Funding Assistive Technology Through State Medicaid Programs

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Funding Assistive Technology Through Medicaid

I. Introduction

According to the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS), "Medicaid is the largest program providing medical and health-related services to America's poorest people."[1] As such, Medicaid representation is an important part of the advocacy work performed by Protection and Advocacy (P&A) programs, Legal Services and Legal Aid organizations, and other disability advocacy groups. In particular, Medicaid is a critical source of funding for people with disabilities who need assistive technology (AT) devices or services.

II. Assistive Technology Defined

Assistive technology is a term that derives from the Technology Related Assistance for Individuals with Disabilities Act of 1988,[2] renamed the Assistive Technology Act in 1998.[3] Known by many as the AT Act, this legislation defines both AT devices and services:

> The term "assistive technology device" means any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve functional capabilities of individuals with disabilities.[4]
>
> * * * * *
>
> The term "assistive technology service" means any service that directly assists an individual with a disability in the selection, acquisition, or use of an assistive technology device.[5]

As shown above, the term "AT device" is broadly defined to include a wide array of equipment that can be of great benefit to individuals with disabilities. Examples of

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[1]See CMS website at: *www.cms.hhs.gov/states/default.asp*.

[2]Pub. L. 100-407, 102 Stat. 1044, former 29 U.S.C. §§ 2201 *et seq*.

[3]29 U.S.C. §§ 3001 *et seq*. Unless otherwise noted, all references to the AT Act are as most recently amended and reauthorized in 2004.

[4]29 U.S.C. § 3002(4).

[5]29 U.S.C. § 3002(5).

AT devices include:

- Power and custom wheelchairs
- Augmentative communication devices and speech generating computers
- Hospital beds
- Prosthetic limbs
- Environmental control units
- Therapy vests for treating the symptoms of respiratory conditions
- Lifting devices, such as hydraulic lifts and ceiling track lifts
- Vehicle modifications, including wheelchair lifts and hand controls
- Assistive listening devices, including hearing aids and personal FM units
- Ramps, lifts, and stair glides

Similarly, the term "AT services" encompasses a broad range of activities including evaluations to determine the need for a device, customizing or adapting a device, maintenance and repairs of the device, and training on how to use the device.[6] Each of these activities is often essential to ensuring the effectiveness of AT for a particular individual.

Because popular use of the term assistive technology is of recent vintage, only a few funding sources have adopted it to date.[7] Thus, advocates must communicate with funding sources in the specific language used by each program. When dealing with Medicaid agencies, the terms "medical equipment" (ME) or "durable medical equipment" (DME) are used most frequently to describe items like wheelchairs, walkers, lifts, and hospital beds. While many AT devices and services may be covered by Medicaid, it is oftentimes necessary to pursue an administrative hearing or file an action in court to obtain such equipment. Knowing the information that follows will assist both attorneys and advocates in this endeavor.

III. Medicaid Overview

Medicaid is the third largest provider of health insurance in the United States, following employer-based coverage and Medicare.[8] As a publicly-funded health insurance program, Medicaid provides certain medically necessary acute health care and long-term care services to approximately 51 million low-income families, elderly individuals, and persons with disabilities. Persons with disabilities under 65 years of

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[6] *Id.*

[7] *See*, definitions of AT devices and services at 34 C.F.R. §§ 300.5 and 300.6 (special education) and 34 C.F.R. §§ 361.5(b)(7) and (b)(8)(vocational rehabilitation), two programs that have adopted the AT Act definitions.

[8] *A Profile of Medicaid: Chartbook 2000*, at *www.cms.hhs.gov/charts/medicaid*.

age account for approximately eight million of the total number of individuals eligible for Medicaid. Access to Medicaid-funded services allows many of these individuals with disabilities to maintain their health and preserve their quality of life.

A. The History and Purpose of the Medicaid Act

Enacted in 1965 as Title XIX of the Social Security Act, the Medicaid program was established as a joint federal/state program to enable states "to furnish rehabilitation and other services to help such families and individuals attain or retain their capability for independence or self care."[9] Since then, the Medicaid Act has been amended numerous times to extend eligibility to additional individuals and to expand the array of covered services. Examples of some of the changes that are of particular relevance to people with disabilities include:

- 1967 (P.L. 90-248) — Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit
- 1971 (P.L. 92-223) — Intermediate Care Facilities for Persons with Mental Retardation benefit
- 1981 (P.L. 97-35) — Home and community-based waiver benefit
- 1987 (P.L. 100-203) — Nursing home reform protections and Pre-admission Screening and Resident Review (PASARR) requirements
- 1987 (P.L. 99-643) — Section 1619(b) provision made permanent allowing Medicaid to continue when SSI is lost due to wages
- 1989 (P.L. 101-239) — Expanded EPSDT benefit to include optional services not otherwise covered by the state.
- 1997 (P.L. 105-33) — Balanced Budget Act amendments establish the original Medicaid buy-in.
- 1999 (P.L. 106-170) — Ticket to Work and Work Incentives Improvement Act amends and broadens the Medicaid buy-in provisions.

Despite these expansions of the Medicaid program, efforts to restrict eligibility,

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[9] 42 U.S.C. § 1396.

reduce covered services, and alter the "entitlement" nature of Medicaid continue to gain momentum. Monitoring Medicaid developments on the national and state level may be a necessary part of your advocacy.

B. Funding of Medicaid Programs

Federal funding is available to state Medicaid programs for both the provision of health care services and for various administrative functions. The amount of federal funding available to a state is referred to as federal financial participation (FFP) and is determined by comparing a state's per capita income to the national average.[10] The FFP for health care services ranges from 50 to more than 80 percent, depending on each state's per capita income formula. The FFP for administrative functions is typically around 50 percent.

C. Federal Oversight of State Medicaid Programs

Federal oversight of state Medicaid programs is provided by the Centers for Medicare and Medicaid Services (CMS), an agency within HHS. CMS is responsible for providing administrative oversight of state Medicaid programs and for promulgating rules and developing policies that state programs must follow. Medicaid state plans must be approved by CMS, as must most state applications for Medicaid waivers. Amendments to either the state plan or to waiver programs are also subject to CMS approval.

D. Administration and Operation of State Medicaid Programs

1. Single State Agency

Each state is required to designate a single state agency to administer and oversee implementation of the Medicaid plan.[11] This single state agency is ultimately responsible for the unlawful denial of Medicaid services even when the decision to deny health care is made by a sub-agency or contractor. Once designated as the single state agency for Medicaid, this agency may not delegate the administration of the program or any activities related to rule-making and policy development to any entity other than its own officials.[12] Additionally, the single state agency must establish a medical care advisory committee and involve its members in both policy development

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[10] 42 C.F.R. § 433.10.

[11] 42 U.S.C. § 1396a(a)(5).

[12] 42 C.F.R. § 431.10.

and program administration.[13]

2. Medicaid State Plan

Each state must develop a Medicaid state plan that describes the administration of the program and identifies the eligibility categories covered by the state. The Medicaid state plan must also list the required and optional categories of service that are available through the state Medicaid program.

Additionally, the state plan must explain how beneficiaries, advocates, and others can review and obtain copies of all current policies and rules governing the operation of the Medicaid program.[14] Policies governing "eligibility, provision of medical assistance, covered services, and recipients' rights and responsibilities" must be available for review in all agency offices, in public and university libraries, and in legal services offices.[15] Many states now maintain Medicaid regulations and policies online to increase public access to these documents.

Although no two state Medicaid programs may be exactly alike, there are certain federal requirements that all Medicaid state plans must satisfy. Examples of these requirements include: reasonable promptness[16]; free choice of providers[17]; equal access to care[18]; comparability of services[19]; reasonable standards[20]; and the amount,

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[13]42 C.F.R. § 431.12.

[14]42 C.F.R. § 431.18.

[15]42 C.F.R.§ 431.18(c)(2).

[16]42 U.S.C. §1396a(a)(8). *See*, *Doe v. Chiles*, 136 F. 3d 709 (11th Cir. 1998); *Boulet v. Celucci*, 107 F. Supp. 2d 61 (D. Mass. 2000); *Sobky v. Smoley*, 855 F. Supp. 1123 (E.D. Cal. 1994).

[17]42 U.S.C. §1396a(a)(23). *See*, *Chisholm v. Hood*, 110 F. Supp. 2d 499 (E.D. La. 2000).

