

FUNDING ASSISTIVE TECHNOLOGY THROUGH STATE MEDICAID PROGRAMS

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Preface

Funding Assistive Technology Through State Medicaid Programs is a publication developed by the National Assistive Technology (AT) Advocacy Project of Neighborhood Legal Services, Inc., as part of our Funding of AT series. Information about the National AT Advocacy Project, and the federal grant that supports it, appears on page iii, below. Originally published in late 2015, this AT funding manual was revised in May 2016 to incorporate information about several important changes to the federal home health regulation that became final in February 2016. As described herein, the new federal definition of medical equipment and other important protections within the revised home health regulation have the potential to eliminate the systemic barriers to medical equipment that exist in some states and to increase access to this critical benefit for individuals with disabilities.

This publication is primarily targeted to attorneys and advocates who work for Protection and Advocacy (P&A) programs nationwide. Some of you may be funded by Protection and Advocacy for Assistive Technology (PAAT) grants and specialize in AT-related advocacy. Others may work for another P&A program but still encounter issues related to Medicaid funding of AT. For example, you may represent clients through the P&A for Individuals with Mental Illness (PAIMI) grant who have mental health concerns, but who also have a physical disability that creates the need for AT devices and services.

This publication is also targeted to a broad secondary audience, including Legal Services/Legal Aid attorneys and advocates; private attorneys who have a disability law practice; individuals who work for State AT Act Projects or Alternative Financing Projects (*i.e.*, AT low-interest loan programs); advocacy agencies such as Independent Living Centers; employees of state and local government programs serving children and adults with disabilities, including special education programs and state vocational rehabilitation agencies; staff members of disability service providers; healthcare professionals; and individuals with disabilities and their families.¹

Representation of Medicaid beneficiaries is an essential part of the advocacy work performed on behalf of people with disabilities. If you represent Medicaid clients, this publication will provide valuable information you can use to support your AT advocacy on their behalf. Included below is a discussion of Medicaid, in general, and several Medicaid service categories that encompass AT devices and services. We have also included a discussion of some of the legal issues you may face when representing clients seeking Medicaid funding for AT. If you cannot devote the time to read this publication in its entirety, we urge you to review the table of contents to get a sense of the issues discussed throughout.

¹ We recognize that individuals without legal training may access this publication through our website at www.nls.org/Disability/NationalAssistiveTechnologyProject. We have made an effort to increase the utility of this publication for these individuals by placing most legal citations in footnotes.

As many readers know, Medicaid is a complicated program and its complexity increases with the passing of time. With this in mind, be aware that this publication is not an exhaustive treatise on Medicaid as there are many Medicaid issues that are not addressed or are not discussed extensively.² Moreover, you will likely need to research the legal issues in your case to a greater level of detail than what is provided here. The citations to federal law, regulation, and policy will provide the foundation for further research, but the information in this publication is not state-specific and is only current through the most recent publication date. Keep in mind that state law, regulations, and policy will likely dominate your research when working on AT cases. We hope this publication expands your thinking about the possibilities of funding AT through your state Medicaid program.

² For a more thorough discussion of Medicaid, you may want to obtain a copy of *An Advocate's Guide to the Medicaid Program* (2013), National Health Law Program. This invaluable resource is available for purchase at www.healthlaw.org.

Publication Credits and Disclaimer

This publication, *Funding Assistive Technology Through State Medicaid Programs*, is published and distributed through the National Assistive Technology (AT) Advocacy Project.³ This project is fully funded under grant award number H224B100001-CFDA 84.224 B., from the Administration for Community Living (ACL) within the U.S. Department of Health and Human Services (HHS) to the Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) with a subcontract to Neighborhood Legal Services, Inc. The opinions expressed herein do not necessarily reflect the position of ACL or HHS, and no official endorsement by ACL or HHS should be inferred.

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³ The National AT Advocacy Project provides nationwide technical assistance, training, and a range of other support services, to attorneys and advocates who work for Protection and Advocacy programs. Our many publications, are available at www.nls.org/Disability/NationalAssistiveTechnologyProject.

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Acronyms and Abbreviations

AT	Assistive Technology
ACL	Administration for Community Living
CCTV	Closed Caption TV
CMS	Centers for Medicare and Medicaid Services
DME	Durable Medical Equipment
EPSDT	Early and Periodic Screening Diagnostic and Treatment
FFP	Federal Financial Participation
FMAP	Federal Medicaid Assistance Percentage
HCBS	Home and Community-Based Services
HCFA	Health Care Financing Administration
HHS	U.S. Department of Health and Human Services
ICF-IID	Intermediate Care Facility for Individuals with Intellectual Disabilities (formerly referred to as ICF-MR)
IPP	Individual Program Plan
LMN	Letter of Medical Necessity
MCO	Managed Care Organization
NF	Nursing Facility
PAAT	Protection and Advocacy for Assistive Technology
PASRR	Preadmission Screening and Resident Review
P&A	Protection and Advocacy Agency
SGD	Speech Generating Device
TITLE XIX	Title XIX of the Social Security Act (Medicaid Act)

Funding Assistive Technology Through State Medicaid Programs

I. Introduction

For the past 50 years, Medicaid has played a vital role in the lives of low-income people who have a critical need for health care. According to the Kaiser Commission on Medicaid and the Uninsured, "Medicaid is the nation's main public health insurance program for people with low income and the single largest source of public health coverage in the U.S." Nationally, nearly 70 million individuals are eligible for Medicaid and people with disabilities make up approximately 16 percent of all Medicaid beneficiaries.⁴ For individuals with disabilities, Medicaid is an essential source of funding for acute health care and long term services and supports, including assistive technology (AT) devices and services. With appropriate AT devices and services, individuals with disabilities can maintain their health, increase their functional abilities, and enhance their independence at home and in the community.

II. What is Assistive Technology?

The term "assistive technology" describes a broad range of medical equipment and devices that can enhance the functional abilities of individuals with disabilities. The term derives from the Technology Related Assistance for Individuals with Disabilities Act of 1988,⁵ subsequently renamed the Assistive Technology Act of 2004,⁶ which broadly 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.⁷

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.⁸

⁴Paradise, Julia, *Medicaid Moving Forward*, March 2015. See <http://kff.org/health-reform/issue-brief/medicaid-moving-forward>.

⁵ Pub. L. 100-407, 102 Stat. 1044, former 29 U.S.C. §§ 2201 *et seq.*

⁶ 29 U.S.C. § 3001 *et seq.* All references to the AT Act are as amended and reauthorized in 2004, unless otherwise noted.

⁷ 29 U.S.C. § 3002(4)

⁸ 29 U.S.C. § 3002(5)

As defined, the term “AT device” encompasses a wide array of equipment, including but not limited to:

- Power and manual wheelchairs
- Speech Generating Devices (SGDs, also referred to as Alternative/Augmentative Communication Devices)
- Hospital beds
- Prosthetic limbs
- Environmental control units
- Therapy vests for treating respiratory conditions
- Patient lifts, including hydraulic and electronic floor, wall and ceiling lifts
- Assistive listening devices, hearing aids, and personal FM units
- Ramps
- Personal Response Systems
- Stair glides
- Standing devices
- Arm and leg braces
- Closed caption television (CCTV) and other vision aids
- Gait trainers

AT services are those services that ensure the effectiveness of an AT device for the user and encompass numerous activities including, assessing the need for a device, customizing or adapting a device, maintaining and repairing a device, and training on the operation of a device.⁹

Popular use of the term "assistive technology" or AT is not widespread and only a few funding sources have adopted it to date.¹⁰ Thus, you should be careful to communicate with funding sources using the terminology employed by each program.

⁹ *Id.*

¹⁰ See 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), as these two programs have adopted the AT Act definitions.

Medicaid agencies typically use the term “durable medical equipment” (DME) or medical equipment (ME) to describe items like wheelchairs, walkers, lifts, and hospital beds, as these items are typically available through the home health benefit. AT devices may also be available through other Medicaid benefit categories, including prosthetic and orthotic devices, speech language pathology, physical therapy, occupational therapy, preventative services, and rehabilitation services.¹¹

III. What is Medicaid?

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.”¹² Over the past 50 years, the Medicaid Act has been amended numerous times to extend eligibility to additional individuals and to expand the array of covered services. Nonetheless, efforts by states to limit eligibility, restrict covered services, or reduce payment rates continue to create barriers to medically necessary services, including DME, medical supplies, and the other coverage categories through which AT can be funded.

B. Administration and Operation of State Medicaid Programs

Federal oversight of state Medicaid programs is provided by the Centers for Medicare and Medicaid Services (CMS), an agency within the U.S. Department of Health and Human Services. CMS promulgates rules and develops policies with which state Medicaid programs must comply. CMS also reviews and approves each state’s Medicaid plan and any requested amendments to the plan.

At the state level, the Medicaid program is administered by a designated single state agency. This agency is responsible for implementing the Medicaid state plan and for all activities related to rule-making and policy development.¹³ The single state Medicaid agency is also responsible for the unlawful denial of Medicaid services, even when the decision to deny health care is made by a sub-agency or contractor.¹⁴ This is particularly important given the number of managed care organizations that contract with state Medicaid programs.¹⁵

¹¹ While many AT devices and services are available through Medicaid, it is sometimes necessary to pursue an administrative hearing or file a lawsuit to obtain such equipment.

¹² 42 U.S.C. § 1396-1.

¹³ 42 C.F.R. § 431.10

¹⁴ 42 U.S.C. § 1396a(a)(5)

¹⁵ According to CMS, approximately 60 percent of all Medicaid beneficiaries in 39 states were enrolled with a Medicaid managed care organization in 2011. This number has continued to increase in certain states since then. See <http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-26-05.html>.

Federal funding is available to state Medicaid programs for both the provision of health care services and various administrative functions. The amount of federal funding a state can claim is based upon the Federal Medical Assistance Percentage (FMAP), which is established by comparing a state's *per capita* income to the national average.¹⁶ The FMAP determines the amount of federal financial participation (FFP) available to each state Medicaid program for the health care services it provides to eligible beneficiaries.

C. The Medicaid State Plan

Each state must develop a Medicaid state plan that describes the administration of the program and identifies the categories of people who are eligible for Medicaid. The state plan also identifies the mandatory and optional categories of services available through the state Medicaid program. Importantly, the state plan must explain how the public can access the state's Medicaid policies and rules governing “eligibility, provision of medical assistance, covered services, and recipients’ rights and responsibilities.”¹⁷ To satisfy this requirement, many states make this information available online.

Although no two state Medicaid programs are exactly alike, there are numerous federal requirements that all Medicaid programs must satisfy. These include:

- reasonable promptness;¹⁸
- free choice of providers;¹⁹
- equal access to care;²⁰
- comparability of services;²¹
- reasonable standards;²² and
- the amount, duration, and scope rule.²³

¹⁶ 42 C.F.R. § 433.10. The FMAP for health care services ranges from approximately 50 to 75 percent.

¹⁷ 42 C.F.R. § 431.18.

¹⁸ 42 U.S.C. § 1396a(a)(8). See *Romano v. Greenstein*, 721 F. 3d 373 (5th Cir. 2013), *aff'd* 2012 WL 1745526 (E.D. La. May 16, 2012); *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).

¹⁹ 42 U.S.C. § 1396a(a)(23). See *Harris v. Olszewski*, 442 F.3d. 456 (6th Cir. 2006); *Chisholm v. Hood*, 110 F. Supp. 2d 499 (E.D. La. 2000).

²⁰ 42 U.S.C. § 1396a(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).

