4130. COMPARABILITY OF SERVICES

A. Background.--Under §1902(a)(10)(B) of the Social Security Act (the Act) and implementing regulations at 42 CFR 440.240, services available to any categorically needy recipient under a State plan must not be less in amount, duration, and scope than those services available to a medically needy recipient. Services available to any individual in the categorically needy group or a covered medically needy group must be equal in amount, duration, and scope for all recipients within the same group. Comparability requirements ensure that coverage of services for the categorically needy continue to be the primary objective of the Medicaid program and prevent the coverage of selected services for the medically needy from diverting resources from the categorically needy. Also, these requirements ensure that each Medicaid individual receives a fair and equitable share of services covered under the State Medicaid plan, and that no individual is prevented arbitrarily from receiving a service once determined to be a member of an eligible coverage group.

In the past, various legislative provisions have been enacted to permit or require that exceptions be made to these comparability requirements. The purpose was to permit flexibility in targeting needed medical services to those individuals who required them while, at the same time, ensuring that the intent of the Medicaid program was upheld.

B. Exceptions.--Effective April 7, 1986, §9501(b) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) (Public Law 99-272) provides an exception to the comparability requirements with respect to additional services made available to pregnant women. Under this exception, you may elect to provide additional services (expansion of coverage) to pregnant women eligible for receiving Medicaid without violating comparability requirements. The only stipulation is that these additional services must be available to all Medicaid pregnant women, however, you do not have to extend them to other individuals or groups.

Additional services for pregnant women would be directed toward the rendition of pregnancy-related services (prenatal, delivery and post-partum) and services for conditions which may complicate pregnancy. These additional services may be comprised of the following:

- greater coverage of existing plan services (required or optional); and
- coverage of optional services not otherwise covered under the plan.

Accordingly, you may establish less restrictive limitations on existing plan services which would allow for increased medical care being made available only to Medicaid pregnant women (e.g., you may wish to provide additional inpatient hospital care or physician care by allowing coverage for additional inpatient days or physician visits). You may also extend coverage for preventative and curative services not presently covered under your Medicaid plan only to your Medicaid pregnant women. These may be services which are currently optional under §§1905(a)(9) and (13) of the Act, including health education and outreach services, clinic services, nutrition counseling, vitamins and other over-the-counter medications, etc.

The following example is an illustration of the use of the comparability exception to expand coverage for pregnant women: If you wish to provide prescribed drugs (an optional service not otherwise available under your plan) and 10 additional days of inpatient hospital care (expansion of a plan limitation on a required service) to your medically needy pregnant women, you would be required to provide comparable benefits to your categorically needy pregnant women, but would not be required to provide these benefits to the entire medically needy and categorically needy populations.

4201. ORGAN TRANSPLANTS

A. Background.--Section l903(i) of the Social Security Act requires the denial of Federal Financial Participation (FFP) for organ transplants unless the State plan provides written standards concerning the coverage of such procedures. The statute does not list the transplant procedures for which standards must be written, but the organs about which questions are most commonly asked are: cornea, kidney, heart, liver, bone marrow, pancreas and combined heart-lung. You can choose to cover no organ transplant procedures, some types of transplants and not others, or all transplants. You should specify in the written standards which organs you cover and any special conditions or limitations which apply to them.

B. Standards for Coverage.--If you choose to cover organ transplant procedures, furnish written standards for the coverage of these procedures which provide that:

- o similarly situated individuals are treated alike;
- o any restriction, on the facilities or practitioners which may provide such procedures, is consistent with the accessibility of high quality care to individuals eligible for the procedures under the State plan; and
- o services are reasonable in amount, duration, and scope to achieve their purpose.

1. Similarly Situated Individuals.--Similarly situated does not mean that anyone with end-stage organ disease, regardless of the etiology, must be covered. Apply transplant criteria fairly and uniformly to all individuals eligible for Medicaid. There is no justification for approving payment for a particular transplant procedure for one eligible recipient and denying payment for that same procedure for another similarly situated eligible recipient needing the same transplant procedure. You may, however, place limitations on coverage. For example, you can choose to cover transplants for the categorically needy, and not cover them for the medically needy. You can also choose to limit coverage to certain clinical conditions or to reasonable patient selection criteria. However, include these conditions in your standards. Do not list general statements such as "coverage is limited to those conditions for which the safety and efficacy of the transplant have been established," or "coverage is limited to nonexperimental procedures," as coverage standards.

2. Facility and Practitioner Restrictions.--In view of the extraordinary expense and complexity of transplant procedures, you can decide to commit your resources only to those facilities and practitioners of demonstrated excellence with regard to a particular procedure, whether located in your State or not. If you choose to restrict the facilities or practitioners, assure that the designated providers render high quality care and that they are accessible, through transportation arrangements made or paid for by the State, to all eligible Medicaid recipients throughout the State.

3. Sufficiency of Services.--Under regulations at 42 CFR 440.230, you are prohibited from "arbitrary" denial or reduction of an eligible recipient's benefits, but you are permitted to place appropriate limits based on medical necessity. You may cover transplants up to a dollar or day limit, and may refuse to continue coverage beyond such limits, even if the patient is currently in a transplant program. However, any limits applicable to transplants, whether in terms of dollars or days, should be reasonably related to the dollars or days necessary to cover the particular type of transplant for most transplant patients in the Medicaid-eligible population. For example, if the average hospital stay for a type of transplant is 30 days, a limit of 14 days would not be considered reasonable, even though such a limit might be acceptable for nontransplant patients.By the same token, you may provide additional coverage for transplant patients above normal State plan limits, and this would not constitute an arbitrary denial or reduction in services for other (nontransplant) recipient groups.

4221. OUTPATIENT PSYCHIATRIC SERVICES.

A. General.--Medicaid provides coverage of various types of organized outpatient programs of psychiatric treatment. These programs are covered primarily as either outpatient hospital services (42 CFR 440.20(a)) or as clinic services (42 CFR 440.90). Problems have sometimes arisen regarding outpatient programs which inappropriately billed Medicaid for chance, momentary social encounters between a therapist and a patient as if they were valid therapeutic sessions. There have also been instances of billing for services without sufficient documentation to establish that the services were clearly related to the patient's psychiatric condition. With the ongoing effort to encourage furnishing psychiatric treatment in the least restrictive setting possible, there is an increasing need for coverage guidelines specifically directed at outpatient programs. The following guidelines can help to ensure appropriate utilization with regard to outpatient psychiatric programs.

B. Outpatient Program Entry.--An intake evaluation should be performed for each recipient being considered for entry into an outpatient psychiatric treatment program. This applies to any organized program or course of treatment that a recipient enters or attends to receive scheduled or planned outpatient psychiatric services. The evaluation is a written assessment that evaluates the recipient's mental condition and, based on the patient's diagnosis, determines whether treatment in the outpatient program would be appropriate.

The evaluation team should include, at a minimum, a physician and an individual experienced in diagnosis and treatment of mental illness (both criteria can be satisfied by the same individual, if appropriately qualified). For each recipient who enters the program, the assessment should include a certification by the evaluation team that the program is appropriate to meet the recipient's treatment needs. The assessment should be made a part of the patient records.

C. Treatment Planning.--For each recipient who enters the outpatient program, the evaluation team should develop an individual plan of care (PoC). This consists of a written, individualized plan to improve the patient's condition to the point where the patient's continued participation in the program (beyond occasional maintenance visits) is no longer necessary. The PoC is included in the patient records, and contains a written description of the treatment objectives for that patient. It also describes:

1. the treatment regimen--the specific medical and remedial services, therapies, and activities that will be used to meet the treatment objectives;

2. a projected schedule for service delivery--this includes the expected frequency and duration of each type of planned therapeutic session or encounter;

3. the type of personnel that will be furnishing the services; and

4. a projected schedule for completing reevaluations of the patient§s condition and updating the PoC.

D. Documentation.--The outpatient program should develop and maintain sufficient written documentation to support each medical or remedial therapy, service, activity, or session for which billing is made. This documentation, at a minimum, should consist of material which includes:

1. the specific services rendered;
2. the date and actual time the services were rendered;
3. who rendered the services;
4. the setting in which the services were rendered;
5. the amount of time it took to deliver the services;
6. the relationship of the services to the treatment regimen described in the PoC and
7. updates describing the patient's progress.

For services that are not specifically included in the recipient's treatment regimen, a detailed explanation of how the services being billed relate to the treatment regimen and objectives contained in the patient's PoC should be submitted with bills. Similarly, a detailed explanation should accompany bills for a medical or remedial therapy, session, or encounter that departs from the PoC in terms of need, scheduling, frequency, or duration of services furnished (e.g., unscheduled emergency services furnished during an acute psychotic episode), explaining why this departure from the established treatment regimen is necessary in order to achieve the treatment objectives.

E. Periodic Review.--The evaluation team should periodically review the recipient's PoC in order to determine the recipient's progress toward the treatment objectives, the appropriateness of the services being furnished and the need for the recipient's continued participation in the program. The evaluation team should perform such reviews on a regular basis (i.e., at least every 90 days) and the reviews should be documented in detail in the patient records, kept on file and made available as requested for State or Federal assessment purposes.

4231. FEDERALLY QUALIFIED HEALTH CENTER (FQHC) AND OTHER AMBULATORY SERVICES

A. Background.--Section 6404 of the Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239) amended §§1905(a) and (l) of the Social Security Act to provide for coverage and definition of Federally Qualified Health Center (FQHC) services and other ambulatory services offered by an FQHC under Medicaid. Payment for services added by §6404 is effective for services provided on or after April 1, 1990. Payment for FQHC services is discussed in §6303.

B. FQHC Services and Other Ambulatory Services.--FQHC services are defined the same as the services provided by rural health clinics (RHCs) and generally described as RHC services. These services include physician services, services provided by physician assistants, nurse practitioners, clinical psychologists, clinical social workers, and services and supplies incident to such services as would otherwise be covered if furnished by a physician or as an incident to a physician's services. In certain cases, services to a homebound Medicaid patient may be provided. For a discussion of RHC services, see the Medicare Rural Health Clinic Manual, Chapter IV. Any other ambulatory service included in a State's Medicaid plan is considered a covered FQHC service, if the FQHC offers such a service.

C. Qualified FQHCs.--FQHCs are facilities or programs more commonly known as Community Health Centers, Migrant Health Centers, and Health Care for the Homeless Programs. For purposes of providing covered services under Medicaid, FQHCs may qualify as follows:

- The facility receives a grant under §§329, 330, or 340 of the Public Health Service (PHS) Act;

- The Health Resources and Services Administration (HRSA) within the PHS recommends, and the Secretary determines that, the facility meets the requirements for receiving such a grant; or

- The Secretary determines that a facility may, for good cause, qualify through waivers of the requirements described above. Such a waiver cannot exceed a period of 2 years.

A list of facilities receiving grants under §§329, 330, and 340, and thereby automatically qualified for provision of and payment for services provided under this section, is found in Exhibit I immediately following this section. The PHS advises HCFA timely of changes in status of grantees and other qualified FQHCs.

Any entity seeking to qualify under this section which does not qualify as a grant receiving facility should contact the PHS for consideration. The PHS is responsible for determining whether an applicant meets eligibility requirements. Applicants for consideration generally must be free-standing entities providing ambulatory care which otherwise qualify under §§329, 330 or 340 of the PHS Act. PHS forwards to HCFA, as determinations are made, a list of qualified entities. HCFA is responsible for the final determination that a facility (other than a grant recipient) can receive payment for services under Medicaid, and will notify states accordingly. Applicants apply to:

Director, Division of Primary Care Services
Bureau of Health Care Delivery and Assistance
U. S. Public Health Service
Room 7A55
5600 Fishers Lane
Rockville, MD 20857

Additionally, an FQHC which is not physician-directed may make certain arrangements similar to those entered into by RHCs, as provided for in § 1861(aa)(2)(B) of the Act. These arrangements concern reviews, supervision and guidance of non-physician staff, preparation of treatment orders, consultation, medical emergencies, and certain other certifying requirements for such facilities. The PHS assures the non-physician directed FQHCs comply with the requirements of §1861 (aa)(2)(B) of the Act.

D. Effective Date.--April 1, 1990 is the effective date for services provided under §6404 of OBRA-89. Submit State plan amendments to the HCFA regional offices no later than June 30, 1990, in order to obtain approval for services provided on or after the effective date. However, when the Secretary determines that State legislation (other than for funding) is necessary in order for the plan to meet the additional requirements of §6404, the State plan is out of compliance only if it fails to comply with such additional requirements after the first day of the first calendar quarter beginning after the close of the first regular session of a State legislature that begins after the date of the enactment of OBRA-89 (December 19, 1989). In a State that has a 2 year legislative session each year of the session is deemed to be a separate regular session of the State legislature.

Exhibit I

FY 1990 CH/MHC Grantee List

REG	90 BDT ST MO	BCRR	PROG	NAME	CITY	ST
01	08	010810	U	SW Community	Bridgeport	CT
01	03	011270	U	Bridgeport Comm	Bridgeport	CT
01	03	011260	U	Community Health	Hartford	CT
01	01	011830	U	Charter Oak Terrace	Hartford	CT
01	06	010070	U	Hill Health Corp	New Haven	CT
01	04	010060	U	Fairhaven Comm Health	New Haven	CT
01	08	010290	U	Roxbury Comp Comm.	Boston	MA
01	07	010160	U	North End Comm Hlth	Boston	MA
01	02	011890	U	Joseph Smith CHC	Boston	MA
01	07	010170	U	Harbor Health Svcs	Boston	MA
01	04	012010	U	Mattapan Comm Hlth	Boston	MA
01	07	010710	U	South Cove Comm.	Boston	MA
01	02	010030	U	Holyoke Health Ctr,	Holyoke	MA
01	07	012160	U	Greater Lawrence	Lawrence	MA
01	08	011460	U	Lowell Community	Lowell	MA
01	03	011430	U	Lynn Community	Lynn	MA
01	07	011930	U	Greater New Bedford	New Bedford	MA
01	08	010860	U	North Shore Comm Hlth	Peabody	MA
01	03	011190	R	Outer Cape Health	Provincetown	MA
01	06	011640	U	Manet Comm Hlth Ctr	Quincy	MA
01	08	010800	U	Family Health &	Worcester	MA
01	06	010830	U	Great Brook Valley	Worcester	MA
01	06	010330	R	Worthington Health	Worthington	MA
01	07	010040	R	Rural Health Centers	Augusta	ME
01	02	012030	R	Bethel Area HC	Bethel	ME
01	07	010340	R	Bucksport Reg Hlth	Bucksport	ME
01	06	011230	R	Sacopee Valley	Kezar Falls	ME
01	12	010380	R	Reg. Medical Center	Lubec	ME
01	12	010420	R	Northern ME Rural	Presque Isle	ME
01	07	010460	R	Kennebec Valley	Waterville	ME
01	05	011580	R	Lamprey Health Care	New Market	NH
01	12	012230	R	Wood River Hlth	Hope Valley	RI
01	01	012240	U	Blackstone Valley	Pawtucket	RI
01	12	010580	U	Providence Ambul.	Providence	RI
01	03	011820	R	Thundermist Hlth Assoc,	Woonsocket	RI
01	07	010640	R	Northern Co. Health	St. Johnsbury	VT
02	01	021270	R/MH	Bridgeton Area	Bridgeton	NJ
02	01	021280	U	Camcare Health	Camden	NJ
02	03	020930	R/MH	Sa-Lantic Health	Hammonton	NJ

Exhibit I(Cont.)

02	04	022290	U	Jersey City Medical	Jersey City	NJ
02	12	020500	U	Newark Comm Hlth Ctr	Newark	NJ
02	01	021300	U	Paterson CHC Network	Paterson	NJ
02	07	021230	U	Plainfield Health	Plainfield	NJ
02	04	020070	U	Henry J. Austin	Trenton	NJ
02	04	020110	U	Whitney M. Young	Albany	NY
02	01	020180	R/MH	Oak Orchard Comm.	Brockport	NY
02	08	021950	U	Soundview Health	Bronx	NY
02	06	021610	U	Morris Heights	Bronx	NY
02	02	020760	U	Bronx Ambulatory	Bronx	NY
02	01	020270	U	Sunset Park	Brooklyn	NY
02	12	021210	U	ODA Primary Care	Brooklyn	NY
02	01	020610	U	CHC East New York	Brooklyn	NY
02	12	022050	U	L B Johnson Health	Brooklyn	NY
02	04	021980	U	Brooklyn Plaza	Brooklyn	NY
02	01	020010	U	North West Buffalo	Buffalo	NY
02	08	021310	R	North Jefferson	Clayton	NY
02	12	021240	R	Cortland Co. Rural	Cortland	NY
02	08	021530	U	Greenburgh Neigh§bd HC	Greenburg	NY
02	08	021500	U	Mt. Vernon N.H.C	Mt. Vernon	NY
02	08	021080	U	Settlement Hlth and	New York	NY
02	12	020390	U	East Harlem Cl. for	New York	NY
02	12	020490	U	William F. Ryan	New York	NY
02	05	021390	U	Chinatown CHC	New York	NY
02	06	020620	U/MH	Fam HC of Orange &	Newburgh	NY
02	08	021520	U	Ossining Open Door HC	Ossington	NY
02	08	021510	U	Peekskill Hlth Ctr	Peekskill	NY
02	01	020870	R	Northern Oswego	Pulaski	NY
02	04	022110	U	Joseph P. Addabbo	Queens	NY
02	01	022070	U	Anthony L. Jordan	Rochester	NY
02	01	020560	U	Rochester Primary	Rochester	NY
02	06	021830	U	Carver Community	Schenectady	NY
02	01	020570	MH	Rochester Gen. Hosp	Sodus	NY
02	04	020160	U	Syracuse Community	Syracuse	NY
02	01	021790	R	Hudson Headwaters	Warrensburg	NY
02	07	021870	R	Barceloneta RH	Barceloneta	PR
02	02	020910	R	Camuy RHI	Camuy	PR
02	05	020660	R/MH	Hosp General de	Castaner	PR
02	03	021250	R	Ciales Health Ctr	Ciales	PR
02	03	020730	MH	Cidra Migrant	Cidra	PR
02	01	021400	R	Florida RHI Hlth Ctr	Florida	PR
02	03	021260	R	Hatillo RHI	Hatillo	PR
02	05	022090	R	Lares Health Center	Lares	PR

Exhibit I(Cont.)

02	07	020670	R/MH	Loiza Comprehensive	Loiza	PR
02	03	021040	MH	Mayaguez Migrant Hlth	Mayaguez	PR
02	06	020650	R/MH	Central Areawide	Naranjito	PR
02	04	020890	R/MH	Patillos RHI	Patillas	PR
02	12	020680	U/MH	Ponce Diagnostic	Playa Ponce	PR
02	05	021030	R	Rincon RH Project	Rincon	PR
02	05	020700	U	Dr. J. S. Belaval	Rio Piedras	PR
02	06	021350	R	Fredericksted Hlth	St. Croix	VI
03	02	031860	U	Community Health Care	Washington	DC
03	04	030070	MH	Delmarva Rural	Dover	DE
03	03	031260	U	Southbridge Medical	Wilmington	DE
03	02	033180	U	Baltimore Medical	Baltimore	MD
03	04	031270	U	South Baltimore	Baltimore	MD
03	07	032810	U	Assoc. Program for	Baltimore	MD
03	12	030150	U	West Baltimore	Baltimore	MD
03	12	030130	U	Parkwest Health	Baltimore	MD
03	07	032750	R	Caroline Hlth	Goldsboro	MD
03	12	031600	R	Tri-State CHC	Hancock	MD
03	06	030170	R	Somerset Co for	Princess Anne	MD
03	06	031220	R	North Penn Comp	Blossburg	PA
03	03	030220	R	Broadtop Area	Broad Top City	PA
03	03	030230	R	Comm. Medical Ctr	Burgettstown	PA
03	02	033930	U	Ches Penn Health	Chester	PA
03	08	032430	R	Glendale Area Med.	Coalport	PA
03	04	032300	R	Keystone Rural	Emporium	PA
03	07	034230	U	Primary Hlth Svcs of	Erie	PA
03	03	034060	R	Shenango Valley Pri.	Farrell	PA
03	02	031700	R	Centerville Clinics	Fredericktown	PA
03	04	033090	R	SE Greene Community	Greensboro	PA
03	04	030290	U	Hamilton Health Ctr	Harrisburg	PA
03	05	031880	MH	Rural Opport.,Inc	Harrisburg	PA
03	03	032440	R	Hyndman Area Medical	Hyndman	PA
03	04	033620	U	SE Lancaster Primary	Lancaster	PA
03	12	032230	U	F.O.R. Sto-Rox NHC	McKees Rocks	PA
03	03	034140	U	Spectrum Health	Philadelphia	PA
03	06	032900	U	Philadelphia Health	Philadelphia	PA
03	06	033780	U	Quality Health	Philadelphia	PA
03	06	033200	U	Greater Philadelphia	Philadelphia	PA
03	12	032220	U	Covenant House Hlth	Philadelphia	PA
03	02	030440	U	Primary Care Health	Pittsburgh	PA
03	12	032560	U	Scranton Primary	Scranton	PA
03	05	030480	R	Barnes Kasson Health	Susquehanna	PA
03	07	030560	R	Rural Hlth Corp of NE	Wilkes Barre	PA

Exhibit I(Cont.)

03	04	031160	U	York Health Corp.	York	PA
03	06	030720	R	Eastern Shore Rural	Accomac	VA
03	03	031970	R	Brunswick Health	Alberta	VA
03	03	032380	R	Tri County Medical	Aylett	VA
03	03	032650	R	Bland County Medical	Bastian	VA
03	08	034170	R	Boydton Comm Hlth	Boydton	VA
03	06	031230	R	Clinch River Health	Dungannon	VA
03	05	033030	R	Western Lee County	Ewing	VA
03	05	032840	R	Ivor Community	Ivor	VA
03	08	034180	R	Lunenburg Co. Health	Kenbridge	VA
03	08	033230	R	Tri - Area Laurel	Laurel Fork	VA
03	08	034050	R	Blue Ridge Health	Lovington	VA
03	08	030700	R	Central Virginia	New Canton	VA
03	05	032240	U	Peninsula Institute	Newport News	VA
03	03	031810	R	Saltville Medical	Saltville	VA
03	06	030740	R	St Charles Council	St Charles	VA
03	03	031760	R	Stony Creek CHC	Stony Creek	VA
03	06	033130	R	E.A. Hawse Retirement	Baker	WV
03	06	030880	R	Valley Hlth Systems,	Barboursville	WV
03	06	030800	R	Clay-Battelle Hlth	Blacksville	WV
03	12	033100	R	Camden-on-Gauley	Camden-on-Gauley	WV
03	12	034090	R	Clay Co Primary Hlth	Clay	WV
03	12	031820	R	Cabin Creek Health	Dawes	WV
03	02	030820	R	Monongahela Valley	Fairmont	WV
03	03	031000	R	Tug River Health	Gary	WV
03	07	034190	R	Minnie Hamilton Hlth	Grantsville	WV
03	06	032580	R	No. Greenbrier/South	Hillsboro	WV
03	06	030890	R	Preston-Taylor CHCs	Kingwood	WV
03	07	030900	R/MH	Intercounty Hlth,	Martinsburg	WV
03	06	031250	R	Bluestone Health	Princeton	WV
03	12	033080	R	Rainelle Medical Center	Rainelle	WV
03	12	034210	R	Tri-County Health	Rock Cave	WV
03	12	032600	R	New River Health	Scarbro	WV
03	02	034120	R	Roane County Family	Spencer	WV
03	04	030790	R	Community Hlth System	Spraque	WV
03	08	030990	R	Monroe Co. Hlth Bd	Union	WV
04	04	042210	R	Autaugaville Medical	Autaugaville	AL
04	02	040070	R	West Alabama Neigh-	Eutaw	AL
04	02	042830	R	Conecuh Medical	Evergreen	AL
04	04	044120	U	Etowah Quality of	Gadsden	AL
04	03	044700	U	Area Health Dev. Bd	Irvington	AL
04	03	048190	U	Central North Ala.	Madison	AL
04	08	044710	U	Franklin Memorial	Mobile	AL
04	06	047080	U	Mobile Co Hlth Dept	Mobile	AL
04	02	040130	U	Montgomery Hlth Svcs	Montgomery	AL
04	12	042180	R	Southern Rural Hlth	Russellville	AL
04	06	045710	R	Jackson Co Primary	Scottsboro	AL

Exhibit I(Cont.)

04	07	042850	R	Rural Hlth Medical	Selma	AL
04	05	048950	R	SE Alabama RHA	Troy	AL
04	12	042450	R	Maude L. Whately	Tuscaloosa	AL
04	08	040040	R	Health Development	Tuscaloosa	AL
04	04	040160	R	Central Alabama	Tuskegee	AL
04	02	041660	R/MH	West Orange Farm	Apopka	FL
04	07	040200	R	Family Medical	Cross City	FL
04	03	045500	R/MH	East Pasco Hlth Ctr,	Dade City	FL
04	02	040210	R/MH	Florida Rural Hlth	Frostproof	FL
04	03	041680	R/MH	Southwest FL Hlth Ctr	Ft Myers	FL
04	02	048960	R	Tri County Health	Greenville	FL
04	04	041700	R/MH	Collier Health	Immokalee	FL
04	08	048970	U	Columbia Co. Health	Lake City	FL
04	05	040290	R	Lafayette Co.	Mayo	FL
04	08	041630	U	Coconut Grove Family	Miami	FL
04	02	040330	U	Economic Opport.	Miami	FL
04	02	040320	U/MH	Community Hlth	Miami	FL
04	02	040310	U	Borinquen Hlth Care	Miami	FL
04	04	044130	U	Stanley C. Myers	Miami Beach	FL
04	12	040340	R/MH	Rural Health Care,	Palatka	FL
04	12	044310	R/MH	Manatee Co. Rural	Parrish	FL
04	01	041670	U	Sunshine Health	Pompano Beach	FL
04	12	044780	R/MH	Gadsden Primary Care	Quincy	FL
04	04	041750	R/MH	Ruskin Migrant & CHC	Ruskin	FL
04	01	041720	R	Central Florida	Sanford	FL
04	06	049070	R	Johnnie Ruth Clark	St. Petersburg	FL
04	04	040250	R	Project Health, Inc.	Sumterville	FL
04	04	0412810	R	Tampa Community Hlth	Tampa	FL
04	07	042710	R	Trenton Medical	Trenton	FL
04	04	040370	R/MH	Florida Comm Hlth	West Palm Beach	FL
04	01	041740	R/MH	Bd of Co Commiss.	West Palm Beach	FL
04	08	040380	R	Wewahitchka Medical	Wewahitchka	FL
04	06	044150	U	Albany Area Primary	Albany	GA
04	06	040400	U	Health South, Inc.	Atlanta	GA
04	07	040410	U	West End Medical Ctr	Atlanta	GA
04	04	040390	R	Northeast Georgia	Crawford	GA
04	08	047430	R	Georgia Highlands	Cumming	GA
04	01	046900	U	Oakhurst Community	Decatur	GA
04	08	049170	MH	Candler County Hlth	Metter	GA
04	06	045260	U	Palmetto Health	Palmetto	GA
04	03	043340	R	Stewart-Webster	Richland	GA
04	08	040490	U	Westside-Urban Hlth	Savannah	GA
04	03	048160	R	Hancock Co Primary	Sparta	GA
04	12	042110	R	Georgia Mountains	Suches	GA
04	02	044790	R	Primary Hlth Care	Trenton	GA
04	05	042390	R	Tri-County Health	Warrenton	GA

Exhibit I(Cont.)

04	08	046980	R	Pike Co. Primary	Zebulon	GA
04	03	044090	U	Northern Kentucky	Covington	KY
04	08	048140	U	Lexington-Fayette Co	Lexington	KY
04	12	046840	U	Louisville Mem Prim	Louisville	KY
04	12	040650	U	Park Duvalle Hlth	Louisville	KY
04	06	044820	R	Health Help, Inc.	McKee	KY
04	02	040670	R	Big Sandy Health	Prestonsburg	KY
04	12	048980	R	Lewis County Primary	Vanceburg	KY
04	05	040600	R	Mountain Comp	Whitesburg	KY
04	05	049100	R	North Benton Co.	Ashland	MS
04	01	042430	R	Coastal Fam Hlth	Biloxi	MS
04	03	042440	U	Rankin Urban Hlth	Brandon	MS
04	05	043060	R	NE Mississippi	Byhalia	MS
04	06	040760	R	Madison Yazoo Leake	Canton	MS
04	06	046150	R	Aaron E. Henry	Clarksdale	MS
04	06	048800	R	Jefferson Compre.	Fayette	MS
04	08	040750	U	Jackson-Hinds Comp Hlth	Jackson	MS
04	05	040570	R	South Mississippi CHC	Laurel	MS
04	08	044470	R	Greene Area Medical	Leaksville	MS
04	03	045780	R	Amite County Med.	Liberty	MS
04	04	042070	R	Greater Meridian	Meridian	MS
04	03	040780	R	Delta Health Center	Mound Bayou	MS
04	07	040770	R	South Central MS	New Hebron	MS
04	07	048420	R	Claiborne Co. Comm.	Port Gibson	MS
04	04	042720	R	East Central MS Hlth	Sebastopol	MS
04	03	045770	R	SE Mississippi RHI,	Seminary	MS
04	06	048870	R	Outreach Health	Shubuta	MS
04	03	046860	R	Three Rivers Area	Smithville	MS
04	12	047330	R	S. W. Hlth Agency	Tylertown	MS
04	04	040840	R	Vicksburg-Warren CHC,	Vicksburg	MS
04	12	041940	R	Tri-County Hlth	Aurora	NC
04	12	040890	R	Orange Chatham Comp	Carrboro	NC
04	05	047770	U	Metrolina Comp	Charlotte	NC
04	07	040910	U	Lincoln CHC/Durham	Durham	NC
04	01	045800	R/MH	Goshen Medical	Faison	NC
04	04	040940	R/MH	Migrant Family Hlth	Hendersonville	NC
04	07	046610	R	Twin Co Rural Health	Hollister	NC
04	12	045200	R	Western Med Group/Boone	Mamers	NC
04	06	045810	R	Morven Area Medical	Morven	NC
04	04	040900	R/MH	Tri-County Comm.	Newton Grove	NC
04	08	049000	R	Robeson Health	Pembroke	NC
04	03	040860	MH	Migrant Hlth Program	Raleigh	NC
04	12	041000	U	Wake Hlth Svcs, Inc.	Raleigh	NC

Exhibit I(Cont.)

04	06	046800	R	Person Fam Med Ctr	Roxboro	NC
04	12	041020	R	Greene Co. Hlth Care,	Snow Hill	NC
04	03	041060	R	Vance Warren Comp.	Soul City	NC
04	03	046910	R	Stedman Wade Hlth	Wade	NC
04	05	049190	R	Bertie County Rural	Windsor	NC
04	08	044920	R	Caswell Family	Yanceyville	NC
04	02	042310	R	Calhoun Falls Area	Calhoun Falls	SC
04	05	041110	U	Franklin C. Fetter	Charleston	SC
04	08	045220	R	Rural Health Svcs,	Clearwater	SC
04	05	041090	MH	SC Mig. Hlth Proj.	Columbia	SC
04	05	047000	R	Britton§s Neck Hlth	Conway	SC
04	02	040110	R	Midlands Primary	Eastover	SC
04	05	043770	R	Allendale Co.- Rural	Fairfax	SC
04	06	047060	R	Little River Medical	Little River	SC
04	07	045050	R	Sandhills Medical	McBee	SC
04	05	048430	R	St James - Santee	McClellanville	SC
04	03	046930	R	Black River	Olanta	SC
04	12	041180	R	Orangeburg Co.	Orangeburg	SC
04	06	041190	R	Beaufort Jasper	Ridgeland	SC
04	06	045230	R	Society Hill Family	Society Hill	SC
04	06	042780	R/MH	Megals Rural Hlth	Trenton	SC
04	02	041230	R/MH	Benton Medical	Benton	TN
04	12	041260	U	Chattanooga Hamilton	Chattanooga	TN
04	02	042160	R	Laurel Fork - Clear	Clairfield	TN
04	04	041780	R	Upper Cumberland	Cookville	TN
04	07	041440	R	Mountain Peoples	Huntsville	TN
04	05	041370	R	Perry County	Linden	TN
04	04	047820	R	Union Grainger	Maynardville	TN
04	01	041410	U	Memphis Health	Memphis	TN
04	05	049040	R	Stewart Co./Tenn Dpt	Nashville	TN
04	02	041420	U	Matthew Walker	Nashville	TN
04	02	044110	U	United Neighborhood	Nashville	TN
04	04	046810	R	Rural Community	Parrotsville	TN
04	05	0412790	R	Rural Hlth Svcs Cons.	Rogersville	TN
04	03	045420	R	Citizens of Lake Co.	Tiptonville	TN
04	01	041290	R	Morgan Co. Hlth	Wartburg	TN
05	03	052180	R	Rural Health Inc.	Anna	IL
05	07	050030	R	Community Health	Cairo	IL
05	01	053320	R	Southern Illinois	Centerville	IL
05	12	051870	U	Frances Nelson	Champaign	IL
05	02	051720	U	New City Health Ctr,	Chicago	IL
05	02	050080	U	KOMED Health Center	Chicago	IL
05	03	050060	MH	Illnois Migrant	Chicago	IL

Exhibit I(Cont.)

05	06	051050	U	Claretian	Chicago	IL
05	01	053280	U	Near North Health	Chicago	IL
05	07	053210	U	Erie Family Hlth Ctr	Chicago	IL
05	04	052130	R	Christopher Greater	Christopher	IL
05	05	053150	U	Community Health	Decatur	IL
05	04	05004D	R/MH	Shawnee Hlth Svcs	Murphysboro	IL
05	01	052140	R	Henderson Co Rural	Oquawka	IL
05	12	052760	U	Crusaders Central	Rockford	IL
05	06	051020	U	People§s Hlth Ctr	Indianapolis	IN
05	12	053200	U	Community Health	Indianapolis	IN
05	05	053110	R/MH	Indiana Health	Indianapolis	IN
05	06	052200	R	Downriver Community	Algonac	MI
05	12	050210	R	Regional Health	Baldwin	MI
05	04	050220	R/MH	MARCHA	Bangor	MI
05	12	052820	R	Monway Citizens	Carleton	MI
05	02	052070	U	Cass CHC	Detroit	MI
05	01	051990	U	Detroit Health Dept	Detroit	MI
05	04	051680	R	East Jordon Family	East Jordon	MI
05	04	053300	U	Hamilton Area	Flint	MI
05	04	052030		Cherry Street Services	Grand Rapids	MI
05	03	053160	R	Thunder Bay, CHC	Hillman	MI
05	01	050290	R	Northern Michigan	Houghton Lake	MI
05	03	056230	U	Family Health Center	Kalamazoo	MI
05	05	051980	R	Alcona Medical	Lincoln	MI
05	03	051440	R	Upper Pennisula	Newberry	MI
05	04	052510	R/MH	Pullman Health	Pullman	MI
05	04	050360	R/MH	Health Delivery Inc.	Saginaw	MI
05	03	050380	MH	Sparta Health Ctr	Sparta	MI
05	04	052250	R	Sterling Area Health	Sterling	MI
05	04	052910	R	Citizens Health	Temperance	MI
05	03	050390	MH	Northwest Michigan	Traverse City	MI
05	06	052710	R	Cook Area Hlth	Cook	MN
05	06	052700	R	Cook Co Clinic	Grand Marais	MN
05	04	051770	U	Indian Hlth Board	Minneapolis	MN
05	03	050320	MH	Migrant Health	Moorehead	MN
05	03	053020	U	Westside Community	St. Paul	MN
05	12	052730	U	Model Cities Health	St. Paul	MN
05	03	050560	R	Barnesville Hlth	Barnesville	OH
05	03	052270	R	P.R.A.V. Health Svcs,	Chillcothe	OH
05	01	051570	U	Cincinnati Health	Cincinnati	OH
05	01	050990	R	South. Ohio Hlth Svcs	Cincinnati	OH
05	01	050580	U	Hough Norwood Fam	Cleveland	OH
05	04	050960	R/MH	Community Hlth Svcs	Freemont	OH

Exhibit I(Cont.)

05	04	050640	R/MH	Family Hlth Service	Greenville	OH
05	05	051660	R	Ironton-Lawrence Co	Ironton	OH
05	02	052900	R	Community Action	Piketon	OH
05	05	053010	U	Toledo Family	Toledo	OH
05	12	051780	U	Cordelia Martin HC/	Toledo	OH
05	08	051490	R	Northern Health Ctrs,	Lakewood	WI
05	06	050840	R	Marshfield Medical	Marshfield	WI
05	04	053060	U	16th Street Clin/HOPE	Milwaukee	WI
05	03	056220	U	Milwaukee Comprehens.	Milwaukee	WI
05	01	052670	U	Indian Hlth Bd of	Milwaukee	WI
05	06	052810	R	North Woods Medical	Minong	WI
05	04	050900	MH	La Clinica De Los	Wildrose	WI
06	01	060940	R	White River Rural	Augusta	AR
06	06	062090	R	Mid-Delta Rural Hlth	Clarendon	AR
06	05	062140	R	CABUN Rural Hlth	Hampton	AR
06	12	060060	R	Lee Co Cooperative	Marianna	AR
06	08	060080	R	Rural Health Inc.	Paragold	AR
06	06	060110	U	Jefferson Comp Care	Pine Bluff	AR
06	02	062730	R	Mainline Health	Portland	AR
06	12	060140	U	East Arkansas Family	West Memphis	AR
06	06	060180	R	Teche Action Board	Franklin	LA
06	08	063380	U	Bayou Comprehensive	Lake Charles	LA
06	08	060190	R	Natchitoches Area	Natchitoches	LA
06	01	062480	R	Catahoula Parish	Sicily Island	LA
06	01	060240	U	Albuquerque Family	Albuquerque	NM
06	07	060330	R	Health Centers of	Espanola	NM
06	08	060360	R	Gallup/Thoreau/Grants	Gallup	NM
06	05	060370	R	Ben Archer Health	Hatch	NM
06	02	062160	R	Centro Rural de	Loving	NM
06	08	061290	R/MH	La Casa de Bueno	Portales	NM
06	07	063010	R/MH	La Clinica de	San Miguel	NM
06	01	063450	R	Presbyterian Med	Santa Fe	NM
06	07	063920	U	La Familia Medical	Santa Fe	NM
06	07	060490	MH	Oklahoma State	Altus	OK
06	08	063930	R	Konawa Community	Konawa	OK
06	02	060530	U	Community Hlth Ctrs	Oklahoma City	OK
06	05	063890	U	Morton Health Center	Tulsa	OK
06	02	062650	R	Panhandle Rural	Amarillo	TX
06	08	061000	R	Chapparral Hlth Clinic	Benavides	TX
06	08	061510	U/MH	Brownsville Comm.	Brownsville	TX
06	04	062120	R/MH	South Texas Rural	Cotulla	TX
06	05	060670	R/MH	Vida y Salud	Crystal City	TX
06	12	061010	U	Martin L. King, Jr.,	Dallas	TX
06	07	060680	U	Los Barrios Unidos	Dallas	TX

Exhibit I(Cont.)

06	12	060710	R/MH	Cross Timbers	De Leon	TX
06	07	060740	R/MH	United Medical Svc	Eagle Pass	TX
06	02	063520	R	Centro Medico Del	El Paso	TX
06	12	061230	U	Centro de Salud	El Paso	TX
06	12	060810	R	Gonzales County	Gonzales	TX
06	08	060820	R	Comm Hlth Svc Agency	Greenville	TX
06	05	060840	R/MH	Su Clinica Familiar/	Harlingen	TX
06	05	061610	U	Galveston Co. Coord.	La Marque	TX
06	04	060900	U/MH	Laredo-Webb Co Hlth	Laredo	TX
06	06	061220	R/MH	South Plains Rural	Levelland	TX
06	08	061260	R	East Texas Community	Nacogdoches	TX
06	08	061190	R	Jasper-Newton Comm	Newton	TX
06	01	060750	R/MH	Hidalgo Co. Health	Pharr	TX
06	06	060950	R/MH	South Plains Health	Plainview	TX
06	08	062390	R	Atascoso RHI Health	Pleasanton	TX
06	04	063190	U	City of Port Arthur	Port Arthur	TX
06	02	060970	R/MH	Comm Action Council	Rio Grande City	TX
06	04	063940	U	Ella Austin Comm.	San Antonio	TX
06	03	062360	U/MH	Barrio Comp Family	San Antonio	TX
06	05	063250	U	Centro Del Barrio	San Antonio	TX
06	08	063910	R/MH	Uvalde Co.-Clinic,	Uvalde	TX
07	03	071170	U	Community Hlth Care	Davenport	IA
07	08	071790	U	Broadlawns Medical	Des Moines	IA
07	02	070050	MH	Muscatine Migrant	Muscatine	IA
07	02	071410	U	Peoples Comm Hlth	Waterloo	IA
07	05	071800	MH	Kansas City Wyandott	Kansas City	KS
07	07	070090	MH	Kansas State Dept	Topeka	KS
07	08	070150	U	Hunter Health Clinic	Wichita	KS
07	12	071660	R	Caldwell Co Medical	Hamilton	MO
07	08	070290	U	Samuel U. Rodgers	Kansas City	MO
07	05	070270	U	Swope Pkwy Comp	Kansas City	MO
07	05	070300	R	NE Missouri Hlth &	Kirksville	MO
07	03	072130	R	Northwest Missouri	Mound City	MO
07	08	071370	R	New Madrid Group	New Madrid	MO
07	12	071670	R	Central Ozark	Richland	MO
07	02	071700	U	Family Care Center	St. Louis	MO
07	06	072100	U	Peoples Clinic	St. Louis	MO
07	02	070370	U	St. Louis Compre	St. Louis	MO
07	03	071190	U	Neighborhood HC, Inc	St. Louis	MO
07	06	070430	R	Big Springs Medical	Van Buren	MO
07	04	070450	MH	Nebraska State Dept	Lincoln	NE
07	03	072110	U	Charles Drew Medical	Omaha	NE
08	12	080030	R/MH	Valley Wide Health	Alamosa	CO

Exhibit I(Cont.)

08	07	081260	R	Gilpin/Columbine	Black Hawk	CO
08	01	081460	U	Comm Hlth of	Colorado Springs	CO
08	01	080010	MH	Colorado Dept. of	Denver	CO
08	01	080060	U	Denver Dept of Hlth	Denver	CO
08	07	080100	R	Dolores Co. Hlth	Dove Creek	CO
08	06	080130	R/MH	Plan de Salud del	Fort Lupton	CO
08	04	080140	R/MH	Sunrise Community	Greeley	CO
08	02	081650	R	La Clinica Campesina	Lafayette	CO
08	08	081740	R	Uncomphadre Combined	Norwood	CO
08	06	080170	U	Pueblo Comm Hlth	Pueblo	CO
08	05	082500	U	Yellowstone City/	Billings	MT
08	02	082160	MH	Montana Migrant	Billings	MT
08	08	083270	R	Butte CHC-Silver Bow	Butte	MT
08	01	082110	R	Mercer-Oliver	Center	ND
08	05	080890	R	Union County Health	Elk Point	SD
08	02	080500	R	NW South Dakota	Faith	SD
08	12	081030	R	East River Health	Howard	SD
08	04	082100	R	Isabel Comm RHI	Isabel	SD
08	08	080590	R	South Dakota Rural	Pierre	SD
08	01	081450	U	Sioux River Valley	Sioux Falls	SD
08	08	081690	R	Tri-County Hlth Care,	Wessington Spring	SD
08	07	082240	R	Wayne Co. Medical	Bicknell	UT
08	08	082480	R	Enterprise Valley	Enterprise	UT
08	08	082490	R	Green River CHC	Green River	UT
08	05	080510	MH	Utah Rural Dev. Corp.	Midvale	UT
08	05	082050	U	Weber County Comm.	Ogden	UT
08	01	080220	U	Salt Lake City Comm	Salt Lake City	UT
08	03	080830	MH	Tri-County Dev. Corp.	Guernsey	WY
08	03	080710	MH	Northwestern Comm.	Worland	WY
09	06	090030	R	West Pinal Family	Casa Grande	AZ
09	12	093030	R/MH	Clinica Adelante,	El Mirage	AZ
09	06	090090	R	Mariposa Community	Marana	AZ
09	07	091300	R	Lake Powell Family	Page	AZ
09	12	093070	U	Memorial Family	Phoenix	AZ
09	08	090130	R/MH	Valley Health Ctr,	Somerton	AZ
09	01	090160	U	El Rio Santa Cruz NHC	Tucson	AZ
09	03	093590	R	United Community	Tuscon	AZ
09	05	090210	R	Family Health Fnd. of	Alviso	CA
09	01	093660	U	Inland Empire CHC	Bloomington	CA
09	06	090250	R/MH	Clinicas de Salud	Brawley	CA
09	12	090260	R	Intermountain Comm.	Brownsville	CA
09	04	091600	R/MH	Buttonwillow Health	Buttonwillow	CA
09	12	093150	R/MH	El Progresso del	Coachella	CA

Exhibit I(Cont.)

09	04	090290	U	Drew Hlth Foundation	East Palo Alto	CA
09	02	093320	U/MH	Sequoia Comm Health	Fresno	CA
09	01	091050	R/MH	La Clinica Popular	King City	CA
09	04	090390	R/MH	Clinica Sierra Vista	Lamont	CA
09	07	091650	R	Long Valley Hlth Ctr,	Laytonville	CA
09	04	093160	U	Arroyo Vista Family	Los Angeles	CA
09	02	091040	U	Asian Pacific Venture	Los Angeles	CA
09	12	093110	U	Altamed	Los Angeles	CA
09	01	090490	U	Community Hlth Fdn	Los Angeles	CA
09	12	090440	U	Watts Health	Los Angeles	CA
09	12	093210	R/MH	El Concilio de Madera	Madera	CA
09	04	090470	R/MH	Merced Family	Merced	CA
09	07	090710	R/MH	Nipomo Comm Med Ctr,	Nipomo	CA
09	04	090540	U	West Oakland Health	Oakland	CA
09	04	091030	U	Asian Health Svcs	Oakland	CA
09	05	091230	U	La Clinica de la	Oakland	CA
09	07	090850	MH	North Sacramento	Olivehurst	CA
09	12	091000	U	Northeast Valley	Pacoima	CA
09	06	090560	R/MH	United Health Ctrs of	Parlier	CA
09	03	093640	MH	Porterville Family	Porterville	CA
09	04	091240	U	West Contra Costa	Richmond	CA
09	01	093120	U	Logan Heights Family	San Diego	CA
09	04	090530	U	San Francisco Med.	San Francisco	CA
09	03	090660	U	Mission Neighborhood	San Francisco	CA
09	01	090670	U	North East Medical	San Francisco	CA
09	01	090720	R/MH	North County Hlth	San Marcos	CA
09	01	091080	U	San Ysidro Health Ctr	San Ysidro	CA
09	07	093080	U	UC Irvine (CCOC)	Santa Ana	CA
09	05	093650	MH	Clinicas del Camino	Saticoy	CA
09	12	090780	R/MH	Agricult§l. Workers	Stockton	CA
09	07	091960	R	Northeast Rural	Susanville	CA
09	01	093190	U	Tiburcio Vasquez	Union City	CA
09	02	091760	R	Commonwealth of Saipan	Saipan	CM
09	05	093530	R	Guam Health Dept.	Agana	GU
09	04	093410	R	K K V Comprehensive	Honolulu	HI
09	03	090990	R	Waianae Coast	Waianae	HI
09	08	091570	R	Central Nevada Rural	Babbitt	NV
09	04	090820	U	CHC of S. Nevada	Las Vegas	NV
09	01	093680	R	Republic of Palaui	Koror	PW
09	02	093570	R	Ministry of Health	Marshall Islands	TT
09	01	091920	R	Ponape State Hosp.	Ponape	TT
10	07	100020	U	Anchorage Neighborhd	Anchorage	AK
10	07	101610	R	Glenns Ferry Area	Glenns Ferry	ID
10	04	100160	R	Terry Reilly Health	Nampa	ID

Exhibit I(Cont.)

10	04	100280	R	Mountain Health	Nampa	ID
10	03	101630	R/MH	Valley Family Health	Payette	ID
10	07	100180	R	Health West Inc.	Pocatello	ID
10	03	101650	R/MH	Family Health Svcs,	Twin Falls	ID
10	08	100790	MH	Clinica Del Valle		OR
10	07	100010	R	Southeast Oregon	Chiloquin	OR
10	04	101230	MH	Virginia Garcia Mem	Cornelius	OR
10	03	102080	R/MH	La Clinica del Carino	Hood River	OR
10	07	101120	U	Multnomah Co Dept.	Portland	OR
10	12	100760	U	NW Human Svcs, Inc.	Salem	OR
10	04	100340	R/MH	Salud Medical Center	Woodburn	OR
10	03	100360	R	N E W Health Programs	Chewelah	WA
10	08	100270	R	West Coast Health	Copalis Beach	WA
10	04	101770	MH	Okanogan Farmworkers	Okanogan	WA
10	12	100460	R	Columbia Basin Hlth	Othello	WA
10	08	101520	R/MH	La Clinica/South	Pasco	WA
10	03	100640	U	Puget Sound Neighbor	Seattle	WA
10	04	101020	U/MH	Sea-Mar Community	Seattle	WA
10	03	100630	U	Central Seattle	Seattle	WA
10	06	100450	U	Community Health Care	Tacoma	WA
10	04	101030	R/MH	Yakima Valley Farm	Topennish	WA
10	04	100570	R/MH	N C WASH Mig Health	Wenatchee	WA

Exhibit I(Cont.)

1990 HOMELESS GRANTEES

SECTION 340 HEALTH CARE FOR THE HOMELESS

Project Name:	City:	State:
Charter Oak Terrace/Rice Heights Health Center	Hartford	CT
Hill Health Center	New Haven	CT
Southwest Bridgeport Comm. Hlth Ctr.	Bridgeport	CT
Windham Area Comm. Action Prog., Inc.	Danielson	CT
Boston Health Care for Homeless Project	Boston	MA
Springfield Hlth Svs. for the Homeless	Springfield	MA
Worcester Area Community Mental Health Center, Inc.	Worcester	MA
City of Manchester Public Health Dept.	Manchester	NH
Providence Ambulatory Hlth Care Found	Providence	RI
Community Hlth Ctr. for Burlington, Inc.	Burlington	VT
William F. Ryan CHC	New York	NY
United Hospital Fund	New York	NY
Bowery Residents Committee Human Services, Corp.	New York	NY
Westchester Health Network Neighborhood Health Association of Mt. Vernon	White Plains	NY
Newark Homeless Health Care Project	Newark	NJ
Under 21 - Covenant House	New York	NY
St Vincent§s Hospital	New York	NY
NY Childrens Health Project	New York	NY
Jersey City Family Hlth Ctr	Jersey City	NJ
San Juan Department of Health	San Juan	PR
Henry J. Austin Hlth Ctr. HCH	Trenton	NJ
Health Care for the Homeless Proj., Inc.	Washington	DC
Health Care for the Homeless	Baltimore	MD
Primary Health Care Services	Erie	PA
Philadelphia Health Mgmt. Corporation	Philadelphia	PA
Primary Care Health Services	Pittsburgh	PA
Rural Health Corporation of NE PA	Wilkes-Barre	PA
The Daily Planet	Richmond	VA
Peninsula Institute for Comm. Hlth	Hampton	VA
Valley Health Systems, Inc.	Huntington	WV
Georgia Hill Street Neighborhood Fac.	Atlanta	GA
Birmingham Hlth Care for the Homeless	Birmingham	AL
Charleston Interfaith Crisis Ministry	Charleston	SC
Chattanooga Hamilton County Hlth Dept.	Chattanooga	TN

Exhibit I(Cont.)

Lincoln Community Health Center, Inc.	Durham	NC
Midlands Center for the Homeless	Eastover	SC
Broward County HCH	Ft. Lauderdale	FL
Jackson-Hinds Comprehensive HC	Jackson	MS
Lexington-Fayette County Hlth Dpt	Lexington	KY
Seven Counties Services, Inc.	Louisville	KY
Memphis Health Center, Inc.	Memphis	TN
Camillus Health Concern	Miami	FL
Pinellas County Department St.	Petersburg	FL
Metropolitan Health Dept.	Nashville	TN
Wake Health Services, Inc.	Raleigh	NC
Tampa Community Health	Tampa	FL
Travelers and Immigrants Aid	Chicago	IL
Crusaders Central Clinic	Rockford	IL
Indiana Health Centers, Inc.	Indianapolis	IN
East Side Promise, Inc.	Indianapolis	IN
Visiting Nurse Services of So. Mich.	Battle Creek	MI
Ingham County Health Dept.	Lansing	MI
St. Mary§s Health Services	Grand Rapids	MI
Family Health Center, Inc.	Kalamazoo	MI
Detroit Health Care for the Homeless	Detroit	MI
Downriver Community Services	Algonat	MI
Hamilton Family Health Ctr.	Flint	MI
Hennepin Cty Homeless Assistance Proj.	Minneapolis	MN
West Side Health Center, Inc.	St. Paul	MN
ECCO Family Health Center	Columbus	OH
Cordelia Martin Health Center	Toledo	OH
Cincinnati Health Network	Cincinnati	OH
Federation for Community Planning	Cleveland	OH
Coalition for Comm. Hlth Care	Milwaukee	WI
New Orleans Health Department	New Orleans	LA
Albuquerque Hlth Care for the Homeless	Albuquerque	NM
Community Health Center, Inc.	Oklahoma City	OK
Morton Comprehensive Health Serv. Inc.	Tulsa	OK
Amarillo Hospital District	Amarillo	TX
Dept of Hlth & Human Serv. - Dallas	Dallas	TX
City of Forth Worth Health Department	Fort Worth	TX
Harris County Hospital Dist.	Houston	TX
Guadalupe Economic Services Group	Lubbock	TX
The United Way of San Antonio & Bexar Cty	San Antonio	TX
Community Health Care, Inc.	Davenport	IA
Polk County Health Services	Des Moines	IA

Exhibit I(Cont.)

People's Community Health Clinic, Inc.	Waterloo	IA
Hunter Health Clinic, Inc.	Wichita	KS
Charles Drew Health Center	Omaha	NE
Swope Parkway Health Center	Kansas City	MO
Grace Hill Neighborhood Health Center	St. Louis	MO
Colorado Coalition for the Homeless	Denver	CO
Community Hlth Ctr of Colorado Springs	Colorado Spgs	CO
Health Care for the Homeless	Rapid City	SD
Salt Lake Community Health Ctrs, Inc.	Salt Lake City	UT
El Rio Santa Cruz Neighborhood Hlth Ctr	Tucson	AZ
Maricopa County Dept. of Hlth Services	Phoenix	AZ
The Family Health Foundation	Alviso	CA
Drew Health Foundation	E. Palo Alto	CA
Clinica Sierra Vista, Inc.	Lamont	CA
Logan Heights Family Health Center	San Diego	CA
Merced Family Health Centers, Inc.	Merced	CA
San Francisco Community Clinic	San Francisco	CA
Northeast Valley Health Corp.	Pacoima	CA
Nipomo Community Medical	Nipomo	CA
Sequoia Community Health	Fresno	CA
West Contra Cost HC Corp.	Richmond	CA
WCDCH Hosp. Board, Inc.	Waianae	HI
Sacramento County Health Dept.	Sacramento	CA
Santa Cruz Co. Hlth Svcs Agency	Santa Cruz	CA
Alameda Co. Health Care Svcs Agency	Oakland	CA
Santa Barbara County Hlth Care Svcs	Santa Barbara	CA
Terry Reilly Health Services	Nampa	ID
White Bird Clinic	Eugene	OR
Sea Mar Community Health Ctr.	Seattle	WA
Multnomah County Health	Portland	OR
Metropolitan Development	Tacoma	WA
Central Seattle Community Hlth Ctrs	Seattle	WA
Northwest Human Services	Salem	OR

4250. MINIMUM FEDERAL CRITERIA FOR STATES TO USE IN MAKING PREADMISSION AND ANNUAL REVIEW DETERMINATIONS ABOUT ADMISSION TO OR CONTINUED RESIDENCE IN NURSING FACILITIES FOR INDIVIDUALS WHO HAVE MENTAL ILLNESS OR MENTAL RETARDATION

The Omnibus Budget Reconciliation Act of 1987 (OBRA 87) sets forth three sections that address preadmission screening and annual resident review (PASARR) requirements:

o With respect to new admissions occurring on or after January 1, 1989, §1919(b)(3)(F) prohibits a nursing facility (NF) from admitting any new resident who has mental illness (MI) or mental retardation (MR) (or a related condition), unless the State mental health or State mental retardation authority has determined that, because of his/her physical and mental condition, the prospective resident requires the level of services provided by a NF. In addition, where it is determined that admission to the NF is appropriate, a determination must be made as to whether active treatment is required.

o With respect to all current residents who have MR or MI and who were admitted prior to January 1, 1989, §1919(e)(7)(B) requires the State mental health or the State mental retardation authority to have reviewed and determined by April 1, 1990:

-- Whether or not the resident, because of his/her physical and mental condition, requires the level of services provided by a NF or requires the level of services of an inpatient psychiatric hospital for individuals under age 21 or of an institution for mental diseases (IMD) providing medical assistance to individuals 65 years or older in the case of residents with MI or the level of services of an ICF/MR in the case of residents with MR. In the case of residents with MI, the statute further specifies that the determination made by the State mental health authority must be based on an evaluation performed by an independent person or entity; and

-- Regardless of the outcome of the NF level of care determination, whether or not the resident requires active treatment for his/her MI or MR.

Section 1919(e)(7)(B)(iii) requires that PASARR reviews and determinations be repeated on at least an annual basis on all NF residents who have MI or MR.

o Section 1919(f)(8) requires the the Secretary to develop, by not later than October 1, 1988, minimum criteria for the States to use in making the required determinations on new admissions and current residents and in permitting individuals adversely affected to appeal such determinations. However, §1919(e)(7)(A) requires the States to have a PASARR program in operation by the effective dates regardless of whether the Federal criteria are available.

We have been advised that the plain reading of the statute's language and the absence of any apparent limitations mean that <u>any</u> person with MI or MR must be screened if he or she already resides in or is to be admitted to a NF. Furthermore, the statute does not provide any basis for limiting preadmission screening or annual reviews to only those

individuals who have a "known diagnosis" of MI or MR. In order for facilities and States to protect themselves from the imposition of possible sanctions for failure to identify some individuals who have MI or MR, all individuals applying to or residing in a Medicaid-certified NF should be screened in some fashion to determine if they have MI or MR regardless of the "known diagnosis."

We would note that the statute makes preadmission screening requirements applicable to "new admissions." Thus a screening system which differentiates from admissions to an NF those which are "new" (as opposed, for example, to admissions of individuals who had been inpatients but were admitted to a hospital and are now being readmitted) would comply with the law.

We have also been advised that the statute provides no basis for limiting preadmission screening or annual reviews by method of payment. Therefore, all individuals, regardless of whether they are private payers, Medicare beneficiaries, or Medicaid-eligible individuals, must be screened if they reside in or apply to a Medicaid-certified NF. These requirements do not apply to a facility participating solely in Medicare as an skilled nursing facility (SNF).

Because an IMD can be a NF, and all NFs are subject to the PASARR requirements, we have been advised that NFs which participate in Medicaid as IMDs are subject to PASARR. We note that the definition of a NF set forth in §1919(a) appears to be somewhat inconsistent with the definition of an IMD in that it states that a NF is an institution that "is not primarily for the care and treatment of mental diseases." We believe, however, that the best reading of these two definitions is that a NF can be both a NF and an IMD. In such situations, the NF maintains its status as a certified NF, but the IMD classification applies. That is, when NFs provide IMD services for persons over 65 years of age or inpatient patient psychiatric services for individuals under 21, we consider these facilities in the context of these benefits even though they meet NF requirements. For individuals aged 22 to 64, residence in an IMD precludes them from receiving any Medicaid benefits.

The PASARR requirements do not currently apply to swing beds because the existing swing bed regulations at 42 CFR 482.66(b) list those SNF requirements which swing beds must meet and would need to be revised to include PASARR requirements before they would be applicable. When we revise these regulations, we anticipate requiring that PASARR apply to swing beds.

The statutory PASARR requirements make no specific reference to time frames within which the State mental health and mental retardation authorities must perform the required screenings and make the required determinations.We intend to specify in forthcoming regulations that determinations must be made in a timely manner. We believe that timely action is necessary in order to prevent unnecessary extensions of inpatient hospital stays or inappropriate delays in providing needed services to individuals with MI or MR while they await screening by the State.

To the greatest degree possible a State should interface the PASARR process with other existing or future NF preadmission screening and resident assessment procedures. For example, data compiled as part of the preadmission screening (PAS), which, by definition, takes place prior to admission, may be used in conducting the initial assessment which must be performed on a new resident. Currently, these initial assessments must be performed no later than 14 days after the date of admission. As of October 1, 1990, they will have to be performed within the first 4 days after the date of admission. Similarly, the results of the routine annual resident assessment (or more frequent assessments which are precipitated by a change in the resident's status) may be used for purposes of identifying residents with MI or MR who must be referred to the State mental health or mental retardation authorities for the annual resident reviews (ARRs).

Residents who are subject to annual reviews fall into two groups: 1) all who were previously identified as having MI or MR through preadmission screening or initial reviews and who were, for one reason or another, permitted to enter or remain in a nursing facility; and 2) any other residents who are later discovered to have MI or MR. If a resident, who was either not identified as having MI or MR (and therefore was not referred for further screening) or was found not to have MI or MR as a result of the preadmission screening or initial resident review, is later found to have a previously undiagnosed or a new condition of MR or MI, that individual should be referred to the State authorities for screening and a determination.

We envision that discovery of "new" cases of MR or MI will occur in one of two ways. Unlike MR which has a constant nature, MI frequently has an episodic character. Some NF residents may develop MI while in the NF. Development of a new condition or a significant worsening of an existing condition would be a change in the resident's health status which should trigger a reassessment under current regulations (483.20(b)(4)(iv)). We also anticipate that once the uniform data set is in use for routine annual resident assessments (as required by OBRA §87 as of October 1, 1990), some conditions which had previously been inadequately or incorrectly diagnosed may be detected.

The facility should immediately refer "new" cases of MR or MI to the State mental health or mental retardation authorities. At the State's option, the actual screening may be postponed until the next scheduled resident review session at that facility. If the facility is willing to accept responsibility for meeting the resident's new treatment needs in the short term, it may retain the resident until a State determination has been made. However, if the facility believes it cannot meet the resident§s needs, that inability would serve as grounds for a more immediate transfer of the individual to a more appropriate setting.

States should be aware that they are responsible if they fail to screen or review any individuals who genuinely have MI or MR. Facilities are also accountable if they admit or allow any individuals to stay who should have been screened or reviewed but were not (unless, in the case of a continuing resident, the facility has notified the State authorities and is awaiting screening). Therefore, in order to ensure that no one who actually has MI or MR is missed, we would advise the State mental health and mental retardation authorities to perform screenings and make determinations on any individuals when they learn that they are suspected of having MI or MR.

