Appendix II: Table of Contents

Appendix II

State Medicaid Manual, Section 4480: Personal Care Services

Section 4480: Personal Care Services

A. General.—Effective November 11, 1997, HCFA published a final regulation in the Federal Register that removed personal care services from regulations at 42 CFR 440.170 and added a new section at 42 CFR 440.167, A Personal Care Services in a home or other location. The final rule specifies the revised requirements for Medicaid coverage of personal care services furnished in a home or other location as an optional benefit. This rule conforms to the Medicaid regulations and to the provisions of §13601(a)(5) of the Omnibus Budget Reconciliation Act (OBRA) of 1993, which added §1905(a)(24) to the Social Security Act to include payment for personal care services under the definition of medical assistance

Under §1905(a)(24) of the Act, States may elect, as an optional Medicaid benefit, personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for persons with mental retardation (ICF/MR), or institution for mental disease. The statute specifies that personal care services must be: (1) authorized for an individual by a physician in a plan of treatment or in accordance with a service plan approved by the State; (2) provided by an individual who is qualified to provide such services and who is not a member of the individual's family; and (3) furnished in a home or other location.

B. Changes Made by Final Regulation.—Personal care services may now be furnished in any setting except inpatient hospitals, nursing facilities, intermediate care facilities for the mentally retarded, or institutions for mental disease. States choosing to provide personal care services may provide those services in the individual's home, and, if the State so chooses, in settings outside the home.

In addition, services are not required by Federal law to be provided under the supervision of a registered nurse nor does Federal law require that a physician prescribe the services in accordance with a plan of treatment. States are now permitted the option of allowing services to be otherwise authorized for the beneficiary in accordance with a service plan approved by the State.

C. Scope of Services.—Personal care services (also known in States by other names such as personal attendant services, personal assistance services, or attendant care services, etc.) covered under a State's program may include a range of human assistance provided to persons with disabilities and chronic conditions of all ages which enables them to accomplish tasks that they would normally do for themselves if they did not have a disability. Assistance may be in the form of hands-on assistance (actually performing a personal care task for a person) or cueing so that the person performs the task by him/her self. Such assistance most often relates to performance of ADLs and IADLs. ADLs include eating, bathing, dressing, toileting, transferring, and maintaining continence. IADLs capture more complex life

activities and include personal hygiene, light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, medication management, and money management. Personal care services can be provided on a continuing basis or on episodic occasions. Skilled services that may be performed only by a health professional are not considered personal care services.

1. Cognitive Impairments.—An individual may be physically capable of performing ADLs and IADLs but may have limitations in performing these activities because of a cognitive impairment. Personal care services may be required because a cognitive impairment prevents an individual from knowing when or how to carry out the task. For example, an individual may no longer be able to dress without someone to cue him or her on how to do so. In such cases, personal assistance may include cueing along with supervision to ensure that the individual performs the task properly.

2. Consumer-Directed Services.—A State may employ a consumer-directed service delivery model to provide personal care services under the personal care optional benefit to individuals in need of personal assistance, including persons with cognitive impairments, who have the ability and desire to manage their own care. In such cases, the Medicaid beneficiary may hire their own provider, train the provider according to their personal preferences, supervise and direct the provision of the personal care services and, if necessary, fire the provider. The State Medicaid Agency maintains responsibility for ensuring the provider meets State provider qualifications (see E below) and for monitoring service delivery. Where an individual does not have the ability or desire to manage their own care, the State may either provide personal care services without consumer direction or may permit family members or other individuals to direct the provider on behalf of the individual receiving the services.

D. Definition of Family Member.—Personal care services may not be furnished by a member of the beneficiary's family. Under the new final rule, family members are defined to be "legally responsible relatives." Thus, spouses of recipients and parents of minor recipients (including stepparents who are legally responsible for minor children) are included in the definition of family member. This definition necessarily will vary based on the responsibilities imposed under State law or under custody or guardianship arrangements. Thus, a State could restrict the family members who may qualify as providers by extending the scope of legal responsibility to furnish medical support.

E. Providers.—States must develop provider qualifications for providers of personal care services and establish mechanisms for monitoring the quality of the service. Services such as those delegated by nurses or physicians to personal care attendants may be provided so long as the delegation is in keeping with State law or regulation and the services fit within the personal care services benefit covered under a State's plan. Services such as assistance with taking medications would be allowed if they are permissible in States' Nurse Practice Acts, although States need to ensure the personal care assistant is properly trained to provide medication administration and/or management.

States may wish to employ several methods to ensure that recipients are receiving high quality personal care services. For example, States may opt to a criminal background check or screen personal care attendants before they are employed. States can also establish basic minimal requirements related to age, health status, and/or education and allow the recipient to be the judge of the provider's competency through an initial screening. States can provide training to personal care providers. States also may require agency providers to train their employees. States can also utilize case managers to monitor the competency of personal care providers. State level oversight of overall program compliance, standards, case level oversight, attendant training and screening, and recipient complaint and grievance mechanisms are ways in which States can monitor the quality of their personal care programs. In this way, States can best address the needs of their target populations and develop unique provider qualifications and quality assurance mechanisms.

Health Care Financing Administration
Center for Medicaid and State Operations

March 9, 1998

Dear State Medicaid Director:

This letter is one of a series that provides guidance on the implementation of the Balanced Budget Act.

We are writing to alert you to a change in policy on section 4733 of the Balanced Budget Act of 1997 (BBA) from that set forth in our State Medicaid Director letter dated November 24, 1997. Section 4733 created an optional categorically needy group designed to provide Medicaid eligibility to disabled working individuals who, because of relatively high earnings, cannot qualify for Medicaid under one of the other statutory provisions under which disabled working individuals may be eligible for medical assistance.

In an enclosure to the November 24 letter, we described a two-step eligibility process consisting of a family income test of 250 percent of the Federal poverty level, followed by an individual eligibility determination. The family income test required that the family's gross income, essentially without deductions or exemptions, be compared to 250 percent of the poverty level for a family of the size involved.

Since release of the November 24 letter, concerns have been raised about the use of the family's gross income for the family income test. The primary objection is that using the family's gross income limits the amount of income individuals could have and still qualify for eligibility under this group to a point where, in approximately half the States, the income standard under section 4733 is lower than the income standard under section 1619(b) of the Act.

In view of these concerns, and after careful consideration of the options available, we have decided to change our policy on the family income test. Instead of using the family's gross income, States wishing to cover this group should measure the family's net income against the 250 percent family income standard. The family's net income is determined by applying all appropriate SSI income disregards, including the earned income disregard, to the family's total income. The result, i.e., the family's net income, is then compared to the 250 percent income standard.

Use of the family's net, rather than gross, income will have the affect of greatly increasing the amount of income a disabled individual can have and still qualify for eligibility under this group. This in turn will enable States to provide Medicaid to a greater number of disabled individuals, who without such coverage might not be able to work.

The revised enclosure explains use of the net, rather than gross, family income test. It also provides information, which was not included in the earlier version, on use of section 1902(r)(2) more liberal methodologies, as well as use of more restrictive policies in 209(b) States. We also make it clear that the SSI income standard, which is used to determine the individual's eligibility following the family net income test, includes optional State supplementary payments. Finally, the revised enclosure discusses the use of substantial gainful activity (SGA) as a criterion in determining eligibility under this group.

We apologize for any inconvenience issuance of our previous policy may have caused. Any questions about this provision or this letter should be directed to Roy Trudel of my staff at (410) 786-3417.

Sincerely,

Sally K. Richardson
Director, Center for Medicaid and State Operations

Enclosure

Enclosure

Determining Eligibility for Individuals Under Section 4733 of BBA

The eligibility determination for individuals in this group is essentially a sequential two-step process.

1. The first step is a net income test, based on the family's combined income, including all earnings. (A family can also be just one individual; i.e., a family of one.) The family's net combined income must be less than 250 percent of the federal poverty level for a family of the size involved. Family income is determined by applying all appropriate SSI disregards and exemptions, including the earned income disregard, to the family's total income. If the family's income, after all deductions and exemptions have been applied, is equal to or exceeds 250 percent of the appropriate poverty level, the individual is not eligible for Medicaid under this provision.

   It is up to the State to determine what constitutes a "family" in the context of this provision. As one example, a State could choose to consider a disabled adult living with his or her parents as a family of one for purposes of meeting the 250 percent family income standard.

2. Assuming the individual has met the net family income test, the second step is a determination of whether he or she meets the disability, assets, and unearned income standards to receive an SSI benefit. Income of other family members used in Step 1 is not included (unless the individual has an ineligible spouse whose income is subject to the SSI deeming rules). To be eligible under this provision, the individual must meet all SSI eligibility criteria (including categorical requirements).

   SSI methodologies are used in making this determination except that all earned income received by the individual is disregarded. The individual's countable unearned income (e.g., title II disability benefits) must be less than the SSI income standard (in 1998, $494 for an individual), or the standard for optional State supplementary payments (SSP) if the State makes such payments. If unearned income equals or exceeds the SSI/SSP income standard, the individual is not eligible for Medicaid under this provision.

   The individual's countable resources must be equal to or less than the SSI resource standard ($2,000 for an individual).

   Under section 1902(r)(2) of the Act, States may use more liberal income and resource methodologies than are used by the SSI program in determining eligibility for this group. Also, 209(b) States may, but are not required to, apply their more restrictive eligibility policies in determining eligibility for this group.

   There is no requirement that the individual must at one time have been an SSI recipient to be eligible under this provision. However, if the individual was not an SSI recipient, you must do a disability determination to ensure that the individual would meet the eligibility requirements for SSI. A disability determination for an individual who was not previously an SSI recipient should not consider whether the individual engaged in substantial gainful activity (SGA), since use of SGA as an eligibility criterion would in almost all instances result in the individual not being eligible under this group, effectively negating the intent of this provision.

Health Care Financing Administration
Center for Medicaid and State Operations

July 29, 1998

Dear State Medicaid Director:

In the Americans with Disabilities Act (ADA), Congress provided that "the Nation's proper goals regarding individuals with disabilities are to assure equality of opportunity, full participation, independent living, and economic self-sufficiency for such individuals." 42 U.S.C. § 12101(a)(8). Title II of the ADA further provides that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs or activities of a public entity, or be the subject of discrimination by any such entity." 42 U.S.C. § 12132. Department of Justice regulations implementing this provision require that "a public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 C.F.R. § 35.130(d).

We have summarized below three Medicaid cases related to the ADA to make you aware of recent trends involving Medicaid and the ADA.

In L.C. & E.W. v. Olmstead, patients in a State psychiatric hospital in Georgia challenged their placement in an institutional setting rather than in a community-based treatment program. The United States Court of Appeals for the Eleventh Circuit held that placement in an institutional setting appeared to violate the ADA because it constituted a segregated setting, and remanded the case for a determination of whether community placements could be made without fundamentally altering the State's programs. The court emphasized that a community placement could be required as a "reasonable accommodation" to the needs of disabled individuals, and that denial of community placements could not be justified simply by the State's fiscal concerns. However, the court recognized that the ADA does not necessarily require a State to serve everyone in the community but that decisions regarding services and where they are to be provided must be made based on whether community-based placement is appropriate for a particular individual in addition to whether such placement would fundamentally alter the program.

In Helen L. v. DiDario, a Medicaid nursing home resident who was paralyzed from the waist down sought services from a State-funded attendant care program which would allow her to receive services in her own home where she could reside with her children. The United States Court of Appeals for the Third Circuit held that the State's failure to provide services in the "most integrated setting appropriate" to this individual who was paralyzed from the waist down violated the ADA, and found that provision of attendant care would not fundamentally alter any State program because it was already within the scope of an existing State program. The Supreme Court declined to hear an appeal in this matter; thus, the Court of Appeals decision is final.

In Easley v. Snider, a lawsuit, filed by representatives of persons with disabilities deemed to be incapable of controlling their own legal and financial affairs, challenged a requirement that beneficiaries of their State's attendant care program must be mentally alert. The Third Circuit found that, because the essential nature of the program was to foster independence for individuals limited only by physical disabilities, inclusion of individuals incapable of controlling their own legal and financial affairs in the program would constitute a fundamental alteration of the program and was not required by the ADA. This is a final decision.

While these decisions are only binding in the affected circuits, the Attorney General has indicated that under the ADA States have an obligation to provide services to people with disabilities in the most integrated setting appropriate to their needs. Reasonable steps should be taken if the treating professional

determines that an individual living in a facility could live in the community with the right mix of support services to enable them to do so. The Department of Justice recently reiterated that ADA's "most integrated setting" standard applies to States, including State Medicaid programs.

States were required to do a self-evaluation to ensure that their policies, practices and procedures promote, rather than hinder integration. This self-evaluation should have included consideration of the ADA's integration requirement. To the extent that any State Medicaid program has not fully completed its self-evaluation process, it should do so now, in conjunction with the disability community and its representatives to ensure that policies, practices and procedures meet the requirements of the ADA. We recognize that ADA issues are being clarified through administrative and judicial interpretations on a continual basis. We will provide you with additional guidance concerning ADA compliance as it becomes available.

I urge you also, as we approach the July 26 anniversary of the ADA, to strive to meet its objectives by continuing to develop home and community-based service options for persons with disabilities to live in integrated settings.

