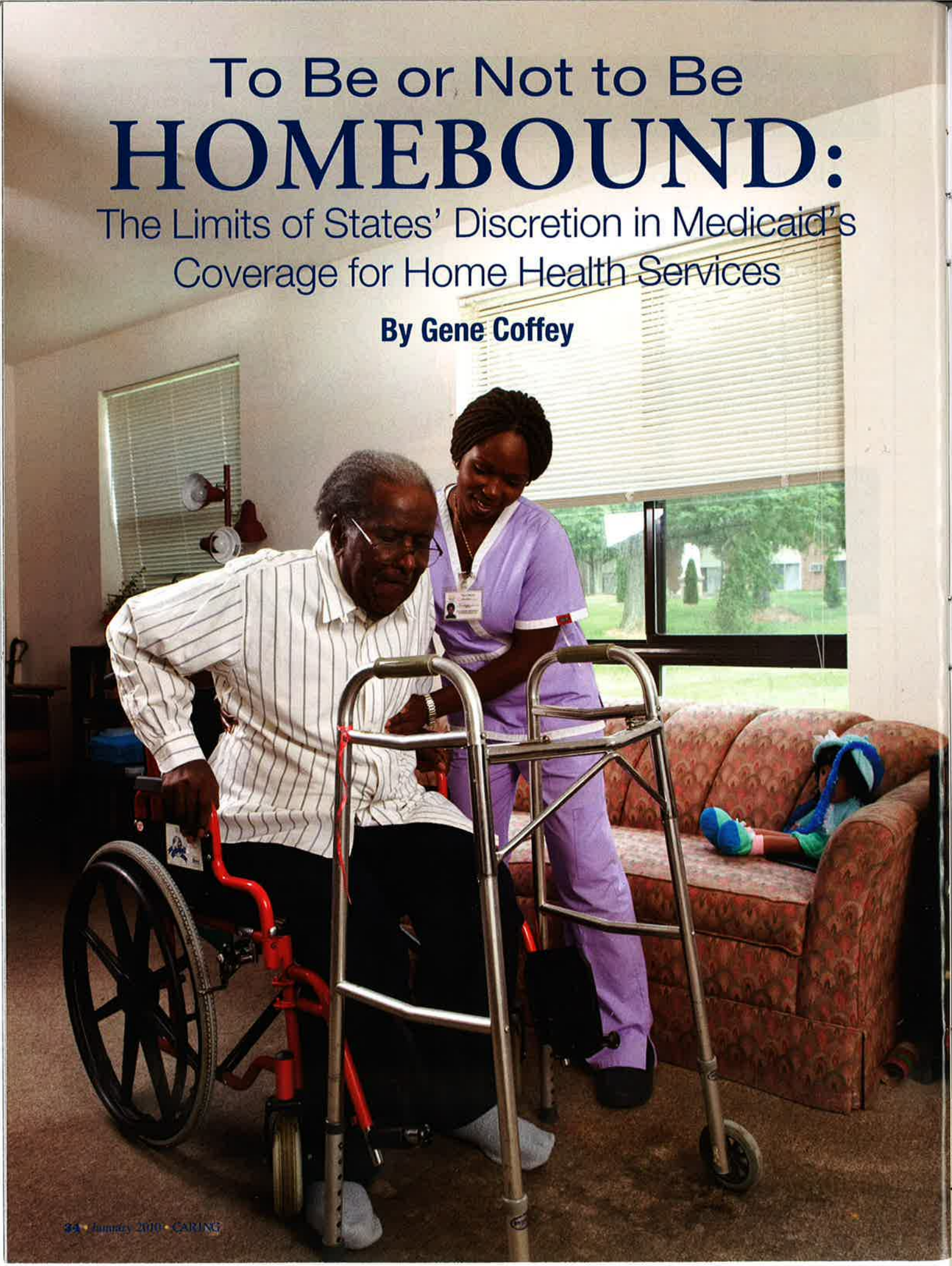
To Be or Not to Be HOMEBOUND:

The Limits of States' Discretion in Medicaid's Coverage for Home Health Services

By Gene Coffey



Medicaid's coverage for home health services is a critical source of support for individuals with chronic needs. Generally, the Medicaid services available to individuals striving to stay in the community, such as personal care services or a package of home and community-based services delivered through a waiver or state plan benefit, are completely at state option to provide.

The home health benefit, however, has the unique status in the Medicaid program of being a mandatory community-based service that is long-term in nature. Furthermore, while many Medicaid recipients are also enrolled in Medicare (the "dual eligibles") and thereby may receive Medicare coverage for home health care services, Medicaid's home health eligibility requirements are less restrictive than Medicare's, which may provide these individuals with greater access to the service.