[18]42 U.S.C. §1396a(a)(30)(A). *See*, *Clayworth v. Bonta*, 295 F. Supp. 2d 1110 (E.D. Cal. 2003); *Clark v. Kizer*, 758 F. Supp. 2d 572 (E.D. Cal. 1990) aff'd in part, vacated in part on other grounds sub nom., *Clark v. Coye*, 967 F. 2d 585 (9th Cir. 1992).

[19]42 U.S.C. §1396a(10)(B). *See*, *Parry v. Crawford*, 990 F. Supp. 1250 (D. Nev. 1998); *Sobky v. Smoley*, 855 F. Supp. 1123 (E.D. Cal. 1994).

[20]42 U.S.C. §1396a(a)(17). *See*, *Lankford v. Sherman*, 451 F. 3d. 496 (8th Cir. 2006); *Fred C. v. Texas Health and Human Services Comm'n*, 988 F. Supp. 1032 (W.D.

duration, and scope rule.[21] One or more of these legal requirements can often provide the basis for successfully challenging a reduction, denial, or termination of medically necessary AT devices and services.

IV. Medicaid Coverage of Assistive Technology

The Medicaid Act identifies numerous categories of health care services for which FFP is available. These broad categories of services do not identify the specific medical treatments, procedures, or devices that are covered by Medicaid. Rather, particular treatments, health services, or medical equipment are covered by a state Medicaid program if the treatment, service, or device fits within one or more of the broad categories of services identified in a state's Medicaid plan.

Each category of service listed in the Medicaid Act is either a required or optional service. Participating states are required to cover the following categories of services as a condition of receiving FFP:[22]

A. Medicaid's Required Services

- Inpatient hospital care
- Outpatient hospital care
- Physician's services
- Nurse midwife services
- Pediatric and family nurse practitioner services
- Federally qualified health center
- Laboratories and x-ray services
- Rural health clinic services
- Prenatal care
- Family planning services
- Nursing facility services for persons over age 21
- Home health care services for persons over 21 who are eligible for nursing facility services (includes medical supplies and equipment)
- Early and periodic screening, diagnosis, and treatment for persons under age 21 (EPSDT)
- Vaccines for children

Tex. 1997), aff'd, 167 F. 3d 537 (5th Cir. 1998); *Hunter v. Chiles*, 944 F. Supp. 914 (S.D. Fla. 1996).

[21] 42 C.F.R. § 440.230. *See*, *Estaban v. Cook*, 77 F. Supp. 2d 1256 (S.D. Fla. 1999); *Brisson v. Department. of Social Welfare*, 702 A.2d 405 (S.Ct. Vt 1997).

[22] 42 U.S.C.§1396d(r).

In addition to the required services that state Medicaid programs must provide, each state has the discretion to determine which of the approximately 30 optional services listed in the Medicaid Act will be included in its scope of coverage. Importantly, this discretion to include certain optional services and exclude others does not apply to children. Since 1989, the EPSDT provisions of the Medicaid Act have required states to cover all medically necessary services, including both required and optional services, for Medicaid-eligible children under the age of 21.[23]

Once an optional service is identified in the state plan, this service must be provided in conformity with all federal requirements.[24] The optional services authorized by the Medicaid Act include the following.

B. Medicaid's Optional Services

- Podiatrists' services
- Optometrists' services and eyeglasses
- Chiropractic services
- Private duty nurses
- Clinic services
- Dental services
- Physical therapy
- Occupational therapy
- Speech, hearing and language therapy
- Prescribed drugs
- Dentures
- Prosthetic devices
- Diagnostic services
- Screening services
- Preventive services
- Rehabilitative services
- Services for persons age 65 or older in mental institutions
- Intermediate care facility services
- Intermediate care facility services for persons with MR/DD and related conditions
- Inpatient psychiatric services for persons under age 22
- Christian Science schools
- Nursing facility services for persons under age 21
- Emergency hospital services
- Personal care services

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[23] *Doe v. Chiles*, 136 F.3d 709 (11th Cir. 1998).

[24] As noted above, all categories of services are available to Medicaid beneficiaries under the age of 21. 42 C.F.R. § 441.57.

- Hospice care
- Case management services
- Respiratory care services
- Home and community-based services for individuals with disabilities and chronic medical conditions
- PACE - Program for All-Inclusive Care for the Elderly

B. Understanding Medicaid Coverage of Services

Whether a particular AT device or service is covered by a state's Medicaid program will depend upon which categories of service are included in the state plan and how each category of service is defined in federal and state law or policy.[25] Understanding the definitions of the categories of services included in a state's Medicaid plan is the first step is establishing whether a device is actually "covered" by the state.

1. Services Defined in Federal Law

For many coverage categories, federal regulations provide an explicit definition or description of the service.[26] The following are examples of several required and optional services defined by federal law that are relevant to coverage of AT devices and services.

- **Home Health Services**, a required service for individuals who are otherwise eligible for nursing facility services, includes not only home health nursing and home health aides, but also: medical supplies, equipment and appliances suitable for use in the home; physical therapy, occupational therapy, and speech pathology and audiology services provided by a home health agency or facility licensed to provide medical rehabilitation services.[27]

  Within this category, nursing services, home health aide services, and medical supplies, equipment and appliances are required benefits while physical therapy, occupational therapy, and speech and audiology services provided by a home health agency are considered optional services that a state may choose not to include in its home health benefit.

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[25]As noted above, all categories of services are available to Medicaid beneficiaries under the age of 21. 42 C.F.R. § 441.57.

[26]*See*, 42 C.F.R. Part 440.

[27]42 C.F.R. § 440.70.

- **Prosthetic Devices**, an optional service, is defined to include a "replacement, corrective, or supportive device prescribed by a physician or other licensed practitioner of the healing arts . . . [which will] prevent or correct physical deformity or malfunction; or support a weak or deformed portion of the body."[28]

- **Physical therapy, Occupational therapy and Services for Individuals with Speech, Hearing and Language Disorders**, optional services, include the services of a licensed therapist and "any necessary supplies and equipment."[29]

- **Home and Community-Based Waiver Services**, an optional service, may include environmental accessibility adaptations, specialized medical equipment and supplies, and personal emergency response systems.[30]

2. Categories of Service Not Defined by Federal Law

When there is no federal definition for a category of service, state Medicaid programs may define the service in state law or policy. In such instances, the state definition of the category of service must be consistent with all requirements of the Medicaid Act and its implementing regulations and cannot be so narrowly defined as to defeat the purpose of the service or the overall purpose of the Medicaid program.[31]

DME is an example of a Medicaid service that is not defined in federal law. Many states define DME as equipment with one or more of the following characteristics:

(1) can withstand repeated use;

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[28]42 C.F.R. § 440.120(c).

[29]42 C.F.R. § 440.110.

[30]In developing a Home and Community-Based Waiver program, states can choose from a variety of services to include as part of the waiver program. Appendix B-1 of a state's application for a HCBW program contains the definitions of each allowed waiver service.

[31]*See*, *Brisson v. Dep't of Social Welfare*, 702 A.2d 405 (Vt. 1997)(Medicaid agency's refusal to cover a closed caption TV (CCTV) under the optional eyeglasses category was held to be an impermissible limitation on the amount, duration, and scope of that service category because the state failed to provide for those in greatest need of that service); *Cushion v. Department of PATH*, 807 A.2d 425 (Vt. 2002)(Medicaid agency's exclusion of coverage for partial dentures was an impermissible limitation of services under the optional dental services benefit).

(2) is primarily and customarily used to serve a medical purpose;
(3) is generally not useful to a person in the absence of illness or injury;
(4) is appropriate for use in the home.

Knowing a state's definition of DME is critical to understanding whether an AT device fits within this category of service or whether another service may be a more appropriate coverage category.

C. Establishing That an AT Device Fits Within the Scope of One or More Covered Services.

Medicaid reimbursement for AT should be available if the device or service fits within the scope of a covered category of service. Given the broad reach of Medicaid's required and optional categories of service, many devices may fit within one or more of the categories of service found in the Medicaid state plan. As discussed above, physical therapy, occupational therapy, and speech therapy, which by definition include necessary equipment, and prosthetics are categories of service that often allow for coverage of particular AT devices. Of particular importance to AT advocates, however, is DME. All states cover some type of DME as part of the array of services provided under the state's home health benefit, however, DME also may be available to beneficiaries who are not eligible for home health. Understanding the scope of a state's coverage of DME is an important starting point for obtaining Medicaid funding of AT.

