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Ian McCaslin, M.D.
Director
P.O. 6500
615 Howerton Ct.
MO HealthNet Division
Jefferson City, MO 65102-6500

Re: Repealing Missouri's homebound requirement

Dear Dr. McCaslin:

We are writing to request that the MO HealthNet Division repeal its illegal requirement that Medicaid recipients be confined to their homes in order to receive home health services. The homebound requirement violates federal law and defies directives from the Centers for Medicare & Medicaid Services (CMS) and federal courts. The Agency's outdated policy disregards the *Olmstead* requirement to ensure that people with disabilities function in the most integrated settings possible and contradicts the important policy goal of encouraging community access for these individuals. Further, it penalizes individuals with disabilities who try to function in their community rather than remain homebound by denying them medically necessary home health services. In order to receive such services, elderly and disabled Missourians are forced to become homebound, which itself has serious adverse health consequences such as increased risk of death, susceptibility to disease, cognitive decline, suicidal thoughts, and mental distress. The State must repeal the homebound requirement to comply with federal law, promote the health of people with disabilities, and allow them to live in the most integrated settings possible.

I. Missouri's homebound requirement is illegal.

The State of Missouri requires that MO HealthNet individuals be "confined to their home" in order to receive medically necessary home health services.¹ Missouri's homebound requirement violates federal law by imposing additional conditions on the receipt of a mandatory Medicaid service. States cannot add requirements beyond what is

¹ 13 C.S.R. § 70-90.010(1)(B).

already allowed by federal law and regulations,² and federal law does not condition the receipt of home health services on being homebound.³ Thus, Missouri's homebound requirement violates federal law by preventing disabled individuals who are not homebound from obtaining medically necessary home health services to which they are entitled.

Providing home health services to those who are homebound while refusing to cover them for individuals with similar needs who are not homebound amounts to an arbitrary distinction based upon the individual's condition—being homebound—rather than their need for the services and violates the prohibition against arbitrary denials and reductions in 42 C.F.R. § 440.230(c). It also violates the prohibition against states providing services that are not equal “in amount, duration, and scope for all recipients within” a covered Medicaid group, 42 C.F.R. § 440.240(b), as the non-homebound cannot receive any home health services, but those in the same coverage group who are homebound can. As noted by CMS, “[w]hile current regulations specify that these services must be provided to an individual at his place of residence, it is not necessary that the person be confined to the home for the services to be covered under the Medicaid home health benefit. The ‘homebound’ requirement is a Medicare requirement that **does not apply** to the Medicaid program.”⁴

CMS has instructed Missouri that the homebound requirement is illegal on at least three separate occasions. In 2000, in response to the Supreme Court's decision in *Olmstead v. L.C.*,⁵ CMS informed all State Medicaid Directors that homebound requirements are illegal because they violate federal regulations.⁶ In 2005, CMS reminded Missouri that its homebound requirement is illegal when it required Missouri to remove from a proposed State Plan Amendment the statement that “[t]o be eligible for home health services, a recipient must ... be confined to his home.”⁷ In 2006, “CMS ... directly told Missouri that its ‘homebound requirement...is out of compliance with CMS

² See *Comacho v. Tex. Workforce Comm'n*, 408 F.3d 229, 235 (5th Cir. 2005) (“Texas cannot add additional requirements for Medicaid eligibility.”); *T H v. Jones*, 425 F.Supp. 873, 877 (D.C. Utah 1975) (“[T]o the extent that the states impose conditions on the provision of [AFDC and Medicaid] in conflict with federal standards, the latter must prevail.”), *aff'd*, 425 U.S. 986 (1976).

³ 42 C.F.R. § 440.70. Rather, states must provide home health services to all categorically needy Medicaid recipients. 42 C.F.R. §§ 440.210(a)(1). All Missouri Medicaid recipients are categorically needy.

⁴ Letter from the Center for Medicaid and State Operations, to State Medicaid Directors, at 1 (July 25, 2000), Attachment 3-g, <http://www.cms.hhs.gov/smdl/downloads/smd072500b.pdf> (Attachment 3-g is titled “Prohibition of Homebound Requirement in Medicaid Home Health – Clarification”).

⁵ *Olmstead v. L.C.*, 527 U.S. 581 (1999).

⁶ Letter from the Center for Medicaid and State Operations, *supra* note 4, at 1.

⁷ Letter from James G. Scott, to Gary Sherman, at 1-3 (November 21, 2005).

policy.”⁸ CMS recognized that a homebound requirement prevents people with disabilities from living in the most socially integrated setting possible and encourages institutionalized care, which violates the purpose of the Americans with Disabilities Act:

The restriction of home health services to persons who are homebound to the exclusion of other persons in need of these services ignores the consensus among health care professionals that community access is not only possible but desirable for individuals with disabilities. ... Further, ensuring that Medicaid is available to provide medically necessary home health services to persons in need of those services who are not homebound is an important part of our efforts to offer persons with disabilities services in the most integrated setting appropriate to their needs, in accordance with the Americans with Disabilities Act.⁹

In spite of these clear policy directives and important public policy goals, Missouri continues to defy CMS and condition the receipt of home health services on being homebound.