For discussion purposes, these Federal minimum criteria present a two-step process. The first step, which is referred to as Level I, involves identification of individuals who are suspected of having MI or MR and need to be subjected to further screening (through Level II). (See §4250.1.) The second step, Level II, is the actual PASARR process by which determinations are made by the State as to whether the individual requires the level of services provided by a NF or another type of facility and (if required) whether the individual requires active treatment. (See §4250.2.) This discussion of the Level II process is, in turn, broken down into three components: PASARR/NF, PASARR/MI, and PASARR/MR which should provide answers to both statutory questions. (See §§4251-4253.) However, as will be explained in these sections, some of the determinations which are required may be made categorically by the State rather than with respect to individuals.

As noted above, the statute requires that a determination be made as to the need for active treatment for all current residents who have MI or MR, regardless of whether they do or do not need the level of services provided by a NF. For new admissions on or after January 1, 1989, a determination as to active treatment needs is only required if the individual is determined to require NF level of services. Under each level (Identification and PASARR) we are providing criteria for both evaluating residents and making determinations based on the data complied through the evaluation. (See Evaluation Criteria and Determination Criteria under both levels.)

We are outlining criteria, not process. We propose that each State may develop its own process. If the State chooses, it may require facilities or hospital discharge planners to do the Level I screening and make referrals to the State. Alternatively, the State may retain the Level I function or delegate/contract it to another entity. The statute clearly requires, however, that the administration of the Level II screening, the actual PASARR, is a responsibility of the State mental health and mental retardation authorities although they may do so under contract or by delegation. In the case of individuals with MI, the evaluation phase of Level II must be delegated/contracted to a person or entity independent of the State mental health authority.

This discussion treats this screening process as a whole; however, screening need proceed only so far as is necessary to make the determinations required by the law. Thus, if screening quickly reveals that an individual does not have MI or MR, further evaluation is not necessary to meet the statutory requirement.

We believe that decisions as to appropriate placement for current or prospective residents who have MI or MR are not governed by the availability of placement alternatives. If availability of placements were to be considered, there would have been no purpose for Congress to have allowed States the option of submitting Alternative Disposition Plans (ADPs), as provided for in the statute at §1919(e)(7)(D). The purpose of the ADP provision is to give those States which need additional time to create the alternative placement slots and arrange for the provision of active treatment services the opportunity to continue to be in compliance so long as they are making adequate progress toward developing the needed placement slots and services. Placement by the State of individuals with MI or MR in NFs as a means of avoiding responsibility for provision of the active treatment these individuals need will no longer be tolerated.

4250.1 Level I - Identification (ID) of Individuals With Mental Illness or Mental Retardation.--

A. Purpose.--The purpose of the ID screen is to determine which NF applicants or residents have MI or MR and are subject to PASARR. Because the statute excludes dementias from the definition of MI, individuals with a supportable primary diagnosis of dementia (including Alzheimer's disease or a related disorder) are not subject to PASARR (unless they have a concurrent diagnosis of MR). These individuals with dementia will also be detected through this ID screen.

In using these criteria, States are encouraged to develop and to coordinate this screening process with existing State procedures to identify the needs of individuals who have a diagnosis of MI or MR. Because a large proportion of new NF admissions come from hospitals, States may find it practical to have hospitals perform the Level I screening for prospective residents as part of discharge planning. Alternatively, as States determine appropriate, they may elect to have NFs perform the Level I screening on new admissions as well as on their current residents who must be identified for purposes of referral for annual resident review. However the State chooses to design its Level I process, a system must be in place for identifying all individuals with MI or MR so that the required determinations by the State mental health or mental retardation authority can be made.

B. Definitions.--The following definitions of MI, dementia, and MR are applicable for the Level I (ID) process:

1. Mental Illness.--An individual is considered to have MI if he/she has a current primary or secondary diagnosis of a mental disorder (as defined in the Diagnostic and Statistical Manual of Mental Disorders, 3rd Edition (DSM-III-R)) and does not have a primary diagnosis of dementia (including Alzheimer's disease or a related disorder).

2. Dementia.--An individual is considered to have dementia if he/she has a primary diagnosis of dementia (as described in the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition (DSM-III-R). As described in DSM-III-R, diagnostic criteria for dementia include:

(a) Demonstrable evidence of impairment in short- or long-term memory;
(b) At least one of the following:

(1) Impairment of abstract thinking;
(2) Impaired judgment;
(3) Other disturbances of higher cortical function; and
(4) Personality change.

(c) The disturbance in (a) or (b) significantly interferes with work or usual social activities or relationships with others;
(d) Not occurring exclusively during the course of delirium;
(e) Either (1) or (2):

(1) Evidence from the history, physical examination, or laboratory tests, of a specific organic factor that is is judged to be etiologically related to the disturbance; or

(2) In the absence of such evidence, an etiologic organic factor can be presumed if the disturbance cannot be accounted for by any nonorganic mental disorder.

3. Mental Retardation and Related Conditions.--An individual is considered to have MR if he/she has a level of retardation (mild, moderate, severe or profound) as described in the American Association on Mental Deficiency's Manual on Classification in Mental Retardation (1983), page 1:

> Mental Retardation refers to significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period.

The provisions of this section also apply to persons with "related conditions," as defined by 42 CFR 435.1009, which states: "Persons with related conditions" means individuals who have a severe, chronic disability that meets all of the following conditions:

(a) It is attributable to-

(1) Cerebral palsy or epilepsy; or

(2) Any other condition, other than MI, found to be closely related to MR because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with MR, and requires treatment or services similar to those required for these persons.

(b) It is manifested before the person reaches age 22;
(c) It is likely to continue indefinitely; and
(d) It results in substantial functional limitations in three or more of the following areas of major life activity:

(1) Self-care;
(2) Understanding and use of language;
(3) Learning;
(4) Mobility;
(5) Self-direction; and
(6) Capacity for independent living.

Any other condition includes autism. (See §4398.)

C. ID Evaluation Criteria.--The State should assure that the ID screening process is in place for determining whether each resident in and each applicant to a NF has MI or MR. The process must meet the following evaluative criteria.

1. For MI.--The individual has a primary or secondary diagnosis of MI and does not have a primary diagnosis of dementia. (See definitions of MI and dementia in §4250.1B).

Because the statutory definition refers to DSM-III-R, we cannot use a MI definition more limited than one which includes all mental disorders listed in DSM-III-R. Therefore, all individuals having a mental disorder listed in DSM-III-R will have to have the required PASARR determinations made with respect to them.

In determining whether an individual has a primary or secondary diagnosis of MI and does not have a primary diagnosis of dementia, the evaluator should use discretion in reviewing patient data. For example, in determining an individual's diagnosis, the evaluator should look behind the diagnostic labels used in the patient records. When no MI diagnosis is indicated, the evaluator should look to see if there is any presenting evidence of MI, including possible disturbances in orientation, affect, or mood. A recent (within the last 2 years) history of MI, if known, should also serve as a clue to the evaluator that he or she should investigate further to see whether the MI is, in fact, a current primary or secondary problem. On the other hand, when evidence of current nonpsychiatric primary and secondary problems is clearly present, an individual should not be labeled MI and be needlessly put through the Level II determination process simply as a result of a past MI. The evaluator should also consider the prescription of a major tranquilizer or psychoactive drug on a regular basis in the absence of a justifiable neurological disorder as an indication that further screening is advisable to uncover masked symptoms. Again, however, such medications may be properly used for patients without a mental disorder; and evidence of drug use need not be taken as an indication that further review is needed when there is a medical justification for its use that is not in connection with a mental disorder.

Because dementias are sometimes misdiagnosed as MI (or vice-versa), the evaluator should examine the charts of individuals diagnosed as having MI or suffering from dementia for the possibility of a misdiagnosis. A diagnosis of dementia should be supported by positive evidence from a thorough mental status examination which focuses especially on cognitive functioning and which is performed in the context of a complete neurological or neuro-psychiatric examination. A neurological examination on its own may corroborate a diagnosis of dementia but is not determinative.

2. For MR or Persons With Related Conditions.--The individual has a diagnosis of MR. (See definition of MR in 4250.1B.)

In evaluating whether an individual has a diagnosis of MR, the person performing the Level I (ID) should investigate whether there is any history of MR or developmental disability in the individual's past. The evaluator should also look for any presenting evidence (cognitive or behavioral functions) that may indicate that the person has MR or developmental disability. Referral by an agency which serves persons with MR (or other developmental disabilities) and which has deemed the individual to be eligible for that agency's services should also be an indication that a State (PASARR) determination is needed.

D. ID Determination Criteria.--The findings of the ID evaluation and interpretation should be used in making a determination as to whether or not the individual has (or is suspected of having) MR or MI and, if so, should be subjected to a Level II (PASARR) screening. There are three possibilities:

1. Criterion - IS MI/MR.--Any individual for whom there is a positive response to the evaluation criteria described in §4250.1C, must not be admitted to or allowed to continue to reside in a Medicaid-certified NF without being determined appropriate for nursing facility placement through the Level II (PASARR) process.

2. Criterion - Dementia.--Individuals who are found to have a primary diagnosis of dementia (including Alzheimer's disease or a related disorder) as defined in §4250.1B, as a result of the evaluation criteria described in §4250.1C, are not subject to the Level II (PASARR) process for admission to or continued residence in a Medicaid-certified NF, unless they are also MR.

o Explanation: Section 1919(b)(3)(f)(i) and (e)(7)(G)(i) exclude persons with a primary diagnosis of dementia (including Alzheimer's disease or a related disorder) in defining individuals considered to have MI. This exclusion, however, does not apply to individuals with a primary diagnosis of dementia and a secondary diagnosis of MR because the definition of MR in the statute simply refers to a diagnosis of MR and makes no mention of an exclusion for dementia.

3. Criterion - IS NOT MI/MR.--Any individual for whom there is a negative response to all ID evaluative criteria for MR or MI and for whom there is no other evidence of a condition of MI or MR may be admitted or continue to reside in a Medicaid-certified NF without being subjected to a review and determination through the Level II (PASARR) process.

E. Recording Determinations.--There should be a record of the ID determination and the evaluation and interpretation upon which the determination was based in the nursing facility resident's record.

4250.2 Level II - Preadmission Screening and Annual Review (PASARR) for Individuals with MR or MI.--

A. Purpose.--The purpose of the PASARR process is to determine: (1) in the case of each nursing facility applicant with MI or MR, whether the applicant requires the level of services provided by a NF, and (2) in the case of NF resident, whether the resident requires the the level of services provided by a NF or an intermediate care facility for the mentally retarded (ICF/MR), inpatient psychiatric hospital for persons under 21, or an institution for mental diseases (IMD) for individuals 65 and older. For applicants with MR or MI who are found to require the level of services provided by a NF and for all current residents with MR or MI, a second determination must also be made as to whether or not the resident requires active treatment.

As noted in §4250 of this manual, responsibility for Level II (PASARR) determinations rests with the State mental health and State mental retardation authorities although we have been advised that they may delegate the screenings or perform them directly. In the case of individuals with MI, the evaluation phase of Level II must be delegated/contracted to a person or entity independent of the State mental health authority.

Also as noted in §4250 of this manual, we intend to specify in forthcoming regulations that preadmission screenings and determinations must be performed timely in order to prevent unnecessary extensions of inpatient hospital stays or inappropriate delays in providing needed services to individuals with MI or MR while they await screening by the State.

These required determinations only address the appropriateness of placement and the need for services, not the provision of services. Even though §1919(e)(7)(B), which describes the determinations which must be made, refers only to institutional settings, it does not preclude alternative placements. Section 1919(e)(7)(C), lists the choices that must be offered to residents who have resided in a NF for 30 months or more and who are found not to need a NF level of services but to require active treatment. This section clearly envisions the possibility of alternative placement in noninstitutional settings. For those residents who have resided in a NF for less than 30 months and are found to require only active treatment, some other placement (whether institutional or community-based) must be arranged. As noted in §4250, we believe that determinations as to appropriate placement for current or prospective residents who have MR or MI are not governed by the availability of placement alternatives.

B. Definitions.--The following definitions and discussions may assist States in making Level II determinations.

1. Active Treatment.--A continuous program for each client with MR or MI which includes aggressive, consistent implementation of a program of specialized and generic training, specific therapies or treatments, activities, health services and related services, as identified in an individualized plan of care, which has the following characteristics:

- For individuals with MI, the plan must be developed under and supervised by a physician. The prescribed components of the individualized active treatment program must be provided by a physician or other qualified mental health professionals.

- For individuals with MR, the individual program plan must be developed and supervised by an interdisciplinary team that represents areas that are relevant to identifying the client§s needs and to designing programs that meet the client’s needs.

The purpose of the active treatment is--

- For individuals with MR, to direct them toward the acquisition of the behaviors necessary for the client to function with as much self-determination and independence as possible; to prevent or decelerate regression or loss of current optimal functional status.

- For persons with MI who are experiencing an acute episode of severe MI which necessitates 24-hour supervision by trained mental health personnel, to diagnose or reduce the recipient's psychotic or neurotic symptoms which necessitated institutionalization, to improve his/her level of functioning and, whenever possible, to achieve the recipient's discharge from inpatient status at the earliest possible time.

Active treatment for a persons with MR does not include services to maintain generally independent clients who are able to function with little supervision or in the absence of a continuous active treatment program. For persons with MI, active treatment does not include intermittent psychiatric services to clients who do not require 24-hour supervision by trained mental health personnel. For both groups, the term active treatment does not include, in the case of a resident of a NF (including residents with MI or MR who are determined to require the level of care provided by a NF), services the facility must provide or arrange for its residents under §1919(b)(4) of the Act (though some of these services clearly would become an integral part of an active treatment regimen if one were required).

Persons with MR or MI who need active treatment should be considered for placement in facilities which most appropriately suit the level of services they need. While NF placement is not prohibited, settings such as an IMD, an inpatient psychiatric hospital, an ICF/MR, or an appropriately supervised community setting must also be considered.

NOTE: Currently we have separate Medicaid definitions for active treatment in the ICF/MR and the psych under 21 contexts (42 CFR §§435.1009 and 483.440 for the ICF/MR benefit and 441.154 for the psych under 21 benefit). Active treatment is also required to be provided in psychiatric hospitals under Medicare. In forthcoming regulations we will need to establish a generic definition or descriptive statement about active treatment because the statute clearly excludes active treatment from NF services. As a result, someone who requires active treatment while in a NF requires something the NF usually would not provide and which the statute considers to be distinct from NF services. Until such time as regulations are promulgated, the above given definition is advisory.

We believe that active treatment is a concept which embraces a wide range of services and involves a complex set of competent interactions among the facility's staff and between the staff and the resident. While some components of an active treatment program may be identified as NF services, other components are services which are more

specialized than those which a NF usually provides. Active treatment, however, is not simply a collection of disparate services: it is a concept that embraces the whole range of services a patient needs. The total effect of active treatment is that the individual components are integrated and directed toward achieving the goals established in each individual resident's plan of care.

The need for integration of services may be best illustrated by specific example. If the plan of care for a particular resident contains a program to modify a certain behavior, every staff member in the facility who interacts with that resident during a 24-hour period must be aware of that program and skilled in implementing it so that he or she can appropriately deal with the undesirable behavior whenever it is manifested and can consistently reinforce the new behavior. It would do the resident with MR or MI little good to have only the psychologist who designed the program and who spends only a fraction of the day with the resident versed in administering the program.

It should be noted that individuals who need mental health services and who are admitted to or retained in a NF must receive them whether or not the State determines they constitute "active treatment" or are of a lesser intensity.

2. Appropriate Placement.--Placement of an individual in a NF may be considered "appropriate" when the individual's needs are such that he/she meets the minimum standards for admission and the individual's needs for treatment do not exceed the level of services which the facility is capable of providing.

NOTE: As stipulated by §1919(e)(7), the first question which must be answered concerning an applicant to or a resident of a NF is whether or not he/she needs the level of services provided by a NF. Section 1919(a)(1) defines a NF as "An institution . . . which is primarily engaged in providing to residents: (1) skilled nursing services . . .; (2) rehabilitation services . . .; or (3) on a regular basis, health-related care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities." In other words, an individual requiring health-related care and services above the level of room and board could be considered to meet this definition.

If meeting the minimum criterion for entrance or residence were the only consideration, few individuals in need of some type of supervision would fail to qualify for NF level of services. However, both the old and new regulations relating to long-term care facilities require that a facility be capable of meeting the total needs of any individual which it admits or retains (the existing regulations are at 42 CFR 442.306 while the new regulations are at 42 CFR 483.25). We also believe that the intent of Congress was both to ensure placement of individuals with MR or MI where their total needs would be best served as well and to provide active treatment to those individuals with MR and MI for whom NF placement is appropriate, either because they have medical

needs, as identified by a prioritized needs assessment, which, despite the need for active treatment, require a NF level of services, or because they fall into the group of long-term residents to whom Congress allowed the choice of staying in the NF even though they do not need the NF level of services but do need active treatment.

Because the provision of active treatment requires a high degree of cross-disciplinary competence for staff to interact with each of these individuals with MR or MI around the clock, as needed, it continues to be our experience that long-term care facilities which are not organized to meet the unique needs of the population with MR or MI exclusively cannot readily provide continuous active treatment. Some NFs, however, may need to develop this capability to meet the active treatment needs of individuals with MR or MI. This may be possible if they were to do so with increased staffing and funding, by the State or some other source. The specialized facilities which normally provide active treatment, such as ICFs/MR and psychiatric hospitals, are equipped, staffed, and funded on an enriched basis so that they can provide it. Since the statute clearly envisions that active treatment can and must be provided in NFs under some circumstances, increased funding will, in most cases, be required to enable the facility to provide the specialized services that these residents with MR or MI need. The statute also clearly distinguishes active treatment from NF services and indicates that FFP cannot be made available for active treatment as NF services.

Although Medicaid payment may not be made for active treatment services as NF services, States may use other Medicaid benefits to fund aspects of active treatment programs for individuals with MI or MR who are in a NF. For example, services provided in the context of the rehabilitation services, clinic services, or physical, occupational, or speech therapy services optional benefits might be used to meet some of the more discrete services required by the resident's active treatment program if these optional services are available under the State plan or the State wishes to add them (subject to the amount, duration and scope and comparability requirements listed in 42 CFR 440, subpart B). Similarly, in providing active treatment for short-term residents who are determined to be inappropriate for continued residence in a NF, the States could use other optional Medicaid services such as case management or personal care services to coordinate some components of an active treatment program or to provide the support services needed for community placement. However, the package of services comprising an active treatment program is not able to be funded as "active treatment" and, as noted above, aspects of the package that fall outside the scope of established Medicaid benefits may not be eligible for FFP.

States should bear in mind that for any individuals with MR or MI who are permitted to enter or allowed to stay in a NF (whether under the PASARR process or by failure to be subjected to PASARR) and who need active treatment:

o FFP will not be available for active treatment services which are billed as NF services; and

o facilities will be held responsible for provision of all services which the resident needs (including active treatment needs) through the State's survey and certification processes and Federal oversight surveys.

C. PASARR Evaluation Criteria.--Each State's mental health authority and mental retardation authority should assure that a PASARR evaluation process is established that meets the following criteria:

o PASARR should be adapted to the cultural background, language, ethnic origin and means of communication used by the person.

o PASARR programs should contain the minimum Federal evaluative criteria included in:

-- PASARR/NF - Minimum criteria for determining level of nursing care service needs for individuals with MI or MR. (See §4251.);

-- PASARR/MI - Minimum criteria for determining active treatment needs for individuals with MI. (See §4252.);

-- PASARR/MR - Minimum criteria for determining active treatment needs for individuals with MR. (See §4253);

-- PASARR/MI/MR - Minimum criteria for determining active treatment needs for individuals with a dual diagnosis of MI and MR. (See §§4252-4253.)

o Information that is necessary for determining whether it is appropriate for the individual with MI or MR to be placed in a NF or in another appropriate residential and program setting (if a NF resident) should be gathered throughout all applicable portions of the PASARR evaluation. (See discussion on interrelatedness of the three instruments in §4251).

o Current and relevant assessment information obtained prior to the initiation of the PASARR may be used (e.g., prior evaluations of mental and physical status) if this assessment information is considered to be valid and accurate.

o As appropriate for individuals with MR or MI, PASARR findings should be:

-- accurate and correspond to the person's current functional status;

-- descriptive (i.e., the presence of diagnosis, numerical test scores, intelligence quotients, developmental levels, etc., in the absence of specific statements which interpret what the diagnosis, scores, quotients, and levels mean in terms of the person's functional status should not be acceptable); and

-- interpreted to the person (or a designated legal representative of the person if he/she is incapable of understanding the PASARR findings), to the family, and to the parent or legal guardian of a minor person, if available.

o The results of the PASARR evaluation should be described in a report which includes:

-- identification of the name and professional title of the person(s) performing the evaluation(s) and the date on which each portion of the evaluations or assessments was administered;

-- a summary of the person's positive traits or developmental strengths and weaknesses or developmental needs; and

-- if active treatment is needed, identification of the MR and/or mental health services required to meet the person's identified active treatment needs, regardless of the availability of those services.

o Findings from this evaluation should be used by the State mental health or mental retardation authorities in making the required determinations about whether the individual with MI or MR requires the level of services provided by a NF and whether active treatment is needed.

o If a determination is made to permit admission of an individual who requires active treatment, the determination should be supported by specific findings that the NF to which the individual is to be admitted can meet the active treatment needs he or she has.

o The PASARR process should be stopped if at any time during the PASARR it is found that the individual does not have MI or MR or that he/she has a primary diagnosis of dementia (including Alzheimer's disease or a related disorder) and does not have a diagnosis of MR or a related condition.

D. PASARR Determination Criteria.--The relevant statutory provisions require determinations, based on the preadmission screening or annual review evaluation findings, as follows:

1. Can be Admitted to a NF.--Any individual with MR or MI who requires the level of services provided by a NF, whether or not he/she also requires active treatment, can be admitted, if appropriate. (See definition of appropriate placement in §4250.2B for this and all following classifications.) If active treatment is also required, these services will have to be provided in addition to the nursing facility services. These active treatment services will have to be provided largely at other than Federal expense.

2. Cannot be Admitted to a NF.--Any individual with MR or MI who does not require the level of services provided by a NF, regardless of whether or not he/she needs active treatment, should be considered inappropriate for placement and cannot be admitted. (The PASARR/MR and/or PASARR/MI portions of the evaluation which investigate the need for active treatment do not have to be done for this group if NF care is not needed.)

3. Can be Considered Appropriate for Continued Placement in a NF.--Any resident with MR or MI who requires the level of services provided by a NF, regardless of the length of his/her previous stay or whether he/she needs active treatment, can continue to reside there, if appropriate. If active treatment is also required, these services will have to be provided in addition to the NF services. These active treatment services will have to be provided largely at other than Federal expense.

4. May Choose to Remain in the NF Even Though Placement Would Otherwise be Considered Inappropriate.--Any resident with MR or MI who does not require the level of services provided by a NF but does require active treatment and who has resided in a NF at least 30 months may choose to continue to reside in the facility or he/she may choose to receive covered services in an alternative appropriate institutional or noninstitutional setting. Wherever the individual chooses to reside, he/she must be provided with the active treatment services which he/she needs, largely at other than Federal expense. If the resident chooses to stay in the NF, FFP will be available for the NF level of services.

5. Cannot be Considered Appropriate for Continued Placement and Must be Discharged (Short-Term Residents).--Any resident with MR or MI who does not require the level of services provided by a NF but does require active treatment and who has resided in the facility less than 30 months must be discharged in accordance with the transfer and discharge requirements of §1919(c)(2). Active treatment services must be provided by the State to the individual in an alternative setting, largely at other than Federal expense.

6. Cannot be Considered Appropriate for Continued Placement in a NF and Must be Discharged (Long-Term Residents).--Any resident with MR or MI, even though he/she has resided in the NF for 30 months or more, who requires neither NF level of services nor active treatment must be discharged in accordance with the requirements of §1919(c)(2).

The decision trees for the preadmission screening (PAS) and annual resident review (ARR) processes, which are presented on the following page, diagram these statutory placement determinations.

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4251. MINIMUM EVALUATION CRITERIA SPECIFIC TO SCREENING PERSONS WITH MR OR MI FOR THE NEED FOR NF LEVEL OF SERVICES - (PASARR/NF)

The purpose of the PASARR/NF process should be to determine, as a result of a review of the data obtained, whether or not the person with MR or MI, because of his/her physical and mental condition, needs the level of services provided by a NF. (See the definition of "appropriate placement" in §4250.2.)

DATA COMPILATION

The PASARR/NF instrument should assess whether the individual's total needs are such that they can only be met on an institutional basis and, if so, whether the NF is the appropriate institutional setting for meeting those needs. At a minimum the PASARR/NF instrument should include:

- o evaluation of physical status;
  - -- diagnoses;
  - -- date of onset;
  - -- medical history; and
  - -- prognosis.

- o evaluation of mental status; and
  - -- diagnoses;
  - -- date of onset;
  - -- medical history;
  - -- medical history; and
  - -- prognosis.

- o functional assessment (Activities of Daily Living).

DATA INTERPRETATION

The data interpretation phase of the PASARR/NF should attempt to prioritize the residents physical and mental needs and assess the severity of each condition. While the PASARR/MR and PASARR/MI portions of Level II will specifically address the individual's need for active treatment, the presence of certain diagnoses or prognoses under the physical and mental evaluations should serve as indicators during the PASARR/NF process that NF placement is or is not appropriate.

The PASARR/NF and PASARR/MI and/or PASARR/MI processes, while being separate instruments with separate purposes, should not be considered to be mutually exclusive determination processes and should not be conducted in isolation of each other (if both determinations as to placement and active treatment are required). The PASARR process taken as a whole should lead to placement decisions which make sense both by providing individuals who need active treatment with these services and by allowing for delivery of

needed services in the most logical and cost effective manner through specialization (except for the long-term residents who are allowed to stay in NFs). Establishing a hierarchy of patient needs is essential to the placement process. For example, a secondary need for active treatment should not preclude admission or residence in a NF if there is a medical need which requires intensive skilled nursing interventions and the NF is capable of adequately meeting the individual's active treatment needs. Nor should a primary need for a rigorous course of active treatment, which is of such an intensity that it can only be provided in a specialized facility, be subordinated to lesser physical needs which could be met in a NF but could also be served as adequately in a specialized inpatient setting such as an ICF/MR, a psychiatric hospital, or an IMD as they could be dealt with in a NF.

In evaluating the data concerning a client's mental status, the evaluator should bear in mind that not all mental disorders described in DSM-III-R will require active treatment. DSM-III-R describes eight diagnoses under Axis I which, by definition, presents psychiatric diagnoses. Axis II presents patterns of personality defenses and/or developmental problems that one brings to a situation. Axis II diagnoses are not clinical syndromes. When a psychiatric diagnosis is assigned, Axis I represents the clinical syndrome, and Axis II represents those things that should be kept in mind while dealing with the Axis I diagnosis. Many psychiatrists do not consider the Axis II items to be mental illnesses at all.

We believe that minor mental disorders, such as Axis II diagnoses on their own, which do not require active treatment, should not keep people out of NFs. We believe that the determinations as to MI a State is required to make need not all be made with respect to specific individuals. A State could, for example, formally determine that certain minor psychiatric diagnoses such as nail-biting, tobacco abuse (smoking), mild depression, inhibited sexual desire, or hypochondriasis are diagnoses for which active treatment is not needed and that individuals who have these diagnoses are not in need of active treatment. If a State did this, individuals with such diagnoses who need NF care could be admitted to NFs without the need for a further specific individual determination by the State mental health authority as to the need for active treatment.

The State could presumably also determine that certain diagnoses always warrant active treatment and indicate that individuals evidencing these latter diagnoses should always be subjected to an individual PASARR/MI evaluation and determination as to the need for active treatment. We will consider whether to specify in regulations conditions such as the five major mental illnesses on Axis I which require active treatment (i.e., schizophrenic, paranoid, major affective, schizoaffective disorders and atypical psychosis) for which individual screening would always be needed.

The State could also make categorical determinations that certain mental conditions would normally require active treatment services of such an intensity that most, although not all, NFs would be incapable of meeting these needs. In such cases, a more specialized care setting would be the more appropriate placement; and the plan of care in that facility would have to address the totality of the resident's physical and mental needs.

The State should recognize, however, that all DSM-III-R mental illnesses are mental illnesses under any approvable screening system and require determinations, either categorically or individually. All Level II determinations, regardless of how they are arrived at, must be recorded in the resident's record.

Just as the State may make certain advance categorical determinations concerning diagnoses which will or will not require active treatment, the State may also make categorical determinations under Level II concerning certain physical conditions which would normally indicate that the individual would require NF level of services. For example, the State could specify that the presence of certain physical conditions such as terminal illness, convalescence from an acute physical illness, or severe illness (i.e. conditions such as comatose, ventilator dependent, or functioning at a brain stem level; or diagnoses such as chronic obstructive pulmonary disease, Parkinson's disease, Huntington's disease, amyotrophic lateral sclerosis, congestive heart failure, or similarly debilitating physical illnesses) normally would require NF level of services. Screening to determine active treatment needs for individuals in these physical need groups (through the PASARR/MI or PASARR/MR components of Level II) should not, however, be categorically waived. To the extent that the resident falling into one of these categories could also benefit from active treatment services while in the NF, these secondary active treatment needs would also have to be met; and the plan of care would need to address all the resident's needs.

There are also cases in which the patient's condition upon screening is such that a definitive determination for placement purposes cannot be made. For example, many individuals with delirium arising as a result of treatment provided during a prior hospital stay may or may not have a diagnosis of mental illness or mental retardation which could affect a placement decision. A State may approve provisional admissions and subsequent reassessment where such cases make an effective preadmission determination impossible and the individual is manageable in the NF setting.

The State could also make an advance determination that individuals "of advanced years" who need both NF level of services and active treatment and who are not a danger to themselves or others may be allowed to decline active treatment in a NF. A decision to provide the resident an option to forego active treatment is left open as to age because some elderly persons with MI or MR can benefit greatly from continued active treatment services. Such a decision should, therefore, be made by the client or his/her representative in consultation with his/her caregivers.

States should note that the "advanced years" option can only apply as a practical matter to individuals with concomitant NF needs. The statute accords long-term residents with MI or MR (those who have resided in a facility for 30 months or more) who do not need NF level of services but do need active treatment the choice of remaining in the NF to receive it. Because the need for active treatment is the only qualifying reason for a continued stay, we believe that individuals in this group should not have an unqualified option of declining active treatment. If a resident in this group were to decline active

treatment, he/she would require no needed services. The resident should understand that if he/she refuses active treatment, the facility would have grounds for discharge since none of the resident's needs require NF care. Most elderly residents with MI or MR, however, are likely to have some need for NF level of services in addition to a need for active treatment and, therefore, would have a choice if the State elected to offer this option.

Finally, a State could make an advance determination with respect to very short stays, for example, for respite purposes or in order to permit alternative arrangements for longer term care to be made that NF care is appropriate. In such cases, as in all others, appropriate treatment would need to be provided during the person's stay in the NF.

4252. MINIMUM CRITERIA SPECIFIC TO THE SCREENING OF PERSONS WITH MI - (PASARR/MI)

The purpose of the PASARR/MI process should be to determine, as a result of the data obtained, whether or not the person with MI needs the implementation of an active treatment program for mental illness.

DATA COMPILATION

A. The PASARR/MI process should include a comprehensive history and physical examination of the person. At a minimum, the examination must address the following areas (if not previously addressed):

- o complete medical history;
- o review of all body systems;
- o specific evaluation of the person's neurological system in the areas of:
  - -- motor functioning;
  - -- sensory functioning;
  - -- gait;
  - -- deep tendon reflexes;
  - -- cranial nerves; and
  - -- abnormal reflexes.
- o In case of abnormal findings which are the basis for a NF placement, additional evaluations should be conducted by appropriate specialists; and
- o If the history and physical examination of the PASARR/MI process are not performed by a physician, then a physician's review and concurrence with the conclusions should be required.

B. The PASARR/MI process should provide a comprehensive drug history of all current or immediate past utilization of medications that could mask symptoms or mimic MI.

C. The PASARR/MI process should include a psychosocial evaluation of the person. At a minimum, this should include an evaluation of the following:

- current living arrangements;
- medical and support systems; and
- If the psychosocial evaluation is not conducted by a social worker, then a social worker's review and concurrence with the conclusions should be required.

D. The PASARR/MI process should include a comprehensive psychiatric evaluation. At a minimum, this evaluation should address the following areas:

- complete psychiatric history;
- evaluation of intellectual functioning, memory functioning, and orientation;
- description of current attitudes and overt behaviors;
- affect;
- suicidal/homicidal ideation;
- degree of reality testing (presence and content of delusions) and hallucinations; and
- If the psychiatric evaluation is not performed by a physician, then a board-certified psychiatrist's review and concurrence with the conclusions should be required.

E. The PASARR/MI process should include a functional assessment of the individual's ability to engage in activities of daily living and the level of support which would be needed to assist the individual to perform these activities while living in the community. The assessment should determine whether this level of support can be provided to the individual in an alternative community setting or whether the level of support needed is such that NF placement is required. At a minimum, this evaluation should address the following areas:

- self-monitoring of health status;
- self-administering and/or scheduling of medical treatments, including medication compliance;
- self-monitoring of nutritional status;
- handling money;
- dressing appropriately; and
- grooming.

DATA INTERPRETATION

The PASARR/MI process should insure that, based on the data compiled, a board-certified psychiatrist validates the diagnosis of MI and determines whether a program of psychiatric active treatment is needed.

4253. MINIMUM CRITERIA SPECIFIC TO THE SCREENING FOR PERSONS WITH MR (PASARR/MR)

The purpose of the PASARR/MR process should be to determine, as a result of the data obtained in this section, whether or not the person with MR or a related condition needs the implementation of a continuous active treatment program, as defined at 42 CFR 435.1009, "Active Treatment in Intermediate Care Facilities for the Mentally Retarded."

DATA COMPILATION

A. The PASARR/MR process should review the individual's comprehensive history and physical examination results so that the following minimum information can be identified:

- o a list of the individual's medical problems;
- o the level of impact these problems have on the individual's independent functioning;
- o a list of all current medications used by the individual; and
- o current response of the individual to any prescribed medications in the following drug groups:

  - -- hypnotics;
  - -- antipsychotics (neuroleptics);
  - -- mood stabilizers and antidepressants;
  - -- antianxiety-sedative agents; and
  - -- anti-Parkinsonian agents.

B. The PASARR/MR process should assess:

- o self-monitoring of health status;
- o self-administering and/or scheduling of medical treatments; and
- o self-monitoring of nutritional status.

C. The PASARR/MR process should assess:

- o self-help development (such as toileting, dressing, grooming, and eating);
- o sensorimotor development (such as ambulation, positioning, transfer skills, gross motor dexterity, visual motor/perception, fine motor dexterity, eye-hand coordination, and extent to which prosthetic, orthotic, corrective or mechanical supportive devices can improve the individual's functional capacity);
- o speech and language (communication) development (such as expressive language (verbal and nonverbal), receptive language (verbal and nonverbal), extent to which nonoral communication systems can improve the individual's function capacity, auditory functioning, and extent to which amplification devices (e.g., hearing aid) or a program of amplification can improve the individual's functional capacity);

- social development, such as interpersonal skills, recreation-leisure skills, and relationships with others;
- academic/educational development, including functional learning skills;
- independent living development (such as meal preparation, budgeting and personal finances, survival skills, mobility skills (orientation to the neighborhood, town, city), laundry, housekeeping, shopping, bedmaking, care of clothing, and orientation skills (for individuals with visual impairments);
- vocational development, including present vocational skills;
- affective development (such as interests, and skills involved with expressing emotions, making judgments, and making independent decisions); and
- presence of identifiable maladaptive or inappropriate behaviors of the individual based on systematic observation (including, but not limited to, the frequency and intensity of identfied maladaptive or inappropriate behaviors).

DATA INTERPRETATION

D. The PASARR/MR process should insure that a psychologist who meets the qualifications of a Qualified Mental Retardation Professional, as defined in 42 CFR 483.430(a):

- identifies the individual's intellectual functioning measurement; and
- validates that the individual has MR or is a person with a related condition.

E. The PASARR/MR process should review the data collected from this section and identify to what extent the person's status compares with each of the following characteristics commonly associated with a need for active treatment:

- inability to take care of most personal care needs;
- inability to understand simple commands;
- inability to communicate basic needs and wants;
- inability to be employed at a productive wage level without systematic long-term supervision or support;
- inability to learn new skills without aggressive and consistent training;
- inability to apply skills learned in a training situation to other environments or settings without aggressive and consistent training;
- inability to demonstrate behavior appropriate to the time, situation or place without direct supervision;
- demonstration of severe maladaptive behavior(s) which place the person or others in jeopardy to health and safety;
- inability or extreme difficulty in making decisions requiring informed consent; and
- presence of other skill deficits or specialized training needs which necessitates the availability of trained MR personnel, 24 hours per day, to teach the person functional skills.

4395. INAPPROPRIATE PLACEMENT OF MENTALLY RETARDED PERSONS IN SNFs AND ICFs.

It has been estimated that up to 10 percent of the residents of SNFs and ICFs are mentally retarded persons. The appropriateness of many of these placements has been challenged by groups who represent these individuals. These groups are concerned that as a result of inappropriate placement many retarded persons in general care facilities are not receiving the developmental services they need.

Inappropriate placement may result from inadequate evaluation, incorrect diagnosis, or lack of needed programs or facilities. When inappropriate placements continue to be made because of the absence of suitable alternative care, this removes much of the incentive to develop those alternatives. These problems have been compounded by pressures to deinstitutionalize the residents of large facilities. The developmental needs of mentally retarded persons place a particularly compelling responsibility on the facilities, inspection of care teams, and facility surveyors to assure that the placement of these individuals is appropriate and that needed services are, in fact, delivered.

This section emphasizes the need for appropriate placement to satisfy the developmental needs of mentally retarded individuals. If the primary need of a mentally retarded person is active treatment for his/her retardation, then the person should be placed in an ICF/MR. Chronically handicapped persons who are stable but who have severe disabilities have sometimes been placed in nursing homes not because their conditions preclude them from living in another environment but because continued coverage under Medicaid is sought.

Only a small percentage of mentally retarded persons would appropriately be placed in SNFs. This group would include those individuals whose physical condition requires skilled medical care on an inpatient basis that cannot be provided in an ICF/MR or other type of facility or home. It should be stressed that even when the primary needs of retarded persons in SNFs are medical, their developmental needs must still be met by the facility to the extent allowed by the individual's overall physical condition. In most cases, however, if their medical needs are so great that SNF care is required, the patients will not generally be well enough to receive a typical program of a wide spectrum of developmental training, especially if it is provided outside the facility. In such cases, the facility must still aggressively pursue those areas of intervention needed, (e.g., gustatory stimulation, range of motion, toilet training as possible). A patient well enough to attend outside training would nearly always be well enough to be placed in an ICF/MR or other appropriate setting. 42 CFR 456.609 indicates that the inspection of care team must determine whether the services available in the facility promote the patient's maximum physical, mental, and psychosocial functioning. If retarded residents are not receiving the care described above, this requirement would result in a negative inspection of care finding. Continued general acceptance of the inappropriate placement of retarded persons in nursing homes is unacceptable.

Another small group that may appropriately be placed in a general care facility would include those mentally retarded persons of advanced age for whom developmental training is no longer appropriate. These persons may appropriately be placed in an ICF if institutional care is required. This decision must be made on an individual basis rather than at an arbitrary age because some elderly retarded persons benefit greatly from continued developmental services.

Providers should be aware that failure to comply with the above mentioned regulation governing the appropriate placement of mentally retarded persons in SNFs and ICFs could affect Federal reimbursement. Utilization Review is a State plan requirement and disallowance of payment may be made to correct this problem; inappropriate placement may also jeopardize the "approved" status of a State plan. Section 2363 of the Deficit Reduction Act of 1984 (Public Law 98-369) has altered the requirements relating to UC penalties and has made some items previously subject to UC penalties (i.e., certification and recertification of the need for care, plan of care, and utilization review) State plan requirements not subject to the penalties. However, these requirements may still be the subject of disallowances. Utilization Control penalties are also still in place under the Inspection of Care provision and such penalties may be imposed where findings of inappropriate placements have been cited and not corrected.

4396. APPLICATION OF THE EDUCATIONAL SERVICES EXCLUSION IN ICFs/MR.

A. Background.--Medicaid payment may be made only for "medical assistance" and not for the services covered as educational services under Public Law 94-142 (The Education of the Handicapped Children Act of 1975). ICF/MR services must be distinguished from "educational services" because FFP is not available for "educational services." The regulatory educational services exclusion in 42 CFR 441.13(b) that relates to individuals in ICFs/MR was intended to avoid Medicaid expenditures for categories of services funded by the States exclusively or through other funding sources as well as to preclude payment for services which are not health-related.

B. Guidelines for use in Distinguishing Educational Services.--Problems that have arisen in connection with the application of the exclusion have been the result of an attempt to make the distinction between ICF/MR services and education services solely on the basis of the nature of the services, that is, to determine which services are always educational and which services are always ICF/MR services. For the reasons discussed below, this method is of limited usefulness and must be supplemented with other criteria for making the determination.

The basic approach to determining whether services provided to individuals under age 22 are educational services or are ICF/MR services is to know what is required under the State and Federal laws governing education and the contents of the Individualized Education Plan (IEP) for each individual. Services which are required under education laws will not be reimbursed under Medicaid. Public Law 94-142 made Federal education funds available only to States which have a State plan under which each handicapped child under age 22 is assured of a free and appropriate public education suited to his or her needs. It also required that the course of education for the child be described in an IEP. State education laws or constitutional provisions establish additional provisions beyond those of Public Law 94-142 and its implementing regulations. These sources spell out the minimum requirements for a free and appropriate public education and define "Special Education" (34 CFR 300.14) and "Related Services" (34 CFR 300.13) in connection with these requirements. "Special Education" includes, for example, classroom instruction, instruction in physical education, home instruction, and instruction in hospitals and institutions, speech pathology, or any other related service and also includes vocational education. "Related Services" include transportation and such developmental, corrective and other supportive services as are required to assist a handicapped child to benefit from special education, and includes speech pathology and audiology, psychological services,

physical and occupational therapy, recreation, early identification and assessment of disabilities in children, counseling services, and medical services for diagnostic or evaluation purposes. It also includes school health services, social work services in schools, and parent counseling and training. Both Public Law 94-142 and the regulations make it clear that these services must be provided under an IEP and the regulations contain minimum requirements as to the contents and scope of the IEP.

P.L. 94-142 requires the provision of the services which are needed by the student as spelled out in the plan but it does not require that the State, under the rubric of educational requirements, also supply the services of parents or others who ordinarily may be expected to provide care and some types of training for the student during the time when he or she is not in school. In order to distinguish between educational and related services and what may also be appropriate ICF/MR services, it is necessary to view the services both from the perspective of the Federal and State education statutes and from the requirements that relate to ICFs/MR. The simplest example might relate to home activities designed to complement educational activities. During the course of a free and appropriate public education, an individual might receive speech therapy to assist him or her in acquiring communications skills. The cost of providing these services in the school are clearly educational costs and no FFP would be available for them. However, once the individual has returned to the ICF/MR, staff might assist the student with further speech therapy as a Medicaid reimbursable part of the active treatment regimen that the facility is required to plan and provide.

It is important to note that the "active treatment" that an individual in an ICF/MR requires and receives consists not only of the services reimbursed by Medicaid which are provided by the staff of the ICF/MR but often includes services required by the individual that are provided in disparate settings and funded through a variety of sources. The fact that a service is included as part of the individual's "active treatment" does not necessarily mean that FFP is available for it. Other factors, including the liability of another party or organization to pay for the care, must be considered. Thus, it is necessary to go beyond the nature of the services and whether or not ICF/MR standards require their provision to determine whether or not they are subject to the educational services exclusion.

The individual's IEP must describe the types and amounts of educational and related services which will be provided in accordance with State and Federal requirements. The individual treatment plan should reflect how the State is complying with education requirements and the times and locations at which those requirements are being met. All the services described in the IEP are excluded from FFP, whether provided by State employees, by staff of the ICF/MR or by others. FFP is not available for any payment to an ICF/MR for those services required by the IEP. Review of the State and Federal laws and regulations governing the provision of education and related services is needed to assure that the IEP complies with these requirements. Services required under these laws which are not contained in the IEP but are provided by the ICF/MR would also not be eligible for FFP.

For educational services themselves, experience has shown that audits can be clear cut. Educational services are often provided in facilities or areas within an ICF/MR or on its property which are specifically identified for providing these services by or under contract with the State educational agency. The cost of these services, such as salaries,

building depreciation costs, overhead, utilities, etc., would not be eligible for FFP. This would be true even if an individual did not, in fact, receive the services described in the IEP. However, whether or not educational services are provided in a specifically identified facility or area, no FFP is available for education or related services provided to a client during the periods of time the IEP requires that educational and related services be provided.

In reviewing "related services," it is necessary to determine the purpose for which the service is provided and the location where it is provided. Many of the services defined above as "related services" in connection with education services are also services which fall within the realm of "active treatment" and are required to be provided, as needed, by the ICF/MR. For example, a client's IEP might call for a period of training each day to assist him or her in holding a spoon and using it to eat. The cost of this activity would be an educational cost subject to the exclusion. ICF/MR staff may well reinforce and continue the same type of instruction before and after the formal training as part of the individual's program of active treatment. The costs the ICF/MR incurs for this activity would be eligible for FFP.

In States where a free and appropriate public education for individuals under 22 is limited to a part of the year, e.g., 210 days, it may be appropriate for the ICF/MR to provide certain services which could be considered education or related services during periods when the State educational system is not responsible for the individual. An example would be a case in which the State is not responsible to provide speech therapy activities (as a related service under the client's IEP) during the summer but the ICF/MR determined that these services were needed by the individual. The speech therapy services could be provided by the ICF/MR as part of active treatment and would be eligible for FFP.

The educational services exclusion is applicable to services which may not be listed in the IEP, as well as to persons over the age of 22, to whom the requirements of Public Law 94-142 do not apply. For example, some inpatients of ICFs/MR are developmentally disabled but not mentally retarded and it may be that a client who is able to do the work wishes to enroll in academic courses (e.g., community college courses). For persons over the age of 22, educational services would not be eligible for FFP but "related services," as discussed above, would not be excluded.

Because of the many ways that both the education and Medicaid regulations can be interpreted, we are defining educational services not eligible for FFP as those which are:

1. provided in the building, rooms or area designated or used as a school or educational facility; and

2. provided during the specific hours and time periods in which the educational instruction takes place in the normal school day and period of time for these students; and

3. included in the IEP for the specific student or required by Federal and State educational statutes or regulations; and

4. related services provided to a student under 22 years of age.

4397. APPLICATION OF THE VOCATIONAL SERVICES EXCLUSION IN ICFs/MR

The vocational training exclusion flows from two basic interpretations of the Medicaid statute. First, that services paid for under the program must be "medical or remedial" within the meaning of the Act. Second, that Medicaid will not pay for services for which a different State or Federal program is obligated to pay. (See §§1905(a)(6) and 1902(a)(25) of the Act.)

The Vocational Rehabilitation Act (Public Law 93-112) does not mandate the provision of vocational services to all handicapped persons. It authorizes funds for the States to provide a broad spectrum of evaluation, training, job placement, and other work-related services to qualified persons. Historically, many persons with mental retardation living in residential facilities (including ICFs/MR) have been served by vocational rehabilitation programs, but these programs do not include all adult mentally retarded persons in ICFs/MR who are involved in vocational training and work-related programs. Clients living in ICFs/MR often work in off-site vocational rehabilitation programs or worksites. Some clients may work in programs at the ICF/MR that are provided by the facility. Other programs at the facility may be sponsored by the State's vocational rehabilitation unit. Thus, it may not be possible to use the funding source or the location of the services as the sole test of whether the services are vocational training services.

For persons under the age of 22, it will not generally be necessary to distinguish vocational training separately because the education services exclusion also applies to these services (see §4396). Department of Education regulations (34 CFR 300.14) implementing Public Law 94-142 specifically include "vocational education" in their definition of "Special Education." These regulations define vocational education as:

> "…organized educational programs which are directly related to the preparation of individuals for paid or unpaid employment, or for additional preparation for a career requiring other than a baccalaureate or advanced degree."

Thus, for many clients under age 22 the question of whether services may be separately characterized as "vocational training" is resolved when it is determined that the services are education services. If services are provided for under State or Federal education law or regulations or are reflected in the client's Individualized Education Plan, they are not eligible for Federal Financial Participation (FFP). Also, States may not receive FFP if services must be provided pursuant to another State or Federal program.

In the case of clients to whom Federal and State education requirements do not apply (generally those who are over age 21 or, if under 21, have entered the labor force) further distinctions are necessary. In such cases, to determine whether service costs should be excluded under the "vocational training" exclusion, the following principles must be applied:

- No FFP is available if the services are required or funded under a State or Federal vocational training program, whether or not the clients are compensated for the work;

- o If the services are provided by the ICF/MR, no FFP is available when the activity in which the client is engaged is also for the purpose of teaching the client the skills to perform tasks in an employment situation.

The test of whether the purpose would relate to an "employment" situation does not relate solely to a determination about the usefulness of the activity or to whether the client is paid for the work. The test is whether the services are provided with the reasonable expectation that the client would be able to participate in a sheltered workshop or in the general work force within one year. In reviewing the activity program, the compensation level of the client, the nature of the activity, and the level of supervision necessary for the client as well as the programmatic objectives in the plan of care should be considered in making a determination as to the purpose of the program for the particular client.

Determine whether the services being provided are directly related to preparing the client for paid or unpaid employment or are instead provided to increase the overall level of functioning of the individual. For example, a number of services which consist of skills training (sometimes called "prevocational" services) may be aimed at a more general result. These include teaching a client such concepts as compliance, attending, task completion, problem solving, and safety. These services are eligible for FFP for clients over age 21 when provided pursuant to the plan of care unless included under another program funded or required under State or Federal law.

4398. PERSONS WITH RELATED CONDITIONS

A. Background--General.--Section 1905 of the Social Security Act (Act) authorizes optional Medicaid coverage for services in intermediate care facilities (ICFs). Section 1905(d) of the Act indicates that the term "intermediate care facility services" may include services in a public institution for the mentally retarded or "persons with related conditions" (ICF/MR). Private facilities may also participate.

Initial Medicaid regulations published in 1974 defined "persons with related conditions" by using a cross-reference to the definition of developmental disability in the Developmental Disabilities Services and Facilities Construction Act (DDSFCA), Public Law 91-517, enacted on October 30, 1970 (changed to the Developmental Disabilities Assistance and Bill of Rights Act in 1975, (DDABRA)).

B. History of DDABRA Definition.--The 1970 definition of developmental disability included specific diagnoses which were considered to be closely related to mental retardation. The definition read " . . . a disability attributable to mental retardation, cerebral palsy, epilepsy, or another neurological condition of an individual found by the Secretary to be closely related to mental retardation or to require treatment similar to that required for mentally retarded individuals, whose disability originates before such individual attains age 18, which has continued or can be expected to continue indefinitely, and which constitutes a substantial handicap to such individual."

1. Since 1970, the DDABRA definition of developmental disability has been amended. In 1975, Public Law 94-103 amended the definition to:

a. Add autism to the list of specific conditions; dyslexia resulting from a disability otherwise specified in the definition was also added;
b. Expand the reference to "other neurological conditions" to cover any conditions closely related to mental retardation by virtue of a similar impairment or a requirement for similar treatment; and
c. Relate "substantial handicap" to the ability to function normally in society.

2. On October 1, 1978, an amendment to DDABRA, Public Law 95-602 revised the definition of developmental disability even further to read as follows:

"The term §developmental disability' means a severe, chronic disability of a person which--

a. Is attributable to a mental or physical impairment or combination of mental and physical impairments;
b. Is manifested before the person attains age 22;
c. Is likely to continue indefinitely;
d. Results in substantial functional limitations in three or more of the following areas of major life activity:

- o Self-care,
- o Receptive and expressive language,
- o Learning,
- o Mobility,
- o Self-direction.
- o Capacity for independent living, or
- o Economic self-sufficiency.

e. Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated."

The 1978 amendment changed the focus of the definition from a categorical to a functional one. Thus, the revised definition included any mental or physical impairment that limits the person's functional ability in certain activities and no longer included only specific diagnoses that previously had been used to limit the definition to those impairments closely resembling mental retardation.

C. Medicaid Program Effects of Changes.--In 1974, Medicaid regulations were promulgated to implement the ICF/MR benefit under Medicaid. The DDABRA (then DDSFCA) definition of "developmental disability" was adopted for the Medicaid definition of "persons with related conditions" because it seemed to be an appropriate and convenient means of defining the term. However, when all existing Medicaid regulations were recodified, effective October 1, 1978, as part of the Department's initiative to rewrite regulations in a clear, concise, easily understandable format, the cross-reference to DDABRA inadvertently included the words "as amended" after the phrase "Public Law 91-517 enacted on 10/30/70."

This change made the definition inconsistent with other sections of the Medicaid statute. In the paragraph following section 1905(a)(19) the statute clearly excludes Medicaid payment for "any individual who has not attained 65 years of age and who is a patient in an institution for mental diseases" with the exception of individuals under age 21 in psychiatric facilities. Therefore, the statute limits Medicaid payment for inpatient psychiatric care to individuals within specified age groups in specified inpatient settings. These restrictions do not apply to ICFs/MR. Section 1905(c) specifically excludes services in an institution for mental diseases or mental defects from the definition of intermediate care facility services. Furthermore, the definition of intermediate care facility services for the mentally retarded in section 1905(d) of the Act does not include services in an institution for mental diseases.

The DDABRA definition, as amended by Public Law 95-602, caused confusion about the kind of care covered under the ICF/MR benefit.

D. Current Definition.--In May 1986 HCFA established a new definition of "persons with related conditions" at 42 CFR 435.1009. This definition combines many of the features of the 1975 developmental disability definition in the DDABRA with elements of the 1978 definition. In addition, this definition of "related conditions" was designed to:

- o Be consistent with statutory provisions of the Medicaid program;
- o Be independent of the DDABRA definition of developmental disability; and
- o Exclude facilities established for treating mental illness.

The definition in 4435.1009 now reads:

"Persons with related conditions" means individuals who have a severe, chronic disability that meets all of the following conditions:

1. It is attributable to--

   - o Cerebral palsy or epilepsy; or
   - o Any other condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these persons.

2. It is manifested before the person reaches age 22.

3. It is likely to continue indefinitely.

4. It results in substantial functional limitations in three or more of the following areas of major life activity:

   - o Self-care,
   - o Understanding and use of language,
   - o Learning,
   - o Mobility,
   - o Self-direction, or
   - o Capacity for independent living.

E. Discussion.--Although this definition necessarily includes reference to specific individuals for whom this benefit is designed, it is important to recognize that this term is defined in the context of determining what services may qualify as "intermediate care facility services." The focus thus is on the nature of the services which are covered. Conversely, these services would not be covered if the individual did not need the active treatment provided by an ICF/MR. The determination as to who is eligible for ICF/MR care must be based on the need of each individual for ICF/MR services and not merely on the diagnosis of the individual.

The main purpose of the changes made in the definition is to prevent facilities established for the purpose of caring for mentally ill persons from participating in the Medicaid program as ICFs/MR. Such facilities would more appropriately be considered IMDs under the law and services to their inpatients between the ages of 22 and 65 excluded from payment.

Concern has been expressed that the new definition of "persons with related conditions" does not include autism, although this diagnosis had been included in one of the earlier definitions of developmental disability. Autism is a disorder which is developmental in nature and which routinely requires treatment similar to that provided to individuals who have mental retardation and persons with related conditions. In fact, the Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM III), which is universally recognized as authoritative by the medical community, specifically classifies autism as a pervasive developmental disorder. Moreover, the DSM III indicates that only 30 percent of individuals with autism have an I.Q. of 70 or more. Further, current knowledge on the subject of autism indicates that those individuals with autism who have low cognitive ability and those who have high cognitive ability are both dysfunctional and/or retarded because of their disabilities in the areas of communication and socialization, which profoundly interfere with the activities of daily living. Thus, ICF/MR placements for individuals with this disorder are generally appropriate. There is no basis for requiring that dually diagnosed individuals be primarily mentally retarded or have any other primary condition in assessing the need for ICF/MR placement.

Concern has also been expressed that the revised definition could result in institutions solely or primarily devoted to the treatment of autistic individuals being treated as institutions for mental diseases rather than ICFs/MR. This will not be the case. A facility dedicated to the treatment of autistic individuals would appropriately be considered to be an ICF/MR. That is, the nature of the facility would be such that it is for the treatment of mentally retarded persons and persons with related conditions. Once it is participating as an ICF/MR, the treatment of some autistic individuals who are not mentally retarded but who require treatment in that facility would also be appropriate and would qualify for Federal matching funds. Thus, a facility dedicated to the treatment of all autistic individuals, whether or not previously existing, would appropriately be considered an ICF/MR. Autistic beneficiaries are covered under Medicaid and deserve ICF/MR services as appropriate to their needs.

4415. NURSE PRACTITIONER SERVICES

A. Background.--Section 6405 of OBRA 1989 (P.L. 101-239) provides for the availability and accessibility of services furnished by a certified pediatric nurse practitioner (CPNP) or a certified family nurse practitioner (CFNP) to recipients eligible for or receiving Medicaid. Section 6405 amended §1905(a) of the Act. This provision requires that CPNP and CFNP services be covered to the extent that CPNPs and CFNPs are authorized to practice under State law or regulations regardless of whether they are supervised by or associated with a physician or other health care provider. You are also required to offer direct payment to CPNPs and CFNPs as one of your payment options.

B. CPNP Requirements.--A CPNP is a registered professional nurse who must meet the following requirements:

o If your State has specific qualifications for pediatric nurse practitioners, the practitioner must:

- Be currently licensed to practice in the State as a registered professional nurse; and

- Meet the requirements for qualification of pediatric nurse practitioners in the State in which he or she furnishes services.

o If your State does not specify by specialty, qualifications for pediatric nurse practitioners, but does define qualifications for nurses in advance practice or general nurse practitioners, the practitioner must:

- Meet qualifications for nurses in advance practice or general nurse practitioners as defined by your State; and

- Have a pediatric nurse practice limited to providing primary health care to persons less than 21 years of age.

C. CFNP Requirements.--A CFNP is a registered professional nurse who must meet the following requirements:

o If your State has specific qualifications for family nurse practitioners, the practitioner must:

- Be currently licensed to practice in the State as a registered professional nurse; and

- Meet the requirements for qualification of family nurse practitioners in the State in which he or she furnishes services.

o If your State does not specify by specialty, qualifications for family nurse practitioners, but does define qualifications for nurses in advance practice or general nurse practitioners, the practitioner must:

- Meet qualifications for nurses in advance practice or general nurse practitioners as defined by your State; and

- Have a family nurse practice limited to providing primary health care to individuals and families.

D. Nurses in Advance Practice or General Nurse Practitioners.--In some States, State law does not specifically name nurse practitioners according to specialty, but may instead define nurses in advance practice or nurse practitioners. Generally this means the nurse has met advanced practice requirements beyond the 2 to 4 years of basic nursing education required of all registered nurses. In these States, therefore, registered nurses must meet the State requirements for nurses advance practice or general nurse practitioner, have a pediatric nurse practice limited to providing primary health care to persons less than 21 years of age, or a family nurse practice limited to providing primary health care to individuals and families.

E. Coverage of Services.--Your State plan must:

o Provide that CPNP or CFNP services are furnished to the categorically needy, to the extent CPNPs or CFNPs are legally authorized to practice under State law or regulations;

o Specify whether those services are furnished to the medically needy; and

o Provide that CPNPs or CFNPs, regardless of whether their services are furnished under the supervision of, or associated with a physician or other health care provider, may choose to be paid through an independent provider agreement between you and the practitioner or paid through the employing provider.

4420. NURSE-MIDWIFE SERVICES

A. Background.--Section 965 of OBRA 1980 (P.L. 96-499) provided for the availability and accessibility of nurse-midwife services to women eligible for or receiving Medicaid. Section 965 was incorporated into §1905(a)(17) of the Act, with the term "nurse-midwife" defined in §1905(m) of the Act. Section 1905(a)(17) of the Act required that nurse-midwife services be covered to the extent that the nurse-midwife is authorized to practice under State law or regulations. It also required you to offer direct reimbursement to nurse-midwives as one of your payment options. In addition, the definition of a nurse-midwife in §1905(m) of the Act was limited to registered nurses who perform services in the area of management of the care of mothers and babies throughout the maternity cycle. This definition had the effect of limiting nurse-midwife services to those in this area. (Section 1905(m) of the Act no longer defines nurse-midwife for purposes of §1902(a)(17) of the Act. It is now defined by reference to §1891(gg) of the Act, which contains essentially the same definition.)

Section 13605 of OBRA 1993 (P.L. 103-66) expanded the scope of nurse-midwife services to include all nurse-midwife services authorized under State law, whether or not they are performed in the area of management of the care of mothers and babies throughout the maternity cycle.

B. Definition of Services.--Nurse-midwife services include services that nurse-midwives perform within their scope of practice authorized by State law or regulations without regard to whether the services are performed in the area of management of the care of mothers or babies throughout the maternity cycle. The services furnished in managing the care of mothers and/or babies have been expanded to include services provided outside of the maternity cycle. In the case of inpatient or outpatient hospital services or clinic services, these services are furnished by or under the direction of a nurse-midwife to the extent permitted by the facility. Nurse-midwives usually work in association with obstetrician-gynecologists or other physicians to whom they refer patients with high risk conditions or complications.

C. Nurse-Midwife Certification Requirements.--A nurse-midwife is a registered professional nurse who:

- Is currently licensed to practice in the State as a registered professional nurse;
- Is legally authorized by the State or regulations to practice as a nurse-midwife; and
- Has completed a program of study and clinical experience for nurse-midwives, as specified by the State.

If the State does not specify a program of study and clinical experience that nurse-midwives must complete to practice in the State, the nurse-midwife must meet one of the alternative certification, education, and/or experience requirements specified in 42 CFR 440.165(b)(4).

D. Coverage of Services for Categorically Needy.--You must provide that nurse-midwife services are furnished to the categorically needy to the extent nurse-midwives are legally authorized to practice under State law or regulations. You may also choose to provide for these services for the medically needy in your State plan.

4421. SERVICES FOR PREGNANT WOMEN

A. Coverage of Services.--Services to pregnant women fall within three categories:

1. Pregnancy-Related Services.--Coverage of pregnancy-related services up to and including delivery includes all prenatal and delivery services as defined in your approved State plan. If you have a medically needy program, provide these services to medically needy pregnant women under §1902(a)(10)(C)(iii)(II) of the Act. Due to the comparability of services provisions of §1902(a)(10)(B)(ii) of the Act, make comparable services available to categorically needy pregnant women. (See §4130.) If you do not include the medically needy in your State plan, services available to categorically needy pregnant women must, under the comparability of services provisions of §1902(a)(10(B)(i) of the Act, include at least the full range of services available to the categorically needy group. You may elect to expand services only for the pregnant women group under the exception to the comparability of services requirement. (See §4130B.)

2. Post-Partum Services.--For the length of time specified in §§3306 and 3571, provide pregnancy-related and post-partum services available under your State plan to women who, while pregnant, were eligible for, applied for, and received Medicaid. At a minimum, provide a continuation of those services during this post-partum period that were available under your State plan to these women before the pregnancy terminated. You are not required to identify the specific treatments covered as pregnancy-related in your State plan for this post-partum period. However, list the major categories of services or any changes in services limits (e.g., inpatient hospital, physician services) that are available only as pregnancy-related services and indicate if you elect this additional coverage under the exception to the comparability of services provision for pregnancy-related services described in clause (VII) in the matter following §1902(a)(10)(F) of the Act. (See §4130B.)

