



Q&A

The Medicaid Home Health Service Final Rule: Many Helpful Changes

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Q: Our office works with clients who need home health services, including medical equipment, appliances, and supplies. Over the years, the state Medicaid agency has imposed a number of limits on this coverage. For example, the individual must be homebound to receive coverage for home health services and many items of medical equipment are excluded from coverage altogether. I understand the federal government recently issued regulations addressing Medicaid home health coverage. Can you summarize the regulations?

A: Yes. The U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services (CMS) issued final Medicaid home health regulations on February 2, 2016. Explained below, the regulations make a number of helpful changes to Medicaid coverage.

Discussion

Medicaid background

Congress created the Medicaid program in 1965 by adding title XIX to the Social Security Act, 42 U.S.C. §§ 1396-1396w-5. The purpose of Medicaid is, in part, to “enable each state to furnish rehabilitation and other services to help . . . [aged, blind, or disabled] individuals attain or retain capability for independence or self-care....”¹ State participation in Medicaid is optional. However, once a state chooses to participate, and thereby receive federal matching funds for program expenditures, it “must comply with requirements imposed both by the Act itself and by the Secretary of Health and Human Services.”²

Participating states must provide medical assistance for individuals identified as “categorically needy,” a group that consists of individuals who are aged, blind, or disabled, working disabled individuals, and children and pregnant women who meet

¹ 42 U.S.C. § 1396-1.

² *Schweiker v. Gray Panthers*, 453 U.S. 34, 37 (1981).

eligibility requirements for specified cash assistance programs or fall below federal poverty level standards.³ States may also provide medical assistance to other, optionally categorically needy individuals as well as the “medically needy”—those who would qualify for Medicaid but for excess income.⁴

In addition to deciding which population groups will receive medical assistance, the state determines which services it will cover.⁵ The Medicaid Act mandates inclusion of eight enumerated services.⁶ A state may also opt to provide other services, such as prescription drugs, dental services, and prosthetic devices.⁷ Once a state elects to provide a service, whether mandatory or optional, it becomes part of the state Medicaid plan, and the state “must comply with all federal statutory and regulatory mandates.”⁸

Of note, for all Medicaid beneficiaries entitled to nursing facility services, states *must* cover home health services.⁹ This includes the basic categorically needy population groups and can include medically needy populations if nursing facility services are offered to the medically needy within the state. The home health service must include: (1) nursing services, as defined in the state’s nurse practice act; (2) home health aide services provided by a home health agency; and (3) medical supplies, equipment, and appliances.¹⁰ At state option, the home health service can also include physical therapy, occupational therapy, or speech pathology and audiology services.¹¹

The Final Rule

On February 2, 2016, CMS issued a Final Rule amending the existing Medicaid home health regulation.¹² Disability rights advocates welcomed the rule, which is a long-overdue finalization of a regulation originally proposed in 2011.¹³ The Rule does the following:

³ 42 U.S.C. § 1396a(a)(10)(A)(i).

⁴ *Id.* §§ 1396a(a)(10)(A)(ii) and (C); *Gray Panthers*, 453 U.S. at 37.

⁵ *See* 42 U.S.C. §§ 1396a(a)(10), 1396d(a).

⁶ 42 U.S.C. §§ 1396a(a)(10), 1396d(a)(1)-(5), (17), (21), (28) (listing: inpatient hospital, outpatient hospital, laboratory and x-ray, nursing facility, physician, nurse-midwife, nurse-practitioner, and freestanding birth center services)

⁷ *Id.* §1396a(a)(10) and 1396d(a) (listing categories of optional medical assistance). These optional services are required for children under age 21 when needed to “correct or ameliorate” a condition. 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B), 1396d(r).

⁸ *Lankford v. Sherman*, 451 F.3d 496, 504 (8th Cir. 2006) (citation omitted); *see also Weaver v. Reagen*, 886 F. 2d 194, 197 (8th Cir. 1989), *Eder v. Beal*, 609 F. 2d 695, 701-02 (3d Cir. 1979).

⁹ 42 U.S.C. § 1396a(a)(10)(D). For those not entitled to nursing facility services, home health is an optional service, *id.* § 1396d(a)(7).

