been made in that fiscal year for expenditures under the State plan for these individuals if the waiver had not been granted; and
5. The State will provide to the Secretary annually, consistent with a data collection plan designed by the Secretary, information on the impact of the waiver on the type and amount of medical assistance provided under the State plan and on the health and welfare of its beneficiaries.

Additionally, the law specifically provides that a waiver granted under section 1915(c) may include a waiver of the requirements of section 1902(a)(1) and (10) of the Social Security Act. Under section 1902(a)(1) of the Act, a State plan for medical assistance must be in effect throughout the State. Section 1902(a)(10), as amended by Pub. L. 97-35 of the Act, sets forth certain Medicaid eligibility and service coverage requirements. It requires the plan to provide that services available to the categorically needy beneficiary are not less in amount, duration and scope than services available to the medically needy and are equal in amount, duration and scope for all categorically needy beneficiaries.

Waivers granted under section 1915(c) of the Act shall be for an initial term of three years and, if requested by the State, shall be extended for additional three-year periods unless the Secretary determines that, for the previous three-year period, the State did not meet the assurances discussed above (in (1) through (5)).

Section 1915(d), as added by section 2175 and redesignated as section 1915(e) by section 2176 of Pub. L. 97-35, provides that the Secretary shall monitor the implementation of the waivers granted to determine if the requirements of the waivers are being met. After giving the State notice and an opportunity for a hearing, the Secretary shall terminate any waivers if noncompliance has occurred.

Under the waiver, the State may exclude those individuals for whom there is a reasonable expectation that home and community-based services would be more expensive than Medicaid services the individual would otherwise receive.

A waiver will allow a State to provide Medicaid to individuals for such services as case management, homemaker, home health aide, personal care, adult day health, habilitation, and respite care, and other services requested by the State and approved by the Secretary. The services must be consistent with plans of care, which are subject to the State's approval.

Section 2177 of the Omnibus Budget Reconciliation Act of 1981 also amends the new section 1915 of the Social Security Act. It adds a new subsection (f) that affects subsection (c) as well as other parts of title XIX. Section 1915(f) provides that a request from a State for approval of a State plan amendment or waiver, including a waiver request under section 1915(c), shall be deemed granted unless the Secretary, within 90 days after the date of its submission to the Secretary, either denies the request

in writing or informs the State in writing of any additional information needed to make the determination on the request. The request will be deemed granted 90 days after the receipt of the additional information, unless the Secretary denies the request in writing within the 90 days.

Regulatory Provisions

The provisions of the new regulations parallel the statute with clarifying or implementing policy as discussed below.

The new regulations add a new § 440.180, defining home or community-based services, to 42 CFR Part 440; and a new Subpart G to Part 441, specifying requirements for providing these services. They also add new §§ 435.232, 435.728, and 435.735 to the eligibility regulations, specifying new eligibility provisions that allow States to cover certain individuals who would otherwise be institutionalized. The regulations also make technical amendments to § 431.50, Statewide; § 440.1, the basis and purpose section of the regulations defining Medicaid services; § 440.170(f), Personal care services in a recipient's home; and § 440.250, Limits on comparability of services.

The purpose of these regulations is to give the States the maximum opportunity for innovation in furnishing noninstitutional services to beneficiaries, with a minimum of Federal regulation. Basically, we will measure the States' proposals against the statutory requirements rather than against a detailed additional set of Federal guidelines or criteria. That is, we will require the State requesting a waiver to describe its proposal, to explain how it satisfies the statutory requirements of section 1915(c) and, with regard to some specific requirements, to make assurances that those requirements are met. However, we are not generally mandating how the States must establish or implement their community care programs.

Using our experience with demonstration projects, which tested an expanded range of noninstitutional services, we will be able to offer technical assistance to States interested in requesting waivers. We can provide the States with information, for example, on successful procedures and services for a case management system and home health aides. We can also provide assistance to States that they can use in developing their community care programs and, in requesting appropriate waivers and State plan changes.

Note.—References in this document to "the level of care provided in an ICF" include the level of care furnished to beneficiaries in

ICFs for the mentally retarded (ICF/MR) (42 CFR 440.150(c)).

A. Definition of Services

The regulations provide that home or community-based services for which a waiver may be granted under this provision may consist of the following services (other than room and board):

1. Case management services.
2. Homemaker services.
3. Home health aide services.
4. Personal care services.
5. Adult day health services.
6. Habilitation services.
7. Respite care services.
8. Other services requested by the State and approved by the Secretary.

We are not going to try to define these terms in our regulation. Instead, we are requiring that the States define them in their waiver request. The States thus have broad discretion in determining the nature of the services to be covered, subject to the budgetary restraints discussed below.

The following discussion of services is presented solely for the purpose of providing the States with suggestions on how they might begin developing a waiver proposal.

1. "Case management" is commonly understood to be a system under which responsibility for locating, coordinating and monitoring a group of services rests with a designated person or organization. It was Congress' view (H. Rept. 97-158, p. 321) that the case manager should be responsible for locating available sources of help from within the family and community so that the burden of care will not be exclusively borne by formal health and social agencies. Thus, an "informal network" of friends, relatives, churches, etc., can be used wherever feasible to strengthen the elderly or disabled person's ties with his or her own community.

2. "Homemaker services" is normally viewed as consisting of general household activities (meal preparation and routine household care) provided by a trained homemaker when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for himself or others in the home.

3. "Home health aide services" would typically include the performance of simple procedures such as the extension of therapy services, personal care, ambulation and exercise, household services essential to health care at home, assistance with medications that are ordinarily self-administered, reporting changes in the patient's condition and needs, and completing

appropriate records. (See 42 CFR 405.1227(a) and 440.70 for the Medicare and current Medicaid provisions on home health aides.)

4. "Personal care services" are presently defined for the Medicaid program in 42 CFR 440.170(f) as services furnished to a recipient in his or her home that are prescribed by a physician in accordance with the recipient's plan of treatment and provided by an individual who is—

- (i) Qualified;
- (ii) Supervised by a registered nurse; and
- (iii) Not a member of the recipient's family.

States can furnish home health aide and personal care services under their State plan without seeking a waiver under section 1915(c). However, they can also seek such a waiver to provide these services in a manner that departs from these definitions.

5. "Adult day health services" are discussed in the legislative history as encompassing "both health and social services needed to insure the optimal functioning of the client, as well as habilitation services suitable for the care of the mentally retarded and the developmentally disabled" (H. Rept. 97-158, p. 321). In our view, such care should be furnished for four or more hours per day on a regularly scheduled basis, for one or more days a week in an outpatient setting. We also believe that meals provided as a part of these services could be covered. Although section 1915(c)(1) has a general prohibition against the payment for room and board, the Conference Report (H. Rept. 97-208, p. 966) indicates that Congress was aware of the manner in which homemaker and adult day health services are provided under title XX. That statute contains a similar prohibition against payment for "room and board". The title XX regulations at 45 CFR 1396.1 define "board" as "three meals a day or any other full nutritional regimen". Under this definition, title XX now pays for individual meals provided as part of adult day health services. We are adopting the title XX approach. Accordingly, Federal financial participation (FFP) will be available for meals that are provided as a part of adult day health services.

