



STATE OF DELAWARE
STATE COUNCIL FOR PERSONS WITH DISABILITIES
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MEMORANDUM

DATE: August 23, 2012

TO: Ms. Sharon L. Summers, DMMA
Planning & Policy Development Unit

FROM: Daniese McMullin-Powell, ^{DMMA/CIT} Chairperson
State Council for Persons with Disabilities

RE: 16 DE Reg. 170 [DMMA Proposed PACE Regulation]

The State Council for Persons with Disabilities (SCPD) has reviewed the Department of Health and Social Services/Division of Medicaid and Medical Assistance's (DMMA's) proposal to establish enrollment standards for the Program for All Inclusive Care for the Elderly (PACE) in Delaware. The proposed regulation was published as 16 DE Reg. 170 in the August 1, 2012 issue of the Register of Regulations. SCPD has the following observations.

First, the key eligibility standards are compiled in §5. There is some "tension" between §5 and §9 in the context of nursing home residency. The CMS document indicates that 7% of PACE enrollees live in nursing homes. Section 9 recites as follows:

9. Nursing facility services are part of the PACE benefit package.

The PACE Organization must notify the Division of Medicaid and Medical Assistance (DMMA) eligibility worker of the individual's placement in a nursing facility.

The PACE individual is not required to contribute to the cost of their care while in a nursing facility.

Thus, the CMS guidance and §9.0 suggest that residents of nursing homes may be eligible for the program. However, §5 requires, as a matter of eligibility for enrollment, that the applicant "(b) living in the community." SCPD infers that an individual must be in the community upon initial enrollment but that "continued eligibility" is not affected by post-enrollment nursing home residency. It would be helpful if DMMA clarified this aspect of eligibility.

Second, §10 b. contains the following justification for involuntary termination from the program:

Has decision making capacity and is consistently non-compliant with the individual plan of care and enrollment agreement, which may impact the participant's health and welfare in the community;...;

This section would literally authorize termination for recurrent "minor/inconsequential" non-compliance with "minor/inconsequential" impact on health and welfare. Providers have a financial incentive to terminate eligibility of "expensive" individuals and it would be preferable to deter involuntary termination in the absence of significant non-compliance. There is also no requirement that the non-compliance be "wilful" rather than inadvertent. For example, an elderly individual's plan may contemplate self-administration of medications. Due to memory deficits, the individual may periodically forget to take medications which affect the individual's welfare. Under a literal reading of the regulatory standard, the individual could be terminated from the program based on consistent non-compliance impacting health. Consider the following substitute:

Has decision making capacity and is wilfully and consistently non-compliant with material components of the individual's plan of care and enrollment agreement which may significantly impact the participant's health and welfare in the community;...

Third, §10.b. contains the following additional justification for involuntary termination from the program:

Engages in disruptive, threatening or non-compliant behavior which jeopardizes his or her safety or the safety of others;...

Individuals with Alzheimer's, dementia, Tourette's or TBI may exhibit such behavior as a symptom of disability. Terminating their eligibility for symptoms of disability would violate §504 and the ADA. CMS requires programs to provide accommodations to participants with disabilities, not "dump" them. Cf. attached CMS Medicaid Director Guidance (July 29, 1998) and CMS Medicaid Director Guidance (May 10, 2010). See also attached October 11, 1985 HHS OCR LOF to Delaware DHSS which held the following regulation violated §504:

57.809 Mental Illness

A. Patients who are, or become, mentally ill and who may be harmful to themselves or others, shall not be admitted or retained in a nursing home.

OCR commented as follows:

Conditions such as Alzheimers Disease may be considered a mental impairment under the definition of handicapping condition; however the presence of this condition and its manifestations may in no way render one ineligible for the receipt of services normally

provided. ...It is our preliminary determination, based on the preceding discussion, that Section 57.809 as written violates Section 504 of the Rehabilitation Act and its implementing regulation 45 CFR Section 84.4 and Section 84.52(a)(1).

Rather than authorizing termination from the program, enrollees manifesting such behavior due to disability should be considered for specialized treatment. See, e.g., 16 DE Admin Code 3225, §§5.5, 5.12 and 7.0; and 16 DE Admin Code 3201, §5.6. Consider the following substitute:

Has decision making capacity and wilfully engages in disruptive, threatening or non-compliant behavior which is not symptomatic of disability and which jeopardizes his or her safety or the safety of others;...

