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DLC Disability Law Center, Inc.

August 27, 2018

Daniel Tsai, Assistant Secretary for MassHealth
Executive Office of Health and Human Services
One Ashburton Place, 11th Floor
Boston, MA 02108

Re: Beneficiary Access to Home Health and DME and MassHealth Compliance with Home Health Regulations at 42 CFR § 440.70

Dear Assistant Secretary Tsai,

We appreciate that MassHealth has been open to engaging with beneficiaries and advocates on changes in the delivery of long term services and supports. We are writing to bring to your attention the need for MassHealth to make further amendments to its policies and regulations for authorization of home health agency and durable medical equipment and medical supplies (DME) in order to comply with federal Medicaid regulations at 42 CFR § 440.70 (81 Fed. Reg. 5530 (Feb. 2, 2016). MassHealth amended its home health agency regulations effective in July 2017 to add the face-to-face provision required by the 2016 regulations, but MassHealth regulations are not in compliance with other important provisions of the rule. Our organizations have past and current clients denied home health aide services and DME based on MassHealth policies that do not comply with federal law. We ask that the Office of Medicaid immediately issue a Provider Bulletin bringing its policies into compliance with federal law and meet with stakeholders on necessary amendments of the regulations and managed care contracts to ensure that "beneficiaries receive the home health benefits to which they are entitled to under the Medicaid statute." 81 Fed. Reg. at 5545.

Home health aide services are unlawfully conditioned on a skilled nursing or therapy need

<u>MassHealth regulations explicitly condition home health aides on a concurrent skilled nursing or therapy need</u>

MassHealth regulations explicitly state that a condition for payment of medically necessary home health aide services is that such services "are provided pursuant to skilled nursing or therapy services." 130 CMR § 403.416(A)(1). Elsewhere, the regulations provide that "[t}he MassHealth agency pays for nursing visits and home health aide services provided pursuant to a need for skilled nursing services." 130 CMR § 424. The MassHealth Guidelines for Medical Necessity Determination for Home Health Services state

that "[Home Health Aides] provide health-related personal care in the home when the member has a concurrent specific skilled need for which the home health agency registered nurse or physical, occupational or speech-language therapist is treating the member, and there is a subsequent need for assistance with personal care." (Section II. A. 3. h).

Federal Medicaid regulations explicitly prohibit States from conditioning home health services, such as home health aides, on the existence of a skilled nursing or therapy need

Conditioning home health aide services on the existence of a skilled nursing or therapy need is expressly prohibited by federal law. Federal regulations define home health services as including home health aides and explicitly provide that "[c]overage of home health services cannot be contingent upon the beneficiary needing nursing or therapy services." 42 CFR § 440.70(b). This clarifying language was added in 2016. 81 Fed. Reg. 5530, 5566 (Feb 2, 2016). In the preamble to the 2016 rule, CMS stated,

> "We have revised § 440.70(b) to clarify that coverage of Medicaid home health services cannot be contingent upon the beneficiary needing nursing or therapy services. We do not believe it is an accurate reading of section 1902(a)(10)(D) or the Act, or § 441.15 to impose such a requirement." 81 Fed Reg. at 5533.

In a recent bulletin concerning state compliance with the Medicaid home health final regulation, CMS stated that it will not excuse a delay in state compliance for certain provisions which codify "longstanding Medicaid home health policy [including]: The prohibition on requiring that the availability of all home health service is contingent upon the individual needing nursing or therapy services found in § 440.70(b)." CMCS Informational Bulletin from Timothy B. Hill, Acting Director, Center for Medicaid and CHIP Services, Compliance with Medicaid Home Health Final Regulations, April 5, 2018.

MassHealth members have been denied medically necessary home health services based on the state's unlawful policy

MassHealth members have been and continue to be denied medically necessary home health aide services based on this rule. For example, a child represented by HLA had been receiving 34 hours a week of home health aide services with an RN visit every 60 days. MassHealth determined that the child had no skilled nursing need, and therefore his home health aide hours should be gradually reduced to zero. He was 8 years old, diagnosed with autism, fed through a G-tube, legally blind, developmentally delayed and one of several children with complex needs living in the home. The home health aides provided help with multiple activities of daily living and monitoring for self-injurious behavior. In her written decision dated May 9, 2017, the hearing officer stated, "MassHealth indicated in its testimony that the basis for its action was that the appellant failed to demonstrate a medically predictable, recurring need for nursing services..). I agree." The hearing officer upheld the elimination of home health aide hours based on the lack of a skilled nursing need.

