

# Regulatory Analysis Form

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<p>(1) Agency Department of Public Welfare Office of Medical Assistance Programs</p>	<p>This space for use by IRRC</p> <p style="text-align: center;">2007 FEB 16 PM 2:28</p> <p style="text-align: center;">INDEPENDENT REGULATORY REVIEW COMMISSION</p> <p>IRRC Number:</p>
<p>(2) I.D. Number (Governor's Office Use)</p> <p style="font-size: 1.5em; text-align: center;">14-491</p>	<p style="font-size: 1.5em; text-align: center;">2452</p>
<p>(3) Short Title Home Health Agency Services</p>	
<p>(4) Pa. Code Cite 55 Pa.Code Ch. 1249</p>	<p>(5) Agency Contacts &amp; Telephone Numbers</p> <p style="padding-left: 20px;">Primary Contact: Betty Burris, 772-6161</p> <p style="padding-left: 20px;">Secondary Contact: Dawn Poppenwimer, 772-6047</p>
<p>(6) Type of Rule Making (Check One)</p> <p><input type="checkbox"/> Proposed Rule Making</p> <p><input checked="" type="checkbox"/> Final Order Adopting Regulation</p> <p><input type="checkbox"/> Final Order, Proposed Rule Making</p> <p><input type="checkbox"/> Omitted</p>	<p>(7) Is a 120-Day Emergency Certification Attached?</p> <p><input checked="" type="checkbox"/> No</p> <p><input type="checkbox"/> Yes: By the Attorney General</p> <p><input type="checkbox"/> Yes: By the Governor</p>
<p>(8) Briefly explain the regulation in clear and nontechnical language.</p> <p>The purpose of this final-form rulemaking is to remove the requirement that a recipient be homebound to qualify for Home Health Agency (HHA) services and to remove the limits for HHA visits from the regulation.</p>	
<p>(9) State the statutory authority for the regulation and any relevant state or federal court decisions.</p> <p>The Public Welfare Code, Act of June 13, 1967 (P.L. 31, No. 21)(62 P.S. §§ 403, 443.2(2) and 509).</p>	

## Regulatory Analysis Form

(10) Is the regulation mandated by any federal or state law or court order, or federal regulation? If yes, cite the specific law, case or regulation, and any deadlines for action.

The Department is issuing this final-form rulemaking to comply with a Federal directive clarifying Federal regulations regarding the Medicaid home health benefit. Based upon *Olmstead v. L.C.*, 527 U.S. 681 (1999), the Health Care Financing Administration (HCFA), now the Centers for Medicare and Medicaid Services' (CMS), clarified its position that requiring that a person be "homebound" in order to qualify for Medicaid HHA services violates Federal regulatory requirements in 42 CFR 440.230(c) and 440.240(b).

(11) Explain the compelling public interest that justifies the regulation. What is the problem it addresses?

The final-form rulemaking will permit the attending physician to prescribe medically necessary HHA services to MA recipients who are not homebound if the HHA service would avoid or delay the need for treatment in a hospital or other institutional setting for the condition being treated or if the MA recipient has an illness, injury or mental health condition that justifies providing the service in the home instead of a physician's office, clinic or other outpatient setting.

In addition, the removal of the limits on HHA visits from the regulation will formalize a process whereby recipients with a medically necessary and appropriate need for continued care in excess of the Fee Schedule limitations can apply for a program exception as authorized in 55 Pa. Code § 1150.63. It will no longer be necessary to seek a waiver of the regulation from the Secretary of the Department for payment for HHA visits that exceed the service limits.

## Regulatory Analysis Form

(12) State the public health, safety, environmental or general welfare risks associated with non-regulation.

MA recipients who are not homebound but are in need of medical care that can be provided more cost effectively in their own homes may be required to remain in a hospital, long-term care facility or other institutional setting in order to receive medically necessary care.

Under current regulation, after the first 28 days of unlimited home health care, payment is limited to 15 home visits per month, per treatment plan. In cases where it is medically necessary that the limit be exceeded, a request must be made directly to the Secretary of Public Welfare to waive the current regulation. The amendment to the regulation will allow the attending physician to prescribe and the MA recipient to receive medically necessary HHA visits beyond the existing service limits, if approved through a program exception.