If you have any questions concerning this letter or require technical assistance, please contact Mary Jean Duckett at (410) 786-3294.

Sincerely,

Sally K. Richardson, Director
Director, Center for Medicaid and State Operations

Health Care Financing Administration
Center for Medicaid and State Operations

September 4, 1998

Dear State Medicaid Director:

We have received a number of inquiries regarding coverage of medical equipment (ME) under the Medicaid program in light of the ruling of the United States Court of Appeals for the Second Circuit in DeSario v. Thomas. In that case, the court examined the circumstances under which a State may use a list to determine coverage of ME and offered its interpretation of HCFA's policies. We have concluded that it would be helpful to provide States with interpretive guidance clarifying our policies concerning ME coverage under the Medicaid program and the use of lists in making such coverage determinations. This guidance is applicable only to ME coverage policy.

As you know, the mandatory home health services benefit under the Medicaid program includes coverage of medical supplies, equipment, and appliances suitable for use in the home (42 C.F.R. § 440.70(b)(3)). A State may establish reasonable standards, consistent with the objectives of the Medicaid statute, for determining the extent of such coverage (42 U.S.C. § 1396(a)(17)) based on such criteria as medical necessity or utilization control (42 C.F.R. § 440.230(d)). In doing so, a State must ensure that the amount, duration, and scope of coverage are reasonably sufficient to achieve the purpose of the service (42 C.F.R. § 440.230(b)). Furthermore, a State may not impose arbitrary limitations on mandatory services, such as home health services, based solely on diagnosis, type of illness, or condition (42 C.F.R. § 440.230(c)).

A State may develop a list of pre-approved items of ME as an administrative convenience because such a list eliminates the need to administer an extensive application process for each ME request submitted. An ME policy that provides no reasonable and meaningful procedure for requesting items that do not appear on a State's pre-approved list, is inconsistent with the federal law discussed above. In evaluating a request for an item of ME, a State may not use a "Medicaid population as a whole" test, which requires a beneficiary to demonstrate that, absent coverage of the item requested, the needs of "most" Medicaid recipients will not be met. This test, in the ME context, establishes a standard that virtually no individual item of ME can meet. Requiring a beneficiary to meet this test as a criterion for determining whether an item is covered, therefore, fails to provide a meaningful opportunity for seeking modifications of or exceptions to a State's pre-approved list. Finally, the process for seeking modifications or exceptions must be made available to all beneficiaries and may not be limited to sub-classes of the population (e.g., beneficiaries under the age of 21).

In light of this interpretation of the applicable statute and regulations, a State will be in compliance with federal Medicaid requirements only if, with respect to an individual applicant's request for an item of ME, the following conditions are met:

> The process is timely and employs reasonable and specific criteria by which an individual item of ME will be judged for coverage under the State's home health services benefit. These criteria must be sufficiently specific to permit a determination of whether an item of ME that does not appear on a State's pre-approved list has been arbitrarily excluded from coverage based solely on a diagnosis, type of illness, or condition. The State's process and criteria, as well as the State's list of pre-approved items, are made available to beneficiaries and the public. Beneficiaries are informed of their right, under 42 C.F.R. Part 431 Subpart E, to a fair hearing to determine whether an adverse decision is contrary to the law cited above.

We encourage you to be cognizant of the approval decisions you make regarding items of ME that do not appear on a pre-approved list, to ensure that the item of ME is covered for all beneficiaries who are

similarly situated. In addition, your list of pre-approved items of ME should be viewed as an evolving document that should be updated periodically to reflect available technology.

HCFA's Regional Offices will be monitoring compliance with the statute and regulations that are the subject of this guidance. Any questions concerning this letter or the ME benefit may be referred to Mary Jean Duckett of my staff at (410) 786-3294.

Sincerely,

Sally K. Richardson
Director, Center for Medicaid and State Operations

Health Care Financing Administration
Center for Medicaid and State Operations

January 14, 2000

Dear State Medicaid Director:

The recent Supreme Court decision in Olmstead v. L. C., 119 S.Ct. 2176 (1999), provides an important legal framework for our mutual efforts to enable individuals with disabilities to live in the most integrated setting appropriate to their needs. The Court's decision clearly challenges us to develop more opportunities for individuals with disabilities through more accessible systems of cost-effective community-based services.

This decision confirms what this Administration already believes: that no one should have to live in an institution or a nursing home if they can live in the community with the right support. Our goal is to integrate people with disabilities into the social mainstream, promote equality of opportunity and maximize individual choice.

The Department of Health and Human Services (DHHS) is committed to working with all affected parties to craft comprehensive, fiscally responsible solutions that comply with the Americans with Disabilities Act of 1990 (ADA). Although the ADA applies to all State programs, Medicaid programs play a critical role in making community services available. As a consequence, State Medicaid Directors play an important role in helping their States comply with the ADA. This letter conveys our initial approach to Olmstead and outlines a framework for us to respond to the challenge.

The Olmstead Decision

The Olmstead case was brought by two Georgia women whose disabilities include mental retardation and mental illness. At the time the suit was filed, both plaintiffs lived in State-run institutions, despite the fact that their treatment professionals had determined that they could be appropriately served in a community setting. The plaintiffs asserted that continued institutionalization was a violation of their right under the ADA to live in the most integrated setting appropriate. The Olmstead decision interpreted Title II of the ADA and its implementing regulation, which oblige States to administer their services, programs, and activities "in the most integrated setting appropriate to the needs of qualified individuals with disabilities." (28 CFR 35.130(d)). In doing so, the Supreme Court answered the fundamental question of whether it is discrimination to deny people with disabilities services in the most integrated setting appropriate. The Court stated directly that "Unjustified isolation . . . is properly regarded as discrimination based on disability." It observed that (a) "institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life," and (b) "confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment."

Under the Court's decision, States are required to provide community-based services for persons with disabilities who would otherwise be entitled to institutional services when: (a) the State's treatment professionals reasonably determine that such placement is appropriate; (b) the affected persons do not oppose such treatment; and (c) the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others who are receiving State-supported disability services. The Court cautioned however, that nothing in the ADA condones termination of institutional settings for persons unable to handle or benefit from community settings. Moreover, the State's responsibility, once it provides community-based treatment to qualified persons with disabilities, is not unlimited.

Under the ADA, States are obliged to "make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program or activity." (28 CFR 35.130(b)(7)). The Supreme Court indicated that the test as to whether a modification entails "fundamental alteration" of a program takes into account three factors: the cost of providing services to the individual in the most integrated setting appropriate; the resources available to the State; and how the provision of services affects the ability of the State to meet the needs of others with disabilities. Significantly, the Court suggests that a State could establish compliance with title II of the ADA if it demonstrates that it has:

- a comprehensive, effectively working plan for placing qualified persons with disabilities in less restrictive settings, and

- a waiting list that moves at a reasonable pace not controlled by the State's endeavors to keep its institutions fully populated.

Olmstead and the Medicaid Program

Olmstead challenges States to prevent and correct inappropriate institutionalization and to review intake and admissions processes to assure that persons with disabilities are served in the most integrated setting appropriate. Medicaid can be an important resource to assist States in meeting these goals. We want to work closely with States to make effective use of Medicaid support in our planning and implementation of Olmstead. As an example of the interface between Olmstead's explanation of the State's ADA obligation and your Medicaid program we would point to the State's responsibility, under Medicaid, to periodically review the services of all residents in Medicaid-funded institutional settings. Those reviews may provide a useful component of the State's planning for a comprehensive response to Olmstead. States must also be responsive to institutionalized individuals who request that their situation be reviewed to determine if a community setting is appropriate. In such a case the State has a duty to redress the situation, subject to the limits outlined by the Court and the ADA. As another example, States may choose to utilize their Medicaid funds to provide appropriate services in a range of settings from institutions to fully integrated community support.

Comprehensive, Effectively Working Plans

As we have noted, the Supreme Court in Olmstead indicated that a State may be able to meet its obligation under the ADA by demonstrating that it has a comprehensive, effectively working plan for placing qualified persons with disabilities in the most integrated setting appropriate, and a waiting list that moves at a reasonable pace not controlled by a State's objective of keeping its institutions fully populated. The Department believes that comprehensive, effectively working plans are best achieved with the active involvement of individuals with disabilities and their representatives in design, development and implementation.

The Court's Olmstead decision regarding the integration requirement applies to all individuals with disabilities protected from discrimination by title II of the ADA. Although Olmstead involved two individuals with mental disabilities, the scope of the ADA is not limited only to such individuals, nor is the scope of Olmstead limited to Medicaid beneficiaries or to services financed by the Medicaid program. In addition, the requirement to provide services in the most integrated setting appropriate applies not only to persons already in institutional settings but to those being assessed for possible institutionalization.

The enclosure to this letter offers some recommendations about key principles and practices for States to consider as they develop plans. We recognize that there is no single plan that is best suited for all States, and accordingly that there are many ways to meet the requirements of the ADA. We certainly hope States and people with disabilities will expand and improve on these ideas. Although these plans

encompass more than just the Medicaid program, we realize the important role played by State Medicaid Directors in this area. As just one example, Federal financial participation will be available at the administrative rate to design and administer methods to meet these requirements, subject to the normal condition that the changes must be necessary for the proper and efficient administration of the State's Medicaid program. Because of your significant role, we have taken this opportunity to raise these issues with you.

The principles and practices contained in the accompanying technical assistance enclosure also serve as an important foundation for the DHHS Office for Civil Rights' (OCR) activities in this area. As you know, OCR has responsibility for investigating discrimination complaints involving the most integrated setting issue. OCR also has authority to conduct compliance reviews of State programs and has already contacted a number of States to discuss complaints. OCR strongly desires to resolve these complaints through collaboration and cooperation with all interested parties.

Next Steps for the Department of Health and Human Services

Consultation: We have begun consultation with States (including State Medicaid Directors and members of the long term care technical advisory group, who share responsibility for Medicaid) and with people with disabilities. We look forward to building on this start. Many States have made great strides toward enabling individuals with disabilities to live in their communities. There is much that we can learn from these States. We are interested in your ideas regarding the methods by which we might accomplish such continuing consultation effectively and economically.

Addressing Issues and Questions Regarding Olmstead and Medicaid: As we move forward, we recognize that States may have specific issues and questions about the interaction between the ADA and the Medicaid program. In response to the issues and questions we receive, we will review relevant federal Medicaid regulations, policies and previous guidance to assure that they (a) are compatible with the requirements of the ADA and the Olmstead decision, and (b) facilitate States' efforts to comply with the law.

Technical Assistance: In response to any issues raised by the States, the DHHS working group will develop a plan to provide technical assistance and information sharing among States and stakeholders. Responses to questions and technical assistance materials will be published on a special website. We are also funding projects in a number of States to assist with nursing home transition. Finally, we seek your ideas on the additional forms of technical assistance you would find most helpful for home and community-based services and conferences for State policy makers. We will use your suggestions to facilitate the implementation of the integration requirement.

We invite all States and stakeholders to submit questions and recommendations to our departmental workgroup co-chaired by the Director of HCFA's Center for Medicaid and State Operations and the Director of the DHHS Office for Civil Rights. Please send such written correspondence to:

DHHS Working Group for ADA/Olmstead
c/o Center for Medicaid and State Operations
HCFA, Room S2-14-26, DEHPG
7500 Security Blvd.
Baltimore MD 21244-1850

Conclusion

The Administration and DHHS have a commitment to expanding home and community-based services and offering consumers choices in how services are organized and delivered. Over the past few years, DHHS has focused on expanding and promoting home and community-based services, offering support

and technical assistance to States, and using the flexibility of the Medicaid program. The Olmstead decision affirms that we are moving in the right direction and we intend to continue these efforts.

We recognize that this interim guidance leaves many questions unanswered; with your input, we expect to develop further guidance and technical assistance. We recommend that States do the following:

- Develop a comprehensive, effectively working plan (or plans) to strengthen community service systems and serve people with disabilities in the most integrated setting appropriate to their needs;
- Actively involve people with disabilities, and where appropriate, their family members or representatives, in design, development and implementation;
- Use the attached technical assistance material as one of the guides in the planning process;
- Inform us of questions that need resolution and of ideas regarding technical assistance that would be helpful.

We look forward to working with you to improve the nation's community services system.

Sincerely,

Timothy M. Westmoreland, Director
Center for Medicaid and State Operations

Thomas Perez, Director
Office for Civil Rights

Enclosure: Developing Comprehensive, Effectively Working Plans
Fact Sheet: Assuring Access to Community Living for the Disabled

Developing Comprehensive, Effectively Working Plans

Initial Technical Assistance Recommendations

In ruling on the case of Olmstead v L.C., the Supreme Court affirmed the right of individuals with disabilities to receive public benefits and services in the most integrated setting appropriate to their needs. The Supreme Court indicated that a State can demonstrate compliance with its ADA obligations by showing that it has a comprehensive, effectively working plan for placing qualified persons with disabilities in less restrictive settings, and a waiting list that moves at a reasonable pace not controlled by the State's endeavors to keep its institutions fully populated.