¹⁰ 42 C.F.R. §§ 440.70(b)(1)-(3), 441.15.

¹¹ *Id.* § 440.70(b)(4).

¹² Medicaid Program; Face-to-Face Requirements for Home Health Services; Policy Changes and Clarifications Related to Home Health, 81 Fed. Reg. 5529 (Feb. 2, 2016) (amending 42 C.F.R. § 440.170).

¹³ *See* 76 Fed. Reg. 41032 (July 12, 2011) (proposed regulation).

- Makes explicit that “[c]overage of home health services cannot be contingent upon the beneficiary needing nursing or therapy services.”¹⁴
- Clarifies that the state cannot deny coverage of medical equipment, appliances or supplies to individuals who have a disability. The previous rule made items available on the basis of “illness or injury,” thus raising concerns that individuals with congenital conditions or developmental disabilities could be denied coverage.¹⁵
- Clarifies that medical supplies, equipment and appliances are covered if they are “suitable for use in any setting in which normal life activities take place...”¹⁶ Thus, the state cannot “prohibit a beneficiary from receiving home health services in any setting in which normal life activities take place,” other than an inpatient facility (e.g., a hospital, nursing facility, or ICF) or a setting in which Medicaid is or could make payment for inpatient services that include room and board. For example, depending on the individual, the setting could be a school.¹⁷

Under the prior rule, some states argued that home health benefits could be limited to a beneficiary’s residence. Courts had held, however, that such a limitation violated the Medicaid Act.¹⁸ *Skubel v. Fuoroli*, for example, prohibited the Connecticut Medicaid program from refusing to cover children’s nursing services during periods when they were engaged in educational and social activities outside the home.¹⁹

- Clarifies that “[h]ome health services cannot be limited to services furnished to beneficiaries who have disabilities or illness sufficiently severe to make them “homebound.”²⁰

Even before this regulation, CMS had informed states they could not impose a homebound requirement as a precondition to receiving home health services.²¹ Nevertheless, some states had maintained restrictive coverage policies.²²

¹⁴ 42 C.F.R. § 440.70(b).

¹⁵ *Id.* § 440.70(b)(3)(ii).

¹⁶ *Id.* § 440.70(b)(3).

¹⁷ 81 Fed. Reg. at 5543.

¹⁸ See *Skubel v. Fuoroli*, 113 F.3d 330 (2d Cir. 1997) (citing *Detsel* and prohibiting state from limiting home health services to child’s residence); *Detsel v. Sullivan*, 895 F.2d 58 (2d Cir. 1990) (invalidating state rule limiting private duty nursing services to recipient's residence).

¹⁹ *Skubel*, 113 F.3d at 338.

²⁰ 42 C.F.R. § 440.70(c)(1).

²¹ See Letter to State Medicaid Directors, *Olmstead Update No. 3* (July 25, 2000) (att. 3-g) (prohibiting a homebound requirement) (on file with author).

²² See Mem. from Office of Inspector General to CMS (July 1, 2013) (listing 11 states with homebound requirements: AL, AR, IN, MT, NE, NM, ND, PA, SD, UT, WV), <http://oig.hhs.gov/oei/reports/oei-07-13-00060.pdf> (last visited Feb. 26, 2016); Letter to Mr.

- Requires the state definition of “supplies” to include “health care related items that are consumable or disposable, or cannot withstand repeated use by more than one individual, that are required to address an individual medical disability, illness or injury.”²³
- Requires the state definition of “equipment and appliances” to include “items that are primarily and customarily used to serve a medical purpose, generally are not useful to an individual to the absence of a disability, illness, or injury, can withstand repeated use, and can be reusable or removable.”²⁴

The previous regulation did not define medical equipment and supplies except to say they should be suitable for use in the home. This made the regulation susceptible to shifting and conflicting implementation within and among states. The revised regulation is intended to ensure that home health benefits, including equipment and supplies “will be available to all who are entitled to the mandatory home health benefit...”²⁵