(13) Describe who will benefit from the regulation. (Quantify the benefits as completely as possible and approximate the number of people who will benefit.)

The final-form rulemaking will benefit physicians and Home Health Agencies enrolled in the MA Program as well as MA recipients of HHA services.

(14) Describe who will be adversely affected by the regulation. (Quantify the adverse effects as completely as possible and approximate the number of people who will be adversely affected.)

No one will be adversely affected by the final-form rulemaking.

(15) List the persons, groups or entities that will be required to comply with the regulation. (Approximate the number of people who will be required to comply.)

Physicians and Home Health Agencies enrolled in the MA Program will be required to comply with the final-form rulemaking.

## Regulatory Analysis Form

(16) Describe the communications with and input from the public in the development and drafting of the regulation. List the persons and/or groups who were involved, if applicable.

The proposed rulemaking was discussed extensively with members of the Pennsylvania Homecare Association (PHA). Their comments and recommendations were taken into consideration and PHA concurred with the proposed amendments to the regulation. In addition, the proposed amendments were announced at the October 23, 2003, Medical Assistance Advisory Committee meeting and the February 11, 2004, Long-Term Care Subcommittee meeting. There were no comments.

(17) Provide a specific estimate of the costs and/or savings to the regulated community associated with compliance, including any legal, accounting or consulting procedures that may be required.

None.

(18) Provide a specific estimate of the costs and/or savings to local governments associated with compliance, including any legal, accounting or consulting procedures that may be required.

None.

(19) Provide a specific estimate of the costs and/or savings to state government associated with the implementation of the regulation, including any legal, accounting, or consulting procedures that may be required.

It is anticipated that the final-form rulemaking will result in no additional cost to the Department. Allowing providers to prescribe medically necessary HHA services for MA recipients who are not homebound and those MA recipients to receive medically necessary HHA services will result in more MA recipients qualifying for HHA services, but additional costs associated with increased HHA services utilization will be offset by decreased utilization of hospital or other institutional services. The Department anticipates no fiscal impact on the private sector or the general public as a result of this rulemaking.

Linda J. Lieberberg 1-3-07

## Regulatory Analysis Form

(20) In the table below, provide an estimate of the fiscal savings and costs associated with implementation and compliance for the regulated community, local government, and state government for the current year and five subsequent years.  
 (Dollar Amounts In Thousands)

	FY 06-07 Year	FY +1 07-08 Year	FY +2 08-09 Year	FY +3 09-10 Year	FY +4 10-11 Year	FY +5 11-12 Year
<b>SAVINGS:</b>						
Regulated Community						
Local Government						
State Government						
<b>Total Savings</b>	\$0	\$0	\$0	\$0	\$0	\$0
<b>COSTS:</b>						
Regulated Community						
Local Government						
State Government	\$0	\$0	\$0	\$0	\$0	\$0
<b>Total Costs</b>	\$0	\$0	\$0	\$0	\$0	\$0
<b>REVENUE LOSSES:</b>						
Regulated Community						
Local Government						
State Government						
<b>Total Revenue Losses</b>	\$0	\$0	\$0	\$0	\$0	\$0

(20a) Explain how the estimates listed above were derived.

It is anticipated that this regulations change will result in no additional costs to the Department. This change will allow providers to prescribe more cost-efficient home and community based care as opposed to more costly hospital or institutional care services. Any increase to costs related to additional Medical Assistance recipients receiving home health agency services will be offset by the reduced service costs previously incurred in more costly hospital and institutional settings.

Linda Dorelly 1-3-07

### Regulatory Analysis Form

(20b) Provide the past three years expenditure history for programs affected by the regulation.

(Dollar Amounts In Thousands)

Program	FY 02-03	FY 03-04	FY 04-05	FY 05-06
MA-Outpatient	\$516,832	\$677,979	\$842,991	\$945,950

(21) Using the cost-benefit information provided above, explain how the benefits of the regulation outweigh the adverse effects and costs.