We strongly urge States to increase access to community-based services for individuals with disabilities by developing comprehensive, effectively working plans for ensuring compliance with the ADA. There is no single model plan appropriate for all States and situations. In developing their plans, States must take into account their particular circumstances. However, we believe there are some factors that are critically important for States that seek to develop comprehensive, effectively working plans. Our intent in this enclosure is to identify some of the key principles, including the involvement of people with disabilities throughout the planning and implementation process. These principles also will be used by the Office for Civil Rights as it investigates complaints and conducts compliance reviews involving "most integrated setting" issues. We strongly recommend that States factor in these principles and practices as they develop plans tailored to their needs.

Comprehensive, Effectively Working Plans

Principle: Develop and implement a comprehensive, effectively working plan (or plans) for providing services to eligible individuals with disabilities in more integrated, community-based settings. When effectively carrying out this principle:

- The State develops a plan or plans to ensure that people with disabilities are served in the most integrated setting appropriate. It considers the extent to which there are programs that can serve as a framework for the development of an effectively working plan. It also considers the level of awareness and agreement among stakeholders and decision-makers regarding the elements needed to create an effective system, and how this foundation can be strengthened.

- The plan ensures the transition of qualified individuals into community-based settings at a reasonable pace. The State identifies improvements that could be made.

- The plan ensures that individuals with disabilities benefit from assessments to determine how community living might be possible (without limiting consideration to what is currently available in the community). In this process, individuals are provided the opportunity for informed choice.

- The plan evaluates the adequacy with which the State is conducting thorough, objective and periodic reviews of all individuals with disabilities in institutional settings (such as State institutions, ICFs/MR, nursing facilities, psychiatric hospitals, and residential service facilities for children) to determine the extent to which they can and should receive services in a more integrated setting.

- The plan establishes similar procedures to avoid unjustifiable institutionalization in the first place.

Plan Development and Implementation Process

Principle: Provide an opportunity for interested persons, including individuals with disabilities and their representatives, to be integral participants in plan development and follow-up. When effectively carrying out this principle:

- The State involves people with disabilities (and their representatives, where appropriate) in the plan development and implementation process. It considers what methods could be employed to ensure constructive, on-going involvement and dialogue.

- The State assesses what partnerships are needed to ensure that any plan is comprehensive and works effectively.

Assessments on Behalf of Potentially Eligible Populations

Principle: Take steps to prevent or correct current and future unjustified institutionalization of individuals with disabilities. When effectively carrying out this principle:

- The State has a reliable sense of how many individuals with disabilities are currently institutionalized and are eligible for services in community-based settings. The plan considers what information and data collection systems exist to enable the State to make this determination. Where appropriate, the State considers improvements to data collection systems to enable it to plan adequately to meet needs.

    1. The State evaluates whether existing assessment procedures are adequate to identify institutionalized individuals with disabilities who could benefit from services in a more integrated setting.

    2. The State also evaluates whether existing assessment procedures are adequate to identify individuals in the community who are at risk of placement in an unnecessarily restrictive setting.

    3. The plan ensures that the State can act in a timely and effective manner in response to the findings of any assessment process.

Availability of Community-Integrated Services

Principle: Ensure the Availability of Community-Integrated Services. When effectively carrying out this principle:

- The plan identifies what community-based services are available in the State. It assesses the extent to which these programs are able to serve people in the most integrated setting appropriate (as described in the ADA). The State identifies what improvements could be accomplished, including in information systems, to make this an even better system, and how the system might be made comprehensive.

- The plan evaluates whether the identified supports and services meet the needs of persons who are likely to require assistance in order to live in community. It identifies what changes could be made to improve the availability, quality and adequacy of the supports.

- The State evaluates whether its system adequately plans for making supports and services available to assist individuals who reside in their own homes with the presence of other family members. It also considers whether its plan is adequate to address the needs of those without family members or other informal caregivers.

- The State examines how the identified supports and services integrate the individual into the

community. The State reviews what funding sources are available (both Medicaid and other funding sources) to increase the availability of community-based services. It also considers what efforts are under way to coordinate access to these services. Planners assess the extent to which these funding sources can be organized into a coherent system of long term care which affords people with reasonable, timely access to community-based services. Planners also assess how well the current service system works for different groups (e.g. elderly people with disabilities, people with physical disabilities, developmental disabilities, mental illness, HIV-AIDS, etc.). The assessment includes a review of changes that might be desirable to make services a reality in the most integrated setting appropriate for all populations.

- The plan examines the operation of waiting lists, if any. It examines what might be done to ensure that people are able to come off waiting lists and receive needed community services at a reasonable pace.

Informed Choice

Principle: Afford individuals with disabilities and their families the opportunity to make informed choices regarding how their needs can best be met in community or institutional settings. When effectively carrying out this principle:

- The plan ensures that individuals who may be eligible to receive services in more integrated community-based settings (and their representatives, where appropriate) are given the opportunity to make informed choices regarding whether—and how—their needs can best be met.

- Planners address what information, education, and referral systems would be useful to ensure that people with disabilities receive the information necessary to make informed choices.

Implications for State and Community Infrastructure

Principle: Take steps to ensure that quality assurance, quality improvement and sound management support implementation of the plan. When effectively carrying out this principle:

- Planners evaluate how quality assurance and quality improvement can be conducted effectively as more people with disabilities live in community settings.

- The State also examines how it can best manage the overall system of health and long term care so that placement in the most integrated setting appropriate becomes the norm. It considers what planning, contracting and management infrastructure might be necessary to achieve this result at the State and the community level.

FACT SHEET

Assuring Access to Community Living for the Disabled

Overview: On June 22, 1999, the U.S. Supreme Court affirmed that policy by ruling in Olmstead v. L.C. that under the Americans With Disabilities Act (ADA) unjustifiable institutionalization of a person with a disability who, with proper support, can live in the community is discrimination. In its ruling, the Court said that institutionalization severely limits the person's ability to interact with family and friends, to work and to make a life for him or herself.

The Olmstead case was brought by two Georgia women whose disabilities include mental retardation and mental illness. At the time the suit was filed, both plaintiffs were receiving mental health services in state-run institutions, despite the fact that their treatment professionals believed they could be appropriately served in a community-based setting.

In accordance with that Court ruling, the U.S. Department of Health and Human Services (HHS) today issued guidance to state Medicaid directors on how to make state programs responsive to the desires of disabled persons to live in appropriate community-based settings. The Administration's goal is to integrate people with disabilities into the social mainstream with equal opportunities and the chance to make choices.

In addition, HHS Secretary Donna E. Shalala wrote to the governor of each state, underlining the Department's commitment to community services for those with disabilities and noting that the Olmstead decision applied to all relevant state programs, not just Medicaid.

The Olmstead Decision

The Court based its ruling in Olmstead on sections of the ADA and federal regulations that require states to administer their services, programs and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.

Under the Court's ruling, certain principles have emerged:

- unjustified institutionalization of people with disabilities is discrimination and violates the ADA;

- states are required to provide community-based services for persons with disabilities otherwise entitled to institutional services when the state's treatment professionals reasonably determine that community placement is appropriate; the person does not oppose such placement; and the placement can reasonably be accommodated, taking into account resources available to the state and the needs of others receiving state-supported disability services; a person cannot be denied community services just to keep an institution at its full capacity; and, there is no requirement under the ADA that community-based services be imposed on people with disabilities who do not desire it.

The Court also said that states are obliged to "make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program or activity." Meeting the fundamental alteration test takes into account three factors: the cost of providing services in the most integrated setting; the resources available to the state; and how the provision of services affects the ability of the state to meet the needs of others with disabilities.

Olmstead and the Medicaid Program

The Medicaid program can be an important resource to assist states in meeting the principles set out in Olmstead. In its letter / guidance to State Medicaid Directors, the Health Care Financing Administration, which oversees the Medicaid and Medicare programs, reminds states they have an obligation under Medicaid to periodically review the services of all residents in Medicaid-funded institutions.

The letter also reminds states they may chose to utilize their Medicaid funds to provide appropriate services in a range of settings from institutions to fully integrated community support.

HCFA urges states to develop comprehensive working plans to strengthen community service systems and to actively involve people with disabilities and their families in the design, development and implementation of such plans. HCFA also encourages states to take steps to prevent future inappropriate institutionalization of persons with disabilities and to assure the availability of community-based services.

Next Steps

Over the past few years, HHS has focused on expanding and promoting home and community-based services, offering support and technical assistance to states and using the flexibility of the Medicaid program. The Olmstead decision affirms that we are moving in the right direction.

To help states comply with the Court ruling, HCFA and the HHS Office for Civil Rights have begun working with states and the disability community toward the goals of promoting home and community-based services; honoring individual choice in service provision; and acknowledging that resources available to a state are limited by the need to serve both community-based and institutionalized persons.

In addition to continued technical assistance to states, HHS will review relevant federal Medicaid regulations, policies and previous guidance to assure that they are compatible with requirements of the ADA and Olmstead decision and that they facilitate states' efforts to comply with the law.

Health Care Financing Administration
Center for Medicaid and State Operations

March 29, 2000

Dear State Medicaid Director:

On December 17, 1999, President Clinton signed the "Ticket to Work and Work Incentives Improvement Act of 1999" into law. In signing this legislation, President Clinton emphasized that it will enable the nation to better ensure that "No one will have to choose between taking a job and having health care." This legislation improves access to employment training and placement services for people with disabilities who want to work. It also offers States unprecedented opportunities to eliminate barriers to employment for people with disabilities by improving access to health care coverage available under Medicare and Medicaid. The Health Care Financing Administration (HCFA) will be providing information on an ongoing basis concerning implementation of this important legislation.

The concern expressed most frequently by people with disabilities who want to work is the fear of losing coverage for health care should their employment cause them to lose eligibility for benefits such as Medicare and Medicaid. Often these individuals cannot get private health insurance. The loss of Medicare and Medicaid would leave them without a way to pay for medical expenses and for basic supports they require to live. Many, therefore, fear working as not in their best interests if it would result in the loss of their Medicare or Medicaid coverage. Others may be employed, but are careful to limit their employment to the very low levels that will not jeopardize such coverage.

Title II of the new legislation entitled "Expanded Availability of Health Care Services" contains five provisions that specifically address the concerns many people with disabilities have about possible loss of health care if they return to work. Three of the provisions affect the Medicaid program, and are described more fully below. The remaining two provisions include: (1) an extension to 78 months (versus the previous 24 month limit) of premium-free Medicare Part A benefits for beneficiaries who lose Title II cash assistance because they return to work; and (2) a consumer protection provision which at the policyholder's request requires suspension of Medigap coverage and premiums for disabled policyholders who are entitled to Medicare Part A benefits if the individual is covered under certain group health plans. The law now requires that the policy be automatically reinstated if the policyholder provides timely notice that he or she lost the group health coverage.

It will take some time to develop detailed guidance on the provisions affecting the Medicaid program. In the meantime, though, I want to provide each of you with a summary of the Medicaid provisions and information on who you can contact for further information and technical assistance. I hope you will begin seriously considering the options available to States to make a real, positive contribution to efforts to assist people with disabilities to gain and sustain competitive employment.

New Eligibility Groups (Section 201 of the legislation). Two new optional categorically needy Medicaid eligibility groups are created by the new statute. Under the subsection (XV) eligibility group, States can cover individuals at least age 16 but less than 65 years of age who, except for earned income, would be eligible to receive Supplemental Security Income (SSI) benefits, regardless of whether they have received SSI cash benefits. This group is similar to the group created by section 4733 of the Balanced Budget Act (BBA), except that there is no 250 percent of the Federal poverty level family income limit, AND under this new group States are free to establish their own income and resource standards, or have no income or resource standards if they choose.

Under what we are calling the "Medical Improvement and Employment Security" group, States can cover employed individuals with a medically improved disability who lose Medicaid eligibility under the subsection (XV) eligibility group described above because their medical conditions have improved

to the point where they are no longer disabled under the SSI definition of disability. If a State wants to cover this group, it must cover the subsection (XV) group described above.

As with the original BBA group, States may impose premiums or other cost-sharing charges on a sliding scale based on income for individuals eligible under both of the new eligibility groups. For individuals with annual adjusted gross income (as defined by the IRS) that exceeds $75,000, States are required to charge 100 percent of the premiums they may impose. However, States can subsidize the premium cost for these individuals, using State funds.

Medicaid Infrastructure Grant Program (Section 203 of the legislation). This eleven year grant program makes $150 million available over the first five years to States to design, establish and operate State infrastructures that:

- implement the Medicaid eligibility group(s) discussed above;
- design and plan a Medicaid demonstration for employed individuals with potentially severe physical or mental impairments;
- plan, design or evaluate improvements to the Medicaid State Plan for purposes of providing more effective employment support; and / or
- create a State-to-State Medicaid Infrastructure Center to serve as a regional technical assistance provider for health care improvements supporting employment.

Funds may also be used to conduct outreach campaigns to educate beneficiaries about the availability of such health care and related coverage for competitively employed individuals with disabilities. Subject to availability of the overall annual amount appropriated for this grant program, the minimum award to States is $500,000 per fiscal year.

To be eligible for grant funds, a State must make personal assistance services available under its State Medicaid plan to the extent necessary to assist individuals with disabilities to maintain employment. The grant program is designed to reward States for their efforts in encouraging individuals with disabilities to be employed, and to give proportionately more funding to States that have elected to cover the eligibility group for working individuals with disabilities.

