ISSUE BRIEF

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Creating Pathways to Work

Redesigning Medicaid for the Future:

Home Modification & Assistive Technology Recommendations for Rhode Island Consumer Choice Global Medicaid Waiver

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Redesigning Medicaid for the Future: *Home Modification & Assistive Technology Recommendations for Rhode Island Consumer Choice Global Medicaid Waiver*

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One of the key areas we need to address, as we strive to rebalance the long-term care system from institutional care in nursing homes to community based care preferably in a person's home, is the ability of an individual to function safely in their home with a chronic illness or after an injury or elective surgery.

Various studies have examined the positive benefits of assistive technology (AT; e.g. adapted computers, powered mobility devices, augmentative communication devices (ACDs) and home modifications (HM; e.g. structural changes such as widening doorways or building an access ramp) in enhancing the abilities of persons with disabilities and seniors to function independently, safely, and successfully in their home environments (Mann, *et al*., 1999; Verbrugge and Sevak, 2002; Calkins and Namazi, 1991).

The ways in which policy and procedures are developed and implemented to provide for assistive devices and home modifications in the Medicaid program has a tremendous impact on the degree to which Medicaid recipients have access to these services. Unfortunately, RI Medicaid is not providing much of these services currently. It is suspected that this is partly due to case management staff time limitations and their overall understanding about when and how to get these services to the clients. In addition, basic home modifications such as widening of doorways have not been approved.

Current Policy: Rhode Island Medicaid [1]

I. *Home Modifications- Environmental Accessibility Adaptations*

- Definition of Home Modifications is based on the following CMS broad definition: "Those physical adaptations to the private residence of the participant or the participant's family, required by the participant's service plan that is necessary to ensure the health, welfare and safety of the participant or that enable the participant to function with greater independence in the home. Such adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric and plumbing systems that are necessary to

[1] All information obtained from Rhode Island Medicaid Staff

accommodate the medical equipment and supplies that are necessary for the welfare of the participant. Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the participant. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g. in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheel chair). All services shall be provided in accordance with applicable State or local building codes and are prior approved on an individual basis by the DHS CAH."

- Current Medicaid Procedures for Obtaining Home Modifications – Environmental Accessibility Adaptations

- The process for obtaining grab-bars, a hand held shower or raised toilet seat is the same as that for minor assistive devices, that is, a physician's order or C.M.N. (Certificate of Medical Necessity) and a medical supply company completed M.A. Prior Authorization Request form submitted to the EDS Prior Authorization Unit for approval by the DHS Center for Contracts and Payments.

- More extensive equipment additionally requires an Independent Living Center Home Accessibility Evaluation. This involves a home visit by an I.L. Center mobility specialist who completes a two- page form describing, and providing justification for the equipment or modification. This evaluation is a reimbursable service for waivers administered by DHS, namely the A/D, HAB and the Personal Choice waivers, but is not available as a covered service for DEA or MR-DD waivers. DEA and MR-DD waiver participants must work directly with their case managers to submit requests for environmental accessibility adaptations.

- Home Accessibility Evaluations may be completed either by a Rehabilitation Specialist from a hospital, nursing facility or community Home Nursing Care agency. Reimbursement through Medicaid is available for Home Accessibility Evaluations completed by P.A.R.I. or by OSCIL for waivers administered by DHS. Independent Living Centers work closely with medical supply companies and are knowledgeable regarding specialized equipment. DHS Case Managers and Adult Service Social Case Workers need to include the provision of equipment or modifications on the CP-5 Plan of Care and will want to follow up on requests to assist with any communication problems or other barriers that might lead to a delay in service delivery.

- The following steps apply:
  1. Identify the need. Does this individual require additional equipment for help with transfers from bed to chair or to the bathroom? Is there safe egress from the home for a client with mobility impairment? (Note that Independent Living Centers are funded to provide information and referral and to be a community resource for individuals with disabilities.)

  2. Contact OSCIL at 738-1013 or P.A.R.I. at 725-1966 to arrange for an Independent Living Center Home Accessibility Evaluation by a mobility specialist for completion of the Request for Prior Authorization for Rehab/Adaptive Equipment form, and help with locating an appropriate provider.

3. Identify the provider of the equipment or modification to record this information on the CP-5. Providers must be either a Durable Medical Equipment company with a R.I. Medicaid E.D.S. provider number, or a licensed contractor with a R.I. Tax payer I.D. number, registered with the Secretary of State's Office, and enrolled as an EDS provider.