²¹ 42 U.S.C. § 1396a(10)(B). See *Lankford v. Sherman*, 451 F.3d 496 (8th Cir. 2006) ; *Jasset v. R.I. Dep't of Human Servs.*, No. C.A. PC 05-3815, 2006 WL 2169891, (R.I. Super. Ct. July 31, 2006); *Conley v. Dep't of Health*, 287 P.3d 453 (Utah Ct. App. 2012); *Jacobus v. Dep't of PATH*, 857 A.2d 785 (Vt. 2004); *Parry v. Crawford*, 990 F. Supp. 1250 (D. Nev. 1998); *Sobky v. Smoley*, 855 F. Supp. 1123 (E.D. Cal. 1994).

²² 42 U.S.C. § 1396a(a)(17). See *Fred C. v. Texas Health and Human Services Comm'n*, 988 F. Supp. 1032 (W.D. Tex. 1997), *aff'd* 167 F. 3d 537 (5th Cir. 1998); *Hunter v. Chiles*, 944 F. Supp. 914 (S.D. Fla. 1996).

²³ 42 C.F.R. § 440.230. *Esteban 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).

One or more of these requirements may provide the legal basis for challenging a Medicaid denial of medically necessary AT devices or services.

IV. What Benefits Does Medicaid Provide?

A. Medicaid's Mandatory and Optional Benefit Categories

The Medicaid Act identifies numerous categories of health care services for which FFP is available. These broad categories of services are classified as either mandatory or optional services. Participating states are required to cover the following categories of services as a condition of receiving FFP:²⁴

- Inpatient hospital care
- Outpatient hospital care
- Physician's services
- Nurse midwife services
- Certified pediatric and family nurse practitioner services
- Federally qualified health center
- Laboratories and x-ray services
- Rural health clinic services
- Freestanding birth centers
- Family planning services
- Nursing facility services
- Home health services (includes medical supplies and equipment)
- Early and periodic screening, diagnostic, and treatment for persons under age 21 (EPSDT)
- Vaccines for children

In addition to the required services state Medicaid programs must provide, each state has discretion to include in its state plan any of the optional services listed in the Medicaid Act. Once an optional category of service is identified in the state plan, it must be provided in conformity with all federal requirements.²⁵ The optional services authorized by the Medicaid Act include those listed below:

- Podiatry services
- Optometry services
- Eyeglasses

²⁴ State Medicaid programs are also required to ensure "necessary transportation for beneficiaries to and from providers . . ." 42 C.F.R. § 431.53(a).

²⁵ See *Lankford v. Sherman*, 451 F.3d 496, 504 (8th Cir. 2006); *Tallahassee Mem'l Reg'l Med. Ctr. v. Cook*, 109 F.3d 693, 698 (11th Cir. 1997); *Weaver v. Reagen*, 886 F.2d 194, 197 (8th Cir. 1989); *Ellis v. Patterson*, 859 F.2d 52, 54 (8th Cir. 1988); *Meyers ex rel. Walden v. Reagan*, 776 F.2d 241, 243-44 (8th Cir. 1985); *Eder v. Beal*, 609 F.2d 695, 702 (3d Cir. 1979); *Edmonds v. Levine*, 417 F. Supp. 2d 1323, 1326 (S.D. Fla. 2006); *Sobky v. Smoley*, 855 F. Supp. 1123, 1127 (E.D. Cal. 1994); *McMillan v. McCrimon*, 807 F. Supp. 475 (C.D. Ill. 1992).

- Chiropractic services
- Private duty nursing services
- Clinic services
- Dental services/dentures
- Physical therapy
- Occupational therapy
- Speech, hearing, and language therapy
- Prescription drugs
- Prosthetics
- Diagnostic services
- Screening services
- Preventive services
- Rehabilitation services
- Services for persons age 65 or older in mental institutions
- Intermediate care Facilities for Individuals with Intellectual Disabilities /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
- Hospice care
- Case management services
- Respiratory care services
- Tuberculosis related services
- Home and community-based waiver services
- Community First Choice option
- PACE – Program for All-Inclusive Care for the Elderly
- Tobacco cessation programs

Importantly, a state's discretion to cover some optional services and exclude others from its state plan does not apply to children due to the EPSDT requirements of the Medicaid Act.²⁶ For children and youth under 21 years of age, states must:

cover all medically necessary services that are included within the categories of mandatory and optional services listed in section 1905(a), regardless of whether such services are covered under the State Plan. These include physician and hospital services, private duty nursing, personal care services, home health and medical equipment and supplies, rehabilitative services, and vision, hearing, and dental services. Covered EPSDT services also include “any other medical care,

²⁶ 42 U.S.C. §1396d(r); 42 U.S.C. §1396a(a)(43); 42 U.S.C. §1396d(a)(4)(B). See *S.D. ex rel. Dickson v. Hood*, 391 F.3d 581 (5th Cir. 2004) (requiring Louisiana Medicaid to cover medically necessary incontinence briefs as “home health supplies” for children eligible for EPSDT services.)

and any other type of remedial care recognized under State law, specified by the Secretary."²⁷

B. Defining Medicaid's Broad Benefit Categories

Federal regulations expressly define some of the mandatory and optional benefit categories relevant to coverage of AT devices and services.²⁸

1. The Mandatory Home Health Benefit

The home health category of service is a mandatory benefit for Medicaid-eligible individuals who are otherwise entitled to nursing facility services.²⁹ This means that individuals who are categorically needy, *i.e.*, beneficiaries receiving SSI, disabled adult children, qualified disabled workers and low income families, are eligible for home health services when medically necessary. In some states, individuals who qualify for Medicaid as medically needy also may be eligible for home health services if the state makes nursing facility services available to them.³⁰

The home health benefit consists of several services, some of which are mandatory for states to provide, while others are optional.³¹ Of particular importance to individuals seeking AT devices is the mandatory service of medical supplies, equipment and appliances.³² Historically, the terms medical supplies, equipment and appliances were undefined in federal regulation, resulting in myriad state definitions and inconsistent coverage determinations across the states. On February 2, 2016, CMS published a final rule establishing a federal definition of this benefit.³³ According to CMS, a standardized definition was necessary because "in the absence of a generally applicable definition of [medical equipment], there has been confusion as to the proper scope of the benefit."³⁴

²⁷ *EPSDT - A Guide for State Coverage in the Medicaid Benefit for Children and Adolescents*, CMS, June 2014. Available at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html>.

²⁸ 42 C.F.R. Part 440(b).

²⁹ 42 U.S.C. §1396a(a)(10)(D); 81 Fed. Reg. 5531.

³⁰ Individuals seeking home health services need not actually require the level of services provided in a nursing facility. 42 C.F.R. § 440.70(b); 81 Fed. Reg. 5533.

³¹ 42 C.F.R. § 440.70(b).

³² Other mandatory home health services are nursing and home health aides. Optional home health services include physical therapy, occupational therapy, and speech and audiology services.

³³ The effective date of this rule is July 1, 2016; however, compliance with certain provisions of the rule, *i.e.*, implementation of the face-to-face encounter, will not be required for up to one year in states in which the legislature has met in that year or two years in which the state legislature meets biennially. 81 Fed. Reg. 5530. Other provisions of the revised rule codify existing law and policy, *i.e.*, homebound prohibition, *DeSario* requirements, so there should be no delay in states' compliance with these requirements. As explained by CMS, certain provisions of this rule "incorporate principles that are already applicable in practice." 81 Fed. Reg. 5538.

³⁴ 81 Fed. Reg. 5532.

Under the revised regulation, medical supplies, equipment and appliances are defined as:

Supplies are health care related items that are consumable or disposable, or cannot withstand repeated use by more than one individual, that are required to address an individual medical disability, illness or injury.³⁵

Equipment and appliances are items that are primarily and customarily used to serve a medical purpose, generally are not useful to an individual in the absence of a disability, illness or injury, can withstand repeated use, and can be reusable or removable.³⁶

While these services are now defined to “better align” with the Medicare definition of durable medical equipment,³⁷ CMS has instructed that “Medicaid coverage of equipment and appliances is not restricted to the items covered as durable medical equipment in the Medicare program.”³⁸ States that limit their DME coverage to those items covered by Medicare can no longer do so.

2. Other Optional Benefits

Other optional services, if included in your state's Medicaid state plan for adult beneficiaries, may also provide coverage for assistive technology devices or services.³⁹ Some of these services include:

Prosthetic Devices are defined as 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 part of the body.”⁴⁰

Physical Therapy, Occupational Therapy, and Services for Individuals with Speech, Hearing, and Language Disorders include the services of a licensed therapist and “any necessary supplies and equipment.”⁴¹

Preventative Services include “services recommended by a physician or other licensed practitioner of the healing arts . . . [to] prevent disease, disability, and other health conditions or their progression; prolong life; and promote physical and mental health and efficiency.”⁴²

³⁵ 42 C.F.R. § 440.70(b)(3)(i).

³⁶ 42 C.F.R. § 440.70(b)(3)(ii).

³⁷ The Medicare DME benefit is defined at 42 C.F.R. § 414.202.

³⁸ 42 C.F.R. §440.70(b)(3)(ii).

³⁹ As explained on page 6, all optional services must be available to beneficiaries under the age of 21 when medically necessary. 42 U.S.C. § 1396d(r)(5).

⁴⁰ 42 C.F.R. §440.120(c).

⁴¹ 42 C.F.R. §440.110.

⁴² 42 C.F.R. §440.130(c).

Rehabilitative Services are defined as “any medical or remedial services, recommended by a physician or other licensed practitioner of the healing arts . . . for maximum reduction of physical or mental disability and restoration of a recipient to his best functional level.”⁴³

Home and Community-Based Waiver Services may provide environmental accessibility adaptations, adaptive aids, specialized medical equipment and supplies, and personal emergency response systems.⁴⁴

In the absence of a federal definition for a Medicaid category of service, states must define the service in a manner consistent with the 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.⁴⁵

V. How is Medicaid Coverage of AT Established?

Medicaid coverage of an AT device or service is established when the item or service fits within the definition of one or more benefit categories included in the state plan.⁴⁶ This test for Medicaid coverage of medical equipment and supplies has been applied by federal and state courts across the country, spanning several decades, and addressing numerous items of equipment.⁴⁷ Consequently, the definitions of these

⁴³ 42 C.F.R. § 440.130(d).

⁴⁴ 42 C.F.R. § 440.180. In developing an HCBS waiver program, states can choose from an array of services, some of which encompass AT devices and services. Appendix C of a state’s application for a 1915(c) HCBS waiver program defines several of the allowed waiver services.

⁴⁵ See, e.g., *Bontrager v. Indiana Family & Soc. Servs. Admin*, 697 F.2d 604, 610 (7th Cir. 2012) (holding \$1,000 annual cap on dental treatments inconsistent with the purpose of the dental category of service); *Cushion v. Department of PATH*, 807 A.2d 425 (Vt. 2002) (holding Medicaid agency’s exclusion of partial dentures from coverage was an impermissible limitation of services under the optional dental services benefit). *Brisson v. Dept. of Social Welfare*, 702 A.2d 405 (Vt. 1997) (holding Medicaid agency’s refusal to cover a closed caption TV (CCTV) under the optional eyeglasses benefit to be an impermissible limitation on the scope of this service because the state failed to provide for those in greatest need of the service).

⁴⁶ As noted above, all categories of services are available to Medicaid beneficiaries under the age of 21 when medically necessary. 42 C.F.R. § 441.57.

