



## **Fact Sheet**

### **Medicaid Coverage of Medical Equipment and Supplies<sup>1</sup>**

Prepared by Jane Perkins & Sarah Somers  
National Health Law Program (NHeLP)

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This Fact Sheet explores Medicaid coverage of medical equipment and supplies, explaining the federal laws that address this coverage, discussing notable court and administrative fair hearing decisions applying them, and offering suggestions to advocates for navigating coverage barriers to securing the equipment that clients need.

#### *The Applicable Laws*

Medicaid coverage of medical equipment and supplies is governed primarily by two statutory provisions, the first dealing with home health services and the second, with Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits. Each of these laws, implementing regulations, and cases applying them are discussed below.

#### *Medicaid Basics*

The Medicaid Act makes some low-income people categorically eligible (*e.g.*, children and people with disabilities) and allows states to cover additional groups (*e.g.*, the medically needy).<sup>2</sup> Medicaid provides for coverage of more than 30 categories of health services.<sup>3</sup> Some services, such as physician services, hospital services, home health, and EPSDT, must be covered.<sup>4</sup> Others, including rehabilitation services and occupational, physical, and speech therapies, are optional benefits for adults.<sup>5</sup> Medical assistance must be provided with reasonable promptness, and states must decide the

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<sup>1</sup> This Fact Sheet is dedicated to Marge Gustas, Neighborhood Legal Services in Buffalo, N.Y., for her years of dedicated and dogged representation of low-income children who need equipment and supplies.

<sup>2</sup> 42 U.S.C. §§ 1396a(a)(10)(A), (C). Medically needy individuals have incomes that exceed the categorical eligibility limits (often requiring them to spend down the excess income to qualify for coverage) and may have access to a more limited scope of benefits. *Id.* § 1396a(a)(10)(C).

<sup>3</sup> *Id.* §§ 1396a(a)(10)(A), 1396d(a).

<sup>4</sup> *Id.* § 1396d(a)(10)(A).

<sup>5</sup> *Id.*

extent of coverage using reasonable standards.<sup>6</sup> The statute also includes a “comparability” provision that requires states to ensure that the medical assistance made available to any categorically needy individual “shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual.”<sup>7</sup>

### *Medical equipment as a home health service*

States participating in the Medicaid program must provide “for the inclusion of home health services for any individual who, under the State plan, is entitled to nursing facility services.”<sup>8</sup>

Home health services are defined as those services provided to a beneficiary at a place of residence, on the orders of a licensed health care practitioner, and as part of a written plan of care.<sup>9</sup> Coverage of the following services is required: (1) nursing services; (2) home health aide services; and (3) medical supplies, equipment and appliances (referred to collectively here as medical equipment). States have the option to include physical therapy, occupational therapy, speech pathology, and audiology services as home health services.<sup>10</sup>

In February 2016, the federal government finalized regulations that address coverage of home health services, with particular emphasis on medical equipment, in part to ensure that medical equipment “will be available to all who are entitled to the mandatory home health benefit....”<sup>11</sup>

Prior to 2016, the regulations did not define medical equipment except to say that it should be suitable for use in the home. As a result, the law was susceptible to shifting and conflicting implementation within and among states. The regulations now define the benefit, providing that:

- (i) 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.

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<sup>6</sup> *Id.* §§ 1396a(a)(8) (regarding reasonable promptness), 1396a(a)(17)(A) (regarding reasonable standards).

<sup>7</sup> *Id.* § 1396a(a)(10)(B).

<sup>8</sup> *Id.* § 1396a(a)(10)(D). *See also Id.* § 1396d(a)(7) (listing home health services as a category to be covered under Medicaid).

<sup>9</sup> 42 C.F.R. § 440.70(a).

<sup>10</sup> *See* Kaiser Fam. Found., *Medicaid Benefits: Home Health Services – Physical Therapy, Occupational Therapy, and/or Speech Pathology/Audiology* (2018), <https://bit.ly/3ysac9J> (providing state-by-state coverage information).

