



DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201



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TO: Marilyn Tavenner
Administrator
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/S/

FROM: Stuart Wright
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SUBJECT: Memorandum Report: *Some States Improperly Restrict Eligibility for Medicaid Mandatory Home Health Services*, OEI-07-13-00060

This memorandum report assesses the extent to which States have policies that improperly restrict eligibility for Medicaid mandatory home health services to homebound individuals. Under the mandatory home health benefit, States must provide certain home health services to Medicaid beneficiaries who are entitled to nursing facility care. Federal regulations prohibit the arbitrary denial or reduction of the amount, duration, and scope of a required service on the basis of a beneficiary's diagnosis, type of illness, or condition. In a 2000 policy letter, the Centers for Medicare & Medicaid Services (CMS) notified State Medicaid agencies that restricting eligibility for home health services to homebound individuals violates these regulations because (1) the scope of the medical assistance made available to non-homebound individuals is reduced and (2) such restrictions result in services being denied on the basis of a beneficiary's condition (i.e., not being homebound).

SUMMARY

For all States, we reviewed the sections of the Medicaid State plans (State plans) and current State policies that define eligibility for the mandatory home health benefit. Eleven States have improper eligibility restrictions on the mandatory home health benefit in the policy documents we reviewed. The written policy for one of these eleven States made exceptions to its restrictions in certain circumstances. For two other States, staff explained that the restrictions had been incorrectly included in their States' policies and were not being enforced.

BACKGROUND

Medicaid Home Health Services

Sections 1902(a)(10)(D) and 1905(a)(7) of the Social Security Act (SSA) establish the mandatory home health benefit in the Medicaid program. Under the mandatory home health benefit, States must provide the following services to Medicaid beneficiaries who are entitled to nursing facility care: nursing care, home health aides, and medical supplies, equipment, and appliances.¹ Under this benefit, States may also provide optional home health services, including physical therapy, occupational therapy, and speech pathology and audiology services. States must offer mandatory home health services to Medicaid beneficiaries who are entitled to nursing home care, but States may not condition receipt of services on the need for institutional care.² In 2011, States spent \$4.9 billion on mandatory home health services.^{3, 4}

Medicaid State Plans

State plans detail how each State administers its Medicaid program, what services will be covered for which eligibility groups, and how services will be paid. To change any part of an existing State plan, a State must submit a State plan amendment (SPA) to the appropriate CMS regional office. CMS reviews the SPA and either approves it or communicates with the State regarding necessary changes.⁵ Once an SPA is approved, it becomes part of the State plan.

State Restrictions on Eligibility for Home Health Services

Federal regulations require that Medicaid services made available to any categorically or medically needy individual shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual.⁶ Furthermore, Federal regulations prohibit the arbitrary denial or reduction of the amount, duration, and scope of a required service on the basis of a beneficiary's diagnosis, type of illness, or condition.⁷

¹ SSA §§ 1902(a)(10)(D) [42 U.S.C. 1396a] and 1905(a)(7) and 42 CFR §§ 440.70 and 441.15. For the purpose of this report, we refer to all services furnished under these authorities as “mandatory home health services.”

² 42 CFR § 441.15(c). Mandatory home health services must be covered for all individuals who are eligible for nursing facility care as defined in the State Medicaid plan. States cannot limit these services to beneficiaries whose condition is such that they require nursing home care.

³ This was the most recent complete data on Medicaid home health expenditures available at the time of this report. CMS, *Financial Management Report for FY 2002 through FY 2011*, total computable expenditures for home health services.

⁴ States can also provide home health services through Medicaid waivers. Under waiver authority, a State can define home health services and identify target populations in a way that would be prohibited for mandatory home health services. For example, under a § 1915(c) home- and community-based services waiver, a State would provide services only to those who qualify for nursing home care, could include home services not generally covered under 42 CFR § 441.15, and could waive the comparability requirements at 42 CFR § 440.240(b) to alter the scope of services for the target population. For this reason, our report focuses on the mandatory State Plan home health benefit and excludes home health services furnished under other Medicaid authorities.

⁵ 42 CFR §§ 430.14, 430.15, and 430.16.

⁶ SSA § 1902(a)(10)(B); 42 CFR § 440.240(b).

⁷ 42 CFR § 440.230(c).

In July 2000, CMS released a State Medicaid Director letter summarizing its efforts to review Federal policies to ensure fulfillment of the Americans with Disabilities Act.⁸ This letter stated that, although Medicare requires beneficiaries to be homebound to qualify for home health services,⁹ imposing a homebound requirement on Medicaid home health benefits violates Medicaid regulations related to “amount, duration, and scope of services” at 42 CFR § 440.230 and “comparability of services” at 42 CFR § 440.240. In July 2011, CMS published a Notice of Proposed Rulemaking that would revise Medicaid regulations to clarify that home health services cannot be restricted to individuals who are homebound or to services furnished in the home; the rule had not yet been finalized at the time of this report.¹⁰

CMS has taken action regarding improper eligibility restrictions in at least one State. CMS notified the Missouri Medicaid program in 2005 and again in 2009 that its restriction of home health services to homebound individuals was a violation of Federal law. In February 2010, CMS notified the State that it intended to withhold a portion of Federal reimbursement for home health services until the State submitted (and CMS approved) an SPA to bring it into compliance with Federal requirements.¹¹ Missouri submitted an amendment to its State plan removing the restriction.