The Eighth Circuit Court of Appeals also recognized that Missouri’s homebound requirement is improper, in a case involving the State’s cuts to durable medical equipment in 2005. In *Lankford v. Sherman*, the court held that Missouri did not provide a meaningful opportunity to obtain durable medical equipment through home health services, as Missouri improperly restricts home health services to those who are homebound. The Court found that the homebound requirement is “out of compliance with CMS policy” and “ignores the consensus among health care professionals that community access is not only possible, but desirable for individuals with disabilities.”¹⁰ While Missouri reinstated durable medical equipment as a separate stand-alone service, it continues to ignore the Eighth Circuit’s finding that “...any ‘homebound’ requirement is specifically prohibited.”¹¹

Other courts have invalidated less severe state restrictions on home health services because they limit community access. In *Skubel v. Fuoroli*, the court recognized the negative health impact of a state policy that failed to cover nursing services provided outside the home under “home health services.”¹²

⁸ *Lankford v. Sherman*, 451 F.3d 496, 512-13 (8th Cir. 2006) (quoting Email from Megan K. Buck, Centers for Medicare and Medicaid Services, to Karen A. Lewis, Division of Medical Services Executive Assistant (April 5, 2006)).

⁹ Letter from the Center for Medicaid and State Operations, *supra* note 4, at 1.

¹⁰ *Lankford*, *supra* note 8, at 512-13 (quoting Letter from the Center for Medicaid and State Operations, *supra* note 4, at 1).

¹¹ *Id.* at 512.

¹² *Skubel v. Fuoroli*, 113 F.3d 330, 336-37 (2d Cir. 1997) (quoting without citation the Letter from the Center for Medicaid and State Operations, *supra* note 4, at 1: “The restriction ignores the consensus among

Community access is a crucial part of the psychological and social well-being of all persons with disabilities, and may have benefits for physical health as well. This point is well documented and undisputed. ... The technology and knowledge now exist to allow many people with disabilities, elderly or not, to venture into the community, where before they would have been considered permanently homebound.¹³

That state restriction was held invalid.¹⁴ Another court recognized that not covering private nursing care provided to an ill child for a few hours each day so she could attend school deprived her of physical, psychological, and social benefits.¹⁵ That state's action was also held invalid.¹⁶ Missouri's homebound requirement restricts community access even more than the policies challenged in these cases. Whereas those states still *covered* home health services provided in the homes of Medicaid recipients, Missouri does not cover *any* home health services if the person is not homebound. Thus, Missouri Medicaid recipients are more likely to stay home and remain socially isolated because their home health services may be *completely* terminated for nonmedical absences.

The State thus restricts community access for people with disabilities in violation of federal Medicaid law and the Americans with Disabilities Act. Missouri must repeal the homebound requirement to come into compliance. Moreover, lifting the homebound requirement would promote the health and well-being disabled Missourians by allowing them greater access to their communities. It would also save Missouri money by preventing unnecessary and more expensive institutionalized care that results when people are forced to forego home health services and their conditions deteriorate because they do not qualify under Missouri's restrictive requirements.¹⁷

health care professionals that community access is not only possible but desirable for disabled individuals.”).

¹³ *Id.*

¹⁴ *Id.* at 337.

¹⁵ *Detsel v. Sullivan*, 895 F.2d 58, 60 (2d Cir. 1990).

¹⁶ *Id.* at 66.

¹⁷ For example, a study of terminally ill patients found that providing in-home palliative care, compared to usual care, significantly increased patient satisfaction and reduced hospitalizations and emergency department visits, thereby reducing the costs of care by 33 percent. Richard Brumley et al., Increased Satisfaction with Care and Lower Costs: Results of a Randomized Trial of In-Home Palliative Care, 55 J. Am. Geriatrics Soc'y 993, 997-98 (2007).

II. Missouri's homebound requirement harms people with disabilities by denying medically necessary home health care services or forcing them to become homebound in order to receive those services.

The homebound requirement penalizes individuals who are willing and able to function in the community by depriving them of medically necessary home health services that they simply cannot afford to purchase on their own. Denying home health services affects individuals who have recovered enough from an injury or illness to leave the house, but have difficulty learning self-care and require more teaching and monitoring to stay healthy.¹⁸ Such teaching and monitoring can be most effectively provided by home health providers.

Other individuals are unable to obtain the care they would receive from home health providers in any other setting.¹⁹ For example, most physicians do not want to monitor an open wound daily, and it may be too difficult for a person with an open wound to visit a physician's office daily.²⁰ Thus, a disabled individual may not be monitored properly or may needlessly endanger herself in order to travel to the physician. Even an individual who makes it to the physician's office may still have difficulty obtaining services, as demonstrated by this example from Medicare's Home Health Independence demonstration project:

One ... [enrollee] was a quadriplegic who needed catheter changes on a regular basis, but her physician's office was small and equipped only with an examination table. It was difficult for her to transfer between her wheelchair and the table. At home, [however,] she had equipment help her transfer to her hospital bed, which allowed greater flexibility for changing her catheter.²¹

Providing home health care to these individuals will give them access to more effective, less expensive care that will improve their health and lower State Medicaid costs.²² However, without home health care, many MO HealthNet participants will go without medically necessary services, causing their conditions to worsen and ultimately requiring them to have more expensive treatments.

