



Q&A

State Medicaid Policy Regarding Exclusive Coverage Lists

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- Q:** My client is a 40-year-old Medicaid enrollee who requested coverage of a microprocessor-controlled lower limb. Her managed care organization denied coverage, citing a state Medicaid policy that lists items excluded from coverage regardless of medical necessity. The microprocessor-controlled limb is on the list. Can we challenge this exclusion?
- A:** Yes. The item may be classified as medical equipment and supplies, which are part of the mandatory Medicaid home health benefit. Under this benefit, states cannot use lists of excluded equipment. Coverage of the requested item may also be required if it falls within another service category that the state has elected to cover, such as prosthetic devices. If this is the case, Medicaid's comparability requirements will come into play. Finally, the Americans with Disabilities Act may be implicated.

Discussion

The Medicaid Act requires participating states to cover certain benefits and gives them the option to cover others. See 42 U.S.C. §§ 1396a(a)(10), 1396d(a). Thus, Medicaid coverage will depend on whether the requested item fits within the definition of a mandatory benefit that the state must cover or an optional benefit that the state has elected to cover.

In this case, there are multiple service categories that may come into play, including:

- **Home health services:** Home health services are a mandatory Medicaid benefit for any individual who is entitled to receive nursing facility services. See 42 U.S.C. § 1396a(a)(10)(D), see, e.g., *Lankford v. Sherman*, 451 F.3d 496 (8th Cir. 2006) (noting that home health is a mandatory requirement if the individual is *entitled to* (but not necessarily receiving) nursing facility services). Home health services are otherwise an optional benefit for adults. 42 U.S.C. § 1396d(a)(7).

The home health service has mandatory and optional components. Medical supplies, equipment, and appliances are part of the mandatory home health benefit that states must cover. See 42 C.F.R. § 440.70. Equipment and appliances are home health under Medicaid if they are “items that are primarily and customarily used to serve a medical purpose, generally are not useful to an individual in the absence of a disability, illness or injury, can withstand repeated use, and can be reusable or removable.” *Id.* § 440.70(b)(3)(ii).

- Prosthetic devices: Prosthetic devices are an optional Medicaid benefit for adults. See 42 U.S.C. § 1396d(a)(12). Prosthetic devices are “replacement, corrective, or supportive devices prescribed by a physician or other licensed practitioner of the healing arts within the scope of his practice as defined by State law to (1) Artificially replace a missing portion of the body; (2) Prevent or correct physical deformity or malfunction; or (3) Support a weak or deformed portion of the body.” 42 C.F.R. § 440.120(c). States must cover prosthetic devices for children and youth under age 21 as a part of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. See 42 U.S.C. §§ 1396a(a)(10)(A), 1396d(r)(5). Insurers that cover microprocessor-controlled limbs often refer to them as prosthetic devices.
- Rehabilitative services. Rehabilitative services are an optional Medicaid benefit for adults. See 42 U.S.C. § 1396d(a)(13)(C). Rehabilitative services are “any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level.” *Id.*; 42 C.F.R. § 440.130(d). States must cover rehabilitative services for children and youth under age 21 as part of the EPSDT benefit. See 42 U.S.C. §§ 1396a(a)(10)(A), 1396d(r)(5).

Reading through these service definitions, it is clear that requested treatments may sometimes fit within more than one coverage category.¹ To illustrate, take augmentative communication devices. These items can be defined as more than one of the services described above. In such cases, the state Medicaid agency cannot shoehorn the requested service into just one coverage category. For example, a state could not classify the augmentative device as a prosthetic and then decline coverage because it has not elected to cover prosthetics. Federal Medicaid law is clear on this point. When the Centers for Medicare & Medicaid Services (CMS) amended the home health regulation in 2016, it expressly agreed with commenters’ position that, when a particular item cannot be covered under one category, states must determine whether it can be covered under another category. See Medicaid Program; Face-to-Face Requirements for Home Health Services; Policy Changes and Clarifications Related to Home Health,

¹ States typically include their own definitions of covered services in their laws and policy manuals. Those definitions should be assessed, keeping in mind that if they conflict with the federal definition, the federal definition will control.