NOTE: There is no FFP available for post-partum services related to induced abortions which are not federally funded.

3. Services for Conditions That May Complicate Pregnancy.--You may elect to provide services to pregnant women for the treatment of nonpregnancy conditions that may complicate pregnancy and that are not currently available under your State plan. In electing to provide these services, you need only provide them to all pregnant women covered under your plan. These services are not subject to the other comparability of services requirements. You are not required to specify in your State plan the particular treatments or conditions that are covered under this provision. However, specify the addition of any major categories of services (inpatient hospital, physician, etc.) or changes in service limits that you elect to make available only to pregnant women under the exception to the comparability of services requirement. (See §4130B.)

B. Definitions.--

1. Pregnancy-Related Services.--Services for the treatment of conditions or complications that exist or are exacerbated because of pregnancy.

2. Prenatal Services.--Services to a woman during pregnancy which are directed to protecting and insuring the health of the woman and the fetus.

3. Delivery Services.--Services necessary to protect the health and safety of the woman and fetus from the onset of labor through delivery.

4. Post-Partum Services.--Services rendered to an eligible woman following termination of pregnancy for the length of time specified in §§3306 and 3571 for any health conditions or complications that are pregnancy-related.

4430. LEGAL BACKGROUND AND AUTHORITY

The Medicaid program (title XIX of the Social Security Act) provides medical assistance to certain categories of individuals with low income. Medicaid is jointly financed by the Federal and State governments and administered by the States. Generally, States set eligibility and coverage standards but are required by Federal rules to cover certain categories of individuals and to guarantee the availability of certain medical services. Individuals who receive cash assistance under a program authorized by the Social Security Act automatically qualify for Medicaid and are referred to as "categorically needy." States are given the option to provide certain health care and services to the medically needy (individuals whose income is more than allowed for the categorically needy, but whose incurred medical expenses put an extreme financial burden on them).

Under section 1902(a)(10) of the Social Security Act (42 U.S.C. 1396a(a)(10)) and regulations at 42 CFR 440.210, required services for the categorically needy include hospital and physician services. These same services may be offered to the medically needy as either optional or required services depending on the make-up of each individual State's Medicaid plan (reference 42 CFR 440.220). Under 42 CFR 440.230(c), a Medicaid agency may not arbitrarily deny or reduce the amount, duration and scope of a required service to an otherwise eligible beneficiary solely because of the diagnosis, type of illness or condition. Accordingly, States have received Federal matching funds in expenditures for medically necessary abortions.

Since Fiscal Year (FY) 1977, Congress has included in each HHS Appropriations Act, a provision limiting the Department's funding of abortions. Section 209 of P.L. 94-439, Labor-HHS Appropriations Act for FY 1977, (October 1, 1977 through September 30, 1978), prohibited the Department from using any funds appropriated under the Act to pay for abortions "except where the life of the mother would be endangered if the fetus were carried to term." This limitation was continued in effect by two joint resolutions, P.L. 95-103 and P.L. 95-165, that provided continuing appropriations through November 1977.

The HHS Appropriations Act for the remainder of FY 1978, P.L. 95-205, placed slightly less stringent limitations on the Department's funding of abortions during that period. That Act prohibited the Federal funding of abortions except in the following three circumstances:

1. Where the life of the mother would be endangered if the fetus were carried to term;

2. For such medical procedures necessary for the victims of rape or incest, when such rape or incest has been reported promptly to a law enforcement agency or public health service, and

3. In those instances where severe and long-lasting physical health damage to the mother would result if the pregnancy were carried to term when so determined by two physicians.

These limitations were enacted in identical form in the HEW Appropriations Act for FY 79.

The two joint resolutions (section 118 of P.L. 96-86, effective October 1, 1979 through November 20, 1979; and section 109 of P.L. 96-123, effective November 20, 1979 through September 30, 1980) that appropriated funds for FY 1980 further restricted the circumstances under which the Department could fund abortions. Public Law 96-123 allowed HHS to fund abortions only where the life of the mother would be endangered if the fetus were carried to term, or in instances of promptly reported rape or incest. This act did not allow the Department to fund abortions where the mother would suffer severe and long-lasting physical health damage unless one of the two circumstances existed.

The HEW Appropriations Act for FY 1978 required the Department to issue regulations and establish procedures that "rigorously enforce" the limitations on the Federal funding of abortions that were contained in the Act. Thus, since February 1978, the Department's regulations also have limited the Federal funding of abortions.

On January 15, 1980, the U.S. District Court for the Eastern District of New York ruled in McRae v. Secretary, HHS(Civ. No. 76 C 1804) and New York City Health and Hospitals Corporation v. Secretary, DHEW, (Civ. No. 76 C 1805), that provisions contained in HEW appropriations Acts since FY 1977 that limit the use of Federal funds for abortions under Medicaid are unconstitutional. On the date that it issued the rulings, the District Court stayed its judgment for 30 days, through February 14, 1980. Both the District Court and the United States Supreme Court denied the Federal government's motions to extend the stay pending appeal to the Supreme Court. Therefore, Federal funding became available for medically necessary abortions performed on or after February 19, 1980. This condition applies through September 19, 1980. The U.S. Supreme Court granted review of both the McRae and New York City Health and Hospitals Corporation cases.

Specifically, the District Court ruled that the provisions commonly refered to as "the 'Hyde Amendment' are unconstitutional as applied to abortions that are necessary in the professional judgment of the pregnant woman's attending physician, exercised in the light of all factors, physical, emotional, psychological, familial, and the woman's age, relevant to the health-related well-being of the pregnant woman." The District Court enjoined the Department from enforcing the Hyde Amendment to the extent that it prohibits Federal funding under the Medicaid program of medically necessary abortions as defined above.

The District Court's ruling also meant that States were required to cover all medically necessary abortions under their Medicaid program. This was so because States' failure to cover all medically necessary abortions in the absence of provisions limiting the Federal funding of those procedures would be a violation of our regulations on amount, duration and scope at 42 CFR 440.230. Those regulations state that Medicaid services mandated by statute and regulation may not be arbitrarily denied or reduced in amount, duration or scope solely because of a recipient's diagnosis, type of illness or condition.

On June 30, 1980, the United States Supreme Court reversed and remanded the decisions of the United States District Court for the Eastern District of New York in McRae v. Secretary, DHEW. The Supreme Court ruled that the Hyde amendment does not violate the United States Constitution and, in addition, the court ruled that the Medicaid act does not require States to cover any abortions for which Federal funding is not available.

The plaintiffs in McRae stated that they expected to file a petition for a hearing. The Supreme Court rules provided that if such a petition is filed, the effective date of the decision is stayed while the court considers the petition for rehearing. Thus, Federal Medicaid funding continued to be available for all "medically necessary" abortions, and States were required to cover all "medically necessary" abortions under Medicaid until the Supreme Court ruled on the petition for rehearing.

On September 17, 1980 the United States Supreme Court denied the appellees' petition for a rehearing in Harris v. McRae. The District Court received the Supreme Court's judgment on September 19, 1980 and vacated its injunction that day. This means that for abortions performed on or after September 20, 1980 Federal funds under Medicaid will be available only for those abortions that are covered under the fiscal year 1980 Appropriations Act as interpreted by our regulations in 42 CFR 441.200 et seg. FR 61598 (October 26, 1979); i.e., life of the mother would be endangered or instances of promptly reported rape or incest. (Federal funds under Medicaid are available for all "medically necessary" abortions performed during the period February 19, 1980 through September 19, 1980.) During this period the controlling factor as to whether FFP was available was the date the abortion was performed.

On October 1, 1980 the President signed a joint resolution, (Public Law 96-369) making continuing appropriations for FY 1981. Section 101(c) of the continuing resolution for fiscal year 1981 (Pub. L. 96-369, enacted October 1, 1980 and expired December 15, 1980) prohibited the use of any funds appropriated under that Act to pay for abortions, with certain exceptions. Federal funds could be used if the life of the mother would be endangered if the fetus were carried to term, or if the procedure were necessary for the victims of rape or incest when the rape was reported within 72 hours to a law enforcement agency or public health service. States were free under this appropriation to choose not to fund abortions. Section 109 of Public Law 96-536 further continued these provisions until June 5, 1981.

Section 402 of the Supplemental Appropriations and Recession Act of 1981 (Pub. L. 97-12 enacted June 5, 1981), for supplemental and continuing appropriations for FY 1981, amended section 109 of Pub. L. 96-536 and further restricted the use of Federal funds for abortions under Medicaid. That Act provided that Federal funds were only available for abortions if the life of the mother would be endangered if the fetus were carried to term. On June 9, 1981 we informed State agencies by telegram of that change.

On December 15, 1981, the President signed the "Joint Resolution Making Further Continuing Appropriations for FY 1982 and for Other Purposes" (Pub. L. 97-92). This law appropriated funds for the Department's programs for the period through March 31, 1982. Section 101 of Pub. L. 97-92 continues in effect the restrictions on Federal funding for abortions contained in the Supplemental Appropriations and Recession Act of 1981. Subsequently, on March 31, 1982, the President signed the "Joint Resolution Making Further Continuing Appropriations for FY 1982" (Pub. L. 97-161). This law appropriates funds for the period April 1, 1982 to September 30, 1982 and extends the provisions of Pub. L. 97-92 concerning abortions. Thus, no FY 1982 funds may be used to pay for abortions except where the life of the mother would be endangered if the fetus were carried to term. Moreover, States may choose not to fund abortions to the extent they deem appropriate.

TITLE XIX--GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

Section 1902, State Plans for Medical Assistance

Section 1902(a)(10) provides inter alia: (A) for making medical assistance available, including at least the care and services listed in paragraphs (1) through (5) and (17) of section 1905(a), e.g., inpatient hospital services (other than services in an institution for tuberculosis or mental diseases) and physicians' services, to all individuals receiving aid or assistance under any plan of the State approved under titles I, X, XIV, or XVI, or Part A or Part E of title IV (including pregnant women deemed by the State to be receiving such aid as authorized in section 406(g) and individuals considered by the State to be receiving such aid as authorized under section 414(g)), or with respect to whom supplemental security income benefits are being paid under title XVI;

(B) that the medical assistance made available to any individual described in subparagraph (A)____ . . .

(ii) shall not be less in amount, duration, or scope than the medical assistance made available to individuals not described in subparagraph (A);

(C) that if medical assistance is included for any group of individuals described in section 1905(a) who are not described in subparagraph (A); then

* * *

(ii) the plan must make available medical assistance.

CITATION OF REGULATION

42 CFR Public Health
Part 440, Services: General Provisions

§440.230 Sufficiency of amount, duration, and scope

(a) The plan must specify the amount, duration, and scope of each service that it provides for--
(1) The categorically needy; and
(2) Each covered group of medically needy.

(b) Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose.

(c) The Medicaid agency may not arbitrarily deny or reduce the amount, duration, or scope of a required service under §§440.210 and 440.220 to an otherwise eligible recipient solely because of the diagnosis, type of illness, or condition.

(d) The agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures.

Part 441, Services: Requirements and Limits Applicable to Specific Services--Subpart E Abortions.

§441.200 Basis and Purpose

This subpart implements Federal law that places restrictions on the use of Federal funds for abortions except under the circumstances described in this subpart.

§441.201 Definition.

As used in this subpart--"Physician" means a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he or she practices.

§441.202 General rule.

FFP is not available in expenditures for an abortion except as specified in 441.203.

§441.203 Life of the mother would be endangered.

FFP is available in expenditures for an abortion when a physician has found, and certified in writing to the Medicaid agency, that on the basis of his or her professional judgment, the life of the mother would be endangered if the fetus were carried to term. The certification must contain the name and address of the patient.

§441.206 Documentation needed by the Medicaid agency.

FFP is not available in any expenditures for abortions, as provided for under 441.203, if the Medicaid agency has paid without first having received the certification as specified in that section.

§441.208 Recordkeeping requirements.

Medicaid agencies must maintain copies of the certification as specified in §441.203 for 3 years under the recordkeeping requirements at 45 CFR 74.20.

4431. FEDERAL FUNDING OF ABORTIONS

Since fiscal year 1977, Congressional restrictions have been placed on appropriated funds for the Department's programs which fund abortions. Since enactment of Public Law 97-12 (effective on June 5, 1981), FFP is only available in expenditures for an abortion when a physician has found, and so certified in writing to the Medicaid agency, that on the basis of his/her professional judgment, the life of the mother would be endangered if the fetus were carried to term. The certification must contain the name and address of the patient. Congress prohibited the use of Federal funds appropriated under Public Law 97-12 and subsequent public laws for abortions for victims of rape or incest.

However, no matter which restrictions were in place when the abortion was performed or when FFP was claimed, and even if a State were under court order to pay for medically necessary abortions that were outside the scope of the various Hyde amendments, HCFA must look at the restrictions on the use of Federal funds in place at the time those funds are used to pay the States' claim to determine if Federal funds can in fact be used. For example, appropriations enacted by Public Law 97-12 excluded Federal funds for abortions performed for victims of rape or incest. Accordingly, such services cannot be reimbursed unless the State is able to establish that funds used to pay for the abortion services did not derive from these appropriations. Thus, the controlling factor is not when the abortion was performed or when FFP was claimed, but rather which Federal funds were used to pay for the abortion service. The one exception to this rule is that HCFA has paid and will continue to pay for medically necessary abortions performed during the periods October 1, 1976 - August 4, 1977 and February 19 - September 19, 1980, when the Department was under Federal court orders requiring Medicaid coverage for medically necessary abortions.

Generally, the appropriation restrictions attached to the Federal funds provided to a State at the beginning of the quarter (the quarterly estimate) are not controlling unless the State can show on a case-by-case basis that those particular Federal funds were used to pay the provider who performed the abortion. A State's payment for a particular abortion service is not considered identified until after the quarterly expenditure report (Form HCFA-64) is submitted. Therefore, the Federal funds used to reimburse a State for an abortion service are provided to a State after HCFA reviews the State§s expenditure report and issues a subsequent supplemental grant award to finalize that expenditure report. Thus, the restrictions attached to the Federal appropriation referenced in the finalizing grant award for a given calendar quarter governs whether abortions the State paid for during that quarter are eligible for FFP. Finally, the documentation requirements specified in 42 CFR 441.206 must be satisfied before the claim is approved for payment.

4432 FEDERAL FUNDING OF ABORTION RELATED SERVICES

A. Background.--Since fiscal year 1977, Congress has passed Appropriations Acts that contain restrictions on the funding of abortions. Under the Supplemental Appropriations and Rescission Act of 1981, P.L. No. 97-12, FFP became available for abortions performed only where the life of the mother would be endangered if the fetus were carried to term. All subsequent pertinent Congressional measures have continued that limitation on the use of Federal funds for abortions. 42 CFR, Part 441, Subpart E specifies that FFP is available for abortions only when a physician has found and certified in writing to the Medicaid agency that in his/her professional judgment, the life of the mother would be endangered if the fetus were carried to term.

B. Scope of Services.--For purposes of FFP, noninduced, naturally occurring abortions are not subject to the abortion restriction. Therefore, FFP is available for the costs associated with treating spontaneous and missed abortions. In addition, FFP is available for treating any medical problems resulting from a medically unsupervised abortion (i.e., where someone other than a physician, such as the patient, has induced the abortion), or an ectopic (tubal) pregnancy, which often results in a naturally occurring abortion and usually requires surgical removal of the fetus.

1. Abortion Related Services for Which FFP is Not Available.--FFP is not available for the costs of medically induced/performed abortions where the life of the mother would not be endangered if the fetus were carried to term. FFP is therefore not available for the costs of services directly related to the performance of such abortions, as follows:

- Physician/surgical charges for performing the abortion. These charges include the usual, uncomplicated pre and post operative care and visits related to performing the abortion.

- Hospital or clinic charges associated with the abortion. This includes the facility fee for use of the operating room, supplies and drugs necessary to perform the abortion and charges associated with routine, uncomplicated pre and post operative visits by the patient.

- Physician charges for administering the anesthesia necessary to induce or perform an abortion.

- Drug charges for medication usually provided to or prescribed for the patient who undergoes an uncomplicated abortion. This includes routinely provided oral analgesics and antibiotics to prevent septic complication of abortion, and Rho-GAM (an immune globulin administered to Rh-negative women who have an abortion).

- Charges for histo-pathological laboratory tests performed routinely on the extracted fetus or abortion contents.

o Charges for other laboratory tests performed prior to performing the nonmatchable abortion to determine the anesthetic/surgical risk of the patient (e.g., CBC, electrolytes, blood typing).

2. Abortion Related Services for Which FFP is Available.--FFP is available for the costs of all services related to an abortion where the physician has certified in writing to the Medicaid agency that in his/her professional judgment, the life of the mother would be endangered if the fetus were carried to term. FFP is also available for the costs of certain specific services associated with a non-Federally funded abortion if those services would have been performed on a pregnant woman regardless of whether she was seeking an abortion. Those services include:

o Charges for pregnancy tests which would have been performed whether or not the individual was seeking an abortion;

o Charges for tests to identify sexually transmitted diseases (e.g., chlamydia, gonorrhea, syphillis) and other laboratory tests routinely performed on a pregnant patient, such as Pap smear and urinalysis; and

o Charges for all services, tests and procedures performed post-abortion for complications of a non-Federally funded therapeutic abortion, including charges for a hospital stay beyond the normal length of stay for abortions and charges for services following a septic abortion, etc.

3. FFP Available for Multiple Medical Procedures Involving an Abortion.--Title XIX of the Act provides that FFP is paid to the States at the regular Federal medical assistance percentage (FMAP) rate for the costs incurred for covered medical services. Conversely, FFP is not available for the cost of noncovered services. The statute further provides that FFP is available at the rate of 90 percent for the costs of family planning services.

When multiple procedures are performed during a single hospital stay or clinic visit, you must distinguish between costs attributable to an abortion or other procedure matched at the FMAP, and those attributable to a family planning service, such as a sterilization. You must then determine whether each of the procedures meets applicable Federal requirements for FFP. To the extent that a procedure which does not meet Federal requirements extends the hospital stay or course of clinic treatment, that portion of the claim may not be submitted for FFP. In addition, all ancillary services related solely to the procedure which does not meet applicable requirements for FFP must also be deleted from the claim for FFP.

For example, if during a hospital stay for an FFP eligible abortion, a sterilization is performed which does not meet Federal requirements for FFP and which extends the hospital stay, the costs associated with the sterilization and the extended hospitalization must be deleted from your claim for FFP. Similarly, if the abortion itself does not meet Federal requirements but the sterilization does, the costs which are normally attributable to the

performance of the eligible sterilization may be claimed for FFP. However, use the criteria described in §§4432.B.1 and B.2 to determine whether the various services related to the FFP ineligible abortion could be claimed for FFP.

4. Exclusion of Claims for FFP for Services Related to FFP Ineligible Abortions.--Each State must have appropriate procedures for identifying abortion related services. Each State needs a method for determining whether physicians§ and laboratory services, pharmaceuticals and anesthetics associated with a hospital stay or clinic visit during which an abortion is performed are related to it. Services described in §4432.B.1 related to abortions which do not meet Federal funding criteria must be excluded from claims for FFP.

Because State payment systems are not standard, there is no Federally prescribed method for accomplishing this result. Each State must devise appropriate procedures and HCFA verifies both that the procedures are in place and that they are operating properly to exclude inappropriate claims for FFP.

4434. LEGAL BACKGROUND AND AUTHORITY

The Medicaid program (title XIX of the Social Security Act) provides medical assistance to certain categories of individuals with low income. Medicaid is jointly financed by the Federal and State governments and administered by the States. Generally, States set eligibility and coverage standards but are required by Federal rules to cover certain categories of individuals and to guarantee the availability of certain medical services. Individuals who receive cash assistance under a program authorized by the Social Security Act automatically qualify for Medicaid and are referred to as "categorically needy." States are given the option to provide certain health care and services to the medically needy (individuals whose income is more than allowed for the categorically needy, but whose incurred medical expenses puts an extreme financial burden on them).

Under section 1902(a)(10) of the Social Security Act (42 U.S.C. 1396a(a)(10)) and regulations at 42 CFR 440.210, required services for the categorically needy include hospital and physician services. These same services may be offered to the medically needy as either optional or required services depending on the make-up of each individual State's Medicaid plan (reference 42 CFR 440.220). Under 42 CFR 440.230(c), a Medicaid agency may not arbitrarily deny or reduce the amount, duration and scope of a required service to an otherwise eligible beneficiary solely because of the diagnosis, type of illness or condition. On November 8, 1978, the Department issued final rules governing FFP in the payment of sterilization procedures for sterilization under certain federally assisted programs. In order for FFP to be available for hysterectomies, the rules included the following requirement:

1. Federal funds are not available for hysterectomies performed solely for the purpose of sterilizing the patient;

2. Federal funds are available when a hysterectomy is being done for a reason other than sterilization provided that:

   a. The person securing authorization to perform the hysterectomy informs the patient, and her representative, if any, orally and in writing, that the operation will make her sterile; and
   b. The patient, or the representative, signs a statement acknowledging receipt of the information.

The statement referred to in item 2b is commonly referred to as the "acknowledgment statement."

The regulations were developed to safeguard patients rights by ensuring that women will make informed and voluntary choices; and to emphasize that hysterectomies are not an appropriate or acceptable means of sterilization.

On August 4, 1982 the Department published final regulations in the Federal Register which amend the hysterectomy requirement. The regulations eliminate the need to inform women who are already sterile or who require a hysterectomy as an emergency life-saving procedure, that the hysterectomy would render them incapable of reproducing. The amended regulations were effective upon publication. In addition, if a State so chooses, the regulation can be made retroactive to March 8, 1979, when the initial regulations became effective, or any date thereafter through the date of publication of these regulations.

TITLE XIX--GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

Summary of Section 1902, State Plans for Medical Assistance

Section 1902(a)(10) provides, inter alia: (A) for making medical assistance available, including at least the care and services listed in paragraphs (1) through (5) and (17) of section 1905(a), e.g., inpatient hospital services (other than services in an institution for tuberculosis or mental diseases) and physicians' services, to all individuals receiving aid or assistance under any plan of the State approved under titles I, X, XIV, or XVI, or Part A or Part E of title IV (including pregnant women deemed by the State to be receiving such aid as authorized in section 406(g) and individuals considered by the State to be receiving such aid as authorized under section 414(g)), or with respect to whom supplemental security income benefits are being paid under title XVI;

(B) that the medical assistance made available to any individual described in subparagraph (A)---

***

(ii) shall not be less in amount, duration, or scope than the medical assistance made available to individuals not described in subparagraph (A);

(C) that if medical assistance is included for any group of individuals described in section 1905(a) who are not described in subparagraph (A); then

***

(ii) the plan must make available medical assistance....

SUMMARY OF CITATION OF REGULATION

42 CFR Public Health
Part 440, Services: General Provisions

§440.230 Sufficiency of amount, duration, and scope

(a) The plan must specify the amount, duration, and scope of each service that it provides for
(1) The categorically needy; and
(2) Each covered group of medically needy.

(b) Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose.

(c) The Medicaid agency may not arbitrarily deny or reduce the amount, duration, or scope of a required service under §§440.210 and 440.220 to an otherwise eligible recipient solely because of the diagnosis, type of illness, or condition.

(d) The agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures.

Part 441, Services: Requirements And Limits Applicable To Specific Services Subpart F Sterilization.

§441.250 Applicability.

This subpart applies to sterilizations and hysterectomies reimbursed under Medicaid.

§441.252 Definitions.

As used in this subpart:

"Hysterectomy" means a medical procedure or operation for the purpose of removing the uterus.

§441.252 State plan requirements.

A State plan must provide that the Medicaid agency will make payment under the plan for sterilization procedures and hysterectomies only if all the requirements of this subpart were met.

§441.255 Sterilization by hysterectomy.

(a) FFP is not available in expenditures for a hysterectomy if--

(1) if it was performed solely for the purpose of rendering the individual permanently incapable of reproducing or

(2) if there was more than one purpose to the procedure, it would not have been performed but for the purpose of rendering the individual permanently incapable of reproducing.

(b) FFP is available in expenditures for a hysterectomy not covered by paragraph (a) of this section only under the conditions specified in paragraphs (c), (d), or (e) of this section.

(c) FFP is available if--

(1) The person who secured authorization to perform the hysterectomy has informed the individual and her representative, if any, orally and in writing that the hysterectomy will make the individual permanently incapable of reproducing and

(2) The individual or her representative, if any, has signed a written acknowledgment of receipt of that information.

(d) Effective on March 8, 1979 or any date thereafter through the date of publication of these regulations at the option of the State, FFP is available if--

(1) The individual--

(i) Was already sterile before the hysterectomy; or

(ii) Requires a hysterectomy because of a life-threatening emergency situation in which the physician determines that prior acknowledgment is not possible; and

(2) The physician who performs the hysterectomy--

(i) Certifies in writing that the individual was already sterile at the time of the hysterectomy, and states the cause of the sterility; or

(ii) Certifies in writing that the hysterectomy was performed under a life-threatening emergency situation in which he or she determined prior acknowledgment was not possible. The physician must also include a description of the nature of the emergency.

(e) Effective March 8, 1979 or any date thereafter through the date of publication of these regulations at the option of the State, FFP is available for hysterectomies performed during a period of an individual's retroactive Medicaid eligibility if the physician who performed the hysterectomy certifies in writing that--

(1) The individual was informed before the operation that the hysterectomy would make her permanently incapable of reproducing or

(2) One of the conditions in paragraph (d)(1) of this section was met. The physician must supply the information specified in paragraph (d)(2) of this section.

§441.256 Additional condition for Federal Financial Participation (FFP).

(a) FFP is not available in expenditures for any sterilization or hysterectomy unless the Medicaid agency, before making payment, obtained documentation showing that the requirements of this subpart were met. This documentation must include a sterilization consent form, or acknowledgement of receipt of hysterectomy information or a physician§s certification under §441.255(d)(2) as applicable.

(b) With regard to the requirements of §441.255(d) for hysterectomies performed from March 8, 1979 through November 2, 1982, FFP is available in expenditures for those services if the documentation showing that the requirements of that paragraph were met is obtained by the Medicaid agency before submitting a claim for FFP for that procedure.

4435. STERILIZATION BY HYSTERECTOMY

Since March 8, 1979, Federal funds are not available for a hysterectomy performed solely for the purpose of sterilization. Federal funds, however, are available for medically indicated hysterectomy procedures (e.g., removal of a cancerous uterus) provided that the individual and her representative, if any, have been informed orally and in writing that the procedure will render her incapable of reproducing. The individual or her representative, if any, must acknowledge receipt of this information in writing. The original regulations did not provide any exception to the requirement for a hysterectomy procedure. The written acknowledgment is acceptable if the patient signs the statement either before or after the hysterectomy is performed. However, when the patient signs the acknowledgment statement after surgery, in order to meet the intent of the regulation the statement must contain language which clearly states that she was informed before surgery of the consequences of the hysterectomy, i.e., that it would render her sterile.

There is no specific content or format to be used for the written acknowledgment. Therefore, any document signed by the recipient or her representative which reasonably indicates that she received the required information will satisfy the regulatory requirement.

4435.1 Waiver of the Hysterectomy Acknowledgment Statement

Effective August 4, 1982, the Hysterectomy Acknowledgment statement is no longer required in the following circumstances and FFP is available when the appropriate documentation is obtained.

A. The individual was already sterile before the operation, and the physician who performs the hysterectomy certifies that the individual was already sterile at the time of the hysterectomy, and states the cause of the sterility.

B. The individual requires a hysterectomy because of a life-threatening emergency situation (i.e., the individual was in imminent danger of loss of life; for example, the patient must undergo a hysterectomy due to a perforated uterus or uteroplacental apoplexy) in which the physician determines that prior acknowledgment is not possible, and the physician who performs the hysterectomy (1) certifies in writing that the hysterectomy was performed under a life-threatening emergency situation in which he or she determined prior acknowledgment was not possible, and (2) describes the nature of the emergency.

4435.2 Retroactivity of the Provision Waiving the Acknowledgment Requirement

At the States' option, the waiver of acknowledgment requirement provision and other parts of this guideline (i.e., the patient or his representative, if any, may sign the acknowledgment requirement either before or after the operation) may also be retroactive to the original date of the implementation of the sterilization regulation, March 9, 1979, or any date thereafter at the option of the State depending upon whether the State or the provider is resubmitting a retroactive claim for FFP.

A. State Paid Claim For Which FFP Has Not Been Claimed

At the States' option, effective March 9, 1979 or any time thereafter through November 2, 1982 (90 days after publication of the regulation) FFP is available if, prior to submitting the claim for FFP, the State obtains written certification from the physician who performed the hysterectomy that the individual was--

1. Already sterile before the hysterectomy, and states the cause of the sterility, or
2. Requires a hysterectomy because of a life-threatening emergency situation in which the physician determines that prior acknowledgment is not possible, and include a description of the nature of the emergency.

Normally, the State may claim FFP for an expenditure up to 2 years after the calendar quarter in which the State made the expenditure. However, since this claim may be time-barred by this provision, the time limits imposed under 45 Part 95 are waived with respect to this claim until 90 days after publication of the regulations on August 4, 1982.

B. FFP Disallowed In A State Paid Claim as a Result of Federal Audit or Review

If FFP has been recouped from the State in the type of claims provided for by the waiver provision, the State must identify the claim and obtain the physician's certification before it claims FFP. The time limits normally imposed for States to submit claims for FFP are waived with respect to these claims until 90 days after publication of the regulations on August 4, 1982.

C. State Paid The Providers' Claims, But Later Recouped Payment As A Result Of An Audit Or Review.

If the State has recouped payment from the provider or initially denied claims under the waiver provision, the provider is responsible for identifying such claims and must submit new claims which meet the requirements of the amended provision.

For claims previously denied during the retroactive period because the Federal requirements were not met, the provider is given from the date of publication of the regulations, August 4, 1982, to whatever period of time the provider normally has for submitting claims for payment, e.g., if the providers normally have 1 year to submit their claims for payment, then for those denied claims during the retroactive period the providers have 1 year beginning with the date of publication of these regulations to submit their claims along with this documentation, and therefore the period expires 1 year from the date of publication of the regulations.

The required documentation should consist of certification by the physician who performed the procedure that the individual was sterile (stating the name of the condition) or the hysterectomy was performed due to an emergency life-threatening situation (describing the emergency).

4435.3 Retroactive Eligibility

Federal funding is available for hysterectomies performed during a period of a Medicaid beneficiary's retroactive eligibility. In order for payment to be made in these cases, the physician must submit a written statement certifying that one of the following conditions were met:

A. He or she informed the woman before the operation that the procedure would make her sterile, or

B. The women met one of the exceptions provided in the waiver provision. In this case the statement must describe the cause of the sterility or the nature of the emergency when one of the above conditions are met no written acknowledgment by the woman or her representative is required.

4435.4 Conditions For Federal Financial Participation (FFP) to be Available in the Payment of Hysterectomy Procedures

FFP is not available in the payment of a hysterectomy procedure unless the Medicaid agency, before making payment, obtained the appropriate documentation. This documentation must include an acknowledgment of receipt of hysterectomy information or a physician certification that the individual was already sterile at the time of the hysterectomy, stating the cause of the sterility, or that the hysterectomy was performed under a life-threatening emergency situation in which the physician determined prior acknowledgment was not possible and describing the nature of the emergency.

With regards to claims submitted for the retroactive period, March 8, 1979 through 90 days after publication of the regulations, FFP is available for those claims meeting the waiver provision if the State agency obtains the appropriate documentation.

4440. HOME AND COMMUNITY-BASED SERVICES - BASIS, SCOPE, AND PURPOSE

A. Legislation.--Section 1915(c) of the Act authorizes the Secretary of Health and Human Services (HHS) to waive certain Medicaid statutory requirements to enable you to cover a broad array of home and community-based services as an alternative to institutionalization. This provision was added to the statute as part of P.L. 97-35, OBRA 1981 and amended by P.L. 99-272, COBRA 1985, P.L. 99-509, OBRA 1986, P.L. 100-203, OBRA 1987, P.L. 100-360, the Medicare Catastrophic Coverage Act of 1988, P.L. 100-647, the Technical and Miscellaneous Revenue Act, P.L. 101-508, OBRA 1990 and §4743 of P.L. 105-33, BBA 97. Prior to P.L. 97-35, the Medicaid program provided little coverage for long term care services in a noninstitutional setting, but offered full or partial coverage for such care in an institution. In an effort to address these concerns, §2176 of P. L. 97-35 was enacted, adding §1915(c) to the Act. A home and community-based services waiver offers you broad discretion not generally afforded under the State plan to address the needs of individuals who would otherwise receive costly institutional care provided under the State Medicaid plan.

Additionally, the law specifically provides that a home and community-based services waiver may include a waiver of the statewideness and comparability requirements of §1902(a)(1) and (10)(B) of the Act. Under §1902(a)(1) of the Act, a State plan for medical assistance must be in effect throughout the State. Section 1902(a)(10)(B) requires the plan to provide comparable services (in amount, duration and scope) to all categorically needy individuals and to each covered medically needy group and also requires that the services available to the categorically needy not be less in amount, duration and scope than those available to medically needy beneficiaries. Under a waiver of these statewideness and comparability requirements, home and community-based services do not have to be provided throughout the State. You may target home and community-based services to a limited, select group of eligibles, such as the developmentally disabled. You are not required to provide the services to all eligible individuals who require a hospital (see NOTE), NF or ICF/MR level of care. Under the waiver, you may also exclude those individuals for whom there is a reasonable expectation that home and community-based services would be more expensive than the Medicaid services the individual would otherwise receive in an institution.

Lastly, §1902(a)(10)(A)(ii)(VI) of the Act authorizes optional categorical eligibility to individuals who would be eligible under the State plan if they were in a medical institution and who would require the level of care provided in a hospital, NF or ICF/MR but for the provision of home and community-based services described in §1915(c) of the Act, the cost of which could be reimbursed under the State plan. This may include (depending on the State plan), but is not limited to, individuals who would be eligible for Medicaid in an institution because income from parents or a spouse is not deemed available to them, and individuals who would be eligible for Medicaid under a special income level if they were institutionalized. (See 42 CFR 435.217 and 42 CFR 435.236.)

NOTE: Under P.L. 99-509, individuals may participate in a waiver if they require a hospital, NF or ICF/MR level of care. This provision applies to applications for waivers (or renewals thereof) approved on or after October 21, 1986.

B. Regulations.--HCFA published a final rule with comment period in the Federal Register on July 25, 1994. This final rule expands coverage of Medicaid home and community-based services under §1915(c) of the Social Security Act and responds to public comments that were received as a result of the June 1, 1988 publication of a proposed rule. These regulations were codified at 42 CFR 440.180 (Subpart A), 42 CFR 440.250 (Subpart B), and 42 CFR 441.300 through 441.310 (Subpart G).

4441. HOME AND COMMUNITY-BASED SERVICES - PROCESS

A. Applicability.--The process applies to initial requests for a home and community-based services waiver (including general waiver requests described in §4442 and model waiver requests described in §4443), to requests for renewals described in §4444, and to requests for amendments to approved waivers described in §4445, except as may be otherwise specified in those sections.

B. Submission.--Send your request for a home and community-based services waiver under §1915(c) of the Act to:

Health Care Financing Administration
Center for Medicaid and State Operations
Disabled and Elderly Health Programs Group
Division of Benefits, Coverage and Payment
Mail Stop C4-13-01
7500 Security Boulevard
Baltimore, MD 21244-1850

Submit an original and two copies of the request. Attach a copy of all required information and documentation to each copy of the request. Also send one copy of the letter and all attachments to your HCFA RO. In the letter of request, include the name and telephone number of an individual who may be contacted with specific technical questions on the request.

C. Timeframes.--The law specifies that the Secretary must approve or deny a request for a §1915(c) waiver, or request additional information, by the 90th day after receipt or the waiver request will be deemed approved. The date of receipt is the earliest date the request is received by the HCFA official to whom it is addressed.

While the Department may take the full 90 days to render a decision, HCFA's analysis of the waiver request and preparation of a recommendation for action must generally be completed by the 60th day after receipt. It is imperative that you respond to informal (i.e., unwritten) requests for additional information as soon as possible, since such requests do not stop the clock.

D. Additional Information.--If HCFA has concerns regarding an initial waiver request or amendment proposal which are significant enough to prevent approval, but there is a reasonable expectation that the problems can be resolved, HCFA may make a formal request in writing for additional information. When HCFA issues a formal request, this stops the 90-day approval period that began with receipt of the State's original waiver submission. When the response is received, HCFA again has a new 90-day period to approve or deny the request beginning with the date HCFA receives your response. No further formal request may be made unless you withdraw the waiver and submit a revised waiver request.

HCFA may, however, request informal additional information through meetings or telephone contact. Such request cannot stop the clock and as such is usually made only when the needed information is expected to resolve the problems preventing approval. Because informal requests do not stop the clock, it is important that your response be provided to HCFA as soon as possible. The use of same-day or overnight private delivery services is appropriate in many cases.

E. Effective Date.--The effective date of a new waiver will be established by HCFA in consultation with you but may be no earlier than the date of HCFA's approval action. This also applies to a renewal request that HCFA has determined is a new waiver request and not a renewal request. Therefore, it is suggested that you plan your new proposal with effective dates at the beginning of a calendar quarter at least 90 but not more than 180 days after receipt of the proposal by HCFA. Moreover, it is also suggested that the effective date be the first day of the month or of the calendar quarter to facilitate the reporting of data on the waiver.

Because the effective date of a new request will depend on the date approved, any formal request for additional information will likely necessitate a revised effective date. An initial approved waiver continues for a 3-year period from the effective date and may be renewed. (See §4444.)

F. Review of Waiver Request.--Requests for new Medicaid home and community-based services waivers are reviewed by several different components of HCFA CO with respect to each component's area of specialty. Moreover, the appropriate HCFA RO also reviews each new request and provides comments for use in developing a recommendation for action. As of October 1, 1993, HCFA ROs have lead responsibility for waiver renewals and amendments to renewed waivers.

4442. WAIVER REQUEST REQUIREMENTS

In order to provide home and community-based services (not available under your State plan) to individuals who would otherwise require institutionalization, any request (except a model request as detailed in §4443) for a §1915(c) waiver must address all of the requirements of §§4442.1-4442.11.

4442.1 Scope of Waivers Requested.--Home and community-based services waivers under §1915(c) of the Act allow FFP to be available for a number of services, including those services outside the State Medicaid plan which are not included in the definition of "medical assistance" in §1905(a) of the Act. However, it must be demonstrated that the provision of such services will enable you to serve recipients at a cost which is not more than the cost of serving such individuals in a hospital, NF, or ICF/MR (whose costs would otherwise be reimbursed under your State plan). The services proposed to be provided in the waiver must not duplicate services which are provided under your State Medicaid plan. However, you may provide services under a waiver similar to those provided under the State plan where they are defined differently under the waiver or where they differ in amount, duration, or scope from those provided in the State plan.

If you do not intend to offer the services under the waiver to all individuals who qualify for medical assistance, include a request for waiver of §1902(a)(1) or §1902(a)(10)(B), or both as appropriate. A waiver of §1902(a)(10)(B) is a necessary component of all waiver proposals. If a waiver is requested of "statewideness" (§1902(a)(1)), inform HCFA of the political subdivisions in which waivered services will be offered.

Section 4118 of OBRA-87 provided a technical amendment to specifically provide in §1915(c)(3) of the Social Security Act for a waiver of §1902(a)(10)(C)(i)(III) to allow for the use of institutional deeming rules for the medically needy. Reinstatement of this waiver is retroactive to waivers or renewals approved on or after October 21, 1986.

Application of institutional deeming rules means that income and resources are not deemed to the recipient from a spouse or parent; thus making an individual eligible for Medicaid who might not otherwise qualify. This allows you to cover under home and community-based services waivers medically needy individuals who would not be eligible for waiver services under the community rules, but would be eligible under institutional rules.

You may wish to request a waiver of §1902(a)(10)(C)(i)(III) to allow for the use of institutional deeming rules for the medically needy population.

If you intend to limit in any way the recipient's freedom of choice to participate in the waiver or to choose the provider(s) of service, apply separately to HCFA for a waiver of the freedom of choice provisions authorized under §1915(b) of the Act. Section 2100 describes the procedures for this application. Otherwise, the requirements of §4442.7 must be met.

4442.2 Description of Waiver Participants.--Describe in the waiver request who is eligible to receive the waivered services. Indicate the Medicaid groups (e.g., categorically needy, optional categorically needy or medically needy) to be eligible under the waiver plus any additional targeting criteria that will be applied, e.g., elderly, mentally retarded. For an eligibility group to be included under the waiver, the eligibility group must be included under the State plan. The waiver request must satisfy the following eligibility requirements:

A. Indicate if you wish to include the optional categorically needy eligibility group authorized under §1902(a)(10)(A)(ii)(VI) of the Act (individuals who would be eligible for Medicaid if they were in an institution, who have been determined to need home and community-based waiver services in order to remain in the community, and who are covered under the terms of the waiver) in this waiver and specify which eligibility group or groups you are including under this authority in this waiver.

B. All home and community-based waiver recipients found eligible under 42 CFR 435.217, are subject to post-eligibility calculations. Explain how the applicable provisions will be applied (see 42 CFR 435.726 and 42 CFR 435.735 and §1924 of the Act) regarding post-eligibility treatment of income and resources of those receiving home and community-based services who are eligible under the special home and community-based waiver eligibility group (specified in 42 CFR 435.217). Include the amounts of income to be protected for a beneficiary, spouse, and family and incurred medical expenses not subject to copayment by a third party. (This requirement is applicable only to individuals eligible under the special home and community-based waiver eligibility group.)

Section 9502(e) of COBRA and §9435(a) of OBRA-86, which apply to waivers or waiver renewals approved before, on, or after April 7, 1986, provide that you may set your own maintenance needs deduction amounts for individuals without regard to the limits imposed by regulations at 42 CFR 435.726(c)(1) and 42 CFR 435.735(c)(1). Establish a maximum maintenance needs deduction amount which will not be exceeded for any individual under the waiver, and the maintenance

needs deduction amount must be based on a reasonable assessment of the individual's needs. Except for those restrictions, you may establish the deduction amount for individuals at any level you choose. You may also establish different deduction amounts for different individuals, or groups of individuals, based on an assessment of each individual's or group's particular needs.

The upper limits for maintenance needs deduction amounts already established in regulations for spouses and dependent children continue to apply. However, as with the deduction amount for individuals described above, you may establish the deduction amount for a spouse or dependent children based on an assessment of each spouse's or family's needs. (See §3590.9.)

Pending publication of final regulations, spousal impoverishment eligibility rules, specified at §1924 of the Act, may be used for individuals with a community spouse (whose eligibility is determined under 42 CFR 435.217).

States have an option concerning the application of the post-eligibility rules for individuals with a community spouse. States may use the spousal impoverishment post-eligibility rules specified at §1924 of the Act or the post-eligibility rules specified at 42 CFR 435.726 and 435.735. (Spousal impoverishment post-eligibility rules can be used only if the State is using spousal impoverishment eligibility rules.)

The spousal impoverishment post-eligibility rules provide for a more generous community spouse and family allowance than the rules under 42 CFR 435.726 and 42 CFR 435.735. The spousal protection rules also provide for a personal needs allowance (PNA) described in §1902(q)(1) of the Act for the needs of the institutionalized individual. This allowance is a "reasonable amount for clothes and other personal needs of the individual...while in an institution." For an institutionalized individual, this can be as low as $30 per month. Unlike the institutionalized individual whose room and board is being covered under Medicaid, the personal needs of the home and community-based waiver recipient must include a reasonable amount for food and shelter as well as for clothing. The $30 monthly PNA is not a sufficient amount for these needs when the individual is living in the community.

Therefore, States which elect to treat home and community-based services waiver participants with community spouses under the §1924 spousal rules must use as the personal needs allowance either the maintenance amount which the State has elected under 42 CFR 435.726 or 42 CFR 435.735, or an amount that the State can demonstrate is a reasonable amount to cover the individual's maintenance needs in the community.

C. Indicate that services will only be furnished to those eligible beneficiaries who, but for this provision, would require the level of care provided in a hospital, NF, or ICF/MR.

D. Indicate that home and community-based services will not be provided to recipients who are inpatients of a hospital, NF, or ICF/MR.

E. Indicate if you accept the option not to offer home and community-based services to individual beneficiaries on the basis that you can reasonably expect that the services would cost more than institutional services.

F. Be limited to one of the following target groups or any subgroup thereof:

- o Aged or disabled, or both;
- o Mentally retarded or developmentally disabled, or both; or
- o Mentally ill.

4442.3 Definition of Services.--"Home and community-based services" means services that are furnished under a waiver granted under the provisions of Part 441, Subpart G of 42 CFR. The services may consist of any of the following services, as defined by the agency, that meet the standards specified in §4442.4:

- o Case management services;
- o Homemaker services;
- o Personal care services;
- o Adult day health services;
- o Habilitation services;
- o Respite care services;
- o Day treatment or other partial hospitalization services, psychosocial rehabilitation services and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness; and
- o Other services requested by the Medicaid agency and approved by HCFA as cost effective and necessary to avoid institutionalization.

A. General.--

1. Specify which services will be provided under the waiver, and define each service. Provide at least one of the services listed in §4442.3.

2. The definition of each service must be exhaustive (e.g., a detailed list of each item of medical equipment that may be provided) or closed-ended (i.e., "only those medical supplies needed for the respirator-related needs of a respirator-dependent patient"). The definition may not include such phrases as "including but not limited to . . .," "for example . . .," "including . . .," etc.

3. No service may be provided under the waiver if it is already provided under the State plan unless the nature or the amount of the service, when provided under the waiver, would not be covered if provided under the State plan. For example, if the waiver provides for the coverage of home health aide services, the maximum number of visits allowed under the waiver could be greater than the limit contained under the State plan. The amount chargeable for waiver services is that amount incurred after any limits in State plan services have been reached. Similarly, if the State

proposed to provide home health aide services which were defined more broadly than those available under the State plan, these could be included as waiver services.

4. Define each specific service separately. Multiple services commonly considered separate services (e.g., personal care and habilitation services) generally may not be packaged as a single "comprehensive" service to which one expansive definition is applicable. Further, each definition must be reasonably related to the common meaning(s) of the service defined. A combined service definition (bundling) will be considered if you establish that the bundling of services will permit more efficient delivery of services and not compromise either an individual's access to services or free choice of providers. (See §4442.8C.2.d.)

5. Assure HCFA that each "other" service, independent of any others, is essential to prevent institutionalization, and provide a reasonable explanation as to why it is essential.

6. Cost out each "other" service, documenting the estimated costs and utilization with actual cost data (e.g., from studies or current price lists), and demonstrate the cost effectiveness of each. This documentation must be separate from that provided in your overall cost demonstration using the formula prescribed in 42 CFR 441.303(f).

B. Considerations Related to Specific Services.--

1. FFP is not available for personal care services or any waiver services when provided to recipients by legally responsible relatives, i.e., spouses or parents of minor children, when the services are those that these persons are already legally obligated to provide.

2. Services provided by relatives or friends, except as noted in item B.1., may be covered only if the relatives or friends meet the qualifications for providers of care, there are strict controls to assure that payment is made to the relative or friend as providers only in return for specific services rendered, and there is adequate justification as to why the relative or friend is the provider of care, e.g., lack of other qualified provider in remote areas. Medicaid payment may be made to qualified parents of minor children or to spouses for extraordinary services requiring specialized skills (e.g., skilled nursing, physical therapy) which such people are not already legally obligated to provide.

3. Prevocational, educational or supported employment services may not be provided under the waiver other than as part of habilitation services as defined below.

Effective on or after April 7, 1986 until October 1, 1997, you may include in your definition of habilitation services furnished to individuals who have been discharged from a NF or ICF/MR prevocational, educational, and supported employment services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully outside an institution. Effective October 1, 1997, expanded habilitation applies to any eligible individual that the State determines requires the expanded habilitation services. The legislative requirement that an individual be discharged from an NF or ICF/MR has been deleted. States may, however, continue to include the discharge requirement for the expanded habilitation services noted above.

a. Prevocational services are services aimed at preparing an individual for paid or unpaid employment but which are not job task oriented. They could include teaching a client such concepts as compliance, attending, task completion, problem solving and safety. They are aimed at a more generalized result. In distinguishing prevocational services coverable under a waiver from noncovered vocational services, consider the following criteria. Prevocational service activities:

o Are provided to persons who are not expected to be able to join the general work force or participate in a transitional sheltered workshop within 1 year (excluding supported employment programs),

o If compensated, are compensated at less than 50 percent of the minimum wage,

o Include activities which are not primarily directed at teaching specific job skills but at underlying habilitative goals (e.g., attention span, motor skills), and

o Are reflected in a plan of care directed to habilitative rather than explicit employment objectives consonant with the aims outlined in the preceding criteria.

b. Educational services are special education and related services (as defined in §4(a)(4) of the 1975 Amendments to the Education of the Handicapped Act) (Public Law 94-142) (20 U.S.C. 140(16) and (17)) to the extent they are not prohibited under §4442.3B3e.

c. Supported employment is paid employment which:

o Is for persons for whom competitive employment at or above the minimum wage is unlikely and who, because of their disabilities, need intensive ongoing support to perform in a work setting;

o Is conducted in a variety of settings, particularly worksites in which persons without disabilities are employed; and

o Is supported by any activity needed to sustain paid work by persons with disabilities, including supervision, training and transportation.

d. Habilitation services do not include special education and related services (as defined in §4(a)(4) of the 1975 Amendments to the Education of the Handicapped Act (20 U.S.C. 1401(16), (17)) which otherwise are available to the individual through a State or local educational agency and vocational rehabilitation services which otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973. (See 29 U.S.C. 730.)

In this context "otherwise are available" means that coverage would be denied under a waiver, on that basis, only if:

o An individual is determined eligible for the special educational or vocational rehabilitation services offered by other agencies, and

o The individual is actually receiving, or will actually receive, the services under those other programs.

Therefore, when habilitation services which include prevocational, educational and/or supported employment services are furnished under a waiver, you must:

o If you do not delete the discharge requirement for expanded habilitation, describe how you will ensure that prevocational, educational and/or supported employment services will be furnished only to individuals who have been discharged from a Medicaid certified NF or ICF/MR who do not have these services available to them e.g., use of a trailer code to indicate that a person meets that requirement; and

o Assure HCFA that prevocational, educational and/or supported employment services are not available to individuals who will receive them under the Rehabilitation Act of 1973 or the Education of the Handicapped Act and explain why these services are not available. An example is an individual who has applied for vocational rehabilitation from the State vocational rehabilitation agency but has been rejected because of the protracted length of time that is necessary to achieve meaningful rehabilitation goals.

4. Institutional respite care is defined as overnight care furnished in a Medicaid certified institution (hospital, NF, or ICF/MR), foster home, or community residential facility that meets all relevant State licensure or certification requirements as specified in the waiver. Payment under the waiver for room and board costs as part of respite care can be authorized only for care provided in these facilities. The request must assure that when respite care is provided, payment for other duplicative services under the waiver is precluded (e.g., payment for adult day care when the patient is receiving respite care).

5. Each environmental modification must have a specific adaptive purpose that provides accessibility and safety. Secondly, environmental modifications may not be shown as recurring costs for all recipients in years 2 and 3, or in renewals, when it is clear that only a one time cost is incurred. List environmental modifications exhaustively.

6. Transportation services must be provided by the most cost efficient mode. This is not intended to require competitive bidding but to assure that the mode of transportation selected is the least costly practical option, e.g., van vs. ambulate.

7. There must be either an exhaustive list of medical supplies and equipment to be provided, or a definition which contains a clear limit on the range of such supplies and equipment. Moreover, the costs of supplies must be separately determined from the cost of durable equipment if purchased under the waiver. Equipment costs often do not recur in each waiver year and may not be charged to the program again until the life of the equipment is considered exhausted. Acquire durable equipment by the least costly method (rental vs. purchase) dependent upon its anticipated use.

8. Where you propose to provide care in a residential setting (e.g., assisted living, residential therapeutic foster care), there must be a clear differentiation between waiver services and nonwaiver services (e.g., room and board). There must also be a detailed cost allocation strategy

provided as part of the waiver request to explain how the cost of waiver services in the residential setting will be determined and segregated from ineligible waiver costs.

9. Recreational activities may be covered only to the degree that they are not diversional in nature and are included in a plan of treatment related to a specific therapeutic goal.

10. Services such as patient care training may be provided to individuals other than the recipient (e.g., family or close friends) to the extent that they are necessary to enable the recipient to be cared for outside of an institution.

11. Payment for services provided under a home and community-based waiver must be made directly to the provider of the services. No payment may be made to the recipient or any entity other than the provider of waiver services except as specified below for costs of rent and food attributed to an unrelated, live-in personal caregiver. This does not, of course, rule out payment to an organization which functions as a fiscal intermediary, organized health care delivery system, or a governmental entity under a voluntary reassignment. (See item 16 below.)

12. Except for respite care furnished in a State approved facility that is not private residence (see item 4), FFP is not available for room and board of the recipient as part of a home and community-based service. Board means three meals a day or any other full nutritional regimen. Room means hotel or shelter type expenses including all property related costs such as rental or purchase of real estate and furnishings, maintenance, utilities, and related administrative services.

Section 4741(a) of OBRA 1990 provides that the room and board exclusion does not include an amount established by you to reflect the portion of costs of rent and food attributable to an unrelated personal caregiver who is residing in the same household with an individual who, but for the assistance of such caregiver, would require admission to a hospital, NF, or ICF/MR. Unrelated is defined as someone who is unrelated by blood or marriage to any degree. A personal caregiver provides a covered waiver service (as defined in your waiver package) to meet the recipient's physical, social, or emotional needs (as opposed to services not directly related to the care of the recipient, i.e., housekeeping or chore services). Therefore, when a waiver service is provided by an unrelated, live-in personal caregiver, FFP is available to the waiver recipient for the additional costs he/she may incur for the room and board of such caregiver. Under Medicaid and SSI rules, for payment not to be considered income to the recipient, payment for the portion of the costs of rent and food attributable to an unrelated live-in personal caregiver must be made directly to the Medicaid recipient. You may utilize any reasonable method of apportioning the cost of rent and food, subject to review and approval by HCFA. FFP for live-in caregivers is not available in situations in which the recipient lives in the caregiver's home or a residence owned or leased by the provider of Medicaid services.

This provision does not provide any exceptions to other existing Medicaid requirements resulting in a change in the way an individual's income may be counted in determining Medicaid eligibility or to allow payment to a recipient rather than a provider of service.

13. Case management is commonly understood to be an activity which assists individuals in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational, and other appropriate services, regardless of the funding source for the services to which access is gained. The responsibility for these activities rests with a specific person or organization. Case management services may be used to locate, coordinate, and monitor necessary and appropriate services and may be used to encourage the use of cost effective medical care by referrals to appropriate providers and to discourage over utilization of costly services such as emergency room care for routine procedures. Case management services may also serve to provide necessary coordination with providers of nonmedical services, such as local education agencies or department of vocational rehabilitation, when the services provided by these entities are needed to enable the individual to function at the highest attainable level or to benefit from programs for which he or she might be eligible.

Case management activities are authorized under a number of payment authorities and appropriate payments may be made for such services in the context in which they are provided so long as duplication of funding is avoided. For example:

o Case management may be provided by vendors under §1915(b), (c) or (g) according to the circumstances dictated by one or another of those sections. In such cases, Federal payments are at the FMAP rate.

o Case management may also be an integral and inseparable part of an otherwise covered Medicaid service listed in §1905(a). If so, the FMAP is also the appropriate matching rate since that is the rate that is applied to the services of which case management functions are a part.

o Case management functions may also be performed by employees of the State Medicaid agency, either in general administrative support of the State plan or to administer a waiver under §1915(b). In such cases, the matching rate is that determined under §1903 (i.e., the 50 percent administrative match or, if appropriate, one of the premium match rates).

a. Within the context of home and community-based waiver services, case management may include (but is not limited to) the following functions:

- o Evaluation and/or reevaluation of level of care,
- o Assessment and/or reassessment of the need for waiver services,
- o Development and/or review of the plan of care,
- o Coordination of multiple services and/or providers,
- o Monitoring of quality of care,
- o Review of medical necessity of waiver services, and
- o Determination of cost effectiveness or waiver services for an individual.

When you request case management as a home and community-based service, specify the functions which comprise the service.

b. Claim case management as a service cost at your FMAP rate:

(1) For those functions included in the definition of a case management service as approved in a home and community-based waiver, regardless of who performs the functions which comprise them (e.g., State employees, the State's contractor, waiver provider, or any other entity),

(2) When furnished by a provider of waiver services (or State plan services) as an integral and inseparable part of another covered Medicaid waiver or State plan service. For example, where a home health agency prepares a plan of care for recipients, since the preparation of these plans is required as a part of home health services, separate payment for the case management component is not made but is included in the payment made for the home health services, or such case management activities are reimbursed as covered home health agency services such as skilled nursing, home health aide, or

(3) When provided as optional targeted case management services under §1915(g)(1) as part of an approved Medicaid State plan amendment.

NOTE: When any service is provided as a waiver service, any client services which may precede the patient's eligibility for waiver services cannot be reimbursed unless, and until, the client becomes eligible for waiver services.

c. Where case management is not requested as a home and community-based service, costs attributable to case management functions may be claimed as State administrative costs if the functions are not part of any defined waiver service or State plan service, and otherwise meet the requirements necessary to be considered allowable State administrative costs.

14. FFP is available for day treatment or partial hospitalization services, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility) when provided to individuals who have been diagnosed as being chronically mentally ill. However, these waiver services may be provided only to individuals age 22 through 64 who would not be in an institution for mental diseases (IMD) in the absence of the waiver. In addition, FFP would not be available for these waiver services for individuals under age 22 or over age 64 who, absent the waiver would be placed in an IMD and you have not opted to include the benefits in 42 CFR 440.160 and 42 CFR 440.140 in your State plan.

15. FFP is not available to facilities providing services in residential settings on days when waiver recipients are temporarily absent and are not receiving covered waivered services (sometimes called reserve bed days). Medicaid payment may be made only for waiver services actually provided to an eligible recipient. Since providers incur fixed costs such as rent, staff salaries, insurance, etc., even when a waiver recipient is temporarily absent, you may account for such continuing costs when developing payment rates for these providers. For example, rent is generally paid for a period of 1 month. However, day habilitation services are generally furnished only 5 days per week. You may take the entire month's rental cost into consideration in setting the rate paid for services furnished on the days the recipient is present. Similarly, if data show that a

recipient is served in residential habilitation an average of 325 days per year and the slot is held open when the recipient is on a leave of absence, you may consider the entire yearly cost to the provider when establishing its rate of payment. However, in the rate setting process, it must be assumed that a facility will not have a 100 percent utilization rate every day of the year. Consequently, payment rates are established by dividing the provider's total allowable costs by the number of Medicaid patient days you estimate recipients will actually utilize.

16. A variety of waiver services may be provided by an organized health care delivery system (OHCDS). An OHCDS must provide at least one service directly (utilizing its own employees) and may contract with other qualified providers to furnish other waiver services. When you use an OHCDS, your provider agreement is with the OHCDS. Since it is the system itself which acts as the Medicaid provider, it is not necessary for each subcontractor of an OHCDS to sign a provider agreement with the Medicaid agency. (However, subcontractors must meet the standards under the waiver to provide waiver services for the OHCDS.) When utilizing an OHCDS to provide waiver services, payment is made directly to the OHCDS and the OHCDS reimburses the subcontractors. Waiver providers may not be restricted to participating only through an OHCDS. Such an arrangement must be voluntary.

4442.4 Safeguards - Assurances and Documentation.--Provide the following assurances and supporting documentation:

A. Assurances.--Provide an assurance that necessary safeguards have been taken to protect the health and welfare of the recipients of the services. The safeguards must include:

1. Adequate standards for each type of provider that will provide services under the waiver;

2. That any applicable State licensure or certification requirements are met for services, individuals, or entities furnishing services provided under the waiver; and

3. That all facilities covered by §1616(e) of the Act, in which home and community-based services will be provided, are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

B. Documentation.--

1. Identify the type of provider who will provide each waiver service and supply HCFA with a legible copy of the health and safety standards applicable to each provider type. When the only provider requirement is licensure or certification, provide only the applicable State or Federal law or regulatory citation. It is not necessary to provide copies of the statutory or regulatory licensure or certification standards. For each service that requires provider standards other than, or in addition to, State or Federal licensure or certification, you must specify the applicable educational, professional, or other standards that you require for each service provider.

2. If waiver services will be provided in facilities covered by §1616(e) of the Act, identify the Keys amendment standards which govern each of these of facilities. It is not necessary to furnish copies of the Keys amendment standards. However, these copies must be readily

available at the Medicaid agency to be provided to HCFA upon request. Although you must provide the assurance cited above regardless of whether services will be provided in such facilities, if no waiver services will be provided in the facilities, include a statement to that effect.

3. The health and safety standards included must be provider specific. Explain how the standards will assure recipients' health and safety.

4. Proposed or draft standards are not acceptable.

5. Provide a description of how you will implement and monitor the enforcement of the health and safety standards. You are required to include the results of such monitoring efforts as part of your required annual report (Form HCFA-372).

6. Indicate if you have licensure or certification requirements for any services (or for individuals who furnish these services) provided under the waiver. If so, explain to which providers or individuals they apply.

7. FFP is not available for waiver services furnished by providers who are not in compliance with the standards approved as part of a waiver for the period in which the provider is noncompliant.

NOTE: Provider standards are the criteria which a provider must meet in order to provide waiver services. In order for the standards to be adequate, they must describe the qualities and/or characteristics which assure the provider's capability to perform the service in a safe and effective manner, e.g., training, education, experience, professional credentials, licensing and/or certification or physical plant. Providers may not be required to furnish services statewide since this is unnecessary to assure services are performed in a safe and effective manner.

4442.5 Evaluations - Assurances and Documentation.--

A. Assurance.--Include the assurance that the agency will provide for an evaluation (and periodic reevaluations) of the need for the level of care provided in a hospital, NF, or ICF/MR, as defined by 42 CFR 440.10, §1919(a) of the Act, and 42 CFR 440.150, respectively, when there is a reasonable indication that individuals might need such services in the near future but for the availability of home and community-based services.

NOTE: Evaluation means the review of a client's condition to determine whether he/she requires the level of care provided in a hospital, NF, or ICF/MR as defined by 42 CFR 440.10, §1919(a) of the Act, and 42 CFR 440.150, respectively, and, therefore whether he/she may participate in the waiver. Periodic reevaluations mean a review, at least annually, to determine a recipient's continued need for the level of care described above.

B. Documentation.--

1. If used, describe the factors in addition to the hospital, NF, and ICF/MR level of care requirements as part of your client evaluation and reevaluation process.

2. Include a copy of the written evaluation and reevaluation instrument used to determine the level of care and describe how the evaluations and reevaluations will be made.

3. Describe the party or parties responsible for the evaluation and reevaluation, their qualifications, the factors they will use to evaluate and reevaluate the recipient's need for a hospital, NF, or ICF/MR level of care, and when evaluations and reevaluations will be made. This includes the criteria used to determine level of care.