Fourth, it is unclear if “assisted living” services are part of the PACE benefit package. Compare §9.0. This could be clarified. Assisted living settings are required to be “homelike” (16 DE Reg. 3225, §3.0 (definition of “homelike”)) and may be less restrictive settings than nursing facilities.

Fifth, the CMS document recites as follows: “If you disagree with the interdisciplinary team about your care plan, you have the right to file an appeal.” The DMMA regulation omits any reference to the right to a hearing to contest denial of program eligibility (§5.0); involuntary termination from the program (§10.0); and disagreements about the plan of care. It would be preferable to clarify that 16 DE Admin Code 5000 applies.

Thank you for your consideration and please contact SCPD if you have any questions or comments regarding our position on the proposed regulation.

cc: Ms. Rita Landgraf
Ms. Rosanne Mahaney
Mr. Brian Posey
Mr. Brian Hartman, Esq.
Governor’s Advisory Council for Exceptional Citizens
Developmental Disabilities Council

16reg170 dmma-pace 8-23-12



DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

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

July 29, 1998

Dear State Medicaid Director:

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

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

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

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

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

While these decisions are only binding in the affected circuits, the Attorney General has indicated that under the ADA States have an obligation to provide services to people with disabilities in the most integrated setting appropriate to their needs. Reasonable steps should be taken if the treating professional determines that an individual living in a facility could live in the community with the right mix of support services to enable them to do so. The Department of Justice recently reiterated that ADA's "most integrated setting" standard applies to States, including State Medicaid programs.

States were required to do a self-evaluation to ensure that their policies, practices and procedures promote, rather than hinder integration. This self-evaluation should have included consideration of the ADA's integration requirement. To the

extent that any State Medicaid program has not fully completed its self-evaluation process, it should do so now, in conjunction with the disability community and its representatives to ensure that policies, practices and procedures meet the requirements of the ADA. We recognize that ADA issues are being clarified through administrative and judicial interpretations on a continual basis. We will provide you with additional guidance concerning ADA compliance as it becomes available.

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

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

Sincerely,

/s/

Sally K. Richardson
Director

cc

All HCFA Regional Administrators

All HCFA Associate Regional Administrators for Medicaid and State Operations

Lee Partridge, American Public Human Services Association

Joy Wilson, National Conference of State Legislatures

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Center for Medicaid, CHIP, and Survey & Certification

SMDL# 10-008

May 20, 2010

Re: Community Living Initiative

Dear State Medicaid Director:

July 26, 2010, will mark the 20th anniversary of the enactment of the Americans with Disabilities Act (ADA). In June 2009, President Obama announced the “Year of Community Living” to mark the 10th anniversary of the *Olmstead v. L.C.* decision, in which the U.S. Supreme Court affirmed a State’s obligation to serve individuals in the most integrated setting appropriate to their needs.¹ In the *Olmstead* decision, the Court held that the unjustified institutional isolation of people with disabilities is a form of unlawful discrimination under the ADA.

Shortly after arriving at the Department of Health and Human Services (HHS), Secretary Sebelius announced the Community Living Initiative. As part of this initiative, HHS is working with several Federal agencies, including the Centers for Medicare & Medicaid Services (CMS), to implement solutions that address barriers to community living for individuals with disabilities and older Americans. HHS is also partnering with the Department of Housing and Urban Development (HUD) to improve access and affordability of housing for, people with disabilities and older Americans with long-term care needs. The HHS Office for Civil Rights is also collaborating with the Department of Justice to advance civil rights enforcement of the ADA and the U.S. Supreme Court’s *Olmstead* decision. Additional agencies involved in the Community Living Initiative include:

- Administration on Aging (AoA)
- Administration for Children and Families
- Health Resources and Services Administration
- Substance Abuse and Mental Health Services Administration
- HHS Office on Disability
- HHS Office of the Assistant Secretary for Planning and Evaluation

¹ *Olmstead v. L.C.*, 527 U.S. 581 (1999).