Under the revised definition, a service or item may fit within more than one Medicaid service category. For example, orthopedic shoes could meet the state’s definition of a prosthetic device (if the state covers this optional service), but orthopedic shoes also meet the definition of medical equipment and appliances and, thus, must be covered under the mandatory home health benefit. According to CMS:

items and services that meet the criteria for coverage under the home health benefit must be covered according to home health coverage parameters. To ensure full coverage for medical equipment and appliances, we will require that, to the extent that there is overlap in coverage with another benefit [citing prosthetics and rehabilitative services], states must nevertheless provide for the coverage of these items under the mandatory home health benefit. . . . [R]egardless of coverage category, the expectation remains that individuals receive all medically necessary medical supplies meeting the definition finalized under this regulation.²⁶

Interestingly, six weeks after the Final Rule was published, the Second Circuit Court of Appeals decided *Davis v. Shah*, holding that New York’s Medicaid program acted illegally when it eliminated coverage of compression stockings and orthopedic shoes for beneficiaries with all but a few conditions.²⁷ While deciding the case on Medicaid’s

Ronald J. Levy, Dir., Mo. Dep’t of Soc. Servs., from Charlene Frizzera, Acting Admin. CMS (Feb. 26, 2010) (citing Missouri for improper homebound requirements) (on file with author).

²³ 42 C.F.R. § 440.70(b)(3)(i).

²⁴ *Id.* § 440.70(b)(ii).

²⁵ *See* 81 Fed. Reg. 5532-33.

²⁶ *Id.* at 5535-36. States also cannot restrict access to equipment that meets the criteria for coverage under the home health benefit by carving out the equipment and offering it only to individuals who qualify for home and community based waiver services. *Id.* at 5538.

²⁷ *Davis v. Shah*, _ F.3d _, 2016 WL 1138768 (2d Cir. Mar. 24, 2016).

comparability-among-beneficiaries requirement and the Americans with Disabilities Act/§ 504, the court included discussion that struggled with the import of the Final Rule, which it described as “so general that, if applied literally ... would mandate the provision of any ‘health care related items’ whatsoever.”²⁸

- Clarifies that Medicaid coverage of equipment and supplies cannot be limited to items covered as DME in the Medicare program.²⁹
- Allows states to use a list of preapproved medical equipment, supplies and appliance for “administrative ease” but prohibits them for imposing absolute exclusions of coverage and requires them to have processes and criteria for individuals to request items not on the list. The process must be made known to individuals, be based on “reasonable and specific criteria,” and include the right to a fair hearing if coverage is denied.³⁰ Notably, this regulation codifies long-standing policy contained in a September 4, 1998 CMS guidance document and its instruction in light of the Second Circuit case, *DeSario v. Thomas*, which was vacated by the Supreme Court.³¹
- Aligns Medicaid with Medicare by providing that payment will not be made for home health services unless the treating physician (or, if applicable, non-physician practitioner) documents that there was a face-to-face encounter with the beneficiary that is related to the primary reason that the individual needs home health. The encounter must occur within 90 days before or within 30 days after the start of the home health services. For the initiation of medical equipment, the face-to-face encounter must be related to the primary reason that the individual needs the equipment, and the encounter must occur no more than six months prior to the start of the service.³² The encounter may occur through telehealth.³³ Note: According to CMS, no law requires this aspect of the Final Rule to apply in Medicaid managed care, and the agency is deferring to the states to determine the application of the face-to-face requirement in managed

²⁸ *Id.* at * 11.

²⁹ 42 C.F.R. § 440.70(b)(ii).

³⁰ *Id.* § 440.70(b)(v).

³¹ Letter to State Medicaid Directors (Sept. 4, 1998) (responding to *DeSario* and requiring states to provide individuals with the opportunity to show that they need items not on the state’s coverage list) (on file with author). See *DeSario v. Thomas*, 139 F.3d 80 (2d Cir. 1998) (allowing exclusive lists in determining coverage of medical equipment), *vacated mem. sub nom. Slekis v. Thomas*, 525 U.S. 1098 (1998), *same case*, No. 396CV646 (D. Conn. June 23, 1999) (settlement agreement eliminating exclusive lists) (on file with author).