<sup>11</sup> 42 C.F.R. § 440.70(b). *See* Medicaid Program; Face-to-Face Requirements for Home Health Services; Policy Changes and Clarifications Related to Home Health, 81 Fed. Reg. 5530, 5533 (Feb. 2, 2016) (amending 42 C.F.R. § 440.70).

(ii) 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. State Medicaid coverage of equipment and appliances is not restricted to the items covered as durable medical equipment in the Medicare program.<sup>12</sup>

The 2016 Rule also clarified that:

- States cannot categorically deny coverage of medical equipment to individuals with disabilities. The previous rule made items available on the basis of “illness or injury,” thus raising concerns that individuals with congenital conditions or developmental disabilities could be denied coverage.<sup>13</sup> They cannot.
- Medical supplies, equipment and appliances are to be covered if they are “suitable for use in any setting in which normal life activities take place....”<sup>14</sup> Thus, the state cannot “prohibit a beneficiary from receiving home health services in any setting in which normal life activities take place,” other than an inpatient facility (e.g., a hospital, nursing facility, or ICF) or a setting in which Medicaid is or could make payment for inpatient services that include room and board. For example, depending on the individual, the setting could be a school.<sup>15</sup>
- States may use a list of preapproved medical equipment for “administrative ease” but cannot impose absolute coverage exclusions. States must have processes and criteria for individuals to request items not on the preapproved list. The process must be made known to individuals, based on “reasonable and specific criteria,” and include the right to a fair hearing if coverage is denied.<sup>16</sup> This regulation codifies long-standing policy contained in a

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<sup>12</sup> 42 C.F.R. § 440.70(b)(3). Commenters on the proposed rule objected to the reusable/removable requirement, concerned that it might be interpreted to exclude customization. CMS responded: “Although we appreciate commenters raising the concern that these terms could be read to prohibit the customization of equipment, we do not agree that customization would necessarily make the items unusable for other individuals.” 81 Fed. Reg. at 5540.

<sup>13</sup> 42 C.F.R. § 440.70(b)(3)(ii).

<sup>14</sup> *Id.* § 440.70(b)(3).

<sup>15</sup> 81 Fed. Reg. at 5543. Under the prior rule, some states argued that home health benefits could be limited to a beneficiary’s residence. Courts had held this limitation violated the Medicaid Act. *See Skubel v. Fuoroli*, 113 F.3d 330 (2d Cir. 1997) (prohibiting Connecticut Medicaid program from refusing to cover children’s nursing services during periods when they were engaged in educational and social activities outside the home); *accord Detsel v. Sullivan*, 895 F.2d 58 (2d Cir. 1990) (invalidating state rule limiting private duty nursing services to recipient’s residence).

<sup>16</sup> 42 C.F.R. § 440.70(b)(v).

September 4, 1998 Centers for Medicare & Medicaid Services (CMS) guidance document,<sup>17</sup> and it reflects the holding of the Second Circuit in *DeSario v. Thomas*.<sup>18</sup>

- Provides that payment will not be made for home health services unless the treating physician (or, if applicable, non-physician practitioner) documents that there was a face-to-face encounter with the beneficiary that is related to the primary reason that the individual needs home health. For the initiation of medical equipment, the face-to-face encounter must be related to the primary reason that the individual needs the equipment, and the encounter must occur no more than six months prior to the start of the service.<sup>19</sup> The encounter may occur through telehealth.<sup>20</sup>

Finally, the regulations acknowledge that a service or item may fit within more than one Medicaid service category. For example, orthopedic shoes could meet the state's definition of a prosthetic device (if the state covers this optional service), but orthopedic shoes also meet the definition of medical equipment and, thus, would have to be covered under the mandatory home health benefit. According to CMS:

items and services that meet the criteria for coverage under the home health benefit must be covered according to home health coverage parameters. To ensure full coverage for medical equipment and appliances, we will require that, to the extent that there is overlap in coverage with another benefit, states must nevertheless provide for the coverage of these items under the mandatory home health benefit.... [R]egardless of coverage category, the expectation remains that individuals receive all medically necessary medical supplies meeting the definition finalized under this regulation.<sup>21</sup>

Table I provides an annotated listing of significant court cases applying the just-discussed Medicaid coverage requirements.