D. AT and Durable Medical Equipment

It is not uncommon for states to maintain a medical equipment and supply manual for Medicaid-enrolled DME providers.[32] These manuals often contain a list of covered equipment ranging from apnea monitors to wheelchairs, and sometimes identify coverage criteria for items on the list. As explained below, such lists, when utilized as an exclusive list of covered items, can cause problems for state Medicaid programs.

1. The *DeSario* Case and the 1998 State Medicaid Director Letter

In 1996, Medicaid beneficiaries challenged Connecticut Medicaid's absolute

[32]Many states currently post their provider manuals on the state's Medicaid agency website. If you are unable to locate the provider manual on your state website, you may find it on the website of the fiscal agent that the state has contracted with to administer certain aspects of the program. EDS, ACS, and Unisys are some of the entities that typically act as fiscal agent for state Medicaid programs.

exclusion of certain equipment from coverage as DME.[33] At the time the *DeSario v. Thomas* case was filed, Connecticut Medicaid, like many other state Medicaid programs, maintained a list of covered DME. Any item of equipment or device not found on the list was excluded from Medicaid coverage.

Although the *DeSario* plaintiffs prevailed in the district court, their success was not long lived. On appeal, the U.S. Court of Appeals for the Second Circuit reversed the lower court's decision and upheld Connecticut Medicaid's use of an exclusive list of covered DME. While the case was pending in the U.S. Supreme Court, however, CMS, on September 4, 1998, issued its own analysis of the issues raised by the Second Circuit's decision - - a response which ultimately led the Supreme Court to vacate the appellate court's decision.

The importance of CMS's analysis of DME coverage by Medicaid cannot be overstated.[34] While this policy clarification indicates that state Medicaid agencies may maintain lists of pre-approved DME for administrative convenience, it makes clear that state Medicaid programs must also provide beneficiaries "a meaningful opportunity for seeking modifications of or exceptions to a State's pre-approved list." Specifically, this interpretive guidance from CMS sets out the following requirements for DME coverage:

- States may use DME formularies (i.e., approved lists) as an administrative convenience, but the state must provide a reasonable and meaningful procedure for requesting items that do not appear on a State's approved list.

- The process for approving items that do not appear on the list must be timely and employ reasonable and specific criteria by which an individual item of DME can be judged for coverage.

- These criteria must be sufficiently specific to permit a determination of whether an item of DME that does not appear on the state's approved list has been arbitrarily excluded from coverage based solely on a diagnosis, type of illness or condition.

- In evaluating a request for an item of DME, a state may not use a "Medicaid population as a whole" test which requires a beneficiary to demonstrate that, absent coverage of the item requested, the need of "most" Medicaid recipients will not be met. This test, in the DME context,

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[33] *DeSario v. Thomas*, 139 F.3rd 80 (2nd Cir. 1998), cert granted, judgment vacated, *Slekis v. Thomas*, 525 U.S. 1098 (1999).

[34] *See*, *www.cms.hhs.gov/smdl/downloads/SMD090498.pdf* for the full text of this State Medicaid Director Letter.

establishes a standard that virtually no individual item of DME can meet.

- The approved list and the process for seeking modifications and exceptions to the DME list must be made available to all Medicaid beneficiaries.

Any review of a state's list of Medicaid-covered DME (and list of excluded items) should be viewed with the above principles in mind.

2. Application of the CMS Letter Regarding DME Coverage.

Since the CMS guidance letter was issued in 1998, several federal and state courts have addressed the issue of DME coverage. These cases illustrate that states' attempts to unreasonably limit the scope of equipment covered by Medicaid often run afoul of the CMS policy statement. For example, in *Lankford v. Sherman*, the Eighth Circuit Court of Appeals addressed Missouri Medicaid's DME list and the state's attempt to severely limit the scope of medical equipment available for most beneficiaries.[35] Noting that the 1998 CMS letter was entitled to "considerable deference" the Court ultimately concluded that the state's restrictions on DME appeared unreasonable in light of the CMS directive and relevant case law.

In *Estaban v. Cook*, the court struck down Florida Medicaid's cost cap of $582 on wheelchairs for adult beneficiaries. Citing the September 1998 CMS letter, the court reasoned that the Medicaid agency failed to provide a reasonable and meaningful procedure for requesting items (in this instance, custom and power wheelchairs) that did not appear on the state's pre-approved list. The court held that the state's absolute limitation on coverage for wheelchairs "runs counter to its articulated purpose for including wheelchairs under its DME coverage: to minimize the effects of mobility impairments."[36]

Similarly, in *T.L. v. Colorado Department of Health Care Policy and Financing*, a state appellate court struck down the state Medicaid agency's use of a list of excluded DME, relying heavily on the September 1998 CMS letter.[37] At issue was the absolute exclusion of a hot tub that was needed for therapeutic purposes. The court ruled that, "by expressly excluding home health [i.e., DME] coverage for hot tub or jacuzzi acquisitions under all circumstances and without regard to medical necessity," the state regulation "violates federal law and the objectives of Title XIX [of the Social Security

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[35] 451 F. 3d 496 (8th Cir. 2006).

[36] *Estaban v. Cook*, 77 F.Supp. 2d at 1260, 1261 (S.D. Fla. 1999).

[37] 42 P.3d 63 (Colo. App. 2001).

Act] and is therefore invalid."[38] The court remanded the case to the administrative law judge to determine: i) whether the hot tub meets the DME definition; ii) whether the hot tub therapy is medically necessary; iii) whether, and at what cost, the petitioner could obtain that therapy outside the home (i.e., whether the home-based therapy is the least costly alternative); and iv) whether the primary purpose of the hot tub is to provide comfort rather than treatment to the petitioner.

Finally, in *Bell v. Agency for Health Care Administration*, a state appellate court considered Florida Medicaid's exclusive list of DME and supplies for adults and the impact on the petitioner who was seeking insulin pump supplies that were not on the list.[39] Citing both the *Estaban* decision and the September 1998 CMS letter, the court observed that Florida Medicaid's rules did not provide a procedure for adult beneficiaries to obtain DME or DME supplies not on the exclusive list and held that Florida Medicaid "violates federal law by arbitrarily and unreasonably excluding coverage of benefits that may be medically necessary."[40]

These cases clearly illustrate the limits on a state's discretion to categorically exclude a particular item of medical equipment from Medicaid coverage. Do not overlook the utility of the CMS letter in challenging a denial of DME by a state Medicaid agency.

E. AT for Residents of Medicaid-Funded Institutions

In some states, establishing a Medicaid beneficiary's entitlement to specialized or customized DME when the individual resides in a nursing facility (NF) or intermediate care facility for persons with mental retardation (ICF-MR) may present a different set of challenges from those faced by Medicaid beneficiaries living in the community. Despite such obstacles, there is strong support in the Medicaid Act entitling these Medicaid beneficiaries to medically necessary DME.

1. Nursing Facilities

In 1986, the Institute of Medicine (IOM), acting at the request of Congress, conducted a study of the plight of people residing in nursing facilities.[41] One year later,

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[38] 42 P.3d at 67.

[39] 68 So.2d 1203 (Fla. App. 1 Dist. 2000).

[40] 768 So.2d at 1205.

[41] *See*, *Improving the Quality of Care in Nursing Homes ,Committee on Nursing Home Regulation*, Institute of Medicine (1986). The full text of this report can be read online at *www.books.nap.edu/books*.

the IOM's findings of deplorable conditions and widespread neglect of NF residents led to the passage of the Nursing Home Reform Act (NHRA). This amendment to the Medicaid Act, enacted as part of the Omnibus Budget Reconciliation Act (OBRA) of 1987, instituted quality standards for nursing facilities and an enforcement process to ensure that these standards are met. The Act also established a clear statement of the rights of all nursing facility residents and the special protections applicable to residents with mental retardation or mental illness.