⁴⁷ See e.g., *Alvarez v. Betlach*, 572 F. App’x 519 (9th Cir.) cert. denied, 135 S. Ct. 870 (2014) (rejecting Arizona Medicaid’s exclusion of incontinence briefs); *Lankford v. Sherman*, 451 F.3d 496 (8th Cir. 2006) (rejecting Missouri Medicaid’s restrictions on DME coverage); *Fred C. v. Texas Health & Human Services Comm’n*, 988 F.Supp. 1032 (W.D.Tx. 1997), affirmed per curiam 167 F.3d 537 (5th Cir. 1998) (requiring coverage of augmentative communication devices as DME and prosthetic devices); *Meyers v. Reagen*, 776 F.2d 241 (8th Cir. 1985) (requiring coverage of augmentative communication devices that fit within the scope of the equipment included in Medicaid’s speech-language pathology service); *Davis v. Shah*, No. 12-CV-6134 CJS, 2012 WL 1574944, (W.D.N.Y. May 3, 2012) (rejecting exclusion of orthopedic footwear and compression stocking as DME for certain beneficiaries) *Hiltibran v. Levy* 793 F.Supp.2d 1108 (W.D.Mo. 2011) (granting preliminary injunction requiring coverage of incontinence aids for adults as medical equipment); *Jasset v. R.I. Dept. of Hum. Serv.*, 2006 WL 2169891 at * 5 (R.I. Super. July 31, 2006) (citing *Bristol v. R.I. Dept. of Hum. Serv.*, 1997 WL 839884, at *5 (R.I. Super. Jan. 30, 1997) (prohibiting intent to go to work or school as a coverage criterion for a wheelchair because neither is related to medical necessity)); *Blue v. Bonta*, 99 Cal.App. 4th 980, 121 Cal.Rptr.2d 483 (Cal App. 2002)

various categories of service is key to establishing whether an AT device is covered by the state's Medicaid program.⁴⁸

A. AT and Durable Medical Equipment

Medicaid coverage of an AT device as DME is established when the item is "primarily and customarily used to serve a medical purpose, generally not useful to an individual in the absence of a disability⁴⁹, illness or injury, can withstand repeated use, and can be reusable or removable."⁵⁰ Items that meet this definition cannot be limited to those provided in a Medicaid beneficiary's home.⁵¹ Specifically, the federal home health regulation now states that beneficiaries can receive home health services "in any setting in which normal life activities take place."⁵² The only exceptions are hospitals, nursing facilities, intermediate care facilities for individuals with intellectual disabilities, or any

(requiring coverage of stairway elevator based on Medi-Cal DME definition); *T.L. v. Colorado Dept. of Health Care Policy & Fin.*, 42 P.2d 63 (Colo. App. 2002) (prohibiting express exclusion of whirlpool bath from consideration as DME and without consideration of medical need); *Will T. v. Taylor*, 465 F.Supp.2d 1267 (N.D. Ga. 2000) (requiring coverage of speech generating devices as DME, prosthetic devices and equipment under the speech-language pathology benefit); *Bell v. Agency for Health Care Admin.*, 768 So.2d 1203 (FL. App. 2000) (requiring coverage and provision of insulin pumps when medically necessary); *Johnson v. Minn. Dept. of Human Serv.*, 565 N.W.2d 453, 456 (Minn. App. 1997) (requiring coverage of a standing wheelchair to meet recipient's specific medical needs); *Davis v. Shrader*, 687 N.E.2d 370 (Ind. App. 1997) (requiring coverage of orthopedic shoes; precluding use of irrebuttable presumptions against coverage of specific types of treatment within covered services); *Ohlson v. Weil*, 953 P.2d 939 (Colo. App. 1997) (requiring coverage of body brace that meets Medicaid's DME definition); *Brisson v. Dep't of Social Welf.*, 702 A.2d 405 (VT. 1997) (prohibiting exclusion of closed circuit television because it meets Medicaid's definition of eyeglasses); *Hunter v. Chiles*, 944 F.Supp. 914 (S.D. Fl. 1996) (requiring coverage of speech generating devices as DME); *Myers v. State of Mississippi* 3:95 CV 185 LN (Slip Op. S.D. Miss. 1995) (requiring coverage of speech generating devices as DME); *Bowers v. Thompson*; No. 89-2-00553-8 Stipulation & Agreement & Consent Order (Wash. Super. Ct. Thurston County Oct. 15, 1990) (class action consent decree establishing medical necessity as decision-making standard for durable medical equipment, prosthetic devices and non-durable medical supplies); *Ledet v. Fischer*, 638 F. Supp. 1288, 1291 (M.D. La. 1986) (requiring coverage of eyeglasses regardless of diagnosis); *Baker v. Commonwealth of Pa. Dept. of Pub. Welfare*, 502 A.2d 318 (Pa. Commw. 1985) (requiring coverage of wheelchair with 500-pound carrying capacity).

⁴⁸ See e.g., *Fred C. v. Texas Health and Human Services Commission*, 924 F. Supp. 788, 791-92 (W.D. Tex. 1996), and 988 F. Supp. 1032 (W.D. Tex. 1997) (finding augmentative communication devices are both medical equipment and prosthetic devices), *affirmed per curiam*, 167 F.3d 537 (5th Cir. 1998) (reviewing DME only); *accord William T. ex rel. Gigi T. v. Taylor*, 465 F.Supp.2d 1267, 1284-87 (N.D. Ga. 2000) (alternative communication devices are home health services, prosthetic devices, and speech-language pathology equipment); *Conley v. Dept. of Health*, 287 P.3d 452, 465-68 (Utah. Ct. App. 2012)(review of augmentative communication devices under speech language pathology and DME).

⁴⁹ The word "disability" was added to the term "illness or injury" to address concerns that the previous language could be read to deny medical equipment and supplies to individuals with "congenital conditions or developmental disabilities." 81 Fed. Reg. 5540.

⁵⁰ 42 C.F.R. § 440.70(b)(3)(ii).

⁵¹ 42 C.F.R. § 440.70(c)(1). This provision codifies the principles established in *Detsel v. Sullivan*, 895 F.2d 58 (2d Cir.1990), and *Skubel v. Fuoroli*, 113 F.3d 330 (2d. Cir. 1997), that private duty nursing and home health services cannot be restricted to services furnished in the home. According to CMS "the purpose of this provision is to ensure the delivery of home health services not only in the home, but also in the community when the beneficiary is participating in normal life activities. 81 Fed. Reg. 5530, 5532.

⁵² 42 C.F.R. § 440.70(b)(3).

setting in which payment is or could be made under Medicaid for inpatient services that include room and board.⁵³ As explained by CMS, "states may not deny requests for items based on the grounds that they are for use outside of the home."⁵⁴

Just as states cannot limit where medical equipment and supplies will be used, home health services cannot be restricted to individuals who are "homebound." Among the 2016 revisions to the home health regulation is a provision clearly stating that "[h]ome health services cannot be limited to services furnished to beneficiaries who are homebound."⁵⁵ This revision codifies earlier CMS policy prohibiting states from imposing a "homebound" requirement for Medicaid beneficiaries seeking home health services.⁵⁶ The homebound prohibition for Medicaid home health services is particularly important for individuals who are dually eligible for Medicare and Medicaid.⁵⁷ While some dually-eligible beneficiaries may not qualify for Medicare home health services because they are not homebound, they may "still qualify for Medicaid home health services, if they meet the state's medical necessity criteria for the service."⁵⁸

Finally, states cannot limit the scope of DME available through the Medicaid home health benefit by establishing absolute exclusions of certain DME items. While states can establish lists of covered items in their rules and policies, supplier manuals,⁵⁹ or fee schedules for purposes of administrative convenience, they cannot restrict the scope of this benefit by excluding non-listed equipment that meets the definition of DME.⁶⁰ This important revision to the home health regulation codifies longstanding federal policy, as previously explained to the states in the policy guidance known as the *DeSario Letter*.⁶¹

⁵³ 42 C.F.R. §440.70(c)(1).

⁵⁴ 81 Fed. Reg. 5532.

⁵⁵ 42 C.F.R. §440.70(c)(1).

⁵⁶The prohibition on imposing a homebound requirement on home health services has been in effect for decades. On July 5, 2000, CMS issued policy guidance to the states explaining that Medicaid services must be provided in compliance with the Americans with Disabilities Act so that individuals with disabilities can live in the most integrated setting. As such, CMS explained that imposing a homebound requirement on receipt of Medicaid home health benefits violates Medicaid regulations related to "amount, duration, and scope of services" at 42 C.F.R. § 440.230 and "comparability of services" at 42 C.F.R. § 440.240. See Olmstead Letter No. 3, Attachment 3-g at <http://www.nasddd.org/resource-library/medicaid-hcbs-authorities/medicaid-hcbs-authorities/hcbs-waiver-state-medicaid-director-letters/olmstead-state-medicaid-director-letters/>.

⁵⁶ 42 C.F.R. §440.70(c)(1).

⁵⁷ 81 Fed. Reg. 5542-5543.

⁵⁸ 81 Fed. Reg. 5543.

⁵⁹ The state's DME manuals may be posted on the Medicaid agency's website or that of its contracted fiscal agent or managed care organizations.

⁶⁰ 42 C.F.R. § 440.70(b)(3)(v).

⁶¹ The *DeSario Letter* is available on the CMS website at <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD090498.pdf> (issued September 4, 1998).

1. The *DeSario Letter*

In 1996, several Connecticut Medicaid beneficiaries challenged the state's exclusive list of covered DME and its list of expressly excluded DME items.⁶² Under the state's rules, beneficiaries were unable to obtain these items of DME through prior authorization or the fair hearing process.⁶³ The district court found this regulation to be an unlawful presumption against coverage.⁶⁴ The agency appealed, but revised its coverage lists so that beneficiaries could obtain an unlisted or expressly excluded item if they could demonstrate that coverage was justified based on the needs of "the Medicaid population as a whole."⁶⁵ The U.S. Court of Appeals for the Second Circuit upheld the exclusive list of covered items and the "Medicaid population as a whole" standard as consistent with the Medicaid Act's reasonable standards requirement and amount, duration, and scope rule.⁶⁶

In response to this decision, the Health Care Financing Administration (HCFA, now CMS) issued policy guidance to state Medicaid directors to clarify that the Second Circuit's interpretation was incorrect. Known as the *DeSario Letter*, this policy guidance clarifies several important principles governing access to medical equipment (ME) through the home health benefit by Medicaid beneficiaries:

- First, Medicaid agencies may "develop a list of pre-approved items of [DME] as an administrative convenience because such lists eliminate the need to administer an extensive application process for each ME request submitted." To remain current, the state's pre-approved list should be updated periodically to reflect changes in available technology. In addition to this pre-approved list, states must also establish a "reasonable and meaningful procedure" within the DME request and appeal process for Medicaid beneficiaries to seek "modifications of or exceptions to a State's pre-approved list." This means that exclusive coverage lists and lists of expressly excluded DME items are prohibited.
- Second, to be "reasonable and meaningful," the state's procedure for determining coverage of medical equipment must allow for timely individualized decisions based upon the state's general DME definition.⁶⁷ The state may not use a "Medicaid population as a whole" test or require a beneficiary to demonstrate that, absent coverage of the item requested, the needs of "most" Medicaid recipients will not be met. As explained, this test, when applied in the DME context, establishes a standard that virtually no individual item of DME can meet.

⁶² *DeSario v. Thomas*, 139 F.3d 80 (2nd Cir. 1998), *rev'g* 963 F. Supp. at 120 (D.Conn. 1997), *cert. granted, vacated and remanded sub nom Slekis v. Thomas*, 525 U.S. 1098 (1999).