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<sup>17</sup> Letter to State Medicaid Directors (Sept. 4, 1998), <https://bit.ly/3xyx4ms> (responding to *DeSario* and requiring states to provide individuals with the opportunity to show that they needed items not on the state's coverage list).

<sup>18</sup> *DeSario v. Thomas*, 139 F.3d 80 (2d Cir. 1998), *cert. granted, judgment vacated*, 119 S. Ct. 864 (1999) (remand to 2d Circuit for consideration in light of September 4, 1998 HCFA letter).

<sup>19</sup> 42 C.F.R. § 440.70(f). *See also* 81 Fed. Reg. at 5536 (noting that the encounter can be a well-mom or well-baby visit if, while examining the condition of the mother or child, the provider determines that home health services/equipment is required to address the condition). *See also id.* § 440.70(f)(3) (describing non-physician practitioners).

<sup>20</sup> *Id.* § 440.70(f)(6). For discussion, *see* 81 Fed. Reg. at 5556-57.

<sup>21</sup> 81 Fed. Reg. at 5535-36 (citing prosthetics and rehabilitative services). States cannot restrict access to equipment that meets the criteria for coverage under the home health benefit by carving out the equipment and offering it only to individuals who qualify for home and community based waiver services. *Id.* at 5538.

## Table I

### Examples of cases requiring Medicaid coverage of medical equipment for adults<sup>22</sup>

*Davis v. Shah*, 821 F.3d 231 (2d Cir. 2016): New York Medicaid's limited coverage of orthopedic footwear and compression stockings to patients with only certain conditions violated Medicaid's comparability requirement.

*Alvarez v. Betlach*, 572 F. App'x 519 (9th Cir. 2014): Arizona Medicaid was required to cover adults' medically necessary incontinence supplies.

*Lankford v. Sherman*, 451 F.3d 496 (8th Cir. 2006): Missouri Medicaid could not exclude coverage of medical equipment for people with disabilities who were not blind (exclusions included wheelchair batteries and accessories, breathing equipment, catheters, and parenteral nutritional supplies).

*Esteban v. Cook*, 77 F. Supp. 2d 1256 (S.D. Fla. 1999): Florida Medicaid was required to cover motorized wheelchairs.

*Hodges v. Smith*, 910 F. Supp. 646 (N.D. Ga. 1995): Liquid diet administered through gastrostomy tube can be a medical supply that Medicaid must cover.

*Conley v. Dep't of Health*, 287 P.3d 452 (Utah 2012): Medicaid comparability requirements meant that Utah Medicaid must cover speech augmentative communication device.

*Layer v. Novello*, 795 N.Y.S.2d 810 (App. Div. 2005): Evidence in the case required New York Medicaid to cover standing device for person with cerebral palsy.

*Blue v. Bonta*, 121 Cal. Rptr. 2d 483 (Cal. Ct. App. 2002): California Medicaid could not exclude coverage of stairway chair lifts.

*Nichols v. Office of Med. Assistance Progs.*, 15 P.3d 578 (Or. Ct. App. 2000): Evidence in the case required Oregon Medicaid to cover flotation bed and pressure-reducing mattress.

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<sup>22</sup> See also *supra* notes 15 & 18.