The standard of care set by the NHRA is a high one.[42] Pursuant to these provisions of the Medicaid Act and its implementing regulations, residents of NFs are entitled to services and activities that will allow them "to attain or maintain the highest practicable physical, mental, and psycho-social well-being."[43] The key to meeting this standard of care for NF residents is a comprehensive assessment of each individual's "functional capacity." Such assessment must be completed on an annual basis or whenever there is a significant change in an individual's physical or mental condition.[44] Quarterly examinations of residents are required to ensure "the continued accuracy of the assessment."[45]

Assessments for NF residents with mental retardation, related conditions or mental illness must include additional considerations as required by the Pre-Admission Screening and Resident Review ("PASARR") provisions of OBRA '87. For example, assessment of a NF resident with mental retardation or a related condition must consider, among other things, motor, speech, and social development, academic, vocational, and independent living skills and "the extent to which prosthetic, orthotic, corrective, or mechanical support devices can improve the individual's functional capacity."[46] An assessment of a resident with mental health concerns must at least examine the individual's ability to perform activities of daily living, self-monitoring of health and nutritional status and "specific therapies and activities for the treatment of an

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[42]Despite the passage of the NHRA more than 20 years ago, serious problems persist in the standard of care afforded NF residents. *See*, *e.g.*, *Nursing Home Conditions in Texas: Many Nursing Homes Fail to Meet Federal Standards for Adequate Care*, Special Investigations Division, Committee on Government Reform, U.S. House of Representative (2002).

[43]42 U.S.C. §1396r(b)(2); 42 C.F.R. § 483.25.

[44]42 U.S.C. §§1396r(b)(3)(A) and 1396r(b)(3)(C); 42 CFR § 483.20(b).

[45]42 U.S.C. §1396r(b)(3)(C)(ii).

[46]42 C.F.R. § 483.136.

acute episode of mental illness."[47] If such assessments indicate a need for additional specialized services, NF residents with mental retardation, related conditions, or mental health concerns may be entitled to such services.

The assessments and reassessments of NF residents mandated by OBRA '87 form the basis for the plan of care that must be established for each individual.[48] Developed by a team of people, including the attending physician, a registered nurse, the resident, or his or her family, the care plan must describe the needs of the resident and how the facility will meet these needs.[49] In addition to the preservation of a resident's general health and well-being, the plan of care must provide for services that will ensure that his or her ability to perform activities of daily living - - bathing, dressing, grooming, transferring and ambulation, toileting, eating, and the use of speech, language or "other functional communication systems" - - does not decline, unless such decline is "unavoidable."[50]

Access to rehabilitative or specialized services is often essential to ensure that NF residents maintain their ability to perform activities of daily living or to address other needs. Rehabilitative services such as physical, occupational, and speech therapies must be provided if these services are included in a NF resident's plan of care.[51] Specialized services are those needed to maintain or increase one's level of independent functioning and to preserve one's health status.[52]

In light of the high standard of care established by the NHRA, one might expect that NF residents have easy access to AT devices and services when such equipment is medically necessary. This is not the case in some states, however, due, in large part, to the manner in which Medicaid payments are made to the nursing facility for eligible residents. The Medicaid payment made to NFs, often referred to as the "per diem" or "daily rate," necessarily covers a range of medical services and supplies for each resident. By federal regulation, the Medicaid payment must include nursing services, dietary services, an activities program, room/bed maintenance services, routine

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[47]42 C.F.R. § 483.134.

[48]42 U.S.C.§1396r(b)(2)(a).

[49]42 U.S.C. §1396r(b)(2)(A-B); 42 C.F.R. § 483.25.

[50]42 C.F.R. § 483.25(a)(1).

[51]42 C.F.R. § 483.45. Therapies, including physical, occupational, and speech therapy, are defined elsewhere in the Act's implementing regulations and include any necessary supplies and equipment required as part of the therapeutic regimen. 42 C.F.R. § 440.110.

[52]42 C.F.R. § 483.120.

personal hygiene items, and medically related social services.[53] Aside from these services, states may handle payment for other services needed by NF residents several different ways.

Some states have clear DME policies that state whether particular items are covered for NF residents.[54] For example, Nebraska Medicaid policy identifies covered items of DME, describes the coverage criteria for each item, and specifically notes whether the item is covered for residents of NFs.[55] A review of this policy indicates that augmentative communication devices and power wheelchairs are covered for NF residents.[56] Similar policies exist in Texas where procedures have been put in place to provide augmentative communication devices and customized power wheelchairs to nursing facility residents, with payment for this AT made to the NFs outside of the daily rate.[57]

On the other hand, some state Medicaid policies make clear that specific items of equipment for NF residents must be covered by the facility rather than by a separate Medicaid payment mechanism. In Colorado, for example, Medicaid policy specifically states that "[s]upplies and equipment required by a client residing in a nursing facility… are not a benefit of the DME/supply program."[58] This policy contains a long list of supplies and equipment that are included in the daily rate paid to the facility, including "medically necessary manual or power wheelchairs for intermittent or full-time use."[59]

In light of the varying methods state Medicaid agencies use to pay for services for NF residents, it may be necessary to fully research Medicaid policies governing coverage of and payment for DME, NF payment rules, other long term care policies

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[53] 42 C.F.R. § 483.10(c)(8)(i)(A-F).

[54] Nebraska HHS Finance and Support Manual, 471 NAC 7-013.

[55] Unlike some state policies, Nebraska Medicaid policy also identifies the DME that is covered for residents of ICFs-MR.

[56] The policy governing coverage of wheelchairs makes clear that Nebraska Medicaid covers non-standard wheelchairs "needed for the client's permanent and full-time use." It is presumed to be the responsibility of the NF to provide standard wheelchairs to residents who have a temporary need for such equipment.

[57] See, 40 TAC §§19.2613 and 19.2614.

[58] Colorado Dept. Of Health Care Policy and Financing, Staff Manual, Volume 8, Section 8.593.

[59] Colorado Dept. Of Health Care Policy and Financing, Staff Manual, Volume 8, Section 8.442.

governing covered services, as well as any other categories of services (i.e., prosthetics) that include the type of equipment needed by a NF resident with a disability. Despite some of the procedural obstacles that may restrict access to AT by NF residents, the high standard of care and services required by the NHRA serves as a strong basis for establishing that such residents are entitled to medically necessary AT devices and services.

2. Residents of ICFs-MR

The addition of ICF-MR facilities to the array of optional Medicaid services in 1971 was intended to assist states in providing appropriate services to eligible beneficiaries with certain developmental disabilities. According to federal Medicaid regulations, the "primary purpose" of ICFs-MR is to "furnish health or rehabilitative services to persons with mental retardation or persons with related conditions."[60] Central to the achievement of this purpose is the provision of a continuous program of active treatment. Active treatment includes "specialized and generic training, treatment, health services, and related services" which will allow residents to acquire independence and exercise self-determination or will slow or otherwise prevent the loss of current skills.[61]

To ensure that residents of ICFs-MR receive active treatment, interdisciplinary teams must conduct comprehensive functional assessments of all aspects of development, including health and nutrition, sensorimotor, affective, speech and language, cognitive, social, and independent living skills.[62] These comprehensive functional assessments, which must be completed within 30 days of admission to the facility, form the basis for each resident's individual program plan.[63] The individual program plan must contain specific objectives that are stated in measurable behavioral terms and are prioritized. Staff with responsibility for implementing the plan must be identified and the type and frequency of data collection must be identified.

AT devices can be of great value to ensure residents gain independent living skills, consistent with the state objectives of their individual program plans. Alternative and augmentative communication devices, for example, should be provided to those residents who cannot rely on oral speech as their primary mode of communication.

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[60] 42 C.F.R. § 440.150(a)(2).

[61] 42 C.F.R § 483.440(a)(i-ii).

[62] 42 C.F.R. § 483.440(c)(3).

[63] 42 C.F.R. § 483.440(c).

F. AT for Home and Community-Based Waiver Participants

Since 1981, the Medicaid Act has permitted states to seek waivers that allow flexibility in administering the Medicaid program generally.[64] Specifically, CMS, by waiver, may permit a state plan for Medicaid to include "home or community-based services" for persons who, without provision of those services, would require institutional care.[65] Federal Medicaid waiver provisions allow states to obtain FFP for a variety of services that are different from, or beyond the scope of, the services typically covered by states. These services may include "such other services requested by the State as the Secretary may approve . . ."[66]

A Medicaid beneficiary receiving services under a home and community-based waiver may receive funding not only for items covered under the standard Medicaid program, but also a broader range of technology. Home modifications, such as ramps, stair lifts, and grab bars, fall within this category and are covered services under home and community-based waiver programs in many states. Vehicle modifications may also be covered, including ramps, lifts, and raised roofs.

V. Requesting Medicaid Authorization of AT

A. The Prior Authorization Process

Many states require medical equipment and supplies to be prior authorized in order to be eligible for Medicaid reimbursement. That is, prior to obtaining AT, the Medicaid beneficiary, in conjunction with a Medicaid-enrolled provider (i.e., the DME vendor), must request that the state Medicaid agency approve coverage of the equipment.