4. The evaluation and reevaluation instrument must be final. Drafts or proposed instruments are not acceptable.

5. Indicate whether the evaluation and reevaluation instrument and process is identical to that used for hospital, NF, or ICF/MR admissions. If it differs, explain how and why it differs and provide an assurance that the outcome of the new evaluation/reevaluation form is reliable, valid, and fully comparable to the form used for hospital, NF, or ICF/MR placement.

6. Include the agency's procedure to ensure the maintenance of written documentation on all evaluations and reevaluations and the procedure to ensure reevaluations of need at regular intervals. Include an explanation of how, where, and for how long you will maintain written documentation of all evaluations and reevaluations. (In accordance with 45 CFR Part 74, Subpart D, written documentation of all evaluations and reevaluations must be maintained, at a minimum, 3 years from the submission of each Form HCFA-372.)

7. Indicate that the cost of the client evaluation will not be considered a cost reimbursable under the waiver unless, and until, the recipient is receiving waiver services. Costs associated with nonwaiver eligibles may not be claimed or reported as waiver service costs. Such costs, however, may be claimed as administrative costs as activities necessary for the proper and efficient administration of the State plan.

4442.6 Plan of Care.--Explain in detail how the statutory requirements (§1915(c)(1) and (4)) for an individual written plan of care will be met:

o Include in the plan of care an assessment of the individual to determine the services needed to prevent institutionalization.

NOTE: The term "assessment" means an examination of an individual who has been determined (through an evaluation) to meet the level of care requirements for participation in a waiver, to determine what waiver services are needed to prevent institutionalization or whether waiver services constitute an acceptable alternative to institutional care.

o Describe the content of the plan of care and make clear that it includes the medical and other services to be given, their frequency, and the type of provider to furnish them.

NOTE: FFP is not available for waiver services which are furnished without a written plan of care.

o Include in the waiver request a description of the qualifications of the individuals who will be responsible for developing the individual plan of care and specify the type of provider that will develop the plan of care.

o Indicate in the waiver request that the written plan of care is subject to approval by the Medicaid agency and specify the extent to which you will review plans of care.

o Effective April 7, 1986, the State agency administering the Medicaid plan may, whenever appropriate, enter into cooperative arrangements with the State agency responsible for administering the program for children with special health care needs under title V, the Maternal and Child Health Block Grant, in order to assure improved access to coordinated services to meet their needs.

4442.7 Freedom of Choice - Assurances and Documentation.--

A. Assurance.--Include the assurance that when a recipient is determined to be likely to require the level of care provided in a hospital, NF, or ICF/MR, the recipient or his or her legal representative will be:

o Informed of any feasible alternatives available under the waiver; and

o Given the choice of either institutional or home and community-based services.

NOTE: Feasible alternatives may only be determined after the assessment of an individual's care needs and an evaluation of level of care. Thus, it is not expected that a client will be offered waiver services if the assessment indicates he or she cannot be adequately served in the community.

B. Documentation.--Provide a description of the agency's plan for informing eligible recipients of the feasible alternatives available under the waiver and allowing recipients to choose either institutional services or home and community-based services as part of the waiver request. Include how the client's free choice will be documented.

State in the waiver request that the agency will provide an opportunity for a fair hearing under 42 CFR Part 431, Subpart E, to beneficiaries who are not given the choice of home and community-based services as an alternative to hospital, NF, or ICF/MR services, or who are denied the service or provider of their choice.

4442.8 Cost Effectiveness - Assurances and Documentation.--

A. In your request, assure that:

1. The average per capita fiscal year expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made in that fiscal year for the level of care provided in a hospital, NF, or ICF/MR under the State plan had the waiver not been granted.

a. These expenditures must be reasonably estimated and documented by the agency; and

b. The estimates must be annualized and cover each year of the waiver period.

c. In making estimates for a waiver that applies only to individuals with a particular illness (e.g., AIDS) or condition (e.g., chronic mental illness) who are inpatients of, or who would require the level of care provided in, a hospital, NF, or ICF/MR, you may estimate the average per capita expenditures for such individuals without including expenditures of other individuals who are inpatients of applicable hospitals, NFs, or ICFs/MR.

d. Effective December 22, 1987, when making estimates for a waiver that applies only to individuals with developmental disabilities who are inpatients of a NF but have been determined, on the basis of your evaluation, to need an ICF/MR level of care, you may estimate the average per capita expenditures that would have been made in a waiver year for those individuals under the State plan based on the average per capita expenditures for inpatients of an ICF/MR without regard to the availability of beds for such inpatients.

NOTE: The fiscal year of a waiver program starts with the effective date of the waiver and ends 12 months later.

2. The agency's actual total expenditures for home and community-based and other Medicaid services provided to individuals under the waiver will not, in any year of the waiver period, exceed the amount that would be incurred by Medicaid for these individuals in a hospital, NF, or ICF/MR in the absence of a waiver.

B. General Documentation.--

1. Estimates of average per capita expenditures must cover each year of the term of the waiver.

2. All formula factors must be labeled, formulas worked to solution, and the arithmetic must be correct.

3. The cost per unduplicated recipient determined using the formula must be less with the waiver than without the waiver or both per recipient costs must be equal. In waivers estimating little or no cost savings, describe the fiscal controls to be put in place to preclude expenditures which would exceed institutional costs.

4. Provide a formula for each level of care and in the aggregate. For example, a request proposing to deinstitutionalize residents of both hospitals and NFs must include three formulas for each year of the waiver: one for hospital recipients, one for NF recipients, and one in the aggregate.

5. The estimates must be reasonable, based on statistically sound and valid procedures, and verifiable. Present your data on the basis of the average cost per unduplicated recipient.

Unduplicated recipients refers to the total number of recipients receiving services referred to in each of the formula elements of the simplified formula. You need to know this number in order to compute the average per capita cost for each of the formula elements. An "unduplicated" recipient is only counted once for purposes of determining the average per capita cost for each formula element. Thus, when an individual is served under any single formula value category on multiple occasions during the year, he or she is counted as one unduplicated recipient in the applicable

single formula value category. For example, a recipient who receives waiver services during the waiver year and leaves the waiver but returns to the waiver in the same waiver year is counted as one recipient for purposes of determining formula values C, D, and D' in that waiver year.

6. In developing the average per capita cost estimates, use actual data on costs as reflected in your most recent Form HCFA-2082. Waivers that are targeted to individuals with a particular illness or condition are exempted from this requirement and instead you must document actual costs for the target population. Explain any discrepancies with the Form HCFA-2082. Resolve discrepancies due to erroneous Form HCFA-2082 reports by submitting a revised Form HCFA-2082 prior to approval of the waiver proposal to:

Office of Medicare and Medicaid Cost Estimates
Office of the Actuary
N3-26-00
7500 Security Boulevard
Baltimore, MD 21244-1850

NOTE: For renewals, HCFA compares the average per capita cost figures to the most recent Form HCFA-372 or HCFA-372(S) data. For renewal requests that do not have average per capita cost figures for the appropriate institutional level of care in its Form HCFA-372 or HCFA-372(S), you will need to document thoroughly your basis for your estimates of the average per capita cost of the appropriate institutional level of care.

7. In estimating cost and utilization for home and community-based services, use actual data for the most recent year before the waiver takes effect when such data is available. Also, provide the assumptions on which estimated utilization is based and the source of research supporting those assumptions (e.g., demonstration studies, etc.). Similarly, cost out each service to be provided, including the unit cost of each service and the projected utilization of each service. Furnish all assumptions driving such cost/utilization estimates and the source of any data or research supporting those assumptions.

8. OBRA 1990 permits you to estimate your average per capita institutional expenditures in waivers that apply to individuals with mental retardation or a related condition and who reside in an ICF/MR at the time it is terminated, by determining the average per capita expenditures that would have been made in a FY for these individuals without regard to any such terminations. You may use the ICF/MR costs that would have been incurred in these terminated facilities. This provision applies as if included in the enactment of OBRA 1981 but applies only to facilities decertified on or after November 5, 1990.

9. Do not provide data for institutional groups not included in the waiver.

C. Cost Effectiveness Formula.--Demonstrate the cost effectiveness or cost neutrality of the requested waiver by satisfying the following equation:

$$D + D' \leq G + G'$$

For the equation to be considered acceptable, the factor values have to meet the requirements and definitions indicated below.

NOTE: If any of the following requirements are not met, the differences must be fully explained and documented. All average per capita cost estimates must be based on statewide data except in waivers that apply only to individuals with a particular illness or condition who are inpatients of, or would require the level of care provided in, a hospital, NF, or ICF/MR. In the latter case, the average per capita costs may be based on the specific costs attributable to the involved clients.

For waivers that apply only to individuals with a particular illness or condition and who are inpatients of, or would require the level of care provided in, hospitals, NFs, or ICFs/MR, you are not required to use the entire patient population. The estimates may be based on only the number of such inpatients of the hospitals, NFs, or ICFs/MR, who are comparable to the waiver group but not expected to be included in the waiver program. Provide detailed documentation describing how the data for the group were derived.

1. C Value.--The C value reflects the estimated annual unduplicated number of individuals who are expected to receive home and community-based services under the waiver. Although factor C is not a part of the revised cost neutrality formula, you are required to indicate the number of unduplicated waiver individuals you intend to serve in each year of the waiver program. You must anticipate that individuals may leave the waiver program during the course of any waiver year. Therefore, estimates of the C value must include an adjustment to reflect both phase in and phase out of particular clients throughout each waiver year. Although it may be useful for you to conceptualize your waiver population in full year equivalents or waiver slots, the C value submitted must be adjusted to reflect an unduplicated recipient count which incorporates clients turnover expectations.

The C value constitutes a limit on the size of the waiver program. This number may be revised through an amendment request when you determine that you need to increase or decrease the number of individuals you estimate you will serve under the waiver.

2. D Value.--The D value must equal the estimated annual average per capita Medicaid cost for home and community-based services for individuals in the waiver program. For the D value to be acceptable:

a. The D value must be broken out into unit cost and utilization components, both of which must be fully explained and documented. Also, identify the unit, e.g., day, hour, month, trip, etc. All estimates must reflect whole numbers of persons and services, fractions of persons or services are unacceptable.

b. The cost component must include a cost per unit of service for each service rendered. The cost per unit must be reasonably estimated. (See §4441.3 regarding the room and board component of services provided by live in caregivers.)

Any increase projected in the unit cost per service must be demonstrated to not exceed the Medical Consumer Price Index unless a higher rate can be justified.

c. The utilization component to be applied to unit cost must include a utilization rate for each individual type of service. The utilization rate must be reasonably estimated based on a comparable population. In waiver renewal requests, HCFA expects utilization trends established during the waiver to be documented and continue through the renewal period.

d. If bundling of services is authorized, you must document the cost and utilization of each component service that makes up the bundled service to support the final cost and utilization of the bundled service used in the cost effectiveness or cost neutrality formula.

e. For each service, multiply the unit cost times the utilization rate to derive the service cost per recipient. (See NOTE.)

f. Multiply the service cost per recipient by the number of recipients expected to need each type of service to obtain an overall cost per service.

g. Add together the overall cost per service for all services to obtain an overall cost for waiver services.

h. Divide the overall cost of waiver services by the C value as defined in subsection C.1. to obtain the D value. (C X D) equals the overall cost of waiver services in step g.

i. The following is an example of how the derivation of the D value may be displayed:

Waiver Services	Unit Cost	No. of Recipients Receiving Services	Average Units Per Recipient (Adjusted for Client Turnover/ Average Length of Stay)	Total Cost

NOTE: The D value in the cost effectiveness/neutrality formula must take into account the expected phase in and phase out of unduplicated recipients throughout each waiver year in order to reasonably estimate the per capita cost of waiver services.

3. D'Value.--The D' value must equal the estimated annual average per capita Medicaid cost for all services other than waiver services that are provided to individuals in the waiver program including expanded EPSDT services and institutional costs when a person leaves the waiver for institutionalization and returns to the waiver in the same waiver year. If you include a waiver service that is also covered under the State plan and define the service identically except for utilization limits, the State plan services, up to the imposed limit, would be included under D'. The

services provided under the waiver that exceed the State plan utilization limits would be included under factor D as waiver costs. The D' factor also includes all State plan services that are provided to individuals while they are also receiving waiver services. For the D' value to be acceptable:

a. An explanation with supporting documentation of how the D' value was derived must be provided.

b. The D' value must equal or exceed the G' value as defined in §4442.8. Where the D' value is less than the G' value, the difference must be fully explained and documented.

4. G Value.--The G value must equal the estimated annual average per capita Medicaid cost for hospital, NF, or ICF/MR care that would be incurred for individuals served in the waiver, were the waiver not granted. For the G value to be acceptable:

a. The G value must be reasonably related to the total cost for the level of care (from the Form HCFA-2082) divided by the annual number of unduplicated recipients. For waivers that apply only to individuals with a particular illness or condition, you may use estimates based only on that particular group. You must provide an explanation with supporting documentation of how the value was derived.

b. The projected first year G value must not deviate substantially from previous year trends. Any inflation adjustment must be no greater than the current Medical Consumer Price Index (MCPI) unless a higher rate is fully justified by the State.

NOTE: See §4442.8.B.8 regarding the inclusion of costs of terminated ICF/MR beds.

5. G' Value.--The G' value must equal the estimated annual average per capita Medicaid costs for all services other than those included in factor G for individuals served in the waiver, were the waiver not granted. The G' value includes expanded EPSDT services that are not accounted for in the G value. For the G' value to be acceptable:

a. An explanation with supporting documentation of how the G' value was derived must be provided.

b. The G' value must be less than or equal to the D' value as defined in §4442.8 unless fully explained and documented.

c. In situations where a waiver will provide services to individuals who although requiring a NF level of care are hospitalized because NF placement is not possible, the actual cost of caring for these individuals in a hospital should be shown in this value. Therefore, in this situation, the G' value would be the weighted average of all other State plan services not included in factor G.

6. Computation of Expenditures for Individuals With a Particular Illness or Condition.--For a waiver that applies only to individuals with a particular illness or condition who are inpatients of, or require the level of care provided in, hospitals, NFs, or ICFs/MR, you may determine the average per capita expenditures that would have been made in a waiver year for these individuals under the State plan separately from the expenditures for other individuals in the affected hospitals, NFs, or ICFs/MR. That is, for waivers directed at any specified group, you may make expenditure estimates specific to that group of patients who are inpatients of Medicaid certified hospitals, NFs, or ICFs/MR distinguished by illness or condition, regardless of the costs for those inpatients in the respective certified facilities. While this method may be used, you are not precluded from using the usual method of estimating average per capita expenditures, e.g., include the cost of all Medicaid recipients. AIDS or AIDS related conditions are examples of a particular illness or diagnosis, while chronic mental illness or ventilator dependency are considered examples of conditions.

This provision applies to current inpatients of Medicaid certified facilities and is effective for new waivers and renewals of waivers approved on or after October 21, 1986. Previously, under the authority of §9502(d) of COBRA (P.L. 99-272), the use of other than statewide data was restricted to the physically disabled and was effective for services furnished on or after August 13, 1981. The COBRA provision was superseded by §9411(a)(3) of OBRA 1986 (P.L. 99-509) which expanded the authority to use less than statewide data for individuals with a particular illness or condition who are deinstitutionalized. Section 8437 of the Technical and Miscellaneous Revenue Act of 1988 (P.L. 99-5009) further expanded the OBRA 1986 provision by clarifying that less than statewide data may be used for waivers serving individuals with a particular illness or condition who are inpatients in or who would require the level of care in a hospital, NF, or ICF/MR. This provision is effective for waiver applications submitted before, on, or after November 10, 1988, the date of enactment of the Technical and Miscellaneous Revenue Act of 1988.

7. Effect of the Preadmission Screening Requirement on Cost Estimates.--For waivers serving individuals with mental retardation or a related condition, you may revise your per capita cost estimates to take into account increases in ICF/MR costs resulting from implementation of the preadmission screening requirement. It is expected that increased costs resulting from the preadmission screening requirement affect your estimate of formula value G. This provision is effective for expenditures made on or after January 1, 1989. Any revisions to your per capita expenditure estimates for this purpose must be made through the usual amendment process.

4442.9 Annual Report - Assurance and Documentation.--

A. Assurance.--Include the assurance that annually the agency will provide HCFA with information on the waiver's impact. The information must be consistent with a data collection plan designed by HCFA (currently Forms HCFA 372 and/or 372(S)) and must address the waiver's impact on:

1. The type, amount, and cost of services provided under the State plan; and

2. The health and welfare of recipients.

B. Forms HCFA-372 or 372(S).--The first year Form HCFA 372 or Form HCFA 372(S) report must be submitted on or before the 18th month after the effective date of the waiver. Subsequent reports for years 2 through 5, as applicable, are due on or before 6 months after each anniversary date (the 30th, 42nd, 54th and 66th month, respectively, after the effective date of the waiver).

C. Documentation.--Describe your system for collecting the information needed to complete required HCFA reports.

4442.10 Financial Accountability - Assurance and Documentation.--

A. Assurance.--Include the assurance that there will be financial accountability for funds expended for home and community-based services, provision will be made for an independent audit of your waiver program (except as HCFA may otherwise specify for particular waivers), and that you will maintain and make available to HHS, the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver, including reports of any independent audits conducted.

B. Documentation.--

1. Accountability.--

a. Assure HCFA that you will maintain and require providers of these services to maintain financial accountability for funds expended for these services.

b. The Medicaid State Agency is directly accountable for expenditures made for Medicaid home and community-based waiver services irrespective of the involvement of any other State agencies in the administration of the waiver or the provision of waiver services. Where the administration of a waiver depends on agreements between State agencies, copies of those agreements must be submitted with the request for a waiver. The absence of an agreement needed to document the satisfaction of a required assurance may be considered by HCFA to be equivalent to the absence of the assurance.

c. Describe the records and information that will be maintained to support financial accountability and inform HCFA how you will meet the requirement. In accordance with 45 CFR Part 74, Subpart D, records and information to support financial accountability must be maintained, at a minimum, 3 years from the submission of each Form HCFA-372 or HCFA-372(S) report. Explain how these records will ensure that there is an audit trail for all State and Federal funds. The audit trail must begin at the point of service to the beneficiary and follow through to the claim for FFP.

d. Use the Medicaid Management Information System (MMIS) to track the costs of waiver services. If you do not have a MMIS, provide a detailed description of the audit trail.

e. Indicate that providers will be advised of their accountability for funds.

2. Independent Audit.--If you conduct an audit under the provisions of the Single Audit Act of 1984 (P.L. 98-502), the completion of such an audit will be deemed to satisfy the independent audit requirement. If you do not conduct an audit under the Single Audit Act, the following applies.

a. HCFA may exempt you from meeting this requirement if you request it and justify the basis for the exception; for example, by demonstrating that the cost of the audit would exceed the potential savings that would accrue from the waiver program. Documentation must include a statement of the proposed cost as provided (and signed) by the organization who would perform the audit and a description of the relationship of that organization to the Medicaid State Agency (MSA).

b. In order to meet the independent audit requirement contained in 42 CFR 441.302(b), the audit must be performed by an independent auditor. An "independent auditor," as defined in section 5.f. of OMB Circular A-128 Audits of State and Local Governments, means:

(1) A State or local government auditor who meets the independence standards specified in generally accepted government auditing standards, as defined in Chapter IV. B. of the Standards for Audit of Government Organizations, Programs, Activities, and Functions, developed by the Comptroller General, dated February 27, 1981; or

(2) A public accountant who meets such independence standards.

The waiver request or renewal request must indicate whether the audit will be performed by an entity outside of State government. If it is not to be performed by an outside entity, the request must indicate who would perform it, provide a description of how the entity related to the MSA, its umbrella agency and any other State agency with any responsibility for the waiver, and indicate to whom the entity reports within State government.

c. The auditors must verify that:

(1) Only allowable home and community-based services waiver expenditures under an approved waiver are being claimed for FFP on the Form HCFA-64.

(2) You are correctly reporting all your home and community-based services waiver expenditures on the Form HCFA-64.

d. The audit must be made in accordance with standards for governmental auditing, applicable Federal statutes, regulations, and policy issuances, and your approved home and community-based services waiver. It must also include tests of the accounting records and other auditing procedures as deemed necessary. At a minimum, the audit must cover the following:

(1) Your system for reimbursing home and community-based waiver services, especially the procedures employed in accumulating expenditures for the purpose of preparing the Form HCFA-64. This includes a test of either all claims or a sample of claims made on the Form HCFA-64 to the source documentation and a verification that you are maintaining all records, information, and supporting documentation to assure financial accountability in accordance with 42 CFR 441.301(b).

(2) Home and community-based services providers, including a verification that the reimbursement rates were established and adjustments made in accordance with the approved methodology, that services were actually provided and billings are specific to eligible recipients, that the services were actually reimbursed at the appropriate rate for the correct number of days and in accordance with the provider agreement, and that documentation exists to support all of these items. HCFA expects the auditors to make on site visits to the providers.

(3) The eligibility of your home and community-based services recipients, including a verification that eligibility has been established as of the effective date of the waiver and that eligibility is supported by care record documentation. In conjunction with the verification of provider billings, ensure that the recipient's case record supports services provided and billed.

(4) Your home and community-based services waiver reporting on the Form HCFA-64, including a verification of the information reported on the Forms HCFA 64.9 and 64.9p, Line 1.R., and a verification that all waiver costs have been reported as such in those two sections (as opposed to being claimed elsewhere on the Form HCFA-64).

e. The final audit report is generally structured as follows:

- o Background,
- o Purpose and Scope,
- o Findings,
- o Conclusions,
- o Recommendations, and
- o Supporting Attachments/Appendices.

f. The independent audit must cover the period up to the final year of the waiver and must be completed and made available to HCFA no later than 90 days before the expiration of the waiver.

You may have each waiver year audited separately or may have several years combined into one audit.

When a waiver expires or is terminated, the independent audit of all payments made under the waiver is due within one year after the date of termination.

Submit copies of the final audit report to:

- o Associate Regional Administrator, Division of Medicaid, HCFA, and
- o Director, Medicaid Bureau, HCFA

4442.11 Independent Assessment of the Waiver.--Indicate whether you will provide for an independent assessment of the waiver that evaluates the quality of care provided, access to care, and cost effectiveness of the waiver.

For the assessment to be considered independent, it may be performed by an outside contractor, university, or other entity outside of the State government. It may also be performed by another entity within the State government that is not responsible to the Medicaid State agency or the agency responsible for administering the waiver program (including another administrative part of an umbrella agency in the State of which the Medicaid agency or the agency administering the waiver is also a part.)

For example, a State which has an audit or assessment office that does not report to the MSA or any other agency with any responsibility for the waiver may perform an independent assessment even if that audit or assessment office reports to the umbrella agency incorporating the MSA.

The request must indicate the organization to perform the assessment and describe its relationship to the State. The waiver request or renewal request must indicate whether the assessment is to be performed by an entity outside of State government. If it is not to be performed by an outside entity, the require must indicate the entity to perform it, provide a description of how the entity relates to the MSA and any other State agency with any responsibility for the waiver, and indicate to whom the entity reports within State government.

The results of the assessment must be submitted to HCFA at least 90 days prior to the expiration of the approved waiver period and must cover the period up to the final year of the waiver.

Submit copies of the final assessment report to:

- o Associate Regional Administrator, Division of Medicaid, HCFA, and
- o Director, Medicaid Bureau, HCFA

The assessment should verify that:

- o The waiver is cost effective/neutral for each year of its existence. For example, you may include a valid statistical sampling of recipients under the waiver to assess the need for inpatient services in a hospital, NF, or ICF/MR or to ensure that without the waiver there is medical evidence to support institutionalization. Through this sampling, verify that recipients are given proper information as to their choice of institutional services or home and community-based services.

- o Necessary safeguards are in place to ensure the health and safety of the recipient. For example, you may include a verification of a valid statistical sample of providers in the assessment and a further verification of quality of care furnished to the recipient population.

- o Individuals receiving waiver services are in fact Medicaid eligible.

- o The appropriate target groups are being properly claimed in accordance with the law and regulations.

4443. HOME AND COMMUNITY-BASED SERVICES - MODEL WAIVER REQUEST

A. Background.--Under the authority of OBRA 1981 (P.L. 97-35) and amended by P.L. 99-272, COBRA, P.L. 99-509, OBRA 1986, P.L. 100-203, OBRA 1987, P.L. 100-360, the Medicare Catastrophic Coverage Act of 1988, P.L. 100-647, the Technical and Miscellaneous Revenue Act

of 1988, P.L. 101-508, OBRA 1990 and P.L. 105-33 and BBA 1997, you can offer, through a Secretarial waiver, home and community-based services to individuals who otherwise would require institutionalization. Interim final regulations implementing these provisions were published in the Federal Register on October 1, 1981. Final regulations were published in the Federal Register on March 13, 1985, which amended the interim rules. A notice of proposed rule was published on June 1, 1988 and a final rule with comment period was published on July 25, 1994 which incorporated the legislation noted above (except § 4743 of P.L. 105-33, BBA 1997) and comments received as a result of the notice of proposed rule. Further, §1902(a)(10)(A)(ii)(VI) of the Act, as added by §137(b)(7) of TEFRA 1982, permits coverage as optional categorically needy for the individuals who will receive home and community-based services under the waiver, and who, if they did not receive home and community-based services, would require institutional care. For example, if an individual would qualify for Medicaid in the institutional setting because the income of the parents or of a spouse was not deemed available to the individual, you may elect this optional coverage group and apply these same deeming rules when determining eligibility for home and community-based services. This option allows you to eliminate situations where individuals must remain institutionalized to retain Medicaid eligibility even though the recipient could receive the necessary services at home and at a lower cost to Medicaid.

Section 4118 of OBRA 1987 amended §1915(c)(3) of the Act to provide for a waiver of the community income and resource requirements for the medically needy, as specified in §1902(a)(10)(C)(i)(III) of the Act. Reinstatement of this waiver is retroactive to waivers or renewals approved on or after October 21, 1986.

Waiving of the community income and resource requirements for the medically needy allows individuals who might not otherwise qualify for Medicaid under community rules to qualify. For example, by waiving the requirements specified at §1902(a)(10)(C)(i)(III) of the Act, income is not deemed from parent to child or spouse to spouse, or States may apply the spousal impoverishment eligibility rules.

You may wish to request a waiver of the community income and resource requirements for the medically needy, as specified at §1902(a)(10)(C)(i)(III).

Section 4743 of BBA 1997 eliminated the legislative requirement that an individual be discharged from an NF or ICF/MR to be eligible for expanded habilitation services (pre-vocational, educational and supported employment).

B. Model Waiver Request.--To assist you in utilizing the home and community-based waiver process to avoid unnecessary institutionalization and to reduce expenses, a model waiver request (see Exhibit A) can be submitted in addition to or in lieu of a regular home and community-based waiver services request. You are required to offer at least one home and community-based service under the model request, e.g., case management services. You must meet all statutory and regulatory requirements for waivers that were published in the Federal Register on October 1, 1981, and as amended on March 13, 1985, June 1, 1988, and July 25, 1994.

Prior to April 7, 1986, you were limited to a total of up to 50 cases for each model request. The term "cases" in this context was defined as 50 unduplicated recipients per waiver year. Effective April 7, 1986 through December 21, 1987, the model waiver was limited to 50 individual

participants in the waiver at any one time. Effective December 22, 1987, model waivers may contain up to 200 individuals at any one time. However, you are not required to serve 200 persons under a model waiver. Individuals who leave the waiver may be replaced throughout the waiver year. In submitting estimates for a model waiver request, adjust your value of C to reflect the expected turnover during each waiver year. Therefore, the C value of model waivers may be greater than 200 unduplicated recipients to accommodate the replacement of individuals who leave the waiver program. Model waivers previously approved to serve 50 individuals however, must be amended should you wish to serve more individuals than were originally approved.

If you wish to use waivers to cover larger numbers of recipients or to provide a comprehensive range of services, utilize the regular waiver system or submit another model request. This separation between model waiver requests and other waiver requests will enable us to process both types of requests more efficiently. See §§4440ff for more detailed information about the waiver requirements and the regular waiver system.

C. Instructions for Completing a Model Waiver Request.--Many of the items in the model waiver request (see Exhibit A) do not need further information from you and are required by the statute or regulations. The State official's signature on the request indicates your agreement and acceptance of the particular item.

Heading. Enter the name of the State.

Item 1. No information required.

Item 2. In order to obtain approval of your model waiver request, provide to recipients under the waiver at least one home and community-based service, e.g, case management services. You may also request approval under the model waiver request to provide other home and community-based services; however, the addition of such services will necessitate additional documentation.

Approval to provide one or more of the following services may be requested:

- Case management services;
- Homemaker services;
- Home health aide services;
- Personal care services;
- Adult day health services;
- Habilitation services;
- Respite care services;
- Day treatment or other partial hospitalization services, psychosocial rehabilitation services and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness; and

o Other services requested by the Medicaid agency and approved by HCFA as cost effective and necessary to avoid institutionalization.

Attach a complete description and definition of each service to the model waiver request that you propose to offer. See §4442.3 for additional information about these requirements.

Home and community-based services waivers allow you to provide as medical assistance, services not included in the definition of "medical assistance" in §1905(a) of the Act. However, it must be demonstrated that the provision of such services will enable you to serve recipients more cost effectively outside of a hospital, NF, or ICF/MR (whose costs would otherwise be reimbursed under the State plan). Therefore, the services proposed to be provided in the waiver must not duplicate services which are provided under your State Medicaid plan. However, you may provide services under a waiver similar to those provided under the State plan where they are defined differently under the waiver or which differ in amount, duration or scope from those provided in the State plan.

Item 3. Check the categories you wish to include under the waiver: categorically needy, optional categorically needy, or medically needy. Also check which applicable target groups you wish to include.

You may include in a model waiver blind or disabled individuals who are eligible under the special home and community-based waiver eligibility group included in 42 CFR 435.217. The special home and community-based waiver eligibility group specified under 42 CFR 435.217 is made up of individuals who would be eligible for Medicaid if they were in an institution, who have been determined to need home and community-based services in order to remain in the community, and who are covered under the terms of the waiver. If you include individuals eligible under the special home and community-based waiver eligibility group in a waiver request, it must also provide information on the post-eligibility treatment of income and resources of those individuals receiving home and community-based services furnished under a waiver. Information on post-eligibility treatment of income and resources must follow regulations at 42 CFR 435.726 for non-209(b) States and regulations at 42 CFR 435.735 for 209(b) States and §1924 of the Social Security Act for an individual with a community spouse.

NOTE: Section 9502(e) of COBRA and §9435(a) of OBRA 86, which apply to waivers or waiver renewals approved before, on, or after April 7, 1986, provide that you may set your own maintenance needs deduction amounts for individuals without regard to the limits imposed by regulations at 42 CFR 435.726(c)(1) and 42 CFR 435.735(c)(1). You must establish a maximum maintenance needs deduction amount which will not be exceeded for any individual under the waiver, and the maintenance needs deduction amount must be based on a reasonable assessment of the individual's needs. Except for these restrictions, you may establish the deduction amount for individuals at any level you choose. You may also establish different deduction amounts for different individuals, or groups of individuals, based on an assessment of each individual's or group's particular needs.

The upper limits for maintenance needs deduction amounts already established in regulations for spouses and dependent children continue to apply. However, as with the deduction amount for individuals described above, you may establish the deduction amount for a spouse or dependent children based on an assessment of each spouse's or family's needs. (See §3590.9.)

Pending publication of final regulations, spousal impoverishment eligibility rules, specified at §1924 of the Act, may be used for individuals with a community spouse (whose eligibility is determined under 42 CFR 435.217).

States have an option concerning the application of the post-eligibility rules for individuals with a community spouse. States may use either the spousal impoverishment post-eligibility rules specified at §1924 of the Act or the post-eligibility rules specified at 42 CFR 435.726. (Spousal impoverishment post-eligibility rules can be used only if the State is using the spousal impoverishment eligibility rules.)

The spousal impoverishment post-eligibility rules provide for a more generous community spouse and family allowance than the rules under 42 CFR 435.726 and 42 CFR 435.735. The spousal protection rules also provide for some personal needs allowance (PNA) described in §1902(q)(1) of the Act for the needs of the institutionalized individual. This allowance is a "reasonable amount for clothing and other personal needs of the individual...while in an institution." For an institutionalized individual, this can be as low as $30 per month. Unlike the institutionalized individual whose room and board are covered under Medicaid, the personal needs allowance of the home and community-based waiver recipient must include a reasonable amount for food and shelter as well as for clothing. The $30 monthly PNA is not a sufficient amount for these needs when the waiver recipient is living in the community.

Therefore, States which elect to treat home and community-based services waiver participants with community spouses under the §1924 spousal rules must use as the individual's personal needs allowance either the maintenance amount which the State has elected under 42 CFR 435.726 or 42 CFR 435.735, or an amount that the State can demonstrate is a reasonable amount to cover the costs of the individual's maintenance needs in the community.

You may wish to provide home and community-based services to blind or disabled individuals who are 18 years of age or less under the model waiver request if you do not opt to cover them under §1902(e)(3) of the Act. Under this provision, you have the option of covering disabled children age 18 or under who are living at home and who would be eligible for SSI or a State supplementary payment, and therefore Medicaid, if they were in a medical institution. However, even if you cover such individuals under §1902(e)(3), you may also wish to cover them under the model waiver request to provide home and community-based services which are not otherwise included in the State Medicaid plan. Further, under the model waiver, you may also be granted a waiver of the statewideness requirement under §1902(a)(1) and the comparability requirements under §1902(a)(10)(B) of the Act.

Item 4. Check yes or no.

Item 5. Attach a specific description of how the services will differ from those provided under the State plan and provide the criteria which distinguish these from services provided under the State plan in terms of amount, duration and scope of services. Also attach a description of the types of individuals you intend to serve under the waiver and any additional targeting restrictions.

Item 6. Check yes or no. If yes is checked, show which geographic subdivisions (e.g., counties) will be included.

Item 7. Attach a description of the qualifications of the individuals who will be responsible for developing a recipient's plan of care. Documentation requirements specified in §4442.6 must also be met.

Item 8. No information required.

Item 9. No information required.

Item 10. Check yes or no. If yes is checked, explain in detail how such determinations will be made and implemented. This description must include the procedure to be used, including how costs will be estimated and compared.

Item 11. Enter the name of the State.

Item 11(a). Submit the documentation specified in §4442.4B unless this documentation was submitted to HCFA for a previously approved waiver request. If previous documentation was provided, specifically identify the standards applicable to each provider and where they are located in the previously approved proposal.

Item 11(b). Submit the documentation specified in §4442.10B. You may be exempt from meeting the independent audit requirement if you request an exemption and document the reasons, e.g., if the cost of the audit exceeds the estimated savings of your waiver program. (See §4442.10B.)

Item 11(c). Submit the documentation specified in §4442.5B.

Item 11(d). Submit a description of your plan for informing eligible recipients of the alternatives available under the waiver and allowing recipients to choose either institutional services or home and community-based services. The plan must describe how the client's free choice will be documented.

If you intend to limit in any way the recipient's freedom of choice to participate in the waiver or to choose the provider(s) of service, separately apply to HCFA for a waiver of the freedom of choice provisions authorized under §1915(b) of the Act. Procedures for this application are found in §2100. Otherwise, the requirements of this assurance must be met.

Item 11(e). Develop an estimate, based on actual cost data, of the average per capita cost of the individual's care in the institution as compared to the cost of that individual's care in the home or community setting. These estimates are to be provided in accordance with the equation specified in 42 CFR 441.303(f). This estimate is to include cost and data for the individuals for whom you will provide home and community-based services. Estimates of hospital or nursing home average

per capita costs must be drawn from actual experience and from the most recent figures entered on the Form HCFA-2082, unless you have an equally reliable source of alternate data. See §4442.8 for additional information about these requirements.

Items 11(f) and 11(g). No further information is needed.

Item 12. If you opt to provide an independent assessment, the assessment must meet the requirements specified in §4442.11.

The heading of the application must include the name of the State and the closing must include the signature, title and date of signature of the appropriate single State agency or State Medicaid official.

Effective for waiver requests received after September 9, 1985, the effective date for a new waiver is established by HCFA prospectively on or after the date of approval and after consultation with you.

EXHIBIT A

MODEL WAIVER REQUEST
Special Targeted Home and Community-Based Services Waiver

State_____

Waiver Title_____

1. A waiver is requested for an initial 3-year period (or 5-year renewal) under §1915(c) of the Social Security Act to provide home and community-based services to individuals who would otherwise require the level of care provided in a hospital, nursing facility, or intermediate care facility for the mentally retarded, the cost of which would be reimbursed under the State Medicaid plan.

2. The State requests that the following home and community-based services be included under this waiver request:

_____

Other home and community-based services (not available under the State plan) which the State proposes to offer are:

A complete description and definition of all home and community-based services to be provided under this waiver is attached. (For waivers which include prevocational, educational and supported employment services as part of habilitation services or which provide day treatment or other partial hospitalization services, psychosocial rehabilitation services and clinic services for individuals which chronic mental illness, see §4442.3 for required assurances.)

3. The sole purpose of this request is to provide authority for the State to furnish the requested services in the home and community setting to no more than 200 individuals at any one time during the waiver who would be Medicaid-eligible if institutionalized. These individuals will be from among the following categories:

(a) Categorically needy ____ Yes ____ No.

(b) Optional categorically needy ____ Yes ____ No.

(c) Medically needy ___ Yes ___ No.

Under authority of §1902(a)(10)(A)(ii)(VI), such individuals would be eligible for Medicaid services even if they would otherwise be ineligible for Medicaid while living at home because of the SSI deeming rules or because of a 209(b) State's deeming rules. Such individuals include:

(d) Blind or disabled children with an ineligible parent(s) where income deemed from the parent(s) would cause the applicant to be ineligible for SSI if the family shared a household; _____ Yes _____ No.

(e) Blind or disabled individuals with an ineligible spouse where income deemed from the spouse would cause the applicant to be ineligible for SSI if the family shared a household; _____ Yes _____ No.

(f) Blind or disabled children with an ineligible parent(s) where income deemed from the parent(s) or the child's own income, up to 300 percent of the SSI payment amount, would cause the applicant to be ineligible for SSI if the family shared a household; and*
_____ Yes _____ No.

*NOTE: If a State elects to cover individuals under 3(d) through 3(h) it must include information on the post-eligibility treatment of income and resources of these individuals in accordance with regulations at 42 CFR 435.726 for individuals in a non-209(b) State and regulations at 42 CFR 435.735 for individuals in a 209(b) State or §1924 of the Social Security Act.

(g) Blind or disabled individuals with an ineligible spouse where income deemed from the spouse or the individual's own income, up to 300 percent of the SSI payment amount, would cause the applicant to be ineligible for SSI if the family share a household.**
_____ Yes _____ No.

(h) Other (specify):_____

4. A waiver of the requirements of §1902(a)(10)(c)(i)(III) of the Act relating to income and resource eligibility rules applicable in the community for the medically needy is requested. _____ Yes _____ No.

5. A waiver of the amount, duration, and scope requirements in §1902(a)(10)(B) of the Act is requested. (A description of how the services will differ from the State plan provision and the criteria on which this was based is attached. Also attached is a description of the types of individuals to be served under the waiver and additional targeting restrictions.)

6. A waiver of the statewideness requirements in §1902(a)(1) of the Act is requested.
(a) _____ No.

(b) _____ Yes. Waivers will apply to individuals only in the following geographic subdivisions:

7. An individual written plan of care will be developed by qualified individuals for each recipient covered under this waiver. This plan of care will describe the services to be furnished, their frequency, and the type of provider who will furnish them. The plan of care will be subject to the approval of the State Medicaid agency. (A description of the qualifications of the individuals who will be responsible for developing the plan of care is attached.)

**NOTE: If a State elects to cover individuals under 3(d) through 3(h) it must include information on the post-eligibility treatment of income and resources of these individuals in accordance with regulations in 42 CFR 435.726 for individuals in a non-209(b) State and regulations in 42 CFR 435.735 for individuals in a 209(b) State or §1924 of the Social Security Act.

8. The services will not be furnished to recipients while they are inpatients of a hospital, NF, or ICF/MR.

9. Federal financial participation for services will not be available in expenditures for the cost of room and board of a recipient except when provided as part of respite care in a facility approved by the State (hospital, NF, foster home, or community residential facility) that is not a private residence.

10. The State will refuse to offer home or community-based services to any recipient for whom it can reasonably be expected that the cost of home or community-based services furnished to that recipient would exceed the cost of the level of care provided in a hospital, NF, or ICF/MR. _____

Yes _____ No. (If yes, a description of how this determination will be made and implemented is attached.)

11. The _____ Medicaid agency provides the following assurances to HCFA:

(a) Necessary safeguards have been taken to protect the health and welfare of the recipients of the services. (A description of the safeguards is attached.) Those safeguards include:

1. Adequate standards for all types of providers that provide services under the waiver; (a copy of the standards applicable to each provider of service is attached, including, if applicable, standards established for all facilities subject to §1616(e) of the Act);

2. Assurance that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver; and

3. Assurance that all facilities covered by §1616(e) of the Act, in which home and community-based services will be provided, are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

(b) The agency will assure financial accountability for funds expended for home and community-based services, provide for an independent audit of its waiver program (except as HCFA may otherwise specify for particular waivers), and it will maintain and make available to HHS, the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver, including reports of any independent audits conducted. (A description of the records and information that will be maintained is attached.)

(c) The agency will provide for an evaluation (and periodic reevaluations) of the need for the level of care provided in a hospital, NF, or ICF/MR, as defined by 42 CFR 440.10, §1919(a) of the Act, and 42 CFR 440.150, respectively, when there is a reasonable indication that individuals might need such services in the near future but for the availability of home and community-based services. Written documentation of all evaluations and reevaluations will be maintained. (A description of the agency's plan for such evaluations including the frequency of reevaluation and including record retention procedures as well as a copy of the evaluation instrument is attached.)

(d) When a recipient is determined to be likely to require the level of care provided in a hospital, NF, or ICF/MR, the recipient or his or her legal representative will be:

1. Informed of any feasible alternatives available under the waiver; and

2. Given the choice of either institutional or home and community-based services.

The agency will provide an opportunity for a fair hearing under 42 CFR Part 431, Subpart E, to beneficiaries who are not given the choice of home and community-based services as an alternative to hospital, NF or ICF/MR services or who are denied the service of their choice or the provider of their choice.

(e) The average per capita fiscal year expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made in that fiscal year for the level of care provided in a hospital, NF, or ICF/MR under the State plan had the waiver not been granted. (An explanation with supporting documentation as described in 42 CFR 441.303(f) is attached.)

(f) The agency's actual total expenditures for home and community-based and other Medicaid services provided to individuals under the waiver will not, in any year of the waiver period, exceed the amount that would be incurred by Medicaid for these individuals in a hospital, NF, or ICF/MR, in the absence of a waiver.

(g) The agency will provide HCFA annually with information on the impact of the waiver on the type, amount, and cost of services provided under the State plan and on the health and welfare of recipients. The information will be consistent with a data collection plan designed by HCFA. For purpose of this model waiver, data will be maintained on the cost and utilization of services for each individual.

12. The agency will provide for an independent assessment of the waiver that evaluates the quality of care provided, access to care, and cost effectiveness of the waiver.

Yes _____ No _____

Signature : _____
Title : _____
Date : _____

Attachment(s)

4444. HOME AND COMMUNITY-BASED SERVICES - PROCEDURES TO REQUEST RENEWAL OF APPROVED WAIVERS

A. Background.--Section 1915(c) of the Social Security Act permits you to offer, under a waiver of statutory requirements, an array of home and community-based services that an individual needs to avoid institutionalization. HCFA published a final rule with comment period in the Federal Register on July 25, 1994. This final rule expands coverage of Medicaid home and community-based services under § 1915(c) of the Social Security Act and responds to public comments that were received as a result of the June 1, 1988 publication of a proposed rule. These regulations were codified as 42 CFR 440.180 through 440.250 and 441.301 through 441.310. These regulations allow FFP in the cost of waiver services provided by the State in accordance with the terms of the approved waiver for an initial 3-year period from the waiver effective date. (See §4441E.) Upon your request, the waiver may be renewed for additional 5-year periods.

B. Renewals.--Prior to September 30, 1986, waivers were granted for an initial term of 3 years and, if requested by you and approved by HCFA, were renewed for additional 3-year periods. Effective September 30, 1986, waivers are granted for an initial term of 3 years and, upon your request may be renewed for additional 5-year periods if HCFA's review of the prior waiver period indicates that the assurances you made as a condition of approval have been and continue to be met. In determining whether a waiver may be renewed, HCFA will place great weight on your past waiver performance which is evidenced in part by the assessment conducted by the HCFA regional offices and your correction of any resulting deficiencies. HCFA will also consider the adequacy of the assurances and documentation submitted in support of the renewal request.

C. Instructions for Submitting a Request for a Waiver Renewal.--Waivers which have not been formally renewed by the end of the waiver period automatically expire. HCFA has no obligation to notify you in advance that a waiver's expiration date is nearing nor to formally notify you when expiration occurs. It is therefore suggested that requests for waiver renewals be submitted to HCFA at least 90 days, but no earlier than 180 days, prior to the end of the waiver period. This will allow HCFA sufficient time to review the renewal package and request and review any additional information needed prior to the expiration of the waiver. (See §4441B.)

NOTE: The fact that you are preparing to submit additional information or that additional information submitted is under review by HCFA does not change the expiration date. HCFA must approve, deny, or request additional information on the renewal request within 90 days of receipt, but HCFA is not obligated to complete action before the expiration date if it falls within the 90-day time periods.

If within 90 days of receipt of the renewal request, HCFA is unable to make a finding, based on the information you provided, that the assurances have been met and that the waiver is cost effective or cost neutral, HCFA may either formally request additional information or disapprove the request. (See §4441.D.) For waivers expiring after September 29, 1986, HCFA may, however, in doing so, grant you up to a 90-day extension of the current waiver to permit you the opportunity to more fully document that the statutory and regulatory requirements are met without jeopardizing the continuity of the waiver or to submit a new waiver request. All or part of the temporary extension may be subsumed into the latest approved waiver period.

HCFA will determine whether a request for renewal of an existing waiver is actually a renewal request or a request for a new waiver. If you make significant changes to your waiver program, HCFA will consider it to be a new waiver. On the other hand, minor changes can be included in your renewal request.

When a renewal request is treated as a new request and additional information is requested of you, HCFA may extend your current waiver (those expiring after September 29, 1986) as initially approved for a period of up to 90 days if the current waiver is about to expire. Thus, you would have the opportunity to respond to HCFA's request without jeopardizing the continuity of the current waiver.

If you submit a renewal request after the expiration date of your waiver, the request will be treated as a new waiver request by HCFA.

Effective with waiver requests received after September 9, 1985, the effective date for a waiver will be established by HCFA prospectively on or after the date of approval and after consultation with you. This also applies to renewal requests received after September 9, 1985, which are considered by HCFA to be new requests.

Waiver renewal requests that are considered to be new requests must be limited to one of the following target groups or any subgroup thereof that you may define:

- o Aged or disabled, or both;
- o Mentally retarded or developmentally disabled, or both; or
- o Mentally ill.

As of October 1, 1993, waiver renewals, amendments to renewed waivers, and requests for temporary extensions of existing waivers are to be submitted to your respective regional office.

D. Content of a Waiver Renewal Request.--Requests for waiver renewals must contain the following:

1. A formal request for a renewal of the existing waiver, signed by the appropriate single State Agency or State Medicaid official.

2. A statement that all of the assurances and information you provided in the approved waiver as required by 42 CFR 441.302(a) - (f) remain in effect, including any amendments approved by HCFA. If the assurances or other documentation provided are to be implemented differently under the renewed waiver, the changes must be described. This includes any changes in licensure or certification requirements for providers of home and community-based services and any changes made in the level of care assessment process or team. If the evaluation instrument to be used under the extended waiver differs from the instrument approved in the original waiver, a copy must be submitted. The same applies to the Medicaid Agency's safeguards to protect the health and welfare of waiver recipients.

3. Average per capita expenditure estimates, as described in 42 CFR 441.303(f), for each year of the renewed waiver. Submit individual formulas for each year for each level of care covered in the waiver (hospital, NF, ICF/MR), as well as a combined formula for each year. Additionally, submit current data on the actual cost of the individual home and community-based services to support the revised cost data contained in the formulas. Data in the per capita expenditure estimate formula must be expressed in terms of average annual cost per unduplicated recipient. This data must be consistent with data supplied on Forms HCFA-372/372(S) and HCFA-2082. (See §4442.8 for further instructions about these requirements.)

4. A statement that the same services described in the original waiver will be provided under the renewed waiver. Describe any changes in the service package or in the manner in which the services are to be provided. Submit standards for providers or facilities of any new services not included in the approved waiver. See §4442.4 for further instructions about these requirements.

5. A statement that the eligibility requirements and procedures described in the original waiver remain in effect under the renewed waiver. Describe any changes in the requirements or procedures which are being made.

6. Documentation to support a conclusion that you have taken appropriate corrective action to resolve problem areas identified through Federal monitoring activities.

7. Documentation to support a conclusion that the waiver program was cost effective or cost neutral during the previous waiver period. Renewal requests are not approved unless you have submitted:

o The required Form HCFA-372/372(S) for all but the final year of the waiver period and accepted Forms HCFA-372/372(S) for all but the last 2 years of the waiver period; and

o The results of the independent assessment of the waiver if you opted to have one performed. (See §4442.11.) The results of the assessment must be submitted to HCFA at least 90 days prior to the expiration of the approved waiver period and cover all but the final year of the waiver.

NOTE: HCFA exercises its authority to require that any waiver elements (e.g., services, eligibility criteria, fiscal data, etc.) approved in the original waiver request but subsequently determined to be impermissible under the statute or regulations be appropriately modified or deleted from the request prior to granting renewal. Therefore, the standards applied by HCFA in reviewing renewal requests do not differ significantly from that currently applied to initial waiver requests.

You may submit an entire copy of your waiver to request renewal of the program. However, this may delay consideration of the request. In situations where the waiver has been subject to amendments or was substantially revised during the initial approval process, HCFA may require submission of the entire waiver renewal proposal if it believes the approved waiver document has become unacceptably complex due to multiple revisions.

E. Content of Subsequent Waiver Renewal Requests.--Requests for second and subsequent renewals of waiver programs must contain the same information as an initial request. (See §§4442-4442.11.) Because second and subsequent renewals will take place at 5 year intervals, it is necessary that you submit the entire waiver proposal to assure that the waiver file accurately represents all revisions and amendments to the program which have taken place. You are exempt from this requirement on second and subsequent renewals if the renewal contains no changes to the approved waiver and no amendments have been made since the waiver was initially approved.

4445. HOME AND COMMUNITY-BASED SERVICES - AMENDMENTS

A. When an Amendment Is Required.--An amendment is required when a change in a waiver results in the waiver document no longer accurately reflecting the policies and procedures in the approved waiver document. The amendment usually must be approved by HCFA prior to the implementation of the proposed change. However, there are instances where amendments may be approved with a retroactive effective date as far back as the beginning of the waiver year in which it is submitted. Some examples of such situations would be revisions to the cost estimates, deletion of a waiver service, or compliance with revised State rules or regulations.

B. Submission.--An amendment request is processed like a waiver request. (See §4441 for process related instructions.) Amendment requests consist of two types: substantive requests and technical requests.

It is to your benefit to submit technical amendments under separate cover from substantive amendments. This maximizes the likelihood of approval without the delay caused by a request for additional information, which is often necessary on substantive amendments.

1. Technical Amendment.--A technical amendment is any amendment in which the change has no impact on cost or utilization of services (directly or indirectly). Such amendments must be accompanied by specific assurances that there will be no change to the costs, utilization of services, or number of persons served by the waiver, and an explanation of why this is so.

2. Substantive Amendment.--A substantive amendment is any amendment which directly or indirectly affects any of the values under which the waiver was shown to be cost effective or cost neutral at its approval. Therefore, in most cases, a change in any of the following would constitute a substantive amendment:

a. Any change in the number of waiver recipients served, the cost of waiver services, or the mix of beneficiary groups or services provided.

NOTE: Although the C x D FFP limitation has been eliminated effective for waiver applications (or renewals) filed before, on, or after April 7, 1986 and for services furnished on or after August 13, 1981, if you anticipate substantial changes in your cost estimates, submit these changes in the form of an amendment to your waiver. This amendment should provide a complete explanation of the reasons for the change and recomputed cost effectiveness or cost neutrality formulas documenting the continued cost effective or cost neutrality of the waiver program.

b. Changes to the definition of services.

c. Changes to who is eligible to participate.

d. Changes to who may provide services.

e. Changes in health and safety standards for providers which would increase the cost of services (e.g., change in the number of individuals who can be cared for in a foster home).

f. Changes necessary to implement specific statutory provisions, e.g., the 1985 COBRA provisions pertaining to habilitation services or maintenance of income standards and the 1997 BBA provisions which deleted the requirement that individuals be discharged from an NF or ICF/MR to be eligible for expanded habilitation.

Requests for substantive amendments must be accompanied by a revised formula which demonstrates that the waiver will remain cost effective or cost neutral with the amendment. The formula format to be used must comply with the formula given in 42 CFR 441.303(f) for amendments approved on or after August 24, 1994.

4446. HOME AND COMMUNITY-BASED SERVICES - TERMINATIONS

A. Voluntary Terminations.--When you choose to voluntarily terminate your home and community-based waiver before the expiration of the waiver period, you must notify HCFA in writing 30 days before terminating services to recipients. You must also notify recipients of services under the waiver in accordance with 42 CFR 431.210, 30 days before terminating services.

B. Involuntary Terminations

1. Cause for Involuntary Termination.--If HCFA finds that you have violated any of the assurances made in your approved waiver request, or are otherwise in violation of Federal regulations applicable to home and community-based waivers, you will be given a notice of HCFA'§s findings and an opportunity for a hearing to rebut those findings. If HCFA determines that you are not in compliance with the regulations after the notice and any hearing, HCFA has the discretion to terminate the waiver. HCFA will, in making this decision, take into account any information you

have submitted with respect to why the waiver should not be terminated, including corrective action plans and evidence of corrective action undertaken.

Circumstances which may, at HCFA's discretion, result in involuntary termination of a waiver include but are not limited to cases in which:

a. HCFA finds that your actual total expenditures for home and community-based and other Medicaid services provided to individuals under the waiver exceed, for any year of the waiver period, the amount that would be incurred by Medicaid for these individuals in a hospital, NF, or ICF/MR without a waiver.

b. The health and welfare of waiver recipients have been jeopardized.

c. You have not maintained accurate financial records documenting the cost of waiver services.

d. You have failed to complete satisfactorily required HCFA reports needed to evaluate the operation of the waiver.

e. You have failed to comply with any other requirement established for the home and community-based waiver program in Federal regulations.

f. You have operated the waiver in a manner which is grossly inconsistent with the waiver as approved by HCFA.

2. Process.--When HCFA believes that termination of a waiver is warranted, HCFA will advise you in writing of its findings and will offer you an opportunity for a hearing to rebut the findings. Procedures specified at 45 CFR Part 213 are applicable to your requests for hearings on terminations.

Where the hearing results in termination of the waiver, or you choose to accept termination without a hearing, you must notify recipients of services under the waiver in accordance with 42 CFR 431.210, and must notify them 30 days before terminating services.

THE NEXT PAGE IS 4-487.

4460. NURSE AIDE REGISTRY

Establish and maintain a nurse aide registry of individuals who have successfully completed a nurse aide training and competency evaluation program or competency evaluation program approved by the State or have been deemed to have completed a nurse aide training and competency evaluation program or have had the competency evaluation requirement waived. (See §2504.)

A. Registry Function.--Ensure that the nurse aide registry:

o Lists all individuals who have successfully completed a nurse aide training and competency evaluation program or competency evaluation program approved by the State;

o Lists all individuals who have been deemed to have completed a nurse aide training and competency evaluation program;

o Lists all individuals for whom the requirement to complete a nurse aide competency evaluation program has been waived by the State;

o Lists all nurse aides who have been found by the State to have abused or neglected a resident or misappropriated resident property;

o Removes entries for all individuals who have performed no nursing or nursing-related services for monetary compensation for a period of 24 consecutive months except those individuals who have been found to have abused or neglected residents or misappropriated resident property;

o Discloses the date of eligibility for placement on the registry and any information pertaining to a finding of resident abuse or neglect or misappropriation of resident property to everyone requesting information about an individual on the registry. (You may disclose any additional information you deem necessary.);

o Provides individuals on the registry with all information in the registry on them when findings of resident abuse or neglect or misappropriation of resident property are made or upon request;

o Permits all individuals on the registry sufficient opportunity to correct any misstatements or inaccuracies contained in the registry;

o Is sufficiently accessible to meet the needs of the public and health care providers;

o Provides requested information promptly; and

o Does not impose any charges related to registration on individuals listed in the registry.

The nurse aide registry may include information on home health aides who have successfully completed a home health aide training and competency evaluation program approved by the State if home health aides are differentiated from nurse aides.

B. Registry Information.-- The following items must be maintained and retrievable from the nurse aide registry for each individual who has completed a nurse aide training and competency evaluation program or competency evaluation program approved by the State, who has been deemed to have completed a nurse aide training and competency evaluation program, or for whom the State has waived the competency evaluation requirement:

- The individual's full name.
- Information necessary to identify the individual.
- The date the individual became eligible for placement in the registry.
- Any finding by you of resident abuse or neglect or misappropriation of resident property by an individual documenting:

-- Your investigation, including the nature of the allegation andthe evidence that led you to conclude that the allegation was valid;

-- The date of the hearing (if the individual chose to have one) and its outcome; and

-- A statement disputing the allegation, if the individual chose to make one.

Findings of resident abuse or neglect or misappropriation of resident property against a nurse aide must be included in the registry within 10 working days and must remain in the registry permanently, unless the finding was made in error, the individual was found not guilty in a court of law, or the State is notified of the individual's death.

C. Responsibility for the Nurse Aide Registry.-- The State may contract the daily operation and maintenance of the registry to a non State entity; however, the State must maintain overall accountability for operation of the registry and compliance with regulations, and only the State survey agency is permitted to place findings of resident abuse or neglect of misappropriation of resident property on the registry.

4470. SPECIFICATION OF RESIDENT ASSESSMENT INSTRUMENTS FOR USE IN LONG TERM CARE FACILITIES

4470.1 Statutory Requirements--Sections 1819(b)(3), 1819(e)(5), 1819(f)(6)(B), 1919(b)(3), 1919(e)(5), and 1919(f)(6)(B) of the Act specify assessment requirements for skilled nursing facilities (SNFs) for Medicare and nursing facilities (NFs) for Medicaid, which provide nursing, medical, and rehabilitative care to Medicare and/or Medicaid beneficiaries. These provisions require facilities to conduct comprehensive, accurate, standardized, and reproducible assessments of each resident's functional capacity using a resident assessment instrument that has been specified by the State. In addition, all resident assessment instruments must include the minimum data set of core elements, common definitions and utilization guidelines specified by HCFA. (See §4470.2.)

These provisions place specific responsibilities on the Department, the State, and providers. HCFA is responsible for specifying the minimum data set, common definitions and utilization guidelines and for designating one or more resident assessment instruments for use by the States. The States are responsible for specifying the resident assessment instrument for use by facilities in the State. The State may use a resident assessment instrument designated by HCFA or specify its own instrument provided that it includes the minimum data set and has been approved by HCFA. The providers are responsible for using the specific assessment instrument that has been specified by the State.

4470.2 Definitions

- Minimum Data Set (MDS)--A minimum set of screening and assessment elements, including common definitions and coding categories, needed to comprehensively assess an individual nursing home resident. The items in the MDS standardize communication about resident problems and conditions within facilities, between facilities, and between facilities and outside agencies.

- Common Definitions--Standardized explanations of each element specified in the MDS.

- Coding Categories--Levels of measurement for each element included in the MDS.

- Triggers--Levels of measurement (coding categories) of MDS elements that identify residents who may require further evaluation using resident assessment protocols designated by the State.

o Resident Assessment Protocols (RAPs)--Structured frameworks for organizing MDS elements, and additional clinically relevant information about an individual that contribute to care planning. (The State is not required to use the term "resident assessment protocol" in defining structured frameworks.)

o Resident Assessment Instrument--A standardized system comprised of the MDS and RAPs, including triggers, that result in a comprehensive, accurate, standardized, reproducible assessment of each long term care facility resident's functional capabilities.

o Utilization Guidelines--Instructions concerning when and how to use the resident assessment instrument.

4470.3 MDS and Resident Assessment Instrument Designated by HCFA.--HCFA is responsible for specifying the MDS, its common definitions and utilization guidelines, and for designating one or more resident assessment instruments. HCFA's proposed resident assessment instrument is specified in Appendix R of the State Operations Manual (SOM). Copies of Appendix R may be obtained by writing to:

Director, Division of Long Term Care Services
Office of Survey and Certification, HCFA
Meadows East Building - Area 2-D-2
6325 Security Boulevard
Baltimore, MD 21207
Attn: Nursing Home Branch

The resident assessment instrument is comprised of the utilization guidelines, the MDS of core elements and common definitions, and the RAPs. The utilization guidelines are specified in Appendix R, Part I; the core elements of the MDS and common definitions are specified in Part II; and the RAPs, triggers and instructions for use in Part III.

4470.4 Specification of a State Resident Assessment Instrument.--The State must specify a resident assessment instrument for use in the long term care facilities in your State participating under Medicare and/or Medicaid. You may either specify the resident assessment instrument designated by HCFA, which is comprised of utilization guidelines, the MDS with common definitions, and the 18 RAPs with triggers and a documentation format (see Appendix R) or you may specify an alternate instrument for use in your State. If you specify an alternate instrument, it must be approved by HCFA. To receive approval, an alternate instrument must contain:

o The Utilization Guidelines. See Appendix R, Part I of the SOM.

o The MDS. See Appendix R, Part II of the SOM. All data elements and corresponding coding categories specified in the MDS must be contained in the State's instrument. You may not alter the MDS definitions or the coding categories used with each MDS element. You are encouraged to maintain the elements within the section in which they appear on the MDS and maintain the order of the sections of the MDS. However, if adequately justified by supporting clinical or operational rationale and accompanied by a conversion table between the State's instrument and HCFA's MDS, you may request approval to:

- Reorder the major sections of the MDS. For example, Section E. -Physical Functioning and Structural Problems on the MDS may be moved to between Section B. -Cognitive Patterns and Section C. -Communication/Hearing Patterns and the sections relettered.

- Relocate an MDS element(s) from one section of the MDS to another as long as the change does not interfere with the element's effectiveness for assessment.

- Include data elements additional to those in the MDS that are needed to meet unique State operational needs. These additional items will only be reviewed by HCFA to assure there is no conflict with elements included in the MDS, i.e., HCFA will not evaluate the merits of your including those elements.

o RAPs. An alternate resident assessment instrument must include structured frameworks for organizing MDS elements and additionally relevant information about an individual that contributes to care planning. The State is not required to use the term RAP in an alternate instrument and a State's protocol.

A State developed alternate resident assessment instrument must provide frameworks for comprehensive assessment in the following care areas:

- Cognitive loss/dementia;

- Visual function;

- Communication;

- Activities of daily living functional potential;

- Rehabilitation potential (HCFA's instrument combines the Rehabilitation RAP with the ADLs RAP);

- Urinary incontinence and indwelling catheter;

- Psychosocial well-being (In the HCFA-designated instrument, in addition to a distinct psychosocial well-being protocol, there are three distinct RAPs that bear on psychosocial functioning: "mood", "behavior", and "delirium".);

- Activities;
- Falls;
- Nutritional status;
- Feeding tubes;
- Dehydration/fluid maintenance;
- Dental care;
- Pressure ulcers;
- Psychotropic drug use; and
- Physical restraints.