### *Medical equipment as an EPSDT service*

The Medicaid Act mandates that states participating in the Medicaid program provide Early and Periodic, Screening, Diagnostic, and Treatment services to Medicaid-eligible children under 21 years of age.<sup>23</sup> As CMS has noted:

The EPSDT benefit is more robust than the benefit for adults and is designed to assure that children receive early detection and care, so that health problems are averted or diagnosed and treated as early as possible.<sup>24</sup>

Thus, EPSDT coverage is broad. Children must receive all services coverable under the Medicaid Act when they are necessary to “correct or ameliorate” physical and mental illnesses and conditions “whether or not such services are covered under the state plan” for adults.<sup>25</sup> This includes medical equipment, appliances, and supplies. The federal Medicaid agency has provided useful examples of services that, depending on the needs of the child, may be covered as medical equipment:

- Decubitus cushions, bed rails;<sup>26</sup>
- Car restraint seat;<sup>27</sup>
- Computer system and bedside communication device for a child with cerebral palsy;<sup>28</sup>
- Exercise equipment, including exercise bikes, therapeutic toys, swing sets, and tricycles;<sup>29</sup>
- Augmentative communication devices, printers, and software;<sup>30</sup>
- Beeper to promote communication with child with TBI.<sup>31</sup>

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<sup>23</sup> 42 U.S.C. §§ 1396a(a)(10)(A), 1396d(a)(4)(B), 1396a(a)(43) & 1396d(r).

<sup>24</sup> Ctrs. for Medicare & Medicaid Servs., *EPSDT—A Guide for States: Coverage in the Medicaid Benefit for Children* 1 (June 2014).

<sup>25</sup> 42 U.S.C. § 1396d(r)(5) (incorporating benefits listed in § 1396d(a)).

<sup>26</sup> *EPSDT—A Guide for States*, *supra* note 24, at 10.

<sup>27</sup> Memorandum from Rozann Abato, Acting Director, HCFA Medicaid Bureau, to Associate Reg. Admin., Dallas (June 14, 1993) (stating restraint seat may be prescribed as medically necessary as a prosthetic device or home health service for child with spastic motions).

<sup>28</sup> Letter from Rozann Abato, Acting Director, Medicaid Bureau, to State Medicaid Directors (May 26, 1993) (finding state could determine that under certain circumstances computers are equipment that may be covered when used for a medical purpose).

<sup>29</sup> Letter from A.W. Schnellbacher, Chief, Program Operations Branch, Division of Medicaid (Reg. VIII) to Richard Allen, Medicaid Director, Colorado (Mar. 7, 1996) (stating these benefits may be coverable rehabilitative and preventive services or therapy benefits and must be provided to EPSDT beneficiaries when medically necessary).

<sup>30</sup> *EPSDT—A Guide for States*, *supra* note 24, at 10; *see also* HCFA, Chicago Regional State Letter No. 82-92 (Dec. 1992).

<sup>31</sup> HCFA, Chicago Regional State Letter No. 82-92 (Dec. 1992).

CMS has further stated that

[i]f a service, supply, or equipment that has been determined to be medically necessary for a child is not listed as covered (for adults) in a State Medicaid Plan, the state will nonetheless need to provide it to the child as long as the service or supply could be covered under the State Plan.... In such circumstances, the state would need to develop a payment methodology for the service, supply or equipment, including the possibility that payment may need to be made using a single-service agreement with an in-state provider or an out-of-state provider who will accept Medicaid payment.<sup>32</sup>

Finally, States do not satisfy their obligations under EPSDT by simply covering services. They must “arrang[e] for (directly or through referral to appropriate agencies, organizations, or individuals) corrective treatment” covered through the EPSDT provisions.<sup>33</sup> States also have affirmative obligations to inform families about the existence and availability of EPSDT.<sup>34</sup>

While there are fewer court cases involving coverage of medical equipment for children, as opposed to adults, litigation does occur. For example, multiple courts have ordered states to cover medically necessary disposable incontinence underwear under EPSDT.<sup>35</sup> Other cases have required coverage of augmentative communication devices. *Hunter v. Chiles*, 944 F. Supp. 914 (S.D. Fla. 1996), for instance, required Florida Medicaid to cover these devices as EPSDT services and said the State could not shift the responsibility for coverage onto local school districts.<sup>36</sup>

Children have also obtained coverage of medical equipment through administrative hearings. Table 2 annotates some of the notable administrative hearing decisions obtained by Marge Gustas, Neighborhood Legal Services (Buffalo, NY), over her years of representing children with disabilities.