³² 42 C.F.R. § 440.70(f). See also 81 Fed. Reg. at 5536 (noting that the encounter can be a well-mom or well-baby visit if, while examining the condition of the mother or child, the provider determines that home health services or equipment is required to address the condition). See 42 C.F.R. § 440.70(f)(3) (describing non-physician practitioners).

³³ *Id.* § 440.70(f)(6). For discussion, see 81 Fed. Reg. at 5556-57.

care “to be meet the needs of their beneficiaries.”³⁴

The rule takes effect on July 1, 2016.³⁵ However, CMS will not require “compliance” with the rule for up to one year if the legislature has met in that year, otherwise for two years.³⁶ There is some indication from the preamble to the Rule that this compliance delay is to allow states and health providers time to implement the face-to-face encounter requirements.³⁷

Conclusion and Recommendations

The Final Rule brings needed clarity to an area of Medicaid coverage that has been confusing and shifting from state-to-state. As states move toward compliance, advocates should be aware that:

- States maintain their authority to define the home health benefit, including medical equipment, appliances and supplies, so long as the definitions are consistent with the Medicaid Act and regulatory framework. States can, continue to place limits on the amount and duration of home health services, including medical equipment, appliances and supplies, so long as those limits must meet the sufficiency requirements set forth in 42 C.F.R. § 440.230. However, the Final Rule clarifies the permissible *scope* of medical equipment, appliances and supplies; thus, scope limitations within state definitions of medical supplies, equipment, and appliances are not consistent with sufficiency of the benefit.

The Medicaid requirements for comparability continue to apply.³⁸ States can also apply medical necessity criteria; however, these “must be based on accepted medical practices and standards.”³⁹

- Home modifications differ from medical equipment. The costs of structural home modifications are not covered under the home health benefit because they would

³⁴ *Id.* at 5537. By contrast, *benefits* offered in managed care must be the same as the benefits offered in the state plan. Therefore, “the approved state plan home health benefit must be offered in managed care.” *Id.* at 5548.

³⁵ 81 Fed. Reg. 5530.

³⁶ *Id.* at 5530.

³⁷ *Compare* 81 Fed. Reg. at 5534-35, 5545 (noting that CMS is delaying compliance with the Medicare face-to-face encounter requirements, using the same one or two year delay based on state legislative sessions) *with id.* at 5545 (noting that restrictions, such as those requiring a home setting, may need to be revised but stating that this “will not be overly burdensome”). Indeed, most of the home health benefit changes are codifying long-standing federal and judicial guidance.

³⁸ *See* 42 U.S.C. § 1396a(a)(10)(B); 42 C.F.R. §§ 440.240(a), (b)(1).

³⁹ 81 Fed. Reg. at 5533.

be costs of shelter. By contrast, medical equipment is “removable.”⁴⁰ To provide a few examples: shower chairs, standing frames, chair lifts, customized wheelchairs, and cochlear implants may all be considered items of medical equipment.⁴¹ CMS notes that states may need to implement standards “to determine coverage of the specific items previously funded under sections 1915(c) or (i), such as ceiling lifts or chair lifts that could now be seen in appropriate circumstances to meet the home health definition and be medically necessary for an individual.”⁴²

- Medical equipment must also be “reusable.” However, as CMS notes, “customization would not necessarily make the items unusable for other individuals.”⁴³ Additional guidance from CMS may be needed to fully understand what sort of customization will cause an item to no longer be considered medical equipment.
- States may need to amend their regulations and policy manuals. Some states may need to amend the state Medicaid plan and home and community based care waivers. Advocates should engage in ongoing monitoring to ensure this process moves as quickly as possible.
- NHeLP continues to assess implementation of the Final Rule and the import of cases, such as *Davis v. Shah*. Please contact us if questions arise in your work.

⁴⁰ *Id.* at 5539. Similarly, vehicular modifications are not medical equipment because, according to CMS, “they are a component of a vehicle that is not medical in nature.” *Id.*

⁴¹ *See* 81 Fed. Reg. at 5538 (“We note that we do not regard this definition to expand the scope of medical equipment to include environmental or structural housing modifications. Nor does it include equipment that is designed to have a general use and will serve more people than just the Medicaid beneficiary.”).

⁴² 81 Fed. Reg. 5542.

⁴³ *Id.* at 5540.