⁶³ *Id.* at 125-26;130.

⁶⁴ *Id.* at 134.

⁶⁵ *Id.* at 139, 142-43.

⁶⁶ *Id.* at 139.

⁶⁷ States' flexibility to define the DME benefit is constrained by the 2016 federal definition of this benefit. 42 C.F.R. § 440.70(b)(3)(i-ii). 81 Fed. Reg. 5538.

Nor can the state exclude items from coverage based solely on a diagnosis, type of illness, or condition.

- Third, the opportunity to seek non-listed DME must be available to Medicaid beneficiaries of all ages. States cannot exclude medical equipment for Medicaid beneficiaries when the item meets the DME definition.
- Fourth, the state's fair hearing process must be authorized to determine whether an adverse decision is contrary to federal Medicaid requirements, including the reasonable standards requirement and amount, duration, and scope regulation.

These principles have been reaffirmed by CMS numerous times since the *DeSario Letter* was issued. In 2011, CMS invited comment as to whether it would be useful to the states to incorporate the principles stated in the *DeSario Letter* in the final home health rule.⁶⁸ Ultimately, CMS determined it was necessary to codify this policy into rule and has now expressly affirmed that "[s]tates are prohibited from having absolute exclusions of coverage on medical equipment, supplies, or appliances."⁶⁹ Again noting that states may maintain a list of preapproved medical supplies, equipment, and appliances for "administrative ease" the regulation is clear that:

States must have processes and criteria for requesting medical equipment that is made available to individuals to request items not on the State's list. The procedure must use reasonable and specific criteria to assess items for coverage.⁷⁰ When denying a request, a State must inform the beneficiary of the right to a fair hearing.

States that exclude certain items of DME by rule, policy, or practice must bring their home health benefit into compliance with the revised home health regulation by eliminating such exclusions. For example, CMS wrote to the Texas Medicaid Director in 2013 to clarify this principle as applied to Medicaid coverage of ceiling lifts. As CMS explained, "[t]his means that medically necessary ceiling lifts will be reimbursed by CMS as part of the Texas home health benefit if these lifts meet the state's definition of DME."⁷¹

2. Application of the *DeSario Letter* Regarding DME Coverage.

With one exception, federal and state courts addressing the *DeSario Letter* have uniformly interpreted this policy guidance to prohibit categorical exclusions of medical equipment that meets the state's DME definition. Initially, the U.S. Supreme Court reviewed the *DeSario Letter* as this guidance was issued while the *DeSario* plaintiffs'

⁶⁸ 76 Fed. Reg. 41,034.

⁶⁹ 42 C.F.R. § 440.70(b)(3)(v).

⁷⁰ The new federal definition of medical supplies, equipment and appliances identifies the reasonable and specific criteria for determining whether an item is covered by Medicaid. 42 C.F.R. § 440.70(b)(3)(i-ii).

⁷¹ CMS Letter to Texas Health and Human Services Commission, May 21, 2013. Available at <http://www.nls.org/files/Disability%20Law%20Hotlines/National%20AT%20Advocacy/TXDMEfinal05212013.pdf>.

petition for certiorari was pending. The Supreme Court responded by granting the petition, vacating the Second Circuit decision, and remanding the case to the Court of Appeals based upon this clarification of federal policy.⁷² Ultimately, Connecticut Medicaid accepted the *DeSario Letter* as a prohibition on DME exclusions and adopted a new DME procedure consistent with this guidance.⁷³

Since then, other courts have also interpreted the *DeSario Letter* to prohibit categorical DME exclusions – exclusive lists of covered DME and lists of excluded DME – like those at issue in *DeSario*.⁷⁴ These cases illustrate that states' attempts to unnecessarily limit the scope of equipment covered by Medicaid run afoul of this federal guidance. Nonetheless, one court decision stands as an outlier on this critical point. In 2014, in direct conflict with the express language of the *DeSario Letter* and all other judicial interpretations of CMS policy, the U.S. Court of Appeals for the Fifth Circuit upheld a state's categorical exclusion of ceiling lifts from coverage as DME through the home health benefit.⁷⁵ In this case, the Court interpreted the *DeSario Letter* to authorize states to maintain a "never approved" list of DME.⁷⁶ This interpretation is inconsistent with every other court decision finding such lists to violate the Medicaid Act's reasonable standards requirement and amount duration and scope regulation.⁷⁷ It is also contrary to the 2016 revisions to the home health regulation incorporating the *DeSario* principles.⁷⁸ This regulation now unequivocally states that Medicaid programs "are prohibited from having absolute exclusions of coverage on medical equipment, supplies, or appliances."⁷⁹ As CMS explains, "because of the unique nature of medical supplies, equipment, and appliances, scope limitations within the applicable federal and state definitions are not consistent with the sufficiency of the benefit."⁸⁰

⁷² *Slekis v. Thomas*, 525 U.S. 1098 (1999).

⁷³ Pursuant to Conn. Admin. Reg. § 17b-262-716(a)(4): "Beneficiaries will use the prior authorization and administrative appeal process to establish that an item not on the agency's pre-approved list nonetheless fits the DME definition and is medically necessary. Equipment items meeting these criteria will be provided."

⁷⁴ See *Lankford v. Sherman*, 451 F.3d 496, 512-13 (8th Cir. 2006) (rejecting exclusive list of DME with no exceptions); *William T. ex rel. Gigi T. v. Taylor*, 465 F. Supp. 2d 1267, 1279 (N.D. Ga. 2000) (finding the *DeSario Letter* 'fully supports plaintiffs' contention that states may not categorically deny coverage for a particular [equipment item]"); *Esteban v. Cook*, 77 F. Supp. 2d 1256, 1260 (S.D. Fla. 1999) (same); *T.L. v. Colorado Dept. of Health Care & Fin.*, 42 P.3d 63,66 (CO. App. 2002) (same); *Bell v. Agency for Health Care Admin.*, 768 So.2d 1203, 1205 (Fla. App. 1st Dist 2000) (rejecting exclusive list of covered DME).

⁷⁵ *Detgen v. Janek*, 752 F.3d 627 (5th Circuit 2014).

⁷⁶ *Id.* at 632-633.

⁷⁷ 42 U.S.C. § 1396a(a)(17); 42 C.F.R. §440.230.

⁷⁸ In fact, the preamble to the 2016 home health regulation specifically identifies ceiling lifts and chair lifts as items that, while previously provided through HCBS waiver programs, "could now be seen in appropriate circumstances to meet the home health definition and be medically necessary for an individual." 81 Fed. Reg. 5542.

⁷⁹ 42 C.F.R. § 440.70(b)(3)(v).

⁸⁰ 81 Fed. Reg. 5539.

B. AT and Other Medicaid Benefit Categories

In some cases, a requested AT device may not meet the definition of DME or the beneficiary may not be eligible for home health services. In those instances, there may be a more appropriate benefit category for establishing Medicaid coverage of the necessary AT item. Given the broad scope of Medicaid's required and optional categories of service, an AT device may fit within one or more benefit categories found in the Medicaid state plan.⁸¹ As discussed above, physical therapy, occupational therapy, and speech therapy, which by definition include necessary equipment, prosthetics, preventative services, and rehabilitative services are categories of service that may also allow for coverage of particular AT devices.

Keep in mind that states cannot characterize an AT device as belonging in one category of service, to the exclusion of all others, in an attempt to limit the scope of coverage. For example, a state cannot solely cover speech generating devices (SGDs) under the optional category of speech language pathology services in order to limit their availability to children (and deny them to adults), when SGDs also satisfy the definitions of DME, prosthetic device, or other benefit category included in the state plan.⁸² This approach also has been used by some states to restrict access to certain AT devices to HCBS waiver participants. CMS is clear, however, that this type of restriction is unacceptable. As explained, "[s]tates may not restrict access to equipment that meets the criteria for coverage under the home health benefit by carving certain equipment out of home health and offering it only to individuals who qualify under a state's [HCBS waiver programs]."⁸³ Accordingly, to the extent there is "overlap" of coverage between items of DME and other benefit categories, such items must be provided through home health.⁸⁴

C. AT for Residents of Medicaid-Funded Facilities

While most AT obtained through Medicaid is covered as DME through the home health benefit, keep in mind that individuals residing in certain institutions are not eligible for home health services, including DME. In some states, establishing a Medicaid beneficiary's entitlement to specialized or customized medical equipment when the individual resides in a Nursing Facility (NF) or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) presents a different set of challenges than for those Medicaid beneficiaries living in the community. Despite these obstacles,

⁸¹ See *Fred C. v. Texas Health and Human Services Commission*, 924 F. Supp. 788, 791-92 (W.D. Tex. 1996), and 988 F. Supp. 1032 (W.D. Tex. 1997) (finding augmentative communication devices are both medical equipment and prosthetic devices), *affirmed per curiam*, 167 F.3d 537 (5th Cir. 1998) (reviewing DME only); *William T. ex rel. Gigi T. v. Taylor*, 465 F.Supp.2d 1267, 1284-87 (N.D. Ga 2000) (alternative communication devices are home health services, prosthetic devices, and speech-language pathology equipment).

⁸² *Conley v. Dept. of Health*, 287 P.3d 452 (Utah. Ct. App. 2012) (coverage of speech generating devices under speech language pathology and DME).

⁸³ 81 Fed. Reg. 5538.

⁸⁴ 81 Fed. Reg. 5535.

the Medicaid Act strongly supports the entitlement of these residents to medically necessary medical equipment or AT.

1. Nursing Facility Residents

In 1986, the Institute of Medicine (IOM), acting at the request of Congress, investigated the plight of nursing facility (NF) residents.⁸⁵ One year later, the IOM's findings of deplorable conditions and widespread neglect of NF residents led to the passage of the Nursing Home Reform Act (NHRA), which was made part of the Omnibus Budget Reconciliation Act of 1987.⁸⁶ The provisions added to the Medicaid Act instituted quality standards for nursing facilities and an enforcement process to ensure these standards are met. The NHRA also established a clear statement of the rights of NF residents and the special protections applicable to those residents with intellectual disabilities or mental health needs.

The standard of care set by the NHRA is a high one -- NF residents are entitled to services and activities that will allow them "to attain or maintain the highest practicable physical, mental, and psycho-social well-being."⁸⁷ The key to meeting this standard of care is a comprehensive assessment of each individual's "functional capacity." This assessment must be completed on an annual basis or when there is a significant change in the resident's physical or mental condition.⁸⁸ Quarterly examinations of residents are required to ensure "continued accuracy of the assessment."⁸⁹

Assessments for NF residents with intellectual disabilities, related conditions, or mental health conditions must include additional considerations arising from the Pre-Admission Screening and Resident Review ("PASRR") requirements. For example, assessment of an NF resident with intellectual disabilities 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."⁹⁰ An assessment of a resident with mental health needs must, at a minimum, examine the individual's ability to perform activities of daily living, self-monitor health and nutritional status, and his or her need for "specific therapies and activities for the treatment of an acute episode of mental illness."⁹¹ If the assessment indicates a need for additional specialized services, NF residents with intellectual disabilities, related conditions, or mental health concerns must be provided such services.

⁸⁵ See, *Improving the Quality of Care in Nursing Homes*, Committee on Nursing Home Regulation, Institute of Medicine (1986). The full text of this report is available at www.books.nap.edu/books.

⁸⁶ P.L. 100-203.

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

⁸⁸ 42 U.S.C. §§ 1396r(b)(3)(A); 1396r(b)(3)(C); 42 C.F.R. § 483.20(b).