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<sup>32</sup> *EPSDT—A Guide for States*, *supra* note 24, at 10.

<sup>33</sup> 42 U.S.C. §1396a(a)(43)(C).

<sup>34</sup> *Id.* §1396a(a)(43)(A), (B).

<sup>35</sup> *See, e.g., S.D. ex rel. Dickson v. Hood*, 391 F.3d 581 (5th Cir. 2004); *Smith v. Benson*, 703 F. Supp. 2d 1262 (S.D. Fla. 2010); *Ekloff v. Rodgers*, 443 F. Supp. 2d 1173 (D. Ariz. 2006).

<sup>36</sup> *Hunter v. Chiles*, 944 F. Supp. 914 (S.D. Fla. 1996).

**Table 2**

**Examples of administrative decisions (N.Y. Office of Admin. Hearings) requiring Medicaid coverage of medical equipment for children<sup>37</sup>**

- *In re: K.L.*, No. 8259073Q (May 11, 2021): The ALJ reversed the agency's refusal to cover a Spirit Plus Adjustable Car Seat, which allowed K.L. to be safely and securely positioned. The agency said a less costly adaptable car seat could be used. However, evidence from the parent and providers established that K.L. has scoliosis and little if any muscle tone, is nonverbal, and cannot reposition herself. The ALJ found that the car seat suggested by the agency was not comparable to the Spirit Plus and ordered coverage.
- *In re: A.F.*, No. 6630954H (July 21, 2014): The ALJ reversed the agency's denial of a power wheelchair, with additions (e.g., power tilt, micro touch joystick). The agency cited safety concerns and argued that the features were for the caregiver, not A.F., a 3-year-old with spinal muscular atrophy. Testimony from A.F.'s physical and occupational therapists and parent established that she uses the chair and was at an optimal learning age for improving her use.
- *In re: B.M.*, No. 6338216M (Aug. 8, 2013): The ALJ reversed an agency decision denying coverage of Walk Aide External Functional Neuromuscular Stimulators, based on testimony and letters of medical necessity from the 15-year-old's treating physician and physical therapists. The agency had denied coverage saying that an Ankle Foot Orthotic (AFO) was a less costly alternative; however, evidence established that the Walk Aide normalized B.M.'s gait pattern, while the AFO limited his gait and created a fall risk.
- *In re: J.B.*, No. 5731516R (Apr. 13, 2011): The Medicaid agency denied coverage of a Rifton tricycle for J.B., a five-year-old with Angelman Syndrome, a neurogenetic disorder causing balance issues, motor impairment, and seizures. The agency took the position that the tricycle was recreational, rather than medical in nature. However, evidence established that the Rifton tricycle had modifications that differentiated it from a regular tricycle, and J.B.'s physical therapist and parent provided examples of various ways the child was using the equipment for therapeutic and medical purposes. The ALJ reversed.

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<sup>37</sup> Copies of these decisions are on file with the authors.



## Conclusion and Key Issues

Under the laws discussed above, there can be no doubt that state Medicaid programs must cover medically necessary medical equipment and supplies for adults and children. However, as the case citations illustrate, coverage disputes are certain to continue to arise.

There are also a number of evolving issues. Below, we identify some key, current issues and offer suggestions for dealing with them.

- Problems with broken equipment:<sup>38</sup> Over the last few years, equipment breakdown has increased in frequency. A recent study found wheelchair breakdowns are “highly prevalent,” with nearly 64% of those surveyed needing at least one repair.<sup>39</sup> And while the need for repairs does not vary across funding source, those on Medicaid and Medicare and people of color are more likely to experience adverse consequences due to the breakdown (e.g., they are less likely to have back-up equipment).<sup>40</sup>