METHODOLOGY

This evaluation included all 50 States, the District of Columbia, and 3 Territories: Puerto Rico, Guam, and the U.S. Virgin Islands.¹² (For the purpose of this report, we refer to these 54 entities as States.) In January and February 2013, we asked each State to provide us with copies of its policies defining eligibility for mandatory home health services.¹³ These policies included State administrative codes, provider manuals, and other policy documents. Two States provided additional information regarding their written policies in response to our request. We also asked each of the 10 CMS regional offices to provide us with copies of the sections of the current State plan that defined eligibility for mandatory home health services for each of the States within the office’s

⁸ CMS, State Medicaid Director letter, *Olmstead Update No. 3*, July 25, 2000.

⁹ 42 CFR § 409.42(a). The *Medicare Benefit Policy Manual* explains that patients must be “confined to the home” (i.e. homebound)—meaning that “leaving home would require a considerable and taxing effort”—to qualify for Medicare home health services. CMS, *Medicare Benefit Policy Manual*, Pub. No. 100-2, ch. 7, § 30.1.1.

¹⁰ 76 Fed. Reg. 41032, 41033, and 41038 (July 12, 2011). The proposed rule reflects a 1997 2nd Circuit Court of Appeals decision that found that the State could not limit coverage of home health services to those provided at the individual’s residence. See *Skubel v. Fuoroli*, 113 F. 3d 330 (2d Cir. 1997).

¹¹ 75 Fed. Reg. 10289 (March 5, 2010).

¹² The remaining two Territories—the Commonwealth of the Northern Marianas Islands and American Samoa—were excluded from this evaluation. These two Territories have waivers under § 1902(j) of the SSA that waive all requirements of Title XIX except three provisions relating to the Federal Medical Assistance Percentage, a dollar limit specific to each Territory, and payments for medical assistance as defined by § 1905(a) of the SSA. Thus, the requirements prohibiting eligibility restrictions do not apply to these two Territories. The 1902(j) waiver is available only to these two Territories.

¹³ We collected only documents related to the mandatory State Plan home health benefit; we excluded home health services furnished under other Medicaid authorities from this evaluation.

jurisdiction. We reviewed all of these documents to determine whether any State had improperly restricted eligibility for mandatory home health services.

Results of this study are based on our review of the State plans and policy documents provided in response to our request. Our methodology was based on the policy documents that States submitted in response to our request; we did not question individual States about whether their documented restrictions were being enforced.

Standards

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

RESULT

Eleven States have policies that improperly restrict eligibility for mandatory home health services to homebound individuals

Eleven States have language—one in its State plan and 10 in other State policy documents—that restricts eligibility for the mandatory home health benefit to homebound individuals in violation of CMS’s interpretation of the applicable statute and regulation. These 11 States are Alabama, Arkansas, Indiana, Montana, Nebraska, New Mexico, North Dakota, Pennsylvania, South Dakota, Utah, and West Virginia. With the exception of West Virginia, these States apply the homebound restrictions to all services provided through the mandatory home health benefit. West Virginia makes exceptions to the homebound restriction when certain skilled medical procedures for adults or skilled services for infants and children are necessary. In general, the 11 States’ restrictions on eligibility for home health services were similar to Medicare’s restriction that individuals must be “confined to the home,” meaning that “leaving home would require a considerable and taxing effort.”¹⁴

Two of the eleven States, New Mexico and Utah, stated in their responses to our request that although their policies restricted eligibility for home health services to homebound individuals, those policies were incorrect and were not being enforced. New Mexico staff explained that an SPA removing the homebound restriction was being drafted but had not been submitted to CMS. Utah staff explained that the homebound restriction was incorrectly included in the provider manual; they further stated that the restriction had never been enforced and would be corrected in the next revision of the provider manual.

CONCLUSION

According to the documents that States supplied in response to our request, 11 States have policies that improperly restrict eligibility for their mandatory home health benefit to homebound individuals. Such restrictions violate CMS’s interpretation of the requirements of § 1902(a)(10)(B) of the SSA and Federal regulation at 42 CFR § 440.230(c) because the scope of the medical assistance made available to non-homebound individuals is reduced. Such restrictions further violate CMS’s

¹⁴ 42 CFR § 409.42(a); CMS, *Medicare Benefit Policy Manual*, Pub. No. 100-2, ch. 7, § 30.1.1.

interpretation of Federal requirements at 42 CFR § 440.240(b) because they deny services on the basis of a beneficiary's condition (i.e., not being homebound). We encourage CMS to finalize its proposed rule clarifying that home health services cannot be restricted to individuals who are homebound or to services furnished in the home. After finalizing the proposed rule, CMS may want to consider issuing guidance specific to home health services and homebound eligibility restrictions, explaining why such restrictions are improper.

This report is being issued directly in final form because it contains no recommendations. If you have comments or questions about this report, please provide them within 60 days. Please refer to report number OEI-07-13-00060 in all correspondence.