But as with many other Medicaid services, disputes relating to eligibility for home health services occasionally arise. An example is a Missouri Medicaid regulation that requires Medicaid enrollees to be "confined to the home" in order to receive coverage for home health services.[1] On October 30, 2009, the Centers for Medicare & Medicaid Services (CMS) wrote Missouri Medicaid officials to advise them that they had 30 days from their receipt of the notice to submit a state plan amendment eliminating the requirement or face compliance proceedings that could result in the withholding of federal reimbursement for the state's Medicaid expenditures.[2]

This issue brief provides an overview of the boundaries of a state's Medicaid home health service standard, including a discussion of the controversy in Missouri, in order to provide useful background for advocates trying to maximize the community-based options of persons with chronic needs.

Medicaid's Home Health Benefit

Federal law dictates that states must provide Medicaid coverage for home health services to: categorically needy recipients age 21 years and older; categorically needy recipients under age 21 if nursing facility services are available to them under the state plan; and medically needy recipients if nursing facility services are available to them under the state plan.[3]

The benefit itself must include, at a minimum, nursing services, home health aide services, and medical supplies, equipment and appliances.[4] Nursing services are defined in the federal regulations as services that meet the definition of nursing in the state's Nurse Practice Act and are provided on a part-time or intermittent basis by a qualified home health agency, or, in the absence of an agency, by a registered nurse who is licensed to practice in the state.[5] With regard to home health aide services, the federal regulations list many different competencies that a home health aide must demonstrate.[6] However, the regulations do not specifically identify what a home health aide must do, which means that "states have great flexibility in choosing which competencies they want their aides to focus on. . . . This flexibility is by design, allowing states to best address the needs of their target populations."[7]

The medical equipment element offers broad coverage to recipients of home health services for those items that are medically necessary. States may develop lists of pre-approved items "as an administrative convenience."[8] However, a state that does so must provide a "meaningful opportunity" for a home health services recipient to request any item that does not appear on the list.[9]

In addition to these mandatory elements of the home

health services benefit, states may also offer coverage under the home health benefit for physical, occupational and speech therapy, and indeed, most states do include therapies in their home health benefit.[10]

Because, however, of the high costs states incur in the operation of their Medicaid programs, states may attempt to contain their spending for services such as home health services through the imposition of a standard of medical need. States generally have the discretion to place "appropriate limits" on the coverage for a service through a medical necessity test,[11] but where are those limits as they relate to Medicaid's coverage of home health services?

Federal Regulations and CMS Guidance

To begin with, there is a requirement that states must impose on Medicaid enrollees seeking coverage for home health services. Specifically, coverage is limited to Medicaid beneficiaries who have been prescribed home health services by a physician as part of a written plan of care that is reviewed by the physician every 60 days.[12] The regulations also contain a clear limitation on the states' ability to restrict home health benefits, in that the state may not condition a Medicaid beneficiary's receipt of home health coverage on the individual's need for institutional care.[13] So what additional restrictions, if any, may states impose between these boundaries? Nothing else is contained in the regulations, but further guidance has been provided by CMS in the form of policy statements, the primary one being a letter the agency sent to state Medicaid directors in 2000.

The letter followed the U.S. Supreme Court's ruling in Olmstead v. L.C., 527 U.S. 581 (1999), that the Americans with Disabilities Act (ADA) requires states, in the operation of state programs such as Medicaid, to attempt to serve people with disabilities in the most integrated settings possible. Shortly after this ruling, CMS (then the Health Care Financing Administration, or HCFA) began transmitting a series of "Olmstead" letters to state Medicaid agencies. One of the first was sent in January 2000, in which CMS "strongly urge[d]" states "to increase access to community-based services for individuals with disabilities by developing comprehensive, effectively working plans for ensuring compliance with the ADA."[14] CMS also pledged in the letter to "review relevant federal Medicaid regulations, policies and previous guidance to assure that they (a) are compatible with the requirements of the ADA and the Olmstead decision, and (b) facilitate States' efforts to comply with the law."[15]

Medicaid's home health standard ended up being part of this review. On July 25, 2000, the agency sent a letter to state Medicaid directors informing them that, among other things, they were prohibited from requiring that Medicaid enrollees be "homebound" in order to receive coverage for home health services.[16] The agency stated, "While current regulations specify that [home health] services must be provided to an individual at his place of residence, it is not necessary that the person be confined to the home for the service to be covered under the Medicaid home health benefit. The 'homebound' requirement is a Medicare requirement that does not apply to the Medicaid program."[17] (Emphasis provided).