6. "Habilitation services" are typically health and social services needed to insure optimal functioning of the mentally retarded or persons with related conditions.

7. "Respite care"—The Conference Report (H. Rept. 97-208, p. 966) states that respite care is given to individuals unable to care for themselves and is provided on a short term basis to the

individual because of the absence or need for relief of those persons normally providing the care. Respite care services may be provided in the individual's home or in a facility approved by the State such as a hospital, nursing home, foster home or community residential facility. As noted above, section 1915(c)(1) of the Act precludes Federal payment for room and board when furnished as a home or community-based service. However, since the statute specifically authorizes the provision of respite care, and the Conference Report indicates that Congress intended that respite care include full-time, short-term institutional care, which always under the Medicaid program has included room and board, we have concluded that Congress intends to create an exception to the general statutory prohibition against room and board. Accordingly, Federal funds will be available for respite care provided under the waiver, including any room and board that may result from furnishing respite care outside a private residence. When respite care is furnished in a setting that charges a "per diem" rate, the room and board is considered part of the "per diem" rate.

8. *Other services*—The State may also request HCFA's approval to provide other home and community-based services not listed here. Such services may include, for example, but not be limited to, nursing care, medical equipment and supplies, physical and occupational therapy, speech pathology and audiology, and minor physical adaptations to the home. We will approve these services and others if the State demonstrates in its waiver request that they are cost-effective (i.e., their cost would not raise the cost of home and community-based care for the beneficiaries to whom they are provided to an amount greater than the cost of the level of care provided in an SNF or ICF), describes the services in detail, and assures HCFA that the services are necessary to avoid institutionalization.

B. Context of Waiver Requests

Requests for waivers must contain—

- (1) The information as described below in C;
- (2) The assurances discussed below in D; and
- (3) The required supporting information discussed below in E.

Section 1915(c) describes this provision as a waiver. We are implementing it in that fashion. Therefore, we are requiring that the State submit supporting explanation and documentation in the form of a waiver request. If the State does not intend to offer home and community-based

services to all individuals who would otherwise likely require institutionalization, it must also include a request for a waiver of the requirements of either section 1902(a) (1) or (10) of the Social Security Act, or both, if applicable. If the State intends not to offer the home or community-based services to beneficiaries on the basis that it can reasonably expect that the services would cost more than the services the beneficiaries would otherwise receive, the State must also explain in its waiver request how it will make and implement such determinations.

C. Waiver Request Requirements

The waiver request must describe the services the State is offering under the waiver and who is eligible to receive them. It must also state that the services will only be furnished to those eligible beneficiaries who, but for the provision of the home and community-based services, would require the level of care provided in an ICF or SNF.

The request must indicate how the statutory requirements for a plan of care will be met. The services provided a beneficiary must be furnished under a plan of care that is written specifically for that beneficiary. The State has discretion in designing the plan of care process and prescribing who writes individual plans of care. Based on our experience and that of the States, we expect the plan of care to include the medical and other services to be given, their frequency, and the type of provider to furnish them. Plans of care are subject to the State's approval, and the State has the discretion to set up its own approval process. The waiver request must include a description of the qualifications of the individual or individuals who will be responsible for developing the individual plan of care.

D. State Assurances

Section 1915(c) of the Act explicitly requires that a waiver can be approved only if the State provides us with satisfactory assurances of the following:

1. *Safeguards*—The State must assure us that necessary safeguards have been taken to protect the health and welfare of the beneficiaries receiving the services. Under the statute, these safeguards must include adequate standards for provider participation. These regulations do not attempt to define these safeguards or to prescribe how they are to be developed. It is the State's responsibility to determine what the necessary safeguards are, to define them or specify how they will be developed and implemented, and to

explain how they satisfy the statute. If the State has licensure or certification requirements for any services (or for the individuals who furnish these services) provided under the waiver, it must assure HCFA that the standards in the licensure or certification requirements will be met.

The State must also assure us that it will maintain, and require providers of these services to maintain, financial accountability for funds expended with respect to these services. Again, it is the State's responsibility to inform us how it will meet this requirement and, in particular how it will assure that there is an audit trail for all State and Federal funds.

2. Individual assessments.—Services under the waiver may be furnished only to an individual who, but for these services, would require the level of care provided in an SNF or ICF. This does not mean that the individual must be receiving the level of care provided in an SNF or ICF before receiving the noninstitutional services. It means, rather, that the individual, in the absence of the noninstitutional services, would require the level of care provided in an SNF or ICF. Thus, the state must assure us that, for each beneficiary encompassed by the waiver, it will provide an objective method for evaluating the beneficiary's need for the level of care provided in an SNF or ICF.

The new section requires the States to provide for an evaluation of the need for the level of care provided in an SNF or ICF with respect to all individuals who are entitled to medical assistance for these services and who may require these services. Section 1903(g) of the Act requires specific recertification of the need for institutional care with respect to beneficiaries who are already inpatients. Accordingly, under the waiver, a State would not be required to perform any further evaluation of those inpatients, although it would, of course be free to do so. It would, however, be required to perform an evaluation for all beneficiaries or Medicaid applicants for whom there is a reasonable indication that they might need the level of care provided in an SNF or ICF in the near future. In making this evaluation, the level of care provided in an SNF or ICF, as defined at 42 CFR 440.40 and 440.150 respectively, must be used. Other factors, whether medical or not, may be employed as the State deems appropriate. The State, in its assurance, must include a copy of the written assessment instrument that will be used, must describe how those assessments will be made, and specify who has responsibility for doing them.

The waiver request would have to describe, for example, the party or parties responsible for the assessment, what factors they will use to evaluate and reevaluate the recipient's need for the level of care provided in an SNF or ICF, and when evaluations and reevaluations will be made.

Our regulations require that the State maintain written documentation of all such evaluations and reevaluations. (The State need not keep the documentation itself but may arrange for the provider or for another person or agency to keep it.) The State must include in its waiver request an explanation of how it will satisfy this requirement. Congress clearly intended that these services would be made available only to individuals who had been determined to need inpatient SNF or ICF services in the absence of the alternative noninstitutional services. Therefore, we believe the maintenance of documentation is necessary to insure an audit trail and to enable us to determine whether only those individuals who would otherwise have required institutionalization were being provided these services.