CMS recognizes the important role that Medicaid plays in States' efforts to ensure compliance with the ADA and *Olmstead*. In the early 2000s, CMS (then the Health Care Financing Administration) issued a series of letters to State Medicaid Directors to identify policies, tools, and expectations for home and community-based services (HCBS) and their role in *Olmstead* compliance. These letters, collectively known as "the *Olmstead* letters," identified services that help transition individuals from institutional to community settings and maintain their community living status. The letters also described the obligations of States under Federal Medicaid rules to provide services necessary to assure the health and welfare of individuals served under Medicaid section 1915(c) waiver programs.

Since the passage of the ADA and the *Olmstead* decision, progress has been made to improve community living opportunities for people with disabilities. However, the demand for community services continues to grow, and many individuals in need of these services struggle without them. In addition, State budget constraints threaten the progress that has been achieved, raising concerns about compliance with the ADA and *Olmstead*.

The Patient Protection and Affordable Care Act, P.L. 111-148, enacted March 23, 2010, and the Health Care and Education Reconciliation Act of 2010, P.L. 111-152, enacted March 30, 2010, (together referred to as the Affordable Care Act), is designed to increase accountability, give more choices, and bring down costs in the health insurance system. The Affordable Care Act also provides new opportunities to serve more individuals in home and community-based settings, adding to the available tools for realization of the integration mandate of the ADA, as required by the *Olmstead* decision. While this letter will provide some basic information related to the Affordable Care Act, additional guidance documents will be issued in the near future.

In anticipation and recognition of the important anniversary of the ADA, CMS issues this Community Living Initiative letter to provide information on new tools for community integration, as well as to remind States of existing tools that remain strong resources in State efforts to support community living. We will provide separate guidance to describe the newly enacted provisions of the Affordable Care Act that provide additional opportunities for Medicaid beneficiaries to receive services in the most integrated settings.

With the issuance of this letter, CMS reaffirms its commitment to the policies identified in "the *Olmstead* Letters" and hopes to build upon those earlier innovations. CMS offers the following tools and information to help States make greater strides in achieving the promise of the ADA and *Olmstead*:

Opportunities and Partnership – Tools for Community Living

Availability of Technical Assistance

CMS offers a variety of resources for technical assistance to States regarding the design and operation of their Medicaid programs. Listed here are new and existing resources that may aid States as they devise strategies to ensure individuals are able to access quality HCBS.

- *Technical Assistance to Support Greater Community-Based Service System Capacity*
Under President Obama's leadership, CMS is committed to providing guidance and leadership to advance opportunities for the full community inclusion of all individuals. While we understand that States currently face unprecedented budget shortfalls, we also recognize the partnership opportunities between CMS and the States provided by the

Medicaid program. As part of this partnership, CMS commits to provide targeted technical assistance to States to help them meet their obligations under the ADA. Specifically, this technical assistance, to be provided at State request, will identify the Medicaid tools available to increase the State's system capacity to serve individuals in the community. Technical assistance can also help identify the strategies States can employ to ensure that services meet the needs and preferences of each individual. States interested in receiving Medicaid-related technical assistance on methods to better meet their Olmstead obligations may request assistance by sending an e-mail to the following mailbox: Medicaid-Olmstead_Technical_Assistance@cms.hhs.gov. CMS will coordinate the appropriate team of CMS and other Federal experts to address the specific State needs.

- *Technical Assistance for Quality in HCBS*
CMS continues to offer technical assistance through the National Quality Enterprise (NQE) to assist States in developing and improving the structures to ensure the health and welfare of individuals served through HCBS waivers. The NQE, which provides assistance at no cost to States, is a valuable resource that States can use to design and improve their quality improvement systems. States can access the assistance of the NQE at www.nationalqualityenterprise.net.
- *Technical Assistance for Implementation of Preadmission Screening and Resident Review (PASRR)*
Under Federal requirements, States must assure that individuals with mental disabilities or developmental disabilities being considered for admission to a nursing facility are evaluated to determine the most integrated setting to meet their needs. CMS has established the new National PASRR Technical Assistance Center, which provides technical assistance to States, at no cost, to facilitate this reform activity. To request technical assistance or to gain information regarding PASRR, visit PASSRassist.org.