Medicaid Demonstration (Section 204 of the legislation). This program, which is funded at $250 million over six years, enables States to provide the full Medicaid benefits package to workers with potentially severe disabilities. These workers must be at least 16 but less than 65 years old, and have a specific physical or mental impairment that can reasonably be expected, but for the receipt of Medicaid services, to lead to blindness or disability as defined under the SSI program. Under the demonstration, a State defines the number of people with the physical or mental impairments it chooses to cover. The intention of the demonstration is to measure the effect of providing early intervention in the form of Medicaid benefits and services on the ability of participants to retain competitive employment. States are permitted to operate sub-State demonstrations.

Funds under both the Medicaid Infrastructure Grant Program and the Medicaid Demonstration will be available beginning October 1, 2000. Two requests for proposals (RFPs) will be released this summer with complete details on how States can apply for funds under both the infrastructure grant program, and the demonstration program. We plan to issue State Medicaid Directors letters in advance to alert States to the pending release of the RFPs.

HCFA also is preparing guidance materials for States on the options created by this legislation. Additional letters to State Medicaid Directors will provide more detailed information about the new eli-

gibility groups. A draft State Medicaid plan pre-print for States to use in submitting plan amendments to cover these groups also will be made available.

In addition, we will be providing ongoing technical assistance and education around the new health care programs as well as participating in several public information sessions on the entire Act sponsored by the Social Security Administration. If you have questions about the new eligibility groups created by the Ticket to Work and Work Incentives Improvement Act of 1999, please contact Roy Trudel at 410-786-3417 (e-mail rtrudel@hcfa.gov). If you have questions about the Medicaid Infrastructure Grants or the Medicaid Demonstration, please contact Carey O'Connor at 202-690-7865 (e-mail coconnor2@hcfa.gov).

We are excited about the opportunities presented by the legislation, and look forward to working with you as you begin to consider the options available to your State to really make a difference in the lives of people with disabilities who want to work.

Sincerely,

Timothy M. Westmoreland, Director
Center for Medicaid and State Operations

Olmstead Update No: 2
Subject: Questions and Answers
Date: July 25, 2000

Dear State Medicaid Director:

In our January 14, 2000 letter to you we conveyed our initial approach to compliance with the decision in Olmstead v. L.C., 119 S.Ct. 2176 (1999) and outlined a framework for us to respond to the challenge of crafting comprehensive, fiscally responsible solutions that comply with the Americans with Disabilities Act. As that letter indicated, the Olmstead decision challenges States to prevent and correct inappropriate institutionalization of persons with disabilities and to review intake and admissions processes to assure that persons with disabilities are served in the most integrated setting appropriate. We indicated our willingness to work closely with States to make effective use of Medicaid support in your planning and implementation of Olmstead. In that letter we also recognized that States may have specific issues and questions about the interaction between the ADA and the Medicaid program and we invited you to submit your comments to the DHHS Working Group for ADA/Olmstead.

Since the issuance of that letter we have received numerous questions from States and the disability community. We have begun to review, analyze and develop responses to those questions. Attached to this letter are some of the questions we have received along with our responses.

We urge you to continue to submit your questions and recommendations to us so that we may assist you. Such written correspondence may be sent to:

DHHS Working Group for ADA/Olmstead
c/o Center for Medicaid and State Operations
HCFA, Room S2-14-26, DEHPG
7500 Security Boulevard
Baltimore, MD 21244-1850

or e-mailed to: ADA/Olmstead@hcfa.gov

This letter, as well as future questions and answers, will be posted on the Health Care Financing Administration's ADA/Olmstead website. That site can be found at http://www.hcfa.gov/medicaid/olmstead/olmshome.htm.

We look forward to continuing our work with you to improve the nation's community service system.

Sincerely,

Timothy M. Westmoreland, Director
Center for Medicaid and State Operations

Thomas Perez, Director
Office for Civil Rights

Olmstead / ADA Questions and Answers

On January 14, 2000, the Department of Health and Human Services issued a letter to State Medicaid Directors discussing the Supreme Court's decision in Olmstead v. L.C., 119 S.Ct. 2176 (1999). In Olmstead, the Supreme Court affirmed that the unjustified segregation and institutionalization of people with disabilities constitutes unlawful discrimination in violation of the Americans with Disabilities Act (ADA). The January 14 letter sets out a process for technical assistance and information sharing, and indicated that questions and recommendations sent to the departmental workgroup would be posted on a special website. Accordingly, the following set of Qs&As has been posted on the site (*see* http://www.hcfa.gov/medicaid/olmstead/olmshome.htm).

QUESTIONS ABOUT COMPLAINT INVESTIGATION AND DEVELOPING "COMPREHENSIVE, EFFECTIVELY WORKING" PLANS

Q1. Since the Supreme Court's ruling, the Department of Health and Human Services (DHHS) has received over 150 complaints from individuals and organizations alleging that States are not providing services to qualified individuals with disabilities in the most integrated setting. How is DHHS addressing these complaints?

A. DHHS' Office for Civil Rights (OCR) is responsible for investigating complaints alleging discrimination on the basis of disability by public entities related to health and human services, and by entities receiving funds from DHHS. OCR's first objective is to work promptly and cooperatively with all parties involved, including States and individuals with disabilities, to obtain voluntary compliance whenever possible that reflects the balanced approach outlined in Olmstead.

The Olmstead v. L.C. decision indicates that a court might find a State in compliance with the ADA integration mandate if it can demonstrate that it has a "comprehensive, effectively working plan[s]" for providing services to individuals with disabilities in the most integrated setting, and a waiting list that moves at a reasonable pace not motivated by a desire to keep institutions full. While the court did not require States to undertake planning, we believe planning is a prudent and very practical recommendation for moving forward.

In appropriate cases, therefore, OCR is urging States to bring all relevant stakeholders together to develop and implement comprehensive and effective working plans for providing services to all qualified individuals with disabilities in the most integrated setting. OCR also is working with States to cooperatively resolve complaints filed on behalf of individuals. Only if OCR cannot negotiate a satisfactory resolution will ADA title II complaints be referred to the Justice Department (DOJ) for resolution.

Q2. What is the Federal government doing to aid States in developing these plans, and to help States increase their capacity to provide community-based treatment and supports for people with disabilities?

A. DHHS is providing technical assistance to promote effective implementation of its longstanding policy of facilitating care and service provision in the most integrated setting. Specifically, OCR is working with the Health Care Financing Administration (HCFA) to provide technical assistance regarding individual State's compliance with the ADA. Also, Federal financial participation is available at the administrative rate to design and administer plans to serve individuals with disabilities in the most integrated setting, subject to the normal condition that the changes must be necessary for the proper and efficient administration of the State's Medicaid program.

Even more significantly, DHHS is reviewing its own policies, programs, statutes and regulations to identify ways to enhance and improve the availability of community-based services. The Department recognizes that key programs, such as Medicaid, may sometimes present difficulties for people with disabil-

ities to have access to quality care in the community. The Department is developing and will implement its own comprehensive plan to eliminate these barriers. Recognizing that housing is a critical need, we are also working with the Department of Housing and Urban Development (HUD) to improve affordable, accessible housing opportunities for people with disabilities (see Q17 below). DHHS is committed to working with States to increase community-based alternatives to institutional care.

Q3. What recommendations does DHHS have regarding the elements of a comprehensive, effectively working plan?

A. HCFA and OCR have developed a set of plan recommendations which were attached to the January 14, 2000 State Medicaid Director letter and we encourage States to follow them. Listed below are some of the principles underlying the recommendations contained in the letter. For complete information regarding how to effectively carry out each principle, please consult the January 14 letter.

- **Comprehensive, Effectively Working Plans**

  Principle: *Develop and implement a comprehensive, effectively working plan (or plans) for providing services to eligible individuals with disabilities in more integrated, community-based settings.*

- **Plan Development and Implementation Process**

  Principle: *Provide an opportunity for interested persons, including individuals with disabilities and their representatives, to be integral participants in plan development and follow-up.*

- **Assessments on Behalf of Potentially Eligible Populations**

  Principle: *Take steps to prevent or correct current and future unjustified institutionalization of individuals with disabilities.*

- **Availability of Community-Integrated Services**

  Principle: *Ensure the Availability of Community-Integrated Services.*

- **Informed Choice**

  Principle: *Afford individuals with disabilities and their families the opportunity to make informed choices regarding how their needs can best be met in community or institutional settings.*

- **Implications for State and Community Infrastructure**

  Principle: *Take steps to ensure that quality assurance, quality improvement and sound management support implementation of the plan.*

Q4. Does the Olmstead decision require States to have plans to provide services to people with disabilities in the most integrated setting?

A. The decision does not require a State to have such a plan. However, developing and implementing a comprehensive plan or supplementing existing plans to address unmet needs is an important way States may be able to demonstrate that they are in compliance with ADA requirements and actively address discrimination.

The decision indicates that a court might find a State in compliance with the ADA integration mandate if it can demonstrate that it has a "comprehensive, effectively working plan[s]" for providing services to

individuals with disabilities in the most integrated setting.

Ideally, all people with disabilities would already be provided with services in integrated settings, thereby eliminating the need for planning. As a practical matter, however, many States—including those that have made significant investment in the development of community-based services—still face unmet needs. Developing and implementing the kind of plan described by the Supreme Court in Olmstead is a recommended step towards addressing these needs.

Q5. If a State already has a plan, does it need to develop a new one?

A. It depends on how comprehensive and effective the existing plan is. Ultimately, States must be able to demonstrate that their existing plans are comprehensive and effectively working. States are encouraged to evaluate their existing plans using the Recommendations attached to DHHS' January 14 letter, supplement existing plans as necessary, and monitor them to ensure that they are being implemented.

Q6. Why should a State engage in planning activity undertaken in response to an OCR complaint? Will it protect the State from other investigations or litigation?

A. Regulations issued under title II of the ADA direct OCR to investigate complaints against health and human service-related State and local government entitles. OCR has informed States against which it has received Olmstead-type complaints of its desire to try and resolve complaints by helping the State convene stakeholders to develop a comprehensive, effectively working plan to serve individuals with disabilities in the most integrated setting appropriate to their needs. Where States or other "respondents" (entities against which OCR has received complaints) engage in planning processes in good faith and at a reasonable pace, OCR may determine it is possible to allow plan development to proceed in lieu of investigation. Where a State or other respondent evinces no intent to undertake planning, or where delays in doing so evidence a lack of good faith, or where States or other respondents utterly fail to involve stakeholders in plan development, OCR may determine it necessary to commence full-blown investigation. Following investigation, if a violation is found and no resolution is reached, cases may be referred to DOJ for litigation.

The next question concerns the effect of such planning efforts upon legal claims brought by private litigants, or by non-OCR government actors, such as the DOJ. An agreement between a State and OCR would not have any direct impact on pending and future title II litigation brought by a private party or DOJ unless the private parties or DOJ enter into explicit agreements with the State that incorporate OCR's agreement, either in whole or in part.

That said, although there is no direct linkage between OCR complaint investigations and resolution activities and pending investigations or litigation brought by other private parties and DOJ, there may be situations where creating linkages may result in opportunities to bring all parties to the table to resolve pending claims through negotiation.

Q7. If a State decides to develop a comprehensive plan, what form must it take? Must there be only one plan, or can there be multiple plans?

A. The precise form of the plan is best determined by those who are responsible for developing and implementing it. That said, if OCR has a complaint against a State, and OCR has determined it possible as a preliminary matter to address the complaint by allowing plan development to proceed, OCR may require the State to have a framework that pulls together the essential elements of the various plans. In other words, to address a complaint filed with OCR, the State typically will be asked to demonstrate the pace at which services to people with disabilities are being provided in the most integrated setting, even if more detailed planning documents are developed as "subplans."

Q8. In its letter to State Medicaid Directors dated January 14, 2000, DHHS recommends that States "actively involve people with disabilities in the planning process." Does this mean the Department believes that groups should be involved in medical treatment decisions?

A. The Department strongly encourages States to provide an opportunity for interested persons, including individuals with disabilities and their representatives, to participate in the State's overall plan development process. All stakeholders, including advocacy organizations, should participate in the plan development process to ensure that any plan is comprehensive, works effectively and is designed to meet the needs and concerns of all people with disabilities. Consumer directed organizations, such as independent living centers, often have specific expertise in helping people with disabilities transition from nursing homes and institutions into the community which States may wish to utilize. Decisions regarding the treatment and specific placement of an individual with a disability must be made by that individual in conjunction with the individual's treating professionals.

QUESTIONS ABOUT WHO IS AFFECTED BY OLMSTEAD V. L.C.

Q9. The decision in Olmstead v. L.C. involved two women with mental retardation and mental illness. Is the decision limited to people with similar disabilities?

A. No. The principles set forth in the Supreme Court's decision in Olmstead apply to all individuals with disabilities protected from discrimination by title II of the ADA. The ADA prohibits discrimination against "qualified individual(s) with a disability." The ADA defines "disability" as:

> (A) a physical or mental impairment that substantially limits one or more of an individual's major life activities;
> (B) a record of such an impairment; or
> (C) being regarded as having such an impairment.