⁸⁹ 42 U.S.C. § 1396r(b)(3)(C)(ii); 42 C.F.R. § 483.20(c).

⁹⁰ 42 C.F.R. § 483.136.

⁹¹ 42 C.F.R. § 483.134.

The assessments and reassessments of NF residents mandated by the NHRA form the basis for the plan of care established for each individual.⁹² Developed by a team of people, including the attending physician, a registered nurse, and the resident or his or her family, the plan of care must describe the needs of the resident and how these needs will be met.⁹³ In addition to preserving each resident's general health and well-being, the plan of care must provide services to ensure the resident's 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."⁹⁴

Specialized rehabilitative services are often essential to ensure that NF residents maintain their ability to perform activities of daily living or to address other needs. If needed, rehabilitative services such as physical, occupational, and speech therapies must be included in a NF resident's plan of care.⁹⁵ Specialized services are those needed to increase PASRR-eligible residents' level of independent functioning and to preserve their optimal functional status.⁹⁶

In light of the high standard of care established by the NHRA, you might think 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 NFs 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 per diem payment must include nursing services, dietary services, an activities program, room/bed maintenance services, routine personal hygiene items, and medically related social services.⁹⁷ Depending on individual state requirements, additional services, including DME, may be included in the daily rate or may be separately reimbursed by Medicaid.⁹⁸ For example, Nebraska Medicaid policy identifies items of DME for NF residents that are separately paid for by Medicaid.⁹⁹ This policy indicates that SGDs and power wheelchairs are available to NF

⁹² 42 U.S.C. § 1396r(b)(2)(a).

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

⁹⁴ 42 C.F.R. § 483.25(a)(1).

⁹⁵ 42 C.F.R. § 483.45, *citing* 42 C.F.R. § 483.440(a). Therapies, including physical, occupational, and speech therapy, are defined in 42 C.F.R. § 440.110 and include any necessary supplies and equipment required as part of the therapeutic regimen.

⁹⁶ 42 C.F.R. § 483.120.

⁹⁷ 42 C.F.R. § 438.10(c)(8)(i)(A-F).

⁹⁸ The rights of NF residents to Medicaid-funded DME do not diminish because of the manner in which Medicaid payment is made. Whether DME is included in the daily rate or separately reimbursed, may impact how you advocate for your client to obtain AT devices or services.

⁹⁹ Nebraska HHS Finance and Support Manual, 471 NAC 7-005. This policy also indicates that these items of DME are available to residents of ICF-IIDs.

residents.¹⁰⁰ Texas Medicaid also provides Medicaid reimbursement for custom power wheelchairs and SGDs outside of the daily rate paid to the NF.¹⁰¹

In other states, Medicaid policies make clear that specific items of equipment for NF residents must be covered by the facility rather than through a separate Medicaid payment mechanism. In Colorado, for example, Medicaid policy specifically identifies a list of medical equipment and other services that are included in the daily rate paid to the facility, including medically necessary manual or power wheelchairs.¹⁰²

Given the different NF payment methods used by state Medicaid agencies, you should fully research your state's Medicaid policies concerning coverage of medical equipment, NF payment rules, or other long term care policies governing covered services, as well as any other categories of state plan services (i.e., prosthetics) that may include the type of equipment needed by a NF resident. Despite some of the procedural barriers that may inhibit access to AT by NF residents, the law is clear these residents are entitled to medically necessary AT devices and services.

2. Residents of Intermediate Care Facilities for Individuals with Intellectual Disabilities

The addition of ICF-IID facilities (formerly referred to as ICF-MR facilities) to the array of optional Medicaid services in 1971 was intended to assist states in providing appropriate services to beneficiaries with certain developmental disabilities. According to federal Medicaid regulations, the “primary purpose” of ICFs-IIDs is to “furnish health or rehabilitative services to persons with Intellectual Disabilities or persons with related conditions.”¹⁰³ 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 allows residents to acquire independence and exercise self-determination or slow or otherwise prevent the loss of current skills.¹⁰⁴

To ensure that ICF-IID residents 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.¹⁰⁵ These assessments, which must be completed within 30 days of admission to the facility, form the basis for each resident’s individual program plan (IPP).¹⁰⁶ The IPP must contain specific objectives that are stated in measurable behavioral terms and are prioritized for the resident. Staff who are

¹⁰⁰ The policy governing coverage of wheelchairs is clear that Nebraska Medicaid covers non-standard wheelchairs. The NF is responsible for providing standard wheelchairs to residents who need such equipment.

¹⁰¹ 40 Tex. Admin. Code § 19.2613 (SGDs); § 19.2614 (custom power wheelchairs).

¹⁰² 10 CCR 2505-8.440.1(B).

¹⁰³ 42 C.F.R. § 440.150(a)(2).

¹⁰⁴ 42 C.F.R. § 483.440(a)(1)(i-ii).

¹⁰⁵ 42 C.F.R. § 483.440(c)(3).

¹⁰⁶ 42 C.F.R. § 483.440(c).

responsible for implementing the plan must be identified and the type and frequency of data collection must be established.

AT devices should be provided to residents to ensure that independent living skills are obtained and stated objectives are met. For example, SGDs should be provided to those residents who cannot use oral speech as their primary mode of communication. Numerous other items of AT, including environmental control units, adapted eating utensils, or certain computer software programs can also support the acquisition of independent living skills and should be provided to residents as needed.

3. AT for Participants in Home and Community-Based Services Waiver Programs.

Since 1981, the Medicaid Act has permitted states to seek optional waivers that allow certain flexibility in administering their Medicaid programs.¹⁰⁷ HCBS waiver programs, often referred to as 1915(c) waivers, have provided necessary community support services to thousands of people with disabilities who, without these services, would require institutional care.¹⁰⁸

A similar benefit, known as the 1915(i) Home and Community-Based State Plan Option, has been available to state Medicaid programs since 2005.¹⁰⁹ This optional service also extends the benefits available through a 1915(c) waiver to individuals with disabilities.¹¹⁰ As of March 2015 only 15 states have chosen the option to provide home and community-based services as a state plan service for specific population groups.

Another state plan option, "Community First Choice," was established under the Affordable Care Act of 2010.¹¹¹ This optional service allows states to provide long-term services and supports to individuals in their homes rather than in institutions. States choosing to implement this option are entitled to a 6 percent increase in their FMAP for the services provided through this benefit.¹¹² The purpose of the Community First Choice option is to provide personal care and habilitation services so that individuals with disabilities can remain in their own homes. While AT devices and services and medical equipment are generally excluded from this benefit, certain limited equipment that may increase independence or substitute for human assistance can be provided through this program.¹¹³

¹⁰⁷ 42 U.S.C. § 1396n(b).

¹⁰⁸ 42 U.S.C. § 1396n(c).

¹⁰⁹ 42 U.S.C. § 1396n(i).

¹¹⁰ These states include: California, Colorado, Connecticut, Florida, Idaho, Indiana, Iowa, Louisiana, Maryland, Michigan, Mississippi, Montana, Nevada, Oregon, Wisconsin, and the District of Columbia. See <http://kff.org/medicaid/state-indicator/section-1915i-home-and-community-based-services-state-plan-option/>.

¹¹¹ 42 U.S.C. § 1396n(k).

¹¹² 42 U.S.C. § 1396n(k)(2).

¹¹³ 42 U.S.C. § 1396n(k)(C)(iii-iv); 42 U.S.C. § 1396n(k)(B)(ii).

Importantly, these HCBS options represent a potential source of funding for AT devices and services. With these waiver programs, states can obtain FFP for a variety of services that are different from, or beyond the scope of, the services typically covered by the state plan. These may include “such other services requested by the State as the Secretary may approve . . .”¹¹⁴ Home modifications such as installing permanent ramps, widening doorways, or making bathrooms accessible, and adaptive aids, which help improve physical functioning or access to the environment, fit within this category and are covered services under HCBS waiver programs in many states. Some waiver programs provide vehicle modifications, as well.

Waiver services cannot duplicate state plan services but can augment these services when approved by CMS. For example, if a state limits the number of annual home health aide visits that are available as a state plan service, they may augment this service by allowing additional home health aide visits through the waiver. But, as stated previously, the preamble to the 2016 home health regulation reaffirms that a state must consider a requested AT item or service under **any** benefit category included in its state plan and cannot restrict these items to HCBS Waiver programs.¹¹⁵

This latter point is particularly important in HCBS waiver programs that apply an individual cost cap for waiver services. Participants should not have to utilize their limited waiver funds to obtain an AT device or service that is available, or should be available, through other state plan benefits. If, however, an item is not covered by any state plan service categories, a waiver participant may be able to obtain the item through the Medicaid waiver program.

VI. When is AT Medically Necessary?

Once Medicaid coverage of an AT device is established, the beneficiary must demonstrate that the requested item is medically necessary. As described below, the beneficiary's treating medical professionals play a critical role at this stage of the process.

A. The Meaning of Medical Necessity

The Medicaid Act does not include a general definition of medical necessity that applies to all beneficiaries. The Act does make clear that, for Medicaid beneficiaries under 21 years of age, medical necessity is established when requested health care, diagnostic services, treatment, or other measures are required "to correct or ameliorate defects and physical and mental illnesses and conditions . . ."¹¹⁶ This means that for children and youth, Medicaid services must be provided if needed to correct, to compensate for, or to improve a condition, or to prevent a condition from worsening.¹¹⁷

¹¹⁴ 42 U.S.C. § 1396n(c)(4)(B); 42 CFR 44.180; 42 C.F.R. § 44.180; HCBS Waiver Application App. C-1.

¹¹⁵ 81 Fed. Reg. 5538.

¹¹⁶ 42 U.S.C. §1396d(r)(5).

¹¹⁷ See *Ekloff v. Rodgers*, 443 F. Supp. 2d 1173, 1181 (D. Ariz. 2006) (holding "the phrase 'to correct or ameliorate' within the EPSDT provision is meant to include incontinence briefs for preventive purposes for

In the absence of a federal medical necessity definition for adult beneficiaries, some states define this term to require that the requested Medicaid service be appropriate for the beneficiary's medical condition or disability and that provision of the service be consistent with accepted standards of medical practice. Some states also recognize that services may be medically necessary if they will "prevent" illnesses or injuries.¹¹⁸ A state's medical necessity definition may be found in state statute, rule, policy, or the agency's provider manuals.¹¹⁹

B. Establishing Medical Necessity

1. The Face-to-Face Encounter

Since 2011, Medicare has required a face-to-face encounter between patient and health care provider prior to, or in some instances, shortly after, initiation of home health services. This requirement will now apply to home health services, including medical equipment, provided through Medicaid.¹²⁰ Upon implementation of this new requirement by the states, Medicaid beneficiaries seeking DME must have a face-to-face encounter with the ordering physician or a non-physician provider such as a nurse practitioner, a clinical nurse specialist, or a physician assistant.¹²¹ This face-to-face encounter can be conducted through the telehealth procedures utilized by the state.¹²² Regardless of the manner in which the face-to-face encounter occurs, it must take place no more than 6 months prior to the start of service and "must be related to the primary reason the beneficiary requires medical equipment."¹²³ The physician ordering the DME or supplies must explain the "clinical correlation" between the face-to-face encounter and the requested item of DME.¹²⁴ Failure to follow these procedures for any item of DME specified by CMS to be subject to this requirement under the Medicare program will result in the denial of Medicaid payment for the requested item.¹²⁵

While not explicitly stated in the Medicaid home health regulation, CMS has explained that states have the discretion to determine whether the face-to-face

Plaintiff children."); See also *A.M.T. v. Gargano*, 781 F. Supp. 2d 798, 806-07 (S.D. Ind. 2011) (adopting the definition of "ameliorate" used by the district court in *Ekloff*—"to make better or more tolerable" in light of "Congress' intent to be inclusive rather than exclusive with EPSDT.")