3. Informing beneficiaries of choice.—Beneficiaries determined to be likely to require an SNF or ICF level of care must be informed of the feasible alternatives and given a choice as to which type of services to receive. (This would not apply to beneficiaries for whom there is a reasonable expectation that the cost of home and community-based services would be more than the cost of SNF or ICF care, if the State indicates in its waiver request that it will exclude these individuals from coverage under the waiver. See discussion in B above.) The State must explain in its waiver request how this requirement will be met and assure us that it will be met. We are not, however, requiring that the State document that each beneficiary (or his or her representative) has been so informed. In the absence of information to the contrary, we will accept the State's assurance that it has been done.

The Congressional Conference Committee, in its report on this amendment (H. Rept. 97-208, p. 966) emphasized that, while it is expected that the existence of alternatives will encourage the acceptance of community care, the integrity of patient choice must be preserved. The determination of which long-term care options are feasible in a particular case should be based on the individual's needs, as determined by an evaluation, and not on short-term cost savings.

As with other services under Medicaid, a beneficiary who is not given the choice of home or community-based

services as an alternative to SNF or ICF services may request a fair hearing under 42 CFR Part 431, Subpart E, unless the reason for the denial is that the group of which the individual is a part is not included within the scope of the waiver (see 42 CFR 431.220(b)). Since a finding that home or community-based services are not feasible in a particular case constitutes a denial of services covered under a State's Medicaid plan, the Medicaid statute (section 1902(a)(3)) requires that applicants and beneficiaries be provided the procedural protections of the Medicaid administrative hearing process as described in 42 CFR Part 431, Subpart E.

4. Average per capita expenditures.—Congress was concerned that the total of all medical assistance for services provided to individuals who would qualify for home or community-based care under the State plan not exceed, on an average per capita basis, the total expenditures that would be incurred for such individuals if home and community-based services were not available. Accordingly, the statute and these regulations provide that the State, in its waiver request, must assure us that the average per capita expenditure under the waiver does not exceed the average per capita expenditure, as reasonably estimated by the State, that would have been made under the State plan had the waiver not been granted. Congress expected that this provision would assure that aggregate costs will not be greater than they would have been without these alternative services. (H. Rept. 97-208, p. 967)

Average per capita expenditures for services for this purpose means the aggregate Medicaid payment for all long-term care services furnished (taking into account the utilization of each type of service) divided by the number of beneficiaries expected to receive services. (We are excluding from these calculations services other than long-term care services, since they should be unaffected by the waiver, and their inclusion would simply make the calculations more burdensome.) These estimates must cover each fiscal year during the 3-year term of the waiver. To be granted approval by HCFA, the estimates must be reasonable, based on statistically sound and valid procedures, and verifiable. To develop the required assurances, the State will have to develop estimates of the costs and utilization for each type of service and an estimate of the total population that would likely receive these services.

The estimated average per capita expenditures under the waiver is obtained by multiplying (A) the

- if the recipient is determined likely to require SNF/ICF/ICF-MR level of care, the client or his/her representative must be given a choice between institutional and non-institutional services;
- average per capita expenditures under the waiver may not exceed average per capita expenditures for the level of care in long term care institutions if no waiver were granted; and
- HCFA must be given annual information on the impact of the waiver on the type, amount and cost of services provided and on the health and welfare of the recipients.

States will be expected to provide HCFA with the following supporting documentation: (1) a description of the safeguards necessary to protect the health and welfare of recipients; (2) a description of the records and information to be maintained to support financial accountability; (3) a description of the state's plan for evaluating and reevaluating recipients, including information on who will make the evaluations and how, and a copy of the client assessment instrument; and (4) an explanation with supporting documentation of how the per capita expenditure estimate for institutional and non-institutional services will be developed, including estimates of utilization rates and costs.

Average Per Diem Cost Calculations. One keystone element in a state's waiver request will be the documented evidence that average per capita Medicaid expenditures under the waiver will not exceed comparable per capita outlays without the waiver. In order to assure that this statutory requirement is met, the regulations require states to demonstrate that the waiver will not result in increased average per capita Medicaid costs, by applying a mathematical equation set forth in Section 441.303(d). This regulatory equation builds in state-generated data on the estimated number of beneficiaries and average per capita costs of delivering specified services, both with and without a waiver. Of course, a submitting state must be prepared to defend the reasonableness of its projections regarding service costs and number of beneficiaries.

Preliminary calculations by the NASMRPD staff suggest that states which plan to include a substantial percentage of current residents of Title XIX-certified institutions (i.e., SNF's, ICF's and/or ICF/MR's) in the projection population eligible for Medicaid-reimbursed, non-institutional services under the waiver will have an easier time of meeting this critical statutory requirement. By contrast, a state which plans to extend eligibility for non-institutional services to a high proportion of aged, blind and/or disabled persons currently residing at home or in other non-medical community settings will have a more difficult time in proving that average per capita expenditures will not increase under the waiver.

estimated number of beneficiaries who would receive the level of care provided in an SNF or ICF under the waiver times (B) the estimated Medicaid payment per eligible Medicaid user of such care; and adding that figure to the product of (C) the estimated number of beneficiaries who would receive home and community-based services under the waiver or other noninstitutional alternative services included under the State plan times (D) the estimated Medicaid payment per eligible Medicaid user of such services. This figure is to be divided by (F) the estimated number of beneficiaries who would receive the level of care provided in an SNF or ICF under Medicaid in the absence of the waiver plus (H) the estimated number of beneficiaries who would receive any of the noninstitutional, long-term care services otherwise provided under the State plan as an alternative to institutional care.

To illustrate,

$$\frac{(A \times B) + (C \times D)}{F + H} = \text{the estimated average}$$

per capita expenditure under the waiver.

Note.—The product of $A \times B$ would be calculated separately for SNF and ICF levels of care and then added. Similarly, the product of $C \times D$ would be calculated for each type of service covered under the waiver and then added. Thus, the numerator would be the sum of all these products—or the estimated aggregate cost for all long-term care services offered under the plan.

Next, the State will develop an estimate of average per capita expenditures that would result in the absence of a waiver. This estimate is obtained by multiplying (F) the estimated number of beneficiaries who would receive the level of care provided in an SNF or ICF in the absence of the waiver times (G) the estimated Medicaid payment per eligible Medicaid user of such care; and adding that figure to the product of (H) the estimated number of beneficiaries who would receive any of the noninstitutional, long-term care services otherwise provided under the State plan as an alternative to institutional care times (I) the estimated Medicaid payment per eligible Medicaid user of such noninstitutional services. This figure will be divided by the same denominator as before—namely, (F) the estimated number of beneficiaries who would receive the level of care provided in an SNF or ICF under Medicaid in the absence of the waiver plus (H) the estimated number of beneficiaries who would receive any of the noninstitutional, long-term care services otherwise provided under the State plan as an alternative to institutional care.

To illustrate,

$$\frac{(F \cdot G) + (H \cdot I)}{F + H} = \text{the estimated average per capita ex-}$$

penditures in the absence of a waiver.