CMS has also included a PASRR element in the nursing facility resident assessment instrument Minimum Data Set 3.0 to assure a person-centered process to help nursing facility residents transition to community services. Each nursing facility certified to participate in Medicare and Medicaid is required to administer a standard assessment, called the Minimum Data Set (MDS), to all facility residents when they are admitted, and at specified times thereafter. Important changes to the MDS, which will be implemented in October 2010, are discussed below. PASRR is a powerful tool for diversion from institutions, and together with the MDS 3.0, the resident review elements of PASRR are a powerful tool for transition.

Managed Long-Term Services and Supports

CMS continues to identify service delivery models that can be used to further the goals of the ADA. One such tool, when structured carefully, is managed care. CMS published a technical assistance guide that describes the various Medicaid authorities and structures that States can use to enhance the availability of HCBS within managed care delivery systems. These managed care delivery systems allow for the use of capitation payments with both institutional and HCBS services in a global budget, where the resources available to support an individual can follow the

individual wherever they choose to receive their services. The technical assistance guide entitled *Long Term Services and Supports in a Managed Care Delivery System*, is now available online at http://www.cms.hhs.gov/CommunityServices/55_ManagedHCBS.asp#TopOfPage.

Advancing Access to Affordable Housing as a Means to Maximize Opportunities for Community Living

The lack of accessible and affordable housing continues to be an obstacle to serving individuals in the most integrated setting. As part of the Community Living Initiative, HHS has partnered with HUD to improve access to affordable housing for people with disabilities and older Americans with long-term care needs. Progress to date includes:

- On April 5, 2010, HUD issued a final Notice of Funding Availability totaling \$40 million that will provide approximately 5,300 Housing Choice Vouchers over 12 months for non-elderly persons with disabilities living in the community or transitioning out of institutional care. HHS will use its network of State Medicaid agencies and local human service organizations to link eligible individuals and their families to local housing agencies, which will administer voucher distribution. Information for Medicaid agencies regarding the Housing Choice Vouchers and available technical assistance may be found at http://www.cms.hhs.gov/CommunityServices/20_MFP.asp. We strongly encourage State Medicaid agencies to use this information and work with their State's public housing authorities to increase available housing options for individuals with disabilities. Importantly, the applications are due to HUD by July 7, 2010.
- Collaborative partnerships between housing and human service organizations at the Federal, State, and local levels are critical to the ongoing availability of affordable and accessible housing options for the elderly and individuals with disabilities. Working with HUD, CMS expects to initiate targeted capacity building activities to foster effective coordination between housing and human service agencies in the summer of 2010.
- Many Money Follows the Person (MFP) grantees have created or enhanced housing registries (e.g., interactive and online). Ten MFP States set aside State funding to pay rental subsidies as a transitional service until individuals qualify for HUD subsidies. See more information on MFP later in this letter.

Home and Community Based Services - Waiver and State Plan Options

CMS continues to assess our policies and practices to identify ways in which the Medicaid program can assist States in achieving the goals of the ADA, including assisting States in efforts to serve more individuals in community settings. One example of our ongoing assessment process is the Advanced Notice of Proposed Rulemaking (ANPRM) that we published as a part of the Community Living Initiative in June 2009. We published the ANPRM to obtain public input on specific changes to the 1915(c) HCBS waiver program related to the combining of target groups within HCBS waivers and to identify hallmarks of settings where HCBS can be provided. The ANPRM also sought public comment on person-centered planning and how we can ensure that services are provided to individuals in ways that meet their needs and preferences. After a careful review of more than 300 comments, CMS plans to publish a Notice of Proposed Rulemaking (NPRM) to address the issues raised by the public and to solicit additional input from stakeholders. The ANPRM can be found at <http://edocket.access.gpo.gov/2009/E9-14559.htm>.