The use of a prior authorization process by state Medicaid agencies is consistent with the agency's obligation under the federal Medicaid Act to implement utilization controls for state Medicaid expenditures.[67] However, a state Medicaid agency may not use the prior authorization process to impose unreasonable standards for Medicaid coverage of DME or to cause unreasonable delays in obtaining equipment.[68]

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[64]42 U.S.C. § 1396n(a) and (b).

[65]42 U.S.C. § 1396n(c),

[66]42 U.S.C. § 1396n(c)(4)(B); 42 U.S.C. § 1396d.

[67]42 U.S.C. § 1396a(a)(30)(A); 42 C.F.R. § 440.230(d).

[68]42 U.S.C. §§ 1396a(a)(17), 1396a(a)(8).

State Medicaid agencies typically use the prior authorization process to determine whether the requested AT or DME is "covered" by Medicaid. As previously stated, an AT device or service is covered by Medicaid if it fits within one of the categories of service included in the Medicaid state plan. For example, an AT device may be covered as DME, a service that is within the mandatory home health benefit, or if your state has included prosthetic devices in its Medicaid state plan, the device may be covered within that category of service.

The prior authorization process is also used to determine whether the AT is "medically necessary." Thus, the state's approval of a prior authorization request for an AT device or service may depend on whether the state accepts or rejects the opinion of the treating health care professional recommending the device.

B. The Prior Authorization Request

The information required to obtain prior authorization will vary depending on the type of AT requested. For example, assessment information needed for obtaining a wheelchair will be very different from that for an augmentative communication device. There is, however, some general information that is typically required:

- A physician's order (or request from another health professional if allowed by your state Medicaid rules) that identifies the specific AT and explains why the AT is medically necessary.

- An assessment that establishes that the proposed equipment is effective for the individual: for a power wheelchair, for example, that the individual is able to, or will likely be able to, operate it; for an augmentative communication device, that the individual will communicate more effectively, or will likely communicate more effectively, with the device.

Depending on what type of AT being requested, the written assessments may be completed by a speech-language pathologist, physical therapist, or other enrolled provider. These written evaluations can be fairly lengthy and, oftentimes, reports from more than one therapist are necessary to address different areas of expertise. For example, a speech language pathologist may recommend a specific AAC device based on an individual's speech language needs, while an occupational therapist or physical therapist addresses the positioning or other access issues related to use of the device.

C. Prior Authorization Criteria

Some state Medicaid agencies use guidelines or other criteria when evaluating requests for particular types of AT. These guidelines are often found in state Medicaid manuals or in Medicaid provider manuals. Medicaid-enrolled providers should have a copy of the relevant manual for their use. When possible, the guidelines should be followed when submitting a request.

Unless formally promulgated through the state's rule making process, these manuals, and the guidelines contained in them, are not part of the rules governing the Medicaid program. As such, some information in these manuals may not be legitimate. For example, many of these manuals list equipment and devices that are excluded from Medicaid coverage. As was previously discussed, state Medicaid programs are explicitly prohibited from using such exclusionary lists. Since the provisions in these provider manuals are not part of the officially promulgated rules governing the Medicaid program, they are subject to challenge in a Medicaid fair hearing and in court.

VI. Establishing Medical Necessity for AT

A. The Meaning of Medical Necessity

While the Medicaid Act does not define medical necessity, numerous courts have concluded that the determination of what health care or treatment is medically necessary must be consistent with accepted standards of medical practice and must be made by the beneficiary's treating physician.[69] Courts have held that, when determining medical necessity, the opinion of the beneficiary's treating physician trumps the opinion of Medicaid agency personnel.[70] State Medicaid agencies cannot deny a beneficiary access to medical care that is consistent with the beneficiary's medical need and is the only medical care available to treat the beneficiary's medical condition.[71]

Most state Medicaid programs have adopted a definition of medical necessity through statute, rule, or policy. While these definitions are not uniform, there are some common elements found in many of them. For example, states commonly require that the requested Medicaid service be consistent with the beneficiary's medical condition or disability[72] and that provision of the requested service be consistent with the practice of

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[69] *See*, *e.g.*, *Preterm, Inc. v. Dukakis*, 591 F.2d 121, 127 (1st Cir. 1979); *Weaver v. Reagen*, 886 F.2d 194, 200 (8th Cir. 1989); *Pinneke v. Preisser*, 623 F.2d 546, 550 (8th Cir. 1980).

[70] *Weaver v. Reagen*, 886 F.2d 194, 200 (8th Cir. 1989); *Pinneke v. Preisser*, 623 F.2d 546, 550 (8th Cir. 1980).

[71] *Allen v. Mansour*, 681 F. Supp. 1232 (E.D.Mich. 1986).

[72] *See*, *e.g.*, Minnesota Rules § 9505.0175; Ohio Administrative Code § 5101:3-1-01; Title 55 PA Code (Public Welfare) § 1101.21; State of Tennessee, Bureau of Tenncare, Chapter 1210-13-12-.01(23)(1994); W.VA. Medicaid Program Regulations, Durable Medical Equipment Supply Services, Chapter 510.

the medical community.[73] In addition to covering medical services that "treat" medical conditions, some states cover medical services that "prevent" illnesses or injuries.[74]

To demonstrate that AT is medically necessary, a Medicaid-enrolled provider (for example, a doctor, therapist, or home health nurse) must establish that the device or service is necessary to address or accommodate a medical condition and is consistent with accepted standards of medical practice. To do so, the medical provider should prepare a letter of medical necessity or other report explaining the individual's need for the AT device or service. The provider's explanation should be based upon his/her clinical experience and knowledge of what other doctors or therapists who treat persons with similar needs do in similar situations.

B. Medical Necessity for Children

The Medicaid Act, through the EPSDT benefit, requires states to cover all medically necessary services for Medicaid-eligible children and youth under age 21 and provides an expansive definition of medical necessity for these beneficiaries. Under EPSDT, state Medicaid programs must provide "necessary health care, diagnostic services, treatment and other measures . . . to correct or ameliorate defects and physical and mental illnesses and conditions."[75] Services must be covered if they correct, compensate for, or improve a condition, or prevent a condition from worsening - even if the condition cannot be prevented or cured.

VII. Common Barriers to AT

In addition to the many denials of DME based upon general claims of "not covered" or "not medically necessary," there are several other barriers that Medicaid beneficiaries may confront when seeking authorization of AT devices or services. The following is a brief description of some of these barriers and the legal challenges to such obstacles.

A. "Experimental" Treatment

It is not unusual for state Medicaid programs to deny authorization of AT devices

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[73] *See*, *e.g.*, GA Department of Medical Assistance, Provider Manual, § 106.12; Minnesota Rules § 9505.0175; Ohio Administrative Code, § 5101:3-1-01; State of Tennessee, Bureau of Tenncare, Chapter 1210-13-12-.01(23)(1994).

[74] *See*, *e.g.*, Conn. Dept. of Social Services, Regulations, § 17b-262-560(15); 130 CMR 450.204(A); Minnesota Rules, § 9505.0175; N.Y. Social Services Law, § 365-a(2); Washington Administrative Code (WAC) § 388-80-005(44)(1992).

[75] 42 U.S.C. § 1396d(r)(5).

that represent relatively new methods of treatment for particular medical conditions. Often, such denials are premised on the claim that these devices are "experimental." Given the status of Medicaid case law on the issue of experimental treatment, it is necessary to effectively challenge this characterization. An examination of several Medicaid cases provides the necessary background for understanding the exclusion of "experimental" treatment from Medicaid coverage.

To begin, the Medicaid Act requires states to "include reasonable standards . . . for determining eligibility for and the extent of medical assistance under the plan which . . . are consistent with the objectives of this [Act]."[76] In conformity with this requirement, states are allowed to define the meaning of "medical necessity." Once this standard of medical necessity is defined, state Medicaid programs can then "place appropriate limits on a service based on . . . medical necessity . . ."[77]

Over the years, there have been a number of cases that have addressed the issue of Medicaid coverage of treatment that a Medicaid agency seeks to characterize as "experimental." Several of these decisions form the basis for the argument advanced by state Medicaid programs that "experimental" treatment falls outside of the scope of coverage for medically necessary treatment. As described below, these cases have not followed a consistent line of reasoning.