In both of these computations the denominator (i.e., the estimated number of beneficiaries who would likely receive the level of care provided in an ICF or SNF under Medicaid in the absence of the waiver) must be the same number for like periods of time. In particular, if the State wishes to revise its estimate of the denominator at some point after a waiver is approved (in order to adjust for an error in the estimate or for adding an unanticipated increase in the eligible population), that revision would be made in both calculations and the comparison would be re-examined to determine if the waiver is still cost effective.

In developing the estimates of utilization necessary to complete the above computations, the State must use actual data on nursing home cost and utilization and on cost and utilization of community-based services for the most recent year before the waiver takes effect. These figures would be adjusted by the State to reflect anticipated growth in the supply of nursing home beds, availability of community-based services and inflation. Similarly, the State's experience with utilization and cost of home and community-based services provided under title XIX, title XX and other programs should provide a useful basis for the necessary estimates.

The State, in its waiver request, must inform HCFA of what its per capita expenditures are, describe how these were estimated, and describe the factors it employed in deriving the estimates. HCFA will review these estimates very closely to determine if they are reasonable and based on statistically supportable assumptions. Further, HCFA will compare these estimates with data the State must furnish annually on its actual experience. In the event of a discrepancy between actual and estimated per capita expenditures, HCFA will ask the State to explain the basis for the difference or to adjust its estimates.

We will provide further guidance on how to develop estimating methodology and will provide technical assistance to States that request it.

5. Annual report on impact.—The State must assure us that it will provide us annually with information on the impact of the waiver on the type and amount of services provided under the State plan and on the health and welfare of the beneficiaries. The data will have to be consistent with a data collection plan

we are designing. We will provide further guidance to the States on what data must be submitted and in what form. However, such data would include, but not be limited to, the State's actual per capita expenditures for services provided under the waiver.

D. Duration of Waiver

If we approve a waiver request, the waiver may continue for three years. The waiver may be extended for three-year periods thereafter if the State requests it, unless our review of the prior three-year period shows that the assurances the State offered were not met.

The development and implementation of a State home and community-based services program is a time-consuming and complex process, often requiring the coordination of several agencies and, sometimes, State legislative action. In recognition of this, Congress provided that the waiver would be for three-year periods of time. However, Congress also provided in the amendments for the Secretary to monitor implementation of the waivers to assure that the requirements for them are being met. Thus, if HCFA finds that a given State is not meeting the assurances it made in its waiver request or any of the other requirements for a waiver specified in this subpart, the State will be given a notice of these findings and an opportunity for a hearing to rebut the findings. If, after the proceedings, HCFA determines that the State is not in compliance, HCFA will terminate the waiver. Possible grounds for termination will include excessive costs.

If a State wants to terminate its waiver before the completion of the three-year period and no longer provide home and community-based services, it must submit a written request to HCFA showing its intent to terminate the waiver 30 days before terminating services.

Whether HCFA or the State terminates the waiver, the State must notify beneficiaries receiving services under the waiver in accordance with 42 CFR 431.210 and must notify them 30 days before ending services. The State does not have to offer a hearing to beneficiaries when a waiver is terminated.

E. HCFA's Review of Waiver Requests

When we receive a request for a waiver, we will review its contents against the regulations and the statute to determine whether the request meets our requirements. For example, we will review to see that per capita expenditure estimates are reasonable

and that the State has an adequate means for evaluating whether a beneficiary needs the level of care provided in an SNF or ICF. If we find the request inadequate, unrealistic, or not cost-effective, we will return the request for more or better information. If the additional information does not improve the request sufficiently, we will deny it.

F. Eligibility of Beneficiaries

Under 42 CFR 435.231, it is possible for a beneficiary who would not be eligible for Medicaid while in the community to be eligible in an institution. The regulations permit States to set a special income standard that results in a higher institutional eligibility level for institutionalized beneficiaries than the community-based eligibility level. This level cannot exceed 300 percent of the Supplemental Security Income (SSI) community-based payment standard (42 CFR 435.722 and 435.1005). Most States have chosen this option and often the institutional level is significantly higher than the community level. The purpose of current regulations, which recognize the high cost of institutional care, is to enable States, particularly those without spend down mechanisms, such as a medically needy program, to cover institutionalized individuals although their income exceeds the community-based level. However, a beneficiary may lose Medicaid eligibility if he or she leaves the institution and returns to the community. A lack of community-based supportive services and the eligibility effect of § 435.231 have combined to provide an incentive toward institutionalization.

Section 1915(c) of the Act has a target population consisting of beneficiaries who are or who would be eligible for Medicaid in an institutional setting. The statute is not explicit on how beneficiaries are to be determined eligible for new services under the waiver. However, we believe that Congress did not intend that there would be a smaller population eligible for Medicaid for home and community-based services than for institutional long-term care. In addition, the purpose of the law is to provide an incentive for beneficiaries to remain in the community by providing supportive care at home, rather than making it available to them only in an institution.

Under our regulations implementing the changes in Medicaid eligibility made by Pub. L. 97-35, "Medicaid Eligibility and Coverage Criteria", BPP-179-FC, published in the Federal Register of September 30, 1981, we decided to retain, at least for the time being, this and other optional categorically needy

groups. To keep optional categorical coverage under 42 CFR 435.231 for the institutionalized only would deprive the program and the beneficiaries who are eligible for Medicaid only because they are institutionalized of the benefits of having care provided at home and in the community, and of the savings that Congress expected would accrue from the provision of less costly noninstitutional care. Therefore, we are adding new regulations, 42 CFR 435.232, to allow States to cover individuals who would be eligible for institutional services under 42 CFR 435.231 to be eligible for home and community-based services furnished under a waiver. The new regulations, § 435.232, will affect only the base of categorically-needy beneficiaries. Medically needy individuals may become eligible under provisions of other regulations.

These new regulations, § 435.232, are very similar to § 435.231 and permit States to make eligible those categorically needy individuals in the community who—

- (1) Are not eligible for SSI or a State supplement because of their income;
- (2) Have income below a level specified in the plan under § 435.722;
- (3) Would be eligible under § 435.231 if institutionalized; and
- (4) Would require institutional care if not receiving home or community-based services authorized under the waiver.

The effect of the changes just discussed is to remove the bias in favor of institutionalization. Conversely, we do not wish to provide an inequitable incentive for those receiving noninstitutional services.