4. Arrange for a physician's order, preferably a C.M.N. (Certificate of Medical Necessity) to be submitted with R.I. M.A. Prior Authorization Request form to the EDS Prior Authorization Unit. Providers will often work with a physician to obtain correct completion of the C.M.N. They can track prior authorization requests through the EDS Help Desk.

5. Prior authorization requests are reviewed by clinical staff at the DHS Center for Adult Health to insure that recommendations are appropriate and consistent with a participant's health and safety needs. Contact Michelle Amado at 462-0624 if the status of a prior authorization approval is in question. Vendors receive a letter of approval from E.D.S.

6. Follow-up with your client, the Independent Living mobility specialist, and or provider, to help resolve barriers to the timely installation of necessary equipment or completion of home modifications. Be sure that the specialized equipment or modification is listed on the CP-5 Plan of Care.

After reviewing the current RI Medicaid policies I would submit that having the requirement that a physician determine medical necessity and also the requirement of prior approval before a person can request a home modification through a waiver has limited the use of these services. Furthermore, it seems the only time these services are available to RI Medicaid recipients are if they are in a waiver. If you are trying to keep a person from needing to enter a nursing home then these services should be available to someone *before* they meet a nursing home level of care need.

II. *Assistive Devices - Assistive Technology*

- Definition of this service is as follows:
  "Specialized medical equipment and supplies to include (a) devices, controls, or appliances, specified in the plan of care, which enable participants to increase their ability to perform activities of daily living; (b) devises, controls, or appliances that enable the participant to perceive, control, or communicate with the environment in which they live; including such other durable and non-durable medical equipment not available under the State plan than is necessary to address participant functional limitations. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the State plan and exclude those items that are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards of manufacture, design and installation."

- Current Medicaid Procedures for Obtaining Minor Assistive Devices – Specialized Medical Equipment and Supplies

  - Minor assistive devices, such as eating utensils, transfer bench, shower chair aids for personal care, reachers are covered items for participants of Home and Community-based Medicaid Waivers.

  - You may recognize that a certain item would be useful or recommend an evaluation by an independent living center such as P.A.R.I. (People Actively Reaching Independence) or OSCIL (Ocean State Center for Independent Living).

  - Minor assistive devices are subject to a prior approval by the DHS Medical Services Center for Adult Health. This process requires a physician's CMN (certificate of medical necessity) be submitted with the Medical Supply Company's M.A. Prior Authorization request to EDS, the Medicaid fiscal intermediary. All licensed and M.A. registered providers know to send documentation to the Prior Authorization Unit at EDS where it is logged in and forwarded to DHS for approval.

  - The following steps apply:
    1. Identify the need for a minor assistive device,
    2. Obtain a physician's CMN or a physician's order,
    3. Locate a Medical Supply Company who will submit the CMN with an R.I. M.A. Prior Authorization Request form to the EDS Prior Authorization Unit. (The Help Desk at EDS is available to Providers to check on documentation submitted and the status of a request.)
    4. The Center for Contracts and Payments – Michelle Amado 462-0624 approves requests.
    5. The provider receives an authorization letter from EDS and can make arrangements for delivery.

- This process usually takes approximately three weeks. DHS Adult Service and LTC Case Managers may assist A/D Waiver participants to obtain items and should include them on the CP-5 Plan of Care. Occasionally participants in other waivers, such as the DEA or Personal Choice Waiver (formerly P.A.R.I. Waiver) may request basic information about the prior approval process.

- This service is the same for all waivers - I.E. Personal Choice, A/D, MR-DD, Habilitation and DEA. Assistive Devises are included in the Assisted Living Waiver- but not Home Modifications.

Recommended Changes

The October 2006, *Compendium of Home Modification and Assistive Technology Policy and Practices Across the States, Volume I: Final Report* of the U.S. Dept. of HHS Assist Sec. for Planning and Evaluation Office of Disability, Aging and LTC Policy addressed three main questions:

- To what extent do Medicaid State Plans and HCBS waivers cover AT and HM services?
- What are the processes available to Medicaid recipients to obtain AT and HM services"
- What mechanisms—if any—do states use to control use and costs of AT and HM services?

Throughout the country 37 states have ACDs in the state plan, 40 states offer wheelchairs in the state plan and 39 states offer "other services" in the state plan. States that do allow for AT and HM services in the State Plan have the following services and service cost controls.

Access Mechanisms	*States with Requirement*	*States without Requirement*
Service Coordination/Case Manager(n=36)	11	25
Physician Order (n=37)	37	0
Other Health Profess. Assessment (n=33)	29	4
Medical Necessity (n=48)	47	1
Prior Authorization (n=42)	42	0
One or more vendor/supplier bids (n=37)	1	36

SOURCE: ABT Assoc. review of Medicaid State Plan coverage policies, June 2005-February 2006.