¹¹⁸ See e.g., Minnesota Rules § 9505.0175; Ohio Administrative Code § 5160-1-01(B); Title 55 PA Code (Public Welfare) § 1101.21; Tenn. Code Ann. 71-5-144; W.VA. Medicaid Program Regulations, Chapter 527.2.; Conn. Dept. of Social Services, Regulations § 17b-262-673(17); N.Y. Social Services Law, § 365-a(2); 2015 TMPPM DME Handbook § 2.2.2 (Texas).

¹¹⁹ The preamble to the 2016 home health regulation explains that a state's medical necessity criteria must be based upon accepted medical practices and standards. 81 Fed. Reg. 5533.

¹²⁰ The revised regulation incorporates the face-to-face encounter requirement for home health services, as set out in Section 6407 of the Patient Protection and Affordable Care Act of 2010 and Section 504 of the Medicare Access and CHIP Reauthorization Act of 2015.

¹²¹ 42 C.F.R. § 440.70(f)(3).

¹²² 42 C.F.R. § 440.70(f)(6).

¹²³ 42 C.F.R. § 440.70(f)(2).

¹²⁴ 42 C.F.R. § 440.70(f)(5).

¹²⁵ 42 C.F.R. § 440.70(g)(1); 81 Fed. Reg. 5558.

encounter requirement will apply to Medicaid managed care.¹²⁶ If a state requires Medicaid managed care organizations to comply with this requirement, the managed care plans must report to the state "in a manner similar to fee-for-service [Medicaid]."¹²⁷

2. The Letter of Medical Necessity

A qualified medical professional, whether a physician, physical therapist, speech therapist, or other relevant health care provider, must provide support for the claim that a particular AT device or service is medically necessary. Typically, a well-drafted letter of medical necessity (LMN) is part of the prior authorization request for AT and is necessary if a case must go to a Medicaid fair hearing. While there is no special format a LMN must take, there are some general guidelines to follow. Where possible, the LMN should be written on the health care provider's letterhead and should be dated and signed. The letter should list the medical provider's professional title, relevant credentials, and any special licenses he or she may have. The medical provider should explain the nature of his or her relationship with the Medicaid beneficiary, the length of time working with him or her, and any specific evaluations or tests conducted to determine the need for an AT device or service. In particular, the medical professional should specify how the recommended device or service will treat the beneficiary's medical conditions or otherwise address the limitations caused by his or her disability.

An effective LMN should avoid the use of technical terms without explanation when possible, and should describe the beneficiary's limitations in functional terms so that people without the same medical training can understand why the beneficiary requires the requested device.¹²⁸ If the medical provider is recommending a specific item of AT for the beneficiary, he or she should explain any other less costly alternatives that were considered and why these alternatives were ruled out. In particular, the medical providers must explain why other alternative items of equipment are not equally effective in meeting the individual's medical or functional needs.

C. Who Determines Medical Necessity?

The Medicaid program is based on the longstanding principle that treating health care providers play a central role in determining the medical necessity of requested services.¹²⁹ As stated in the legislative history of the Medicaid Act:

The committee's bill provides that the physician is to be the key figure in determining utilization of health services - and provides that it is a physician who is to decide upon admission to a hospital, order tests, drugs

¹²⁶ 81 Fed. Reg. 5564.

¹²⁷ 81 Fed. Reg. 5564.

¹²⁸ For further information on letters of medical necessity, see, *Preparing Letters of Medical Justification: Key Components That Will Support the Need for Durable Medical Equipment Through Medicaid and Other Third Party Insurers*, The AT Advocate, Winter 2006, available at <http://nls.org/files/AT%20Advocate%20Newsletters/Advocatewinter06.pdf>.

¹²⁹ The preamble to the 2016 home health regulation continues this principle by explaining that approval of DME is based upon the physician's judgment of medical need. 81 Fed. Reg. 5541.

and treatments, and determine the length of stay. For this reason the bill would require that payment could be made only if a physician certifies to the medical necessity of the services furnished.¹³⁰

This does not mean state Medicaid programs have no role to play in medical necessity determinations. In *Moore v. Reese*, the U.S. Court of Appeals for the Eleventh Circuit concluded it is a "false dichotomy" to say that either the treating physician or the state's medical expert has "complete control" as to whether a particular Medicaid service is medically necessary.¹³¹ The Court further emphasized that "[w]hile Congress could have conferred the 'final arbiter' role to the state, it did not."¹³²

Needless to say, it is critical that a beneficiary's treating medical provider understand the state's medical necessity standard and clearly document how a recommended AT device or service satisfies this standard. It is also critical that the beneficiary's medical provider supply any additional information, beyond that contained in the LMN that the Medicaid agency may request during the prior authorization process.

VII. What is the Process for Requesting Medicaid Approval of AT?

A. The Prior Authorization Process

Most, if not all, states require medical equipment, supplies, and other benefits to be prior authorized in order to obtain Medicaid reimbursement. This means that the Medicaid beneficiary, typically in conjunction with a Medicaid-enrolled DME supplier, must request that the state Medicaid agency approve the equipment before it is received.

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.¹³³ However, a state Medicaid agency may not use the prior authorization process to cause unreasonable delays in obtaining equipment.¹³⁴ Federal regulations do not set a precise time for prior authorization

¹³⁰ See S. Rep. No. 404, 89th Cong., 1st Sess., reprinted in 1965 U.S.C.C.A.N. 1943. See also *Weaver v. Reagan*, 886 F.2d 194, 200 (8th Cir. 1989) (finding that "[t]he Medicaid statute and regulatory scheme create a presumption in favor of the medical judgment of the attending physician in determining the medical necessity of treatment."); *Pinneke v. Preisser*, 623 F.2d 546, 550 (8th Cir. 1980) (stating that "[t]he decision whether or not certain treatment or a particular type of surgery is 'medically necessary' rests with the individual recipient's physician and not with clerical personnel or governmental officials.")

¹³¹ 637 F. 3d 1220, 1259-1260 (11th Cir. 2011). See *Layer v. Novello*, 17 A.D.3d 1123 (NY AD 4th Dept. 2005) (reversing N.Y. Medicaid's hearing decision upholding denial of a stander and finding that the testimony of the physical therapist as to the medical benefits of passive standing was entitled to significant weight and could not be outweighed solely by the opinions of non-medical personnel or persons not in the same medical profession, citing 18 N.Y.C.R.R. § 513.6(e)).

¹³² *Id.* at 1259.

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

¹³⁴ 42 U.S.C. §§ 1396a(a)(8); 1396a(a)(17).

decisions; however, several courts have found that prior authorization timeframes between 15 and 30 days to be reasonable.¹³⁵

The prior authorization process may include two considerations - coverage of the requested device and the beneficiary's medical need for the item. As explained, an AT device is covered when it fits the definition of DME in the mandatory home health benefit or the definition of any optional services your state has included in its Medicaid state plan. The item is medically necessary if the documentation submitted on behalf of the beneficiary demonstrates the requested item will address the individual's medical or functional needs and there is no less costly, equally effective alternative device that will do so.

B. Requesting Prior Authorization

The information required to obtain prior authorization will vary depending on the AT requested and the type of assessment required. There is, however, some general information that should be included in a prior authorization request:

- Documentation of a face-to-face encounter
- A physician's prescription, order, or LMN that identifies the specific AT requested and explains why this item is medically necessary. (This may come from another health professional if allowed by your state Medicaid rules.)
- An assessment that establishes the recommended equipment is effective in meeting the medical or functional needs of the beneficiary.

Depending on the item of AT requested, the written assessment may be conducted by a speech-language pathologist, physical therapist, occupational therapist or other enrolled health care provider. These written evaluations can be fairly lengthy and, oftentimes, reports from different therapists are required to address different areas of need. For example, a speech language pathologist may recommend a SGD based on an individual's communication needs, while an occupational therapist or physical therapist will address the correct positioning of the device or other access issues.

DME suppliers are often involved in gathering the documentation necessary to support a request for prior authorization of an item of medical equipment and submitting this documentation to the state Medicaid agency or MCO. Medicaid-enrolled DME suppliers should be familiar with the criteria used to determine if a requested AT device is covered and, in some instances, may be able to assist a beneficiary's treating physician or therapist with preparing documentation that fully addresses the beneficiary's medical need for the device. DME suppliers may also play a role in

¹³⁵ See *Ladd v. Thomas*, 14 F. Supp. 2d 222, 225 (D. Conn. 1998) (approving 20 working days); *Kessler v. Blum*, 591 F.Supp. 1013, 1031–32 (S.D.N.Y.1984) (imposing 21 day time limit); *McMahon v. Minter*, No. 3251 (Sup.Ct.Mass., Feb. 24, 1975) (approving consent decree establishing 15 day limit).

ensuring the requested AT is appropriate for the beneficiary as it is the supplier who is often most familiar with the function and components of the requested AT.¹³⁶

Some state Medicaid agencies use prior authorization criteria or guidelines when reviewing requests for particular types of AT. These guidelines are often found in the state's rules or policies or in Medicaid provider manuals and should be addressed by medical providers when preparing a request for AT. Unless formally promulgated through the state's formal rule-making process, these manuals, and the guidelines contained in them, are not part of the rules governing the Medicaid program. As such, this information may be invalid if it conflicts with federal and state requirements. For example, some provider manuals list equipment and devices that are categorically excluded from Medicaid coverage. However, as previously discussed in section V.A.1, above, state Medicaid programs are prohibited from using lists of excluded medical equipment. When the criteria in these provider manuals are not part of the state's officially promulgated Medicaid rules, they may be subject to challenge in a Medicaid fair hearing and in court, if necessary.

C. Medicaid Requests for Additional Information

In certain cases, the state may request additional information during the prior authorization process. This is sometimes referred to as “pending” the request. Typically, if the Medicaid agency pends the request, the physician or therapist should provide any additional medical information and the DME supplier should provide any technical information about the device, such as DME coding.

Importantly, the Medicaid agency cannot unreasonably delay a prior authorization decision by repeatedly asking for additional information. If this occurs, you can request a fair hearing on the basis that the Medicaid agency has failed to act with reasonable promptness in deciding the beneficiary's eligibility for the requested item of equipment.¹³⁷

VIII. What Appeal Rights do Medicaid Beneficiaries Have?

The due process rights of Medicaid beneficiaries are well-established in the law.¹³⁸ These rights, which include timely and adequate notice and the opportunity for a fair hearing before an impartial decision maker, come into play when a Medicaid beneficiary must challenge the denial of an AT device or service by a state Medicaid agency or by the private entities with which the state contracts.

¹³⁶ Advocates should not overlook the assistance that medical equipment suppliers or manufacturers can provide in securing Medicaid approval of AT devices. In some instances, qualified DME suppliers can assist in preparing for a Medicaid fair hearing and may serve as an appropriate witness at the hearing.

¹³⁷ 42 U.S.C. § 1396a(a)(3); 42 C.F.R. § 431.200-.250; 42 C.F.R. § 435.911-.920.

¹³⁸ Medicaid beneficiaries have a property interest in their Medicaid benefits pursuant to the Fourteenth Amendment to the U.S. Constitution. See *Goldberg v. Kelly*, 397 U.S. 254 (1970).