To address the problem, equipment users are seeking to enforce various state and federal laws.<sup>41</sup> In state courts, disability advocates are assessing possible consumer law claims, such as breach of contract, fraud, negligence, and unfair and deceptive acts and practices. There may also be statutory warranty protections, though this varies greatly by state. In a 50-state survey, six states had no warranty protection; 12 states, wheelchair protections only; 32 states, broad assistive technology protections.<sup>42</sup> This survey also found that consumers are rarely informed of these laws. A public records act request to the state office of consumer affairs to assess use of consumer protections is suggested.<sup>43</sup>

Individuals have also enforced the Medicaid Act to require states to replace or repair broken medical equipment. In *Esteban v. Cook*, 77 F. Supp. 2d 1256 (S.D. Fla. 1999), the Florida Medicaid agency was limiting coverage of mobility devices for adults to wheelchairs costing \$582 or less. The cap effectively denied

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<sup>38</sup> For more in-depth treatment, see Ann Scherer, NDRN, Sam Shepard, Disability L. Ctr. & Nat’l Consumer L. Ctr., & Jerry Battle, Nat’l Consumer L. Ctr., *The Intersection of Disability and Consumer Law: Wheelchair Repair, Warranty Protections, and UDAP* (2021). The Intersection of Disability and Consumer Law was the focus of a workshop session during the June 2021 TASC Conference; session materials and transcript are available from NDRN.

<sup>39</sup> Maria Luisa et al., *Type and Frequency of Reported Wheelchair Repairs and Related Adverse Consequences among People with Spinal Cord Injury*, 97 ARCHIVES OF PHYSICAL MED. & REHAB. 1753 (2016).

<sup>40</sup> Lynn Worobey et al., *Increases in Wheelchair Breakdowns, Repairs, and Adverse Consequences for People with Traumatic Brain Injury*, 91 AM. J. OF PHYSICAL MED. REHAB. 463 (2012).

<sup>41</sup> See Scherer et al., supra n. 38.

<sup>42</sup> *Id.*

<sup>43</sup> *Id.*

motorized and customized devices. The agency also argued that it did not need to cover repairs. The court disagreed and held the policy violated Medicaid's requirement to provide services in a sufficient amount, duration, and scope:

Providing manual wheelchairs to eligible Medicaid recipients with severe mobility impairments is not sufficient to achieve the State's purpose. It follows naturally that the State is then required to provide the associated repairs (consistent with the DME coverage handbook) necessary to maintain the motorized wheelchairs in dependable working order.

*Id.* at 1262 (citation omitted). *See also, e.g., Lankford v. Sherman*, 451 F.3d 496 (8th Cir. 2006) (enjoining state Medicaid regulation that, among other things, covered wheelchairs, but excluded batteries, filters, accessories, repairs, and other replacement parts); *Ladd v. Thomas*, 962 F. Supp. 284 (D. Conn. 1997) (requiring Connecticut Medicaid to ensure prompt, timely prior authorization of medical equipment rentals, replacement equipment, and repairs). *See generally Kobe v. Haley*, 666 F. App'x 281 (4th Cir. 2016) (finding case was not moot, even after South Carolina Medicaid provided Kobe with a functioning wheelchair, noting a "pattern of allegedly unreasonable delays" in replacing/repairing medical equipment. Kobe brought overlapping causes of action, including under the Americans with Disabilities and Rehabilitation Acts' integration mandates and the Medicaid Act's "reasonable promptness" provision, 42 U.S.C. § 1396a(a)(8)).

- Interplay between Medicaid and the ADA: Title II of the ADA prohibits discrimination on the basis of disability in public programs, including Medicaid.<sup>44</sup> The *Olmstead* decision established that unjustified institutionalization is a prohibited form of discrimination.<sup>45</sup> A Medicaid beneficiary can show that restrictions on coverage of medical equipment can violate the ADA if those restrictions put an individual at substantial risk of requiring institutional care. For example, courts have found restrictions on coverage of orthopedic footwear, compression stockings, and incontinence supplies to run afoul of the integration mandate.<sup>46</sup> Thus, when investigating a Medicaid equipment claim, be sure to consider risk of institutionalization.
- Home modifications verses medical equipment: The costs of structural home modifications are not covered as home health because they are costs of shelter, and Medicaid does not cover room and board except as part of an institutional

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<sup>44</sup> 42 U.S.C. § 12132. Section 504 of the Rehabilitation Act imposes the same prohibition on programs that receive federal funding.