To be a "qualified" individual with a disability, the person must meet the essential eligibility requirements for receipt of services or participation in a public entity's programs, activities, or services. For example, if the program at issue is open only to children, and that eligibility criterion is central to the program's purpose, the individual must satisfy this eligibility requirement.

Q10. To meet the definition of disability under the ADA and Section 504, a physical or mental impairment must be serious enough to limit a major life activity. What kinds of life activities are considered "major," and when does an impairment "substantially limit" a major life activity?

A. Examples of major life activities include caring for oneself, walking, seeing, hearing, speaking, breathing, working, performing manual tasks, and learning. They also include such basic activities as thinking, concentrating, interacting with others, and sleeping. An impairment "substantially limits" a major life activity when the individual's important life activities are restricted as to the conditions, manner, and duration under which they can be performed in comparison to most people. Some examples of impairments which may, even with the help of medication or devices, substantially limit major life activities are: AIDS, alcoholism, blindness or visual impairment, cancer, deafness or hearing impairment, diabetes, drug addiction, heart disease, and mental illness. The determination whether an impairment "substantially limits" a major life activity must be made on a case-by-case basis.

Q11. What do the other two prongs of the definition, "record of" or "regarded as having" a disability mean?

A. The ADA also protects people who are regarded by others as having a substantially limiting physical or mental impairment, and people who have a record of a substantially limiting physical or mental impairment. For example, a person who is discriminated against based on his or her history of a serious

seizure disorder is protected by the ADA, even if he or she no longer experiences seizures. Likewise, a person with a very mild seizure disorder that does not substantially limit any major life activity and is completely controlled by medication that has no side effects is protected by the ADA if he or she is discriminated against because he or she is perceived as, or "regarded as," having a disability.

Q12. What about elderly people and children? Are they covered?

A. No matter what specific impairment or group of people is at issue—including elderly people and children—each must meet the same threshold definition of disability in order to be covered by the ADA. The question is: "Does the person have an impairment, have a record of impairment, or is he or she being regarded as having an impairment, that substantially limits a major life activity?"

With respect to elderly people, age alone is not equated with disability. However, if an elderly individual has a physical or mental impairment that substantially limits one of more of his or her major life activities, has a record of such an impairment, or is regarded as having such an impairment, he or she would be protected under the ADA.

Q13. Are people with substance abuse problems covered by the ADA?

A. People with substance abuse problems, except for those currently using illegal drugs, are covered by the ADA if they have a disability that substantially limits a major life activity. This means that people who have alcoholism, people who are addicted to non-controlled substances and people who have a history of drug addiction are covered by the ADA if important life activities are restricted as to the condition, manner, and duration under which they can be performed in comparison to most people. In addition, although current illegal drug users are not covered by the Act, persons who use illegal drugs may still be covered if they are discriminated against based on another disability, such as a mental or physical impairment that substantially limits a major life activity.

Q14. What is the relationship between the ADA and Section 504 definition of a person with a disability and the definition of disability used to establish eligibility for entitlement programs such as SSDI/SSI?

A. The definitions of disability used by entitlement programs are not the same as that used by the ADA and Section 504. Thus, the fact that an entitlement program such as SSDI/SSI or Medicaid has determined that a person is not disabled does not mean that they are not covered by the ADA or Section 504. That said, the fact that someone has been found disabled for purposes of an entitlement program, while not conclusive, is usually good evidence to support a finding of disability under the ADA and Section 504.

ADDITIONAL QUESTIONS [SECTION 504; HUD AND DHHS]

Q15. What, if any, relationship does Olmstead v. L.C. have to Section 504 of the Rehabilitation Act of 1973 (Section 504)?

A. Section 504, which was enacted some seventeen years before the ADA, prohibits discrimination on the basis of disability by entities which receive Federal funding. Section 504 and the ADA use the same definition of disability. Title II of the ADA extends Section 504's prohibition of discrimination in Federally assisted programs to all activities of State governments, including those that do not receive Federal financial assistance. Although the Olmstead decision interpreted the ADA, unjustified segregation by a Federally funded program would also constitute disability discrimination under Section 504. A State program receiving Federal funds must comply with both Section 504 and title II of the ADA.

Q16. What about the Department of Housing and Urban Development? Is HUD involved in the Federal government's Olmstead implementation efforts?

A. Historically, the lack of accessible, affordable housing and necessary community based services has been a major barrier to the integration of people with disabilities. Access to affordable housing is frequently a necessary but missing prerequisite for moving out of a nursing home or other institutional settings. HHS and HUD are strongly committed to assisting States to develop comprehensive working plans to strengthen community service systems and to actively involve people with disabilities and their families in the design, development and implementation of such plans. In some States HUD's "community builders" are aiding plan development, and we urge States to take advantage of the opportunity to call upon the expertise of our Federal partners, including HUD, in developing home and community-based infrastructure. Partnerships among housing, health and human services agencies and other key stakeholders in the disability and aging communities will prove central to a State's success.

Q17. We have many questions regarding the impact of this decision and how we can come into compliance with the law. Who should we talk to at HHS?

A. States should direct any questions or requests for technical assistance regarding their ADA and Section 504 obligations in response to the Olmstead decision to the OCR regional office that handles complaints filed in that State. A list of regional contacts—local staff designated to handle "most integrated setting" issues in each region—may be found at the conclusion of this document. Questions regarding Medicaid or Medicare policy should be directed to your HCFA regional office.

OCR REGIONAL OLMSTEAD CONTACTS

REGION I	Peter Chan	(617) 565-1353 (617) 565-3809 fax
REGION II	Patricia Holub	(212) 264-4997 (212) 264-3039 fax
REGION III	Ed Lewandowski Paul Cushing (Backup)	(215) 861-4445 (215) 861-4441 (215) 861-4431 fax
REGION IV	Mildred Wise Roosevelt Freeman	(404) 562-7866 (404) 562-7886 (404) 562-7881 fax
REGION V	Michael Kruley Al Sanchez	(312) 886-5893 (312) 353-5531 (312) 886-2301 fax
REGION VI	George Bennett Ralph Rouse (Backup)	(214) 767-4546 (214) 767-4056 (214) 767-0432 fax
REGION VII	Jean Simonitsch John Halverson Peter Kemp (Backup)	(816) 426-6513 (816) 426-7236 (816) 426-7236 (816) 426-3686 fax
REGION VIII	Andrea Oliver Jean Lovato Velveta Golightly-Howell	(303) 844-4774 (303) 844-7835 (303) 844-5101 (303) 844-6665 fax
REGION IX	Mario Sagatelian Monica Eskridge	(415) 437-8326 (415) 437-8324 (415) 437-8329 fax
REGION X	Bennett Prows Carmen Rockwell	(206) 615-2621 (206) 615-2288 (206) 615-2297 fax

Olmstead Update No: 3
Subject: HCFA Update
Date: July 25, 2000

Dear State Medicaid Director:

On January 14, 2000, we transmitted the first in a series of letters describing the Supreme Court's decision in the case of Olmstead v. L.C. We observed the fact that Medicaid may be of great assistance to States in fulfilling their civil rights responsibilities under the Americans with Disabilities Act (ADA). We also promised to review federal Medicaid policies and regulations to identify areas in which policy clarification or modification would facilitate your efforts to enable persons with disabilities to be served in the most integrated settings appropriate to their needs.

This letter summarizes some of the recent Health Care Financing Administration (HCFA) efforts to review Federal policies in order to facilitate fulfillment of the ADA. These efforts have been directed towards supporting States' initiatives in the following critical areas:

- Assisting people with disabilities to make a successful transition from nursing homes and other institutions into the community;

- Expanding the availability and quality of home and community-based services; and

- Ensuring that services are comparably available to all.

The attached enclosures consist of policy changes and clarifications that HCFA is making that will give States more flexibility to serve people with disabilities in different settings. These serve as guidance on how States may use the flexibility that Medicaid offers to expand services in a variety of ways.

We appreciate the ideas that you and members of the disability community have contributed so far. Most of the clarifications and policy reforms described in this letter emanate from your communications. We continue to invite new ideas because further policy work is required.

We have established an ADA/Olmstead website that contains questions and answers in response to inquiries received since the January 14th letter. The address is **http://www.hcfa.gov/medicaid/olmstead/olmshome.htm**. The website also contains related letters to State Medicaid Directors and Governors and links to other relevant websites. We encourage you to continue forwarding your policy-related questions and recommendations to the Olmstead workgroup through e-mail at ADA/Olmstead@hcfa.gov or in written correspondence to:

DHHS Working Group for ADA/Olmstead
c/o Center for Medicaid and State Operations
HCFA, Room S2-14-26, DEHPG
7500 Security Boulevard
Baltimore, MD 21244-1850

We look forward to a continuation of our work together to improve the nation's community-based services system.

Sincerely,

Timothy M. Westmoreland, Director

Enclosures

HCFA POLICY CHANGES AND CLARIFICATIONS

ATTACHED TO THIS LETTER

Policy	Clarification/Interpretation/Policy Change:
Purpose: Assisting people with disabilities to make a successful transition from nursing homes and other institutions into the community.	
Attachment 3-a: Earliest Eligibility Date in HCBS Waivers.	Discusses a policy change regarding the earliest date of service for which Federal financial participation (FFP) can be claimed.
Attachment 3-b: Community Transition	Explains some of the ways that Medicaid funding may be used to help elderly people and individuals with a disability transition from an institution to a community residence.
Attachment 3-c: Personal Assistance Retainer.	Discusses a HCFA policy change indicating that a State may make payment for personal assistance services under a Medicaid HCBS waiver while a waiver participant is temporarily hospitalized or away from home.
Purpose: Expanding the availability and quality of home and community-based service.	
Attachment 3-d: Habilitation.	Clarifies that habilitation services, including prevocational, educational, and supported employment services, are available under an HCBS waiver to people of all ages, in all target groups, if so specified by the State.
Attachment 3-e: Out-of-State Services.	Clarifies the circumstances under which Medicaid HCBS waiver services may be provided out-of-state.
Purpose: Ensuring that services are comparably available to all.	
Attachment 3-f: Services Provided Under a Nurse's Authorization.	Clarifies that States may receive FFP for services provided at the authorization of a nurse, if the providers meet qualifications specified under the State Plan or Medicaid waiver for these services.
Attachment 3-g: Prohibition of Homebound Requirements in Home Health.	Notifies that the use of a "homebound" requirement under the **Medicaid** home health benefit violates Federal regulatory requirements at 42 CFR 440.230(c) and 440.240(b).

Attachment 3-a
Subject: Earliest Eligibility Date
In HCBS Waivers
Policy Change
Date: July 25, 2000

Timely home and community-based services (HCBS) waiver eligibility determinations are particularly important to ensure that individuals awaiting imminent discharge from a hospital, nursing home, or other institution are able to return to their homes and communities.

Consequently, we have been asked to clarify the earliest date of service for which Federal financial participation (FFP) can be claimed for HCBS and other State plan services when a person's Medicaid eligibility is predicated upon receipt of Medicaid HCBS under a waiver.

Under current Health Care Financing Administration policy, States must meet several criteria (described below) before they can receive FFP for HCBS waiver services furnished to a beneficiary who has returned to the home or community setting. For example, section 1915(c)(1) of the Social Security Act (the Act) requires that HCBS waiver services be furnished pursuant to a written plan of care.

Policy Change: To facilitate expeditious initiation of waiver services, we will accept as meeting the requirements of the law a provisional written plan of care which identifies the essential Medicaid services that will be provided in the person's first 60 days of waiver eligibility, while a fuller plan of care is being developed and implemented. A comprehensive plan of care must be in place in order for waiver services to continue beyond the first 60 days.

The following chart summarizes the above and other requirements.

Earliest Date of HCBS Waiver Eligibility =
The Last Date All of the Following Requirements Have Been Met

1. Basic Medicaid Eligibility: The person is determined to be Medicaid-eligible if in a medical institution.	The eligibility group into which the person falls must be included in the State plan.
2. Level of Care: The person is determined to require the level of care provided in a hospital, nursing facility, or ICF/MR.	Level of care determinations must be made as specified in the approved waiver.
3. Special Waiver Requirements: The person is determined to be included in the target group and has been found to meet other requirements of eligibility specified in the State's approved waiver. These requirements include documentation from the individual that he or she chooses to receive waiver services.	The person must actually be admitted to the waiver.
4. Plan of Care: A written plan of care is established in conformance with the policies and procedures established in the approved waiver.	**Policy Change:** For eligibility determinations we will initially accept a provisional written plan of care which identifies the essential Medicaid services that will be provided in the person's first 60 days of waiver eligibility, while a fuller plan of care is being accomplished. A comprehensive care plan, designed to ensure the health and welfare of the individual, must be developed within this time.
5. Waiver Service: The plan of care must include at least one waiver service to be furnished to the individual, and the State must take appropriate steps to put the plan of care into effect.	

When the eligibility determination has been made finding the individual eligible for the Medicaid HCBS waiver, the State may make a claim for FFP for services furnished beginning on the date on which all of these criteria are met. In subsequent attachments, we provide for special procedures to accommodate reimbursement for certain transition expenses that enable an individual residing in an institution to transition to community residence.