Since beneficiaries determined eligible under a special standard, such as § 435.231, have income in excess of their maintenance needs, it is reasonable to expect these beneficiaries to share in the cost of personal and medical care above a level of income protected for maintenance needs. Current regulations at 42 CFR 435.725 and 435.733 impose this requirement on beneficiaries who are Medicaid eligible under § 431.231. Therefore, to insure equal treatment of institutionalized beneficiaries and beneficiaries receiving home and community-based services under the waiver, we will require beneficiaries who are eligible for home and community-based services under the waiver to share in the cost of the services. We believe that this requirement is supportable under the rationale of *Friedman v. Berger*, 547 F. 2d 724 (2d Cir., 1976). We are adding new §§ 435.726 and 435.735 to 42 CFR Part 435 for categorically needy beneficiaries. The sections are very similar to §§ 435.725 and 435.733, which

lay out the requirements of post-eligibility treatment of income and resources of institutionalized beneficiaries. Section 435.726 deals with beneficiaries who reside in States that provide Medicaid to all SSI beneficiaries or to all SSI beneficiaries and to State supplement beneficiaries. Section 435.735 deals with beneficiaries residing in States with more restrictive requirements than SSI.

There are two major differences in the new sections: (1) there is no provision dealing with consideration of maintenance of the beneficiary's home while he or she is an inpatient; and (2) there is no provision specifying the amount that is to be deducted from a beneficiary's total income and protected for his or her use for personal needs. Instead, there will be a provision discussing a beneficiary's maintenance allowance, which will be deducted from the total income. We are requiring this amount to be based on a reasonable assessment of need but it must not (for beneficiaries subject to the provisions of § 435.726, applicable to States covering all SSI beneficiaries) exceed the highest of:

- (a) The amount of the income standard used to determine eligibility for SSI for an individual living in his own home, if the agency provides Medicaid only to individuals receiving SSI;
- (b) The amount of the highest income standard, in the appropriate category of age, blindness, or disability, used to determine eligibility for an optional State supplement for an individual in his or her own home, if the agency provides Medicaid to optional State supplement recipients under § 435.230; or
- (c) The amount of the medically needy income standard for one person established under §§ 435.811 and 435.814, if the agency provides Medicaid under the medically needy coverage option.

Our reasoning for setting these maximum levels (and those under § 435.735) for beneficiaries only is that they are the levels set under the present regulations at §§ 435.726(c)(2) and 435.733(c)(2) for maximum maintenance levels for spouses in the community. We assume that all other needs of beneficiaries under the waiver, which might otherwise require a higher income level to meet them, will be met by the supportive services furnished under the waiver.

In these regulations the allowances for a beneficiary with only a spouse at home and for a beneficiary with a family at home will be based on the same criteria that are used for beneficiaries

who are eligible for Medicaid because they are institutionalized.

A beneficiary with only a spouse will be allowed the reasonable amount for the beneficiary's maintenance, as determined above, plus a reasonable amount for maintenance of the spouse. The reasonable amount for the spouse will be based on the same criteria used to determine the allowance for the beneficiary.

The allowances for a beneficiary with a family will be the reasonable amount (as determined above) for the beneficiary, plus an additional amount for the maintenance needs of the family. The additional amount will:

(a) Be based on a reasonable assessment of the family's financial needs;

(b) Be adjusted for the number of family members living in the home; and

(c) Not exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's AFDC plan or the medically needy income standard established under 42 CFR Part 435, Subpart I for a family of the same size. See present § 435.725(c)(3).

The State must also deduct from the beneficiary's total income amounts for incurred medical expenses that are not subject to payment by a third party. These expenses include:

(a) Medicare and other health insurance premiums, deductibles, or coinsurance charges; and

(b) Necessary medical or remedial care recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits the agency may establish on amounts of these expenses. See present § 435.725(c)(4).

For beneficiaries subject to the provisions of § 435.735 (applicable to States with more restrictive requirements than SSI), the amount the beneficiary needs for maintenance will be determined in the same manner as the maintenance needs of the spouse under existing regulations at § 435.733. The spouse's needs will be determined the same as in § 435.733, as will the family's needs. Amounts for incurred medical expenses, as in § 435.733, will be deducted from total income.

G. Technical Changes

We are revising § 431.50, Statewide operation, to show that a State need not offer services under the new benefit to all beneficiaries in the State.

We are revising § 440.1, the basis and purpose statement for existing regulations on services, to show the new statutory authority for services that can be furnished under the waiver.

We are amending § 440.170(f) so that personal care services, when furnished under a waiver as home and community-based services, will not have to meet the definitions of these sections.

Finally, we are amending § 440.250, regulations on comparability of services, to provide that, if applicable under the waiver, services provided by the State need not be comparable for all individuals within a group.

Some sections of these regulations are affected by statutory provisions that are implemented by other regulations documents also being published at this time. It would be confusing to present the same section with different wording in different documents (by making, in each document, only the particular changes called for by the statutory provisions implemented by that document). In order to avoid this problem, the sections affected by more than one provision are presented in each document with all the changes required by each of the provisions of law that affect them. However, each of the changes is explained only once, in the preamble of the regulations document that implements the provision which requires that particular change.

Waiver of Proposed Rulemaking

Public Law 97-35 was enacted on August 13, 1981, and section 2176 of that law became effective on that date. In order to have regulations in place as close as possible to the effective date of the law, we must publish these regulations in final form promptly. Because of this, and because we believe that the States and a substantial number of Medicaid recipients may benefit by these regulations, we believe that publication of a notice of proposed rulemaking would be contrary to the public interest. We therefore find good cause to waive notice of proposed rulemaking and our normal 30-day delay in effective date. We will, however, consider any comments on this rule that are mailed by the date specified above in the "Dates" section and make any further changes that may be necessary. We will also respond to the comments when we make any further changes.

Impact Analyses

Executive Order 12291

The Secretary has determined that the proposed regulations do not meet the criteria for a "major rule", as defined by section 1(b) of Executive Order 12291. That is, the proposed regulations will not—

• Have an annual effect on the economy of \$100 million or more;

• Result in a major increase in costs or prices for consumers, any industries, any government agencies or any geographic regions; or

• Have significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or import markets.

Congress estimated that this provision, as it appeared in H.R. 3962, would save \$20 million in fiscal year 1982. Cost or savings estimates for the provision, as enacted, were not developed.

The costs or savings are a function of the balance between deinstitutionalization (some current residents of nursing homes could be returned to the community for less money) and new demand (some people who currently receive care from family and friends despite a medical need for nursing home care will become eligible for Medicaid outside the nursing home setting), and the number of States which choose to exercise this option. Because of these variables, we cannot estimate the cost of this program at this time. (However, Congress indicated (H. Rept. 97-208, p. 967) that it expected the provisions concerning per capita costs to assure that aggregate costs will not be greater than they would have been without the home and community-based services.) Moreover, the purpose of the legislative amendment was to provide the States with sufficient flexibility to develop more economical alternatives to the high cost of long-term care institutional services. To the extent that this purpose is achieved, then the cost of providing the home and community-based services under the waiver will offset the cost of institutional care that would otherwise have been required. Further, by facilitating the use of other providers of care, more competition should be generated. Accordingly, we do not believe the criteria for a "major rule" will be met.

