

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

Center for Medicaid and State Operations
7500 Security Boulevard
Baltimore, MD 21244-1850

Olmstead Update No: 3

Subject: HCFA Update

Date: July 25, 2000

Dear State Medicaid Director:

This letter provides an update of the Health Care Financing Administration activities to support the Supreme Court's decision in Olmstead and the Americans with Disabilities Act to enable individuals with disabilities to live in the most integrated setting appropriate to their needs. It also summarizes policy clarifications or policy reform designed to facilitate States' efforts to support the ADA.

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

cc:

All HCFA Regional Administrators
All HCFA Associate Regional Administrators
Division of Medicaid and State Operations
American Public Human Services Association
Association of State & Territorial Health Officials
National Association of State Alcohol and Drug Abuse Directors, Inc.
National Association of State Directors of Developmental Disabilities Services
National Association for State Mental Health Program Directors
National Association of State Units on Aging
National Conference of State Legislatures
National Governors' Association

**HCFA POLICY CHANGES AND CLARIFICATIONS
ATTACHED TO THIS LETTER**

<i>Policy</i>	<i>Clarification/Interpretation/Policy Change:</i>
<p><i><u>Purpose:</u> Assisting people with disabilities to make a successful transition from nursing homes and other institutions into the community.</i></p> <p><u>Attachment 3-a: Earliest Eligibility Date in HCBS Waivers.</u></p> <p><u>Attachment 3-b: Community Transition</u></p> <p><u>Attachment 3-c: Personal Assistance Retainer.</u></p>	<p>Discusses a policy change regarding the earliest date of service for which Federal financial participation (FFP) can be claimed.</p> <p>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.</p> <p>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.</p>
<p><i><u>Purpose:</u> Expanding the availability and quality of home and community-based service.</i></p> <p><u>Attachment 3-d: Habilitation.</u></p> <p><u>Attachment 3-e: Out -of- State Services.</u></p>	<p>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.</p> <p>Clarifies the circumstances under which Medicaid HCBS waiver services may be provided out-of-state.</p>

<i>Policy</i>	<i>Clarification/Interpretation/Policy Change:</i>
<p><i>Purpose: Ensuring that services are comparably available to all.</i></p> <p><u>Attachment 3-f: Services Provided Under a Nurse’s Authorization.</u></p> <p><u>Attachment 3-g: Prohibition of Homebound Requirements in Home Health.</u></p>	<p>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.</p> <p>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).</p>

Attachment 3-a

Subject: Earliest Eligibility Date in
HCBS Waivers -- **Policy
Change**

Date: July 25, 2000

This attachment describes the earliest date on which a person can be eligible for a home and community-based (HCBS) waiver service.

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.

<p>Earliest Date of HCBS Waiver Eligibility = The Last Date All of the Following Requirements Have Been Met</p>	
<p>1. Basic Medicaid Eligibility: The person is determined to be Medicaid-eligible if in a medical institution.</p>	<p>The eligibility group into which the person falls must be included in the State plan.</p>
<p>2. Level of Care: The person is determined to require the level of care provided in a hospital, nursing facility, or ICF/MR.</p>	<p>Level of care determinations must be made as specified in the approved waiver.</p>
<p>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.</p>	<p>The person must actually be admitted to the waiver.</p>
<p>4. Plan of Care: A written plan of care is established in conformance with the policies and procedures established in the approved waiver.</p>	<p>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.</p>
<p>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.</p>	

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) 786-591.

Attachment 3-b

Subject: Community Transition --
Policy Change

Date: July 25, 2000

This attachment explains some of the ways that Medicaid funding may be used to help elderly people and individuals with a disability make the transition from an institution to a community residence. We focus particularly on case management services, and removal of environmental barriers.

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 determine 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

This attachment clarifies that a State may make payment for personal assistance services under a Medicaid home and community-based services (HCBS) waiver while a waiver participant is temporarily hospitalized or away from home.

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

This attachment clarifies that habilitation services, including prevocational, educational, and supported employment services, are available under a Medicaid HCBS waiver to people of all ages, in all target groups, if so specified by the State.

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

This attachment explains how various provisions of federal law may be met in providing HCBS waiver services to an individual who is out of State.

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 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.

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

This attachment clarifies 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), and is not permissible in Medicaid.

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.