81 Fed. Reg. 5530, 5535 (Feb. 2, 2016) (codified at 42 C.F.R. § 440.70). There is also case support for this principle. See, e.g., *Conley v. Dep't of Health*, 287 P.3d 452 (Utah Ct. App. 2012) (holding state Medicaid agency could not restrict coverage of augmentative speech devices to a particular coverage category when the device also fit within other categories such as home health); *but see Davis v. Shah*, 821 F.3d 231, 250 (2d Cir. 2016) (finding orthopedic footwear and compression stockings to be prosthetics under New York law, not home health).

In this case, it can be argued that the limb fits within multiple coverage categories, including home health medical supplies, equipment, and appliances.

This brings us to the exclusionary coverage list. At one time, a number of state Medicaid programs employed lists that excluded coverage of certain medical equipment regardless of medical necessity. As might be expected, these lists were challenged in court. The most notable case is *DeSario v. Thomas*, 139 F.3d 80 (2nd Cir. 1998), *cert. granted, vacated and remanded sub nom Slekis v. Thomas*, 525 U.S. 1098 (1999).

DeSario concerned a Connecticut Medicaid policy that set a fee schedule for different items of medical equipment. *Id.* at 83. The policy also listed items of medical equipment that were excluded from coverage regardless of whether they were medically necessary. Medicaid beneficiaries who needed excluded equipment sued to enjoin the policy. However, the Second Circuit Court of Appeals decided that Connecticut was not required to cover the excluded items so long as the health care provided was adequate to meet the needs of the Medicaid population as a whole. *Id.* at 94. The Court also said the list was not an unreasonable Medicaid standard, pointing to similar definitions in the Medicare program and noting that the federal government had endorsed the State's policy. *Id.* at 89.

After the Second Circuit issued its opinion in *DeSario*, the Health Care Financing Administration (predecessor agency to CMS) issued a Letter to State Medicaid Directors responding to the case. See Dep't of Health & Human Servs., Health Care Fin. Admin., Dear State Medicaid Director Letter (Sept. 4, 1998), <https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD090498.pdf>. The Letter rejected the "population as a whole" test employed by the Second Circuit because it failed to afford beneficiaries a meaningful opportunity to seek an exception. *Id.* It required states to provide individuals with the opportunity to show that they needed items not on a state's coverage list. And while a state could use a list of pre-approved medical equipment "as an administrative convenience because such a list eliminates the need to administer an extensive application process for each request submitted," the Letter warned states that a medical equipment policy "that provides no reasonable and meaningful procedure for requesting items that do not appear on a State's pre-approved list, is inconsistent with" the Medicaid Act and regulations. *Id.* (citing 42 U.S.C. § 1396a(a)(17) (requiring reasonable standards), 42 C.F.R. § 440.230(b) (requiring a sufficient amount, duration, and scope of coverage), and 42 C.F.R. § 440.230(c) (prohibiting coverage denial based on the diagnosis, type of illness, or condition). Thereafter, the Supreme Court vacated *DeSario* and remanded the case for further

consideration “in light of the interpretive guidance issued by on September 4, 1998.” *Slekis v. Thomas*, 525 U.S. 1098 (1999).

Federal Medicaid regulations, issued in 2016, codify the 1998 State Medicaid Director Letter. These regulations provide that:

States can have a list of preapproved medical equipment supplies and appliances for administrative ease but States are prohibited from having absolute exclusions of coverage on medical equipment, supplies, or appliances. States must have processes and criteria for requesting medical equipment that is made available to individuals to request items not on the State's list. The procedure must use reasonable and specific criteria to assess items for coverage. When denying a request, a State must inform the beneficiary of the right to a fair hearing.