Section 1915(i) and 1915(j) of the Social Security Act (the Act) both provide State plan opportunities to serve individuals in the most integrated setting. Section 1915(i), which permits States to provide HCBS as a State plan option, allows States to serve individuals in the community without linking the benefit to either a current or future need for institutional care. To date, States have used this benefit to provide an array of services, meeting a diversity of needs within the State.² The Affordable Care Act included important changes to 1915(i), and CMS will be issuing guidance on these changes soon. This option offers great promise as a tool to prevent institutionalization and to meet mental health service needs. Section 1915(j) allows States to design self-directed personal assistance or other HCBS for individuals who would otherwise receive State plan personal care or HCBS waiver services.³

CMS also reminds States of the existing features within State plan options and the HCBS waiver program. Examples are highlighted below:

- Behavioral Health. Currently eight States use HCBS waivers to serve children or adults with mental health and substance use needs. These waivers, when coordinated with the State plan benefits available to all Medicaid beneficiaries, can provide valuable services to support individuals in the community.
- Personal Care. Personal Care is an optional state plan benefit that can play an important role in supporting people in their homes and communities, provide necessary help to caregivers, and can prevent or delay the need for institutional care.
- Self-Direction. The self-direction service delivery model is available under multiple Medicaid authorities, including section 1915(c) HCBS waiver programs, section 1915(i) HCBS as a State plan option, and section 1915(j) Self-Directed Personal Assistance Services. Self-direction affords individuals an important option for maximum choice and control over their services, and can be an important tool for the expansion of integrated community services.
- Caregiver Supports. States can offer support, training, and respite care through HCBS waivers and State plan services.
- Peer Supports. This is an evidence-based mental health practice that States may use to expand opportunities for meaningful community inclusion. Qualified peer support providers assist individuals with their recovery from mental health and substance use disorders. CMS recognizes that the experiences of peer support providers can be an important part of effective treatment systems, and has issued guidance regarding State use of peer supports which can be found at <http://www.cms.hhs.gov/SMDL/downloads/SMD081507A.pdf>. While this letter was published in 2007, it contains some important information that States may consider as they expand and improve services.

² As of April 15, 2010, four States have approved 1915(i) HCBS State plan benefits (Iowa, Washington, Nevada, and Colorado).

³ As of April 15, 2010, the following States have 1915(j) programs approved: Arkansas, Florida, New Jersey, California, Oregon, Alabama, and Texas.

Supporting Infrastructure Reforms

The Federal Government has provided grant funds and enhanced Medicaid financing to support State efforts to create more balanced long-term care services and support systems and to assure more informed decision-making and improved access to community-based long-term services and supports.

- The **Money Follows the Person (MFP)** demonstration program provides participating States with many opportunities, including funding for short-term supplemental and demonstration services, MFP support of personnel and infrastructure development, and technical assistance to support efforts to transition individuals from institutions to the community. States continue to make progress in implementing the MFP Demonstration. As of December 2009, States have transitioned over 6,000 persons from institutions to the community through the MFP demonstration. Since the beginning of calendar year 2009, the number of participants transitioning has increased as solutions to barriers were identified and significant technical assistance is continuing to be provided to help meet the MFP benchmarks that the States set. States have closed several large institutions for people with intellectual and development disabilities. More than two-thirds of MFP States have demonstrated continued growth in the percent of long-term care expenditures devoted to community-based services.

The **Medicaid Infrastructure Grants (MIG)** program has provided assistance for State development of local systems that support employment opportunities for individuals with disabilities since 1998; today, 40 States have a Medicaid Buy-In program, where the State can allow individuals with disabilities who work to buy into the Medicaid program through the use of optional eligibility groups. These programs have nearly 120,000 persons enrolled for at least one month. In late Spring 2010, CMS will issue the final grant solicitation authorized under this program. In addition, CMS and the Office of the Assistant Secretary for Planning and Evaluation are collaborating with the Rehabilitation Services Administration, Social Security Administration, Department of Labor, and Substance Abuse and Mental Health Services Administration to produce a guide for the Federal financing of customized employment and the Individual Placement and Support Model of Supported Employment for people with mental health needs.

HCBS Participant Experience Measures

CMS is committed to the development and testing of participant experience measures that could be collected across long-term care service delivery settings to ensure that the State programs improve individuals' quality of life. CMS will make these measures available for States' use to monitor progress and efficacy of their efforts around community living. CMS expects to issue additional information on this initiative by the end of 2010.