A. Timely Decision-Making

State Medicaid agencies must make timely decisions concerning an individual's eligibility for Medicaid services and must "furnish Medicaid promptly without any delay caused by the agency's administrative procedures."¹³⁹ The "reasonable promptness" requirement of the Medicaid Act is of particular importance when an individual is seeking any type of medical care, including AT devices or services that must be approved through prior authorization.¹⁴⁰ As noted in section VII. A, above, courts have determined that a reasonable timeframe for prior authorization decisions is anywhere between 15 and 30 days.

B. Adequate Notice of Adverse Decisions

Timely and adequate notice must be sent whenever a Medicaid program takes "action" against an eligible beneficiary. The term "action" is defined to include the "termination, suspension, or reduction of Medicaid eligibility or covered services,"¹⁴¹ but may also include an "approval" of a service with modifications that do not meet the needs of the beneficiary.¹⁴² 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.¹⁴³

The adequacy of the written notice sent to inform beneficiaries 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 these notices to contain specific information about the proposed action. In particular, a notice 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.¹⁴⁴

¹³⁹ 42 U.S.C. § 1396a(a)(8); 42 C.F.R. § 435.930.

¹⁴⁰ See *Perry v. Chen*, 985 F. Supp. 1197 (D. Ariz. 1996).; *Jeneski v. Myers*, 163 Cal. App.3d 18 (1984), cert. denied *Kizer v. Jeneski*, 471 U.S. 1136 (1985) (holding that notice and hearing rights apply to denial of prior authorization requests for medication.).

¹⁴¹ 42 C.F.R. § 431.201; see, *Olson v. Wing*, 281 F. Supp. 2d 476, (E.D. N.Y. 2003) (holding that recipients of Disaster Relief Medicaid entitled to notice, fair hearings, and continued benefits pending the hearing.)

¹⁴² See *Ladd v. Thomas*, 962 F. Supp. 284, (D. Conn. 1997) (holding that notice and an opportunity for a fair hearing are required when a request for DME is approved, with modifications.).

¹⁴³ See *Parry v. Crawford*, 990 F. Supp. 1250 (D. Nev. 1998) (holding that Medicaid beneficiary seeking ICF/IID services is 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.).

¹⁴⁴ 42 C.F.R. § 431.210. The required content of notices sent to beneficiaries enrolled in Medicaid MCOs is set out in 42 C.F.R. § 438.404(b).

The legal sufficiency of the notice denying, terminating, or reducing Medicaid services is an important issue for Medicaid advocates. In some states, these notices often provide little in the way of a complete, or even accurate, explanation of why a particular service was reduced or denied. Notices containing denial codes with cryptic notations such as “not medically necessary” or “fails to meet prior authorization criteria” or “not covered for individuals over 21 years of age” are legally inadequate and should be challenged by Medicaid advocates. One such challenge resulted in a 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.¹⁴⁵ In addition to providing specific information as to the factual basis for a reduction or denial of service, the state Medicaid agency must also cite and “make available . . . a copy of the specific policy materials necessary . . . to prepare for a fair hearing.”¹⁴⁶

The importance of the content of the denial notice cannot be overstated. The reasons given for the denial or modification of an AT request and the legal basis supporting that decision set the parameters for the fair hearing when one is requested. If your client's denial notice does not conform to federal Medicaid requirements, you may want to raise this issue with the Medicaid agency before proceeding to challenge the merits of the denial, or if appropriate, at a fair hearing.

C. The Right to a Fair Hearing

State Medicaid agencies are required to publicize their hearing procedures and to inform beneficiaries of the right to request a hearing, the procedures to follow to obtain a hearing, and the ability to have an attorney or other representative, including a friend or relative, assist them at the fair hearing.¹⁴⁷ 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 Medicaid agency may provide a state level hearing or may utilize a two-tier system in which an evidentiary hearing is held at the local level, with the Medicaid beneficiary retaining his or her right of appeal to a state agency hearing, when necessary.¹⁴⁸ If the state Medicaid agency implements a local hearing system, the beneficiary must receive any adverse decision in writing and must be informed of the right to appeal the decision to the state agency or request a *de novo* hearing before the state agency.¹⁴⁹

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.¹⁵⁰

¹⁴⁵ See *Cherry v. Tomkins*, 1995 WL 502403 (S. D. Ohio 1995).

¹⁴⁶ 42 C.F.R. § 431.18(e)(2).

¹⁴⁷ 42 C.F.R. § 431.206.

¹⁴⁸ 42 C.F.R. § 431.205.

¹⁴⁹ 42 C.F.R. § 431.232.

¹⁵⁰ 42 C.F.R. § 431.230.

The notice of adverse action must specify this shortened time frame for requesting a hearing if the beneficiary wishes to have his or her benefits continue pending the outcome of the hearing.¹⁵¹ While it is often necessary for Medicaid beneficiaries to continue benefits pending the hearing, you should be aware the agency can “recoup the cost of any services furnished to the recipient, to the extent [the services] were furnished solely by reason of this [hearing request].”¹⁵²

A Medicaid beneficiary who requests a fair hearing has the right to review his or 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.¹⁵³ The fair hearing must be conducted by someone who has no direct involvement with the action that is the subject of the hearing.¹⁵⁴ 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.¹⁵⁵

The beneficiary's presentation of his or her case at the fair hearing should closely align with the reasons given for the denial in the Medicaid agency's notice of adverse action. If the agency contends the AT device is not medically necessary, you should provide written or oral testimony from the medical provider who recommended the device to explain why the agency's determination of medical necessity is incorrect.¹⁵⁶ This is why it is critical the denial notice provides sufficient factual detail as to why the agency denied the AT device in the first instance.

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.¹⁵⁷ Typically, unsuccessful hearing petitioners can seek judicial review of the agency's final administrative decision in state court.¹⁵⁸

D. Appealing Adverse Decisions by Medicaid Managed Care Organizations

Medicaid beneficiaries enrolled in a Medicaid MCO have the same due process rights as beneficiaries in fee-for-service Medicaid.¹⁵⁹ In addition, however, MCOs are required to establish internal grievance and appeal processes for enrollees that can be

¹⁵¹ 42 C.F.R. § 431.210(e).

¹⁵² 42 C.F.R. § 431.230(b).

¹⁵³ 42 C.F.R. § 431.242.

¹⁵⁴ 42 C.F.R. § 431.240(a)(3).

¹⁵⁵ 42 C.F.R. § 431.241.

¹⁵⁶ According to CMS, states "must provide an opportunity for an individualized hearing as to whether the [DME] item is medically necessary in the particular circumstances." 81 Fed. Reg. 5539.

¹⁵⁷ 42 C.F.R. § 431.244.

¹⁵⁸ 42 C.F.R. § 431.245.

¹⁵⁹ As this publication went to press, CMS was expected to issue final rules in early May 2016 addressing a wide range of issues relating to Medicaid managed care, including appeals of denied services.

pursued prior to requesting a fair hearing.¹⁶⁰ These processes must provide the MCO enrollee "a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing."¹⁶¹ States must establish timelines for MCOs to resolve grievances and appeals, with the former not to exceed 90 days, and the later not to exceed 45 days, from the date the MCO receives the grievance or appeal.¹⁶² Expedited resolution of appeals cannot exceed more than three working days following receipt of the appeal.¹⁶³ MCOs must inform the enrollee of the outcome of the appeal in writing and if adverse to the enrollee, inform him or her of the right to request a fair hearing.¹⁶⁴

IX. After the Medicaid Fair Hearing - What's Next?

There are several options if the hearing decision is adverse to your client.¹⁶⁵ If you are employed by a P&A, Legal Services/Legal Aid, or similar program and are thinking about possible court action, some matters you may want to consider include:

- The adequacy of the hearing record to support the merits of the case;
- Whether success in court will have an impact beyond the individual client;
- Whether the individual has other avenues for funding of the AT device and can obtain the device more quickly through one of these sources;
- The resources of the agency and any co-counsel who may be available to work on the case.

A. Judicial Review: Evaluating the Merits of Going to State Court

States typically provide for judicial review of Medicaid hearing decisions in state court through their Administrative Procedures Act. In a judicial review action, the Medicaid beneficiary typically seeks reversal of the fair hearing decision on the basis that it is not supported by substantial evidence, is arbitrary and capricious, or is affected by other errors of law. In cases where the Medicaid decision is marred by procedural errors, the plaintiff may seek remand of the case so that the hearing officer can address these errors to ensure the client receives a meaningful hearing.

¹⁶⁰ Federal regulations currently allow states to require exhaustion of the MCO's appeal process prior to requesting a fair hearing. 42 C.F.R. § 438.408(f)(1)(i). Be sure to check your state's rules or policies to determine if exhaustion of the MCO appeal process is required.

¹⁶¹ 42 C.F.R. § 438.406(b)(2).

¹⁶² 42 C.F.R. § 438.408(b)(1-3).

¹⁶³ These timeframes can be extended for up to 14 days if requested by the enrollee or if the MCO maintains that additional information is needed to resolve the appeal. 42 C.F.R. § 438.408(c).

¹⁶⁴ 42 C.F.R. § 438.408(e).

¹⁶⁵ Any discussion of Medicaid litigation is primarily addressed to attorneys. While an individual can pursue a matter in court *pro se*, or on his or her own without a lawyer, this approach is not recommended.

To determine whether judicial review of a fair hearing decision is the right course of conduct, you should review the entire hearing record, including all hearing exhibits, and a transcript or audio tape of the testimony. If the hearing record is insufficient to support a reversal of the agency's decision, you may decide not to pursue the matter in state court. However, if the administrative hearing record has been fully developed and will support further action in court, you may want to file a petition for judicial review on behalf of your client. Be aware that brief writing is critical to your success in a judicial review case as the underlying facts are often as important as the legal issues involved. Staff at NLS's National AT Advocacy Project are available to assist by providing relevant briefs from its resource library, reviewing your briefs, or consulting on the legal issues in your case.

There are some obvious advantages to pursuing judicial review in state court over filing a lawsuit in federal court. State judicial review often follows a very straightforward process, allowing the case to move from filing to judgment more quickly than in federal court. Since state judicial review is often limited to briefing and oral argument, with little or no additional evidence allowed, the commitment of resources is less than with federal court litigation. Moreover, some very good AT case law has come from state courts. See, *AT and the Courts: Summary of State and Federal Court Decisions*, pp. 29-33, below.

B. Filing a Lawsuit in Federal Court

In the past, federal court was often the forum of choice for public interest lawyers challenging a state's Medicaid rules or policies. A class action would be filed in federal court to ensure that the relief obtained through litigation would benefit all individuals who were affected by an unlawful policy. Since the Supreme Court's 2002 decision in *Gonzaga University v. Doe*, the ability of Medicaid beneficiaries seeking prospective injunctive relief through 42 U.S.C. § 1983 has been limited and the jurisdictional basis for challenges to state Medicaid law and policy in federal court has been closely scrutinized by the courts.¹⁶⁶ In particular, several courts have held that certain provisions of the Medicaid Act relevant in AT litigation, e.g. the reasonable standards requirement, are not enforceable through Section 1983.¹⁶⁷ To be clear, there are many provisions of the Medicaid Act that remain enforceable through Section 1983 by private litigants after *Gonzaga*. However, you must be careful identifying your specific causes of action when pursuing an AT case in federal court.

In 2015, the Supreme Court further restricted access to federal courts by limiting the use of the Supremacy Clause of the U.S. Constitution to bring preemption actions when state laws conflict with the Medicaid Act.¹⁶⁸ In *Armstrong v. Exceptional Child Center*, the Court held that Medicaid providers cannot enforce the Medicaid Act's payment provision through the Supremacy Clause. It is still too early to know the extent

¹⁶⁶ 536 U.S. 273 (2002).