Regulatory Flexibility Act

Section 604 of Public Law 96-354 (the Regulatory Flexibility Act of 1980) requires that each Federal agency prepare, and make available for public comment, a regulatory flexibility analysis on certain regulations. The regulatory flexibility analysis is intended to explain what effect regulatory actions by agencies would have on small businesses and other small entities.

As defined by the Regulatory Flexibility Act, the term "small entities"

includes "small governmental jurisdictions". The latter term is defined as local governments (cities, counties, towns, townships, villages, school districts, or other special districts) with a population of less than fifty thousand persons.

As explained above, these regulations will permit States to offer an array of services to beneficiaries outside of an institutional setting. Although they directly affect States, the regulations could indirectly adversely affect providers of institutional services that are small enough to meet the definition of "small entity", since some individuals may choose a home or community-based service rather than an inpatient service. However, we do not believe the regulations will have a significant economic effect on a substantial number of small entities. These regulations will benefit some entities that were not able to participate previously as providers under Medicaid before because the services they provide are not covered under the Medicaid program. The regulations are intended to expand the universe of small providers and may benefit them economically. Although we do not know how many States will take advantage of the provisions of these regulations, we project that the total number of providers that benefit significantly will be small compared to total number of providers. (Many providers in a position to become Medicaid providers are already reimbursed under other programs for the same services.) Therefore, the Secretary certifies, under section 605(b) of the Regulatory Flexibility Act, that the regulations will not have a significant economic impact on a substantial number of small entities.

Reporting and Recordkeeping Requirements

The Department is required to submit to the Office of Management and Budget for review and approval, 42 CFR 441.301, 441.302, 441.303 and 441.304, which include reporting and recordkeeping requirements. These sections have been submitted to OMB. We will publish a notice in the Federal Register when approval has been obtained indicating the effective date of the reporting.

PART 431—STATE ORGANIZATION AND GENERAL ADMINISTRATION

42 CFR Part 431 is amended as follows:

The authority citation for Part 431 reads as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

2. Section 431.50 is amended by revising paragraphs (a) and (c) to read as follows:

§ 431.50 Statewide operation.

(a) *Basis and purpose.* This section implements section 1802(a)(1) of the Act, which requires a State plan to be in effect throughout the State, and section 1915, which permits certain exceptions.

(c) *Exceptions.* The requirements of paragraph (b) of this section do not apply with respect to:

- (1) Service offered by comprehensive health services organizations (see § 440.250(g)) of this subchapter;
- (2) Services offered by rural health clinics (see § 440.20(b));
- (3) Arrangements under § 431.54(d) to purchase medical services or laboratory and x-ray services (as defined in § 440.30);
- (4) Lock-in or lock-out restrictions under § 431.54(e) and (f); and
- (5) Services offered under a waiver with respect to home and community based services (§ 440.180).

PART 435—ELIGIBILITY IN THE STATES AND DISTRICT OF COLUMBIA

42 CFR Part 435 is amended as follows:

1. The table of contents for Part 435 is amended by adding new §§ 435.232, 435.726 and 435.735 as follows:

Subpart C—Options for Coverage as Categorically Needy

Section
435.232 Individuals receiving home and community-based services who are eligible under a special income level.

Subpart H—Financial Requirements for the Categorically Needy

435.726 Post-eligibility treatment of income and resources of individuals receiving home and community-based services furnished under a waiver: Application of patient income to the cost of care.

435.735 Post-eligibility treatment of income and resources of individuals receiving home and community-based services furnished under a waiver: Application of patient income to the cost of care.

2. The authority citation for Part 435 reads as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

3. Section 435.3 is amended by adding a new statutory citation at the end of the existing text as set forth below.

§ 435.3 Basis

This part implements the following sections of the Act, which state eligibility requirements and standards:

1915(c) Home or community based services.

4. A new § 435.232 is added to read as follows:

§ 435.232 Individuals receiving home and community-based services who are eligible under a special income level.

(a) If the agency provides Medicaid under § 435.231 to individuals in institutions who are eligible under a special income level, it may also cover aged, blind and disabled individuals in the community who—

- (1) Because of their income, are not eligible for SSI or State supplements;
- (2) Have income below a level specified in the plan under § 435.722 (See § 435.1005 for limitations on FFP in Medicaid expenditures for individuals specified in this section);
- (3) Would be eligible for Medicaid under § 435.231 if institutionalized; and
- (4) Will receive home and community-based services under a waiver granted under Part 441, Subpart G, of this subchapter.

5. New §§ 435.726 and 435.735 are added to read as follows:

§ 435.726 Post-eligibility treatment of income and resources of individuals receiving home and community-based services furnished under a waiver: Application of patient income to the cost of care.

(a) The agency must reduce its payment for home and community-based services provided to an individual specified in paragraph (b) of this section, by the amount that remains after deducting the amounts specified in paragraph (c) of this section from the individual's income.

(b) This section applies to individuals who are eligible for Medicaid under § 435.232 and are receiving home and community-based services furnished under a waiver of Medicaid requirements under Part 441, Subpart G of this subchapter.

(c) In reducing its payment for home and community-based services, the agency must deduct the following amounts, in the following order, from the individual's total income (including amounts disregarded in determining eligibility):

- (1) An amount for the maintenance needs of the individual. This amount must be based on a reasonable assessment of need but must not exceed the highest of—

(i) The amount of the income standard used to determine eligibility for SSI for an individual living in his own home, if the agency provides Medicaid only to individuals receiving SSI;

(ii) The amount of the highest income standard, in the appropriate category of age, blindness, or disability, used to determine eligibility for an optional State supplement for an individual in his own home, if the agency provides Medicaid to optional State supplement recipients under § 435.230; or

(iii) The amount of the medically needy income standard for one person established under §§ 435.811 and 435.814, if the agency provides Medicaid under the medically needy coverage option.

(2) For an individual with only a spouse at home, an additional amount for the maintenance needs of the spouse. This amount must be based on a reasonable assessment of need but must not exceed the highest of—

(i) The amount of the income standard used to determine eligibility for SSI for an individual living in his own home, if the agency provides Medicaid only to individuals receiving SSI;

(ii) The amount of the highest income standard, in the appropriate category of age, blindness, or disability, used to determine eligibility for an optional State supplement for an individual in his own home, if the agency provides Medicaid to optional State supplement recipients under § 435.230; or

(iii) The amount of the medically needy income standard for one person established under §§ 435.811 and 435.814, if the agency provides Medicaid under the medically needy coverage option.

(3) For an individual with a family at home, an additional amount for the maintenance needs of the family. This amount must—

(i) Be based on a reasonable assessment of their financial need;

(ii) Be adjusted for the number of family members living in the home; and

(iii) Not exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's AFDC plan or the medically needy income standard established under subpart I of this part for a family of the same size.