These care areas may be combined in different ways to create a RAP comparable to that designated by HCFA. For example, you may have a RAP that combines nutritional status and tube feeding or activities of daily living and rehabilitation potential. However, if you create alternative RAPS through combining care areas, you must provide a cross-walk chart from your RAPs to the above care areas.

Include in each RAP you develop assessment triggers, based on MDS elements or other information requirements, that screen which residents are subject to additional assessment.

If you select alternative triggers and/or information requirements for your RAI, you should provide supporting documentation for your decisions. Such documentation may take the form of citations from the literature, results of field testing, or the consensus of experts that you use to assist in designing these RAPs.

Specify a standardized approach that long term care facilities will use to document information derived from RAPs about the nature of problems, complications and risk factors, the need for referral to appropriate health professionals, and the reasons for deciding to proceed or not to proceed with care planning specific to the triggered problems. There must be provision for identification of the location of these assessment results so that they can be easily retrieved and for certification of completion accuracy. (See the RAP formats designated by HCFA in Appendix R, Part III.) Also, we advise you to encourage facilities to maintain the MDS data in computer readable form.

4470.5 Approval Process.--Inform HCFA by October 19, 1990, whether you intend to specify the resident assessment instrument designated by HCFA or request approval for your State instrument. When requesting approval for your State instrument, include a copy of the instrument and its instructions, and a short narrative specifying how the instrument conforms with the utilization guidelines, the MDS, and RAPs. Include conversion tables and the name, address, and phone number of your State contact. Please send all correspondence concerning this matter to:

Director, Division of Long Term Care Services
Office of Survey and Certification, HCFA
Meadows East Building - Area 2-D-2
6325 Security Boulevard
Baltimore, MD 21207
ATTN: Nursing Home Branch

HCFA will review your instrument to determine whether it is an acceptable alternative, and will communicate directly with State representatives to clarify information, if necessary. HCFA will make every effort to work with you to meet your needs for resident assessment information. After you receive HCFA's approval, notify the providers within your State by providing a copy of the State's specified instrument and the procedures for using the instrument. You must assure that facilities begin using the specified instrument within 90 days after notification from the State. You must facilitate implementation by providing the necessary technical direction and training to facilities.

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, APersonal 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 cuing 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 cuing 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 Alegally 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.

4560. SKILLED NURSING FACILITY (SNF) AND INTERMEDIATE CARE FACILITY (ICF) SERVICES PROVIDED BY SWING BED HOSPITALS

A. Background.--Pursuant to §1913 of the Social Security Act, you have had the option, since July 20, 1982, of amending your State plans to cover SNF-and ICF-type services when provided by certain hospitals. This option was enacted, for both Medicare and Medicaid, because of the shortage of long term care beds in rural areas.

The Medicaid provision allows you to exercise this option with those hospitals which have "swing bed" approvals under Medicare. Under those approvals, the hospitals can "swing" their beds between acute and long term care levels of care, on an as needed basis but, to do so, the hospital must meet the following requirements:

- Be located in a rural area (i.e., located outside of an "urbanized area," as defined by the Census Bureau, and based on the most recent census) and have fewer than 100 beds (excluding beds for newborns and intensive care type units);
- Have a hospital Medicare provider agreement;
- Be granted any necessary certificate of need;
- Be substantially in compliance with the SNF conditions of participation for patient rights, 42 CFR 405.1121(k)(2), (3), (4), (7), (8), (10), (11), (13) and (14); specialized rehabilitative services, 42 CFR 405.1126(a),(b) and (c); dental services, 42 CFR 405.1129; social services, 42 CFR 405.1130; patient activities, 42 CFR 405.1131; and discharge planning, 42 CFR 405.1137(h); (most other SNF conditions would be largely met by virtue of the facility §s compliance with comparable hospital conditions);
- Not have in effect a 24-hour nursing waiver granted under 42 CFR 405.1910(c); and
- Not have had a swing bed approval terminated within the 2 years previous to application for swing bed participation.

However, the Department may grant a swing bed approval, on a demonstration basis, with hospitals meeting all of the statutory requirements except bed size and geographic location.

Under §4005(b)(2) of the Omnibus Budget Reconciliation Act of 1987, effective for swing-bed agreements entered into after March 31, 1988, hospitals with more than 49 beds (but less than 100 beds) are subject to the following:

- If there is an available SNF bed in the geographic region, the extended care patient must be transferred within 5 days of the availability date (excluding weekends and holidays) unless the patient's physician certifies, within that 5-day period, that transfer of that patient to that facility is not medically appropriate on the availability date. In order to do this, hospitals need to identify all SNFs in their geographic region and enter into agreements with them for the transfer of extended care patients under which SNFs are to notify the hospitals of the availability of beds and the dates these beds will be available for extended care patients; and

- The 5 week day transfer requirement and the 15 percent payment limitation do not apply for Medicaid reimbursement purposes.

Hospitals having fewer than 50 beds and rural hospitals which entered into agreements before March 31, 1988 (i.e., those which were licensed for more than 49 beds but who were operating as a 50 or less bed facility) are not subject to the 5 week day transfer requirement or the payment limitation for extended care days. (See §2230.7 of the Provider Reimbursement Manual for the explanation of the payment limitation.)

"Geographic region" is an area which includes the SNFs with which a hospital has traditionally arranged transfers and all other SNFs within the same proximity to the hospital. In the case of a hospital without existing transfer practices upon which to base a determination, the geographic region is an area which includes all the SNFs within 50 miles of the hospital unless the hospital can demonstrate that the SNFs are inaccessible to its patients. In the event of a dispute as to whether an SNF is within this region or the SNF is inaccessible to hospital patients, the HCFA regional office shall make a determination.

B. Limitations and Payment.--If you choose to include in your plan coverage of SNF-or ICF-type services provided by swing bed hospitals, those services will be treated the same as SNF services furnished in a SNF and ICF services furnished in an ICF. Generally, Federal or State requirements applicable to SNF or ICF services would be equally applicable to swing bed long term care services, as appropriate (i.e., SNF requirements would apply to SNF-type services provided in swing beds and ICF requirements would apply to ICF-type services provided in swing beds).

Also, payment for long term care swing bed services under Medicaid are to be reimbursed at SNF or ICF rates, as appropriate. See 42 CFR 447.280.

4570. AMBULATORY SURGICAL CENTER SERVICES.

A. Background.--Ambulatory surgical center (ASC) services are currently coverable as clinic services under regulations at 42 CFR 440.90. They may also be covered under section 1905(a)(18) of the Social Security Act as ". . . any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary."

B. Limitations and Payment.--ASC services provided under this benefit must meet the following requirements:

1. They must be provided by a distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization;

2. They must be furnished to outpatients;

3. They must be furnished by a facility that meets the requirements in sections 42 CFR 416.25-416.49; and,

4. They must be recognized under State law.

4580. PHLEBOTOMY AND CASE MANAGEMENT SERVICES ASSOCIATED WITH THE DRUG CLOZARIL

A. Background.--Clozaril was approved by the Food and Drug Administration in 1989, subject to the requirement that it would be provided only to patients who have weekly white blood cell counts. From February 1990 until June 1991, Sandoz Pharmaceuticals marketed Clozaril with an exclusive distribution system known as the Clozaril Patient Management System (CPMS).

From the perspective of the Medicaid benefit package, HCFA views Clozaril plus the associated services in three pieces: (1) the drug itself; (2) the laboratory tests; and (3) related services consisting of phlebotomy and case management type services to achieve the necessary monitoring. States are required to cover Clozaril, if they cover prescribed drugs under their State plans. In addition, States must provide the required laboratory services to categorically needy individuals. States are not necessarily required to cover the phlebotomy and case management types of services, depending upon whether they are components of mandatory or optional services listed in §1905(a) of the Act. If States cover these services, they may provide the phlebotomy and case management services either separately or can bundle the two services.

If your State chooses to cover case management services separately (unbundled), you can use either targeted case management or administrative case management, as a function necessary for the proper and efficient operation of the Medicaid State plan, as provided in §1903(a) of the Act. Case management may also be a component of other services listed in §1905(a) of the Act, such as physician or clinic services. If your State chooses to cover phlebotomy as a separate (unbundled) service, you can cover it as part of another service listed in §1905(a) of the Act, such as physician, home health or laboratory services. If States do not cover phlebotomy and case management services, the individual must provide for these services in order to receive Clozaril.

Section 1905(a)(22) of the Act defines medical assistance to include, among other things, ". . . any other remedial care recognized under State law, specified by the Secretary." Accordingly, HCFA has determined that the phlebotomy and case management services may be provided as a bundle of component services which an individual must receive in order to receive the drug Clozaril under §1905(a)(22) of the Act.

B. Limitations and Payment.--You may cover the drug Clozaril and the associated services in the following manner:

- The drug must be included under the coverage of prescription drugs described in §1927 of the Act and in 42 CFR 440.120 and reimbursement in accordance with 42 CFR 447, Subpart D;

- The laboratory services, i.e., the white blood cell test must be covered under the laboratory services benefit and performed in accordance with 42 CFR 440.30;

- The remaining services, consisting of phlebotomy and case management type services may be covered as a bundle under other remedial care under the authority of §1905(a)(22) of the Act. Payment rates may be established in accordance with 42 CFR Part 447, Subpart D. Otherwise, case management may be covered separately (unbundled) as a separate service under §1905(a)(19) of the Act or as part of another covered service. Phlebotomy services may be covered separately (unbundled) as part of another service category; and

- The services must be recognized under State law.

4600. USAGE OF CERTIFICATION & TRANSMITTAL, HCFA-1539

A. Approval of Medicaid-Only Facilities.--When the State survey agency (SA) approves or reapproves an ICF or a SNF which participates only in Medicaid or which has a distinct part which participates only in Medicaid, the SA sends you both a yellow copy and a blue copy of the Certification & Transmittal, HCFA-1539. In these cases the HCFA-1539 provides a record of the SA's official determination approving the facility for participation. If you issue a new provider agreement or issue a renewal provider agreement to the facility (see §§4602 and 4602.1), complete items 19-31 of the form, sign the blue copy in the "Determination Approved" block at the bottom, and send the blue copy to the HCFA-RO. Keep the yellow copy.

If you decline to enter into an agreement with a SNF or ICF for good cause even though the SA has issued a determination of approval (see §4602), check box 2 in item 19 of the HCFA-1539 and give your reasons in item 30, "Remarks." Sign the blue copy and send it to the HCFA-RO. Keep the yellow copy.

B. Approval of Medicare-Only and Medicare/Medicaid Institutions.--In all certification approvals other than A, above, the SA sends the HCFA-1539 to the HCFA-RO as a record of its certification findings. The HCFA-RO uses it in making the determination whether to approve the institution and, in most cases, to enter into a provider agreement. In these cases, the SA sends you only the blue copy of the HCFA-1539. If a class of institution is subject to Medicare certification, you cannot enter into a provider agreement with such institution until it is approved for participation by HCFA. The HCFA-1539 is not a notice of approval in these cases. Wait to receive a copy of the HCFA notice of approval before issuing a Medicaid provider agreement.

C. Partial Approvals.--Laboratories and certain other institutions are often approved only for certain services that they perform. Medicaid provider agreements and payments must be limited accordingly. Modifications of coverage may occur quite frequently with laboratory tests, therefore keep track of the coverage change notices which the HCFA-1539s provide. However, as in B, above, wait to receive a copy of the HCFA determination notice of approval before taking any action. Provider agreements if issued to these classes of institutions are to be so worded that they do not require reissuance or modification each time the scope of approved services is modified.

D. Adverse Actions.--Be alert to the receipt of any HCFA-1539s indicating that an institution is no longer approvable, as well as to other notices from HCFA which indicate that a provider is being sanctioned on any grounds. HCFA may terminate participation or, in a Medicare SNF, HCFA may impose an alternative ban on payment for new admissions for eleven months. HCFA may take other adverse actions on grounds of fraud, program abuse, failure to comply with financial terms of the Medicare provider agreement, or utilization practices. Generally, Medicaid sanctions follow suit. See §4650ff for instructions on adverse processes.

In Medicaid-only long-term care facilities, if the HCFA-1539 shows that requirements are not met, promptly undertake the initiative to impose the sanction. However, you may disagree with the SA recommendation whether or not to deny payments for new admissions in lieu of immediate termination. If the SA recommended a denial of payments but you decide to terminate, enter a 2 in block 19 of the HCFA-1539, and explain your decision in Item 30. If the SA recommended termination and you decide to use the denial of payments, enter a 1 in block 19 and explain your decision in Item 30. Circle Item 30 in red ink on the blue copy and notify the SA of these changes so the SA can correct its revisit schedule.

4601. USAGE OF THE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION, HCFA-2567

A. How the HCFA-2567 is Prepared.--The HCFA-2567 is a two-column, five-copy form. The left column is used to list deficiencies found in a SA survey. The right column is for the institution to respond by explaining how and when it will correct each deficiency.

When the SA surveys an institution, it usually issues a written list of deficiency findings by completing the left hand column of a HCFA-2567, citing each quality standard in question. It may omit the HCFA-2567 in some cases when, because the deficiencies present an immediate hazard to the health and safety of the patients or residents, the surveyor intends to recommend swift termination regardless of the possibility of subsequent correction. In terminations, the deficiencies are publicized in other ways. Most SAs even complete the HCFA-2567 to record "no deficiencies found," for reporting purposes. Sometimes the SA performs follow-up surveys to ascertain whether provider deficiencies have been corrected, and in those cases, it reports the fully corrected deficiencies on a Post-Certification Revisit Report, HCFA-2567B.

The usual practice when an institution is in compliance but has correctable deficiencies is to cite the deficiencies verbally at the end of the survey, and send a typed, reviewed Statement of Deficiencies by mail within 10 days. The institution generally has 10 days in which to return the form with the right hand column, Plan of Correction, completed with target dates for each correction. (Of course, the institution can make any response it chooses, such as denying that the deficiencies exist.) The nature of the response can influence the adjudicative conclusion whether the institution is complying with the standards or not. The SA includes copies of the HCFA-2567 in the certification materials sent either to you or to the HCFA-RO.

B. Processing HCFA-2567 for ICFs and Medicaid-Only SNFs.--Pursuant to section 1902(a)(36) of the Act and 42 CFR 431.115, you must:

- Provide in the State Plan that deficiency information will be disclosed in accordance with the regulation (along with ownership and contract information disclosable in accordance with 42 CFR 455.104);

- Have a procedure for disclosing the survey findings;

- Require the SA to:

  - Make the statements of deficiencies available to the public assistance office and Social Security office serving the area where the provider is located;

  - Submit a plan to HCFA for making the findings available to other public assistance agencies in locations where it would be helpful to users of the health service; and

  - Retain the statements and make them available to the public on request immediately upon approving or reapproving the facility and no later than 90 days after each survey.

When you send the certification materials forward to the HCFA-RO after taking your case actions (including following your disclosure procedure), include a copy of the HCFA-2567.

C. All Other HCFA-2567s.--You receive a copy of each HCFA-2567 (and each follow-up HCFA-2567B) after it has been cleared and disseminated by the HCFA-RO for public disclosure. Yours is an informational copy requiring no action. You may disclose its contents to anyone at any time.

4602. PROVIDER AGREEMENTS

A. Medicaid Provider Agreements.--Section 1902(a)(27) of the Act requires a system of formal agreements with every person or institution providing health services to Medicaid patients. Such persons or institutions must agree to furnish:

- Records necessary to fully disclose the extent of the services provided to individuals; and
- The State Medicaid agency or the Secretary of HHS with information requested regarding any payments claimed for providing these services.

42 CFR Part 442 introduces the term, "provider agreements" in this connection. The context makes clear in that Part 442, "provider" means SNF and ICF agreements. In Medicare, provider means a party that cares for the patient awaiting, receiving or recuperating from therapy given by an intervening practitioner, specifically, a hospital, hospice, home health agency, skilled nursing facility, or comprehensive outpatient rehabilitation facility. Part 442 extends the term provider to cover ICFs as well. (A HMO is not a provider; under Part 434 a HMO is a contractor.) You need not include in your definition other institutions which are certified for Medicare, such as independent laboratories and physical therapists, if Medicare defines them as "suppliers" rather than "providers." Your definition must be given in your State Plan, and should be included in any pertinent State regulations.

You may enter into a provider agreement with a SNF or ICF which has been approved by the SA, but you may refuse to enter into one, or you may cancel one, if you have adequate documentation showing good cause. What may constitute good cause is not particularized in the regulation, but should be specified in your State Plan and in any pertinent State regulations. For example, in an area where there is over-bedding in SNFs or ICFs, you may decide not to enter into a provider agreement.

B. Invalidation of Medicaid Provider Agreements by HCFA.--A provider agreement which you enter into may be invalidated by HCFA even if the SA certified the provider, if:

- Improper procedures were used to effect the approval and/or the agreement, or
- Any procedural State plan requirement was violated, or
- The facility is found by HCFA to be actually not in compliance with standards.
- The facility is not in compliance with Federal civil rights requirements.

In the first two instances, the agreement is considered invalid for FFP purposes from the beginning. FFP is disallowed for any payments made for care in the affected facility, and the State's only available appeal is through the HCFA grant disallowance procedures. In the third instance, the facility's participation is terminated prospectively, and the facility can appeal HCFA's overruling of the State action through HCFA's provider appellate procedures.

C. "Coterminous" Effective Dates of Provider Agreements.--If you enter into a provider agreement with a provider that participates in Medicare, the beginning and ending dates of the agreement must be the same as the Medicare agreement. Nonrenewal, cancellation, termination and payment sanction dates must also be the same as for Medicare.

The agreement must be effective on:

- The date the onsite survey is completed;
- The day following the expiration of a current agreement;
- The date the institution meets all requirements, or the date it submits an acceptable plan of correction, whichever is later.

4602.1 Terms of Time-Limited Provider Agreements With SNFs and ICFs.--Time-limited agreements are employed in long term care provider cases. The scheduled expiration of the agreement governs the length of time the certification is valid. Establish the length of the agreement based on the period of certification established by the SA. The length of the agreement may not exceed the certification period recommended by the SA; however, you may establish a shorter certification period when you deem it appropriate.

A. Full 12 Months.--Where there are no standards out of compliance, you may issue an unconditional agreement of 12 full calendar months.

B. Conditional 12 Month Agreement Subject to an Automatic Cancellation Clause.--Where a SNF or ICF is in compliance with the Conditions of Participation (standards for ICFs) but has deficiencies which must be corrected, you may execute a conditional agreement up to 12 full calendar months, subject to an automatic cancellation clause, i.e., 60 days after the projected correction date. Unless the corrections are completed as promised or there is substantial progress in carrying out the Plan of Correction, cancel the agreement.

This type of certification period is most appropriate where, despite the deficiencies, the facility is able to provide an adequate level of patient care, has responded with an acceptable Plan of Correction, and, by its past performance in correcting deficiencies, can reasonably be expected to make the necessary improvements.

C. Period of Certification Which Expires 60 Days After Plan of Correction.--Where a SNF has deficiencies in one or more standards, you may establish an expiration date two full months after the date specified for complete implementation of the Plan of Correction. The SA will resurvey after the implementation date. Cancel the provider agreement at the expiration date unless deficiencies have been corrected by the survey date.

D. Extension of the Agreement.--Extend the term of an expiring agreement one time only, for a period of two full calendar months if:

- The SA notifies you in writing before the original expiration date that the extension will not jeopardize patients' health and safety; and
- The extension is needed either to prevent substantial harm to the facility, to prevent hardship to the patients, or because it cannot be determined before expiration whether the facility has complied.

4603 READMISSION TO THE MEDICARE OR MEDICAID PROGRAM AFTER TERMINATION

A. Readmission of Medicaid-only SNF after Medicare Termination.--Before readmitting a SNF that has been terminated by Medicare, determine that the facility has provided to the SA reasonable assurance that conditions that caused termination will not recur. (When HCFA terminates a Medicaid-only facility pursuant to section 1910(c) of the Act, HCFA makes the reasonable assurance determination.)

The reasonable assurance period must be satisfied before you may issue an agreement to that facility and qualify for FFP. Your failure to require reasonable assurance is a basis for the RO disallowing FFP for the services furnished by that facility (42 CFR 442.30).

B. Readmission Criteria.--After the involuntary termination, cancellation, or nonrenewal of its agreement, the SNF cannot again participate in the Medicare or Medicaid program unless:

- The reasons for the termination, cancellation, or nonrenewal no longer exist;
- There is reasonable assurance that they will not recur; and
- All statutory and regulatory requirements are fulfilled.

C. Reasonable Assurance Concept.--Generally, the facility should be required to operate for a certain period of time without recurrence of the deficiencies which were the basis for the termination. Participation can only resume following that period. If corrections were made before making a new request for participation, the period of compliance before the request is counted as part of the period.

The HCFA-RO makes the determination whether or not the facility is eligible for readmission, for Medicare or Medicare/Medicaid facilities. You make the determination concerning readmission as a Medicaid-only SNF if the SNF had been terminated by HCFA as a Medicare/Medicaid facility.

To determine the reasonable assurance period, evaluate the following considerations:

l. Provider's Compliance History.--When the provider previously participated was compliance maintained historically? Were plans of correction implemented on time? Does the provider have a history of making good faith efforts to correct deficiencies and to maintain compliance? Does the provider have a record as being cited time after time for essentially the same problems? Was adverse action initiated against the provider but not put into effect?

2. The Facility's Compliance History.--Is the facility located in an area which is underserved by needed health professionals? Does the applicant's pay scale or the facility's location deter the hiring and retention of staff? Does the facility have inherent problems which are likely to cause the recurrence of significant deficiencies?

3. Correction of Deficiencies Which Constituted the Basis for Termination.--Have all deficiencies been corrected? Are corrective actions such that compliance is likely to continue?

The SA should conduct onsite visits during the reasonable assurance period to confirm provider compliance.

Examples using the above criteria to establish a reasonable waiting period for readmission follow:

Example A - The Happy Hill Convalescent Home was terminated on September 15, 1984. The facility was cited for several life safety code (LSC) violations: primarily, the absence of sprinklers in hazardous areas and smoke barriers in patient areas. The owner argued that corrective action was too expensive. On October 1, 1984, the facility was purchased by John Swift. Mr. Swift owns several SNFs in the State and is known to be a reputable provider. All of Mr. Swift's other facilities meet the LSC.

Reasonable Assurance - You determine that Mr. Swift may participate when the LSC deficiencies have been corrected and all other conditions are met.

Example B - Pleasant Plains Nursing Home was terminated on September 20, 1984. The facility corrected those deficiencies which led to termination and requested readmission on October 15, 1984. You review the provider's history of compliance and find that historically the facility had met substantially all program requirements. Documentation reveals that the

facility was the subject of uncontrollable staffing shortages which led to the deterioration of care and services and noncompliance with the Conditions. Current information affirms that the staffing problems have been resolved.

Reasonable Assurance - You established 30 days from October 15, 1984, as reasonable based on the facility's good compliance history and the resolution of the problems that led to termination.

Example C - Green Acres Nursing Home was terminated on November/1,/1984. The facility was cited as not meeting several Conditions of Participation. The facility alleged to have corrected all deficiencies on December 1, 1984, and requested immediate readmission. You reviewed the provider's compliance history and noted that one or more Conditions had been cited in each of the previous three surveys, but the facility usually managed to achieve compliance just before termination. Also the provider had been cited repeatedly for the same deficiencies, meaning that the provider was either unable or unwilling to maintain compliance.

Reasonable Assurance - You establish 60 days from December 1, 1984 as reasonable based on the facility's history of not maintaining compliance.

Example D - Fox Chase Nursing Home was terminated on December 21, 1984, for its failure to maintain required staffing levels in nursing, dietary, and medical records. The facility alleged on January 2, 1985, that it hired the necessary staff and requested readmission. Upon review, you find that the facility is located in a remote, underserved rural area. Periodically, the facility has failed to maintain staff since participation began in 1978.

Reasonable Assurance - You establish 90 days from January 2 as reasonable on the grounds that the location of the facility has militated against staff retention, and that 3 months of continued compliance would evidence the facility's ability to retain qualified health professionals.

Example E - The ABC Convalescent Home was terminated on September 15, 1984. Ms. Johnson, the owner of ABC, had repeatedly been cited as not meeting several of the Conditions, but had, until this most recent survey, achieved compliance before termination action would be completed. Ms. Johnson, on October 1, 1984, alleged compliance.

Reasonable Assurance - You establish a 120 day waiting period based on the facility's repeated failure to meet the Conditions of Participation necessary to ensure the health and safety of patients.

Example F - The ABC Convalescent Home was readmitted following a 60 day reasonable assurance period and on the next survey cycle is found not to meet one or more Conditions, and is terminated once more. The provider corrects the deficiencies and requests readmission.

Reasonable Assurance - You establish a 120 day period based on prior termination and failure to maintain compliance following a 2 month reasonable assurance period.

D. Effective Date of Provider Agreement.--The agreement cannot be effective earlier than the date on which compliance is documented via the SA's onsite visits to the institution, and the reasonable assurance provision, if applicable, is met. The reasonable assurance provision only applies to SNFs that were previously a Medicare/Medicaid provider whose agreement was terminated by HCFA.

The HCFA RO monitors State reasonable assurance determinations, particularly if they conflict with the Medicare determination. If HCFA determines that the SA failed to require reasonable assurance from a facility, FFP is deferred until the RO verifies reasonable assurance. If reasonable assurance is not verified, HCFA disallows FFP for that facility. Also, be particularly careful if a SNF is terminated by HCFA under look-behind authority. (See §4651B.) In such cases, do not issue an agreement until HCFA agrees that reasonable assurance has been provided.

4604. AUTHORITY TO GRANT LIFE SAFETY CODE WAIVERS FOR MEDICAID ONLY NFs

When Medicaid NFs and Medicaid distinct part NFs request a waiver of Life Safety Code requirements in accordance with §1919(d)(2)(B)(i) of the Social Security Act, the SA forwards such requests to the HCFA RO for review and approval.

4650. TERMINATION - GENERAL

Termination procedures vary depending on whether or not an institution's deficiencies pose an immediate and serious threat to patient health and safety and depending on how Medicaid cases are affected by HCFA termination procedures. While you are not mandated to meet procedures not specified in the State plan requirements, your State plan should be evaluated against HCFA's requirements because the greater the deviation from operating procedures and general instructions that HCFA believes to be good practice, the greater the risk of FFP disallowances or compliance actions.

4651. BASIS FOR TERMINATING PROGRAM PARTICIPATION

A. Termination of Medicaid Participation.--Terminate a Medicaid agreement or deny payments for new admissions when the SA determines that the provider does not meet applicable program requirements. If a SNF participates concurrently in the Medicare and Medicaid programs and HCFA terminates Medicare participation, Medicaid participation must be coterminous.

B. Cancellation of Medicaid Agreement by the Secretary.--HCFA has authority under §1910(c)(2) of the Act to terminate the approval of a SNF or ICF to participate in the Medicaid program when HCFA determines that the facility fails to comply substantially with the Conditions of Participation, 42 CFR 405, Subpart K (SNFs), or with the standards contained in 42 CFR 442, Subparts D, E, F, or G (ICFs). In these instances the termination is prospective, occurring after the provider has had the opportunity for a formal hearing before an Administrative Law Judge, unless the Secretary determines there is jeopardy to patients' health or safety. If there is an immediate and serious threat to patients' health and safety, termination occurs within 5 days after notification by the RO with opportunity for a post-termination hearing.

This authority is in addition to another look-behind authority under 42 CFR 442.30. The latter provides that a provider agreement is considered invalid for purposes of providing FFP to the State, unless the State has followed proper procedures. e.g.. if you issued a provider agreement even though the SA had not certified the facility as being in compliance. In those instances, the agreement is considered void from its inception, and the State is not entitled to FFP for any of the bills related to the facility. The only appeal provided after this procedural kind of disallowance is through the grant award process.

C. Termination of Medicaid-Only Skilled Nursing and Intermediate Care Facilities.--Federal Medicaid regulations provide for terminations, nonrenewals, and cancellations, but do not fully describe the implementing procedures. Each State has developed procedures for terminating agreements with SNFs and ICFs when those facilities are not found to be in substantial compliance with program requirements. In a Medicaid-only noncompliance

situation, the SA determines that the facility is no longer approvable, prepares the necessary documents, and forwards the documentation to you for termination, nonrenewal or cancellation of the Medicaid agreement. Notify HCFA and the public of your action, and afford the facility notice and opportunity for a hearing.

4651.1 Lock-out of Approved Facility Because of Program Abuse.--Under 42 CFR 431.54(f), you may also "lock out" a SNF or ICF for a reasonable period of time if the facility has abused the Medicaid program. This may occur even though the SA has approved the facility. Criteria and procedures for "lock out" should be spelled out in your State Plan and in any pertinent State regulations.

4651.2 ICF Given Time to Recomply With State Licensure Requirement.--An ICF, including an ICF/MR, which meets all other standards but fails to meet requirements for State licensure which it formerly met, may continue to be approved by the SA. This occurs only for a period of time approved by the SA, and is contingent upon the facility taking positive steps during that time which will regain the level of compliance. Do not terminate such cases, but when you renew the agreement, include a cancellation clause for 60 days after the end of the time period allowed by the SA.

4651.3 Intermediate Sanctions Before Termination.--

A. Denial of Payment for New Admissions All Long-Term Care Facilities.--Before considering termination of a SNF or ICF, consider adjudicatively imposing a ban on payment for new admissions. This presupposes that the deficiencies present no immediate jeopardy to health and safety. Impose the ban for eleven months, though it is possible that changed circumstances could result in either lifting the ban or invoking termination before the eleven months have elapsed. After eleven months, either terminate or reapprove the facility, depending on its re-achieving compliance.

B. Correction/Reduction Plans ICFs/MR Only.--Section 9516 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (§1919 of the Act) provides you two additional options under which ICFs/MR can continue to participate. These options apply only when substantial deficiencies are found by HCFA in physical plant and staffing (or physical plant, staffing and minor deficiencies in other areas) that do not pose an immediate threat to clients' health and safety. You may either submit a reduction plan or a correction plan (See §3651.5). You may submit written plans either to make all necessary staff and physical plant corrections within 6 months of the approval date of the plan, or to reduce permanently the number of beds in certified units within 36 months of the approval date of the plan.

This process applies when, as a result of a direct Federal survey, there is a determination that an ICF/MR fails to comply substantially with physical plant and staffing standards contained in 42 CFR 442, Subpart G. ICFs/MR found to have substantial deficiencies in physical plant. staffing and other areas of care (e.g., active treatment, health care) are not eligible to use the options

available under §1919 of the Act, nor are facilities with no substantial physical plant or staffing deficiencies.

Substantial deficiencies, for purposes of this section, have not been defined by the Statute nor by the implementing regulations at 42 CFR 442.2. Therefore, determinations are made based on the RO judgment and assessment of their surveys' findings and recommendations, since it is not possible to define adequately and fairly the criteria given the wide diversity of facilities and clients served.

After receiving the list of deficiencies from the RO, you have the option to submit to the RO either of the following plans to remedy the deficiencies at the affected ICF/MR within the timeframes prescribed:

- o Within 30 days, a plan to correct, or
- o Within 60 days, a reduction plan.

If you intend to exercise either (or neither) of the options, refer to §1919 of the Act, and the implementing regulations at 42 CFR 442.114.

EXCEPTION: If, as a result of a public hearing, it becomes evident that the proposed reduction plan is not the appropriate option and you decide to submit a correction plan, the correction plan must be received by the RO within 20 days from the date of the public hearing.

Refusal to elect either option will result in termination of the ICF/MR's participation in the Medicaid program in accordance with §1910(c) of the Act.

Current regulations (§§442.105 through 442.111 and 442.113) are not related to the implementation of §1919 of the Act, because they regulate only the actions of the State survey agencies and not those of the Secretary that are authorized by §1919.

1. Correction Plans for ICFs/MR - Specific Requirements: Submit to RO a letter stating you choose the correction plan option along with a completed HCFA-2567. Include a timetable for completing the necessary steps to correct the staff and physical plant deficiencies, and all other minor deficiencies, within 6 months of the approval date of the plan. Even though there must be substantial deficiencies in physical plant and staffing for §1919 to apply, the plan must include how the facility will correct all deficiencies within 6 months.

Written approval or disapproval will be forwarded to you within 30 days of receipt of a proposed correction plan. The RO may assist in the preparation of a plan prior to its submission.

Final Determination: The RO will not delay the process of making a final determination on submitted correction plans beyond the specified 30-day review period for correction plans. Because of the serious nature of the deficiencies that the regulations address, the RO will avoid delaying action to correct the deficiencies. If the RO questions any aspect of the submitted plan or your ability to fulfill the requirements of the plan, they wi11 try to resolve their concerns with you.

If the correction plan is found unacceptable, the RO will notify you of its disapproval and will terminate the ICF/MR's participation in accordance with 1910(c) of the Act. No further negotiation or discussion is possible.

At the conclusion of the time period specified in the plan of correction, the RO will make a compliance or noncompliance determination based on actual conditions at the facility. If a noncompliance determination is made, the ICF/MR's participation will be cancelled in accordance with 1910(c) of the Act.

The facility retains its appeal rights if termination action results from either of these situations.

2. Reduction Plans for ICFs/MR - Specific Requirements.--A number of requirements are imposed if you elect to implement a reduction plan rather than correct the deficiencies cited at the facility in question. This is to assure that any such plan is well conceived, that it has had the benefit of client, family, staff, and public input, and that the quality of life for both the clients remaining in the facility and those receiving community placements is adequately protected. While some flexibility is allowed in the allocation of capital and staff resources between institutional and community settings, fiscal concerns are not to compromise the accessibility or quality of care and services to Medicaid-eligible clients.

The RO will forward written approval or disapproval of the proposed plan to your agency within 60 days of receipt of a proposed reduction plan.

Contents of the Reduction Plan: The following information is necessary to assure that the requirements of the submitted reduction plans will be fulfilled. Provide the RO with these assurances that the reduction plan can be carried out by the State. If the RO is not satisfied with the assurances, it will ask for the additional information necessary to make a final determination.

- Experiences of individuals in the State's relevant home and community-based waivers, if any;

- Recidivism rates from existing community services;

- A comparison of the number of individuals identified as being in need of services with the number of clients currently placed or served in the community;

- The length of time individuals must "wait" for services;

- The types of services being provided i.e., case management, health services and how are client needs assessed;

- Description of the existing system for referrals, into the service system. (What are the entry rules and procedures and how do clients get into the system?);

- The State plan objectives as related to the development of community services, and how those objectives are achieved and monitored;

- Consultation/input from Developmental Disabilities (DD) Council, and Mental Retardation (MR) Program Directors in the State;

- The percentage of home and community services in the State that are accredited by national accrediting organizations;

- Where services are implemented not by the State but by local planning and/or funding authorities, discussion of the prevalence of local authorities and whether they cover the State or are designated to limited districts; discussion of their ability to deliver services;

- Records and information that will be maintained to support financial accountability, including:

  -- Documentation of existing programs and level of funding, and

  -- Projections for growth and how the growth will be funded to accommodate the clients being displaced by the reduction plan.

Assure that community residences in which affected clients are placed meet all applicable State licensure requirements and all applicable State and Federal certification requirements.

- Describe the assessment system that evaluates the quality of care provided in these settings;

- Describe the participation of outside groups such as State and local DD Councils, Community Advisory Councils, Protection and Advocacy agencies, and human rights committees in providing safeguards.

When describing the methods used to select clients and develop services to meet their needs, include the following information:

- A copy of the instrument used for selection;

o A copy of the evaluation instrument used to determine the effectiveness of meeting client needs and reevaluating such actions at regular intervals:

-- Description of how decisions are made for client selection and the process used to determine client needs, i.e., involves the interdisciplinary team, client, and family;

-- The criteria used for client selection including assessment of independent living skills, client strengths, presence of family, homogeneity of skills;

-- The availability of particular services needed generally, as well as specialized service and/or equipment needs, (i.e., physical therapy, community mental health, barrier-free homes).

o Copies of relevant home and community-based standards in which clients will be placed, if any;

o Description of the network/community services required and evidence of provisions through contracts, grants, etc.; and

These requirements may be met through the provision of services under a home and community-based services waiver granted pursuant to §1915(c) of the Act. However, such waivers and amendments to such waivers are separate and distinct from reduction plans approved under §1919 of the Act. Separate application is required for these waivers, and approval of one program does not imply or require approval of the other. (See §4440.)

The reduction plan must not impair the Medicaid eligibility of an affected client without his or her consent. A reduction plan must provide that affected clients. who are eligible for Medicaid while at the facility, shall at their (or their legal guardian's) option, be placed in another setting, or another part of the affected facility that is in full compliance with Federal Medicaid requirements and therefore allows them to retain their Medicaid eligibility. The Medicaid agency may not involuntarily place a client in a setting where he or she loses entitlement to Medicaid. If the client would have remained eligible for Medicaid had the State opted to eliminate the deficiencies in the affected facility, then the State may not, at any time, involuntarily place the client in a setting where he or she loses entitlement to Medicaid. The client may elect to be placed in a setting where he or she does not retain entitlement to Medicaid. Of course, if the client or the client's guardian, voluntarily chooses to move to a setting--for example, back home with his or her family--that causes the client's countable income or resources to exceed the State's eligibility standards, then the client's Medicaid eligibility would be subject to termination under the same terms and procedures as applicable to all Medicaid beneficiaries.

The plan must adequately--

- o Inform clients of the feasible placement alternatives; and
- o Explain how clients will maintain eligibility for medical assistance while placed in the other setting.
- o Provide that the ratio of qualified staff to clients at the affected facility (or part thereof) will be the higher of:
  - -- The ratio which the RO determines is necessary to assure the health and safety of the remaining clients, or
  - -- The ratio which was in effect at the time of the direct Federal survey.

Clients must still receive active treatment. Therefore, the facility must provide adequate staff to provide needed care and services in a safe and healthful environment.

A reduction plan must also provide for the protection of the interests of employees affected by the reduction plan, including:

- o Arrangements to preserve employee rights and benefits;
- o Training and retraining of such employees, where necessary;
- o Redeployment of such employees to community settings under the reduction plan; and
- o Making maximum efforts to guarantee the employment of such employees. (This requirement is not to be construed as guaranteeing the employment of any employee.)

Public Hearing Requirement for Reduction Plans: Notify the general community (including advocacy groups, the courts with which the ICF/MR is involved in litigation, if any, and other interested groups and agencies) of the public hearing on a proposed reduction plan through local media notices. Public notice must be made at least 10 days prior to the hearing date. Additionally, a written individual notice of your public hearing on a proposed reduction plan to clients or their parents, legal guardians and/or interested parties is required. Written individual notice is to include the nearest or most involved member of the affected clients, if any. The notice must include the exact date, time and location of the hearing, as well as the locations where the proposed plan is displayed. Notice to facility staff may be provided through established channels of communication within the ICF/MR. The ICF/MR may notify facility staff through routine written memoranda, posted notices in areas frequented by all staff or through other methods commonly used at the ICF/MR.

The plan must include minutes of the public hearing held at the affected facility with a summary of the issues discussed detailing the various points of view presented by those in attendance.

HCFA is permitted to approve 15 reduction plans per fiscal year, on a first come, first served basis without stipulations regarding the minimal costs that would be incurred to correct the deficiencies. All plans submitted thereafter must demonstrate to the satisfaction of the RO that at least $2,000,000 in State or local funds must be spent to remedy the substantial physical plant and staffing deficiencies found. Since the RO will not know which will be the 16th plan submitted, all reduction plans submitted are to include documentation of the costs involved to correct the substantial physical plant and staffing deficiencies (referred to in §442.116(e)(2)) using the HCFA-2567. Provide documentation from a certified architect or contractor of the projected costs and specific structural changes or renovations necessary to remedy the physical plant deficiencies and documentation of staff budget requests.

The date the RO receives the plan with all needed supporting information will be used to determine whether the plan qualifies for consideration within the first 15 approvals.

Final Determination: Because of the serious nature of the deficiencies that the regulations address, the RO will not delay making a final determination on submitted reduction plans beyond the specified 60-day period for reduction plans (allowing for the statutorily mandated 30 day public comment period). The RO will assist you in the preparation of a plan prior to its submission, if requested. If the RO questions any aspect of the submitted plan or your ability to fulfill the requirements of the plan, they will work with you to resolve their concerns.

Termination of an ICF/MR: Substantial failure to meet any of these reduction plan requirements subjects the State to one of two sanctions:

- Termination of the facility's provider agreement, or
- Disallowance of Federal Medicaid matching payments equal to 5% (five percent) of the cost of care for all eligible individuals in the facility for each month of noncompliance.

The RO has discretion as to which sanction to apply, but must apply one or the other. If, after any six-month period, the RO determines that a State failed to meet the reduction plan provisions §442.116, and determines the State has not made a good faith effort to meet those requirements, or if conditions worsen irrespective of "good faith efforts," the RO will initiate termination procedures. If the RO determines failure to comply with the requirements resulted despite the State's best efforts, the RO will apply a disallowance penalty of five-percent of the cost of care for all eligible individuals in the facility for each month that the requirements were not met. Good faith efforts apply only to the reduction plan. In the case of the correction plan, the RO will make a compliance or noncompliance determination based on actual conditions in the facility and not based on the "good faith efforts" of the provider.

4652. TERMINATION PROCEDURES--IMMEDIATE AND SERIOUS THREAT TO PATIENT HEALTH AND SAFETY

A. Substantial Noncompliance With Program Requirements Which Pose an Immediate and Serious Threat to Patient Health or Safety.--"Immediate and serious threat" is interpreted as a crisis situation in which the health and safety of patients is at risk. Generally, it is a deficient practice which indicates the operator's inability to furnish safe care and services. An immediate and serious threat to patient health or safety may exist in the presence of one or more of the following (or similar) situations. This list is not to be interpreted as all-inclusive, but rather as examples of what HCFA believes may constitute an immediate and serious threat. The surveyor is always expected to describe findings in sufficient detail to show the relative seriousness of the hazard.

o Widespread insect or rodent infestation indicative of food contamination or the possible spread of contagion.

o Failure to control infections as evidenced by the presence of facility acquired infections.

o Widespread patterns of patient abuse or poor patient care, including:

- Instances of malnutrition or dehydration that are unrelated to the patient§s condition and are a result of poor patient care;

- A pattern of negligence by staff with the result that patients are often left lying in urine, feces or other waste;

- Use of physical or chemical restraints in excess of that which is ordered by a physician.

o Drug or pharmaceutical hazards that directly affect patient health and safety, such as:

- Widespread drug errors, mishandling of drugs or other patient related pharmacy problems;

- Failure to provide medications as prescribed;

- Failure to monitor drugs as evidenced by lack of ordered laboratory work, failure to take vital signs as indicated by drug regimen, and lack of other nursing monitoring practices;

- Gross mishandling of drugs such as leaving drug trays unattended and available to patients and visitors.

- Administration of drugs by unqualified staff; or

- Administration of experimental drugs without the informed consent of the patient (or responsible party).

B. Processing of Immediate and Serious Threat Terminations.--When an immediate and serious threat to patient health or safety is documented, all termination procedures are to be completed within 23 calendar days. HCFA believes this to be a reasonable amount of time either for termination or for correction of the deficiencies which constitute an immediate and serious threat. Both you and the SA should accelerate the termination process in cases involving an immediate and serious threat to patient health and safety.

If there is a credible allegation that the threat or deficiency has been corrected, at least one resurvey prior to termination should be conducted by the SA.

Do not use this procedure if there is a time-limited agreement that is subject to cancellation or nonrenewal within 23 days after the survey. In those cases, process the cancellation or nonrenewal as explained in §4654.

Medicaid agreements with facilities that concurrently participate in Medicare must be terminated on the same date the Medicare agreement is terminated (42 CFR 442.20).

4653. TERMINATION PROCEDURES--NONCOMPLIANCE LIMITS CAPACITY OF FACILITY TO FURNISH ADEQUATE LEVEL OR QUALITY OF CARE - NO IMMEDIATE AND SERIOUS THREAT TO HEALTH AND SAFETY

Failure to meet the intent of one or more Conditions is one cause for termination of program participation. If Medicare decides to terminate rather than impose a denial of payments for new admissions, the termination will take effect within 90 days following the date of survey, unless compliance is achieved before the effective date of termination. When Medicare terminates a dually participating SNF, terminate the Medicaid agreement on the same date.

With respect to long-term care facilities as explained in §4651.3 and §4654, termination is one option among other sanctions. If in a Medicaid-only case, you opt to terminate when there is not immediate jeopardy to health and safety, follow §4653.1 through §4655.

4653.1 Interruption of Termination Timetable

A. Credible Allegation of Compliance.--Have the SA conduct a revisit following receipt of any credible allegation of compliance from a facility. A credible allegation is one:

o Made by a facility with a history of having maintained a commitment to compliance, and taking corrective action if required,

o That is realistic in terms of the possibility of the corrective action having been accomplished between the exit conference and the date of the allegation, and

o That actually resolves the problems created by the deficiency.

Only actual restoration of compliance can rescind termination action.

B. Informal Hearings Do Not Interrupt the Timetable.--The process may not be postponed to accommodate informal hearings or meetings or to give the facility additional time to achieve compliance. Such discussion may, however, be conducted within the procedural time limits above, as you deem appropriate. This 90 day procedure provides adequate time for the provider to achieve compliance if your decision is to wait the full time allowed and if the well-being of patients is not jeopardized in the interim.

C. Acceleration of Timetable.--Switch from the 90-day procedures to the accelerated procedures at any point when:

o There is an immediate and serious threat to patient health and safety, or

o An acceptable and reasonable plan of correction is not submitted; i.e., the provider cannot achieve compliance within 90 days, or

o The provider has not shown good faith efforts to achieve and maintain compliance with all program requirements.

D. Termination Coinciding with Change of Ownership.--A change of ownership does not affect completion of a termination action. Do not postpone any required termination. Do not solicit a plan of correction from the new owner. Court appointed receivership is not a basis for cessation of the termination process. Following termination, the new owner may, however, request approval for participation as a new provider, subject to reasonable assurance provisions. (See §4603.)

E. Disagreement Over Deficiencies.--A provider that disagrees with any SA finding regarding a cited deficiency or an acceptable plan of correction should be advised to express its position on the plan of correction in statutory or regulatory terms, and to specify why the SA's citation is not correct. This information does not interrupt the termination process, but is publicly disclosable and will be included in the documentation considered during any subsequent adjudication or hearings.

4653.2 Termination Documentation.--If you have any reservations about the SA§s recommendation to terminate a facility, request copies of the current Survey Report and copies of previous Survey Reports to insure that all items are properly completed.

4653.3 Completion and Forwarding of HCFA-462.--The Adverse Action Extract, HCFA-462, was developed to monitor SA and HCFA-RO adherence to termination processing time limits. The form is used whenever a facility is cited as not meeting one or more Conditions. For ICFs and Medicaid-only SNFs, complete a HCFA-462, when the deficiencies cited result in a certification of non-compliance unless actually corrected before certification. Information provided on the form is entered into the Medicare/Medicaid Automated Certification System (MMACS) and used to monitor any adverse action initiated against a Medicare or Medicaid provider, supplier or facility.

The HCFA-462 is initiated by the SA and copies forwarded to the HCFA-RO immediately following specific SA actions; i.e., survey, followup visits, certification of compliance. For Medicaid-only facilities the SA forwards it to you to complete the appropriate items (10, 12, 13 and 17), in Parts II and III of the form. After you complete it, send a copy to the HCFA-RO.

4654. NONRENEWAL OR CANCELLATION OF TIME LIMITED AGREEMENTS FOR LONG TERM CARE FACILITIES (MEDICARE AND MEDICAID)

A. General.--Time limited agreements (TLAs) of 12 months or less are required by regulations for SNFs and ICFs including ICFs/MR (but not for hospitals having "swing bed" agreements to provide long term care). Like any agreement, a TLA may be terminated. However, unlike other agreements, a TLA may also be nonrenewed or automatically cancelled. The decision to terminate instead of nonrenew or cancel depends on the timing of the onsite survey; i.e., how close in time the survey is to the expiration date or automatic cancellation date, and the seriousness of the deficiencies cited.

Nonrenewal and cancellation are preferred alternatives to termination if termination would be effective later than the time of projected renewal or automatic cancellation date.

B. Nonrenewal of Time Limited Agreements.--A nonrenewal is the decision not to renew a TLA following its expiration.

1. Situations Leading to Nonrenewal.--A facility does not qualify for renewal of its agreement if it has been determined, based on resurvey, that:

- The facility has violated the terms of its agreement or the provisions of title XIX, or applicable regulations; or
- The facility does not substantially meet one or more program requirements (e.g., Conditions of Participation for SNFs and standards for ICFs or ICFs/MR, or has an unacceptable plan of correction); or

- The facility continues to be substantively out of compliance with the same standard(s) (consistently maintains major deficiency) for SNFs, ICFs, or ICFs/MR that were found out of compliance during the last survey on which the current certification period was based. In other words, the deficiency persists through the term of its current agreement.

EXCEPTION: A new period of certification may be approved even though the same standard(s)was out of compliance at the time of resurvey if:

- The deficiencies did not substantially limit the facility's ability to furnish adequate care or adversely affect the health and safety of patients, and

- The facility can document that it achieved compliance during the term of the agreement, but for reasons beyond its control was again out of compliance prior to the expiration of the agreement.

2. Timing of Resurvey.--In nonrenewal cases, the facility must be given formal notice of your decision not to enter into a new agreement prior to the date of expiration of its existing agreement. Therefore, the recertification survey should be completed by the SA between 60 and 120 days in advance of the expiration of the term of the agreement. All nonrenewal procedures must be completed by the expiration date of the current agreement.

Process a termination in lieu of nonrenewal if the renewal date is more than:

- 90 days after finding noncompliance, or

- 23 days if you find there is an immediate and serious threat to patient health and safety.

3. Facility Does Not Want to Renew.--A participating facility may choose not to renew its agreement.

C. Cancellation of Time Limited Agreements

1. General.--The TLA must contain an automatic cancellation clause if uncorrected deficiencies existed at the time of the last survey. In this case, the SA will specify a date not later than the 60th day following the end of the time period specified for such corrections. This should be not later than the end of the ninth month of the agreement. The cancellation clause provides that if the corrections of deficiencies are not made by the date the SA has specified, or if substantial progress has not been achieved in accordance with an accepted plan of correction, the agreement will automatically terminate on that date. However, if substantial progress is made and an updated plan of correction accepted, the facility may continue to participate. The SA establishes a control on all cancellation clause agreements to ensure that a verification visit is performed as soon as possible after the last date specified in the facility's plan of correction.

The procedures implementing the cancellation clause are similar to those required for an involuntary termination. They require comparable development, supporting documentation, and internal clearance action.

However, the basis for invoking this clause may be limited to establishing that the facility has not made substantial progress in carrying out its plan of correction. Whenever a cancellation clause is "invoked", undertake termination action to remove the facility from participation status. All cancellation procedures must be completed by the cancellation date.

The SA will document and notify you if the verification visit establishes that the facility has made the necessary corrections, or has made significant improvement, justifying continuance of the agreement based on an updated plan of correction. To document correction or significant improvement, the SA will use one or both of the following forms:

- HCFA-2567B for deficiencies which have been corrected.
- Revised HCFA-2567 for deficiencies not corrected. The SA will prepare and forward the documentation to you with a HCFA-l539, noting their determination.

2. Substantial Progress in Correcting Deficiencies Where There is a Cancellation Clause.--"Substantial progress" means that corrections are well underway; that there is tangible and visible progress. For example, if the installation of a sprinkler system is required but the system is not yet operating, there should be evidence of progress at the time of the revisit, such as the installation of piping. If the only progress by the facility to date has been a loan application which is still pending, this would not constitute substantial progress sufficient to prevent invoking the cancellation clause. However, extenuating circumstances that are beyond the control of the facility can be considered in determining whether or not to continue the facility in the program.

If the verification visit establishes that the facility has made the necessary corrections, or has made significant improvement justifying continuance of the agreement based on an updated plan of correction, the SA completes the following forms:

- HCFA-2567B for deficiencies which have been corrected.
- HCFA-2567--Includes deficiencies not corrected from the previous HCFA-2567.

Notify the facility that based on the correction of all deficiencies or the revised plan of correction, the cancellation clause will not be invoked and the agreement will continue to its full term.

3. Facility Fails to Make Corrections or Substantial Progress.--Documentation for invoking the cancellation clause need not necessarily be as extensive as that for an involuntary termination. Survey efforts may be limited to the confirmation of the continued existence of the deficiencies. However, the documentation must be clear, convincing, and of the same high quality as that for an involuntary termination action.

4655. NOTICE OF TERMINATION

Notify the facility of its termination, cancellation or nonrenewal, and of its appeal rights in accordance with your State Plan requirements. Publish an advance public notice giving the effective date of and reasons for termination.

4656. ADDITIONAL COMMUNICATIONS WITH FACILITY

After the SA forwards the certification of noncompliance to you, document all further contacts with the facility. Unrecorded visits, surveys, or correctional allegations that were not reported before final termination action could cause embarrassment or even result in failure to sustain the termination action. Even after final termination action, any additional contacts may be pertinent to proper handling of the case.

4657. RELOCATING PATIENTS OR RESIDENTS DISPLACED BY TERMINATION OR CLOSURE

A. General.--There are instances when patients or residents in long term care facilities need to be transferred to other facilities. Specific actions, decisions, and events that require the relocation include:

- Expiration or termination of a facility's provider agreement;
- Expiration or nonrenewal of a facility's State license;
- The facility's inability to provide care and related services because of fire, natural disaster, loss of staff, or another reason beyond its control;
- The facility's voluntary termination of participation in Medicaid and/or Medicare;
- Reclassification of the facility from a skilled nursing to an intermediate care facility; and
- Reclassification of patients to a different level of care.

B. Federal Program Requirement in Relocation of Medical Assistance Patients.--Federal financial participation may be claimed for facilities only if they are certified and participating in Medicaid under a valid agreement. Following termination by you FFP may be continued, for a period not to exceed 30 days if the State shows that it has made reasonable efforts to facilitate the orderly transfer of patients and residents to another facility. (See 42 CFR 441.11(b).) You may claim FFP for costs which are legitimately incurred in relocating Medicaid recipients.

You have the primary responsibility for relocating the patients and residents and for ensuring their safe and orderly transfer from a facility that no longer participates in Medicaid to a participating facility. This is because the State remains responsible for the care and services provided to public assistance recipients. The State's transfer policies must:

- Consider the nature and severity of the facility's failure to meet standards;
- Consider the availability of alternative facilities;
- Ensure that the situation is explained to the recipient and the recipient is permitted to exercise an informed choice as to whether he or she wishes to move and, if so, to which available facility;
- Provide that qualified personnel will assess patients' medical and psychological condition and needs, including the necessity to prepare the patient for transfer;
- Provide for adequate and appropriate transportation on the day the patient or resident is moved; and
- Apprise the receiving facility of the person's condition and needs.

C. State Relocation Activities.--In order for the relocation process to be orderly, the State action must meet at least the following requirements:

- The nature and severity of the facility's failure to meet required standards must be considered;
- The availability of suitable, alternative facilities must be considered;
- The situation must be explained to the individual recipient to permit him/her to exercise an informed choice as to whether he/she wishes to move (where that option is open) and to which facility he/she wishes to transfer;

o A review of the patient's medical and psychological condition and needs, including the need or potential need for preparing the patient for transfer, must be made by qualified personnel;

o Provision must be made for adequate, appropriate transportation on the day when recipients are to be moved; and

o The receiving facility must be fully apprised of the patient's condition and needs.

4658. GUIDANCE TO STATES FOR MEDICAID NURSING FACILITY (NF) REMEDIES

A. Background.--Section 1919(h) of the Act requires you to establish, by law (statute or regulation), remedies for nursing facilities (NFs) that do not meet the requirements of participation. Remedies should be designed to result in faster correction of deficiencies and ensure the health and safety of residents of NFs. You are to impose these remedies for NFs that are not owned by the State or those found noncompliant by HCFA's validation process.

If a NF does not meet one or more of the requirements, and the deficiencies immediately jeopardize the health or safety of the residents, take immediate action to:

o Remove the jeopardy and correct the deficiencies through the appointment of temporary management to oversee the operation of the facility and, at your option, impose one or more of the remedies available in subpart B, or

o Terminate the facility's Medicaid participation, and, at your option, impose one or more of the remedies available in subpart B.

If a NF does not meet one or more of the requirements and the deficiencies do not immediately jeopardize the health and safety of its residents you may:

o Terminate the facility's Medicaid participation,

o Impose one or more of the available remedies in subpart B,

o Do both.

Establish State remedies, by statute or regulation by October 1, 1989, as they are a condition of State plan approval for calendar quarters beginning on or after October 1, 1989.

B. Required State Remedies.--Specify the criteria as to when and how each remedy will be applied, the amounts of any fines, and the severity of each remedy. Design the procedures to minimize the time between identification of violations and final imposition of remedies. Denial of payment for new admissions, appointment of temporary management, and closure are remedies which may be imposed during the pendency of any hearing.

The criteria for all remedies are to provide for incrementally more severe fines for repeated or uncorrected deficiencies. In determining what action to take, consider the NF's compliance history, change of ownership, and the number and gravity of the deficiencies. You may also specify additional remedies that you can demonstrate are as effective in deterring non-compliance and correcting deficiencies as those which follow:

Follow regular procedures to amend your approved State plan to establish at least the following remedies:

1. Denial of Payment for New Admissions.--Deny payment for all Medicaid admissions after you give notice to the NF and the public that the NF is no longer in compliance with one or more of the requirements.

In accordance with §1919(h)(4) of the Act deny payment until the NF is in substantial compliance with the requirements of participation.

2. Civil Money Penalty.--Assess a civil money penalty, with interest, for each day the facility is or was out of compliance with one or more of the requirements of participation, even if the facility subsequently corrects its deficiencies and brings itself into full compliance. Establish criteria for assigning the amount of fines. Impose fines based upon the severity of the deficiencies and impose incrementally more severe fines in cases of repeated or uncorrected deficiencies. Apply all funds collected as a result of these civil money penalties to the protection of the health and property of residents of NFs that the State or HCFA finds deficient. Funds may be used for the cost of relocating residents to other facilities, maintenance or operation of a facility pending correction of deficiencies or closure, and for reimbursement of residents for personal funds lost. Civil money penalties may not be imposed during the pendency of any hearing.

3. Appointment of Temporary Management.--If you determine that there is a need for temporary management to ensure an orderly closure of a facility or while improvements are being made to bring a facility into compliance with all the requirements of participation, appoint temporary management to oversee the operation of the deficient NF and to protect the health and safety of its residents. Temporary management may be State personnel or private individuals with education and the requisite experience in nursing home administration and be licensed in accordance with State law. Do not discontinue temporary management that has been appointed for the period improvements are being made until you have determined that the NF has the management capability to ensure continued compliance with all the requirements of participation.

4. Closure of the NF and/or Transfer of Residents.--In the case of an emergency, close the NF or transfer the residents of the NF to other facilities or do both. For example, an emergency situation may relate to a provider's gross inability to provide care and related services because of fire, natural disaster, epidemic, or other conditions which endanger the health and safety of patients.

C. Alternative Remedies.--Include the specified remedies in subpart B in your approved State plan for any quarter beginning after October 1, 1989. However, you may establish remedies alternative to the specified State remedies (except for the remedy of termination) if, you can demonstrate to the satisfaction of HCFA that your alternative remedies are as effective in deterring noncompliance and correcting deficiencies as those under §1919(h)(2)(A) of the Act. For example, you may already have alternative remedies in place for the licensure program or for the Medicaid program under State law, such as:

- o Civil or administrative fines (different from the specified OBRA remedy);
- o Court-appointed receiver;
- o Conditional/provisional licensing, probationary license, or license revocation; and
- o Withholding of payments.

If so, summarize your past experience with alternative remedies indicating their effectiveness in deterring noncompliance and correcting deficiencies.

Provide the following types of documentation to indicate the effectiveness of your alternative remedies, such as:

- o Procedures for implementing the remedies including explanations of what type of deficiencies trigger the remedies, a method of ranking the seriousness of violations and corresponding remedies, timing of remedies and appeals and specific rules designating responsibility for the violation and liability for the remedies.
- o Identification of the agency responsible for ensuring imposition of the remedies and the amount of resources being devoted to this effort, including legal and other enforcement-related staff.
- o Method of evaluation and supporting data for alternative remedies that have proved to be effective in deterring noncompliance and correcting deficiencies including the number of facilities in evaluation and the rate of recidivism.

Alternatives to the specified remedies must be submitted under the established procedures for approval of State plan amendments.

D. Additional Requirements.--

1. Assuring Prompt Compliance.--If a NF has not complied with any of the requirements of participation within three months after the date the facility is found to be out of compliance with such requirements, impose a denial of payment for individuals admitted to the facility after the date of notice to the NF that it remains out of compliance for a three month period.

2. Repeated Noncompliance.--If you find, on three consecutive standard surveys, that a NF is providing substandard quality of care, then, regardless of any other remedies provided:

- o Impose denial of payment for all new admissions to the NF, and
- o Carry out onsite monitoring of the facility, on a regular basis, as needed, until the facility has demonstrated that it is in compliance with the requirements of participation and that it will remain in compliance.

E. Incentives For High Quality Care.--In addition to the remedies specified under §1919(h)(2) of the Act, you may establish in your approved State plan a program to reward nursing facilities that provide the highest quality care to Medicaid residents. The reward may be in the form of public recognition, incentive payments, or both. The expenses incurred in carrying out such a program shall be considered expenses necessary for the proper and efficient administration of the State plan under Medicaid (§1903(a)(7) of the Act).

Should you elect to use an incentive payment, the State plan amendment must define highest quality care, state the criteria to be met and measurements to be used in awarding an incentive payment. To be considered as "efficient" in the administration of the State plan, the incentive payment must be reasonable, as determined by the RO in its State plan review process.

F. Federal Financial Participation.--Reasonable State expenditures for the proper and efficient administration of the State plan, such as temporary management, closing a NF, transfer of residents to a new NF, and other expenses associated with implementing these remedies are subject to Federal matching payment at the rate of 50 percent. Establish procedures to prevent claiming FFP for expenditures which have been funded by the civil money penalties discussed in subpart B.