Aging and Disability Resource Center (ADRC)

The ADRC program, a collaborative effort of the AoA and CMS, is designed to streamline access to long-term care services and supports. ADRCs play a critical role in supporting health and long-term care reform by improving the ability of State and local governments to effectively manage the system, monitor program quality, and measure the responsiveness of State and local systems of care. ADRCs now operate in at least one community in each of the 50 States and in four Territories. There are currently over 200 ADRC sites across the Nation. Thirty-four ADRCs have Medicaid applications available on the Internet with seven of these allowing consumers to complete and submit the application online. CMS, in collaboration with its HHS

partners, plans to explore expansion of the ADRC program and similar models to ensure streamlined access to information and service supports, as provided in the Affordable Care Act.

Discharge Planning

Minimum Data Set (MDS) for Certified Nursing Facilities

On October 1, 2010, all certified nursing facilities will be required to adopt and implement a new 3.0 version of the MDS. While MDS 3.0 has several new enhancements to ensure the resident assessments are more person-centered, there are notable changes in the MDS' Section Q, which address resident discharge planning. Under Section Q, nursing facilities must now ask residents directly if they are "interested in learning about the possibility of returning to the community." If a resident indicates yes, a facility will be required to make appropriate referrals to community integration agencies such as ADRCs, Centers for Independent Living, State Medicaid Agencies, and Area Agencies on Aging. Further information regarding MDS 3.0 and the CMS training opportunities may be found at:

http://www.cms.hhs.gov/nursinghomequalityinits/25_nhqmids30.asp. This improvement to the MDS ensures that all individuals are asked about their preferences and advised of community options.

Person-Centered Hospital Discharge Planning Model Grants

To further CMS' efforts to strengthen person-centered planning and community-based long-term care options, CMS awarded 10 Person-Centered Hospital Discharge Planning Model Grants between 2008 and 2009, totaling approximately \$12 million. These grants are designed to assist States in developing hospital discharge planning structures and processes that will place greater emphasis on involving consumers and their families in after-care plans, including community-based alternatives to institutional care. Grantees are expected to create and/or enhance systems for the exchange of accurate, useful, and timely information on available home and community-based long-term supports between hospital discharge planners, ADRCs, community-based providers, and individuals and their caregivers. Grantee efforts to date include: development of discharge planning checklists; patient and caregiver information kits and hospital staff training webinars; enhancing online resource directories; developing electronic referral, application, and tracking systems; and employing transition coaches to follow-up with individuals once they are discharged from the hospital back into the community. CMS continues to work closely with the AoA on these grants as the ADRC effort is central to improving the hospital discharge planning process and enhancing community-based long-term care options.

Health Insurance Reform

The Affordable Care Act includes important provisions related to HCBS infrastructure development, quality in HCBS, and important protections for individuals receiving HCBS. Specifically, the reform legislation includes improvements to section 1915(i) of the Social Security Act, an extension of the MFP program, additional funding for ADRCs, and other elements that may aid States in meeting their obligations under the *Olmstead* decision. HHS will provide additional guidance and information, including additional letters to State Medicaid Directors and, in some instances, regulations, related to those provisions.

While the Nation has made great strides in increasing the availability of HCBS, we must continue our efforts to increase the capacity nationally and to ensure that individuals receive the services and supports necessary to realize the full benefits of community living. If you have questions about any of the initiatives described in this letter, please contact Ms. Barbara Coulter Edwards, Director, Disabled and Elderly Health Programs Group, at 410-786-7089.

Sincerely,

/s/

Cindy Mann
Director

cc:

CMS Regional Administrators

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Mr. James E. Harvey
Director
Delaware Department of Health and
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Division of Public Health
Office of Health Facilities Licensing
and Certification
3000 Newport Gap Pike
Wilmington, Delaware 19808

Dear Mr. Harvey:

The Office for Civil Rights has completed its review of Delaware's Nursing Home Regulations for Skilled Care. Our analysis of the State's Regulations and determination regarding the Age Discrimination Act of 1975 and Section 504 of the Rehabilitation Act of 1973 are as follows:

Section 57.3 - General Requirements

57.3 - An institution shall not admit any person under the age of fifteen (15) years of age as a patient unless approved by the State Board of Health.

Analysis

The Age Discrimination Act of 1975 and its implementing Regulation at 45 CFR Part 91, Subpart B Section 91.11(a) states that "No person in the United States shall, on the basis of age, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any program or activity receiving Federal financial assistance". Further, Section 91.11(b)(1) and (2) prohibits a recipient from using age distinctions which have the effect, on the basis of age, of excluding individuals from, or denying them the benefits of, or subjecting them to discrimination, under a program or activity receiving Federal financial assistance; denying or limiting individuals in their opportunity to participate in any Federally assisted program.