42 C.F.R. § 440.70(b)(3)(v).

In sum, states cannot use exclusionary lists of medical equipment. States can list preapproved medical equipment, supplies and appliances for “administrative ease” but cannot impose absolute exclusions on coverage. If using a preapproved list, the state must have processes and criteria for individuals to request unlisted items. 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.

In addition to explaining how the limb is home health medical equipment, the argument can be made to classify the item as a prosthetic device if the state has opted to cover this service. In these instances, Medicaid “comparability” provisions come into play. The Medicaid Act generally requires that the medical assistance made available to a covered individual cannot be less in amount, duration, or scope than the medical assistance made available to any other such individual. See 42 U.S.C. § 1396a(a)(10)(B). Thus, the amount and scope of covered prosthetics cannot be less for individuals who have one type of disability as opposed to another. Federal regulations also require the coverage of prosthetic devices to be sufficient in amount, duration, and scope to reasonably achieve the purpose of the coverage. See 42 C.F.R. § 440.230(b).

Conclusion and Recommendations

Federal regulations and case law make it illegal for state Medicaid programs to use exclusionary lists of medical equipment. Unfortunately, some states have not revisited their policies since the 2016 issuance of the federal regulations. As a result, advocates should:

1. Review state coverage rules and policy manuals to confirm that the state is not using an exclusionary list. If such a list is being used, or if the state’s process for covering items that are not on a pre-approved coverage list is inconsistent with

42 C.F.R. § 440.70, consider writing a letter to the state Medicaid agency informing it of the problem and asking to meet with Medicaid officials to resolve it.

2. If the state continues to use the exclusionary list, investigate whether legal action can be taken. In addition to researching the potential coverage categories for the item (e.g., home health, prosthetics), it will be important to verify the scope of the state's policies. For example, check the state EPSDT benefit to determine whether the item can be covered for a Medicaid beneficiary under the age of 21. If so, this will be an important counter to any argument by the state that the item cannot be covered because it is experimental or investigational.
3. As in any case, verify the facts. Among other things, the treating provider must explain why the item is medically necessary as opposed to preferred. Use of the item on a trial basis, with before-and-after documentation, can be helpful.

It will also be helpful to point out whether other insurers cover the treatment. In the case of microprocessor-controlled limbs, some private insurers have coverage protocols. See, e.g., BlueCross BlueShield of N.C., *Corporate Medical Policy-Microprocessor-Controlled Prostheses for the Lower Limb* (Feb. 2019), https://www.bluecrossnc.com/sites/default/files/document/attachment/services/public/pdfs/medicalpolicy/microprocessor_controlled_prostheses_for_the_lower_limb.pdf; Tufts Health Plan, *Medical Necessity Guidelines: Lower Limb Prosthetic Devices* (July 1, 2019), <https://tuftshealthplan.com/documents/providers/guidelines/medical-necessity-guidelines/lower-limb-prosthetic>. Medicare has also developed coverage policies. See Ctrs. for Medicare & Medicaid Servs., *Lower Limb Prosthetics Work Group Consensus Document* (Sept. 2017), https://www.cms.gov/Medicare/Coverage/DeterminationProcess/downloads/LLP_Consensus_Document.pdf.

4. In addition to focusing on Medicaid law, consider whether the facts support an Americans with Disabilities Act (ADA) claim. This could be argued in a couple of ways: non-coverage may be creating a serious risk of placement in a facility. In the alternative, non-coverage may be causing the client to be unable to access the community settings where people without disabilities pursue daily activities. See, e.g., *Steimel v. Wernert*, 823 F.3d 902 (7th Cir. 2016) (holding unjustified isolation is discrimination under the ADA); *Guggenberger v. Minn.*, 198 F. Supp. 3d 973 (D. Minn. 2016) (finding isolation and segregation from community activities actionable under the ADA).