Any questions concerning this attachment may be referred to Mary Jean Duckett at (410) 786-3294 or Mary Clarkson at (410) 786-5918.

Attachment 3-b
Subject: Community Transition
Policy Change
Date: July 25, 2000

Medicaid home and community-based services (HCBS) waivers are statutory alternatives to institutional care. Many States have found HCBS waivers to be a cost-effective means to provide comprehensive community services in the most integrated setting appropriate to the needs of the individuals enrolled.

Nursing facilities and intermediate care facilities for the mentally retarded (ICFs/MR) likewise play important roles in our long term care system. They are particularly important for short-term rehabilitation, sub-acute care, and crisis management that enable timely hospital discharge. However, short-term stays often become long term residence when complicated planning is required for a return home, special housing or housing modification needs to be arranged, or exceptional one-time expenses must be paid.

This attachment explains several means by which Medicaid may assist States to overcome these barriers to community transition. It addresses the following:

A. Case Management

1. Targeted Case Management Under the State Plan
2. HCBS Case Management
3. Administrative Case Management

B. Assessments for Accessibility

C. Environmental Modifications

D. Modifications Interrupted due to Death

A. Case management. Case management services are defined under section 1915(g)(2) of the Social Security Act (the Act) as "services which will assist individuals, eligible under the plan, in gaining access to needed medical, social, educational, and other services." Case management services are often used to foster the transitioning of a person from institutional care to a more integrated setting or to help maintain a person in the community. There are several ways that case management services may be furnished under the Medicaid program:

1) Targeted case management (TCM), defined in section 1915(g) of the Act, may be furnished as a service to institutionalized persons who are about to leave the institution, to facilitate the process of transition to community services and to enable the person to gain access to needed medical, social, educational and other services in the community. We are revising our guidelines to indicate that TCM may be furnished during the last 180 consecutive days of a Medicaid eligible person's institutional stay, if provided for the purpose of community transition. States may specify a shorter time period or other conditions under which targeted case management may be provided. Of course, FFP is not available for any Medicaid service, including targeted case management services, provided to persons who are receiving services in an institution for mental disease (IMD), except for services provided to elderly individuals and children under the age of 21 who are receiving inpatient psychiatric services.

2) HCBS Case Management may be furnished as a ***service*** under the authority of section 1915(c) when this service is included in an approved HCBS waiver. Persons served under the waiver may receive case management services while they are still institutionalized, for up to 180 consecutive

days prior to discharge. However, Federal financial participation (FFP) is available on the date when the person leaves the institution and is enrolled in the waiver. In such cases, the case management service begun while the person was institutionalized is not considered complete until the person leaves the institution and is enrolled in the waiver. In these cases, the cumulative total amount paid is claimed as a special single unit of transitional case management. To claim FFP for case management services under the waiver, the State may consider the unit of service complete on the date the person leaves the facility and is enrolled in the waiver, and claim FFP for this unit of case management services furnished on that date. The cost of case management furnished as a HCBS waiver service must be estimated in factor D of the waiver's cost-neutrality formula.

3) Administrative Case Management may be furnished as an ***administrative*** activity, necessary for the proper and efficient administration of the State Medicaid plan. When case management is furnished in this fashion, FFP is available at the administrative rate, but may only be claimed for the establishment and coordination of Medicaid services that are not services funded by other payors for which the individual may qualify. Case management furnished as an administrative expense may be eligible for FFP even if the person is not eventually served in the community (e.g., due to death, the individual's choice not to receive waiver services, loss of Medicaid eligibility, etc.). This is because the service is performed in support of the proper and efficient administration of the State plan.

When a State elects to provide case management as both an administrative and a service expense (either under the targeted case management State plan authority, or as a service under a HCBS waiver), the State must have a policy on file with HCFA that clearly delineates the circumstances under which case management is billed as either an administrative or a service expense. This information must be included in the supporting documentation that the State forwards with its State plan or waiver request.

B. Assessments for Accessibility. Environmental modifications are often crucial to a State's ability to serve an individual in the most integrated setting appropriate to his/her needs. The State may assess the accessibility and need for modification in a person's home or vehicle at any time. FFP may be available in the costs of this assessment under several categories:

1) Administrative Expense: FFP may be claimed at the administrative rate for assessments to determine whether the person's home or vehicle may require modifications to ensure the health and welfare of the HCBS waiver participant. When the assessment is performed to determine whether the individual's needs can be met under an HCBS waiver, the administrative costs of the assessment may qualify for FFP regardless of whether or not the person is eventually served under the waiver;

2) Included in Environmental Modifications: The cost of environmental assessment may be included in the cost of environmental modification under an HCBS waiver; or

3) Included in a Relevant Service: The assessment may be performed by another service provider, such as a home health agency or an occupational therapist. FFP would be available at the service match rate when these providers perform assessments in addition to their other duties.

When a State elects to provide assessments for accessibility as a service expense under a HCBS waiver, the State must have a policy on file with HCFA that clearly delineates the circumstances under which these assessments are billed as either an administrative or a service expense. This information must be included in the supporting documentation that the State forwards in support of its HCBS waiver request.

The cost of reassessment may also be found eligible for FFP. Reassessment may be performed to deter-

mine whether new or additional modifications are needed, or whether existing (or newly installed) arrangements continue to be sufficient to meet the individual's needs.

C. Environmental Modifications: It may be necessary to make environmental modifications to an individual's home before an individual transitions from an institution to the community. For example, a wheelchair ramp may need to be built and doors may need to be widened to permit the individual to access his/her home. In such cases, the home modification begun while the person was institutionalized is not considered complete until the date the individual leaves the institution and is enrolled in the waiver. A State may claim FFP for home modifications (including actual construction costs) furnished as a waiver service for up to 180 days prior to discharge when (a) these modifications have been initiated before the individual leaves the institution and enrolls in HCBS waiver, (b) home modifications are included in the approved HCBS waiver. The claim for FFP must indicate the date the individual leaves the institution and enrolls in the waiver as the date of service for allowable expenses incurred during the previous 180 days.

D. Policy Change: Modifications Interrupted by Recipient's Death: The HCBS waivers serve a vulnerable population. Individuals who have chosen to relocate from an institutional to a community residence sometimes die before the relocation can occur. We believe that it would have a chilling effect if States were denied FFP for environmental assessments or modifications for individuals who died before their transition to home or community-based services. Therefore, we will allow the State to claim FFP at the administrative rate for services which would have been necessary for relocation to have taken place when the person has:

1) applied for waiver services,
2) been found eligible for the waiver by the State (but for the person's status as an inpatient in an institution), but
3) died before the actual delivery of the waiver services.

Any questions concerning this attachment may be referred to Mary Jean Duckett at (410) 786-3294 or Mary Clarkson at (410) 786-5918.

Attachment 3-c
Subject: Personal Assistance Retainer
Policy Change
Date: July 25, 2000

Medicaid regulations at 42 CFR 447.40 permit States to make payment to "hold" an institutional bed open for a resident while that individual is hospitalized or away from the facility for a short period. States which make this payment must indicate their intentions (and applicable time limits) in their State plans. We are writing this guideline to inform you that you may choose to implement a similar policy to allow payment for personal assistance services (such as personal care or attendant services) under HCBS waivers. This would enable beneficiaries to have parity between nursing home care and HCBS care in terms of assuring continuity of care and services.

Individuals with disabilities utilize personal assistance services provided under a HCBS waiver to support various activities of daily living. These services are furnished by individuals employed by community-based agencies, or by persons who are self-employed or employed directly by the waiver participant. Typically low payment rates make it unlikely that a provider could afford to give up a day's or week's salary because the waiver consumer is hospitalized or otherwise absent. Rather than wait for the waiver consumer to return, providers are more likely to find permanent employment elsewhere. Those who are employed by agencies are often reassigned to other agency clients - and may not return. Lack of providers can be catastrophic for an individual with disabilities.

Personal assistance retainer payments, as described in this attachment, are limited to services furnished under HCBS waivers. To enable waiver participants to continue to receive services in the most integrated setting appropriate to their needs, we will permit continued payment to personal caregivers under the waiver while a person is hospitalized or absent from his or her home. If a State chooses to make such payments, it must clearly indicate this in its HCBS waiver request.

States that choose to make payments to be made for personal assistance retainers must also specify the limits that will be applied to this service. The personal assistance retainer time limit may not exceed the lesser of 30 consecutive days or the number of days for which the State authorizes a payment for "bed-hold" in nursing facilities.

Any questions concerning this attachment may be referred to Mary Jean Duckett at (410) 786-3294 or Mary Clarkson at (410) 786-5918.

Attachment 3-d
Subject: Habilitation in HCBS Waivers
Clarification
Date: July 25, 2000

Section 1915(c)(4)(B) of the Social Security Act (the Act) permits States to offer habilitation services under a Medicaid home and community-based services (HCBS) waiver. Habilitation services are defined in 1915(c)(5) of the Act as "services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings." The definition includes expanded services such as prevocational, educational, and supported employment services, if not otherwise excluded by law or the terms of a State's approved waiver.

Clarification: States have historically provided habilitation services under an HCBS waiver to individuals with mental retardation or related conditions which occurred before age 22. However, neither the law nor implementing regulations restrict who may receive habilitation services in an HCBS waiver. Other individuals who do not have mental retardation or related conditions, such as persons with traumatic brain injury or other physical disabilities that occurred after age 22, may also benefit from habilitation services under the waiver. Accordingly, States may provide habilitation services - including the expanded habilitation services of educational, prevocational and supported employment services - under an HCBS waiver to people of all ages who qualify for the waiver.

To receive services under a HCBS waiver, an individual must meet all targeting criteria set forth in the approved waiver. These criteria must include the institutional level or levels of care to which the waiver services provide an alternative. We believe that this clarification will expand a State's choices of services which can be provided to persons with disabilities in home and community-based waiver programs. It may also assist States in fulfilling their responsibilities under the Americans with Disabilities Act.

States continue to have the flexibility to target waivers to specific populations and age groups within statutory allowances and to determine what services are provided under the waiver. Any questions concerning this attachment or the home and community-based waiver program may be referred to Mary Jean Duckett at (410) 786-3294 or Mary Clarkson at (410) 786-5918.

Attachment 3-e
Subject: Out-of-State Services
Clarification
Date: July 25, 2000

Out-of-State services have been provided by several States for many years, with excellent results in quality of service and quality of life for the waiver participants. Regulations at 42 CFR 431.52 prescribe the conditions under which a State is required to provide out-of-State services. Section 1902(a)(23) of the Social Security Act (the Act) provides that an individual may receive Medicaid services (including home and community-based services (HCBS) waiver services) from any qualified provider willing to furnish the services.

Historically, out-of-State services have been used to support some individuals attending college, and enabled others to visit family members. In addition, there are some areas near State borders where the closest (or most convenient) provider is located in an adjacent State. When convenience or necessity make it advisable for services to be provided outside the State, there is no restriction to in-State services.

When residential out-of-State services are recommended by a State because services within the State are unavailable or insufficient to meet the person's needs, careful consideration must be given to the reason for providing the services, as well as alternatives which may contribute more to an individual's ability to receive quality supports in a community based setting. Services provided in a location remote from the individual's family and friends may not provide appropriate support for the person to live in the most integrated setting appropriate to his or her needs.

When services are provided out-of-State, the standard waiver requirements must continue to be met. Examples include the following:

> ***Written Plan of Care:*** The services must be in the person's written plan of care (section 1915(c)(1) of the Act). The plan of care must identify the services to be provided, the amount and type of each service, and the type of provider. The requirement that the type of provider be included in the care plan does not mean that the name of the actual provider must be listed in the plan of care. The plan of care is subject to the approval of the Medicaid agency. The actual provider is subject to the approval of the individual receiving services.
>
> ***Waiver-Qualified Provider:*** Services must be furnished by a qualified provider (section 1902(a)(23) of the Act). The provider must meet the standards for service provision that are set forth by the State in the waiver and approved by HCFA. Any standards of licensure or certification which are applicable to the provision of the service must also be met (42 CFR 441.302(a)(2)). This means that any standards applicable to the provision of the service in the State in which the service is furnished must be met, as well as those standards set forth in the approved waiver. If one State were to pay for a service furnished in another, the provider must be qualified under the standards in the waiver, and the service must also meet any applicable requirements in the State in which it is provided.
>
> ***Quality Assurance:*** The State operating the waiver remains responsible for the assurance of the health and welfare of the beneficiary (section 1915(c)(2)(A) of the Act). Oversight may be performed directly by the home State or by the host State in which services are actually received. If it is done by the host State, there must be an interstate compact or agreement setting forth the responsibilities of each party. Under an interstate compact, the State in which services are provided can agree to take over monitoring responsibilities. Some States have compacts which recognize each other's provider agreements. Others recognize each other's provider standards. States have the opportunity to be quite creative in their utilization of these compacts to foster efficient and responsive HCBS programs. We recognize this as an opportunity to expand Medicaid

services to meet the needs of individuals in the most integrated settings appropriate.

Choice of Provider: The provider must be chosen by the individual (section 1902(a)(23) of the Act). The provider of out-of-State services must be chosen just as freely as the provider of in-State services. We realize that in some cases, out-of-State services are much closer and more easily obtained than in-State services. This is particularly true when a neighboring State has a large city on or near a State border.