After comparing other states' policies and practices with RI's current Medicaid policies and procedures I respectfully submit the following recommendations for the Consumer Choice Medicaid Reform Plan.

- As we are looking to develop three levels of long-term care service packages for Medicaid recipients, that prevent and or delay people from going to a nursing home, each of these service packages should include AT and HM services. For example, the level one service package will be available to people who are discharged from a hospital. This service package will be available to people who do not meet a nursing level of care need. (Currently, it does not look like we are not providing AT or HM unless a person is in a waiver—therefore meeting a nursing home level of care need.)

  ⇒ Recommendation: Other states are currently covering the following services in their State Plan amendments and can be used as a good barometer for adding these services to the level one service package: AT services such as ACDs and power or custom wheelchairs or wheelchair adaptations are most frequently covered by State Plan amendments. A few states (AZ, KS, MA, and DC) have covered Personal ER Response Systems (PERS). Others have used the home health DME benefit to cover; specialized rehab equipment, mobility enhancing equipment including grab-bars and handrails (AR); bathtub wall rail, bathtub rail, floor base, toilet rail, transfer tub rail attachment, environmental control units (NJ); AT/adaptive equipment, including lifts, bath chairs, and wall mounted insulin delivery devices, and automatic feeder systems (VA).

  ⇒ Recommendation: Retain the current broad definition of services available for AT and HM.

- In most states around the country, the process available to Medicaid recipients to obtain AT and HM services through a State Plan is a physician order. It is critical to note that only 50% of the waiver programs list a physician order as a requirement. Most HCBS waivers ---and some state plans (11) –offer service coordination or case management to recipients in order to facilitate access to AT and HM services, and both types of Medicaid programs use health professionals such as physical and occupational therapists and speech therapists to assess recipient need for AT or HM services.

  ⇒ Recommendation: Utilize the care coordination/assessment center to facilitate access to AT and HM services in the both in the State Plan and waivers and remove the physician order as a requirement for any waiver AT or HM services. This should constitute "prior authorization".

  ⇒ Recommendation: In order to determine the need for one or more AT or HM service or supply, through a waiver or state plan, a needs assessment/evaluation (Home Accessibility Evaluation) should be performed by a certified OT or PT and reimbursed by Medicaid. (Currently, Home Accessibility Evaluations may be completed either by a Rehabilitation Specialist from a hospital, nursing facility or community Home Nursing Care agency. Reimbursement through Medicaid is available only for Home Accessibility Evaluations completed by P.A.R.I. or by OSCIL for waivers administered by DHS.)

- Medicaid State Plans limit use and contain costs related to AT and/or HM services by reviewing where the services are "medically necessary", require "prior authorization" or sometimes require consumers or providers to obtain one or more bids from potential suppliers before the State would agree to cover the equipment or service. (See Table on P.1)

  ⇒ Recommendation: Move away from the medically oriented to the more functionally oriented requirement (see bullet below).

  ⇒ Recommendation: To be consistent with the competitive bidding process being used elsewhere in Medicaid Reform and consistent with about 50% of the HCBS waiver programs in the country require the recipient or provider to obtain vendor/supplier bids for services.

  ⇒ Recommendation: Using the care coordination/assessment center to facilitate access to AT and HM services in the both in the State Plan and waivers should constitute "prior authorization".

- Unlike State Plans, in which the majority use "medical necessity" criteria to determine coverage of AT and HM services, only about 50% of the HCBS waivers report "medical necessity" as a requirement for coverage. Furthermore, states use terms that are more "functionally" oriented rather than "medically" oriented when describing requirements for AT and HM. For example: "home mod must be necessary because of a physical disability"; "must be necessary to improve the individual's independence and inclusion in the community to avoid institutionalization", or "be necessary to ensure the health, welfare and safety of the individual, or must enable the individual to function with greater independence in the home, and without which, the individual would require institutionalization".

  ⇒ Recommendation: Use the functional criteria language rather than the medical necessity language.

- Many of the HCBS waivers use cost caps or limits to the amount the state would reimburse for AT and HM services. Many states set annual or lifetime limits on the amount that could be spent on HM and AT.

  ⇒ Recommendation: As we expand coverage for HM and AT we should also start using limits on the amount of HM and AT we will allow. The table below shows the types of limits and the number of states using them.

Types of Waiver Limits for AT and HM Services Used within States			
Lifetime or life of waiver limit	Annual service cap or limit	Limit over multiple years	Total waiver cap
# States using: 19	# States using: 31	# States using: 9	# States using: 2

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