Page 2 - James E. Harvey

A recipient is permitted to take an action prohibited by Section 91.11 only if the action reasonably takes into account age as a factor necessary to the normal operation or the achievement of any statutory objective of a program or activity.

Determination

It is our preliminary determination that Section 57.3 of the State's Regulations violates the Age Discrimination Act of 1975 and 45 CFR Part 91 Subpart B Section 91.11.

Unless the State Agency can show that its age distinction is necessary to the normal operation of a nursing home or the achievement of a statutory objective, the age distinction must be removed. Please refer to 45 CFR Sections 91.13, 91.14 and 91.15.

It is my understanding that the State Board of Health may, on a case-by-case basis, consider an application for admission to a nursing home from someone under the age of fifteen. However, if the applicant's age and not the medical condition is the reason for this case-by-case review, then it is probable that this action violates the Age Discrimination Act.

Remedy

If your age distinction does not meet the criteria set forth at 45 CFR Sections 91.13 and 91.14, you may voluntarily resolve this deficiency by deleting from your Nursing Home Regulations any reference to an age criterion. You may also notify the public as well as all skilled care nursing facilities of this change in policy.

Section 57.8 - Services to Patients

57.809 Mental Illness

A. Patients who are, or become, mentally ill and who may be harmful to themselves or others, shall not be admitted or retained in a nursing home.

Analysis

Section 504 of the Rehabilitation Act of 1973 and its implementing Regulation 45 CFR Part 84 prohibit discrimination on the basis of handicap in any program or activity receiving Federal financial assistance. Section 84.3 of 45 CFR defines a handicapped person as one who (1) has a physical or mental impairment which substantially limits one or more major life activities; (2) has a record of such an impairment; or (3) is regarded as having such an impairment.

Specifically 45 CFR Section 84.4 provides that no qualified handicapped person shall, on the basis of handicap, be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination under any program or activity which receives or benefits from Federal financial assistance.

The State Agency may not, solely by reason of the presence or history of handicapping condition (mental illness), deny admission to a nursing home. For purpose of admission to a nursing home, a facility must admit one who is a qualified handicapped person, i.e., meets the essential eligibility criteria and requires the same type of medical or related services that are normally provided. Thus, Section 504 prohibits recipients from categorically excluding persons with mental impairments, as is specified in the State's Regulations at 57.809.

However, a recipient may take into account the behavioral manifestations of the mental impairment in determining whether one is a qualified handicapped individual. If the manifestations are such that the person no longer meets the basic eligibility requirements for the receipt of services or cause substantial interference with the operation of the program (be harmful to self or others), the condition may be taken into consideration.

Conditions such as Alzheimers Disease may be considered a mental impairment under the definition of handicapping condition; however the presence of this condition and its manifestations may in no way render one ineligible for the receipt of services normally provided. However, if there is adherence to State Regulations, one with this disease may not be admitted nor retained in a nursing home, which could violate 45 CFR Part 84.

Determination

It is our preliminary determination, based upon the preceding discussion, that Section 57.809 as written violates Section 504 of the Rehabilitation Act and its implementing Regulation 45 CFR Section 84.4 and Section 84.52 (a)(1).

Remedy

In order to voluntarily resolve this deficiency, we suggest you delete "who are, or become mentally ill and" from the paragraph at 57.809A. Please disseminate the revisions to the public, referral sources and the State's skilled care facilities.

For your reference, we have enclosed a copy of each of the pertinent Regulations.

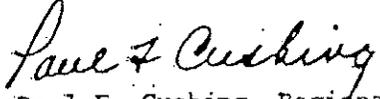
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Please advise us of your plans to correct these deficiencies. We would appreciate a response by November 12, 1985.

If you need technical assistance or if you should have any comments or questions, please contact Ms. Barbara Banks, Director, Investigations Division, at (215) 596-6173.

We appreciate your continuous cooperation.

Sincerely yours,



Paul F. Cushing, Regional Manager
Office for Civil Rights
Region III

Enclosures

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