ADDENDUM A-WAGE INDICES FOR URBAN AREAS

MSA Area	Wage Index
Abilene, TX Taylor, TX	.9414
Akron, OH Portage, OH Summit, OH	1.0734
Albany, GA Dougherty, GA Lee, GA	.8907*
Albany-Schenectady-Troy, NY Albany, NY Greene, NY Montgomery, NY Rensselaer, NY Saratoga, NY Schenectady, NY	.8925
Albuquerque, NM Bernalillo, NM	1.0579
Alexandria, LA Rapides, LA	.9735
Allentown-Bethlehem, PA-NJ Warren, NJ Carbon, PA Lehigh, PA Northampton, PA	1.0518
Alton-Granite City, IL Jersey, IL Madison, IL	.9587
Altoona, PA Blair, PA	1.0249
Amarillo, TX Potter, TX Randall, TX	.9696

ADDENDUM A-WAGE INDICES FOR URBAN AREAS

MSA Area	Wage Index
Anaheim-Santa Ana, CA Orange, CA	1.2445
Anchorage, AK Anchorage, AK	1.4657
Anderson, IN Madison, IN	.9690
Anderson, SC Anderson, SC	.8746
Ann Arbor, MI Washtenaw,MI	1.2090
Anniston, AL Calhoun, AL	.8625
Appleton-Oshkosh-Neenah, WI Calumet, WI Outagamie, WI Winnebago, WI	.9704
Asheville, NC Buncombe, NC	.9508
Athens, GA Clarke, GA Jackson, GA Madison, GA Oconee, GA	.8817
Atlanta, GA Barrow, GA Butts, GA Cherokee, GA Clayton, GA Cobb, GA Coweta, GA De Kalb, GA Douglas, GA	.9417

ADDENDUM A-WAGE INDICES FOR URBAN AREAS

MSA Area	Wage Index
Fayette, GA Forsyth, GA Fulton, GA Gwinnett, GA Henry, GA Newton, GA Paulding, GA Rockdale, GA Spalding, GA Walton, GA	
Atlantic City, NJ Atlantic, NJ Cape May, NJ	1.0649
Augusta, GA-SC Columbia, GA McDuffie, GA Richmond, GA Aiken, SC	.9614
Aurora-Elgin, IL Kane, IL Kendall, IL	.9958
Austin, TX Hays, TX Travis, TX Williamson, TX	1.0590
Bakersfield, CA Kern, CA	1.2271
Baltimore, MD Ann Arundel, MD Baltimore, MD Baltimore City, MD Carroll, MD Harford, MD Howard, MD Queen Annes, MD	1.0860

ADDENDUM A-WAGE INDICES FOR URBAN AREAS

MSA Area	Wage Index
Bangor, ME Penobscot, ME	.9271
Baton Rouge, LA Ascension, LA East Baton Rouge, LA Livingston, LA West Baton Rouge, LA	1.0174
Battle Creek, MI Calhoun, MI	1.0600
Beaumont-Port Arthur, TX Hardin, TX Jefferson, TX Orange, TX	.9874
Beaver County, PA Beaver, PA	1.0863
Bellingham, WA Whatcom, WA	1.0544*
Benton Harbor, MI Berrien, MI	.8734
Bergen-Passaic, NJ Bergen, NJ Passaic, NJ	1.0290
Billings, MT Yellowstone, MT	.9648*
Biloxi-Gulfport, MS Hancock, MS Harrison, MS	.8710
Binghamton, NY Broome, NY Tioga, NY	.9526

ADDENDUM A_WAGE INDICES FOR URBAN AREAS

MSA Area	Wage Index
Birmingham, AL Blout, AL Jefferson, AL Saint Clair, AL Shelby, AL Walker, AL	1.0047
Bismarck, ND Burleigh, ND Morton, ND	1.0100
Bloomington, IN Monroe, IN	.9143*
Bloomington-Normal, IL Mclean, IL	1.0139*
Boise City, ID Ada, ID	1.0755
Boston-Lawrence-Salem-Lowell-Brockton, MA Essex, MA Middlesex, MA Norfolk, MA Plymouth, MA Suffolk, MA	1.0949
Boulder-Longmont, CO Boulder, CO	.9982
Bradenton, FL Manatee, FL	.9199*
Brazoria, TX Brazoria, TX	.8409
Bremerton, WA Kitsap, WA	.8989*
Bridgeport-Stamford-Norwalk-Danbury, CT Fairfield, CT	1.1572

ADDENDUM A-WAGE INDICES FOR URBAN AREAS

MSA Area	Wage Index
Brownsville-Harlingen, TX Cameron, TX	.9217
Bryan-College Station, TX Brazos, TX	.9077
Buffalo, NY Erie, NY	.9787
Burlington, NC Alamance, NC	.8480
Burlington, VT Chittenden, VT Grand Isle, VT	.9654*
Canton, OH Carroll, OH Stark, OH	.9797
Casper, WY Natrona, WY	1.0255
Cedar Rapids, IA Linn, IA	.9379
Champaign-Urbana-Rantoul, IL Champaign, IL	1.0245
Charleston, SC Berkeley, SC Charleston, SC Dorchester, SC	1.0262
Charleston, WV Kanawha, WV Putnam, WV	1.1033
Charlotte-Gastonia-Rock Hill NC-SC Cabarrus, NC Gaston, NC Lincoln, NC	.9776

ADDENDUM A-WAGE INDICES FOR URBAN AREAS

MSA Area	Wage Index
Mecklenburg, NC Rowan, NC Union, NC York, SC	
Charlottesville, VA	1.2925
Albermarle, VA Charlottesville City, VA Fluvanna, VA Greene, VA	
Chattanooga, TN-GA	.9671
Catoosa, GA Dade, GA Walker, GA Hamilton, TN Marion, TN Sequatchie, TN	
Chicago, IL	1.2196
Cook, IL Du Page, IL McHenry, IL	
Chico, CA	1.0558
Butte, CA	
Cincinnati, OH-KY-IN	1.0558
Dearborn, IN Boone, KY Campbell, KY Kenton, KY Clermont, OH Hamilton, OH Warren, OH	
Clarksville-Hopkinsville, TN-KY	.8342
Christian, KY Montgomery, TN	
Cleveland, OH	1.2028
Cuyahoga, OH Geauga, OH Lake, OH Medina, OH	

ADDENDUM A-WAGE INDICES FOR URBAN AREAS

MSA Area	Wage Index
Colorado Springs, CO El Paso, CO	1.1069
Columbia, MO Boone, MO	1.1357
Columbia, SC Lexington, SC Richland, SC	.9603
Columbus, GA-AL Russell, AL Chattahoochee, GA Muscogee, GA	.9199
Columbus, OH Delaware, OH Fairfield, OH Franklin, OH Licking, OH Madison, OH Pickaway, OH Union, OH	1.0423
Corpus Christi, TX Nueces, TX San Patricio, TX	.9648
Cumberland, MD-W VA Allegeny, MD Mineral, WV	.9460
Dallas, TX Collin, TX Dallas, TX Denton, TX Ellis, TX Kaufman, TX Rockwall, TX	1.0774

ADDENDUM A-WAGE INDICES FOR URBAN AREAS

MSA Area	Wage Index
Danville, VA Danville City, VA Pittsylvania, VA	.8701*
Davenport-Rock Island-Moline, IA-ILL Scott, IA Henry, IL Rock Island, IL	.9821
Dayton-Springfield, OH Clark, OH Greene, OH Miami, OH Montgomery, OH	1.1117
Daytona Beach, FL Volusia, FL	.9693
Decatur, IL Macon, IL	.9831*
Denver, CO Adams, CO Arapahoe, CO Denver, CO Douglas, CO Jefferson, CO	1.2141
Des Moines, IA Dallas, IA Polk, IA Warren, IA	1.0709
Detroit, MI Lapeer, MI Livingston, MI Macomb, MI Monroe, MI Oakland, MI Saint Clair, MI Wayne, MI	1.1992

ADDENDUM A-WAGE INDICES FOR URBAN AREAS

MSA Area	Wage Index
Dothan, AL Dale, Al Houston, AL	.8848
Dubuque, IA Dubuque, IA	1.0281
Duluth, MN-WI St. Louis, MN Douglas, WI	.9154
East St. Louis-Belleville, IL Clinton, IL St. Clair, IL	.9717
Eau Claire, WI Chippewa, WI Eau Claire, WI	.9703
El Paso, TX El Paso, TX	.8991
Elkhart-Goshen, IN Elkhart, IN	.8907*
Elmira, NY Chemung, NY	1.0257
Enid, OK Garfield, OK	.9018
Erie, PA Erie, PA	.9927
Eugene-Springfield, OR Lane, OR	.9882
Evansville, IN-KY Posey, IN Vanderburgh, IN Warrick, IN Henderson, KY	1.0093

ADDENDUM A-WAGE INDICES FOR URBAN AREAS

MSA Area	Wage Index
Fargo-Moorhead, ND-MN Clay, MN Cass, ND	1.0051
Fayetteville, NC Cumberland, NC	.9325*
Fayetteville-Springdale, AR Washington, AR	.8307
Flint, MI Genesee, MI	1.1523
Florence, AL Colbert, AL Lauderdale, AL	.8088
Florence, SC Florence, SC	.8072
Fort Collins-Loveland, CO Larimer, CO	.9278
Fort Lauderdale-Hollywood-Pompano Beach, FL Broward, FL	1.1105
Fort Myers, FL Lee, FL	.9242
Fort Pierce, FL Martin, FL St. Lucie, FL	.9943
Fort Smith, AR-OK Crawford, AR Sebastian, AR Sequoyah, OK	.9705
Fort Walton Beach, FL Okaloosa, FL.	.7873*

ADDENDUM A-WAGE INDICES FOR URBAN AREAS

MSA Area	Wage Index
Fort Wayne, IN Allen, IN De Kalb, IN Whitley, IN	.9446
Fort Worth-Arlington, TX Johnson, TX Parker, TX Tarrant, TX	.9281
Fresno, CA Fresno, CA	1.1951
Gadsden, AL Etowah, AL	.9234
Gainesville, FL Alachua, FL Bradford, FL	.9709
Galveston-Texas City, TX Galveston, TX	1.1822
Gary-Hammond, IN Lake, IN Porter, IN	1.1222
Glens Falls, NY Warren, NY Washington, NY	.8813
Grand Forks, ND Grand Forks, ND	.9762*
Grand Rapids, MI Kent, MI Ottawa, MI	.9998
Great Falls, MT Cascade, MT	1.0307

ADDENDUM A-WAGE INDICES FOR URBAN AREAS

MSA Area	Wage Index
Greeley, CO Weld, CO	1.0829*
Green Bay, WI Brown, WI	.9974
Greensboro-Winston-Salem-High Point, NC Davidson, NC Davie, NC Forsyth, NC Guilford, NC Randolph, NC Stokes, NC Yadkin, NC	.9578
Greenville-Spartanburg, SC Greenville, SC Pickens, SC Spartanburg, SC	.9474
Hagerstown, MD Washington, MD	1.0091
Hamilton-Middletown, OH Butler, OH	1.0435
Harrisburg-Lebanon-Carlisle, PA Cumberland, PA Dauphin, PA Lebanon, PA Perry, PA	1.0356
Hartford-Middletown-New Britain-Bristol, CT Hartford, CT Litchfield, CT Middlesex, CT Tolland, CT	1.0692

ADDENDUM A-WAGE INDICES FOR URBAN AREAS

MSA Area	Wage Index
Hickory, NC Alexander, NC Burke, NC Catawba, NC	.9503
Honolulu, HI Honolulu, HI	1.1471
Houma-Thibodaux, LA Lafourche, LA Terrebonne, LA	.9786
Houston, TX Fort Bend, TX Harris, TX Liberty, TX Montgomery, TX Waller, TX	1.1119
Huntington-Ashland, WV-KY-OH Boyd, KY Carter, KY Greenup, KY Lawrence, OH Cabell, WV Wayne, WV	.9809
Huntsville, AL Madison, AL	.8990
Indianapolis, IN Boone, IN Hamilton, IN Hancock, IN Hendricks, IN Johnson, IN Marion, IN Morgan, IN Shelby, IN	1.0555
Iowa City, IA Johnson, IA	1.1423

ADDENDUM A-WAGE INDICES FOR URBAN AREAS

MSA Area	Wage Index
Jackson, MI Jackson, MI	1.0281*
Jackson, MS Hinds, MS Madison, MS Rankin, MS	.9110
Jacksonville, FL Clay, FL Duval, FL Nassau, FL St. Johns, FL	.9914
Jacksonville, NC Onslow, NC	.8848*
Janesville, Beloit, WI Rock, WI	.8907
Jersey City, NJ Hudson, NJ	1.0913
Johnson City-Kingsport-Bristol, TN-VA Carter, TN Hawkins, TN Sullivan, TN Unicoi, TN Washington, TN Bristol City, VA Scott, VA Washington, VA	.9240
Johnstown, PA Cambria, PA Somerset, PA	1.0284
Joliet, IL Grundy, IL Will, IL	1.0893

ADDENDUM A-WAGE INDICES FOR URBAN AREAS

MSA Area	Wage Index
Joplin, MO Jasper, MO Newton, MO	.9579
Kalamazoo, MI Kalamazoo, MI	1.2269
Kankakee, IL Kankakee, IL	.9143
Kansas City, KS Johnson, KS Leavenworth, KS Miami, KS Wyandotte, KS	.9784
Kansas City, MO Cass, MO Clay, MO Jackson, MO Lafayette, MO Platte, MO Ray, MO	.9910
Kenosha, WI Kenosha, WI	1.0913*
Killeen-Temple, TX Bell, TX Coryell, TX	.9402
Knoxville, TN Anderson, TN Blout, TN Grainger, TN Jefferson, TN Knox, TN Sevier, TN Union, TN	.9186
Kokomo, IN Howard, IN Tipton, IN	.9610

ADDENDUM A-WAGE INDICES FOR URBAN AREAS

MSA Area	Wage Index
LaCrosse, WI LaCrosse, WI	.9402*
Lafayette, LA Lafayette, LA St. Martin, LA	1.0162
Lafayette, IN Tippecanoe, IN	.9112
Lake Charles, LA Calcasieu, LA	.9942
Lake County, IL Lake, IL	1.1086
Lakeland-Winter Haven, FL Polk, FL	.9276
Lancaster, PA Lancaster, PA	1.0372
Lansing-East Lansing, MI Clinton, MI Eaton, MI Ingham, MI	1.0514
Laredo, TX Webb, TX	.8561*
Las Cruces, NM Dona Ana, NM	.8455*
Las Vegas, NV Clark, NV	1.2190
Lawrence, KS Douglas, KS	.9797*
Lawton, OK Comanche, OK	.9276*

ADDENDUM A-WAGE INDICES FOR URBAN AREAS

MSA Area	Wage Index
Lewiston-Auburn, ME Androscoggin, ME	.9177*
Lexington-Fayette, KY Bourbon, KY Clark, KY Fayette, KY Jessamine, KY Scott, KY Woodford, KY	.9574
Lima, OH Allen, OH Auglaize, OH	.9987
Lincoln, NE Lancaster, NE	.8670
Little Rock-North Little Rock, AR Faulkner, AR Lonoke, AR Pulaski, AR Saline, AR	1.0183
Longview-Marshall, TX Gregg, TX Harrison, TX	.8561
Lorain-Elyria, OH Lorain, OH	1.0549
Los Angeles-Long Beach, CA Los Angeles, CA	1.3037
Louisville, KY-IN Clark, IN Floyd, IN Harrison, IN Bullitt, KY Jefferson, KY Oldham, KY Shelby, KY	1.0854

ADDENDUM A-WAGE INDICES FOR URBAN AREAS

MSA Area	Wage Index
Lubbock, TX Lubbock, TX	1.0087
Lynchburg, VA Amherst, VA Campbell, VA Lynchburg City, VA	.9240
Macon-Warner Robins, GA Bibb, GA Houston, GA Jones, GA Peach, GA	.9850
Madison, WI Dane, WI	1.0259
Manchester-Nashua, NH Hillsboro, NH Merrimack, NH	.9346
Mansfield, OH Richland, OH	.9177
McAllen-Edinburg-Mission, TX Hidalgo, TX	.8378
Medford, OR Jackson, OR	.9853
Melbourne-Titusville-Palm Bay, FL Brevard, FL	.9333
Memphis, TN-AR-MS Crittenden, AR De Soto, MS Shelby, TN Tipton, TN	1.0765
Miami-Hialeah, FL Dade, FL	1.1492
Middlesex-Somerset-Hunterdon, NJ Hunterdon, NJ Middlesex, NJ Somerset, NJ	1.0633

ADDENDUM A-WAGE INDICES FOR URBAN AREAS

MSA Area	Wage Index
Midland, TX Midland, TX	1.0783
Milwaukee, WI Milwaukee, WI Ozaukee, WI Washington, WI Waukesha, WI	1.0522
Minneapolis-St. Paul, MN-WI Anoka, MN Carver, MN Chisago, MN Dakota, MN Hennepin, MN Isanti, MN Ramsey, MN Scott, MN Washington, MN Wright, MN St. Croix, WI	1.0271
Mobile, AL Baldwin, AL Mobile, AL	.9330
Modesto, CA Stanislaus, CA	1.0795
Monmouth-Ocean, NJ Monmouth, NJ Ocean, NJ	.9863
Monroe, LA Ouachita, LA	.9550
Montgomery, AL Autauga, AL Elmore, AL Montgomery, AL	.9726
Muncie, IN Delaware, IN	.9783*

ADDENDUM A WAGE INDICES FOR URBAN AREAS

MSA Area	Wage Index
Muskegon, MI Muskegon, MI	.9325
Nashville, TN Cheatham, TN Davidson, TN Dickson, TN Robertson, TN Rutherford, TN Sumner, TN Williamson, TN Wilson, TN	1.2287
Nassau-Suffolk, NY Nassau, NY Suffolk, NY	1.2093
New Bedford-Fall River-Attleboro, MA Bristol, MA	.9662
New Haven-Waterbury-Meriden, CT New Haven, CT	1.0667
New London-Norwich, CT New London, CT	1.0667
New Orleans, LA Jefferson, LA Orleans, LA St. Bernard, LA St. Charles, LA St. John The Baptist, LA St. Tammany, LA	1.0164
New York, NY Bronx, NY Kings, NY New York City, NY Putnam, NY Queens, NY Richmond, NY Rockland, NY Westchester, NY	1.3657

ADDENDUM A WAGE INDICES FOR URBAN AREAS

MSA Area	Wage Index
Newark, NJ Essex, NJ Morris, NJ Sussex, NJ Union, NJ	1.1288
Niagara Falls, NY Niagara, NY	.8741
Norfolk-Virginia Beach-Newport News, VA Chesapeake City, VA Gloucester, VA Hampton City, VA James City Co., Va Newport News City, VA Norfolk City, VA Poquoson, VA Portsmouth City, VA Suffolk City, VA Virginia Beach City, VA Williamsburg City, VA York VA	.9783
Oakland, CA Alameda, CA Contra Costa, CA	1.2615
Ocala, FL Marion, FL	1.0100*
Odessa, TX Ector, TX	.9776*
Oklahoma City, OK Canadian, OK Cleveland, OK Logan, OK McClain, OK Oklahoma, OK Pottawatomie, OK	1.0573
Olympia, WA Thurston, WA	1.0573*

ADDENDUM A WAGE INDICES FOR URBAN AREAS

MSA Area	Wage Index
Omaha, NE-IA Pottawattamie, IA Douglas, NE Sarpy, NE Washington, NE	.8944
Orange County, NY Orange, NY	1.0061
Orlando, FL Orange, FL Osceola, FL Seminole, FL	1.0146
Owensboro, KY Daviess, KY	.8848*
Oxnard-Ventura, CA Ventura, CA	1.1987
Panama City, FL Bay, FL	.9077*
Parkersburg-Marietta, WV-OH Washington, OH Wood, WV	.9953
Pascagoula, MS Jackson, MS	1.0139*
Pensacola, FL Escambia, FL Santa Rosa, FL	.9110
Peoria, IL Peoria, IL Tazewell, IL Woodford, IL	1.1158

ADDENDUM A WAGE INDICES FOR URBAN AREAS

MSA Area	Wage Index
Philadelphia, PA-NJ Burlington, NJ Camden, NJ Gloucester, NJ Bucks, PA Chester, PA Delaware, PA Montgomery, PA Philadelphia, PA	1.1760
Phoenix, AZ Maricopa, AZ	1.1122
Pine Bluff, AR Jefferson, AR	.8774*
Pittsburgh, PA Allegheny, PA Fayette, PA Washington, PA Westmoreland, PA	1.1387
Pittsfield, MA Berkshire, MA	.9815
Portland, ME Cumberland, ME Sagadahoc, ME York, ME	.9654
Portland, OR Clackamas, OR Multnomah, OR Washington, OR Yamhill, OR	1.1194
Portsmouth-Dover-Rochester, NH Rockingham, NH Strafford, NH	.8455
Poughkeepsie, NY Dutchess, NY	1.0919

ADDENDUM A WAGE INDICES FOR URBAN AREAS

MSA Area	Wage Index
Providence-Pawtucket-Woonsocket, RI Bristol, RI Kent, RI Newport, RI Providence, RI Washington, RI	.9773
Provo-Orem, UT Utah, UT	.9471
Pueblo, CO Pueblo, CO	1.1600
Racine, WI Racine, WI	1.0014
Raleigh-Durham, NC Durham, NC Franklin, NC Orange, NC Wake, NC	1.0139
Reading, PA Berks, PA	1.0285
Redding, CA Shasta, CA	1.0544
Reno NV Washoe, NV	1.2988
Richland-Kennewick-Pasco, WA Benton, WA Franklin, WA	.9547
Richmond-Petersburg, VA Charles City Co., VA Chesterfield, VA Colonial Heights City, VA Dinwiddie, VA Goochland, VA Hanover, VA Henrico, VA	.8866

ADDENDUM A WAGE INDICES FOR URBAN AREAS

MSA Area	Wage Index
Hopewell City, VA New Kent, VA Petersburg City, VA Powhatan, VA Prince George, VA Richmond City, VA	
Riverside-San Bernardino, CA Riverside, CA San Bernardino, CA	1.1753
Roanoke, VA Botetourt, VA Roanoke, VA Roanoke City, VA Salem City, VA	1.0019
Rochester, MN Olmsted, MN	1.0255
Rochester, NY Livingston, NY Monroe, NY Ontario, NY Orleans, NY Wayne, NY	1.0379
Rockford, IL Boone, IL Winnebago, IL	1.0432
Sacramento, CA Eldorado, CA Placer, CA Sacramento, CA Yolo, CA	1.1422
Saginaw-Bay City-Midland, MI Bay, MI Midland, MI Saginaw, MI	1.0950
St. Cloud, MN Benton, MN Sherburne, MN Stearns, MN	.8806

ADDENDUM A WAGE INDICES FOR URBAN AREAS

MSA Area	Wage Index
St. Joseph, MO Buchanan, MO	.9876
St. Louis, MO-IL Monroe, IL Franklin, MO Jefferson, MO St. Charles, Mo St. Louis, MO St. Louis City, MO	1.0716
Salem, OR Marion, OR Polk, OR	1.0580
Salinas-Seaside-Monterey, CA Monterey, CA	1.2763
Salt Lake City-Ogden, UT Davis, UT Salt Lake, UT Weber, UT	.9669
San Angelo, TX Tom Green, TX	.9288
San Antonio, TX Bexar, TX Comal, TX Guadalupe, TX	1.0517
San Diego, CA San Diego, CA	1.1897
San Francisco, CA Marin, CA San Francisco, CA San Mateo, CA	1.3974
San Jose, CA Santa Clara, CA	1.2954
Santa Barbara-Santa Maria-Lompoc, CA Santa Barbara, CA	1.1117

ADDENDUM A WAGE INDICES FOR URBAN AREAS

MSA Area	Wage Index
Santa Cruz, CA Santa Cruz, CA	1.1387
Santa Rosa-Petaluma, CA Sonoma, CA	1.1832
Sarasota, FL Sarasota, FL	.9880
Savannah, GA Chatham, GA Effingham, GA	.9521
Scranton-Wilkes Barre, PA Columbia, PA Lackawanna, PA Luzerne, PA Monroe, PA Wyoming, PA	.9762
Seattle, WA King, WA Snohomish, WA	1.0881
Sharon, PA Mercer, PA	.9660
Sheboygan, WI Sheboygan, WI	.8857
Sherman-Denison, TX Grayson, TX	.9015
Shreveport, LA Bossier, LA Caddo, LA	1.0656
Sioux City, IA-NE Woodbury, IA Dakota, NE	1.0322
Sioux Falls, SD Minnehaha, SD	.9448

ADDEDNUM A WAGE INDICES FOR URBAN AREAS

MSA Area	Wage Index
South Bend-Mishawaka, IN St. Joseph, IN	.8989
Spokane, WA Spokane, WA	1.1193
Springfield, IL Menard, IL Sangamon, IL	1.1417
Springfield, MO Christian, MO Greene, MO	.9537
Springfield, MA Hampden, MA Hampshire, MA	.9875
State College, PA Centre, PA	1.0573*
Steubenville, Weirton, OH-WV Jefferson, OH Brooke, WV Hancock, WV	.9763
Stockton, CA San Joaquin, CA	1.1647
Syracuse, NY Madison, NY Onondaga, NY Oswego, NY	1.4557
Tacoma, WA Pierce, WA	1.0445
Tallahassee, FL Gadsden, FL Leon, FL	.9270

ADDENDUM A WAGE INDICES FOR URBAN AREAS

MSA Area	Wage Index
Tampa-St. Petersburg-Clearwater, FL Hernando, FL Hillsborough, FL Pasco, FL Pinellas, FL	.9983
Terre Haute, IN Clay, IN Vigo, IN	.8874
Texarkana-TX-Texarkana, AR Miller, AR Bowie, TX	1.1104
Toledo, OH Fulton, OH Lucas, OH Wood, OH	1.1330
Topeka, KS Shawnee, KS	1.1131
Trenton, NJ Mercer, NJ	1.0386
Tucson, AZ Pima, AZ	1.0161
Tulsa, OK Creek, OK Osage, OK Rogers, OK Tulsa, OK Wagoner, OK	1.0392
Tuscaloosa, AL Tuscaloosa, AL	1.0186
Tyler, TX Smith, TX	1.0029
Utica-Rome, NY Herkimer, NY Oneida, NY	.9351

ADDENDUM A WAGE INDICES FOR URBAN AREAS

MSA Area	Wage Index
Vallejo-Fairfield-Napa, CA Napa, CA Solano, CA	1.3293
Vancouver, WA Clark, WA	1.0829*
Victoria, TX Victoria, TX	.8634
Vineland-Millville-Bridgeton, NJ Cumberland, NJ	.9498
Visalia-Tulare-Porterville, CA Tulare, CA	1.1354
Waco, TX McLennan, TX	.8330
Washington, D.C.-MD-VA District of Columbia, DC Calvert, MD Charles, MD Frederick, MD Montgomery, MD Prince Georges, MD Alexandria City, VA Arlington, VA Fairfax, VA Fairfax City, VA Falls Church City, VA Loudoun, VA Manassas City, VA Manassas Park City, VA Prince William, VA Stafford, VA	1.1637
Waterloo-Cedar Falls, IA Black Hawk, IA Bremer, IA	.9100
Wausau, WI Marathon, WI	.9315*

ADDENDUM A WAGE INDICES FOR URBAN AREAS

MSA Area	Wage Index
West Palm Beach-Boca Raton-Delray Beach, FL Palm Beach, FL	.9806
Wheeling, WV-OH Belmont, OH Marshall, WV Ohio, WV	.9831
Wichita, KS Butler, KS Sedgwick, KS	1.1213
Wichita Falls, TX Wichita, TX	.8718
Williamsport, PA Lycoming, PA	1.0262
Wilmington, DE-NJ-MD New Castle, DE Cecil, MD Salem, NJ	1.0893
Wilmington, NC New Hanover, NC	.9015
Worcester-Fitchburg-Leominster, MA Worcester, MA	.9769
Yakima, WA Yakima, WA	1.0039
York, PA Adams, PA York, PA	1.0307
Youngstown-Warren, OH Mahoning, OH Trumbull, OH	1.1040
Yuba City, CA Sutter, CA Yuba, CA	1.0829

* Approximate value for area

ADDENDUM B-WAGE INDICES FOR RURAL AREAS

Non-MSA Area	Wage Index
Alabama	.7791
Alaska	1.3768
Arizona	.8949
Arkansas	.7810
California	1.0108
Colorado	.8322
Connecticut	.9973
Delaware	.9015
Florida	.8721
Georgia	.8502
Hawaii	1.1771
Idaho	.9002
Illinois	.8683
Indiana	.8617
Iowa	.8174
Kansas	.8135
Kentucky	.8154
Louisiana	.8356
Maine	.8672
Maryland	.9315
Massachusetts	.9710
Michigan	.9475
Minnesota	.8589
Mississippi	.8020
Missouri	.8297
Montana	.8701
Nebraska	.7426
Nevada	1.0178
New Hampshire	1.0318
New Jersey*	
New Mexico	.9293
New York	.8716
North Carolina	.8503
North Dakota	.8326
Ohio	.9145
Oklahoma	.8592
Oregon	.9562
Pennsylvania	1.0329
Rhode Island*	
South Carolina	.8087
South Dakota	.7873

ADDENDUM B-WAGE INDICES FOR RURAL AREAS

Non-MSA Area	Wage Index
Tennessee	.7876
Texas	.8123
Utah	.8261
Vermont	.8774
Virginia	.8519
Washington	.9498
West Virginia	.9182
Wisconsin	.8302
Wyoming	.9565

*All counties within the State are classified urban.

LEGAL BACKGROUND AND AUTHORITY

42 CFR, Part 442, Subpart F, Standards for Intermediate Care Facilities Other Than Facilities for the Mentally Retarded; 42 CFR, Part 456, Subpart I, Inspections of Care in Skilled Nursing and Intermediate Care Facilities and Institutions for Mental Diseases

CITATION OF REGULATION

SUBPART F - Standards for Intermediate Care Facilities
Other Than Facilities for the Mentally Retarded

442.306 Written policies and procedures: Admission.

The ICF must have written policies and procedures that insure that it admits as residents only those individuals whose needs can be met--

(a) By the ICF itself;

(b) By the ICF in cooperation with community resources; or

(c) By the ICF in cooperation with other provides of care affiliated with or under contract to the ICF.

456.609 Determinations by team.

The team must determine in its inspection whether--

(a) The services available in the facility are adequate to--

(1) Meet the health needs of each recipient, and the rehabilitative and social needs of each recipient in an ICF; and

(2) Promote his maximum physical, mental, and psychosocial functioning.

(b) It is necessary and desirable for the recipient to remain in the facility;

(c) It is feasible to meet the recipient's health needs and, in an ICF, the recipient's rehabilitative needs, through alternative institutional or noninstitutional services; and

(d) Each recipient under age 21 in a psychiatric facility and each recipient in an institution for the mentally retarded or persons with related conditions is receiving active treatment as defined in #441.154 of this subchapter.

PART 4

SERVICES

Section

General Provisions

Requirements and Limits Applicable to all Services

Requirements and Limits Applicable to Specific Services

*These sections have not been issued yet.

*These sections have not been issued yet.

* These sections have not been issued yet.

* These sections have not been issued yet.

PART 4
SERVICES

For Interim Manual Instructions

IM 4604. AUTHORITY TO GRANT LIFE SAFETY CODE WAIVERS FOR MEDICAID ONLY NFs

When Medicaid NFs and Medicaid distinct part NF providers request a waiver of Life Safety Code requirements in accordance with §1919(d)(2)(B)(i) of the Social Security Act, the SA will forward such requests to the HCFA-RO for review and approval.

4270. FAMILY PLANNING SERVICES

A. Background.--Section 1905(a)(4)(C) of the Act requires States to provide family planning services and supplies (directly or under arrangements with others) to individuals of childbearing age (including minors who can be considered to be sexually active) who are eligible under the State plan and who desire such services and supplies. Section 1902(a)(10)(A) specifies that family planning services be made available to categorically needy Medicaid recipients while §1902(a)(10)(C) indicates that the services may be provided to medically needy Medicaid recipients at the State's option. Section 1903(a)(5) provides that FFP is available at the rate of 90 percent for the cost of family planning services.

B. Scope of Services.--The term "family planning services" is not defined in the law or in regulations. However, the Senate Report accompanying the law stresses Congress' intent of placing emphasis on the provision of services to "aid those who voluntarily choose not to risk an initial pregnancy," as well as those families with children who desire to control family size. In keeping with Congressional intent, you may choose to include in your definition of Medicaid family planning services only those services which either prevent or delay pregnancy, or you may more broadly define the term to also include services for the treatment of infertility. However, the Medicaid definition must be consistent with overall State policy and regulation regarding the provision of family planning services. You are free to determine the specific services and supplies which will be covered as Medicaid family planning services so long as those services are sufficient in amount, duration and scope to reasonably achieve their purpose. You must also establish procedures for identifying individuals who are sexually active and eligible for family planning services.

1. Services Available For FFP 90 Percent Rate.--In general, FFP at the 90 percent matching rate is available for the costs of counseling services and patient education, examination and treatment by medical professionals in accordance with applicable State requirements, laboratory examinations and tests, medically approved methods, procedures, pharmaceutical supplies and devices to prevent conception, and infertility services, including sterilization reversals.

FFP at the 90 percent rate is available for the cost of a Medicaid sterilization if a properly completed sterilization consent form, in accordance with the requirements of 42 CFR 441, Subpart F, is submitted to you prior to payment of the claim.

2. Services Not Available For FFP 90 Percent Rate.--FFP at the 90 percent rate is not available for the cost of a hysterectomy (see §4435) nor for costs related to other procedures performed for medical reasons, such as removal of an intrauterine device due to infection. Only items and procedures clearly provided or performed for family planning purposes may be matched at the 90 percent rate. Abortions may not be claimed as a family planning service. (See §4430.) Similarly, transportation to a family planning service is not eligible for the 90 percent match. Transportation must be claimed as either an administrative cost or a State plan service, in accordance with your approved Medicaid State plan.

4280. ESTABLISHMENT AND USE OF MEDICAID UNIQUE PHYSICIAN IDENTIFIER

A. Background.--Under §1902(x) of the Act, as provided by §4752 of OBRA 1990, the Secretary is required to establish a system for implementation by July 1, 1991. The system must provide for a unique identifier for each physician who furnishes services for which payment may be made under a State plan approved under title XIX of the Act.

The Secretary has required that all mechanized claims processing and information retrieval systems approved for incentive funding under §1903(a)(3) and (r) of the Act contain as file requirements all the data elements required by Part 11 of this manual. (See §§11300 and 11375.) Almost all States have systems approved in accordance with these sections of the statute and the requirements of Part 11. Consequently each State with such an approved system has a unique numbering system for all providers including physicians. The State is required to identify each provider practicing within a group practice by using the individual provider's unique number when filing claims for services rendered by that provider.

B. Establishment of the Requirement.--Effective July 1, 1991, the Secretary establishes each State's unique statewide provider numbers, which are already part of its approved system, as the identifiers required by §1902(x). Those States and jurisdictions which do not have a system approved under §1903(a)(3) and (r) of the Act are also bound by this statutory requirement to establish a statewide unique physician identifier and to fulfill the other requirements of this section and must implement the requirement contained in Part 11.

As permitted by §1902(x), the Secretary exercises discretionary authority in establishing a system which is different from the system established under §9202(g) of COBRA of 1985. The Secretary encourages States to use for cross reference, the Unique Physician Identification Number (UPIN) established under §9202(g), which is described in the Medicare Carriers Manual, Part 4, Professional Relations, Transmittal 1, §1001.

For planning purposes, States are advised that HCFA intends to require that States obtain the Medicare UPIN on all physician billings submitted for Medicaid reimbursement. This Medicaid requirement will be effective subsequent to the Medicare program requiring the physician UPIN as a condition of payment. Additional information regarding the schedule for adoption of the Medicare UPIN for purposes of the Medicaid program will be provided through a subsequent State Medicaid Manual issuance.

4281. RESTRICTION ON PAYMENTS FOR PHYSICIAN SERVICES

A. Limits on Payment of Federal Financial Participation (FFP).--Effective October 1, 1991, §1903(i)(12) provides that payment may not be made for any amount expended for physician's services furnished on or after October 1, 1991 unless the claim for service includes the State's unique physician identifier.

All States with systems approved under §1903(a)(3) and (r) must accept and use, but not exclusively, the common claim form, Health Insurance Claim Form, HCFA 1500, for noninstitutional providers (physicians, durable medical equipment suppliers, laboratories, chiropractors, and podiatrists). The unique physician identifier required under §4280 must appear in the lower right corner block containing physician name, address, phone number and ID # or PIN #, and similarly on any alternative claim form accepted by the State, as a condition of FFP payment.

States and jurisdictions which do not have approved systems must also establish a system of unique physician identifiers. For FFP purposes, each physician claim for services must clearly indicate the appropriate unique physician identifier as required by §§4280 and 4281.

4282. MAINTENANCE OF LIST OF PHYSICIANS BY STATES

A. Monthly Listing of Participating Physicians.--Under §1902(a)(58) of the Act, States are required to maintain a monthly updated list containing each physician's unique identifier, as required by §4280. The list must include all physicians who are certified to participate under the State plan. This requirement applies to Medical Assistance for calendar quarters beginning after September 30, 1991.

All States and jurisdictions are bound by this statute to maintain such lists monthly as a State plan requirement.

4283. CONDITIONS FOR FOREIGN MEDICAL GRADUATE CERTIFICATION

A. Conditions for Assigning Physician Identifiers to Foreign Medical Graduates.--All States and jurisdictions are bound by §4752(d) of OBRA 1990 to not assign a physician identifier to a foreign medical graduate student, as defined under §1886(h)(5)(D) of the Act, unless the individual has:

1. Passed the Foreign Medical Graduate Examination in the Medical Sciences defined in §1886(h)(5)(E) of the Act;

2. Previously received certification from, or has previously passed the examination of, the Educational Commission for Foreign Medical Graduates; or,

3. Held a license from one or more States continuously since 1958.

B. Effective Date.--This requirement applies to issuance of physician identifiers applicable to services furnished on or after January 1, 1992.

4301. HOME RESPIRATORY CARE FOR VENTILATOR-DEPENDENT INDIVIDUALS

A. General.--Prior to enactment of the Omnibus Budget Reconciliation Act of 1986 (OBRA-86) on October 21, 1986, the Medicaid program had no direct provision for home respiratory therapy services. Effective October 21, 1986, §9408 of OBRA-86 amends §1902(e) of the Social Security Act and permits optional coverage of home respiratory therapy services for ventilator-dependent individuals meeting conditions defined in subsection C.

B. Definition.--"Respiratory care for ventilator-dependent individuals" means services provided on a part-time basis, not otherwise available under the State Medicaid plan, that are furnished in the patient's home by a respiratory therapist or other health care professional who the State determines to be trained in respiratory therapy. A recipient's home does not include a hospital, NF, ICF/MR, or other institution as defined in 42 CFR 435.1009.

C. Conditions.--Individuals receiving home respiratory therapy under this provision must:

- Be medically dependent on a ventilator for life support at least 6 hours per day;
- Have been so dependent for at least 30 consecutive days (or the maximum number of days authorized under the State Medicaid plan, whichever is less) as an inpatient in one or more hospitals, NFs, or ICFs/MR;
- But for the availability of these respiratory care services at home, would require respiratory care as an inpatient in a hospital, NF, or ICF/MR, and would be eligible to have payment made for such inpatient care under the State Medicaid plan;
- Have adequate social support services to be cared for at home;
- Wish to be cared for at home; and
- Receive services under the direction of a physician who is familiar with the technical and medical components of home ventilator support and who has medically determined that in-home care is safe and feasible for the individual.

D. Limits on Comparability of Services.--You are not required to make home respiratory services of the same amount, duration, and scope available to anyone except those who meet the specific conditions for coverage in subsection C.

4302. OPTIONAL TARGETED CASE MANAGEMENT SERVICES - BASIS, SCOPE AND PURPOSE

The Consolidated Omnibus Budget Reconciliation Act (P.L. 99-272, COBRA) added §§1915(g)(1) and (g)(2) to the Act. These sections add optional targeted case management services to the list of services that may be provided under Medicaid. Section 1895(c)(3) of the Tax Reform Act of 1986 (P.L. 99-514) added case management services to the list of services in §1905 of the Act. Section 4118(i) of OBRA 1987 (P.L. 100-203) added a section discussing the qualifications of case managers for individuals with developmental disabilities or chronic mental illness. Both the Tax Reform Act and OBRA 1987 amendments are effective as if included in COBRA and are considered effective on April 7, 1986.

A. Background.--Case management is an activity which assists individuals eligible for Medicaid in gaining and coordinating access to necessary care and services appropriate to the needs of an individual. Prior to the enactment of P.L. 99-272, States could not provide case management as a distinct service under Medicaid without the use of waiver authority. However, aspects of case management have been an integral part of the Medicaid program since its inception. The law has always required interagency agreements under which Medicaid patients may be assisted in locating and receiving services they need when these services are provided by others. Prior to the enactment of P.L. 99-272, Federal financial participation (FFP) for case management activities may be claimed in any of four basic areas:

1. Component of Another Service.--Case management may be provided as an integral and inseparable part of another covered Medicaid service. An example of this type of case management is the preparation of treatment plans by home health agencies. Since plan preparation is required as a part of home health services, separate payment for the case management component cannot be made, but is included in the payment made for the service at the Federal Medical Assistance Percentage (FMAP) rate.

2. Administration.--Case management may be provided as a function necessary for the proper and efficient operation of the Medicaid State plan, as provided in §1903(a) of the Act. Activities such as utilization review, prior authorization and nursing home preadmission screening may be paid as an administrative expense. The payment rate is either the 50 percent matching rate or the 75 percent FFP rate for skilled professional medical personnel, when the criteria in 42 CFR 432.50 are met.

3. Section 1915(b) Waivers.--Case management may be provided in a waiver granted under §1915(b) of the Act. Section 1915(b) provides that a State may request that the Secretary waive the requirements of §1902 of the Act, including the freedom of choice requirements in §1902(a)(23), if necessary to implement a primary care case management system as described in 42 CFR 431.55(c).

To qualify for such a waiver, the case management project must be cost effective, efficient, and consistent with the objectives of the Medicaid program. The waiver is needed to restrict the provider from (or through) whom an eligible individual can obtain medical care services (other than in emergency circumstances), provided the restriction does not substantially impair access to services of adequate quality, and that the statutory and regulatory requirements for waiver approvals are met. Upon the written request of the State, case management services furnished on or after April 7, 1986 pursuant to a waiver granted under §1915(b)(1) may be reimbursed at the FMAP rate when these services are performed by a vendor. Because of the nature of case management services under a §1915(b)(1) waiver, this activity, when performed by an employee of the Medicaid agency, is construed as necessary for the proper and efficient administration of the State plan and is therefore an administrative expense.

4. Section 1915(c) Waivers.--Case management may be provided as a service in a waiver granted pursuant to §1915(c) of the Act. Section 1915(c)(4)(B) specifically enumerates case management as a service which may be provided as part of a home and community-based services waiver. In order to provide this service, you must define it as part of a waiver request, and identify the qualifications of the providers. Under such a waiver, case management services must be provided under a written plan of care which is subject to the approval of the State Medicaid agency. Services provided in this fashion are reimbursed at the FMAP rate. Section 4440 supplies additional information concerning home and community-based services waivers.

NOTE: The enactment of P.L. 99-272 and P.L. 99-514 has not altered your authority to provide any of the previous categories of case management.

B. Legislation.--P.L. 99-272 adds case management to the list of optional services which may be provided under Medicaid. Section 9508 of P.L. 99-272 adds a new subsection (g) to §1915 of the Act. This subsection, as amended by P.L. 100-203, provides that:

> "(g)(1) A State may provide, as medical assistance, case management services under the plan without regard to the requirements of section 1902(a)(1) and section 1902(a)(10)(B). The provision of case management services under this subsection shall not restrict the choice of the individual to receive medical assistance in violation of section 1902(a)(23). A State may limit the provision of case management services under this subsection to individuals with acquired immune deficiency syndrome (AIDS); or with AIDS-related conditions, or with either, and a State may limit the provision of case management services under this subsection to individuals with chronic mental illness. The State may limit the case managers available with respect to case management services for eligible individuals with developmental disabilities or with chronic mental illness in order to ensure that the case managers for such individuals are capable of ensuring that such individuals receive needed services.

(2) For purposes of this subsection, the term 'case management services' means services which will assist individuals eligible under the plan in gaining access to needed medical, social, educational, and other services."

In authorizing States to offer case management services, Congress recognized that there was some potential for duplicate payments because the same or similar services have often been provided by other programs or under the Medicaid program itself. H. Rep. No. 453, 99th Cong., 1st Session 546 (1985), which accompanies this portion of P.L. 99-272, emphasizes that payment for case management services under §1915(g) must not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

FFP is available at the FMAP rate for targeted case management services rendered on or after April 7, 1986, when these services are included in the State plan.

C. Technical Statutory Change.--Section 1895(c)(3) of the Tax Reform Act of 1986 adds case management services to §1905(a)(19) of the Act. In so doing, it defines §1905(a)(19) in terms of §1915(g)(2).

D. Purpose.--The purpose of these instructions is to implement these sections of the statute, and to provide clarification regarding the requirements of the statute and how they may be met.

4302.1 Case Management Services - Process.--

A. Applicability.--The process described in this section applies to case management services, as described in §1905(a)(19) and §1915(g) of the Act.

B. Submission and Timeframes.--Case management under either §1905(a)(19) or §1915(g) is an optional service under Medicaid. To provide the service, incorporate it into your Medicaid State Plan by means of a State plan amendment submitted to your servicing regional office. As with all State plan amendments that provide additional services, the effective date may be no earlier than the first day of the calendar quarter in which the amendment is submitted. In no case may FFP be claimed for case management services under §1915(g) provided prior to April 7, 1986.

In order to provide services under §1915(g), submit a separate amendment for each target group. There is no limit to the number or size of target groups to whom you may provide case management services. The target group may be the State's entire Medicaid population.

4302.2 State Plan Amendment Requirements.--Any State plan amendment request to provide optional case management services must address all of the requirements of this section.

A. Target Group.--Identify the target group to whom case management services will be provided. This targeting may be done by age, type or degree of disability, illness or condition (e.g., Acquired Immune Deficiency Syndrome (AIDS) or Chronic Mental Illness), or any other identifiable characteristic or combination thereof. The following examples are target groups currently receiving case management services under §1915(g) of the Act:

- Developmentally disabled persons (as defined by the State);
- Children between the ages of birth and up to age 3 who are experiencing developmental delays or disorder behaviors as measured and verified by diagnostic instruments and procedures;
- Pregnant women and infants up to age 1;
- Individuals with hemophilia;
- Individuals 60 years of age or older who have two or more physical or mental diagnoses which result in a need for two or more services; and
- Individuals with AIDS or HIV related disorders.

In defining the target group, you must be specific and delineate all characteristics of the population.

B. Comparability.--Unless you intend to provide case management services in the same amount, duration and scope to all eligible recipients, indicate that §1915(g)(1) of the Act is invoked to provide these services without regard to the requirements of §1902(a)(10)(B) of the Act. (See 42 CFR 440.240.) The exception to comparability requirements applies only to case management services under §1915(g) of the Act. Comparability requirements relating to all other Medicaid services are unaffected by this section.

C. Statewide Availability.--Indicate whether case management services are available to the target group statewide or whether the authority of §1915(g)(1) of the Act is invoked to provide case management services to the target group on a less than statewide basis. If case management services are not to be provided on a statewide basis, indicate the geographic areas or political subdivisions to be served. The provision of targeted case management services on a less than statewide basis does not excuse you from the requirements of §1902(a)(1) of the Act (see 42 CFR 431.50) in regard to the statewide availability of other Medicaid services.

D. Freedom of Choice.--Section 1915(g)(1) of the Act specifies that there shall be no restriction on free choice of qualified providers, in violation of §1902(a)(23) of the Act. Assure that there will be no restriction on a recipient's free choice of qualified providers of case management services. In addition, assure that case management services will not restrict an individual's free choice of providers of other Medicaid services.

In order to meet the freedom of choice requirements, you must provide for the following:

1. Option to Receive Services.--The receipt of case management services must be at the option of the individual included in the target population. A recipient cannot be forced to receive case management services for which he or she might be eligible.

2. Free Choice of Providers.--Except as indicated for individuals with developmental disabilities or chronic mental illness, an eligible individual must be free to receive case management services from any qualified provider of these services. The recipient may not be limited to case management providers in a clinic, even if the individual receives all other Medicaid services through that clinic. However, in situations where the State has chosen to provide case management services on a less than statewide basis, free choice of the qualified providers is limited to those providers located within all of the identified geographic areas or political subdivisions, as specified in the State plan.

When providing case management services to individuals with developmental disabilities or with chronic mental illness, you may limit the case managers available. This ensures that the case managers for these individuals are capable of providing the full range of needed services to these targeted recipients. This limitation is permissible only with regard to the target groups of developmentally disabled or chronically mentally ill, or any subgroups that you choose to define. If you choose to target a subgroup of individuals who are developmentally disabled or chronically mentally ill, the targeted group (e.g., based on age, degree of impairment) must continue to fit the definition of chronic mental illness or developmental disability. The requirements discussed in items D.1, D.3, and D.4 continue to apply to all target groups.

3. Provider Participation.--Any person or entity meeting State standards for the provision of case management services who wishes to become a Medicaid provider of those services must be given the opportunity to do so. However, the State is not required to extend provider participation to providers located outside the geographic areas in which case management is targeted.

4. Unrestricted Access.--Case management services under §1915(g) of the Act may not be used to restrict the access of the client to other services available under the State plan. This option is, however, available through waivers granted pursuant to §1915(b) of the Act. (See §2100.)

E. Qualifications of Providers.--The statute does not set minimum standards for the provision of case management services. Therefore, establish the minimum qualifications for the providers of case management services. The qualifications set must be reasonably related to the case management functions that a provider is expected to perform. While reasonable provider qualifications are necessary to assure that case managers are capable of rendering services of acceptable quality, use caution in determining the acceptable degree of such qualifications. With the exception of providers of case management services to individuals with developmental disabilities or chronic mental illness, provider qualifications must not restrict the potential providers of case management services to only those viewed as most qualified. Individuals within the specified target group must be free to receive case management services from any qualified provider.

Except as discussed in item D.2, you may not limit the provision of these services to State or other public agencies, but must permit any person or entity that meets the established qualifications in accordance with 42 CFR 431.51(b) to become a Medicaid provider.

F. Nonduplication of Payments.--Payment for case management services under §1915(g) of the Act may not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

In general, payment may not be made for services for which another payer is liable. Exceptions to this general rule include payments for prenatal or preventive pediatric care, including Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services; payments for services covered under a plan for an individual for whom child support enforcement is being carried out; or any payments made through a waiver granted under the cost effectiveness provisions of 42 CFR 433.139(e). Another major exception is that payments may be made to State education agencies to cover the costs of services provided under a recipient's Individualized Education Program.

Payment may not be made for services for which no payment liability is incurred. Similarly, separate payment cannot be made for similar services which are an integral and inseparable part of another Medicaid covered service.

G. Differentiation Between Targeted Case Management Services and Case Management Type Activities for Which Administrative Federal Match May Be Claimed.--You must differentiate between case management services which may properly be claimed at the service match under §1915(g) and case management activities which are appropriate for FFP at the administrative match under the State plan, based upon the appropriate criteria. These two payment authorities do not result in mutually exclusive types of services.

There are certain case management activities which may appropriately be eligible for FFP at either the administrative or the service match rate. Examples of case management activities that may be claimed at either the administrative or the service match rate entail providing assistance to individuals to gain access to services listed in the State plan, including medical care and transportation. In cases where an activity may qualify as either a Medicaid service or an administrative activity, you may classify the function in either category. This decision must be made prior to claiming FFP because of the different rules which apply to each type of function under the Medicaid program.

1. Case Management as a Service Under §1915(g).--FFP is available at the FMAP rate for allowable case management services under §1915(g) when the following requirements are met:

- Expenditures are made on behalf of eligible recipients included in the target group (i.e. there must be an identifiable charge related to an identifiable service provided to a recipient);

- Case management services are provided as they are defined in the approved State plan;

- Case management services are furnished by individuals or entities with whom the Medicaid agency has in effect a provider agreement;

o Case management services are furnished to assist an individual in gaining or coordinating access to needed services; and

o Payment for services is made following the receipt of a valid provider claim. Providers must maintain case records which indicate all contacts with and on behalf of recipients. The case records must document name of recipient, the date of service, name of provider agency and person providing the service, nature, extent, or units of service, and the place of service delivery. In addition, providers must develop a billing system to appropriately identify and bill all liable third parties.

Because §1915(g) of the Act defines case management services as services which assist individuals eligible under the plan in gaining access to needed medical, social, educational, and other services, recipients may obtain access to services not included in the Medicaid State plan. The costs of case management services provided under §1915(g) that involve gaining access to non-Medicaid services are eligible for FFP at the service match rate.

Examples of case management services provided under §1915(g) of the Act may include assistance in obtaining Food Stamps, energy assistance, emergency housing, or legal services. All case management services provided as medical assistance pursuant to §1915(g) of the Act must be described in the State plan. In addition, they must be provided by a qualified provider as defined in the State plan.

When case management is provided pursuant to §1915(g) of the Act, the service is subject to the rules pertaining to all Medicaid services. If you choose to cover targeted case management services under your State plan, as defined in §1915(g) of the Act, you cannot claim FFP at the administrative rate for the same types of services furnished to the same target group.

NOTE: Although FFP may be available for case management activities that identify the specific services needed by an individual, assist recipients in gaining access to these services, and monitor to assure that needed services are received, FFP is not available for the cost of these specific services unless they are separately reimbursable under Medicaid. Also, FFP is not available for the cost of the administration of the services or programs to which recipients are referred.

2. Case Management as an Administrative Activity.--Case management activities may be considered allowable administrative costs of the Medicaid program when the following requirements are met:

o They are provided in a manner consistent with simplicity of administration and the best interest of the recipient, as prescribed by §1902(a)(19) of the Act; and

o Documentation maintained in support of the claim is sufficiently detailed to permit HCFA to determine whether the activities are necessary for the proper and efficient administration of the State plan, as provided by §1903(a) of the Act.

The following list of functions provides examples of activities which may properly be claimed as administrative case management activities, but not as targeted case management services. The omission of any particular function from this list does not represent a determination on HCFA's part that the function is not necessary for the administration of the plan.

- Medicaid eligibility determinations and redeterminations;
- Medicaid intake processing;
- Medicaid preadmission screening for inpatient care;
- Prior authorization for Medicaid services and utilization review; and
- Medicaid outreach (methods to inform or persuade recipients or potential recipients to enter into care through the Medicaid system).

Because activities related to services which Medicaid does not cover are not considered necessary for the administration of the Medicaid plan, the accompanying costs are not eligible for Medicaid FFP at the administrative rate. For example, case management related to obtaining social services, Food Stamps, energy assistance, or housing cannot be considered a legitimate Medicaid administrative expense even though it may produce results which are in the best interest of the recipient. These services can be provided as medical assistance if described in the State plan.

Similarly, setting up an appointment with a Medicaid participating physician and arranging for transportation for a recipient may be considered case management administrative activities necessary for the proper and efficient administration of the Medicaid plan. However, arranging for baby sitting for a recipient's child, although beneficial to the recipient, is not an activity for which administrative FFP can be claimed.

In addition, when a caseworker suspects that physical abuse of a recipient has occurred, the referral to medical care could be considered a reimbursable administrative activity under the Medicaid program. However, assisting the victim in obtaining emergency housing and legal services, although in the best interest of the recipient, is not an activity for which administrative FFP may be claimed. In cases where workers perform activities funded under multiple auspices, careful records must be kept to document the State§s claims for Federal funds under the appropriate authorities.

Administrative case management activities may be performed by an entity other than the single State agency. However, there must be an interagency agreement in effect.

When a State expects to claim FFP for Medicaid administrative case management activities, the costs for these activities must be included in a cost allocation plan submitted to and approved by your HCFA RO. HCFA reserves the right to evaluate the activities for which FFP is claimed to determine whether they meet the requirements (either administrative or service match) for payment. When FFP is claimed for any functions performed as case management administrative activities under §1903(a) of the Act, documentation must clearly demonstrate that the activities were provided to Medicaid applicants or eligibles, and were in some way connected with determining eligibility or administering services covered under the State plan.

H. Case Management Under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program.--Care coordination, including aspects of case management, has always been an integral component of the EPSDT program, as described in 42 CFR 441.61. OBRA 1989 (P.L. 101-239) modified the EPSDT program by adding §1905(r) to the Act. Section 1905(r) requires that States provide any services included in §1905(a) of the Act, when medical necessity for the service is shown by an EPSDT screen, whether such services are covered under the State plan. While case management is required under the expanded EPSDT program when the need for the activity is found medically necessary, this does not mean §1915(g) targeted case management services. Therefore, when the need for case management activities is found to be medically necessary, the State has several options to pursue:

1. Component of an Existing Service.--Case management services may be provided to persons participating in the EPSDT program by an existing service provider such as a physician or clinic referring the child to a specialist.

2. Administration.--Case management services may be provided to EPSDT participants by the Medicaid agency or another State agency such as title V, the Health Department or an entity with which the Medicaid agency has an interagency agreement. Administrative case management activities must be found necessary for the proper and efficient administration of the State plan and therefore must be limited to those activities necessary for the proper and efficient administration of Medicaid covered services. FFP is available at the administrative rate.

3. Medical Assistance.--Case management services may be provided under the authority of §1905(a)(19) of the Act. The service must meet the statutory definition of case management services, as defined by §1915(g) of the Act. Therefore, FFP is available for assisting recipients in gaining access to both Medicaid and non-Medicaid services. FFP for case management services furnished under §1905(a)(19) of the Act is available at the FMAP rate.

Any combination of two or more of the above is possible, as long as FFP is not available for duplication of services.

I. Service Limitations.--The following are not allowable targeted case management services as defined in §1915(g)(2) of the Act.

1. Other Medicaid Services.--When assessing an individual's need for services includes a physical or psychological examination or evaluation, bill for the examination or evaluation under the appropriate medical service category. Referral for such services may be considered a component of case management services, but the actual provision of the service does not constitute case management.

2. Referral for Treatment.--When an assessment indicates the need for medical treatment, referral or arrangements for such treatment may be included as case management services, but the actual treatment may not be considered.

3. Institutional Discharge Planning.--Discharge planning is required as a condition for payment of hospital, NF and ICF/MR services. Therefore, this cannot be billed separately as a targeted case management service.

4. Client Outreach.--Outreach activities in which a State agency or a provider attempts to contact potential recipients of a service do not constitute case management services. The statute defines case management services as, "services which will assist individuals eligible under the plan in gaining access to needed medical, social, educational and other services" (emphasis added). The attempt to contact individuals who may or may not be eligible for case management services does not fall under this definition. However, such outreach activities may be considered necessary for the proper and efficient administration of the Medicaid State plan. When this is the case, FFP is available at the administrative rate.

J. Coordination With Home and Community-Based Services Waivers.--Case management services continue to be available under home and community-based services waivers approved pursuant to §1915(c) of the Act. However, since approval for §1915(c) waiver services may only be granted for services not otherwise available under the State plan, the addition of case management services under the State plan may necessitate the modification of a home and community-based services waiver. In order to comply with the nonduplication of services requirements discussed in §4302B, the following elements apply to waivers under §1915(c).

1. Service Not Included in Waiver.--Home and community-based services waivers (and requests for waivers) which do not contain case management as a waiver service are not affected by this section.

2. Different Target Population.--Home and community-based services waivers (and requests for waivers) which are targeted at a population different from the group(s) to whom targeted case management services are provided are not affected by this section.

3. Duplication of State Plan Service.--When a home and community-based services waiver contains case management as a waiver service and the State adds case management services to the State plan, the following apply:

a. Same Target Population and Service Definition.--If the target population and the service definitions are the same, delete the case management services from the waiver through an amendment request, and make appropriate cost and utilization adjustments to the waiver cost effectiveness formula.

b. Same Service Definition.--If the definition of services is the same, but only a portion of waiver recipients (who receive waiver case management) are now eligible for the State plan service, the service may remain in the waiver. Adjustments must be made to the cost effectiveness formula to reflect the fact that a number of recipients now receive the State plan service.

4. Same Target Population.--If you have targeted case management services in your State plan for a particular group, and you submit a waiver request for the same targeted group, the request for waiver may not include case management services through the waiver under the same definition used in the State plan. If the case management is provided under an identical definition, it must be provided under the State plan and not under the waiver.

K. Payment Methodology.--The amendment must specify the methodology by which payments and rates are made. Indicate the payment methodology for public as well as private providers. Enter this information on attachment 4.19-B of the State plan.

L. Documentation of Claims for Case Management Services.--In order to receive payment for case management services under the plan (i.e., at the FMAP rate), fully document your claim as you do for any other Medicaid service. If you pay for case management services through capitation or prepaid health plans, the requirements of 42 CFR Part 434 must be met. With the exception of claims paid under capitation or prepaid health plan arrangements, you must document the following:

- o date of service,
- o name of recipient,
- o name of provider agency and person providing the service,
- o nature, extent, or units of service, and
- o place of service.

NOTE: While forms of documentation such as time studies, random moment sampling and cost allocation plans may be appropriate for claiming administrative FFP for activities in support of the State plan, these modes of documentation are not acceptable as a basis for Federal participation in the costs of Medicaid services. There must be an identifiable charge related to an identifiable service provided to a recipient.

4302.3 Instructions For Completing Preprint Supplement.--

A. State Plan Amendment.--To include case management services in your State plan, indicate your intentions on Attachment 3.1-A and 3.1-B of the State plan preprint. In addition, complete one preprint supplement for each target group to whom the services will be provided. (OMB approval is required under the Paper Work Reduction Act of 1980 and will be obtained.)

B. Supplement 1 to Attachment 3.1-A.--Exhibit 1 is a copy of supplement 1 to Attachment 3.1-A. Each item must be completed for the amendment to be approved.

Item 1. Define the target group. Indicate any limitations of disease or condition, age, institutional or noninstitutional status or other characteristic(s) by which the target group is identified.

Item 2. Check one category. If services are provided on a less than statewide basis, specify the geographic areas or political subdivisions to which the services will be provided.

Item 3. Check one category.

Item 4. Define case management services as they apply to the target population. Specify any limitations that apply. Indicate the unit(s) of service. Identify any coordination with non-Medicaid programs or agencies.

Item 5. Specify the qualifications of the providers. These qualifications must be reasonably related to the case management function(s) that the providers are expected to perform.

Item 6. No information necessary.

Item 7. No information necessary.

EXHIBIT I

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: _____

CASE MANAGEMENT SERVICES

A. Target Group:

B. Areas of State in Which Services Will Be Provided:

Entire State

Only in the following geographic areas (authority of §1915(g)(1) of the Act is invoked to provide services less than statewide):

C. Comparability of Services:

Services are provided in accordance with §1902(a)(10)(B) of the Act.

Services are not comparable in amount, duration and scope. Authority of §1915(g)(1) of the Act is invoked to provide services without regard to the requirements of §1902(a)(10)(B).

D. Definition of Services:

E. Qualifications of Providers:

F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of §1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

4305. HOSPICE SERVICES

Hospice care is an optional benefit under the Medicaid program. A hospice is a public agency or private organization or a subdivision of either that is primarily engaged in providing care to terminally ill individuals. A participating hospice meets the Medicare conditions of participation for hospices and has a valid provider agreement. Hospice coverage must be available for at least 210 days and may be subdivided into two or more periods at State option. (The Medicare benefit is divided into two 90 day periods and one 30 day period.)

In order to be eligible to elect hospice care under Medicaid, an individual must be certified as being terminally ill. An individual is considered to be terminally ill if the individual has a medical prognosis that his or her life expectancy is six months or less.

4305.1 Physician Certification.--The hospice must obtain the certification that an individual is terminally ill in accordance with the following procedures:

- For the first period of hospice coverage, the hospice must obtain, no later than two calendar days after hospice care is initiated, written certification statements signed by the medical director of the hospice or the physician member of the hospice interdisciplinary group and the individual's attending physician (if the individual has an attending physician).