In June 1980, the Eighth Circuit Court of Appeals rejected Iowa Medicaid's irrebutable presumption that sexual reassignment surgery is never medically necessary in that it is more like cosmetic surgery.[78] Based upon plaintiff's medical evidence, the Court concluded that "a state plan absolutely excluding the only available treatment known at this point in time for a particular condition must be considered an arbitrary denial of benefits based "solely on the 'diagnosis, type of illness, or condition."[79]

Three months later, the Fifth Circuit Court of Appeals held that Georgia Medicaid, in conformity with its discretion to set standards under the Medicaid Act, could exclude experimental forms of treatment on the basis that it was medically unnecessary.[80] Thus, the Court directed the lower court to determine whether Georgia Medicaid's denial of sexual reassignment surgery was based upon a legitimate prohibition against coverage of experimental treatment and whether such surgery was,

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[76]42 U.S.C. §1396a(a)(17).

[77]42 C.F.R. § 440.230(d).

[78]*Pinneke v. Preisser*, 623 F.2d 546 (8th Cir.1980).

[79]Id. at 549.

[80]*Rush v. Parham*, 625 F.2d 1150 (5th Cir. 1980).

in fact, experimental.

More than two decades after these two cases were decided, the Eighth Circuit was again called upon to resolve the issue of Medicaid coverage of sexual reassignment surgery. This time, however, the Court concluded that Iowa Medicaid's "prohibition on funding on sex reassignment surgery is both reasonable and consistent with the Medicaid Act."[81] The Court reached this conclusion despite the fact that a literature search conducted by a medical peer review organization indicated that such surgery is medically necessary for some individuals and is not considered experimental.

In other instances, however, courts have required states to fund certain procedures despite the claim that these procedures are experimental. For example, the Missouri Medicaid program refused to pay for the drug AZT except for patients whose diagnoses and conditions matched the conditions specified on the FDA label for the drug.[82] The state claimed this restriction was an "appropriate limit based upon medical necessity" because the drug was "experimental when used for off-label purposes." The court found that FDA labeling was not intended to limit a physician's use of an approved drug and that AZT was generally accepted in the medical community as an effective treatment for AIDS patients who did not meet the FDA indications. The court held that the drug was not experimental, but "generally accepted by the professional medical community as an effective and proven treatment for [AIDS]."

Similarly, the Seventh Circuit Court of Appeals examined Wisconsin Medicaid's decision to exclude a liver-bowel transplant procedure from coverage on the basis that it was "experimental." Following the Fifth Circuit's analysis of the term "experimental" the Court noted that "the best indicator that a procedure is experimental is its rejection by the professional medical community as an unproven treatment." Nonetheless, the Court acknowledged that there are some newer procedures for which there is no general acceptance by the medical community as of yet and noted that such procedures are not "per se experimental."[83]

To challenge the denial of an AT device that has been characterized as "experimental," it is important to determine: (i) the precise meaning of the term "experimental" as applied by the state Medicaid program; (ii) the expertise of the individual(s) making this decision; and (iii) whether the device is generally accepted by the medical community as an effective treatment for the condition for which it has been prescribed. Armed with this information, it will be easier to challenge the notion that a particular AT device is "experimental" and thus, medically unnecessary.

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[81] *Smith v. Rasmussen*, 249 F. 3d 755, 761 (8th Cir. 2001).

[82] *Weaver v. Reagan*, 886 F.2d. 194 (8th Cir. 1989).

[83] *Miller by Miller v. Whitburn*, 10 F. 3d 1315, 1320 (7th Cir. 1993).

B. Diagnosis-Based Criteria

The "amount, duration, and scope" rule governing Medicaid programs states that a Medicaid agency may not arbitrarily deny or reduce the amount, duration, or scope of a required service to an otherwise eligible beneficiary solely because of his or her diagnosis, type of illness, or condition.[84] This prohibition on diagnosis-based decision-making is relevant when challenging a denial of an AT device that is "covered" for individuals with certain medical conditions, but not others. For example, some Medicaid programs have tried to limit coverage of a device known as a "ThAIRpy Vest" to individuals with cystic fibrosis, thus denying access to this device to individuals with other chronic lung conditions. This is just one example of a medical device that is made available only to those Medicaid beneficiaries with a specific diagnosis or medical condition. Fortunately, there is a long history of litigation in which the courts have rejected such diagnosis-based distinctions.

In 1977, Medicaid beneficiaries challenged a Pennsylvania Medicaid policy that covered eyeglasses for eligible individuals with a specific type of eye pathology but denied eyeglasses to individuals with other types of visual impairment.[85] Soon thereafter, a district court in Vermont similarly concluded that Vermont Medicaid could not provide coverage of eyeglasses to post-cataract surgery patients and deny this same service to individuals with refractive disorders.[86]

In 1979, the First Circuit relied upon this same provision to strike down a state Medicaid agency's limitation on coverage of abortion to life and death situations.[87] The Court held that such restriction crossed the line between permissible discrimination based on degree of need and entered into forbidden discrimination based on medical condition. The Court noted that it is unreasonable to single out one medical procedure, abortion, and limit access to situations of life and death.

The Tenth Circuit reached the same conclusion when faced with a similar restriction on abortion services.[88] In particular, the Court noted that although states may use medical need as a criterion for placing appropriate limits on coverage, a state may not single out a particular medically necessary service and restrict coverage to instances where the patient's life is at risk. "Such a policy denies services solely on the

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[84] 42 C.F.R. § 440.230 (c).

[85] *White v Beal*, 555 F.2d 1146 (3rd Cir. 1977).

[86] *Simpson v. Wilson*, 480 F. Supp. 97 (D. Vt. 1979).

[87] *Preterm v. Dukakis*, 591 F.2d 121 (1st Cir. 1979).

[88] *Hern v Beye*, 57 F.3d 906 (10th Cir. 1995).

basis of diagnosis or condition, and does so arbitrarily because the denial is not in accordance with a uniform standard of medical need."[89]

A similar challenge to Missouri Medicaid's rule limiting Medicaid coverage of AZT to only those beneficiaries who met the diagnostic criteria listed on the FDA label produced the same result.[90] The Eighth Circuit found that this limitation was an arbitrary denial of benefits based solely on diagnoses, type of illness, or condition given the widespread agreement in the medical community that AZT was the only approved treatment for HIV and was an effective treatment even for those who did not meet the FDA indications.

There is one precaution to note when using Medicaid's prohibition against diagnosis-based decision making to challenge the denial of an AT device or service. In 1986, Medicaid beneficiaries in Louisiana brought a case that was very similar to the Pennsylvania eyeglass limitation case.[91] The plaintiffs challenged Louisiana Medicaid's refusal to provide eyeglasses to anyone other than post-cataract surgery patients. Although the plaintiffs ultimately prevailed in this case on other grounds, the court rejected the applicability of Medicaid's prohibition on diagnosis-based decision making to the facts of this case in that eyeglasses are an optional service and the clear language of the prohibition is limited to required services.[92] While not all courts have recognized this distinction, it is important to ensure that the AT device being sought is one that meets the definition of a required service.

C. The Homebound Requirement

For years, many state Medicaid programs have applied a "homebound" requirement to those beneficiaries seeking services through the Medicaid home health benefit. Despite the fact that this "requirement" appears nowhere in the Medicaid Act or its implementing regulations, some states have required that beneficiaries seeking DME and medical supplies satisfy this "homebound" requirement in order to receive medically necessary equipment.

Fortunately for Medicaid beneficiaries in all states, CMS issued a letter to all State Medicaid Directors on July 25, 2000, informing them that this restriction on access to home health services, including durable medical equipment and supplies, violates the

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[89]57 F.3d at 910, quoting *Hodgson v. Board of County Comm'rs*, 614 F.2d 601, 608 (8th Cir. 1980).

[90]*Weaver v Reagan*, 886 F.2d. 194 (8th Cir. 1989).

[91]*Ledet v. Fischer*, 638 F. Supp. 1288 (M.D. La 1986).

[92]*See also*, *Smith v. Rasmussen*, 249 F.3d 755, 761 (8th Cir. 2001).

comparability requirement of the Medicaid Act as implemented by 42 C.F.R. § 440.240; the amount, duration, and scope rule, 42 C.F.R. §440.230 (b); and the prohibition on diagnosis-based decision making, 42 C.F.R. § 440.230(c).[93]

Issued as part of the policy clarification process undertaken by CMS to "facilitate fulfillment of the ADA," this State Medicaid Director letter underscores the important application of the ADA to the operation of Medicaid programs.