Provider Agreements: The provider must have a provider agreement with the Medicaid agency (section 1902(a)(27) of the Act); and Medicaid payment must be made directly to the provider (section 1902(a)(32) of the Act).

Any or all of the above requirements may be met directly by the State which operates the waiver, or indirectly through an interstate compact in which the second State attends to provider agreement and payment activities.

Any questions concerning this attachment may be referred to Mary Jean Duckett at (410) 786-3294 or Mary Clarkson at (410) 786-5918.

Attachment 3-f
Subject: Services Provided Under a Nurse's Authorization **Clarification**
Date: July 25, 2000

This attachment provides policy guidance regarding Medicaid coverage of services provided pursuant to a nurse's authorization by other providers and the availability of Federal Financial Participation (FFP) for those services. States have referred to these services as "nurse-delegated services" or "services provided under a nurse's delegation of authority." This guidance clarifies that States may enable individuals to receive services in the most integrated setting by permitting providers, such as personal care and attendant care providers, to furnish these services.

State Medicaid programs may cover any services authorized by a nurse that fit within a category of services covered under the Medicaid State plan, a home and community-based services (HCBS) waiver, a managed care waiver, or an approved demonstration project. FFP for the services must be claimed under the category appropriate for the service that was furnished. Under this interpretation, health-related services provided at the authorization of a nurse, which would otherwise be classified as nursing services, are billed in the category of the actual provider. For example, the health-related component of personal care services authorized by a nurse, which are provided by a personal care provider, would be billed and reimbursed as personal care services (Medicaid State plan, HCBS waiver, or other waiver).

As with all Medicaid services, the service for which FFP is claimed must meet the definition provided in the approved Medicaid State plan or HCBS waiver, and the actual provider must meet applicable provider qualifications and requirements. For example, if a State includes personal care services under its Medicaid State plan, FFP would be available for activities authorized by a nurse but furnished by a personal care provider who meets the provider qualifications and standards established by the State. States may wish to impose a requirement for authorization for any covered service when such a requirement would further the objective of ensuring appropriate high quality services. Of course, services provided under the authorization of a nurse must also be consistent with State law and regulations.

States may choose to design their payment methodologies to take into consideration the complexity of authorized tasks, and may impose reasonable provider qualifications applicable to particular tasks. For example, States may choose to have two levels of provider qualifications and payment methodologies for personal care providers under its State plan: a basic level applicable to all personal care providers, and a higher level with additional qualifications for personal care providers who provide more complex tasks, such as those authorized by nurses. Qualifications may include additional training and/or demonstrated competency related to tasks authorized by a nurse that would not be required for providers who do not furnish such tasks. As States also establish the qualifications and payment methodologies for waiver providers, these requirements and rates for waiver personal care services or attendant care services may also reflect the same multi-level approach.

Any questions concerning this attachment or Medicaid coverage of services authorized by a nurse may be directed to Mary Jean Duckett at (410) 786-3294 or Mary Clarkson at (410) 786-5918.

Attachment 3-g
Subject: Prohibition of Homebound Requirement in Medicaid Home Health
Clarification

Date: July 25, 2000

The Medicaid home health benefit is an important tool for serving persons with disabilities in integrated settings. Medicaid regulations at 42 CFR 440.70(a)(1) require that home health services be provided to an individual at his or her place of residence. An individual's place of residence for purposes of home health services does not include a hospital, nursing facility, or intermediate care facility for the mentally retarded. Home health services must include part-time or intermittent nursing services, home health aide services, and medical supplies, equipment, and appliances suitable for use in the home. Physical or occupational therapy and speech pathology and audiology services are optional.

While current regulations specify that these services must be provided to an individual at his place of residence, it is not necessary that the person be confined to the home for the services to be covered under the Medicaid home health benefit. The "homebound" requirement is a Medicare requirement that does not apply to the Medicaid program. Imposing a homebound requirement on receipt of Medicaid home health benefits as explained below violates Medicaid regulations related to "amount, duration, and scope of services" at 42 CFR 440.230 and "comparability of services" at 42 CFR 440.240. However, States may still limit the home health benefit in the manner allowed by statute and regulation.

Section 42 CFR 440.230(c) indicates that "the Medicaid agency may not arbitrarily deny or reduce the amount, duration, or scope of a required service under sections 440.210 and 440.220 to an otherwise eligible recipient solely because of the diagnosis, type of illness, or condition." Sections 440.210 and 440.220 relate to required services for the categorically needy and to required services for the medically needy, including home health services. If a State limits home health services to persons who are homebound, while not providing medically necessary home health services to persons who are not homebound, it is arbitrarily denying the home health service based on the individual's condition (i.e., whether or not the individual is homebound) in violation of regulations at 440.230(c).

Section 42 CFR 440.240(b) indicates that "the plan must provide that the services available to any individual in the following groups are equal in amount, duration, and scope for all recipients within the group: (1) The categorically needy. (2) A covered medically needy group." Thus, if a State limits the provision of Medicaid home health services to individuals who are homebound, the State violates Federal requirements at 440.240(b) by providing the services to some individuals within the eligibility group and not to others within the group. However, States may still limit the home health benefit in the manner allowed by statute and regulation.

The restriction of home health services to persons who are homebound to the exclusion of other persons in need of these services ignores the consensus among health care professionals that community access is not only possible but desirable for individuals with disabilities. New developments in technology and service delivery have now made it possible for individuals with even the most severe disabilities to participate in a wide variety of activities in the community with appropriate supports. Further, ensuring that Medicaid is available to provide medically necessary home health services to persons in need of those services who are not homebound is an important part of our efforts to offer persons with disabilities services in the most integrated setting appropriate to their needs, in accordance with the Americans with Disabilities Act.

For purposes of receipt of Medicaid home health services, a person's place of residence continues to be defined by the requirements of 42 CFR 440.70(c).

Any questions concerning this attachment or the home health benefit may be referred to Mary Jean Duckett at (410) 786-3294 or Mary Clarkson at (410) 786-5918.

Health Care Financing Administration
Center for Medicaid and State Operations

August 29, 2000

Dear State Medicaid Director:

This is the second in a series of letters that provide guidance on the implementation of the "Ticket to Work and Work Incentives Improvement Act of 1999" (TWWIIA). This legislation improves access to employment training and placement services for people with disabilities who want to work. It also offers States unprecedented opportunities to eliminate barriers to employment for people with disabilities by improving access to health care. Our first letter, dated March 29, 2000, provided (a) general information about the legislation, (b) an overview of our plans for implementing the two new Medicaid eligibility groups created by the legislation, and (c) a description of our plans for issuing grants to assist States with the infrastructure and for demonstration projects.

This letter provides more detailed information about the two new Medicaid eligibility groups. Those groups are briefly described below, with particular emphasis (as discussed in the enclosure to this letter) on how eligibility is determined for those applying for coverage under these groups.

New Eligibility Groups Related to Employment (Section 201 of the legislation). TWWIIA created two new optional categorically needy Medicaid eligibility groups.

Under what we are calling the **"Basic Coverage Group"** (otherwise known as the subsection (XV) eligibility group), States can cover individuals who are age 16 or over, but under age 65, and who, except for earned income, would be eligible to receive Supplemental Security Income (SSI) benefits, regardless of whether they have ever received SSI cash benefits. This group is similar to the group created by section 4733 of the Balanced Budget Act (BBA), except that eligibility is not limited to people with family income below 250 percent of the Federal poverty level family income limit, AND under this new group States are free to establish their own income and resource standards (including the option to have no income or resource standards at all).

Under what we are calling the **"Medical Improvement Group,"** States can cover employed individuals with a medically improved disability who lose Medicaid eligibility under the Basic Coverage Group described above because their medical conditions have improved to the point where they are no longer disabled under the SSI definition of disability. If a State wants to cover this group, it must cover the Basic Coverage Group described above.

As with the original BBA group, States may impose premiums or other cost-sharing charges on a sliding scale based on income for individuals eligible under both of the new eligibility groups. For individuals with annual adjusted gross income (as defined by the IRS) that exceeds $75,000, States are required to charge 100 percent of the premiums they may impose. However, States can subsidize the premium cost for these individuals, using State funds.

Both of these new eligibility groups become effective on October 1, 2000.

I enclose a detailed explanation of how eligibility is determined under the two new groups. We have also developed draft State plan preprint pages which States can use, if they wish, when submitting Medicaid State plan amendments to implement either or both of these groups. The draft preprint pages are available from your HCFA regional office eligibility contact or State Representative, from the HCFA Central Office contact shown below, or they can be downloaded from HCFA's Work Incentives website at www.hcfa.gov/medicaid/twwiia/twwiiahp.htm.

If you have questions about the new eligibility groups created by the Ticket to Work and Work Incentives Improvement Act of 1999, please contact Roy Trudel of my staff at 410-786-3417 (e-mail: rtrudel@ hcfa.gov).

We look forward to working with you as you consider the options available to your State under this legislation, which has the remarkable potential to assist people with disabilities to work in competitive employment.

Sincerely,

Timothy M. Westmoreland, Director
Center for Medicaid and State Operations

Enclosure: Explanation of Eligibility Groups

ENCLOSURE

EXPLANATION OF ELIGIBILITY GROUPS

The "Ticket to Work and Work Incentives Improvement Act of 1999" (TWWIIA) created two new Medicaid eligibility groups to allow States to provide Medicaid to certain individuals with disabilities who want to work, or who are already working but want to increase their earnings. Both groups are optional categorically needy groups. Following is detailed information about these groups, including how eligibility is determined and your options for charging premiums and other cost-sharing expenses.

I. BASIC COVERAGE GROUP

A. Key Elements Under Section 1902(a)(10)(A)(ii)(XV) of the Act

To be eligible under this group, an individual must:

- Be at least 16 but less than 65 years old;
- Be disabled as defined under the SSI program (except for earnings);
- Have income and resources that do not exceed a standard established by the State.

You have sole discretion to establish income and/or resource standards for this group, including the choice not to have any income and/or resource standard at all if you wish.

The following rules and requirements apply to this group:

- If you choose to establish an income and/or resource standard, SSI methodologies apply in determining eligibility, including the SSI earned income disregard of $65 plus one-half of the remainder. Unlike the BBA Group, all earned income is not automatically disregarded in determining eligibility under this group. However, you can use section 1902(r)(2) of the Act (described below) to disregard additional earned income beyond the SSI earned income disregard, including a total disregard of earned income.
- Section 1902(r)(2) of the Act (optional use of more liberal income and resource methodologies than are used by the SSI program) applies to this group.
- The limitations on Federal Financial Participation (FFP) at section 1903(f) of the Act do not apply to this group. This means that States can use more liberal income methodologies under section 1902(r)(2) without the usual FFP restrictions.
- If a State exercises its option not to establish an income and resource standard for this group, the above requirements are not applicable.
- Section 1902(f) (209(b) States) applies to this group. 209(b) States may (but are not required to) apply their more restrictive eligibility criteria in determining eligibility for this group.
- There is no requirement that an individual must at one time have been an SSI recipient to be eligible under this group. However, if the individual is not currently an SSI or SSDI recipient, you must do a disability determination to ensure that the individual would meet the definition of disability under the SSI program. NOTE: The disability test must be identical to the SSI/SSDI disability test except that employment activity, earnings, and substantial gainful activity (SGA) must not considered in determining whether the individual meets the definition of disability.

- Because this is an optional categorically needy eligibility group, the benefits and services available to individuals eligible under the group are the same as are available to the categorically needy under your State plan.

You may provide services under a home and community-based services (HCBS) waiver to individuals eligible under this group. To do so, you must amend an existing waiver (or apply to HCFA for a new waiver) to cover the group. Individuals receiving services under an HCBS waiver must meet the level of care requirement (i.e., would require the level of care provided in a medical institution if not for receipt of waiver services). NOTE: Individuals eligible for Medicaid under the Basic Coverage Group are eligible under community, not institutional rules. Therefore, institutional rules under HCBS waivers (including spousal impoverishment, institutional deeming of income and resources, and post-eligibility treatment of income) do NOT apply to this group.

B. Limitations on Defining Employment Under the BBA and Basic Coverage (Subsection (XV)) Groups

We are aware that many States, concerned about the potential costs of covering one or more of the eligibility groups created by TWWIIA and the BBA, would like to define "employment" or "work" in a manner similar to the definition of employment discussed later for the Medical Improvement Group. We appreciate States' concerns, but must make it clear that under the statute, defining employment for the Medical Improvement Group applies only to the Medical Improvement Group. There is no authority under the statute to apply that definition (or any similar definition) to the Basic Coverage Group (subsection (XV)) described previously, nor can it be applied to the existing eligibility group created by section 4733 of the BBA (section 1902(a)(10)(A)(ii)(XIII) of the Act).

For both the BBA group and the Basic Coverage Group, you:

- Must require that an individual have earned income; i.e., that the individual be working;

- May require that the individual provide evidence of employment or work; for example, pay stubs, evidence of FICA taxes paid, or other evidence of employment that the State finds appropriate and necessary.