If the hospice does not obtain a written certification within two days after the initiation of hospice care, a verbal certification may be obtained within these 2 days, and a written certification obtained no later than 8 days after care is initiated. If these requirements are not met, no payment can be made for days prior to the certification. The attending physician is a physician who is a doctor of medicine or osteopathy and is identified by the individual at the time he or she elects to receive hospice care as having the most significant role in the determination and delivery of the individual's medical care.

- For any subsequent period, the hospice must obtain, no later than two calendar days after the beginning of that period, a written certification statement prepared by the medical director of the hospice or the physician member of the hospice's interdisciplinary group. The certification must include the statement that the individual's medical prognosis is that his or her life expectancy is six months or less if the terminal illness runs its normal course and the signature(s) of the physician(s). The hospice must retain the certification statements.

4305.2 Election Procedures.--If an individual elects to receive hospice care, he or she must file an election statement with a particular hospice. An election may also be filed by a representative acting pursuant to State law. With respect to an individual granted the power of attorney for the patient, State law determines the extent to which the individual may act on the patient's behalf.

An election to receive hospice care is considered to continue through the initial election period and through any subsequent election periods without a break in care as long as the individual remains in the care of the hospice and does not revoke the election. An individual may designate an effective date for the election period that begins with the first day of hospice care or any subsequent day of hospice care, but an individual may not designate an effective date that is earlier than the date that the election is made.

For purposes of the Medicaid hospice benefit, a nursing facility may be considered the residence of a beneficiary. A beneficiary residing in such a setting may elect the hospice benefit. An addition to hospice reimbursement is made in this situation to take the room and board provided by the facility into account. (See §4308.2). The hospice reimburses the facility for these services.

An individual must waive all rights to Medicaid payments for the duration of the election of hospice care for the following services:

o Hospice care provided by a hospice other than the hospice designated by the individual (unless provided under arrangements made by the designated hospice); and

o Any Medicaid services that are related to the treatment of the terminal condition for which hospice care was elected or a related condition or that are equivalent to hospice care except for services--

- Provided (either directly or under arrangement) by the designated hospice;

- Provided by the individual's attending physician if that physician is not an employee of the designated hospice or receiving compensation from the hospice for those services; or

- Provided as room and board by a nursing facility if the individual is a resident.

After the hospice benefit expires, the patient's waiver of these other Medicaid benefits expires and coverage of certain services provided through the hospice may be possible. For example, if the hospice must provide acute inpatient care in a hospital with which it has an agreement, the hospital could bill Medicaid for covered hospital services.

4305.3 Election, Revocation and Change of Hospice.--The election statement must include the following items of information:

o Identification of the particular hospice that will provide care to the individual;

o The individual's or representative's acknowledgement that he or she has been given a full understanding of hospice care;

- The individual's or representative's acknowledgement that he or she understands that the Medicaid services listed in §4305.2 are waived by the election;
- The effective date of the election; and
- The signature of the individual or representative.

An individual or representative may revoke the election of hospice care at any time. To revoke the election of hospice care, the individual must file a document with the hospice that includes a signed statement that the individual revokes the election for Medicaid coverage of hospice care and the date that the revocation is to be effective. The individual forfeits coverage for any remaining days in that election period if the benefit is broken into periods. If it is not or no periods are left, the revocation is permanent. An individual may not designate an effective date earlier than the date that the revocation is made.

Upon revoking the election of Medicaid coverage of hospice care for a particular election period, an individual resumes Medicaid coverage of the benefits waived when hospice care was elected. An individual may at any time elect to receive hospice coverage for any other hospice election periods for which he or she is eligible.

An individual may change, once in each election period, the designation of the particular hospice from which he or she elects to receive hospice care. The change of the designated hospice is not considered a revocation of the election. To change the designation of hospice programs, the individual must file, with the hospice from which he or she has received care and with the newly designated hospice, a signed statement that includes the following information: the name of the hospice from which the individual has received care, the name of the hospice from which he or she plans to receive care and the date the change is effective. A change of ownership of a hospice is not considered a change in the patient's designation of a hospice, and requires no action on the patient's part.

If an individual is eligible for Medicare as well as Medicaid, the hospice benefit must be elected and revoked simultaneously under both programs if the State offers the benefit.

4305.4 Requirements for Coverage.--To be covered, a certification that the individual is terminally ill must have been completed as set forth in §4305.1, and hospice services must be reasonable and necessary for the palliation or management of the terminal illness and related conditions. The individual must elect hospice care in accordance with §4305.2, and a plan of care must be established before services are provided. To be covered, services must be consistent with the plan of care.

In establishing the initial plan of care, the member of the basic interdisciplinary group who assesses the patient's needs must meet or call at least one other group member (nurse, physician, medical social worker or counselor) before writing the initial plan of care.

At least one of the persons involved in developing the initial plan must be a nurse or physician. This plan must be established on the same day as the assessment if the day of assessment is to be a covered day of hospice care. The other two members of the basic interdisciplinary group must review the initial plan of care and provide their input to the process of establishing the plan of care within two calendar days following the day of assessment.

4305.5 Covered Services.--All services must be performed by appropriately qualified personnel, but it is the nature of the service, rather than the qualification of the person who provides it, that determines the coverage category of the service. The following services are covered hospice services:

- Nursing care provided by or under the supervision of a registered nurse.

- Medical social services provided by a social worker who has at least a bachelor§s degree from a school accredited or approved by the Council on Social Work Education, and who is working under the direction of a physician.

- Physicians' services performed by a physician (as defined in 42 CFR 410.20) except that the services of the hospice medical director or the physician member of the interdisciplinary group must be performed by a doctor of medicine or osteopathy.

- Counseling services provided to the terminally ill individual and the family members or other persons caring for the individual at home. Counseling, including dietary counseling, may be provided both for the purpose of training the individual's family or other care-giver to provide care, and for the purpose of helping the individual and those caring for him or her to adjust to the individual's approaching death.

- Short-term inpatient care provided in a participating hospice inpatient unit, or a participating hospital or nursing facility that additionally meets the special hospice standards regarding staffing and patient areas. Services provided in an inpatient setting must conform to the written plan of care. General inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management which cannot be provided in other settings. Inpatient care may also be furnished to provide respite for the individual's family or other persons caring for the individual at home.

- Medical appliances and supplies, including drugs and biologicals. Only drugs as defined in §1861(t) of the Act and which are used primarily for the relief of pain and symptom control related to the individual's terminal illness are covered. Appliances may include covered durable medical equipment as well as other self-help and personal comfort items related to the palliation or management of the patient's terminal illness. Equipment is provided by the hospice for use in the patient's home while he or she is under hospice care. Medical supplies include those that are part of the written plan of care.

o Home health aide services furnished by qualified aides and homemaker services. Home health aides may provide personal care services. Aides may also perform household services to maintain a safe and sanitary environment in areas of the home used by the patient, such as changing the bed or light cleaning and laundering essential to the comfort and cleanliness of the patient. Aide services must be provided under the general supervision of a registered nurse. Homemaker services may include assistance in personal care, maintenance of a safe and healthy environment and services to enable the individual to carry out the plan of care.

o Physical therapy, occupational therapy and speech-language pathology services provided for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

Nursing care, physicians' services, medical social services and counseling are core hospice services and must routinely be provided directly by hospice employees. Supplemental services may be contracted for during periods of peak patient loads and to obtain physician specialty services.

4305.6 Special Coverage Requirements.--Continuous home care is to be provided only during a period of crisis. A period of crisis is a period in which a patient requires continuous care which is primarily nursing care to achieve palliation or management of acute medical symptoms. Nursing care must be provided by either a registered nurse or a licensed practical nurse and a nurse must be providing care for more than half of the period of care. A minimum of 8 hours of care must be provided during a 24-hour day which begins and ends at midnight. This care need not be continuous, i.e., 4 hours could be provided in the morning and another 4 hours provided in the evening of that day. Homemaker and aide services may also be provided to supplement the nursing care. Continuous home care is covered when it is provided to maintain an individual at home during a medical crisis. If less skilled care is needed on a continuous basis to enable the person to remain at home, this is covered as routine home care.

Respite care is short-term inpatient care provided to the individual only when necessary to relieve the family members or other persons caring for the individual at home. Respite care may be provided only on an occasional basis and may not be reimbursed for more than five consecutive days at a time. Respite care may not be provided when the hospice patient is a nursing home resident.

Bereavement counseling consists of counseling services provided to the individual's family after the individual's death. Bereavement counseling is a required hospice service but it is not reimbursable.

4306. HOSPICE REIMBURSEMENT

With the exception of payment for physician services (see §4307) Medicaid payment for hospice care is made at one of four predetermined rates for each day in which an individual is under the care of the hospice. Establish rates no lower than the rates used under Part A of title XVIII (Medicare), adjusted to disregard cost offsets attributable to Medicare coinsurance amounts, using the same methodology used under Part A. The four rates are prospective rates. There are no retroactive adjustments other than the optional application of the "cap" on overall payments and the limitation on payments for inpatient care, if applicable. The rate paid for any particular day varies depending on the level of care furnished to the individual. The "cap" and the limitations on payment for inpatient care are described in sections that follow.

4306.1 Levels of Care.--There are four levels of care into which each day of care is classified:

- Routine Home Care,
- Continuous Home Care,
- Inpatient Respite Care, or
- General Inpatient Care

For each day that an individual is under the care of a hospice, pay the hospice an amount applicable to the type and intensity of the services furnished to the individual for that day. For continuous home care, the amount of payment is determined based on the number of hours of continuous care furnished to the beneficiary on that day. A description of each level of care follows.

A. Routine Home Care.--Pay the hospice the routine home care rate for each day the patient is under the care of the hospice and you do not pay at another rate. This rate is paid without regard to the volume or intensity of services provided on any given day.

B. Continuous Home Care.--Pay the hospice at the continuous home care rate when continuous home care is provided. (See §4305.6.) The continuous home care rate is divided by 24 hours in order to arrive at an hourly rate. A minimum of 8 hours per day must be provided. Pay the hospice for every hour or part of an hour of continuous care furnished up to a maximum of 24 hours a day.

C. Inpatient Respite Care.--Pay the hospice at the inpatient respite care rate for each day on which the beneficiary is in an approved inpatient facility and is receiving respite care. (See §4305.6.) Pay for respite care for a maximum of 5 days at a time including the date of admission but not counting the date of discharge. Pay for the sixth and any subsequent days at the routine home care rate.

D. General Inpatient Care.--Pay at the general inpatient rate when general inpatient care is provided except as described in §4306.2.

4306.2 Date of Discharge.--For the day of discharge from an inpatient unit, pay the appropriate home care rate unless the patient dies as an inpatient. When the patient is discharged deceased, the inpatient rate (general or respite) is paid for the discharge date.

4306.3 Hospice Payment Rates.--The minimum national Medicaid hospice rates, before area wage adjustments for each of the categories of care described in §4306.1 are:

Routine Home Care Rate	$ 79.85	
Continuous Home Care Rates	465.57	Full Rate-24 hours of care
	19.40	Hourly Rate
Inpatient Respite Care Rate	86.82	
General Inpatient Care Rate	354.73	

These rates are based on the methodology used in setting Medicare rates, adjusted to disregard cost offsets attributable to Medicare coinsurance amounts. Under the Medicaid hospice benefit, no cost sharing may be imposed with respect to hospice services rendered to Medicaid recipients. These rates are in effect for services provided on or after January 1, 1990.

Effective on or after April 1, 1990, the State may choose to establish hospice payment rates at higher amounts than those listed above. In no case may hospice payment amounts be established in amounts lower than the amounts listed above.

4306.4 Local Adjustment of Payment Rates.--The payment rates in §4306.3 are adjusted for regional differences in wages, using indices published in Addenda A and B. To select the proper index for an area, first determine if the hospice is located in one of the Urban Areas listed in Addendum A. If so, use the index for that area. If the hospice is not listed as one of the Urban Areas in Addendum A, use the index number of the rural area for the State listed in Addendum B. If the index number for the applicable area is less than 0.8, use 0.8 as the index. Once the appropriate index figure is determined, the computation of the rates for a hospice can be made using the methodology contained in the following tables in this section. Table I indicates the portion of each of the minimum national hospice Medicaid rates subject to the wage index. Table II is an example of the computation of wage adjusted rates for a hospice located in Baltimore, Maryland, using the minimum national Medicaid rates and the applicable index number of 1.0860. Table III is used to compute the rates applicable to a particular hospice. The wage adjusted continuous care rate is then divided by 24 to determine the hourly billing rate.

TABLE I

	Minimum National Medicaid Rates	Wage component subject to index	Unweighted amount
Routine Home Care	$79.85 (100%)	$54.87 (68.71%)	$24.98 (31.29%)
Continuous Home Care	465.57 (100%)	319.89 (68.71%)	145.68(31.29%)
Inpatient Respite	86.82 (100%)	47.00 (54.12%)	39.82(45.88%)
General Inpatient Care	354.73 (100%)	227.06 (64.02%)	127.67(35.98%)

TABLE II

	Minimum National Medicaid Rates	Wage Compo-nent subject to index	Index for Balt. MD	Adjusted Wage Component	Non-wage Component	Adj. Rate
Routine Home Care	$79.85	$54.87	1.0860	$59.59	$24.98	$84.57
Continous Home Care	465.57	319.89	1.0860	347.40	145.68	493.08
Inpatient Respite	86.82	47.00	1.0860	51.04	39.82	90.86
General Inpatient Care	354.73	227.06	1.0860	246.59	127.67	374.26

TABLE III

	State Established Medicaid Rates col 1	Wage component subject to index (Multiply applicable percentage from Table 1 by col. 1 col 2	Index for your area* col 3	Adjusted wage component (col. 2 x col. 3) col 4	Non-wage component (Multiply applicable percentage from Table 1 by col. 1 col 5	Wage Adjusted Rates for your area (col. 4 + col. 5) col 6
Routine Home Care	_____	_____	_____	_____	_____	_____
Continuous Home Care	_____	_____	_____	_____	_____	_____
Inpatient Respite	_____	_____	_____	_____	_____	_____
General Inpatient Care	_____	_____	_____	_____	_____	_____

Continuous Home Care Rate, adjusted for wages = $:- 24 hours = $ ___ Hourly Rate

* If index for an area is less than 0.8, use 0.8.

4306.5 Limitation on Payments for Inpatient Care.--Payments to a hospice for inpatient care must be limited according to the number of days of inpatient care furnished to Medicaid patients. During the 12-month period beginning November 1 of each year and ending October 31, the aggregate number of inpatient days (both for general inpatient care and inpatient respite care) may not exceed 20 percent of the aggregate total number of days of hospice care provided to all Medicaid recipients during that same period. The State may exclude Medicaid recipients afflicted with acquired immunodeficiency syndrome (AIDS) in calculating this inpatient care limitation. This limitation is applied once each year, at the end of the hospices' "cap period" (11/1 -10/31). For purposes of this computation, if it is determined that the inpatient rate should not be paid, any days for which the hospice receives payment at a home care rate are not counted as inpatient days. Calculate the limitation as follows:

- The maximum allowable number of inpatient days is calculated by multiplying the total number of days of Medicaid hospice care by 0.2.

- If the total number of days of inpatient care furnished to Medicaid hospice patients is less than or equal to the maximum, no adjustment is necessary.

o If the total number of days of inpatient care exceeded the maximum allowable number, the limitation is determined by:

1. calculating a ratio of the maximum allowable days to the number of actual days of inpatient care, and multiplying this ratio by the total reimbursement for inpatient care (general inpatient and inpatient respite reimbursement) that was made,

2. multiplying excess inpatient care days by the routine home care rate,

3. adding together the amounts calculated in 1 and 2, and

4. comparing the amount in 3 with interim payments made to the hospice for inpatient care during the "cap period."

Any excess reimbursement is refunded by the hospice.

4307. PAYMENT FOR PHYSICIAN SERVICES UNDER HOSPICE

The basic payment rates for hospice care which are listed in Table I are designed to reimburse the hospice for the costs of all covered services related to the treatment of the beneficiary's terminal illness, including the administrative and general supervisory activities performed by physicians who are employees of or working under arrangements made with the hospice. These activities are generally performed by the physician serving as the medical director and the physician member of the hospice interdisciplinary group. Group activities include participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care, and establishment of governing policies. The costs for these services are included in the reimbursement rates for routine home care, continuous home care, and inpatient respite care.

Pay the hospice for other physicians' services, such as direct patient care services, furnished to individual patients by hospice employees and for physician services furnished under arrangements made by the hospice unless the patient care services were furnished on a volunteer basis. At your option, the hospice may be reimbursed in accordance with the usual Medicaid reimbursement policy for physicians services contained in 42 CFR 447ff or in accordance with the Medicare methodology for payment of hospice physician services. This reimbursement is in addition to the daily rates. Total payments made to the hospice for these services are counted, along with total payments made at the various hospice daily rates, in determining whether the optional hospice cap amount has been exceeded.

Physicians who are designated by recipients as the attending physician and who also volunteer services to the hospice are, as a result of their volunteer status, considered employees of the hospice in accordance with 42 CFR 418.3. (This enables the hospice to use volunteers to meet the physician core service requirement in 42 CFR 418.80.) All
direct patient care services rendered by these physicians to hospice patients are hospice physician services, and are reimbursed in accordance with the procedures outlined in the preceding paragraph. As stated in the preceding paragraph, physician services furnished on a volunteer basis are excluded from Medicaid reimbursement. You may reimburse the hospice on behalf of a volunteer physician for specific services rendered which are not furnished on a volunteer basis (a physician may seek reimbursement for some services while furnishing other services on a volunteer basis). The hospice must have a liability to reimburse the physician for those physician services rendered. In determining which services are furnished on a volunteer basis and which services are not, a physician must treat Medicaid patients on the same basis as other patients in the hospice. For instance, a physician may not designate all physician services rendered to non-Medicaid patients as volunteered and at the same time seek payment from the hospice for all physician services rendered to Medicaid patients.

EXAMPLE: Dr. Jones has an agreement with a hospice to serve as its medical director on a volunteer basis. Mrs. Smith, a Medicaid recipient, enters this hospice and designates Dr. Jones as her attending physician. Dr. Jones, who does not furnish direct patient care services on a volunteer basis, renders a direct patient care service to Mrs. Smith. Dr. Jones seeks reimbursement from the hospice for this service. The hospice is then paid by the State agency in accordance with the usual payment rules for Medicaid physician services for the specific service Dr. Jones rendered to Mrs. Smith. The hospice then reimburses Dr. Jones for this service. Dr. Jones, by virtue of his volunteer activities, is deemed to be an employee of the hospice in accordance with 42 CFR 418.3. Accordingly, such services are included in determining whether the optional Medicaid cap amount has been exceeded.

The hospice notifies you of the election and the name of the physician who has been designated as the attending physician whenever the attending physician is not a hospice employee. Reimburse an independent attending physician in accordance with the usual Medicaid reimbursement methodology for physician services contained in 42 CFR 447ff. These services are <u>not</u> counted in determining whether the optional hospice cap amount has been exceeded. This is because these services of an independent attending physician are not part of the hospice's care. Note that the only services billed by the attending physician are the physician's personal professional services. Costs for services such as lab or X-rays are not included on the attending physician's bill.

4308. OPTIONAL CAP ON OVERALL HOSPICE REIMBURSEMENT

You may limit overall aggregate payments made to a hospice during a hospice cap period. The cap period runs from November 1st of each year through October 31 of the next year. The total payment made for services furnished to Medicaid beneficiaries during this period is compared to the "cap amount" for this period. Any payments in excess of the cap must be refunded by the hospice. This limit is based on services rendered during the cap year regardless of when payment is actually made. Payments are measured in terms of all payments made to hospices on behalf of all Medicaid hospice beneficiaries receiving services during the cap year, regardless of the year in which the beneficiary is counted in determining the cap. For example, payments made to a hospice for an individual electing hospice care on October 5, 1989, pertaining to services rendered in the cap year beginning November 1, 1988, and ending October 31, 1989, are counted as payments made during the first cap year (November 1, 1988 - October 31, 1989), even though that individual is not counted in the calculation of the cap for that year. (The individual is counted in the cap calculation for the following year since the election occurred after September 27 -see below).

The hospice cap is calculated in a different manner for new hospices entering the program if the hospice has not participated in the program for an entire cap year. In this situation, we require that the initial cap calculations for newly certified hospices cover a period of at least 12 months but not more than 23 months. For example, the first cap period for a hospice entering the program on October 1, 1989, runs from October 1, 1989 through October 31, 1990. Similarly, the first cap period for hospice providers entering the program after November 1, 1988 but before November 1, 1989 ends October 31, 1990.

The cap amount is calculated by multiplying the number of beneficiaries electing hospice care during the period by the current cap amount. This amount is adjusted annually to reflect the percentage increase or decrease in the medical care expenditure category of the Consumer Price Index (CPI) for all urban consumers (U.S. city average), published by the Bureau of Labor Statistics (BLS), from March 1984 to the fifth month of the accounting year. Section 4308.1 explains how the original statutory cap amount of $6,500 is adjusted.

The computation and application of the cap amount is made by the State at the end of the cap period. The hospice is responsible for reporting the number of Medicaid recipients electing hospice care during the period to the State. This must be done within 30 days after the end of the cap period.

The hospice must adhere to the following rules in determining the number of Medicaid beneficiaries who have elected hospice care during the period:

o The beneficiary must not have been counted previously in either another hospice's cap or another reporting year; and

o The beneficiary must have filed an initial election during the period beginning September 28 of the previous cap year through September 27 of the current cap year to be counted as an electing Medicaid beneficiary during the current cap year.

Once a beneficiary has been included in the calculation of a hospice cap amount he or she may not be included in the cap for that hospice again, even if the number of covered days in a subsequent reporting period exceeds that of the period where the beneficiary was included. (This could occur when the beneficiary has breaks between periods of election.)

When a beneficiary elects to receive hospice benefits from two or more different Medicaid certified hospices, proportional application of the cap amount is necessary. A calculation must be made by the State to determine the percentage of the patient's length of stay in each hospice relative to the total length of hospice stay.

EXAMPLE: John Doe, a Medicaid beneficiary, initially elects hospice care from Hospice A on September 2, 1989. Mr. Doe stays in Hospice A until October 2, 1989 (30 days) at which time he changes his election and enters Hospice B.
Mr. Doe stays in Hospice B for 70 days until his death on December 11, 1989. The State determines that the total length of hospice stay for Mr. Doe is 100 days (30 days in Hospice A and 70 days in Hospice B). Since Mr. Doe was in Hospice A for 30 days, Hospice A counts .3 of a Medicaid beneficiary for Mr. Doe in its hospice cap calculation (30 days -: 100 days). Hospice B counts .7 of a Medicaid beneficiary in its cap calculation (70 days -: 100 days).

Readjustment of the hospice cap may be required if information previously unavailable to the State at the time the hospice cap is applied subsequently becomes available.

EXAMPLE: Using the example above, if the State had calculated and applied the hospice cap on November 30, 1989, information was not available at that time to adjust the number of beneficiaries reported by Hospice A, since Mr. Doe did not die until December 11, 1989. The State recalculates the hospice cap to Hospice A based on the information it later receives. The cap for Hospice A after recalculation reflects the proper beneficiary count of .3 for Mr. Doe. The cap for Hospice B reflects the proper beneficiary count of .7 for Mr. Doe.

An additional step is required when more than one Medicaid certified hospice provides care to the same individual, and the care overlaps 2 cap years. In this case, the State must determine in which cap year the fraction of a beneficiary is reported. If the

beneficiary entered the hospice before September 28, the fractional beneficiary is included in the current cap year. If the beneficiary entered the hospice after September 27, the fractional beneficiary is included in the following cap year.

EXAMPLE: Continuing with the case cited in the examples above, Hospice A includes .3 of a Medicaid beneficiary in its cap calculation for the cap year beginning November 1, 1988, and ending October 31, 1989, since Mr. Doe entered Hospice A before September 28, 1989. Hospice B includes .7 of a Medicaid beneficiary in its cap calculation for the cap year beginning November 1, 1989, and ending October 31, 1990, since Mr. Doe entered Hospice B after September 27, 1989.

Where services are rendered by two different hospices to a Medicaid patient, and one of the hospices is not certified by Medicaid, no proportional application is necessary. Count one patient and use the total cap for the certified hospice.

4308.1 Adjustments to Cap Amount.--The original cap amount of $6,500 per year increases or decreases for accounting years that end after October 1, 1984 by the same percentage as the percentage of increase or decrease in the medical care expenditure category of the consumer price index for all urban consumers (United States city average), published by the Bureau of Labor Statistics, from March 1984 to the fifth month of the accounting year. As indicated in 42 CFR 418.309, the hospice cap is applied on the basis of a cap year beginning November 1 and ending the following October 31.

No inflation adjustment was needed to the $6,500 cap in the first cap year, since the fifth month of the accounting year was March 1984. (See table below.) Index numbers are published in this section when they become available to update the statutory amount of $6,500. The index periods for use in updating the hospice cap amount are as follows:

	INDEX PERIOD	INDEX NUMBER	HOSPICE CAP
1st Cap Year	March 1984 to March 1984	1.00	$6,500
2nd Cap Year	March 1984 to March 1985	1.059	$6,884
3rd Cap Year	March 1984 to March 1986	1.137	$7,391
4th Cap Year	March 1984 to March 1987	1.2150	$7,898
5th Cap Year	March 1984 to March 1988	1.2932	$8,406
6th Cap Year	March 1984 to March 1989	1.3861	$9,010
7th Cap Year	March 1984 to March 1990	1.5057	$9,787

The cap amount for the second and subsequent cap years is calculated by multiplying $6,500 by the applicable index number.

In those situtations where a hospice begins participation in Medicaid at any time other than the beginning of a cap year (November 1st), and hence has an initial cap calculation for a period in excess of 12 months, a weighted average cap amount is used. The following example illustrates how this is done.

EXAMPLE: 10/01/84 - Hospice A is Medicaid Certified.
10/01/84 to 10/31/85 - First cap period (13 months) for Hospice A.
Statutory cap for first cap year (11/01/83 - 10/31/84) = $6,500
Statutory cap for second cap year (11/01/84 - 10/31/85) = $6,884
Weighted average cap calculation for Hospice A:
One month (10/01/84 - 10/31/84) at $6,500 = $ 6,500
12 months (11/01/84 - 10/31/85) at $6,884 = $82,608
13 month period $89,108 divided by 13 = $6,854 (rounded)

In this example, $6,854 is the weighted average cap amount used in the initial cap calculation for Hospice A for the period October 1, 1984 through October 31, 1985.

NOTE: If Hospice A had been certified in mid-month, a weighted average cap amount based on the number of days falling within each cap period is used.

4308.2 Additional Amount for Nursing Facility Residents.--When hospice care is furnished to an individual residing in a nursing facility, pay the hospice an additional amount on routine home care and continuous home care days to take into account the room and board furnished by the facility. This amount is determined in accordance with the rates established under §1902(a)(13) of the Act. The additional amount paid to the hospice on behalf of an individual residing in a nursing facility must equal at least 95 percent of the per diem rate that you would have paid to the nursing facility for that individual in that facility under your State plan. In this context, the term "room and board" includes performance of personal care services, including assistance in the activities of daily living, in socializing activities, administration of medication, maintaining the cleanliness of a resident's room, and supervision and assisting in the use of durable medical equipment and prescribed therapies. These additional payment amounts are not subject to the optional cap on overall reimbursement specified in §4308.

In States that do not include the hospice benefit in the State plan, Medicaid payment must still be made under certain circumstances for specified services provided in conjunction with Medicare hospice care for dually eligible individuals who reside in Medicaid reimbursed nursing facilities. When such an individual elects the Medicare hospice benefit and the hospice and the facility have a written agreement under which the hospice is responsible for the professional management of the individual's hospice care and the facility agrees to provide room and board to the individual, pay the hospice an amount equal to the amounts allocated under the State plan for room and board in the facility. Medicaid payment to the facility for nursing facility care is discontinued. These room and board amounts are determined as explained in the first paragraph of this section. If the individual is an individual described in §1902(a)(10(A) of the Act, the State must also provide for payment of any coinsurance amounts imposed under §1813(a)(4).

4310. PRIVATE DUTY NURSING SERVICES

A. Background.--Section 1905(a)(8) of the Act includes private duty nursing services in the definition of medical assistance.

Private duty nursing services are optional. You may elect to cover these services under your program.

42 CFR 440.80 defines private duty nursing services as nursing services for recipients who require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of the hospital or nursing facility, and which are provided:

- By a registered nurse or a licensed practical nurse;
- Under the direction of the recipient§s physician; and
- At the State's option, to a recipient in one or more of the following locations:
  - -- His or her own home;
  - -- A hospital; or
  - -- A nursing facility.

B. Locations Where Services May be Provided.--Private duty nursing services may be provided in a recipient's home, hospital or nursing facility or, for recipients who are eligible for such services in the home, hospital or nursing facility, services may be provided outside of those settings when normal life activities take the recipient outside of those settings.

Although HCFA has directed, in 42 CFR 440.80, that private duty nursing services may only be provided in a recipient's home, hospital or nursing facility, HCFA's interpretation of these regulations was found to be too narrow under the decision in Detsel v. Sullivan. The Court in Detsel found that these regulations were being interpreted in an outdated and narrow manner so as to preclude a claimant who resided at home from receiving Medicaid payment for private duty nursing services rendered during those few hours each day when normal life activities required the claimant to leave home to attend school. The Secretary, the Court found, did not provide a sufficiently reasonable explanation for the limitation on the locations in which private duty nursing services could be provided. Following the Detsel decision, HCFA adopted the policy that for Medicaid recipients who would otherwise be eligible for private duty nursing services pursuant to 42 CFR 440.80, private duty nursing services rendered during those hours when the recipient's normal life activities take him or her outside the home are covered.

The Detsel decision does not, however, alter the basic requirement specified in 42 CFR 440.80(c) that a recipient be required and authorized to receive private duty nursing services in the home, hospital or nursing facility. Therefore, if a recipient wants to obtain private duty services to attend school or other activities outside of the home but does not need such services in the home, hospital or nursing facility, there is no basis for authorizing private duty nursing services. Rather, only those individuals who require and are authorized to receive private duty nursing services in the home, hospital or nursing facility setting may utilize their approved hours outside of those settings during those hours when normal life activities take the recipient outside of those settings. Any limitations a State chooses to impose on private duty nursing services, including maximum hour limits, are not affected by the policy change occasioned by the Detsel case decision. Total time and payment allowed for such services is not expected to exceed that which would have been allowed strictly in a home setting.

C. Scope of Services.--The scope of optional private duty nursing services is broader than that of nursing services under the mandatory home health benefit. Nursing services under the mandatory home health benefit must be provided inside the home (except for certain situations where recipients may receive such services in nursing facilities). (See 42 CFR 440.70(c).) Such services are defined in 42 CFR 440.70(b)(1) as part-time or intermittent. Under the private duty nursing benefit, nursing services can be offered on a more continuous basis and can be offered outside of the home. Regulations define private duty nursing services as more individual and continuous care than is available from a visiting nurse or institutional staff. HCFA has not defined or established parameters for the terms part-time or intermittent but rather leaves it to the State to define home health nursing services and the terms part-time or intermittent. By controlling the definition of these terms, it is the State which dictates where home health nursing services end and private duty nursing services begin.

4320. CLINIC SERVICES.

A. Background.--Section 1905(a)(9) of the Social Security Act authorizes under the term "medical assistance," payment for clinic services. As amended by the Deficit Reduction Act of 1984, section 1905(a)(9) describes clinic services as "services furnished by or under the direction of a physician without regard to whether the clinic itself is administered by a physician." The purpose of the 1984 amendment was to clarify that while clinic services have to be provided under the direction of a physician, the clinic does not have to be administered by a physician. This clarification was needed because the physician direction requirement, which has been a requirement for clinic services since the beginning of the Medicaid program, has been in certain cases interpreted erroneously to mean that clinic administrators had to be physicians.

Regulations at 42 CFR 440.90 define clinic services as preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services that--

1. are provided to outpatients;

2. are provided by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients; and

3. except in the case of nurse-midwife services, as specified in 440.165, are furnished by or under the direction of a physician or dentist.

B. Physician Direction Requirement.--Regulations at 42 CFR 440.90 limit coverage of clinic services to situations in which services are furnished under the direction of a physician. As stipulated by section 1905(a)(9) of title XIX of the Social Security Act, this requirement does not mean that the physician must necessarily be an employee of the clinic, or be utilized on a full time basis or be present in the facility during all the hours that services are provided. However, each patient's care must be under the supervision of a physician directly affiliated with the clinic. To meet this requirement, a physician must see the patient at least once, prescribe the type of care provided, and, if the services are not limited by the prescription, periodically review the need for continued care. Although the physician does not have to be on the premises when his/her patient is receiving covered services, the physician must assume professional responsibility for the services provided and assure that the services are medically appropriate. Thus, physicians, who are affiliated with the clinic, must spend as much time in the facility as is necessary to assure that patients are getting services in a safe and efficient manner in accordance with accepted standards of medical and dental practice. For a physician to be affiliated with a clinic, there must be a contractual agreement or some other type of formal arrangement between the physician and the facility by which the physician is obligated to supervise the care provided to the clinic's patients. Some clinics will require more physician involvement than one person can provide. The size of the clinic and the type of services it provides should be used to determine the number of physicians that must be affiliated with a clinic to meet the physician direction requirement. Also, each clinic must have a medical staff which is licensed by State law to provide the medical care delivered to its patients.

C. Coverage Options.--Clinic services, as defined by 42 CFR 440.90, do not include services provided by hospitals to outpatients. Outpatient hospital services, which are authorized by the regulations at 42 CFR 440.20, are separate and distinct from clinic services. As defined by the regulations, clinic services must be provided by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. Thus, clinic services, in accordance with 42 CFR 440.90, must be provided by a freestanding facility, which means that the clinic may not be part of a hospital. However, a clinic may be located in the same building as a hospital, as long as there is no administrative, organizational, financial or other connection between the clinic and the hospital.
Clinic services are optional; States may or may not elect to cover these services under their Medicaid programs. There are different types of freestanding clinics that are organized and operated to provide medical care to outpatients, and different types of clinic services that are available. If a State elects to cover clinic services, it may choose the type of clinics or clinic services that are covered, provided that the services constitute medical or remedial care. Thus, a State may provide coverage for some but not all kinds of clinic services.

D. Provision of Clinic Services to Residents of SNFs, ICFs, AND ICFs/MR.--Clinic services are defined in part, at 42 CFR 440.90, as services that are provided to outpatients. At 42 CFR 440.2, an outpatient is defined as a patient who is receiving professional services at an organized medical facility, or distinct part of such a facility, neither of which is providing the patient with room and board and professional services on a continuous 24-hour-a-day basis.

The definition of outpatient does not exclude residents of title XIX long term care facilities from receiving clinic services either through an arrangement between the facility and the clinic or from a clinic which is chosen by the resident. However, because of the regulatory requirement that clinic services may be provided to outpatients only, the clinic from which they receive services may not provide them with room and board and professional services on a continuous 24-hour-a-day basis. Futhermore, because of the outpatient requirement, eligibility for clinic services is limited to those patients:

1. who for the purpose of receiving necessary health care go or are brought to a clinic, or other site at which the clinic staff is available; and

2. who the same day leave the site at which the services are provided.

Thus, this requirement precludes residents of skilled nursing facilities, intermediate care facilities and intermediate care facilities for the mentally retarded from receiving clinic services that are provided in the long term care facility itself. Therefore, these services must be provided at a location which is not a part of the long-term care facility. While such services, if provided at the location of the facility, may not be covered as clinic services, they could be covered as long term care services if included in the package of institutional services provided to the residents of the facility.

4370. LESS THAN EFFECTIVE AND IDENTICAL, RELATED OR SIMILAR DRUGS

A. Background.--Less than effective (LTE) drugs are drugs that the Food and Drug Administration (FDA) has proposed to withdraw from the market in a notice of opportunity for a hearing (NOOH) because there is a lack of substantial evidence of effectiveness for all labeled indications and because the Secretary has not determined there is compelling justification for their medical need. Any identical, related or similar (IRS) drugs to those LTE drugs subject to the NOOH are also included in this provision.

Effective October 1, 1981, §2103 of OBRA 1981 terminated Federal financial participation (FFP) under Medicaid for drugs that the FDA has determined to be LTE for which the Secretary has not determined there is a compelling justification for their medical need and for any drug product that is IRS to those drugs subject to the NOOH. However, subsequent legislation led to delays in the implementation of this provision and HCFA continued to pay for these drugs between December 15, 1981 and September 30, 1982. Section 115 of TEFRA provides for implementation of §2103 of OBRA 1981.

States have used the LTE/IRS lists published by HCFA in 1989 as a reference tool in identifying LTE and IRS drugs. HCFA held States accountable for identifying LTE and IRS drugs and did not permit States to claim FFP for expenditures for such drugs.

B. Responsibility for Identifying LTE and IRS Drugs.--Effective January 1, 1993, the responsibility for identifying LTE and IRS drugs for which title XIX FFP is prohibited rests with HCFA. The former policy, which held States responsible for identifying LTE and IRS drugs, has led to disallowances of FFP claimed by the States and, in general, was ineffective both in preventing State payments for LTE and IRS drugs and in minimizing recipient use of LTE and IRS drugs. Audits performed by the Office of the Inspector General found that States were not particularly effective in identifying IRS drugs. State to State variation existed, and HCFA took disallowances against States for Medicaid FFP claimed for payments for these drugs. In appeals of the disallowance decisions, the Departmental Appeals Board upheld the disallowances and noted that it does ". . . not condone a dangerously passive approach to the problem of ineffective drugs. Medicare and Medicaid beneficiaries' use of ineffective drugs can be hazardous, and the State clearly had an obligation to move as quickly as it reasonably could to stop reliance on these drugs." This change in policy recognizes the inherent difficulty associated with identifying LTE and IRS drugs. It also recognizes that States continue to have particular difficulty in identifying IRS drugs, and that change is necessary to minimize recipient use and Medicaid expenditures for ineffective drugs.

In an effort to develop a comprehensive file of LTE and IRS drugs, HCFA and the FDA have entered into an ongoing interagency agreement. Both agencies agree to share certain specified information, on an established periodic basis, in order to produce a comprehensive file of both LTE and IRS drugs for which

FFP is prohibited. The agreement between HCFA and FDA provides for an exchange of information, on an as needed basis, but at least quarterly. HCFA will send to the FDA each quarter a listing which contains every drug product marked as LTE or IRS on the HCFA data base. Each State Medicaid agency will continue to receive a quarterly drug pricing tape file which contains the DESI indicator field values as specified in the data dictionary for that tape file.

If you have questions about drug products included on the list, contact HCFA at the following address:

Health Care Financing Administration
Medicaid Bureau
Office of Medicaid Management
Division of Payment Systems
Drug Rebate Operations Branch
Room 273 East High Rise Building
6325 Security Blvd.
Baltimore, MD 21207

In addition, because the FDA has not yet identified all LTE and IRS drugs which are still on the market, as you become aware of additional drugs or suspect additional drugs should be, but are not included, on the quarterly file, bring these products to HCFA's attention. When necessary, HCFA will consult with the FDA, clarify any discrepancies or issues that you or other interested parties may raise about the file, and amend the file to reflect the clarifications.

4375. TUBERCULOSIS RELATED SERVICES

A. Background.--Section 13603 of OBRA 1993, P.L. 103-66, amends §1902(a)(10) of the Act to allow States to provide tuberculosis (TB) related services to low income persons infected with TB. Section 13603 also created §1902(z) of the Act, which describes who can qualify as a TB-infected individual and lists the TB-related services these individuals can receive. In addition, §13603 amended the list of Medicaid services in §1905(a) of the Act by adding a new category of TB-related services to §1905(a)(19). Also, §13603 amended §1915(g)(1) of the Act to say that a State can limit case management services to TB-infected individuals and amended the matter following §1902(a)(10)(F) of the Act to provide that individuals who are eligible for Medicaid only because they are TB-infected are limited to receiving the TB-related services listed in §1902(z)(2) of the Act. Effective January 1, 1994, States have the option of providing coverage to individuals infected with TB.

B. Definition of Services.--Services available to persons who are eligible on the basis of being TB-infected are limited to those listed in §1902(z) of the Act as listed below.

- Physicians' services and services described in §1905(a)(2) of the Act;
- Laboratory and X-ray services, including services to diagnose and confirm the presence of infection;
- Clinic services and Federally qualified health center services;
- Prescribed drugs;
- Case management services as defined in §1915(g)(2) of the Act; and
- Services, other than room and board, designed to encourage completion of regimens of prescribed drugs by outpatients, including services to observe directly the intake of prescribed drugs.

The listed services are available only if they relate to treatment of TB. However, make the determination based on the individual's circumstances as to whether any particular service relates to the treatment of TB. For example, some prescribed drugs for the treatment of TB can cause side effects which may require additional care by specialists, such as ophthalmologists, and the prescription of additional drugs to treat the side effects. You may cover these services as being TB-related services. However, the treatment of conditions, such as a broken ankle or drug addiction, are not considered to be TB-related.

With the exception of services designed to encourage completion of drug regimens, each of the outpatient services listed above corresponds to a service category already available under Medicaid. Existing Medicaid program requirements apply to the benefits available to TB-infected individuals. Prescribed drugs must meet requirements in 42 CFR 440.120, 441.25, 447.331 and 447.332, and drug rebate provisions as specified in the Act. HCFA believes the services designed to encourage completion of drug regimens vary between States and therefore is taking a broad interpretation of this provision so that you can design the best program appropriate to your needs. Clearly, any services which may be covered under §1905 of the Act, with the exception of inpatient services and room and board, may be available to the extent the services are

related to completion of a prescribed drug regimen. This may, for example, include transportation to and from necessary treatment services, in-home monitoring of the beneficiary's illness and adherence to a prescribed drug regimen, and patient education and anticipatory guidance which may include services provided to family members that are directly related to ensuring that the beneficiary completes the prescribed drug regimen. In addition, this benefit may also encompass other medical services not otherwise included under §1905(a) of the Act that encourage completion of the drug regimen. For example, you may cover pick-up and delivery of prescribed drugs as long as this service is not generally provided for free in the community, or you may cover other medical services designed to minimize barriers to completion of a prescribed drug regimen. However, nonmedical services are excluded. For example, nonmedical services include monetary incentives or gifts used as an incentive to induce beneficiaries to complete drug regimens.

You must specify in your State plan any services you make available under the benefit designed to encourage outpatients to complete regimens of prescribed drugs.

Under 42 CFR 440.230, you must provide each service in a manner that is sufficient in amount, duration, and scope to reasonably achieve its purpose. Therefore, if all or some of the above services are provided, you must ensure that they effectively treat individuals infected with TB.

4385. PREVENTIVE SERVICES

A. Background and Definition.--Medicaid program funding supports preventive care in a variety of contexts. The preventive aspects of some services (such as outpatient hospital services, clinic services, and dental services) are specifically included in the definition of those services in Medicaid regulations. The mandatory Early and Periodic Screening, Diagnosis and Treatment program for individuals under age 21 (EPSDT) also has a definite preventive orientation.

In addition to including preventive care as an integral component of other covered services, each State has the option of covering preventive care as a separate benefit under its Medicaid program, as authorized by sections 1905(a)(13) and 1902(a)(10) of the Act. Federal regulations (42 CFR 440.130(c)) define preventive services under this benefit as ". . . services provided by a physician or other licensed practitioner of the healing arts within the scope of his practice under State law to--(1) Prevent disease, disability, and other health conditions or their progression; (2) Prolong life; and (3) Promote physical and mental health and efficiency."

Additional information on preventive services under Medicaid appears in a notice (BERC-285-N) in the Federal Register of March 27, 1984 (49 FR 11717).

B. Coverage of Services.--In general usage, the term "preventive services" encompasses both personal preventive services performed on a one-to-one basis (such as administering immunizations or screening for disease) and community preventive efforts that do not involve direct patient care (such as water purification). However, for Medicaid coverage of preventive services, a distinction is made between those services that are medical or remedial in nature and those that are not. The statute defines Medicaid as a program of medical assistance, and repeatedly uses the terms "medical" and "remedial" to describe the general types of care for which Medicaid will make payment. (See §§ 1903(a)(1), 1905(a)(6), and 1905(a)(21) of the Act.) Since the inception of the Medicaid program, this medical-remedial orientation has been interpreted to include those services that:

- involve direct patient care; and

- are for the express purpose of diagnosing, treating or preventing (or minimizing the adverse effects of) illness, injury or other impairments to an individual's physical or mental health.

In order for a service to be covered, it must meet both of these elements. Therefore, preventive services that involve no direct patient care, such as services applied at the community level, or environmental services dealing exclusively with an individual's surroundings rather than the individual, are not covered. Further, even if a particular preventive service does involve some direct contact with the individual, it cannot be covered unless it also is expressly for the purpose of addressing the individual's physical or mental health. For example, a social service may be furnished directly to an individual client, but it typically is directed broadly at the individual's overall well-being rather than specifically at the individual's health. While a social service, in the course of addressing an individual's basic life needs (adequate food, housing, income, etc.), may indirectly affect the individual's health as well, it would not be covered under Medicaid because it is

not in itself directly and primarily concerned with the individual's health. Some examples of coverable preventive services, noncovered preventive services at the community level, and nonmedical services that address broader social or environmental concerns are as follows:

o The topical application of fluorides or dental sealants furnished directly to a Medicaid recipient can be covered under Medicaid. However, activities such as fluoridation of a community's water supply are not covered, since there is no direct patient care involved.

o Preventive group counseling by a licensed practitioner of the healing arts (acting within the scope of practice under State law) can be covered when it allows direct, one-to-one interaction between the counselor and the individual recipient. By contrast, disseminating general information on prevention through the mass media involves no direct patient care, and is not covered.

o Investigations to determine the source of a child's elevated blood lead level are patient-oriented and, therefore, covered; however, environmental interventions to remove the lead source are not.

o Nonmedical preventive services that address broader social or environmental concerns are not covered under Medicaid, even when furnished directly to individuals (e.g., counseling on the importance of smoke detectors, or of keeping door and window screens in good repair; instruction on traffic safety).

C. State Preventive Initiatives.--A number of States already offer an effective package of preventive care under their Medicaid programs. Other States have included Medicaid coverage of at least some preventive services. Often, however, a wide range of preventive services may already be available in a State, but the services are fragmented among numerous agencies and programs in addition to Medicaid. As a result, Medicaid recipients may not receive a complete and coordinated program of preventive care.

If you are interested in initiating or expanding a Medicaid preventive care effort, you can take a two-fold approach:

o Medicaid funding of the medically-oriented personal preventive services for which Federal financial participation (FFP) is available under title XIX; and

o increased coordination between Medicaid and other programs that fund or provide preventive care, including referral to social and environmental programs and services.

At present, there is no uniformly accepted nationwide standard that specifies a single set of preventive services, or a particular schedule for their delivery, as being the most effective (and we do not attempt to prescribe one here). We encourage you, in developing an approach to preventive care, to consult with local health authorities and organizations to help identify the most effective set of preventive services for your Medicaid population.

1. Evaluating State Plan Amendments.--While we believe you should have flexibility in designing your own package of preventive care, there are certain general criteria that HCFA applies when reviewing proposed plan amendments for preventive services coverage. The proposed services must:

o Be preventive in nature and fit within the basic medical-remedial framework of the Medicaid program (see subsection B);

o Be directed at the patient rather than at the patient's environment;

o Not be otherwise available to recipients without cost, nor may they duplicate other Federally-funded services; and

o Not entail an additional payment for a service which is logically an inherent part of otherwise paid-for services. For example, in the course of furnishing covered treatment to a recipient, a physician sometimes will provide counseling of a preventive nature. This counseling is an inherent part of the covered services for which payment is already being made under the physician services benefit; thus, a separate, additional payment under the preventive benefit for the counseling aspect of the services would not be made, since this would represent a duplicate payment.

Although the Medicaid statute does not preclude you from funding experimental types of care, HCFA encourages you to consider, in addition, the following guidelines when developing proposals for coverage of preventive services, in order to achieve maximum effectiveness:

o When considering coverage of services to detect disease in its early state, focus on those services that have been proven to be safe and reliable, and that detect diseases for which an effective intervention exists.

o Make sure the services proposed to prevent occurrence of disease or disability (including those to modify predisposing risk factors) have a demonstrated efficacy in preventing disease or disability.

2. Coordination with Other Programs.--The benefits an individual derives from Medicaid-covered preventive services can be significantly enhanced when these services are coordinated with the preventive care available under other programs. In an effort to maximize scarce Medicaid dollars available for preventive services and avoid costly duplication of services, many States have sought the cooperation and active participation of other public as well as voluntary health agencies, such as State, county, and local health agencies, Head Start, community health centers, migrant health centers, and others. HCFA encourages you to follow this example if you are considering the inclusion of preventive services in your plan. Coordination can be achieved through interagency agreements, informal cooperative arrangements and increased referrals between the Medicaid agency and other programs that offer preventive care.

Medicaid regulations (42 CFR Part 431, Subpart M) contain requirements and options for interagency agreements. These include the following:

o The Medicaid agency is required to have an interagency agreement with the State health agency and the State vocational rehabilitation agency, as well as the title V program. The agreements are designed to make maximum use of the services of these agencies.

o The Medicaid agency, in addition, may execute interagency agreements with other health and social service agencies and organizations, involving services that utilize Federal as well as State or local funds. For children, youth and pregnant women, these programs could include Head Start, title XX (Social Services Block Grant), certain education programs, and the Special Supplemental Food Program for Women, Infants, and Children (WIC). Effective coordination between the medically-oriented preventive services offered under a State's Medicaid program and the nutrition services offered by the WIC Program, for example, can play an important role in a State's overall strategy to lower its infant mortality rate.

Often, a recipient may not know about the full range of preventive services that are available under various programs, or how to obtain those services. The Medicaid agency can perform a valuable referral function for Medicaid recipients, and can help to supplement the preventive services available to them under the State plan, by directing them to appropriate preventive care available from other sources. In certain situations, you can also help to utilize available Federal funds most effectively by directly coordinating Medicaid-funded preventive services activities with those of other programs offering related services. Some types of services for which such coordination is appropriate would include examinations, immunizations and treatment services, and such activities as informing recipients about available health services, assisting recipients with transportation to health services and health care case management (ensuring continuity of care).

The increased use of preventive services offers the potential for improving individual health and reducing the cost of treating illness and injury. If you have not already done so, consider reviewing your existing program for ways to make a wider range of preventive services available and accessible to your Medicaid population.

4390. INSTITUTIONS FOR MENTAL DISEASES

A. Statutory and Regulatory Provisions.--The statutory provisions relating to institutions for mental diseases (IMDs) include two categories of covered services and a broad payment exclusion that can preclude payment for services provided to certain individuals in both participating and non-participating facilities.

1. IMD Coverage.--The original Medicaid legislation (P.L. 89-97) included a benefit for individuals 65 years of age or older who are in hospitals or nursing facilities that are IMDs. This provision is in §1905(a)(14) of the Act and regulations relating to this benefit are in Subpart C of 42 CFR 441.

In 1972, the Medicaid program was expanded (P.L. 92-603) to include inpatient psychiatric hospital services for individuals under age 21, or, in certain circumstances, under age 22. This provision is in §1905(a)(16) of the Act. Authority for using additional settings was enacted in P.L. 101-508. This benefit is currently being provided in a wide variety of psychiatric facilities. Regulations for this benefit are in Subpart D of 42 CFR 441.

Both IMD benefits are optional, except that inpatient psychiatric services for individuals under age 21 must be provided in any State as early and periodic screening, diagnosis and treatment (EPSDT) services if they are determined to be medically necessary.

2. IMD Exclusion.--The IMD exclusion is in §1905(a) of the Act in paragraph (B) following the list of Medicaid services. This paragraph states that FFP is not available for any medical assistance under title XIX for services provided to any individual who is under age 65 and who is a patient in an IMD unless the payment is for inpatient psychiatric services for individuals under age 21. This exclusion was designed to assure that States, rather than the Federal government, continue to have principal responsibility for funding inpatient psychiatric services. Under this broad exclusion, no Medicaid payment can be made for services provided either in or outside the facility for IMD patients in this age group.

3. IMD Definition.--In 1988, P.L. 100-360 defined an institution for mental diseases as a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. This definition is in §1905(i) of the Act and in 42 CFR 435.1009. The regulations also indicate that an institution is an IMD if its overall character is that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases.

Facilities with fewer than 17 beds that specialize in treating persons with mental disorders can provide the types of services discussed in item 1 if they meet the regulatory requirements to provide these institutional benefits, but these facilities are not technically IMDs. Because IMDs are defined to be institutions with more than 16 beds, the IMD exclusion applies only to institutions with at least 17 beds.

B. Guidelines for Determining What Constitutes an Institution.--When it is necessary to determine whether an institution is an IMD, the IMD criteria listed in subsection C must be applied to the appropriate entity. In most cases, there is no difficulty in determining what entity to apply the criteria to. But in cases in which multiple components are involved, it may be necessary for the HCFA regional office (RO) to apply the following guidelines

to identify the institution to be assessed. Components that are certified as different types of providers, such as NFs and hospitals, are considered independent from each other.

1. Are all components controlled by one owner or one governing body?

2. Is one chief medical officer responsible for the medical staff activities in all components?

3. Does one chief executive officer control all administrative activities in all components?

4. Are any of the components separately licensed?

5. Are the components so organizationally and geographically separate that it is not feasible to operate as a single entity?

6. If two or more of the components are participating under the same provider category (such as NFs), can each component meet the conditions of participation independently?

The RO may also use other guidelines that it finds relevant in a specific situation. If the answer to items 1, 2, or 3 is "no," or the answer to items 4, 5, or 6 is "yes," for example, there may be a separate facility/component. If it is determined that a component is independent, the IMD criteria in subsection C are applied to that component unless the component has 16 or fewer beds.

C. Guidelines for Determining Whether Institution Is an IMD.--HCFA uses the following guidelines to evaluate whether the overall character of a facility is that of an IMD. If any of these criteria are met, a thorough IMD assessment must be made. Other relevant factors may also be considered. For example, if a NF is being reviewed, reviewers may wish to consider whether the average age of the patients in the NF is significantly lower than that of a typical NF. A final determination of a facility's IMD status depends on whether an evaluation of the information pertaining to the facility establishes that its overall character is that of a facility established and/or maintained primarily for the care and treatment of individuals with mental diseases.

1. The facility is licensed as a psychiatric facility;

2. The facility is accredited as a psychiatric facility;

3. The facility is under the jurisdiction of the State's mental health authority. (This criterion does not apply to facilities under mental health authority that are not providing services to mentally ill persons.);

4. The facility specializes in providing psychiatric/psychological care and treatment. This may be ascertained through review of patients' records. It may also be indicated by the fact that an unusually large proportion of the staff has specialized psychiatric/psychological training or that a large proportion of the patients are receiving psychopharmacological drugs; and

5. The current need for institutionalization for more than 50 percent of all the patients in the facility results from mental diseases.

D. Assessing Patient Population.--The review team applying the guidelines must include at least one physician or other skilled medical professional who is familiar with the care of mentally ill individuals. No team member may be employed by or have a significant financial interest in the facility under review.

In applying the 50 percent guideline (see §4390.C.2), determine whether each patient's current need for institutionalization results from a mental disease. It is not necessary to determine whether any mental health care is being provided in applying this guideline.

For purposes of determining whether a facility is subject to the IMD exclusion, the term "mental disease" includes diseases listed as mental disorders in the International Classification of Diseases, with the exception of mental retardation, senility, and organic brain syndrome. The Diagnostic and Statistical Manual of Mental Disorders (DSM) is a subsection of the mental disorder chapter of the ICD and may also be used to determine whether a disorder is a mental disease.

If it is not possible to make the determination solely on the basis of an individual's current diagnosis, classify the patient according to the diagnosis at the time of admission if the patient was admitted within the past year. Do not include a patient in the mentally ill category when no clear cut distinction is possible.

To classify private patients when review of their records is not possible, rely on other factors such as the surveyor's professional observation, discussion with staff of the overall character and nature of the patient's problems, and the specialty of the attending physician.

When the 50 percent guideline is being applied in a NF, the guideline is met if more than 50 percent of the NF residents require specialized services for treatment of serious mental illnesses, as defined in 42 CFR 483.102(b). Facilities providing non-intensive care for chronically ill individuals may also be IMDs. All NFs must provide mental health services which are of a lesser intensity than specialized services to all residents who need such services. Therefore, in applying the 50 percent guidelines, it is important to focus on the basis of the patient's current need for NF care, rather than the nature of the services being provided.

E. Chemical Dependency Treatment Facilities.--The ICD system classifies alcoholism and other chemical dependency syndromes as mental disorders.

There is a continuum of care for chemical dependency. At one end of the spectrum of care, treatment follows a psychiatric model and is performed by medically trained and licensed personnel. If services are psychological in nature, the services are considered medical treatment of a mental disease. Chemically dependent patients admitted for such treatment are counted as mentally ill under the 50 percent guideline. Facilities with more than 16 beds that are providing this type of treatment to the majority of their patients are IMDs.

At the other end of the spectrum of care are facilities that are limited to services based on the Alcoholics Anonymous model, i.e., they rely on peer counseling and meetings to promote group support and encouragement, and they primarily use lay persons as counselors. Lay counseling does not constitute medical or remedial treatment. (See 42 CFR 440.2(b).) Do not count patients

admitted to a facility only for lay counseling or services based on the Alcoholics Anonymous model as mentally ill under the 50 percent guideline. If psychosocial support provided by peers or staff without specialized training is the primary care being provided in the facility, the facility is not an IMD. The major factor differentiating these facilities from other chemical dependency treatment facilities is the primary reliance on lay staff.

Federal matching funds may not be claimed for institutional services when lay/social treatment is the primary reason for the inpatient stay. Facilities may not claim Medicaid payment for providing covered medical or remedial services in a nursing facility or hospital to patients admitted for treatment of chemical dependency and simultaneously claim that they are providing only lay or social services to those same patients when the 50 percent guideline is being applied. Facilities also may not avoid having their chemically dependent patients counted as mentally ill under the 50 percent guideline by withholding appropriate treatment from those patients. Facilities failing to provide appropriate treatment to patients risk termination from the program.

In determining whether a facility has fewer than 17 beds, it is not necessary to include beds used solely to accommodate the children of the individuals who are being treated. Children in beds that are not certified or used as treatment beds are not considered to be patients in the IMD and therefore are not subject to the IMD exclusion if they receive covered services while outside the facility.

4390.1 Periods of Absence From IMDs.--42 CFR 435.1008(c) states that an individual on conditional release or convalescent leave from an IMD is not considered to be a patient in that institution. These periods of absence relate to the course of treatment of the individual's mental disorder. If a patient is sent home for a trial visit, this is convalescent leave. If a patient is released from the institution on the condition that the patient receive outpatient treatment or on other comparable conditions, the patient is on conditional release.

If an emergency or other need to obtain medical treatment arises during the course of convalescent leave or conditional release, these services may be covered under Medicaid because the individual is not considered to be an IMD patient during these periods. If a patient is temporarily transferred from an IMD for the purpose of obtaining medical treatment, however, this is not considered a conditional release, and the patient is still considered an IMD patient.

The regulations contain a separate provision for individuals under age 22 who have been receiving the inpatient psychiatric services benefit defined in 42 CFR 440.160. This category of patient is considered to remain a patient in the institution until he/she is unconditionally released or, if earlier, the date he/she reaches age 22.

EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) SERVICES

Introduction

5010. OVERVIEW

A. Early and Periodic Screening, Diagnostic and Treatment Benefit.--Early and periodic screening, diagnostic and treatment services (EPSDT) is a required service under the Medicaid program for categorically needy individuals under age 21. The EPSDT benefit is optional for the medically needy population. However, if the EPSDT benefit is elected for the medically needy population, the EPSDT benefit must be made available to all Medicaid eligible individuals under age 21.

B. A Comprehensive Child Health Program.--The EPSDT program consists of two, mutually supportive, operational components:

- o assuring the availability and accessibility of required health care resources and
- o helping Medicaid recipients and their parents or guardians effectively use them.

These components enable Medicaid agencies to manage a comprehensive child health program of prevention and treatment, to systematically:

- o Seek out eligibles and inform them of the benefits of prevention and the health services and assistance available,
- o Help them and their families use health resources, including their own talents and knowledge, effectively and efficiently,
- o Assess the child's health needs through initial and periodic examinations and evaluation, and
- o Assure that health problems found are diagnosed and treated early, before they become more complex and their treatment more costly. Although "case management" does not appear in the statutory provisions pertaining to the EPSDT benefit, the concept has been recognized as a means of increasing program efficiency and effectiveness by assuring that needed services are provided timely and efficiently, and that duplicated and unnecessary services are avoided.

C. Administration.--You have the flexibility within the Federal statute and regulations to design an EPSDT program that meets the health needs of recipients within your jurisdiction. Title XIX establishes the framework, containing standards and requirements you must meet.

Program Requirements and Methods

5110. BASIC REQUIREMENTS

OBRA 89 amended §§1902(a)(43) and 1905(a)(4)(B) and created §1905(r) of the Social Security Act (the Act) which set forth the basic requirements for the program. Under the EPSDT benefit, you must provide for screening, vision, hearing and dental services at intervals which meet reasonable standards of medical and dental practice established after consultation with recognized medical and dental organizations involved in child health care. You must also provide for medically necessary screening, vision, hearing and dental services regardless of whether such services coincide with your established periodicity schedules for these services. Additionally, the Act requires that any service which you are permitted to cover under Medicaid that is necessary to treat or ameliorate a defect, physical and mental illness, or a condition identified by a screen, must be provided to EPSDT participants regardless of whether the service or item is otherwise included in your Medicaid plan.

The statute provides an exception to comparability for EPSDT services. Under this exception, the amount, duration and scope of the services provided under the EPSDT program are not required to be provided to other program eligibles or outside of the EPSDT benefit. Services under EPSDT must be sufficient in amount, duration, or scope to reasonably achieve their purpose. The amount, duration, or scope of EPSDT services to recipients may not be denied arbitrarily or reduced solely because of the diagnosis, type of illness, or condition. Appropriate limits may be placed on EPSDT services based on medical necessity.

5121. INFORMING FAMILIES OF EPSDT SERVICES

A. General Information.--Section 1902(a)(43) of the Act requires that the State plan provide for informing all eligible Medicaid recipients under 21 about EPSDT. The intent of the statute is to allow flexibility of process as long as the outcome is effective, and is achieved in a timely manner, generally within 60 days.

The informing process, which may begin at the intake interview, extends to no later than 60 days following the date of a family's or individual's initial eligibility determination, or of a determination after a period of ineligibility. A combination of face-to-face, oral, and written informing activities is most productive.

The regulation requires you to assure that your combination of written and oral informing methods are effective. Use methods of communication that recipients can clearly and easily understand to ensure that they have the information they need to utilize services to which they are entitled. HCFA considers "oral" methods to include face-to-face informing by eligibility case workers, health aides and providers as well as public service announcements, community awareness campaigns, audio-visual films and film strips.

It is effective and efficient to target specific informing activities to particular "at risk" groups. For example, mothers with babies to be added to assistance units, families with infants, or adolescents, first time eligibles, and those not using the program for over 2 years might benefit most from oral methods.

B. Individuals to Be Informed.--

- Inform all Medicaid-eligible families about the EPSDT program.