¹⁶⁷ *Hobbs v. Zenderman*, 579 F.3d 1171 (10th Cir. 2009); *Lankford v. Sherman*, 451 F.3d 498 (8th Cir. 2006); *Watson v. Weeks*, 436 F.3d 1152 (9th Cir. 2006).

¹⁶⁸ *Armstrong v. Exceptional Child Care Center*, 135 S. Ct. 1378 (2015).

to which this decision may affect Medicaid beneficiaries' access to federal courts when state law or policy conflicts with federal Medicaid requirements, but caution is necessary when bringing a Medicaid AT case in federal court. These jurisdictional issues may impact your choice of forum if you decide to pursue a Medicaid case denying AT devices or services. It is beyond the scope of this publication to cover all of these issues in detail, and we encourage you to fully research the issues you may face when deciding whether to challenge your client's Medicaid denial of AT devices or services in federal court.¹⁶⁹

X. Conclusion

Medicaid is a critical source of funding for AT devices and services. With strong advocacy, people with disabilities can obtain Medicaid funding for equipment that will facilitate communication, enhance mobility, alleviate pain, improve function, preserve health, avoid medical complications, ensure accessibility, increase self-sufficiency or contribute to an individual's ability to live as independently as possible. In a word, the acquisition of appropriate AT for your client can be life-changing.

Dated: May 2016

¹⁶⁹ The National Health Law Program is an excellent resource for P&A and Legal Services/Legal Aid attorneys on these issues and can provide information about the enforceability of specific provisions of the Medicaid Act through 42 U.S.C. § 1983. See *Private Enforcement of the Medicaid Act Pursuant to 42 U.S.C. § 1983*, available at <http://www.healthlaw.org/issues/medicaid/private-enforcement-of-the-medicaid-act-pursuant-to-42-usc-1983#.VU3k3010zIU>.

AT and the Courts: Summary of State and Federal Court Decisions

Braces

Ohlson v. Weil, 953 P.2d 939 (Colo. App. 1997) (requiring coverage of body brace that meets Medicaid's DME definition).

Eyeglasses and Vision Aids

White v. Beal, 555 F.2d 1146 (3d Cir. 1977) (invalidating Pennsylvania Medicaid's restriction of the state's eyeglass benefit to those with eye disease and denying this benefit to those with refractive disorders).

Brisson v. Dep't of Social Welfare, 702 A.2d 405 (Vt. 1997) (requiring coverage of closed circuit television because it meets the federal definition of Medicaid's eyeglass category of service, which includes *other aids to vision* prescribed by a physician skilled in diseases of the eye or an optometrist).

Ledet v. Fischer, 638 F. Supp. 1288 (M.D. La. 1986) (requiring coverage of eyeglasses regardless of diagnosis).

Simpson v. Wilson, 480 F. Supp. 97 (D.Vt. 1979) (requiring coverage of eyeglasses for individuals with refractive disorders as well as those with eye disease).

Hearing Aids

Jasset v. R.I. Dept. of Hum. Serv., 2006 WL 2169891 (R.I. Super. July 31, 2006) (requiring Rhode Island Medicaid to cover binaural hearing aids when medically necessary and without consideration of non-medical criteria such as gainful employment).

Incontinence Supplies

Alvarez v. Betlach, 572 F. App'x 519 (9th Cir.) *cert. denied*, 135 S. Ct. 870 (2014) (requiring Arizona Medicaid to cover incontinence briefs as medical supplies through the home health benefit).

S.D. ex rel. Dickson v. Hood, 391 F.3d 581 (5th Cir. 2004) (requiring Louisiana Medicaid to cover medically necessary incontinence briefs as "home health supplies" for children eligible for EPSDT services).

Hiltibran v. Levy, 793 F.Supp.2d 1108 (W.D.Mo.2011) (requiring coverage of incontinence briefs for adults as medical equipment as that is how they are covered for children under 21 years of age).

Smith v. Benson, 703 F. Supp.2d 1262 (SD Fla. 2010) (requiring Florida Medicaid to cover incontinence briefs as medical supplies and holding that “the state has no discretion to deny funding of medically necessary treatment under ... EPSDT”).

Ekloff v. Rodgers, 443 F. Supp. 2d 1173, 1181 (D. Ariz. 2006) (requiring Arizona Medicaid to cover incontinence briefs for children based upon EPSDT requirements).

Bristol v. R.I. Dept. of Hum. Serv., 1997 WL 839884 (R.I. Super. Jan. 30,1997) (requiring Rhode Island Medicaid to cover incontinence briefs when medically necessary and finding the exclusion of these without regard to medical need is arbitrary and capricious).

Insulin Pumps

Bell v. Agency for Health Care Admin., 768 So.2d 1203 (FL. App. 2000) (requiring Florida Medicaid to cover insulin pumps as DME when medically necessary).

Lifts

Blue v. Bonta, 99 Cal.App.4th 980, 121Cal. Rptr.2d 483 (Cal App. 2002) (requiring Medicaid coverage of stair lift because this device meets Medi-Cal's DME definition).

Kindron v. DeBuono, 266 A.D.2d 896 (NY AD 4th Dept. 1999) (reversing Medicaid fair hearing decision and finding that pool lift was covered as DME and medically necessary for 15 year old girl with spinal muscle atrophy who required hydrotherapy at home).

Multiple DME Items

Lankford v. Sherman, 451 F.3d 496, 511 (8th Cir. 2006) (rejecting Missouri Medicaid's restrictions on DME coverage established by state regulation and noting that "a state's failure to provide Medicaid coverage for non-experimental, medically-necessary services within a covered Medicaid category is both per se unreasonable and inconsistent with the stated goals of Medicaid").

Orthopedic Shoes

Davis v. Shah, No. 14-543-cv (2d Cir. 2016) (affirming summary judgment for the plaintiffs on their claim that New York Medicaid's coverage restrictions for orthopedic shoes and compression stockings, which "deny some categorically needy individuals access to the same scope of medically necessary services made available to others," violates the comparability requirement of the Medicaid Act, the ADA, and Section 504 of the Rehabilitation Act).

Davis v. Shrader, 687 N.E.2d 370 (Ind. App. 1997) (requiring Indiana Medicaid to cover medically necessary orthopedic shoes).

Speech Generating Devices (Augmentative Communication Devices)

Fred C. v. Texas Health and Human Services Commission, 924 F. Supp. 788 (W.D. Tex. 1996), and 988 F. Supp. 1032 (W.D. Tex. 1997) (finding speech generating devices are both medical equipment and prosthetic devices), *affirmed per curiam*, 167 F.3d 537 (5th Cir. 1998) (reviewing DME only).

Meyers ex rel. Walden v. Reagan, 776 F.2d 241 (8th Cir. 1985) (requiring coverage of speech generating devices that fit within the scope of equipment included in Medicaid's speech language pathology benefit).

William T. ex rel. Gigi T. v. Taylor, 465 F.Supp.2d 1267 (N.D. Ga 2000) (requiring coverage of speech generating devices as home health services, prosthetic devices, and speech-language pathology equipment).

Myers v. State of Mississippi, 3:95 CV 185 LN (Slip Op. S.D. Miss. 1995) (requiring coverage of speech generating devices as DME).

Hunter v. Chiles, 944 F. Supp. 914 (S.D. Fl. 1996) (requiring coverage of speech generating devices as DME).

Conley v. Dept. of Health, 287 P.3d 452 (Utah. Ct. App. 2012) (requiring coverage of speech generating devices through speech language pathology services and as DME).

Standers

Godfrey v. Shah, 91 A.D.3d 1294 (NY AD 4th Dept. 2012) (requiring New York Medicaid to provide a sit-to-stand stander to a child upon demonstrating this device was medically necessary to restore her best possible functioning and was the least costly alternative that would meet her medical needs).

Layer v. Novello, 17 A.D.3d 1123 (NY AD 4th Dept. 2005) (reversing N.Y. Medicaid's hearing decision upholding denial of a stander and finding that the testimony of the physical therapist as to the medical benefits of passive standing was entitled to significant weight and could not be outweighed solely by the opinions of non-medical personnel or persons not in the same medical profession).

Wheelchairs

Esteban v. Cook, 77 F. Supp.2d 1256 (SD Fla. 1999) (prohibiting Florida Medicaid from applying a \$582.00 cost cap to custom wheelchairs).

Starkweather v Wing, 242 A.D.2d 961,962 (NY AD 4th Dept. 1997) (requiring coverage of a custom power wheelchair for a 14 year old boy to "increase [his] independence and functional ability . . . especially in emergency situations and to prevent the development of 'learned helplessness'").

Matter of Johnson v. Wing, 237 A.D.2d 960 (NY AD 4th Dept. 1997) (annulling administrative decision denying petitioner a power wheelchair with built-in power tilt-in-space feature so that when petitioner was alone he could reposition himself to promote better circulation and prevent further incidents of decubitus ulcers with the recommended wheelchair).

Matter of Ray v. Wing, 238 A.D.2d 958 (NY AD 4th Dept. 1997) (annulling administrative decision denying petitioner a custom hemi-height wheelchair with specialized seating needed to address numerous medical conditions).

Baker v. Commonwealth of Pa. Dept. of Pub. Welfare, 502 A.2d 318 (Pa. Commw. 1985) (reversing hearing decision denying wheelchair with 500-pound capacity based upon Pennsylvania Medicaid's "invalid regulations" that failed to comply with the Medicaid Act).

Wheelchairs with Integrated Standing Features

Koenning v. Suehs, 897 F. Supp. 2d 528, 552-53 (S.D. Tex. 2012) *vacated sub nom. Koenning v. Janek*, 539 F. App'x 353 (5th Cir. 2013). (holding the state's exclusion of custom power wheelchairs with integrated standing features from coverage as DME violated Medicaid's reasonable standards requirement and amount, duration and scope rule. Although the decision was subsequently vacated by the Fifth Circuit Court of Appeals as moot, the district court's detailed explanation of applicable Medicaid DME case law is instructive.)

Matter of Sorrentino v. Novello, 295 A.D.2d 945 (NY AD 4th Dept. 2002) (annulling a fair hearing decision denying beneficiary a wheelchair with standing feature when the state offered no evidence to refute the medical testimony submitted on Plaintiff's behalf).

Johnson v. Minn. Dept. of Human Serv., 565 N.W.2d 453, 456 (Minn. App. 1997) (requiring coverage of a wheelchair with integrated stander to meet recipient's specific medical needs).

Correa v. North Carolina Department of Health and Human Services, 09-CVS-18112 (Gen. Ct. of Justice, Sup. Ct. Div. 2010) (reversing the agency decision to deny a standing wheelchair for beneficiary under 21 years of age).

Backup Wheelchairs

Gartz v. Wing, 236 A.D.2d 890 (N.Y.A.D. 4th Dept. 1997) (annulling administrative decision denying custom manual wheelchair needed as a backup to petitioner's power wheelchair to access the bathroom at her worksite, visit family, and attend doctor appointments).

Dobson v. Perales, 175 A.D.2d 628 (N.Y.A.D. 4th Dept. 1991) (annulling administrative decision denying petitioner a custom manual wheelchair as a backup to her power wheelchair as needed to go to doctor appointments, visit family, and participate in community/social affairs).

Whirlpool Equipment

T.L. v. Colorado Dept. of Health Care Policy & Fin., 42 P.2d 63 (Colo. App. 2002) (prohibiting express exclusion of whirlpool bath from coverage as DME and the state's failure to consider medical need).