> 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. New developments in technology and service delivery have now made it possible for individuals with even the most severe disabilities to participate in a wide variety of activities in the community with appropriate supports. Further, ensuring that Medicaid is available to provide medically necessary home health services to persons in need of those services who are not homebound is an important part of our efforts to offer persons with disabilities services in the most integrated setting appropriate to their needs, in accordance with the Americans with Disabilities Act.

Although there is no doubt as to the meaning of this letter, some states continue to apply a homebound requirement to requests for home health services.[94] Any denials of AT devices or services issued on this basis should be challenged.

VII. Due Process Protections and Medicaid Benefits

While it may be difficult to obtain Medicaid funding for AT devices and services in some instances, there are significant due process protections available when necessary to challenge unlawful denials of services by state Medicaid agencies or by the private entities with which they contract.[95] Both the United States Constitution[96] and the

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[93]*See*, State Medicaid Director Letter, July 25, 2000, Attachment 3-G.

[94]In *Lankford v. Sherman*, the Eighth Circuit observed that CMS had directly informed Missouri Medicaid that its homebound requirement for home health services was out of compliance with CMS policy. Despite this notification, the state appeared to maintain some type of homebound requirement for home health services in direct conflict with the CMS directive. 451 F.3d 496 (8th Cir. 2006).

[95]*See*, *Perry v. Chen*, 1996 WL 159808 (D. Ariz. 1996), opinion amended and superseded, 985 F.Supp. 1197 (D. Ariz. 1996).

[96]Medicaid beneficiaries have a property interest in their Medicaid benefits pursuant to the Fourteenth Amendment of the U.S. Constitution. *See*, *Goldberg v.*

Medicaid Act[97] protect Medicaid applicants and beneficiaries who are denied Medicaid-funded health care and treatment. These legal protections are described below.

A. Timely Decision-Making

Initially, the state Medicaid agency must make timely decisions concerning an individual's eligibility for Medicaid, in conformity with time lines established by the agency. Federal regulations mandate the outside limit for timely eligibility determinations and any standards set by the state cannot exceed 90 days for individuals applying for Medicaid on the basis of disability and 45 days for all others.[98] The applicable time period begins with the date of application and runs through the date the notice of agency decision is mailed to the applicant. For each Medicaid applicant, the state agency must send a written notice informing him or her of the eligibility determination.[99]

Once an individual is found eligible for Medicaid, the state agency must "furnish Medicaid promptly without any delay caused by the agency's administrative procedures."[100] This reasonable promptness requirement is of particular importance when an individual is seeking any type of medical care, including AT devices or services, that must approved through a prior authorization process.[101] Medicaid applicants and beneficiaries are entitled to request a fair hearing when the Medicaid agency's fails to act promptly upon a claim for medical assistance.[102]

B. Notice of Adverse Decisions

State Medicaid agencies must provide the opportunity for a fair hearing "to any

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Kelly, 397 U.S. 254 (1970)(Public assistance beneficiary has constitutional due process right to challenge a termination of benefits in a pre-termination hearing.).

[97] 42 U.S.C. § 1396a(a)(3); 42 C.F.R. § 431.200-.250; and 42 C.F.R. § 435.911-.920.

[98] 42 C.F.R. § 435.911.

[99] 42 C.F.R. § 435.912.

[100] 42 U.S.C. §1396a(a)(8); 42 C.F.R. § 435.930.

[101] *See*, *Jeneski v. Myers*, 163 Cal. App.3d 18 (1984), cert. denied *Kizer v. Jeneski*, 471 U.S. 1136 (1985)(Notice and hearing rights apply to denial of prior authorization requests for medication.).

[102] 42 C.F.R. § 431.200.

individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness."[103] Consistent with this obligation to provide a fair hearing is the requirement that state Medicaid agencies provide legally sufficient notice concerning the denial of Medicaid services. For individuals previously determined eligible for Medicaid, timely and adequate notice must be sent whenever the agency takes "action" against a beneficiary.[104] This means that each time a Medicaid beneficiary requests a Medicaid service, written notice must be provided if the individual's request is reduced, modified, or denied.[105]

The adequacy of the written notice sent to inform individuals of the Medicaid agency's action on a request for services is a critical starting point for individuals seeking to challenge such denials. The Medicaid Act and its implementing regulations require such notices to contain specific information about the proposed action. In particular, these notices must include: (1) a statement of the proposed action; (2) the reasons for the proposed action; (3) the specific regulations supporting the action; (4) an explanation of the person's right to request a hearing and the type of hearing available to the individual; and (5) a description of the circumstances under which Medicaid eligibility in general or a specific Medicaid service is continued pending the outcome of the hearing.[106]

The adequacy of the notice denying, terminating, or reducing Medicaid services is an important issue for Medicaid advocates. In some states, such notices often provide little in the way of a complete, or even accurate, explanation as to why a particular service was reduced or denied.[107] Notices containing denial codes with cryptic notations such as "not medically necessary" or "fails to meet prior authorization

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[103] 42 U.S.C. §1396a(a)(3); 42 C.F.R. § 430.200.

[104] The term "action" is defined to include "termination, suspension, or reduction" of Medicaid eligibility or covered services and may also include an "approval" of service if the state Medicaid agency approves the service with modifications. 42 C.F.R. § 431.201.

[105] 42 C.F.R. § 435.919. *See*, *Parry v. Crawford*, 990 F. Supp. 1250 (D. Nev. 1998)(Medicaid beneficiary seeking ICF/MR services entitled to notice and an opportunity to request a fair hearing when application is denied despite his repeated requests for the same service. Notice is required after every determination of eligibility for services.).

[106] 42 C.F.R. § 435.912; 42 C.F.R. § 431.210.

[107] In *Thompson v. Roob*, 2006 WL 2990426 (S.D. Ind.), the court held that written denial notices containing an inaccurate description of the relevant eligibility standard violated Plaintiff's due process rights.

criteria" or "not covered for individuals over 21 years of age" are wholly inadequate and should be challenged by Medicaid advocates.[108] One such challenge resulted in the federal court concluding that a Medicaid denial notice containing the statement "you do not have an appropriate level of care" was an insufficient explanation of the basis for denial of home and community based waiver services.[109]

In addition to providing specific information as to the basis for a reduction or denial of service, the state Medicaid agency must also "make available . . . a copy of the specific policy materials necessary . . . to prepare for a fair hearing."[110]

C. The Right to A Fair Hearing

State Medicaid agencies are required to "publicize" their hearing procedures and to inform applicants and beneficiaries of the right to request a hearing, the procedures to follow to obtain a hearing, and the ability to be represented by an attorney or other representative, including a friend or relative.[111] This information must be provided at the time of the initial Medicaid application and whenever the Medicaid agency takes any action affecting an individual's claim.

The state may provide a fair hearing before the state Medicaid agency or may implement a two tier system in which an evidentiary hearing is held at the local level, with the Medicaid applicant or beneficiary retaining his or her right of appeal to a state agency hearing.[112] If the state Medicaid agency implements a local hearing system, the applicant or beneficiary must receive any adverse decision in writing and must be informed of the right to appeal the decision to the state agency or to request a de novo hearing before the state agency.[113]

Ongoing services for a Medicaid beneficiary can continue if a fair hearing is requested within a specified time frame, typically 10 days from the date of notice.[114]

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[108] *See*, *Vargas v. Trainor*, 508 F.2d 485, (7th Cir. 1974),cert denied, 420 U.S. 1008 (1975); *Featherstone v. Stanton*, 626 F.2d 591 (7th Cir. 1980); and *Moffit v. Austin*, 600 F. Supp. 295 (W.D. Ky. 1984).

[109] *See*, *Cherry v. Tompkins*, 1995 WL 502403 (S.D. Ohio 1995).

[110] 42 C.F.R. § 431.18(e)(2).

[111] 42 C.F.R. § 431.206.

[112] 42 C.F.R. § 431.205.

[113] 42 C.F.R. § 431.232.

[114] 42 C.F.R. § 431.230.

The notice of adverse action must specify the time frame for requesting a hearing if the beneficiary wishes to have his or her benefits continue pending the outcome of the hearing.[115] While it is often necessary for Medicaid beneficiaries to continue benefits pending the outcome of a fair hearing, it is important to understand that the agency may "recoup the cost of any services furnished the recipient, to the extent [the services] were furnished solely by reason of this section."[116]

A Medicaid applicant or beneficiary who requests a fair hearing has the right to review his/her case file and all documents to be used by the state at the hearing, call witnesses, establish the facts of the case without interference from the state, and confront and cross-examine adverse witnesses.[117] The fair hearing must be conducted by someone who has no direct involvement with the action that is the subject of the hearing.[118] The issues considered at the hearing must include, among other things, any agency actions involving eligibility determinations and decisions concerning changes in the type or amount of services requested.[119]

Federal regulations require that hearing decisions be based solely on the evidence presented at the hearing. These decisions must summarize the facts of the case, identify relevant regulations and supporting evidence, and be issued within 90 days of the request for a hearing.[120] In most states, unsuccessful hearing petitioners can seek judicial review of the hearing decision in state court.