CMS went on to explain in the letter that denying coverage to individuals because they are not homebound violates the prohibition in 42 C.F.R. §440.230(c) against the arbitrary denial of a required service based on the individual's diagnosis, type of illness or condition.[18] CMS further asserted that a homebound limitation violates the requirement in 42 C.F.R. §440.240(b) that states must provide services "equal in amount, duration and scope for all recipients" within a covered group.[19] Summing up, the agency proclaimed that "the restriction of home health services to persons who are homebound to the exclusion of other persons in need of these services ignores the consensus among health care professionals that community access is not only possible but desirable for individuals with disabilities."[20]

Missouri's Story

At the time the letter was written, Missouri had a "homebound" requirement in its Medicaid home health regulation, which it did not modify in the aftermath of the CMS letter. Missouri's regulation, then and now, dictates that a Medicaid enrollee's coverage for home health is contingent on the indi-

vidual being "confined to his/her home," which the regulation defines as being the circumstance when the individual "has a condition due to an injury or illness which restricts his/her ability to leave his/her place of residence except with the aid of supportive devices, the use of special transportation or the assistance of another person, or if s/he has a condition which is such that leaving his/her home or traveling to obtain the needed healthcare is medically contraindicated."[21] This standard was reflected in Missouri's state Medicaid plan, which indicated that "[t]o be eligible for home health services, a recipient must require the services of a skilled nurse or therapist . . . and be confined to his home."[22]

CMS' attention was drawn to this element of Missouri's home health regulation in 2005, when Missouri attempted to make changes to its coverage for durable medical equipment (DME) under its state plan. Missouri's proposed amendments to its state plan reflected that DME coverage under the home health benefit would be restricted to individuals who were homebound.

Referencing the July 25, 2000, Olmstead letter that clarified that a homebound requirement is illegal, CMS instructed Missouri to remove the homebound requirement from its state plan.[23] While Missouri eventually removed some of the contested elements from its state plan, it did not revise its regulation and continued to apply the homebound requirement, despite efforts by advocates and additional advisories from CMS.[24] The most recent letter to the state agency makes clear, however, that administrative action will commence if the state fails to bring its standard into compliance with the law.

Need for Skilled Care or Therapy Requirement

Missouri's "home confinement" requirement is not the only element of its home health standard that CMS instructed the state to remove. Note again that CMS stated in its 2000 guidance on the homebound requirement that it is a "Medicare requirement that does not apply to the Medicaid program."[25] The Medicare statute itemizes requirements that pertain to coverage for home health services. Specifically, coverage is limited to circumstances in which the individual "is or was confined to his home . . . and needs or needed skilled nursing care . . . on an intermittent basis or physical or speech therapy or, in the case of an individual who has been furnished home health services based on such a need and who no longer has such a need for such care or therapy, continues or continued to need occupational therapy."[26]

The Medicaid statute's home health provision lacks any reference to the need for skilled care or therapy services, which should render these requirements indistinguishable from the homebound requirement as they relate to Medicaid's coverage for the services. Missouri's regulation, however, requires Medicaid recipients to have a need for either intermittent skilled nursing care or physical, occupational or speech therapy in addition to being confined to the home. If the state's homebound requirement is illegal, it would seem to follow that the state's requirement that a Medicaid beneficiary demonstrate a need for intermittent skilled nursing services or therapy would be as well.

While CMS did not reference these other elements in the most recent letter it wrote to Missouri officials, the agency did address these elements in the 2005 letter, as well as in a recent letter sent to a Missouri advocate by the agency's Center for Medicaid & State Operations.[27] In the 2005 letter, CMS stated, "Also, the state may not require that an individual require the services of a skilled nurse or therapist in order to receive either the services of a home health aide, or medical equipment and supplies under home health."[28] These elements were part of the same provision of the state plan that CMS instructed the state agency to delete in the letter.

While CMS has not issued a letter to all state agencies that expressly rejects the inclusion of a need for skilled care or therapies in a Medicaid home health standard as it did

on the homebound issue, its rejection of these elements in the individual letters it has sent reflects a consistency in the agency's approach to the clinical elements identified in the Medicare home health statute—that they may not be imposed against Medicaid beneficiaries. Indeed, that the Medicare and Medicaid home health standards are separate and distinct was recognized even before the July 2000 Olmstead letter.[29]

Moving Forward

Given this background, it will be especially interesting to see if Missouri's "skilled" and "therapy" need requirements will also be removed as the state proceeds to bring its state Medicaid plan into compliance with federal law.