It is clear that MassHealth policy and practice condition home health aide services on the existence of a skilled nursing or therapy need, and that this results in beneficiaries being denied home health services. It is equally clear that this policy and practice violates federal law.

Certain Durable Medical Equipment and Supplies (DME) are unlawfully restricted to Medicare covered DME

MassHealth regulations exclude certain types of DME based on Medicare coverage determinations

MassHealth regulations setting out the medical necessity criteria for DME require that "[i]f the MassHealth agency has not published product-specific medical necessity guidelines, DME providers must adhere to the Current Local Coverage Determination (LCD) policy developed by the Centers for Medicare and Medicaid Services (CMS) when determining medical necessity." 130 CMR § 409.417. This policy is effectively a blanket exclusion of certain types of DME because the DME is not covered by Medicare.

Federal Medicaid regulations define DME more broadly than Medicare, prohibit blanket exclusions of DME, and explicitly state that Medicaid coverage of DME is not restricted to items covered as DME in Medicare

Federal Medicaid regulations define mandatory coverage for "medical supplies, equipment, and appliances suitable for use in any setting in which normal life activities take place." 42 CFR § 440.70(b)(3) (hereafter referred to as DME). The regulations define both "medical supplies" and "equipment and appliances" and explicitly state that "State Medicaid coverage of equipment and appliances is not restricted to the items covered as durable medical equipment in the Medicare program." 42 CFR § 440.70(b)(3)(ii).

According to CMS, the Medicaid definition, "unlike Medicare" does not "limit equipment to items used in the home." 81 Fed. Reg. at 5532. The Medicaid definitions "were intended to ensure that …[i]tems that meet the criteria for coverage under the home health benefit would be covered as such." 81 Fed Reg at 5532-3. The regulations expressly provide that, "[n]othing in this section should be read to prohibit a beneficiary from receiving home health services in any setting in which normal life activities take place" excluding only certain medical facilities. 42 CFR § 440.70(c)(1).

Other long-standing CMS sub-regulatory policies such as prohibiting States from having "absolute exclusions of coverage" on DME, and requiring States to have "processes and criteria for requesting …items not on a State's [preapproved] list" are now set out in regulation. 42 CFR § 440.70(b)(3)(v).The April 2018 CMCS Informational Bulletin cited earlier stating that CMS will not grant States flexibility to vary from "longstanding Medicaid home health policy" includes among these longstanding policies the prohibition on exclusive lists of DME and the prohibition on requiring that a beneficiary be homebound or that services be limited to the home.

MassHealth members have been denied medically necessary DME based on the state's unlawful policies

MassHealth members have been and continue to be denied medically necessary DME based on Medicare criteria that are more restrictive than Medicaid permits. For example, a MassHealth member with Multiple Sclerosis represented by DLC was denied approval for a specialized wheelchair for which there was no specific MassHealth medical necessity guideline. A Medicare LCD provided that Medicare

considers only what the beneficiary needs to perform mobility related ADLS in the home, and that the added capability of the specialized wheelchair at issue was not needed for use in the home. The MassHealth agency representative testified at the hearing that MassHealth relied on this Medicare-related criterion in denying coverage for the wheelchair.

Thus, once more it is clear that MassHealth policies and practices unduly restrict coverage of certain types of DME with the result that beneficiaries are denied medically necessary DME. It is equally clear that these policies and practices violate federal law.

We ask that the Office of Medicaid immediately issue a Provider Bulletin: 1. Eliminating the requirement that home health aide services be contingent on a skilled nursing or therapy need, 2. Adopting the federal Medicaid definition of DME, and 3. Eliminating reliance on Medicare LCDs in determining medical necessity for DME. These changes will also require corresponding clarification in managed care contracts for beneficiaries receiving home health and DME through managed care. We also hope that after issuing a Provider Bulletin, the Office of Medicaid will consult with stakeholders on necessary amendments of the regulations, forms and related MassHealth policies and practices.

We are available to meet with you in regard to the contents of this letter. Please let us know how the Office of Medicaid intends to proceed.

Yours truly,

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