***Via Email***

February 20, 2015

Douglas M. Press
Deputy Director & Chief Counsel
DHCS Office of Legal Services
MS 0010
P.O. Box 997413
Sacramento, CA 95899-7413

Dear Doug:

When we spoke on February 9, you requested that we provide you with additional information about the Medicare DME and federal Medicaid authority that DME is medically necessary when it is needed in or outside the home. You also agreed to do more research on your legal position and to get back to us this week. However, the plain language of the Medi-Cal DME regulation makes clear that Medi-Cal, including managed care plans, must provide DME that is medically necessary ***inside or outside*** of the home. 22 C.C.R. § 51160(d). Under this regulation, Medi-Cal managed care plans must authorize DME even if: (1) it is only needed outside the home, e.g., to access a doctor's office; or (2) it cannot be utilized in every room of the enrollee's home, when the enrollee does not need it in the rooms in which it cannot be used. DHCS has alternated ALJ hearing decisions overturning Medi-Cal plans' denials of requests for DME on the basis that the DME will be only used out of the home. ALJs have also relied on DHCS's incorrect Allied Provider Manual to uphold denials of DME on the basis that the DME will not fit in every room of the beneficiary's home. In both cases, DHCS policy is contrary regulation and federal guidance. DHCS must reverse its legal position and should amend its Provider Manual sections on DME to reflect the correct DME medical necessity standard, and should issue an All Plan Letter to clarify the standard for Medi-Cal managed care plans.

**Medicare**

When we spoke on February 9, you asked us why the Medicare standard for DME is more restrictive than the Medi-Cal standard. By statute, Medicare only covers DME that is "used in the patient's home." 42 U.S.C. § 1395x(n). The Medicare DME statutory definition was established at the beginning of the Medicare program, and "is widely believed to have been drafted to establish a separate payment under part B for wheelchairs provided outside of an institution (such as a hospital) which would otherwise be paid under part A of the program." H. R. 3184, 111th Cong. § 2(a)(6) (2009), *available at* http://www.gpo.gov/fdsys/pkg/BILLS-111hr3184ih/html/BILLS-111hr3184ih.htm. Nevertheless, since at least 1991, CMS through regulation and other guidance has interpreted the statute to limit coverage of DME to exclude equipment that will only be used outside of a person's home. *See* 42 C.F.R. § 414.202 ("Durable medical equipment means equipment. . . [that i]s appropriate for use in the home."); CMS, Medicare Claims Processing Manual Ch. 20 at 11 (2014) ("DME must be for use in patient's residence."), *available at* http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c20.pdf. Members of Congress have repeatedly introduced legislation to clarify that Medicare will cover DME that is solely used outside of the home, but to date, these efforts have not yielded success.

**Medicaid**

The Medicaid Act does not contain any language concerning the scope or location of DME coverage, which is provided as part of the Medicaid home health benefit. *See* 42 U.S.C. § 1396a(a)(10)(D) (mandating coverage of "home health services" for certain individuals); *id.* § 1396d(a)(7) (additional optional coverage of "home health care services"). The Medicaid regulatory provisions governing DME are facially similar to the Medicare regulations. *See* 42 CFR 440.70(b)(3) (providing for coverage of "[m]edical supplies, equipment, and appliances suitable for use in the home"). But in Medicaid CMS has interpreted these provisions only to require that services are provided in a home and community based setting rather than an institutional one. 76 Fed. Reg. 41034 (July 12, 2011) (preamble to proposed rule on Medicaid home health benefit, clarifying that "Medicaid home health services may not be limited to services furnished in the home"); Health Care Financing Agency (HCFA; CMS's predecessor agency) Dear State Medicaid Director Letter at Att. 3-g (July 25 2000) [hereafter Olmstead Update No. 3], *available at* http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/smd072500b.pdf.

CMS's interpretation of the Medicaid DME benefit was informed by the Supreme Court's holding in *Olmstead v. L.C.*, which interpreted the American's with Disabilities Act to require state programs to maximize the integration of people with disabilities into the community. *See Olmstead v. L.C.,* 527 U.S. 581 (1999); *see also* 76 Fed. Reg. 41032-

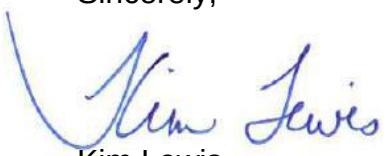
34 (discussing *Olmstead* implications for Medicaid home health). CMS clarified in a 2000 guidance letter implementing *Olmstead* that states should not "ignore[] the consensus among health care professionals that community access is not only possible but desirable for individuals with disabilities. . . ." Olmstead Update No. 3 at Att. 3-g. It noted that any limitation restricting DME to "homebound" beneficiaries "violates Medicaid regulations related to 'amount, duration, and scope of services' at 42 CFR 440.230 and 'comparability of services' at 42 CFR 440.240." *Id; see also Lankford v. Sherman*, 451 F.3d 496, 512-13 (8th Cir. 2006) (relying on Olmstead Update No. 3 to strike down Missouri's rule that limited DME to individuals who were "homebound"); *Skubel v. Fuoroli*, 113 F.3d 330 (2d. Cir. 1997) (striking down New York rule that limited coverage of home health services to those provided at the individual's residence).

**Medi-Cal**

California amended its DME regulations at 51160, in 2000 and again in 2001, to bring them into compliance with the federal mandate to ensure that services were available to support community access by individuals with disabilities. The "out of home" language in the state regulations has operated in Medi-Cal for over a decade to ensure that Medi-Cal beneficiaries can use DME to support access to community services and resources, as required by *Olmstead*. In other states, CMS has threatened to withhold federal Medicaid funding where state DME rules effectively restricted community access. *See, e.g.,* Letter from Charlene Frizzera, Acting Administrator, Center for Medicare & Medicaid Services, to Mr. Ronald J. Levy, Director, Missouri Department of Social Services (Feb. 26, 2010) (enclosed with this letter).

Thank you again for taking the time to meet with us on this issue. We hope this letter will settle the issue regarding the state's obligation and that Director Kent and DHCS will order that the ALJ decisions stand overturning these health plan denials of DME, and will amend the Allied Provider Manual and issue an All Plan Letter to clarify the appropriate standard. Let us know if you would like to discuss next steps. If you have any questions or need any further information, please feel free to contact either of us.

Sincerely,



Kim Lewis,
Managing Attorney

Abbi Coursolle
Staff Attorney

CC: Kevin Donahue, DHCS OLS
Hannah Katch, DHCS
Sarah Brooks, Medi-Cal Managed Care