(4) Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party including—

(i) Medicare and other health insurance premiums, deductibles, or coinsurance charges; and

(ii) Necessary medical or remedial care recognized under State law but not covered under the State's Medicaid

plan, subject to reasonable limits the agency may establish on amounts of these expenses.

§ 435.735 Post-eligibility treatment of income and resources of individuals receiving home and community-based services furnished under a waiver: Application of patient income to the cost of care.

(a) The agency must reduce its payment for home and community-based services provided to an individual specified in paragraph (b) of this section, by the amount that remains after deducting the amounts specified in paragraph (c) of this section from the individual's income.

(b) This section applies to individuals who are eligible for Medicaid under § 435.232, and are eligible for home and community-based services furnished under a waiver of State plan requirements under Part 441, Subpart G of this subchapter.

(c) In reducing its payment for home and community-based services, the agency must deduct the following amounts, in the following order, from the individual's total income (including amounts disregarded in determining eligibility):

(1) An amount for the maintenance needs of the individual. This amount must be based on a reasonable assessment of need but must not exceed the higher of—

(i) The more restrictive income standard established under § 435.121; or

(ii) The medically needy standard for an individual.

(2) For an individual with only a spouse at home, an additional amount for the maintenance needs of the spouse. This amount must be based on a reasonable assessment of need but must not exceed the higher of—

(i) The more restrictive income standard established under § 435.121; or

(ii) The medically needy standard for an individual.

(3) For an individual with a family at home, an additional amount for the maintenance needs of the family. This amount must—

(i) Be based on a reasonable assessment of their financial need;

(ii) Be adjusted for the number of family members living in the home; and

(iii) Not exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under subpart I of this part for a family of the same size.

(4) Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including—

(i) Medicare and other health insurance premiums, deductibles, or coinsurance charges; and

(ii) Necessary medical or remedial care recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits the agency may establish on amounts of these expenses.

PART 440—SERVICES: GENERAL PROVISIONS

42 CFR Part 440 is amended as follows.

1. The authority citation for Part 440 reads as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

2. Section 440.1 is revised to read as follows:

§ 440.1 Basis and purpose.

This subpart interprets section 1905(a) of the Act, which lists the services included in the term "medical assistance," sections 1905 (c), (d), (f)–(i), and (j), which define some of those services, and section 1915(c), which lists as "medical assistance" certain home and community-based services provided under waivers under that section to individuals who would otherwise require institutionalization. It also implements sec. 1902(a)(43) with respect to laboratory services (see also §§ 447.10 and 447.342).

3. Section 440.170 is amended by revising paragraph (f) as follows:

§ 440.170 Any other medical care or remedial care recognized under State law and specified by the Secretary.

(f) *Personal care services in a recipient's home. Unless defined differently by a State agency for purposes of a waiver granted under Part 441, Subpart G of this chapter, "personal care services in a recipient's home" means services prescribed by a physician in accordance with the recipient's plan of treatment and provided by an individual who is—*

(1) Qualified to provide the services;

(2) Supervised by a registered nurse;

and

(3) Not a member of the recipient's family.

4. Section 440.180 is added to read as follows:

§ 440.180 Home or community-based services.

(a) "Home or community-based services" means services that are furnished under a waiver granted under the provisions of Part 441, Subpart G of this subchapter. The services may

consist of any of the following services as defined by the agency (but not including room and board except as specifically provided for in paragraph (b) of this section):

- (1) Case management services;
- (2) Homemaker services;
- (3) Home health aide services;
- (4) Personal care services;
- (5) Adult day health services;
- (6) Habilitation services;
- (7) Respite care services;
- (8) Other services requested by the Medicaid agency and approved by HCFA as cost-effective.

(b) FFP for home community-based services described in paragraph (a) of this section is not available in expenditures for the cost of room and board except when provided as part of respite care in a facility approved by the State that is not a private residence. For purposes of this provision, "board" means three meals a day or any other full nutritional regimen and does not include meals provided as part of a program of adult day health services.

5. Section 440.250 is amended by adding new paragraphs (h) through (k) to read as follows:

§ 440.250 Limits on comparability of services.

(h) Ambulatory services for the medically needy (§ 440.220(b)) may be limited to—

- (1) Individuals under age 18; and
- (2) Individuals entitled to institutional services.

(i) Services provided under an exception to requirements allowed under § 431.54 may be limited as provided under that exception.

(j) If HCFA has approved a waiver of Medicaid requirements under § 431.55, services may be limited as provided by the waiver.

(k) If the agency has been granted a waiver of the requirements of § 440.240 (Comparability of services) in order to provide home or community-based services under § 440.180, the services provided under the waiver need not be comparable for all individuals within a group.

PART 441—SERVICES: REQUIREMENTS AND LIMITS APPLICABLE TO SPECIFIC SERVICES

42 CFR Part 441 is amended as follows:

Subpart G, §§ 441.300–441.305 is added to read as follows:

Subpart G—Home and Community Based Services: Waiver Requirements

Sec.
441.300 Basis and purpose.

- 441.301 Contents of request for a waiver.
- 441.302 State assurances.
- 441.303 Supporting documentation required.
- 441.304 Duration of waiver.
- 441.305 Notification of termination of a waiver.

Authority: Section 1102 of the Social Security Act (42 U.S.C. 1302).

Subpart G—Home and Community-Based Services: Waiver Requirements

§ 441.300 Basis and purpose.

Section 1915(c) of the Act permits States to offer, under a waiver of statutory requirements, an array of home and community-based services that an individual needs to avoid institutionalization. Those services are defined in § 440.180 of this subchapter. This subpart describes what the Medicaid agency must do to obtain a waiver.

§ 441.301 Contents of request for a waiver.

(a) A request for a waiver under this section must consist of—

- (1) The assurances required by § 441.302 and the supporting documentation required by § 441.303;
- (2) When applicable, requests for waivers of the requirements of section 1902(a) (1) or (10) of the Act; and
- (3) A statement as to whether the agency will refuse to offer home or community-based services to any recipient because it can reasonably expect that the cost of the home or community-based services furnished to that recipient would exceed the cost of the level of care provided in an SNF or ICF (or ICF/MR if applicable).

(b) If the agency furnishes home and community-based services, as defined in § 440.180 of this subchapter, under a waiver granted under this subpart, the waiver request must:

- (1) Provide that the services are furnished—
 - (i) Under a written plan of care subject to approval by the Medicaid agency;
 - (ii) Only to recipients who are not inpatients of a hospital, SNF, ICF, or ICF/MR, and who the agency determines would require the level of care provided in an SNF or ICF (or ICF/MR, if applicable) under Medicaid (as defined in §§ 440.40 and 440.150) if not furnished these services;
- (2) Describe the qualifications of the individual or individuals who will be responsible for developing the individual plan of care;
- (3) Describe the group or groups of individuals to whom the services will be offered;
- (4) Describe the services to be furnished; and

(5) Provide that the documentation requirements regarding individual evaluation, specified in § 441.303(c), will be met.