Historically, many battles relating to Medicaid's home health coverage have centered on individuals who have been determined eligible for the benefit but have alleged a denial of an appropriate scope of coverage,[30] especially coverage for medical equipment.[31] The Missouri example, however, demonstrates that the battle may still take place on the front end; i.e., in the initial evaluation of eligibility. Because, as CMS itself has recognized, Medicaid's coverage for home health services plays a critical role in helping individuals stay in their homes and communities while also helping states meet their responsibilities under the ADA, advocates should review their own state Medicaid home health standards to ensure that it provides appropriate access to Medicaid beneficiaries in need of the services.

NAHC thanks the National Senior Citizens Law Center (NSCLC) and author Gene Coffey for permission to reprint this article. For more information, please contact Gene Coffey in NSCLC's DC office, Eric Carlson in NSCLC's LA office, or Anna Rich in NSCLC's Oakland office.

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End Notes:

1 Mo. Code Regs. Ann. Title 13, §70-90.010.

2 Letter from Jackie Glaze, Acting Associate Regional Administrator for Medicaid and Children's Health Operations to Ronald J. Levy, Director of the Missouri Department of Social Services (October 30, 2009) (letter on file with author).

3 42 U.S.C. §1396a(a)(10)(D); 42 C.F.R. §441.15(b).

4 42 C.F.R. §§440.70(b), 441.15(a).

5 42 C.F.R. §440.70(b)(1).

6 42 C.F.R. §484.36.

7 Jason Moran-Bates & Sarah Somers, National Health Law Program, Medicaid Coverage of Home Health Aide Services 3 (2008).

8 Letter from the Center for Medicaid and State Operations to State Medicaid Directors (September 4, 1998), available at http://www.cms.hhs.gov/smdl/downloads/SMD090498.pdf.

9 Id.

10 Audra T. Wenzlow, Robert Schmitz and Kathy Shepperson, Mathematica Policy Research, Inc., A Profile of Medicaid Institutional and Community-Based Long-Term Care Service Use and Expenditures Among the Aged and Disabled Using MAX 2002: Final Report (U.S. Department of Health and Human Services), January 2008, available at http://aspe.hhs.gov/daltcp/reports/2008/profileMAXes.htm.

11 42 C.F.R. §440.230(d).

12 42 C.F.R. §440.70(a)(2).

13 42 C.F.R. §441.15(c).

14 Letter from the Center for Medicaid and State Operations to State Medicaid Directors 5 (January 14, 2000), available at http://www.cms.hhs.gov/smdl/downloads/smd011400c.pdf.

15 Id. at 10.

16 Letter from the Center for Medicaid and State Operations to State Medicaid Directors (July 25, 2000), available at http://www.cms.hhs.gov/smdl/downloads/smd072500b.pdf.

17 Id. at 22.

18 Id.

19 Id.

20 Id, at 22-23.

21 Mo. Code Regs. Ann. Title 13, §70-90.010(3).

22 See Letter from James G. Scott, Associate Regional Administrator for Medicaid and Children's Health, to Gary Sherman, Director of the Missouri Department of Social Services 3 (Nov. 21, 2005) (on file with author).

23 Id. at 2-3.

24 See Letter from Joel Ferber and Jeff Herman, Legal Services of Eastern Missouri, to Ian McCaslin, Director, Missouri HealthNet Division (September 9, 2008); Letter from Letter from Jackie Glaze to Ronald J. Levy 2 (October 30, 2009) (letters on file with author).

25 See note 17 supra

26 42 U.S.C. §1395f(a)(2)(C) (emphasis provided).

27 Letter from Cindy Mann, Director, CMS Center for Medicaid & State Operations to Joel Ferber, Legal Services of Eastern Missouri, Inc. (November 4, 2009) (letter on file with author).

28 Letter from James G. Scott to Gary Sherman 2 (November 21, 2005).

29 " . . . [T]he home health services provisions in the Medicare statute and those in the Medicaid statute are not analogous." Skubel v. Fuoroli, 113 F.3d 330, 336 (2nd Cir. 1997).

30 See e.g., Crabtree v. Goetz, 2008 WL 5330506 (M.D.Tenn. December 19, 2008); Skubel v. Fuoroli, 113 F.3d 330 (2nd Cir. 1997); Deluca v. Hammons, 927 F.Supp. 132 (S.D.N.Y. 1996).

31 See e.g., S.D. ex rel. Dickson v. Hood, 391 F.3d 581 (5th Cir. 2004); Blue v. Bonta, 99 Cal.App.4th 980 (2002); Esteban v Cook, 77 F.Supp.2d 1256 (S.D.Fla. 1999); Bell v. Agency for Health Care Admin., 768 So.2d 1203 (Fla.Ct. App. 2000); Hodges v. Smith, 910 F.Supp. 646 (N.D.Ga. 1995); Deluca v. Hammons, 927 F.Supp. 132 (S.D.N.Y. 1996).