¹⁸ Valerie Cheh et al., Evaluation of the Home Health Independence Demonstration: Barriers to a Successful Experiment were Multifaceted, and Difficult Policy Issues Remain, at 81 (2007), <http://www.cms.hhs.gov/Reports/downloads/homebound.pdf>.

¹⁹ *Id.* at 82.

²⁰ *Id.*

²¹ *Id.*

²² *Id.* at 81-82 (“[S]killed monitoring of chronically ill patients would improve their health, help them avoid future hospitalizations, and in turn, lower ... costs”). See also note 17, *supra*.

The current policy also forces MO HealthNet recipients who can otherwise function and thrive in the community to become “homebound” in order to *qualify* for home health services. Confining these individuals to their homes causes them to be socially isolated and has adverse consequences for their health.²³ Social isolation increases the risk of death,²⁴ susceptibility to disease,²⁵ cognitive decline,²⁶ suicidal thoughts,²⁷ and mental distress.²⁸ Thus, repealing the homebound requirement will improve the health of disabled MO HealthNet participants who would no longer have to be socially isolated in order to qualify for home health services.

III. Conclusion

Missouri’s homebound requirement is illegal and denies medically necessary services to some of the most vulnerable Missourians. This policy restricts community access for people with disabilities, leads to more costly hospitalizations and ultimately pushes people into more expensive institutionalized care. The policy also directly contradicts the preventative purposes of the new MO HealthNet program. In sum, there is no reasonable legal or policy rationale for maintaining this requirement. Therefore, we respectfully request that the MO HealthNet Division repeal this requirement in order to

²³ In Missouri, a person is homebound only if his or her absences for nonmedical reasons are infrequent or of relatively short duration. 13 C.S.R. § 70-90.010(3).

²⁴ See, e.g., Angel Rodriguez-Laso et al., The Effect of Social Relationships on Survival in Elderly Residents of a Southern European Community: A Cohort Study, 7 BMC Geriatrics 19, 24-25, 30 (2007); Thomas Rutledge et al., Social Networks are Associated with Lower Mortality Rates Among Women with Suspected Coronary Disease: The National Heart, Lung, and Blood Institute-Sponsored Women’s Ischemia Syndrome Evaluation Study, 66 Psychosomatic Med. 882, 884 (2004); Kristina Orth-Gomer & Jeffrey V. Johnson, Social Network Interaction and Mortality, 40 J. Chronic Diseases 949, 954 (1987); Lisa F. Berkman & S. Leonard Syme, Social Networks, Host Resistance, and Mortality: A Nine-year Follow-up Study of Alameda County Residents, 109 Am. J. Epidemiology 186, 201 (1979).

²⁵ See, e.g., Thomas Rutledge et al., Social Networks and Incident Stroke among Women with Suspected Myocardial Ischemia, 70 Psychosomatic Med. 282, 284 (2008); John C. Barefoot et al., Social Network Diversity and Risks of Ischemic Heart Disease and Total Mortality: Findings from the Copenhagen City Heart Study, 161 Am. J. Epidemiology 960, 966 (2005); Cohen et al., Social Ties and Susceptibility to the Common Cold, 277 JAMA 1940, 1942 (1997).

²⁶ See, e.g., Karen A. Ertel et al., Effects of Social Integration on Preserving Memory Function in a Nationally Representative US Elderly Population, 98 Am. J. Pub. Health 1215, 1218 (2008); Hui-Xin Wang et al., Late-Life Engagement in Social and Leisure Activities Is Associated with a Decreased Risk of Dementia: A Longitudinal Study from the Kungsholmen Project, 155 Am. J. Epidemiology 1081, 1083-84 (2002); Shari S. Bassuk et al., Social Disengagement and Incident Cognitive Decline in Community-Dwelling Elderly Persons, 131 Annals Internal Med. 165, 169 (1999).

²⁷ See, e.g., Jennifer L. Rowe et al., Social Support and Suicidal Ideation in Older Adults Using Home Healthcare Services, 14 Am. Ass’n for Geriatric Psychiatry 758, 762 (2006); Anthony Feinstein, An Examination of Suicidal Intent in Patients with Multiple Sclerosis, 59 Neurology 674, 675-77 (2002).

²⁸ Cheh et al., *supra* note 18, at 68, 81.

Ian McCaslin, M.D., Director

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comply with federal law, to promote the health of disabled Missourians, and to enable them to live in the least restrictive environment.

Sincerely,



Joel Ferber
Attorney at Law



Jeff Herman
Legal Intern

cc: Deborah Scott, Director
Department of Social Services