§ 441.302 State assurances.

HCFA will not grant a waiver under this subpart unless the Medicaid agency provides satisfactory assurances to HCFA that:

(a) Necessary safeguards have been taken to protect the health and welfare of the recipients of the services. Those safeguards must include adequate standards for provider participation. If the State has licensure or certification requirements for any services or for any individuals furnishing services provided under the waiver, it must assure that the standards in the licensure or certification requirements will be met.

(b) The agency will assure financial accountability for funds expended for home and community-based services, and it will maintain and make available to HHS, the Comptroller General, or their designees, appropriate financial records documenting the cost of services provided under the waiver.

(c) The agency will provide for an evaluation of the need for home and community-based care for recipients who are entitled to the level of care provided in an SNF, ICF, or ICF/MR, as defined by §§ 440.40 and 440.150 respectively, and for whom there is a reasonable indication that they might need such services in the near future.

(d) If a recipient is determined to be likely to require the level of care provided in an SNF, ICF, or ICF/MR services, the recipient or his or her representative will be informed of the feasible alternatives, if any, available under the waiver, and permitted to choose among them.

(e) The average per capita fiscal year expenditures under the waiver will not exceed the average per capita expenditures for the level of care provided in an SNF, ICF, or ICF/MR under the State plan that would have been made in that fiscal year had the waiver not been granted. These expenditures must be reasonably estimated by the agency, and the estimates must cover each year of the waiver period.

(f) The agency will provide HCFA annually with information on the impact of the waiver on the type, amount and cost of services provided under the State plan and on the health and welfare of recipients. The information must be consistent with a data collection plan designed by HCFA.

§ 441.303 Supporting documentation required.

The agency must furnish HCFA with sufficient information to support the assurances required by § 441.302. The information must consist of the following, at a minimum:

- (a) A description of the safeguards necessary to protect the health and welfare of recipients.
- (b) A description of the records and information that will be maintained to support financial accountability.
- (c) A description of the agency's plan for the evaluation and reevaluation of recipients, including a description of who will make these evaluations and how they will be made. The information must include a copy of the evaluation instrument to be used and provide for the maintenance of written documentation of all evaluations and reevaluations.
- (d) An explanation with supporting documentation of how the agency estimated the per capita expenditures for both institutional and noninstitutional services. This information must include the estimated utilization rates and costs for institutional and noninstitutional services included in the plan.

(1) The average per capita expenditure estimate of the cost of all services, both institutional and noninstitutional, under the waiver must not exceed the average per capita expenditure of the cost of all services in the absence of a waiver. The estimates are to be based on the following equation:

$$\frac{(A \cdot B) + (C \cdot D)}{F + H} \leq \frac{(F \cdot G) + (H \cdot I)}{F + H}$$

where:

- A = the estimated number of beneficiaries who would receive the level of care provided in an SNF, ICF, or ICF/MR under the waiver.
- B = the estimated Medicaid payment per eligible Medicaid user of such institutional care.
- C = the estimated number of beneficiaries who would receive home and community-based services under the waiver or other noninstitutional alternative services included under the State plan.
- D = the estimated Medicaid payment per eligible Medicaid user of such home and community-based services.
- F = the estimated number of beneficiaries who would likely receive the level of care provided in an SNF, ICF, or ICF/MR in the absence of the waiver.
- G = the estimated Medicaid payment per eligible Medicaid user of such institutional care.
- H = the estimated number of beneficiaries who would receive any of the noninstitutional, long-term care services otherwise provided under the State plan as an alternative to institutional care.
- I = the estimated Medicaid payment per eligible Medicaid user of the noninstitutional services referred to in H.

§ 441.304 Duration of a waiver.

(a) Except as provided in paragraph (b) of this section, a waiver of State plan requirements to provide home or community-based services approved under this section will continue for a three-year period from the date of the approval. If the agency requests it, the waiver may be extended for three years

after the initial three-year period, if HCFA's review of the prior three-year period shows that the assurances required by § 441.302 of this subpart were met.

(b) If HCFA finds that an agency is not meeting any of the requirements for a waiver contained in this subpart, the agency will be given a notice of HCFA's findings and an opportunity for a hearing to rebut the findings. If HCFA determines that the agency is not in compliance with this subpart after the notice and any hearing, HCFA will terminate the waiver.

§ 441.305 Notification of a waiver termination.

(a) If a State chooses to terminate its waiver before the three-year period is up, it must notify HCFA in writing 30 days before terminating services to recipients.

(b) If HCFA or the State terminates the waiver, the State must notify recipients of services under the waiver in accordance with § 431.210 of this subchapter and notify them 30 days before terminating services.

(Catalog of Federal Domestic Assistance Program No. 13.714, Medical Assistance Program)

Dated: September 16, 1981.

Carolyn K. Davis,
Administrator, Health Care Financing Administration.

Approved: September 24, 1981.

Richard S. Schweiker,
Secretary.

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Survey on State Requests for Medicaid Community Care Waivers

1. Does your state plan to request a Medicaid community care waiver under Section 1915(c) of the Social Security Act in order to provide non-institutional services to otherwise eligible aged, blind and/or disabled clients (check appropriate box)?
- Yes No (need not answer Questions 2-5)
- Decision has not yet been made. Do not know
2. If your state plans to submit such a waiver request, will it include the provision of home and/or community-based services to otherwise eligible mentally retarded and other developmentally disabled persons (check appropriate box)?
- Yes No (need not answer Questions 3-5)
- Decision has not yet been made. Do not know
3. If your state plans to submit a waiver request, which of the following formats will it take (check appropriate box)?
- Combined request for the provision of non-institutional services to otherwise-eligible aged, blind and disabled persons.
- Single purpose request(s) for particular target population(s) (e.g., frail elderly, MR/DD clients, chronically MI, etc.).
- Decision has not yet been made. Do not know
4. If your state plans to include non-institutional services for MR/DD clients in its waiver request, specify which services will be included (check all applicable boxes)?
- Case Management Adult Day Health Home Health Aide
- Homemaker Habilitation Respite Care
- Personal Care Others (specify) _____
- Decision has not yet been made. Do not know
5. If NASMRPD were to arrange a special information-sharing workshop in conjunction with the Association's Annual Meeting in Washington (schedule for Dec. 8-9) would your state be interested in having a representative(s) attend (check appropriate box)?
- Yes Number of representatives _____
- Unable to attend State: _____
- No Contact Person: _____
- Tele. Number: _____

PLEASE FOLD AND RETURN COMPLETED QUESTIONNAIRE TO THE ASSOCIATION (return address on reverse side).