IX. Medicaid and the Courts: A Focus on State Court Judicial Review

If the state agency issues an adverse hearing decision against the Medicaid beneficiary, you will need to decide what, if any, further action should be taken. Typically, the client and his/her attorney have three choices: (1) appeal the matter in state court through judicial review; (2) file a case in federal court; or (3) accept the decision and pursue other funding options. This section will focus the discussion on the first option, state court judicial review.

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[115] 42 C.F.R. § 431.210(e). See also, Jonathan C. v. Hawkins, 2006 WL 3498494 (E.D.Tex.).

[116] 42 C.F.R. § 431.230(b).

[117] 42 C.F.R. § 431.242.

[118] 42 C.F.R. § 431.240.

[119] 42 C.F.R. § 431.241.

[120] 42 C.F.R. §431.244.

A. A Brief Comment on Filing Medicaid Litigation in Federal Court

Many attorneys prefer federal court as the place to enforce Medicaid rights. Since the Medicaid Act does not create its own federal cause of action, enforcement against State officials has historically been pursued through 42 U.S.C. § 1983. However, as many readers know, the ability to use section 1983 to enforce Medicaid Act provisions has been made more difficult in recent years. Any attorney who is considering the federal courts to enforce the Medicaid Act's mandates would be wise to first contact our colleagues at the National Health Law Program before moving forward with your case.

A discussion of what the U.S. Supreme Court and the many lower courts have said about section 1983 and Medicaid Act enforcement is well beyond the scope of this short article. To provide some context for the problem with using section 1983 and the growing use of the U.S. Constitution's Supremacy Clause to state a federal cause of action, the Eighth Circuit's 2006 decision in *Lankford v. Sherman, supra*, is instructive. In that case, the court followed a growing trend in the federal courts and held that a private right of action did not exist under section 1983 to enforce the Medicaid Act's reasonable standards mandate, 42 U.S.C. § 1396a(a)(17). However, in sending the case back to the District Court, the Court of Appeals held that plaintiffs have a private right of action, under the Constitution's Supremacy Clause, to establish that the State's DME regulation was inconsistent with and preempted by the federal Medicaid Act's reasonable standards provisions.[121]

The message from *Lankford* and similar holdings to potential federal litigants is to carefully think through whether your case should be filed in the state or federal courts. If you do file your case in the federal courts, make sure you are up-to-date on what the courts in your Circuit have said about using section 1983 to enforce specific provisions of the Medicaid Act.[122] And finally, do not overlook the possibility of using the Constitution's Supremacy Clause as an alternative cause of action to challenge state laws that are inconsistent with federal mandates.

B. Evaluating the Merits of a State Court Judicial Review Appeal

Every state in the country has some type of judicial review statute, allowing for a state court appeal and review from a final administrative fair hearing decision. This will

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[121] 451 F.2d at 511-512.

[122] The National Health Law Program regularly updates a document titled "42 U.S.C. § 1983 and Enforcement of the Medicaid Act," a 41-page document that reference both favorable and unfavorable federal case law related to whether particular sections of the Medicaid Act can be enforced through section 1983. To obtain a copy of this document, contact Jane Perkins at *perkins@healthlaw.org*.

allow the Medicaid beneficiary's attorney to appeal an adverse decision within the state court system. Although the judicial review statutes will vary somewhat from state to state and state court procedures will vary as well, the evaluation of whether to take the appeal will have similar elements in every state and within your advocacy program, whether it is a P&A program or a legal services/legal aid office.[123]

For the P&A or legal services/legal aid programs considering an appeal or other court action, a number of considerations will come into play:

- the merits of the underlying request for funding;
- the likelihood of success in court;
- the resources of the agency and any collaborators that may be available to work on the case;
- whether the issues involved in the case fit within the agency's priorities;
- whether attorney's fees are available in the event that an appeal or court action is successful;
- whether success in court will have an impact beyond the individual involved[124];
- whether the individual has other avenues for obtaining funding for the item in question.

Often, the attorney evaluating the merits of a potential appeal either was involved in the fair hearing or works with staff who were involved in the hearing. If this is the case, the chances are good that the administrative hearing record was fully developed and will support the court appeal. Of course, even with the best representation, a second look at the case following the administrative hearing and resulting decision, may reveal flaws in the supporting evidence or legal theory that will make you pause before committing the resources it will take to pursue an appeal in court.

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[123] *See*, *e.g.*, N.Y. CPLR § 7803 (allowing for challenges to hearing decisions if arbitrary and capricious, an abuse of discretion, affected by errors of law, or not on the record supported by substantial evidence); Minn.Stat. § 14.69(e)-(f) (provides that the court may reverse or modify an agency decision if the decision was "[u]nsupported by substantial evidence in view of the entire record as submitted" or "[a]rbitrary or capricious"; a reviewing Colorado court may reverse an administrative agency's determination if the court finds that the agency acted in an arbitrary and capricious manner, made a determination that is unsupported by the evidence in the record, erroneously interpreted the law, or exceeded its constitutional or statutory authority. C.R.S. § 24-4-106(7).

[124] In some cases, the decision on whether to proceed in federal rather than state court may depend on whether you will be seeking broader systemic relief than is typically provided through your state court system.

The very troublesome case is one in which the Medicaid beneficiary was not represented at the fair hearing or was represented by an attorney or advocate who was unfamiliar with Medicaid law or the fair hearing process. In these cases, it may be that the hearing record is less than satisfactory and will not support an appeal. In such a case, the attorney may, as an alternative to a court appeal, support the individual in resubmitting their claim for AT prior approval to the Medicaid agency.

In all cases involving the potential appeal from an adverse hearing decision, the attorney should review the full hearing record, including all hearing exhibits and a transcript or tape of the testimony. Even if a very capable attorney or advocate represented the individual at the hearing, the hearing record should be reviewed before proceeding into court. If a good record was not made at the hearing, the attorney may decline to pursue the matter in court and advise the client as to how to put together a stronger case with better medical support in order to proceed through the prior-approval process again. Clearly, pursuing an appeal based on a poor evidentiary record could result in bad precedent for later cases.

While we do not wish to deter attorneys from using the federal courts to pursue claims against state Medicaid agencies – after all, much of the good Medicaid precedent cited in this article is from the federal courts – there are some obvious advantages to filing for judicial review in a state court. State review statutes often create a very straightforward process, allowing the case to move from filing to resolution fairly quickly compared to litigation in federal court. Since state court judicial review is often limited to briefing and arguments, with little or no additional evidence allowed, the commitment of resources is limited.

While an inexperienced attorney may need less support from an experienced litigator when pursuing a case through the state review process, this is not to say that state judicial review should be taken lightly. To prevail on judicial review, brief writing is critical, with the underlying facts often just as important as or more important than the legal issues involved. Even experienced attorneys can benefit from having another person review and edit their briefs in these cases. Staff at the National AT Advocacy Project often provides this service to both inexperienced and experienced attorneys alike. Attorneys should also be urged to contact the National AT Advocacy Project when briefing a case, in state or federal court, as the project maintains an extensive brief bank which includes briefs from many of the successful AT-related state and federal court cases.

X. Conclusion

This article was prepared in connection with a full-day training program on Medicaid funding of AT. Its purpose is to provide a good primer and reference for attorneys and advocates who are working on AT-related Medicaid appeals. While this document and its 120 plus footnotes represents an extensive treatment of the topic, for

many readers it will simply serve as a starting point for research when working on individual cases.

When using this document as a reference, remember you should always follow up to determine whether laws or regulations have been amended, or key court precedent has been reversed or in some way changed by subsequent decisions. It is probably most critical to look at the laws, regulations, and policy governing your state Medicaid program.

Medicaid advocacy generally, and AT advocacy specifically, is a challenging and rewarding endeavor for disability advocates. There are many resources available to individuals practicing in this area of law to assist in their representation of clients needing AT devices and services. You should not hesitate to contact the National Assistive Technology Project for technical assistance with your Medicaid cases involving AT devices and services.

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