- Inform newly eligible families, either determined eligible for the first time, or determined eligible after a period of ineligibility if they have not used EPSDT services for at least 1 year. Use a combination of written and oral methods, generally within 60 days following the date of the eligibility determination.

Families that go on and off the rolls do not have to be informed more than once in a 12-month period.

- There is no distinction between title IV-E foster care families and others. For title IV-E foster care individuals, informing must be with the unit receiving the cash assistance (e.g., foster parent, administrator of institution). Many title IV-E foster care individuals are rotated frequently through foster care homes or institutions, and, in some cases, there are changes in foster parents, institution administrators, or responsible social workers. It is to the individual's benefit that informing be done initially, not only with the unit receiving the cash assistance, but with parties who have legal authority over or custody of the individual.

Informing about EPSDT encourages appropriate planning for the health needs of children. When informing foster parents or administrators of institutions encompass all title IV-E foster care individuals in their care. Inform institutions or homes having a number of individuals annually or more often when the need arises, such as when changes in administrators, social workers or foster parents occur. If an individual is rotated through foster care homes, inform the responsible parties at the homes, unless previously done within the year for other foster care individuals. Annual contact establishes a relationship with the facilities to resolve any problems arising.

o Inform a Medicaid eligible pregnant woman about the availability of EPSDT services for children under age 21 (including children eligible as newborns). A Medicaid eligible woman's positive response to an offer of EPSDT services during her pregnancy, which is medically confirmed, constitutes a request for EPSDT services for the child at birth. For a child eligible at birth (i.e., as a newborn of a woman who is eligible for and receiving Medicaid), the request for EPSDT services is effective with the birth of the child. The parent or guardian of an infant who is not deemed eligible at birth as a newborn must be informed at the time the infant§s eligibility is determined.

C. Content and Methods.--

o Use clear and nontechnical language, provide a combination of oral and written methods designed to inform all eligible individuals (or their families) effectively describing what services are available under the EPSDT program; the benefits of preventive health care, where the services are available, how to obtain them; and that necessary transportation and scheduling assistance is available.

Inform eligible individuals whether services are provided without cost. States may impose premiums for Medicaid on individuals (i.e., pregnant women and infants) whose family income exceeds 150 percent of Federal poverty levels as described in §3571 and, for medically needy participants, may impose enrollment fees, premiums or similar charges for participation in the medically needy program.

o Provide assurance that processes are in place to effectively inform individuals, generally within 60 days of the individual’s Medicaid eligibility determination and, if no one eligible in the family has utilized EPSDT services, annually thereafter.

o Utilize accepted methods for informing persons who are illiterate, blind, deaf, or cannot understand the English language. For assistance in developing appropriate procedures, contact agencies with established procedures for working with such individuals, e.g., State or local education departments, employment security offices, handicapped programs.

o You have the flexibility to determine how information may be given most appropriately while assuring that every EPSDT eligible receives the basic information necessary to gain access to EPSDT services.

5122. EPSDT SERVICE REQUIREMENTS

The EPSDT benefit, in accordance with §1905(r) of the Act, must include the services set forth below. The frequency with which the services must be provided is discussed in §5140.

A. Screening Services.--Screening services include all of the following services:

- A comprehensive health and developmental history (including assessment of both physical and mental health development);
- A comprehensive unclothed physical exam;
- Appropriate immunizations (according to the schedule established by the Advisory Committee on Immunization Practices (ACIP) for pediatric vaccines);
- Laboratory tests (including blood lead level assessment appropriate to age and risk); and
- Health education (including anticipatory guidance).

Immunizations which may be appropriate based on age and health history but which are medically contraindicated at the time of the screening may be rescheduled at an appropriate time. The ACIP schedule is included in §5123.2.C.

B. Vision Services.--At a minimum, include diagnosis and treatment for defects in vision, including eyeglasses.

C. Dental Services.--At a minimum, include relief of pain and infections, restoration of teeth and maintenance of dental health. Dental services may not be limited to emergency services.

D. Hearing Services.--At a minimum, include diagnosis and treatment for defects in hearing, including hearing aids.

E. Other Necessary Health Care.--Provide other necessary health care, diagnostic services, treatment, and other measures described in §1905(a) of the Act to correct or ameliorate defects, and physical and mental illnesses and conditions discovered by the screening services.

F. Limitation of Services.--The services available in subsection E are not limited to those included in your State plan.

Under subsection E, the services must be "necessary . . . to correct or ameliorate defects and physical or mental illnesses or conditions . . ." and the defects,illnesses and conditions must have been discovered or shown to have increased in severity by the screening services. You make the determination as to whether the service is necessary. You are not required to provide any items or services which you determine are not safe and effective or which are considered experimental.

42 CFR 440.230 allows you to establish the amount, duration and scope of services provided under the EPSDT benefit. Any limitations imposed must be reasonable and services must be sufficient to achieve their purpose (within the context of serving the needs of individuals under age 21). You may define the service as long as the definition comports with the requirements of the statute in that all services included in §1905(a) of the Act that are medically necessary to ameliorate or correct defects and physical or mental illnesses and conditions discovered by the screening services are provided.

All services must be provided in accordance with both §1905(a) of the Act and any State laws of general applicability that govern the provision of health services. Home and community based services which are authorized by §1915(c) of the Act are not included among the other health care under subsection E because these services are not included under §1905(a) of the Act.

5123. SCREENING SERVICE DELIVERY AND CONTENT

5123.1 Minimum Standards and Requirements.--

A. State Standards.--Set standards and protocols which, at a minimum, meet the standards of §1905(r) of the Act for each component of the EPSDT services, and maintain written evidence of them. The standards must provide for services at intervals which meet reasonable standards of medical and dental practice and be established after consultation with recognized medical and dental organizations involved in child health care. The standards must also provide for EPSDT services at other intervals, indicated as medically necessary, to determine the existence of certain physical or mental illnesses or conditions. The intervals at which services must be made available are discussed in §5140.

B. Services.--Provide an eligible individual requesting EPSDT services required screening services listed in §5122. This initial examination(s) may be requested at any time, and must be provided without regard to whether the individual's age coincides with the established periodicity schedule. Sound medical practice requires that when children first enter the EPSDT program you encourage and promote that they receive the full panoply of screening services available under EPSDT.

It is desirable that a parent or other responsible adult accompany the child to the examination. When this is not possible or practical, arrange for a follow-up worker, social worker, health aide, or neighborhood worker to discuss the results in a visit to the home or in contacts with the family elsewhere.

C. Who Screens/Assesses?--

o Examinations are performed by, or under the supervision of, a certified Medicaid physician, dentist, or other provider qualified under State law to furnish primary medical and health services. These services may be provided within State and local health departments, school health programs, programs for children with special health needs, Maternity and Infant Care projects, Children and Youth programs, Head Start programs, community health centers, medical/dental schools, prepaid health care plans, a private practitioner and any other licensed practitioners in a variety of arrangements.

o The use of all types of providers is encouraged. Recipients should have the greatest possible range and freedom of choice. It is required, in the case of title V, and encouraged, in the case of the primary care projects (i.e., community health centers), that maximum use be made of these providers. Day care centers may provide sites for examination activities. Encourage cooperation when and where other broad-based assessment programs are unavailable.

o Providers may not be limited to those which have an exclusive contract to perform all EPSDT services. Service providers may not be limited to either the private or public sector or because the provider may not offer all EPSDT services or because it offers only one service. Assure maximum utilization of existing resources to more effectively administer and deliver services.

Medicaid providers who offer EPSDT examination services must assure that the services they provide meet the agency's minimum standards for those services in order to be reimbursed at the level established for EPSDT services.

5123.2 Screening Service Content.--

A. Comprehensive Health and Developmental History.--Obtain this information from the parent or other responsible adult who is familiar with the child's history and include an assessment of both physical and mental health development. Coupled with the physical examination, this includes:

1. Developmental Assessment.--This includes a range of activities to determine whether an individual's developmental processes fall within a normal range of achievement according to age group and cultural background. Screening for developmental assessment is a part of every routine initial and periodic examination.

Developmental assessment is also carried out by professionals to whom children are referred for structured tests and instruments after potential problems have been identified by the screening process. You may build the two aspects into the program so that fewer referrals are made for additional developmental assessment.

a. Approach.--There is no universal list of the dimensions of development for the different age ranges of childhood and adolescence. In younger children, assess at least the following elements:

- o Gross motor development, focusing on strength, balance, locomotion;
- o Fine motor development, focusing on eye-hand coordination;
- o Communication skills or language development, focusing on expression, comprehension, and speech articulation;
- o Self-help and self-care skills;
- o Social-emotional development, focusing on the ability to engage in social interaction with other children, adolescents, parents, and other adults; and
- o Cognitive skills, focusing on problem solving or reasoning.

As the child grows through school age, focus the program on visual-motor integration, visual-spacial organization, visual sequential memory, attention skills auditory processing skills, and auditory sequential memory. Most school systems provide routines and resources for developmental screening.

For adolescents, the orientation should encompass such areas of special concern as potential presence of learning disabilities, peer relations, psychological/psychiatric problems, and vocational skills.

b. Procedures.--No list of specified tests and instruments is prescribed for identifying developmental problems because of the large number of such instruments, development of new approaches, the number of children and the complexity of developmental problems which occur, and to avoid any connotation that only certain tests or instruments satisfy Federal requirements. However, the following principles must be considered:

- o Acquire information on the child’s usual functioning, as reported by the child, parent, teacher, health professional, or other familiar person.

o In screening for developmental assessment, the examiner incorporates and reviews this information in conjunction with other information gathered during the physical examination and makes an objective professional judgement whether the child is within the expected ranges. Review developmental progress, not in isolation, but as a component of overall health and well-being, given the child's age and culture.

o Developmental assessment should be culturally sensitive and valid. Do not dismiss or excuse improperly potential problems on grounds of culturally appropriate behavior. Do not initiate referrals improperly for factors associated with cultural heritage.

o Programs should not result in a label or premature diagnosis of a child. Providers should report only that a condition was referred or that a type of diagnostic or treatment service is needed. Results of initial screening should not be accepted as conclusions and do not represent a diagnosis.

o Refer to appropriate child development resources for additional assessment, diagnosis, treatment or follow-up when concerns or questions remain after the screening process.

2. Assessment of Nutritional Status.--This is accomplished in the basic examination through:

o Questions about dietary practices to identify unusual eating habits (such as pica or extended use of bottle feedings) or diets which are deficient or excessive in one or more nutrients.

o A complete physical examination including an oral dental examination. Pay special attention to such general features as pallor, apathy and irritability.

o Accurate measurements of height and weight, which are among the most important indices of nutritional status.

o A laboratory test to screen for iron deficiency. HCFA and PHS recommend that the erythrocyte protoporphyrin (EP) test be utilized when possible for children ages 1-5. It is a simple, cost effective tool for screening for iron deficiency. Where the EP test is not available, use hemoglobin concentration or hematocrit.

o If feasible, screen children over 1 year of age for serum cholesterol determination, especially those with a family history of heart disease and/or hypertension and stroke.

If information suggests dietary inadequacy, obesity or other nutritional problems, further assessment is indicated, including:

o Family, socioeconomic or any community factors,

o Determining quality and quantity of individual diets (e.g., dietary intake, food acceptance, meal patterns, methods of food preparation and preservation, and utilization of food assistance programs),

o Further physical and laboratory examinations, and

o Preventive, treatment and follow-up services, including dietary counseling and nutrition education.

B. Comprehensive Unclothed Physical Examination.--This includes the following:

1. Physical Growth.--Record and compare the child's height and weight with those considered normal for that age. (In the first year of life, head circumference measurements are important). Use a graphic recording sheet to chart height and weight over time.

2. Unclothed Physical Inspection.--Check the general appearance of the child to determine overall health status. This process can pick up obvious physical defects, including orthopedic disorders, hernia, skin disease, and genital abnormalities. Physical inspection includes an examination of all organ systems such as pulmonary, cardiac, and gastrointestinal.

C. Appropriate Immunizations.--Assess whether the child has been immunized against diphtheria, pertussis, tetanus, polio, measles, rubella, mumps, haemophilus influenzae type b conjugate (Hib), hepatitis B, and varicella zoster (chickenpox); and whether booster shots are needed. The child's immunization record should be available to the provider. When an immunization or an updating is medically necessary and appropriate, provide it and inform the child's health supervision provider.

Provide immunizations as recommended by the Advisory Committee on Immunization Practices (ACIP) on the next page.

The ACIP recommendations as indicated on the next page will be used to determine when Federal financial participation is not available for single antigen vaccines (unless a combined antigen vaccine was medically contraindicated).

Pages 5-14.1 and 5-14.2 are reserved for Figure 1--Recommended Childhood Vaccination Schedule--United States, January-June 1996

D. Appropriate Laboratory Tests.--Identify as statewide screening requirements the minimum laboratory tests or analyses to be performed by medical providers for particular age or population groups. Examples of some of the tests you should consider including as part of your statewide screening requirement are hematocrit or hemoglobin screening, urinalysis, TB skin testing, STD screening, and cholesterol screening. In addition, some State laws require certain screening tests. For example, hereditary/metabolic screening for sickle cell disease is required in many States.

You may develop your minimum laboratory screening requirements by consulting with medical organizations in your State. You may also reference or adopt recognized and accepted clinical practice guidelines such as the American Academy of Pediatrics Guidelines for Health Supervision, the American Medical Association's Guidelines for dolescent Preventive Services, Bright Futures: Guidelines for Health Supervision of Infants, Children and dolescents, or guidance published by the Centers for Disease Control and Prevention. With the exception of lead toxicity screening, physicians providing screening services under the EPSDT program use their medical judgment in determining the applicability of the laboratory tests or analyses to be performed. Lead toxicity screening must be provided as indicated below.

1. Lead Toxicity Screening.--All children are considered at risk and must be screened for lead poisoning. HCFA requires that all children receive a screening blood lead test at 12 months and 24 months of age. Children between the ages of 36 months and 72 months of age must receive a screening blood lead test if they have not been previously screened for lead poisoning. A blood lead test must be used when screening Medicaid-eligible children. A blood lead test result equal to or greater than 10 ug/dL obtained by capillary specimen (fingerstick) must be confirmed using a venous blood sample.

At this time, States may not adopt a statewide plan for screening children for lead poisoning that does not require lead screening for all Medicaid-eligible children.

a. Diagnosis, Treatment, and Follow-Up.--If a child is found to have blood lead levels equal to or greater than 10 ug/dL, providers are to use their professional judgment, with reference to CDC guidelines covering patient management and treatment, including follow up blood tests and initiating investigations to determine the source of lead, where indicated. Determining the source of lead may be reimbursable by Medicaid under certain circumstances. Reimbursement is limited to a health professional's time and activities during an on-site investigation of a child's home (or primary residence). The child must be diagnosed as having an elevated blood lead level. Medicaid reimbursement is not available for any testing of substances (water, paint, etc.) which are sent to a laboratory for analysis.

b. Coordination With Other Agencies.--Coordination with WIC, Head Start, and other private and public resources enables elimination of duplicate testing and ensures comprehensive diagnosis and treatment. Also, public health agencies' childhood lead poisoning prevention programs may be available. These agencies may have the authority and ability to investigate a lead-poisoned child's environment and to require remediation.

E. Health Education.--Health education is a required component of screening services and includes anticipatory guidance. At the outset, the physical and dental screening, gives you the initial context for providing health education. Health education and counseling to both parents (or guardians) and children is required and is designed to assist in understanding what to expect in terms of the child's development and to provide information about the benefits of healthy lifestyles and practices as well as accident and disease prevention.

F. Vision and Hearing Screens.--Vision and hearing services are subject to their own periodicity schedules (as described in §5140). However, where the periodicity schedules coincide with the schedule for screening services (defined in §5122A), you may include vision and hearing screens as a part of the required minimum screening services.

1. Appropriate Vision Screen.--Administer an age-appropriate vision assessment. Consultation by ophthalmologists and optometrists can help determine the type of procedures to use and the criteria for determining when a child is referred for diagnostic examination.

2. Appropriate Hearing Screen.--Administer an age-appropriate hearing assessment. Obtain consultation and suitable procedures for screening and methods of administering them from audiologists, or from State health or education departments.

G. Dental Screening Services.--Although an oral screening may be part of a physical examination, it does not substitute for examination through direct referral to a dentist. A direct dental referral is required for every child in accordance with your periodicity schedule and at other intervals as medically necessary. Prior to enactment of OBRA 1989, HCFA in consultation with the American Dental Association, the American Academy of Pediatrics and the American Academy of Family Practice, among other organizations, required direct referral to a dentist beginning at age 3 or an earlier age if determined medically necessary. The law as amended by OBRA 1989 requires that dental services (including initial direct referral to a dentist) conform to your periodicity schedule which must be established after consultation with recognized dental organizations involved in child health care.

Especially in older children, the periodicity schedule for dental examinations is not governed by the schedule for medical examinations. Dental examinations of older children should occur with greater frequency than is the case with physical examinations. The referral must be for an encounter with a dentist, or a professional dental hygienist under the supervision of a dentist, for diagnosis and treatment. However, where any screening, even as early as the neonatal examination, indicates that dental services are needed at an earlier age, provide the needed dental services.

The requirement of a direct referral to a dentist can be met in settings other than a dentist's office. The necessary element is that the child be examined by a dentist or other dental professional under the supervision of a dentist. In an area where dentists are scarce or not easy to reach, dental examinations in a clinic or group setting may make the service more appealing to recipients while meeting the dental periodicity schedule. If continuing care providers have dentists on their staff, the direct referral to a dentist requirement is met. Dental paraprofessionals under direct supervision of a dentist may perform routine services when in compliance with State practice acts.

Determine whether the screening provider or the agency does the direct referral to a dentist. You are ultimately responsible for assuring that the direct referral is made and that the child gets to the dentist's office in a timely manner.

5124. DIAGNOSIS AND TREATMENT

A. Diagnosis.--

1. When.--When a screening examination indicates the need for further evaluation of an individual's health, provide diagnostic studies. Make the referral for diagnosis without delay, and follow-up to make sure that the recipient receives a complete diagnostic evaluation. If the recipient is receiving care from a continuing care provider, diagnosis may be part of the screening and examination process. Develop quality assurance procedures to assure comprehensive care for the individual.

2. By Whom.--An individual's diagnosis may be performed by a:

- o Physician;
- o Maternal and Child Health (MCH) facility;
- o Community health center;
- o Rehabilitation center;
- o Hospital outpatient department; or
- o Other practitioner or facility qualified to evaluate and diagnose an individual§s health problem.

3. As Outpatient or Inpatient.--Diagnosis can usually be accomplished on an outpatient basis. Where inpatient services are necessary to complete the diagnosis, provide them.

4. Services.--You must make available to recipients diagnostic services which are necessary to fully evaluate defects and physical or mental illnesses or conditions discovered by the screening services.

B. Treatment.--

1. General. - You must make available health care, treatment or other measures to correct or ameliorate defects and physical and mental illnesses or conditions discovered by the screening services. Treatment services may be limited as described in §5122 F.

2. Required Vision and Hearing Treatment, Dental Care. - You must provide the following services:

a. Treatment for defects in vision and hearing, including provision of eyeglasses and hearing aids.

b. Dental care, at as early an age as necessary, needed for relief of pain infections, restoration of teeth, and maintenance of dental health. Dental care includes emergency and preventive services and therapeutic services for dental disease which, if left untreated, may become acute dental problems or may cause irreversible damage to the teeth or supporting structures. For further information, consult HCFA's Guide to Dental Care, EPSDT- Medicaid, prepared in cooperation with the American Society of Dentistry for Children and the American Academy of Pedodontics (HCFA Pub. No. 24515).

o Emergency Services are those necessary to control bleeding, relieve pain, eliminate acute infection; operative procedures which are required to prevent pulpal death and the imminent loss of teeth; treatment of injuries to the teeth or supporting structures (e.g., bone or soft tissues contiguous to the teeth); and palliative therapy for pericoronitis associated with impacted teeth. You may not limit dental services to emergency services.

Routine restorative procedures and root canal therapy are not emergency services.

o Preventive Services, provided either individually or in groups, include:

- Instruction in self-care oral hygiene procedures;

- Oral prophylaxis (cleaning of teeth), both necessary as a precursor to the application of dental caries preventives where indicated, or independent of the application of caries preventives for patients 10 years of age or older; and

- Professional application of dental sealants when appropriate to prevent pit and fissure caries.

o Therapeutic Services include:

- Pulp therapy for permanent and primary teeth;

- Restoration of carious (decayed) permanent and primary teeth with silver amalgam, silicate cement, plastic materials and stainless steel crowns;

- Scaling and curettage;

- Maintenance of space for posterior primary teeth lost permanently;

- Provision of removable prosthesis when masticatory function is impaired, or when existing prothesis is unserviceable. It may include services when the condition interferes with employment training or social development; and

- Orthodontic treatment when medically necessary to correct handicapping malocclusion.

c. Appropriate Immunizations.--If it is determined at the time of screening that immunization is needed and appropriate, then immunization must be provided at that time.

3. Prenatal Care Services.--Just as it can provide enhanced services for at-risk infants, EPSDT can link at-risk adolescents to pre-pregnancy risk education, family planning, pregnancy testing and prenatal care. It is important that all pregnant women obtain early prenatal care and that they and newborns be cared for in a setting that provides quality services appropriate to their level of risk. Late care or no care is related to increased prematurity rates. Low birth weight is the most important predictor of illness or death in early infancy. Higher costs of care are associated with the need for neonatal intensive care, extended and repeated hospitalizations, and followup services for these infants born at risk.

Provide nurse-midwife services in pregnancy, labor, birth, and the immediate postpartum period to the categorically needy, to the extent that they are legally authorized to practice. Offer direct reimbursement to nurse-midwives as one of the payment options.

- Orthodontic treatment when medically necessary to correct handicapping malocclusion.

c. Appropriate Immunizations.--If it is determined at the time of screening that immunization is needed and appropriate, immunization must be provided at that time.

3. Prenatal Care Services.--Just as it can provide enhanced services for at-risk infants, EPSDT can link at-risk adolescents to pre-pregnancy risk education, family planning, pregnancy testing, and prenatal care. It is important that all pregnant women obtain early prenatal care and that they and newborns be cared for in a setting that provides quality services appropriate to their level of risk. Late care or no care is related to increased prematurity rates. Low birth weight is the most important predictor of illness or death in early infancy. Higher costs of care are associated with the need for neonatal intensive care, extended and repeated hospitalizations, and follow up services for infants born at risk.

Provide nurse midwife services in pregnancy, labor, birth, and the immediate postpartum period to the categorically needy to the extent that nurse midwives are legally authorized to practice. Offer direct reimbursement to nurse midwives as one of the payment options.

5140. PERIODICITY SCHEDULE

A. Requirements for Periodic Screening, Vision, Hearing, and Dental Services.--Distinct periodicity schedules must be established for screening services, vision services, hearing services, and dental services (i.e., each of these services must have its own periodicity schedule).

Screening, vision, and hearing services must be provided at intervals which meet reasonable standards of medical practice. You must consult with recognized medical organizations involved in child health care in developing reasonable standards.

Dental services must be provided at intervals you determine meet reasonable standards of dental practice. You must consult with recognized dental organizations involved in child health care to establish those intervals. A direct dental referral is required for every child in accordance with your periodicity schedule and at other intervals as medically necessary. Prior to enactment of OBRA 1989, HCFA, in consultation with the American Dental Association, the American Academy of Pediatrics, and the American Academy of Family Practice (as well as other organizations), required direct referral to a dentist beginning at age 3 or an earlier age if determined medically necessary. The law as amended by OBRA 1989 requires that dental services (including initial, direct referral to a dentist) conform to your periodicity schedule, which must be established after consultation with recognized dental organizations involved in child health care. The periodicity schedule for other EPSDT services may not govern the schedule for dental services. It is expected that older children may require dental services more frequently than physical examinations.

B. Requirements for Interperiodic Screenings.--You must provide for interperiodic screening, vision, hearing, and dental services which are medically necessary to determine the existence of suspected physical or mental illnesses or conditions.

The determination of whether an interperiodic screen is medically necessary may be made by a health, developmental, or educational professional who comes into contact with the child outside of the formal health care system (e.g., State early intervention or special education programs, Head Start and day care programs, the Special Supplemental Food Program for Women, Infants and Children (WIC), and other nutritional assistance programs). For example, a child is screened at age 5 according to your periodicity schedule for vision services and is found to have no abnormalities. At age 6, the child is referred to the school nurse by a teacher who suspects the child has a vision problem. The screening indicates a problem may exist. If the child is referred to a qualified provider of vision care, the services must be covered even though under your periodicity schedule vision services may not be required until the child reaches age 7.

C. General Information.--Sections 1905(a)(4)(B) and 1905(r) of the Act require periodicity schedules to assure that at least a minimum number of health examinations occur at critical points in a child's life. In addition, §1905(r) of the Act requires that medically necessary interperiodic screens be provided.

The periodicity schedule provides a minimum basis for follow-up assessments after initial examination. Examinations must be provided with reasonable promptness to new eligibles after their initial requests. There is flexibility to strengthen the preventive nature of the program by providing screening, diagnostic, and treatment services between otherwise scheduled examinations. Implement periodicity schedules only up to the age at which individuals are no longer eligible.

5150. TRANSPORTATION AND SCHEDULING ASSISTANCE (SUPPORT SERVICES)

To ensure that recipients obtain needed Medicaid services, offer and provide, if requested and necessary, assistance with transportation and scheduling appointments.

Distinguish between a request for EPSDT health care services and a request for support services. A request for health care services under the program implies a request only for the EPSDT services listed in §§5110-5140. Once a request for support services for EPSDT has been made, assume it applies to both the examination and follow-up diagnostic and treatment services.

Offer both transportation and scheduling assistance prior to each due date of a child's periodic examination. Provide this assistance if requested and necessary.

42 CFR 431.53 requires that your plan specify responsibility for the necessary transportation of recipients to and from providers of services and describes the methods to use.

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Utilization of Providers and Coordination With Related Programs

5220. UTILIZATION OF PROVIDERS

A. General.--Take advantage of all resources available. Make arrangements with providers, including physicians practicing in individual or group settings, for the delivery of EPSDT services. Encourage families to develop permanent provider relationships and to avoid fragmentation or duplication of services. This assures more comprehensive care for EPSDT recipients and can result in the reduction of overall health costs over time.

B. Broad Base of Qualified Providers.--Broaden the EPSDT provider base to include, e.g., physicians and dentists in individual and group practices, primary health care centers, community health centers, well child and rural health clinics.

Health care practitioners licensed by you may become qualified to provide EPSDT services. In some States, nurse practitioners and nurse midwives are included. Under the supervision of a physician, nurses and other health care personnel may provide a variety of EPSDT services. Judge qualifications to provide EPSDT services, recognizing applicable State practice laws and regulations.

Nothing in the Medicaid statute shall be construed as limiting providers of EPSDT services to providers who are qualified to provide all diagnostic and treatment items and services or as preventing a provider that is qualified under the plan to furnish one or more (but not all) of such items or services from being qualified to provide such items and services as part of EPSDT services.

If you elect to use providers who furnish less than the full range of screening services, encourage or promote close coordination among the screening providers, particularly where responsibility for the physical exam and the physical or mental health developmental assessment services is shared by more than one provider.

5230. COORDINATION WITH RELATED AGENCIES AND PROGRAMS

Interagency collaborative activities address several goals simultaneously:

- o Containing costs and improving services by reducing service overlaps or duplications, and closing gaps in the availability of services;
- o Focusing services on specific population groups or geographic areas in need of special attention; and
- o Defining the scope of the programs in relation to each other.

Regulations require Medicaid agencies to coordinate services with title V programs, and enter into arrangements with State agencies responsible for administering health services and vocational rehabilitation services and with title V (Maternal and Child Health) grantees.

Coordination includes child health initiatives with other related programs, such as Head Start, the Special Supplemental Food Program for Women, Infants and Children (WIC), school health programs of State and local education agencies (including the Education for all Handicapped Children Act of l975), and social services programs under title XX.

Federal financial participation (FFP) is available to cover the costs to public agencies of providing direct support to the Medicaid agency in administering the EPSDT program.

There is no single "list of approved roles", but cooperating agencies provide a variety of outreach, screening, diagnostic or treatment services, health education and counseling, case management, facilities, funding, and other help in achieving an effective child health program. State and local program managers can help identify available child health resources and make appropriate cross referrals. Active child health coordinating committees, with representation from providers, private voluntary and public agencies are helpful in promoting cooperation in providing health services.

Written agreements are essential to effective working relationships between the Medicaid agency and agencies charged with planning, administering or providing health care to low-income families. Although agreements by themselves do not guarantee open communication and cooperation, they can lay the groundwork for collaboration and best use of each agency’s resources.

Successful relationships are based upon detailed planning, clearly identified roles and responsibilities, program monitoring, periodic evaluation and revision, and constant communication. Agreements are formal documents signed by each agency’s representative or written statements of understanding between units of a single department. Whatever their form, it is essential that their content be developed by all parties involved and that they provide a clear statement of each agency’s responsibilities.

Each agreement must specify the participating parties, their intent, and the date upon which the agreement becomes effective, and must be signed by persons who can make it binding. Agreements need periodic review to determine if they continue to be applicable to the organization, functions, and program of the participating agencies. Reevaluate them annually and whenever a major reorganization occurs. Although the specific content of each agreement varies, they must specify:

- o The mutual objectives and responsibilities of each party to the arrangement;
- o The services each party offers and in what circumstances;
- o The cooperative and collaborative relationships at the State level;
- o The kinds of services provided by local counterparts; and
- o Methods for --
  - Early identification of individuals under 21 needing health services;
  - Reciprocal referrals;
  - Coordinating plans for health services provided or arranged for recipients;
  - Payment or reimbursement;
  - Exchange of reports of services furnished;
  - Periodic review and joint planning for changes in the agreements;
  - Continuous liaison between the parties, including designation of State and local liaison staff; and
  - Joint evaluation of policies that affect the cooperative work of the parties.

5230.1 Relations With State Maternal and Child Health (MCH) Programs.--Title V (MCH block grant) grantees and Medicaid share many of the same populations, providers, and concerns for child health. Assure that each MCH grantee and the State Medicaid agency have in effect a functional relationship via a written interagency agreement which:

- o provides for the maximum utilization of the care and services available under MCH programs; and
- o utilizes MCH grantees to develop a more effective use of Medicaid resources in financing services to Medicaid-eligible children.

The overall goal of a State MCH-Medicaid agreement is to improve the health status of children by assuring the provision of preventive services, health examinations, and the necessary treatment and follow-through care, preferably in the context of an ongoing provider-patient relationship and from comprehensive, continuing care providers. Medicaid agencies reimburse title V providers for these services even if they are provided free of charge to low-income uninsured families.

Inform recipients eligible for title V services of the available services and refer them, if they desire, to title V grantees that offer appropriate services. However, such referral does not relieve you of your obligations to assure the timely delivery of EPSDT services. For further information, consult Promoting the Health of Women and Children Through Planning, prepared by Lorraine V. Klerman, A. Yvonne Russell, and Isabelle Valadian.

A. Organization and Administration of EPSDT Programs.--HCFA encourages State programs to enlist providers who can deliver to children a broad array of services on a continuing basis. State MCH programs can help in a number of ways:

o Recruitment of providers from both the private and public sectors to provide comprehensive, continuing care to children.

o Provision of outreach and referral services at the local levels;

o Utilization of Maternity and Infant Care and Children and Youth Projects, and other specialty and primary care programs as providers of comprehensive, continuing care;

o Delegation of tasks by the Medicaid agency to the State MCH programs to assure that Medicaid-eligible children have access to and receive the full range of assessment, diagnostic, and treatment services. Such delegation can be local, regional, or Statewide.

o Development of health services policies and standards and assessment of quality of care issues. These include implementation of professionally recognized protocols and standards of care, integration of services at local and regional levels within a State, and continuity of care. Assessment should be jointly agreed upon with a view toward: eliminating unnecessary services; duplication; providing acceptable quality of care; and integrating and providing all necessary services.

o Assurance of continuing care. PHS-supported primary care projects provide continuing care to all child clients, regardless of their payment status. State MCH programs develop linkages with these projects to assure the full range of levels of care for mothers, infants, and children including those with special health care needs.

B. Financing and Payment Arrangements for Services Provided by or Through MCH Programs to Medicaid Beneficiaries.--Statutory authority exists in the Social Security Act for Medicaid to reimburse title V programs for the covered services they provide to Medicaid beneficiaries. Each interagency agreement refers to the services and circumstances under which Medicaid reimburses MCH programs.

Describe the payment mechanism. If it is no different than that used for other providers, merely note that the Medicaid fee schedule or reasonable charge structure is employed. Alternative payment arrangements may include:

o Prospective interprogram transfer of funds with retrospective adjustments based upon the volume of services actually delivered;

- o Capitation payments for a pre-determined package of services; or
- o Reimbursement for actual costs.

Interagency financial arrangements may differ from the reimbursement policies employed with providers in the private sector. Limit the reimbursement of overhead costs which are above and beyond the value of vendor payments made for covered services to costs identifiable as supporting services covered through the EPSDT program. For example, a MCH program may provide diagnosis, and treatment and case management services for Medicaid-eligible children.

Outlining payment arrangements in the interagency agreement can clarify the legality of, and circumstances under which, private practitioners in the MCH program may bill through MCH for services provided to Medicaid recipients. Often services are provided in MCH settings by professionals who are not physicians; i.e., nurse practitioners, registered nurses and physician assistants. Detail the conditions under which such services are covered, such as with physician supervision, unless these coverage policies are generally applicable in the Medicaid program and are, therefore, stated elsewhere.

C. Standards of Care Established and Employed by Each Program.-- State MCH agencies have a major role in establishing standards, policies and procedures for health care services. They interpret standards to providers, provide education to enhance implementation, promote quality of care, and assess progress.

D. Mutual Program Referral Arrangements and Outreach Activities by State MCH and EPSDT Programs.--Inform and refer Medicaid recipients eligible for EPSDT services who can obtain needed services through MCH programs and who are eligible for the services of such programs. Address implementation in the interagency agreement.

5230.2 Other Agencies and Programs.--

A. Relations With State or Local Education Agencies.--The development of linkages through the family to public, private, and other community health and social services helps link existing prevention and treatment programs with those services provided in the schools. Schools can be a focal point from which to identify children with problems, to increase student's access to both preventive and curative health services, and to assure appropriate use of health care resources. Coordinating services can avoid duplicating efforts that increase costs of services and adding further stress to the child and family.

There is no single "best" way for schools to relate to EPSDT, since the populations, traditions, resources, and other factors vary greatly. For example, schools in areas with no Medicaid-eligible population do not benefit from bringing EPSDT into the schools. (For further information, see EPSDT: A Guide for Education Programs, published jointly by HCFA and the Department of Education in 1980.)

B. Relations With Head Start.--Head Start shares the same child health and development goals as EPSDT. Approximately 50 percent of Head Start families are also Medicaid families. For further information, see DHHS Publication No. (OHDS) 81-31163 issued January1981.

C. Relations with Special Supplemental Food Program for Women, Infants and Children, Food and Nutrition Service, U.S. Department of Agriculture (WIC).--Coordination with the WIC program is required. WIC provides specific nutritious supplemental food and nutrition education at no cost to low-income pregnant, postpartum, and breastfeeding women, infants and children up to their fifth birthday. WIC serves as an adjunct to good health care. Referrals by EPSDT of all categories of WIC's target population is required.

D. Relations With Housing Programs.--Housing programs offer a physical site and focus from which services can be provided and coordinated. Often, they are locations at which related services (a public health clinic, a Head Start program) are provided.

A joint national HCFA/HUD policy statement encouraged cooperative activities between Medicaid agencies and housing authorities through written interagency agreements whereby housing authorities can make major contributions to EPSDT by assisting in outreach and referral tasks, as well as direct service roles.

E. Relations With Social Service (Title XX) Programs.--HCFA and the Office of Human Development Services jointly issued policy and planning statements to their State constituents. Title XX is a funding mechanism rather than a discrete program, and a variety of services funded under title XX are relevant to EPSDT. For example:

- o Information and Referral Services - correspond to EPSDT's outreach, scheduling, and follow-up;

- o Health-Related Services - correspond to examination services when provided through title XX-funded programs such as Day Care; and

- o Support Services - correspond to transportation, child care, escort services, health education, counseling, and staff training.

5240. CONTINUING CARE

A. General.--Ideally, EPSDT services are part of a continuum of care so that the child's screening services are delivered by someone familiar with his or her episodes of acute illness and who has an ongoing relationship with the family as the regular source of the child's health care. This carries out the general concept that child health services are continuing and comprehensive and that a child is able to receive examination, treatment, and referral services from one provider. Continuing care providers, such as pediatricians and other practicing physicians, HMOs, and community health centers can provide a variety of services and continuously monitor and advise parents on a child's development.

The requirement of formal enrollment with a continuing care provider does not imply that only prepayment arrangements are recognized. It means that the recipient or recipient's family has agreed to use one provider as the regular source of continuing care services for a stated period of time, and that the mutual obligations of both recipient and provider are recognized by signed enrollment agreements.

Enrollment by itself under capitation arrangements or prepaid health plans does not constitute a continuing care arrangement, nor does enrollment in specific categorical health clinics. Providers who furnish only screening services do not provide continuing care.

Use of continuing care providers is encouraged in the belief that they can help both improve the delivery and quality of services and contain costs.

B. Requirements.--A continuing care provider is one who formally agrees: to provide to individuals formally enrolled, screening, diagnosis, and treatment for conditions identified during screening (within the provider's capacity) or referral to a provider capable of providing the appropriate services; maintains a complete health history, including information received from other providers; is responsible for providing needed physician services for acute, episodic and/or chronic illnesses and conditions; and ensures accountability by submitting reports reasonably required by the State agency.

A continuing care provider functions as the health care manager, performing the entire set of EPSDT functions. Providing screening, information, and referral services is part of but does not constitute the complete continuing care set.

Continuing care providers may have to arrange for certain specialty services that are beyond the scope of their practice (e.g., cardiology or ophthalmology); and may agree, at its option, to provide dental services or to make direct dental referrals. The provider must specify in the agreement whether dental services are provided. If the provider does not choose to provide either service, it must refer recipients to the State agency to obtain required dental services.

Similarly, the continuing care provider may agree, at its option, to provide all or part of required transportation and scheduling assistance and specify the transportation and scheduling assistance to be furnished. If the provider does not choose to provide this assistance, it must refer recipients to the State agency.

The continuing care provider may agree to provide recipients with assistance in referrals for services not covered under the Medicaid program. If the provider does not choose to provide this assistance, it must refer recipients to the State agency.

When utilizing continuing care providers, maintain a description of the services provided and assure the providers' compliance with their agreement. HCFA does not specify the content of monitoring protocols, since the design use, evaluation and redesign of monitoring methods are essential elements of your program management. However, specify in the State plan the methods you use to assure that continuing care providers comply with their agreements.

You are responsible for ensuring that there is adequate tracking or case management. Tracking is included in the services which continuing care providers are required to furnish. Employ performance standards, expressed in continuing care agreements, required reports, and monitoring criteria.

The costs of continuing care services are Medicaid costs. Negotiate them on a fee-for-service, fee-for-time or capitation basis.

The agency is deemed to have met EPSDT requirements for participants enrolled with a continuing care provider. "Deeming" is dependent on all other EPSDT program requirements being met. Do not use continuing care providers as a way of dropping responsibility to provide services to eligible children. Do not categorically declare that all children are enrolled with these providers.

You have enhanced flexibility to achieve your desired child health program goals through the use of continuing care providers. Implementing the continuing care option can ease administrative burdens as the provider becomes the case or medical manager. This allows States to monitor a continuing care provider and the services delivered rather than monitoring each enrolled participant.

Administration

5310. PROGRAM MONITORING, PLANNING, AND EVALUATION

A. General.--Establish administrative procedures to identify facilities for examination (screening), diagnosis, and treatment; assure that recipients receive the services of those facilities; and assure that services covered under Medicaid are available.

When facilities or providers who are willing to participate have been identified and have met applicable requirements, provider agreements cannot be denied unless there is good cause. The provider must agree to keep records necessary to disclose the extent of services furnished and information regarding payment claims.

When examination and diagnostic resources throughout the State are insufficient to meet adequately the needs of the program, encourage the development of additional centers. Medical and dental societies, other practitioner organizations, medical and dental schools, State, regional, or local health departments, programs for mothers and children under title V of the Social Security Act, community health centers, developmental disability agencies, university affiliated facilities, day care centers, school health programs, rehabilitation agencies, and voluntary health organizations can be helpful.

Inform recipients about and provide EPSDT services if requested, i.e., screenings, examinations, diagnosis, and treatment. Provide subsequent EPSDT services according to a periodicity schedule which specifies services applicable at each stage of the beneficiary's life, until the age when eligibility ends.

Assure that a participating child is periodically screened and treated in conformity with the schedule and State set timeliness standards. To comply with this requirement, design and employ policies and methods to assure that children receive rescreening and treatment when due. If the family requests assistance with necessary transportation and scheduling to receive Medicaid services, provide it.

Set standards for the timely provision of screening and treatment services which meet reasonable standards of medical and dental practice, as determined after consultation with recognized medical and dental organizations involved in child health care.

Design and employ methods to assure that children receive (1) those screening services initially or periodically requested or due under the periodicity schedule and (2) treatment for all conditions identified as a result of examination or diagnosis.

Consider an initial examination of a newborn determined eligible for Medicaid as an initial examination for purposes of identifying a child as participating in the program.

Consider a recipient receiving services to be participating. This is true whether the recipient has requested services directly from you or elsewhere (e.g., walk-ins) and applies both for initially requested services and all services due under the periodicity schedule. Once you know that a recipient is participating, assure that the recipient receives timely delivery of services for the next encounter under the periodicity schedule.

If an individual declined support services or elected to arrange his/her own appointment with a provider, assure that the individual receives services.

Consider treatment initiated when the child gets to the office for the encounter. It cannot be assumed that the date treatment was initiated is the same as the date the appointment was scheduled.

If a physician or facility provides some of the required screening components, assure provision of the remaining components requested by the family or recipient. If a recipient accepts only specific components, document declination of the others.

B. Providing for EPSDT Services.--When services are requested, provide them in conformity with the established periodicity schedule and timeliness standards. Timeliness standards for initiation of treatment, if required, generally have an outer limit of 6 months after the request for screening services.

If an individual chooses a non-Medicaid provider, it is not a declination of services. Assure recipients of their freedom of choice of provider and inform them of the financial consequences of their choice. Only screening components and treatment services requested of a Medicaid provider need to be monitored or reimbursed.

The designation of a primary physician by an individual recipient may be required when overutilization of covered services is confirmed and when efforts to solicit voluntary cooperation have failed. Make provision to allow change in primary physician designation at least every three months or immediately upon demonstration by the recipient of good cause.

Allow HMO enrollees to receive services from their HMO provider if they are included as part of the contract. If the contract does not include EPSDT services, assure the beneficiary timely delivery of requested services.

C. Reasonable Standards of Medical and Dental Practice.--Effective EPSDT program design and implementation requires continuing involvement of health professional organizations. Screening protocols and services, periodicity schedules, and service delivery timeliness standards must meet reasonable standards of medical and dental practice, determined by the agency after consultation with recognized medical and dental organizations involved in child health care.

The term, "reasonable standards of medical and dental practice," gives States flexibility to weigh different factors, yet precludes inappropriate standards. Health practice standards based on professional judgements are an essential factor.

In determining program standards, consult with recognized organizations, knowledgeable about the general health, growth, development and nutritional status of infants, children and youth. HCFA accepts these determinations as long as they meet reasonable medical and dental practice standards.

The input and assessment of health professional organizations is required and is vital to ensure that State standards are reasonable in terms of medical and dental practice. Although medical care advisory committees are required to advise Medicaid agencies about health and medical care services, and can provide a framework for consultation, they can not substitute for recognized medical and dental organizations involved in child health care.

Maintain a dialogue with such organizations in order to ensure that the standards reflect current professional judgement.

D. Case Management.--Case management is an activity under which responsibilities for locating, coordinating and monitoring necessary and appropriate services for a recipient rests with a specific individual or organization. See Part 4, §4302.

In EPSDT, it centers on the process of collecting information on the health needs of the child, making (and following up on) referrals as needed, maintaining a health history, and activating the examination/diagnosis/treatment "loop."

Case management provides the difference between a fragmented program in which examinations, diagnosis, treatment, and other functions are performed in isolation from each other, and a comprehensive program based on the concept of getting children into the existing "mainstream"' system of health care delivery.

Notifying recipients of the time they are due to receive a screening service is an integral part of your responsibility and an essential part of case management. As individual recipients approach age levels when an EPSDT screening is due, notify them that it is the appropriate time to receive services. For recipients enrolled with a continuing care provider, the provider furnishes that notification.

5320. INFORMATION NEEDS AND REPORTING

HCFA has developed simplified methods to collect information on program activities in order to assure that the goals are met. Maintain records, program manuals, rules and procedures describing the methods used to assure that services are provided appropriately and timely.

- Information must be available at the agency or local office.

- Keep information needed to assess compliance with Federal Medicaid requirements for a minimum of 3 years.

- At the time of review, the reviewer provides the agency with an opportunity to supply any missing data before reaching a finding of non-compliance.

- Determine the nature of the record system. A computer system may be used from which individual case histories can be retrieved if such a system is appropriate and efficient in program administration.

5320.1 Administrative Information Requirements.--The input and assessment of the health professions organizations is vital to validate existing State standards. Agency records must demonstrate that there has been consultation with professional organizations in developing periodicity schedules that are reasonable in terms of medical and dental practice. They also demonstrate how conflicting recommendations or factors were weighed and resolved in order to best serve the needs of a particular State and its EPSDT participants.

Written informing materials for recipients may be contained in one document or in several. The choice of words for explaining the benefits of preventive services and the components of the screening package is optional, but must be in clear and nontechnical language.

Rules and procedures for informing the illiterate, blind, deaf, or those unable to understand the English language are discretionary. However, the agency's records must describe how these individuals are informed and demonstrate that the rules and procedures employed are effective.

5320.2 Records or Information on Services and Recipients.--You must have descriptions of the processes and procedures used for initial informing and how the procedures are monitored. Written informing may be accomplished through computerized mailing, verified by a computer print-out.

Although each case record contains information on informing, written procedures can be used to supplement the documentation.

Where proof of written informing is a computerized print-out, it must indicate the materials mailed, the date the mailing occurred and identify to whom they were sent.

Through program manuals, records, rules, and procedures, you must be able to demonstrate that processes are in place to effectively inform individuals about EPSDT. The procedures must support a determination that informing occurs generally within 60 days of the individual's eligibility determination and, for families which have not used EPSDT services, annually thereafter.

The program manuals, records, rules, and procedures that describe the informing process and content of oral informing must provide sufficient detail to permit a reviewer to determine that required information is delivered. Records generated by agency management activities give you the opportunity to demonstrate that the required procedures are used and that the informing services are effective.

A. Families or Recipients Who Decline EPSDT Services.--Acceptable documentation of a declination of EPSDT services for a family in which at least one member has received EPSDT services or is being tracked under the periodicity schedule is verification of an oral or a written statement that all members of the family no longer wish to participate in the EPSDT program.

Information must be available to show that the recipient either declined services, gave an undecided response, or failed to respond to an offer of services. An undecided or nonresponse is a declination of that periodic examination and not a declination of EPSDT services.

Documentation of the offer may be a dated copy of a letter or form sent to the recipient or a dated record of an in-person or telephone contact. A declination or an undecided response may be a turnaround document, a dated statement from the family (the date of receipt by the agency is the date of declination), or dated documentation of the beneficiary's response to an in-person or telephone contact. A nonresponse may be documented via the absence of a form of recipient response.

If a recipient accepts only specific components of EPSDT, record the components requested to assure that they are provided.

A declination of support services or a failure to respond to specific service scheduling or referral constitutes a declination of that specific periodic service and does not in itself constitute a declination of EPSDT services.

B. Services.--Information must be available showing that all applicable services were provided. Acceptable forms of computerized or manual verification include:

- A provider's claim form itemizing each service given, refused, or medically contraindicated, the date of service(s), and any conditions needing treatment;

- A provider's certification that the examination was provided, the date of service(s), and any conditions found needing treatment; and

- Records of telephone contacts with providers to ascertain that services were provided, the date of service(s), and conditions discovered which required treatment.

When a claims form or provider certification is absent or does not provide contradictory evidence, the recipient's documentation that an examination was received is acceptable. Documentation must be made of any conditions found needing treatment.

When arrangements are made with continuing care providers, whether they are private physicians, HMOs, title V grantees, Indian Health Service clinics, hospitals, or group medical practices for the delivery of EPSDT services, assure compliance with the EPSDT program. Records must be available for your auditing. You provide the methods to be used.

C. Program Reports.--See Part 2, §2700.4. The annual report (Form HCFA-416) contains the following data on EPSDT services provided to children during the previous Federal fiscal year, by age groups (under 1, 1-5, 6-14, 15-20) and categorically or medically needy classification:

- Number of individuals eligible for EPSDT;
- Ratio of recommended initial or periodic screening services per age group member;
- Average period of eligibility;
- Adjusted ratio of recommended initial or periodic screening services per age group member;
- Proportion of eligibles who should receive at least one initial or periodic screening service;
- Number of eligibles who should receive at least one initial or periodic screening service;
- Number of eligibles receiving at least one initial or periodic screening service;
- Participant ratio;
- Expected number of initial and periodic screening services;
- Actual number of initial and periodic screening services;
- Screening ratio;
- Number of eligibles referred for corrective treatment;
- Number of eligibles receiving vision assessments;
- Number of eligibles receiving dental assessments;
- Number of eligibles receiving hearing assessments; and
- Total number of eligibles enrolled in continuing care arrangements.

State managers may collect and analyze more detailed information about eligible children, their services utilization and health status, as part of ongoing program evaluation and planning. Examples of this information include:

- Number of individuals, under health supervision, for whom examinations were not due according to your periodicity schedule;

- Number of individuals found with health problems for whom treatment was initiated during a given time period;

- Major health problems and their relative significance;

- Provider participation, practice and utilization patterns;

- Geographic and demographic utilization analyses to determine outreach or health problem targets; and

- Costs and effects studies comparing the Medicaid expenditure experience of participants and nonparticipants.

5330. TIMELINESS

Set standards for the timely provision of services, which meet reasonable standards of medical and dental practice, as determined after consultation with recognized medical and dental organizations involved in child health care. Employ processes to:

- Effectively inform individuals, generally, within 60 days of the individual's eligibility determination and, in the case of families that have not utilized services, annually thereafter;

- Ensure timely initiation of treatment, generally within an outer limit of 6 months after a request for screening services;

- Substantiate mandated consultations in determining standards through correspondence or meeting records. Memoranda describing advantages and disadvantages of suggested standards can show how you considered and resolved conflicting standards in order to best serve the needs of your particular State and participants.

- Demonstrate that the required standards are employed through reports on numbers, or lists, of recipients overdue for services and the actions taken to assure the provision of needed identified services.

5340. REIMBURSEMENT

A. General Information.--Any service provided to EPSDT eligibles covered under the EPSDT program may be reimbursed under Medicaid, even if it is mandated by another agency or available as a community health service.

Medicaid provides financial access to health care services for individuals determined unable to pay for them, assures availability and delivery of EPSDT services, provides or arranges for covered services, and pays for them unless the beneficiary has liable third party coverage or the services are provided free of charge. Third party resources include Medicare (title XVIII), Railroad Retirement Act, insurance policies (private health, group health, liability, automobile, or family health insurance carried by an absent parent), Workers' Compensation, Veterans Administration Benefits, and Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).

Except for title V services, it is Medicaid policy that services which are available without charge to all individuals in the community may not be reimbursed. Services without charge, for purposes of Medicaid, means that no individual or family is charged for medical care and third party reimbursement is not sought.

The law requires the provision of the services needed by EPSDT clients if the services can be covered under the Medicaid program. Coordination of services to maximize treatment of clients is an essential aspect of the EPSDT program. Therefore, programs which enter into written interagency and/or provider agreements with the Medicaid agency to provide a service mandated on that agency, must specify the terms of reimbursement in such agreements.

The following conditions must be met if Medicaid is to be billed for medical services provided by other agencies or programs financed by Federal and State funds:

- A fee schedule is established for each service billed to Medicaid; and

- Information on third party liable resources is obtained from each Medicaid beneficiary, and billing of all third party liable resources is documented.

B. Services.--Provide payment for screening, vision, hearing, and dental services as well as for other health care, diagnostic, treatment, or other measures which are necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services.

Provide payment for diagnosis and treatment services and continuing medical treatment after an initial referral if medically necessary.

Agreements with other agencies, such as title V grantees, may provide for payment mechanisms that are used for other providers, including the Medicaid fee schedule and reasonable charge structures. Limit reimbursement of overhead costs under interagency agreements to costs identifiable as supporting EPSDT Medicaid services.

Cooperative agreements or contracts with other agencies and programs, such as title V, may include payment for certain administrative functions (e.g., outreach, assessing quality, transportation, and case management).

Seventy-five percent Federal matching is available for the cost of skilled professional medical personnel and directly supporting staff employed by the title XIX agency or other public agency if they meet the requirements of 42 CFR 432.50.

C. Transportation.--Assurance of transportation necessary to secure medical examinations and treatment is a mandatory State plan requirement. Provide transportation of EPSDT participants through Medicaid or cooperative agreements with voluntary and public organizations and with the recipient's family members and friends. You may finance these services through title XX, for example.

If you choose to provide transportation through Medicaid, claim expenditures in accordance with 42 CFR 440.170.

Transportation is recognized as an optional medical service only when furnished by a provider to whom you may make a direct vendor payment, such as an ambulance company. In this instance, claim FFP for transportation of eligible recipients at the applicable Federal medical assistance percentage (FMAP) as a Medicaid service only if you are able to document your claim as any other claim for eligible Medicaid services (i.e., provider agreement, provider number, date of service, eligible recipient, type of service). If you are unable to document the claim as a Medicaid service, reimbursement is not allowed. However, if you make other arrangements to assure transportation, FFP is available as an administrative cost.

Transportation is further defined to include related travel expenses, a term intended to cover other than routine situations. For example, an EPSDT participant may require a particular medical service which is only available in another city, county, or State, and the distance and travel time may warrant staying in that place overnight. Related travel expenses may include the recipient's lodging and meals en route to and from the facility and, if medically necessary, the cost of an attendant to accompany the recipient. The attendant's costs may include transportation, lodging, meals, and salary. However, Federal matching is not available to pay a salary to an attendant who is a member of the recipient's family.

FFP is not available for the advance of capital funds to purchase transportation vehicles.

5350. CONFIDENTIALITY

A. General.--The use or disclosure of information concerning applicants and recipients is restricted to purposes directly related to administration of the title XIX State plan. Medicaid's EPSDT program requires you to provide services for recipients. Since §1905(a)(4)(B) of the Act requires the provision of these services, consider them as activities directly connected with the administration of the plan. Outreach, informing, and assistance with transportation and scheduling appointments for services are also considered activities directly related to State plan administration. Medical information is privileged and may only be released with the patient's permission.

Any agency or provider having a written interagency or provider agreement to perform EPSDT services that include outreach activities and/or assistance with transportation or scheduling appointments is considered an extension or arm of the Medicaid agency. Without his/her consent, an individual's name, address, medical assistance number, and related information may be furnished to such an agency or provider that meets the other confidentiality requirements listed below.

B. Confidentiality Requirements.--The following confidentiality requirements must be met:

- Criteria must specify the conditions for release and use of information about applicants and recipients;
- Information access is restricted to persons or agency representatives subject to legal sanctions or standards of confidentiality at least comparable to those of the Medicaid agency;
- The release of names of applicants and recipients which may be used by outside sources (sources not under agreement with the agency to provide EPSDT services for recipients) is prohibited; and
- Written permission is obtained from a family or individual before responding to a request for information from an outside source.

Information may be exchanged when the agency is located within the State structure if the regulatory requirements for safeguarding information on applicants and recipients are met.

5360. ANNUAL PARTICIPATION GOALS

A. General.--Section 1905(r) of the Act mandates setting annual participation goals not later than July 1 of each year for participation by eligible individuals in your State in early and periodic screening, diagnostic and treatment services. Your annual report on provision of EPSDT (Form HCFA-416) provides data with which to assess your results in attaining those goals.

B. Participant Ratio.--This ratio indicates the extent to which the number of eligibles who should be screened during the year receive at least one initial or periodic screening service. (See §5122.A.)

The unit of measure is the number of eligibles receiving at least one initial or periodic screening service (see line 7 of Form HCFA-416) divided by the unduplicated count of eligibles who should receive at least one initial or periodic screening service. (See line 6 of Form HCFA-416 described in §2700.4.) The unduplicated count of eligibles who should receive at least one initial or periodic screening service is the number of individuals eligible for EPSDT (see line 1 of Form HCFA-416) adjusted based on the Guidelines for Health Supervision of the American Academy of Pediatrics§ (AAP) recommended periodicity schedule and the average period of eligibility in each State.

The goal is for each State to achieve an 80-percent EPSDT participant ratio within 5 years or by FY 1995.

Interval goals are included in Exhibit A. In FY 1989, a proxy measure of State EPSDT participation rates (the number of eligibles enrolled in continuing care arrangements plus the number of initial/periodic screening examinations divided by total eligibles) ranged from 7 percent to 96 percent. You are expected to reduce the difference between current performance and the 80-percent goal by one-fifth each year from FY 1991 through FY 1995. If your program already meets the 80-percent target, no higher goals are set.

C. Screening Ratio.--This ratio indicates the extent to which eligibles receive the number of initial and periodic screening services expected.

The unit of measure is the actual number of initial and periodic screening services (see line 10 of Form HCFA-416) divided by the expected number of initial and periodic screening services. (See line 9.) The expected number of initial and periodic screening services for the number of EPSDT eligibles is reported based on the periodicity schedule recommended in the AAP§s Guidelines for Health Supervision and the average period of eligibility in each State.

The AAP recommended periodicity schedule calls for the following number of screening services by age group (or health supervision examinations, as the AAP calls them):

- o Under 1 (i.e., 0-12 months): 6 (at or by 1, 2, 4, 6, 9, and 12 months);
- o 1 - 5: 6 (at or by 15, 18, and 24 months, and 3, 4, and 5 years);
- o 6 - 14: 5 (at or by 6, 8, 10, 12, and 14 years); or
- o 15 - 20: 3 (at or by 16, 18, and 20 years)

Therefore, the annual numbers of screening services visits expected per age group member, are:

Age Group	Visits	Years per Age Group	Visits Per Age Group Member
Under 1	6	1	6.00
1 - 5	6	5	1.20
6 - 14	5	9	0.56
15 - 20	3	6	0.50

To determine the number of screening services that fully meet the AAP recommendation, multiply the visits per age group member by the estimated number of EPSDT eligibles for each age group.

The goal is for you to achieve, within 5 years or by FY 1995, 80 percent of the expected number of initial and periodic screening services for the number of EPSDT eligibles reported based on the periodicity schedule recommended in the Guidelines for Health Supervision of the AAP and the average period of eligibility in each State. No interval goals have been set.

D. Complete Screening Services. Report a participant as having received screening services (see line 7 of Form HCFA-416) or a screening service as having been received (see line 10 of Form HCFA-416) only if the following complete set of activities comprising a screening service has been furnished:

- o A comprehensive health and developmental history (including assessment of both physical and mental health development);
- o A comprehensive unclothed physical exam;
- o Appropriate immunizations according to age and health history (unless medically contraindicated at the time);
- o Laboratory tests (including lead blood level assessment appropriate for age and risk factors); and
- o Health education (including anticipatory guidance).

Do not report those participants who receive some (but not all) screening service activities, or those who receive interperiodic, vision, hearing, or dental services.

EXHIBIT A

EXPECTED IMPROVEMENT IN EPSDT PARTICIPATION

	1989 Proxy Rate*	% Points Needed	Interval Goals by Fiscal Year 1991	1992	1993	1994	1995
Alabama	40%	48%	56%	64%	72%	80%	
Alaska	70%	10%	72%	74%	76%	78%	80%
Arizona	96%	--	96%	96%	96%	96%	96%
Arkansas	28%	52%	38%	49%	59%	70%	80%
California	63%	17%	66%	70%	73%	77%	80%
Colorado	94%	--	94%	94%	94%	94%	94%
Connecticut	10%	70%	24%	38%	52%	66%	80%
Delaware	7%73%	22%	36%	51%	65%	80%	
Dis of Columbia	24%	56%	35%	46%	58%	69%	80%
Florida	67%	13%	70%	72%	75%	77%	80%
Georgia	44%	36%	51%	58%	66%	73%	80%
Hawaii	28%	52%	38%	49%	59%	70%	80%
Idaho	12%	68%	26%	39%	53%	66%	80%
Illinois	57%	23%	62%	66%	71%	75%	80%
Indiana	9%71%	23%	37%	52%	66%	80%	
Iowa	9%71%	23%	37%	52%	66%	80%	
Kansas	13%	67%	26%	40%	53%	67%	80%
Kentucky	13%	67%	26%	40%	53%	67%	80%
Louisiana	33%	47%	42%	52%	61%	71%	80%
Maine	55%	25%	60%	65%	70%	75%	80%
Maryland	49%	31%	55%	61%	68%	74%	80%
Massachusetts	61%	19%	65%	69%	72%	76%	80%
Michigan	48%	32%	54%	61%	67%	74%	80%
Minnesota	34%	46%	43%	52%	62%	71%	80%
Mississippi	33%	47%	42%	52%	61%	71%	80%
Missouri	37%	43%	46%	54%	63%	71%	80%
Montana	42%	38%	50%	57%	65%	72%	80%
Nebraska	57%	23%	62%	66%	71%	75%	80%
Nevada	62%	18%	66%	68%	73%	76%	80%
New Hampshire	15%	65%	28%	41%	54%	67%	80%
New Jersey	11%	69%	25%	39%	52%	66%	80%
New Mexico	35%	45%	44%	53%	62%	71%	80%
New York	15%	65%	28%	41%	54%	67%	80%
North Carolina	54%	26%	59%	64%	70%	75%	80%
North Dakota	19%	61%	31%	43%	56%	68%	80%
Ohio	49%	31%	55%	61%	68%	74%	80%
Oklahoma	7%73%	22%	36%	51%	65%	80%	
Oregon	43%	37%	50%	58%	65%	73%	80%
Pennsylvania	44%	36%	51%	58%	66%	73%	80%
Rhode Island	45%	35%	52%	59%	66%	73%	80%
South Carolina	79%	1%	79%	79%	80%	80%	80%
South Dakota	21%	59%	33%	45%	56%	68%	80%
Tennessee	27%	53%	38%	48%	59%	69%	80%
Texas	24%	56%	35%	46%	58%	69%	80%
Utah	32%	48%	42%	51%	61%	70%	80%
Vermont	68%	12%	70%	73%	75%	78%	80%
Virginia	52%	28%	58%	63%	69%	74%	80%
Washington	35%	45%	44%	53%	62%	71%	80%
West Virginia	56%	24%	61%	66%	70%	75%	80%
Wisconsin	47%	33%	54%	60%	67%	73%	80%
Wyoming	27%	53%	38%	48%	59%	69%	80%
	39%	41%	47%	56%	64%	72%	80%

* Fiscal year 1989 ratio of continuing care enrollees and initial and/or periodic screening examinations to the average number of eligibles.
Source: Form HCFA-420.

visited on 9/23/2016