- May use your options under the premium and cost-sharing process (described in more detail below) to encourage substantive work efforts while discouraging participation by individuals with high levels of unearned income (e.g., SSDI or other benefits) who do not intend to engage in a substantive work effort. For example, you can establish a two-tiered cost-sharing structure that charges a low amount on earned income, but a high amount on unearned income above a personal maintenance level.

However, under the law a State cannot establish a definition of work or employment for the Basic Coverage Group (or the BBA Group) that sets a minimum standard for number of hours worked during a period of time, or a minimum level of earnings. Any such definition is inherently more restrictive than permitted under the applicable provisions of the Medicaid statute, and as such would be out of compliance with the statute.

NOTE: See section III. below for information concerning State options for requiring payment of premium or other cost-sharing charges. See section IV. below for information on maintenance of effort requirements.

II. MEDICAL IMPROVEMENT GROUP SECTION 1902(a)(10)(A)(ii)(XVI) OF THE ACT

NOTE: TO COVER THIS GROUP, YOU MUST ALSO COVER THE BASIC COVERAGE GROUP DISCUSSED ABOVE.

A. Key Elements

To be eligible under this group, an individual must:

- Be at least 16 but less than 65 years of age;
- Be employed and have a medically improved disability (see below for further explanation);
- Have been eligible under the Basic Coverage Group discussed above, but lost that eligibility because the individual, by reason of medical improvement, is determined at the time of a regularly scheduled continuing disability review to no longer meet the definition of disability under the SSI or SSDI programs;
- Have income and resources that do not exceed a standard established by the State.

You have sole discretion to establish income and/or resource standards for this group, including the choice to not have any income and/or resource standard at all if you wish. The following rules and requirements apply to this group:

- If you choose to establish an income and/or resource standard, SSI methodologies apply in determining eligibility, including the SSI earned income disregard of $65 plus one-half of the remainder. Unlike the BBA Group, all earned income is not automatically disregarded in determining eligibility under this group. However, you can use section 1902(r)(2) of the Act (described below) to disregard additional earned income beyond the SSI earned income disregard, including a total disregard of earned income.
- Section 1902(r)(2) of the Act (optional use of more liberal income and resource methodologies than are used by the SSI program) applies to this group.
- The limitations on Federal Financial Participation (FFP) at section 1903(f) of the Act do not apply to this group. This means that States can use more liberal income methodologies under section 1902(r)(2) without the usual FFP restrictions.
- If a State exercises its option not to establish an income and resource standard for this group, the above requirements are not applicable.
- Section 1902(f) (209(b) States) applies to this group. 209(b) States may (but are not required to) apply their more restrictive eligibility criteria in determining eligibility for this group.
- There is no requirement that an individual must at one time have been an SSI recipient to be eligible under this group. A disability test, different from the SSI/SSDI disability test, will apply and is discussed below in Part II.C. below.
- Because this is an optional categorically needy eligibility group, the benefits and services available to individuals eligible under the group are the same as are available to the categorically needy under your State plan.
- You may provide services under a home and community-based services (HCBS) waiver to individuals eligible under this group. To do so, you must amend an existing waiver (or apply to HCFA for a new waiver) to cover the group. Individuals receiving services under an HCBS waiver must meet the level of care requirement (i.e., would require the level of care provided in a medical institution if not for receipt of waiver services). NOTE: Individuals eligible for Medicaid under the Medical Improvement Group are eligible under community, not institutional rules.

Therefore, institutional rules under HCBS waivers (including spousal impoverishment, institutional deeming of income and resources, and post-eligibility treatment of income) do NOT apply to this group.

Employed Individual with a Medically Improved Disability

To be eligible under the Medical Improvement Group, an individual must be employed, and have a medically improved disability. In the interest of clarity, the following addresses the definitions of "employed individual" and "medically improved disability" as separate topics.

B. Employed Individual

For purposes of determining eligibility under the Medical Improvement Group, an employed individual is one who:

- Is at least age 16 but less than 65 years of age; and

- Is earning at least the Federally required minimum wage AND is working at least 40 hours per month; OR is engaged in a work effort that meets an alternate definition of substantial and reasonable threshold criteria for hours of work, wages, or other measures as defined by the State and approved by the Secretary.

State-Defined Work Effort

As noted above, a State may establish its own definition of employment that differs from the minimum level of earnings and hours worked per month set forth in the statute. A State's alternative definition of work effort must be approved by HCFA. If a State wishes to establish an alternative definition of work effort, it should do so as part of an amendment to its Medicaid plan to cover the Medical Improvement Group.

At this time HCFA does not plan to approve alternative definitions of work effort that involve an across-the-board change in the statutory number of hours worked per month or level of earnings described above. We believe that Congress intended those levels to serve as the reasonable baseline for work effort for the Medical Improvement Group as a whole, and thus should serve as the standard most individuals eligible under the group should be expected to meet.

However, we recognize that there is considerable diversity among people with disabilities, including relative degrees of disability, the employment opportunities available to them, and many other considerations that can affect types and amounts of work people with disabilities do, and consequently how work effort can be measured. Therefore, we will consider alternative definitions of work effort involving different levels of earnings and/or hours worked for identifiable groups of individuals with disabilities provided the State can clearly define the group involved and explain why the proposed alternative definition is in fact reasonable and necessary for members of that group.

We will also consider alternative definitions of work effort using threshold criteria (and ways of determining if those criteria are met) that do not necessarily rely on measuring earnings levels and/or hours worked. It is quite possible that people with disabilities have access to employment and work opportunities where the number of hours worked or level of earnings is not the best or most valid measurement of the quality of the work effort. An example might be people who are self-employed. We believe States are in the best position to identify such situations and address them through alternative definitions and measurements of work effort. Therefore, we will definitely consider such alternative definitions, where appropriate, as part of an amendment to your Medicaid plan to cover the Medical Improvement Group.

C. Defining "Medically Improved Disability"

For purposes of determining eligibility under the Medical Improvement Group, an individual with a medically improved disability is one who:

- Was eligible for Medicaid under the Basic Coverage (subsection (XV)) Group discussed above;
- Continues to have a medically determinable severe impairment, but
- Whose disability, impairment, or condition has, by reason of medical improvement, improved to the point where the individual has lost eligibility under the Basic Coverage (subsection (XV)) Group because it was determined, at the time of a regularly scheduled continuing disability review, that he or she no longer met the definition of disability under the SSI and SSDI programs.

It is important to emphasize that the loss of eligibility under the Basic Coverage Group must be the direct and specific result of loss of disability status because of medical improvement. Loss of disability status for a reason unrelated to medical improvement would not qualify as loss because of medical improvement.

Under the statute, the Secretary is required to define the term "medically determinable severe impairment." Information concerning how that term is defined, as well as information on other related disability issues in the context of the work incentives legislation, will be forthcoming in a separate letter to State Medicaid Directors.

NOTE: See section III below for information concerning State options for requiring payment of premiums or other cost-sharing charges. See section IV below for information on maintenance of effort requirements.

III. PREMIUMS AND COST-SHARING CHARGES

Under the existing eligibility group created by section 4733 of the BBA (section 1902(a)(10)(A)(ii)(XIII) of the Act), States may (but are not required to) require eligible individuals to pay premiums or other cost-sharing charges. If States require such payments, the amount must be set on a sliding scale based on income.

TWWIIA also permits States to require payment of premiums or other cost-sharing charges by individuals eligible under both the Basic Coverage Group and the Medical Improvement Group. While some aspects of the premium and cost-sharing requirements under TWWIIA are similar to those under the BBA, many are different.

A. Key Elements of TWWIIA Premiums and Cost-Sharing

The rules applicable to payment of premiums or other cost-sharing charges under TWWIIA are discussed below. The same basic rules apply to both the Basic Coverage (subsection (XV)) Group and the Medical Improvement Group, and your requirements for payment of premiums or other cost-sharing charges must apply equally to all individuals eligible under either of the two groups.

It should also be emphasized that while you have the option to require payment of premiums or other cost-sharing charges, you are not required to do so. A State can elect to impose no premium or cost-sharing charges at all on individuals eligible under either or both of these groups.

For individuals eligible under the Basic Coverage (subsection (XV)) Group and the Medical Improvement Group you may, in a uniform manner for all individuals eligible under those groups:

a. Require individuals to pay such premiums or other cost-sharing charges, set on a sliding scale based on income, as the State may determine;

b. For any individual whose annual family income is less than 450 percent of the Federal poverty level, you can require payment of premiums only to the extent that the amount of the premiums does not exceed 7.5 percent of the individual's income.

c. For any individual whose (IRS) adjusted gross income exceeds $75,000 annually, you must charge 100% of premiums.

B. Sliding Scale Based on Income

The requirement under (a.) above that payments be on a sliding scale based on income applies to both premiums and other cost-sharing charges. While the degree to which such premiums and charges increase with increasing levels of income is up to the State, the underlying principle is that individuals with higher levels of income should contribute more toward the cost of services they receive than those with less income. A percentage premium or cost-sharing charge (e.g., 5 percent of income) is, by definition, on a sliding scale based on income because the actual amount paid increases as income increases.

For purposes of this provision, premiums are defined as fees (usually monthly) that are charged to secure coverage under one of the work incentives Medicaid eligibility groups. Premiums would normally be paid by the individual directly to the State Medicaid agency. By contrast, cost- sharing charges are defined as any other charges that the State may establish through which an individual eligible under one of the work incentives groups shares in the cost of the care and services provided to him or her under the Medicaid program. Cost-sharing charges can either be paid by the individual directly to the State Medicaid agency, or paid by the individual to providers of services in the form of co-pays, deductibles, or co-insurance payments.

A flat cost-sharing or co-payment charge (e.g., $5.00 for each doctor's visit) does not, if applied alone, meet the requirement that charges be on a sliding scale based on income. However, you can use a flat cost-sharing charge system provided that premiums charged to eligible individuals rise with increasing income, either because the premium is a percentage of income or the specified dollar amount of the premium increases as the individual's income increases. A flat cost-sharing charge in conjunction with a sliding scale premium produces an aggregate premium/cost-sharing charge that would meet the requirement that such charges be on a sliding scale based on income.

This means, for example, that a State's normal cost-sharing requirements, when used in conjunction with a sliding scale premium structure, would meet the sliding scale based on the income requirement. So long as there is a sliding scale premium structure, there is no need for a State to incur the added administrative expense of establishing a cost-share system which is different from that used in the rest of its Medicaid program.

It is important to emphasize that while under (a.) above you may require payment of premiums and other cost-sharing charges, the limitation of 7.5 percent of annual income described in (b) above applies only to premiums. The restrictions and requirements outlined in items (b.) and (c.) do not apply to cost-sharing charges that are not premiums.

Regardless of whether or not you exercise your option to require payment of premiums and other cost-sharing charges for the individuals described above you are required, under the statute, to charge 100 percent of premiums for certain other individuals. Individuals subject to payment of 100 percent of premiums are those whose adjusted gross annual income (as determined under the IRS statute) exceeds $75,000. This amount will increase each year after 2000 by the percentage of the annual Social Security cost-of-living increase.

If you exercise the option described above to require individuals eligible under these groups to pay premiums, "100 percent of premiums" would be the highest amount of premiums that an individual would be required to pay under your premium structure. For individuals with income below $75,000, you can require payment of the same amount of premiums, or a lower amount, provided the total premium for individuals with income below 450 percent of the poverty level does not exceed 7.5 percent of the person's income.

You may, if you wish, subsidize payment of premiums for individuals whose income exceeds $75,000. However, any such subsidy must be made solely with State funds. No Federal matching funds are available for such subsidies.

C. Private Health Insurance and TWWIIA Premiums or Other Cost-Sharing Charges

In some instances an individual eligible under the Basic Coverage Group or the Medical Improvement Group may have access to private health insurance coverage; for example, through employment or membership in an organization. If the individual could be covered under such private health insurance at no cost to him or her you may require, under your premium and cost-sharing rules, that the individual take advantage of that insurance. Where private insurance in the form of a group health plan is available to the individual, although at some cost, section 1906 of the Act allows States to enroll individuals in such plans provided such enrollment is cost-effective AND the State pays the cost of enrollment in the plan, including premiums, deductibles and co-insurance

Unless the State pays the full cost of enrollment in the private health insurance plan (including all premiums, deductibles and co-insurance) you may not require individuals to take advantage of the availability of private health insurance. Section 1906 of the Act does not permit mandatory enrollment in private health insurance when that insurance involves a cost to the individual.

IV. MAINTENANCE OF EFFORT REQUIREMENT

Under the statute, States are not permitted to supplant State funds directed toward programs to enable working individuals with disabilities to work with Federal funds used to provide benefits under the Basic Coverage Group and the Medical Improvement Group. If a State covers either or both of the eligibility groups discussed above, Federal Financial Participation (FFP) will not be available for services provided to individuals eligible under those groups for any fiscal year unless the State establishes, to the satisfaction of the Secretary, that its expenditures for those programs are not less than its expenditures for such programs for the fiscal year ending before December 17, 1999.

We will provide additional information concerning this requirement, including procedures to follow to establish and submit to HCFA baseline expenditure levels and annual reports on State expenditures, as well as HCFA's review and determination process, in a separate letter to State Medicaid Directors.