<sup>45</sup> *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581, 600 (1999).

<sup>46</sup> *See, e.g., Davis v. Shah*, 831 F.2d at 264 (holding plaintiffs stated claim that New York's restrictions on coverage of orthopedic footwear and compression stockings violated the ADA and § 504); *Hiltibran v. Levy*, 793 F. Supp. 2d 1108, 1115-16 (W.D. Mo. 2011) (holding Medicaid policy limiting coverage of incontinence supplies to coverage in an institution or through an HCB waiver violated the ADA's integration mandate). NHeLP was co-counsel in both of these cases.

service.<sup>47</sup> States' designations in this area should be reviewed. *B.B. v. Miller*, No. 1:18-cv-01257 (M.D. Penn.) illustrates why. *B.B.* was filed in 2018 by Disability Rights Pennsylvania on behalf of children with mobility-limiting physical disabilities. Each child needs a wheelchair lift and/or stair glide to get in, out, and/or around their home.<sup>48</sup> The Medicaid agency denied coverage of the items classifying them as home modifications. *B.B.*'s counsel argued that the items were medical equipment within the home health service. They pointed out that, while the items must be attached to the home, they can be removed from it. They filed causes of action seeking coverage of the items under the Medicaid EPSDT provisions. The parties have recently reached a settlement agreement that, among other things, requires the Medicaid agency to

provide Medical Assistance coverage for wheelchair lifts, stair glides, ceiling lifts, metal accessibility ramps that are removable or reusable (as well as other equipment that attaches to the home and is removable or reusable, that is primarily and customarily used for a medical purpose and is generally not useful to an individual in the absence of a disability, illness or injury) and the installation of such equipment for class members to enter and exit the home or to support activities of daily living or as otherwise medically necessary.<sup>49</sup>

- A reminder about electronic visit verification: Effective January 1, 2023, EVV will be required for home health services. CMS initially said that medical equipment that requires a home visit would be subject to EVV.<sup>50</sup> However, in August 2019, CMS changed position: "EVV requirements do not apply to this component of the home health benefit. The delivery, set-up, and/or instruction on the use of medical supplies, equipment or appliances do not constitute an "in-home visit."<sup>51</sup> Advocates should monitor implementation to ensure that EVV is not incorrectly applied to medical equipment.

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<sup>47</sup> See, e.g., 81 Fed. Reg. at 5539; see *id.* at 5538 ("We note that we do not regard this definition to expand the scope of medical equipment to include environmental or structural housing modifications. Nor does it include equipment that is designed to have a general use and will serve more people than just the Medicaid beneficiary.").

<sup>48</sup> Complaint, *B.B. v. Miller*, No. 1:18-cv-01257 (M.D. Penn. June 21, 2018), ECF No. 1.

<sup>49</sup> Settlement Agreement, *B.B. v. Miller*, No. 1:18-cv-01257 (M.D. Penn. pending). See also 81 Fed. Reg. at 5542 (noting states may need to "implement standards to determine coverage of the specific items previously funded under sections 1915(c) [waivers] or (i) [state plan amendment], such as ceiling lifts or chair lifts that could now be seen in appropriate circumstances to meet the home health definition and be medically necessary for an individual.").

<sup>50</sup> CMS, Frequently Asked Questions: Section 12006 of the 21st Century Cares Act Electronic Visit Verification (EVV) Systems for Personal Care Services (PCS) and Home Health Care Services (HHCS), Q&A # 7 (undated), <https://bit.ly/3iEtm6R>.

<sup>51</sup> Calder Lynch, Acting CMS Dep. Admin. & Dir., *CMCS Informational Bulletin: Additional EVV Guidance*, Q&A # 2 (Aug. 9, 2019), <https://bit.ly/3fM2mjV>.