There are no new costs associated with this regulations change.

(22) Describe the nonregulatory alternatives considered and the costs associated with those alternatives. Provide the reasons for their dismissal.

(23) Describe alternative regulatory schemes considered and the costs associated with those schemes. Provide the reasons for their dismissal.

# Regulatory Analysis Form

(20b) Provide the past three-year expenditure history for programs affected by the regulation.

Program	FY -3	FY -2	FY -1	Current FY

(21) Using the cost-benefit information provided above, explain how the benefits of the regulation outweigh the adverse effects and costs.

It is anticipated that the final-form rulemaking will result in no additional cost to the Department. Allowing providers to prescribe medically necessary HHA services for MA recipients who are not homebound and those MA recipients to receive medically necessary HHA services will result in more MA recipients qualifying for HHA services, but additional costs associated with increased HHA services utilization will be offset by decreased utilization of hospital or other institutional services. The Department anticipates no fiscal impact on the private sector or the general public as a result of this rulemaking.

(22) Describe the nonregulatory alternatives considered and the costs associated with those alternatives.

Provide the reasons for their dismissal.

No non-regulatory alternatives were considered since the current homebound requirement is in regulation. Thus, it is necessary to remove this qualifying condition in order to comply with Federal regulation. There is no nonregulatory alternative.

As to the limits on service, this final-form rulemaking will remove the limits from regulation and enable the Department to place the limits on the Fee Schedule.

## Regulatory Analysis Form

(23) Describe alternative regulatory schemes considered and the costs associated with those schemes.

Provide the reasons for their dismissal.

No alternative regulatory schemes were considered.

(24) Are there any provisions that are more stringent than federal standards? If yes, identify the specific provisions and the compelling Pennsylvania interest that demands stronger regulation.

No, there are no provisions that are more stringent than Federal standards; instead, the final-form rulemaking brings Pennsylvania into compliance with Federal standards.

(25) How does this regulation compare with those of other states? Will the regulation put Pennsylvania at a competitive disadvantage with other states?

Many other states have already removed the homebound requirement in order to comply with Federal regulation. This final-form rulemaking will not put Pennsylvania at a competitive disadvantage with other states.

(26) Will the regulation affect existing or proposed regulations of the promulgating agency or other state agencies? If yes, explain and provide specific citations.

This final-form rulemaking will not affect existing or proposed regulations of this or other state agencies.

(27) Will any public hearings or informational meetings be scheduled? Please provide the dates, times, and locations, if available.

No public hearings or informational meetings are scheduled.

(28) Will the regulation change existing reporting, record keeping, or other paperwork requirements?

Describe the changes and attach copies of forms or reports, which will be required as a result of implementation, if available.

The final-form rulemaking will not change existing reporting, record keeping or other paperwork requirements.

(29) Please list any special provisions which have been developed to meet the particular needs of affected groups or persons including, but not limited to, minorities, elderly, small businesses, and farmers.

No special provisions have been developed. This final-form rulemaking applies to all MA recipients and physicians and Home Health Agencies enrolled in the MA Program.



## Regulatory Analysis Form

(30) What is the anticipated effective date of the regulation; the date by which compliance with the regulation will be required; and the date by which any required permits, licenses or other approvals must be obtained?

This final-form rulemaking will be effective upon publication as final rulemaking in the Pennsylvania Bulletin.

(31) Provide the schedule for continual review of the regulation.

The effectiveness of the revised final-form rulemaking will be evaluated as an ongoing process. Necessary and appropriate changes will be made in response to letters and recommendations from other offices, agencies and individuals.

FACE SHEET  
FOR FILING DOCUMENTS  
WITH THE LEGISLATIVE REFERENCE BUREAU

(Pursuant to Commonwealth Documents Law)

2452

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INDEPENDENT REGULATORY  
REVIEW COMMISSION

DO NOT WRITE IN THIS SPACE

Copy below is hereby approved as to  
form and legality. Attorney General

BY: \_\_\_\_\_  
(Deputy Attorney General)

\_\_\_\_\_  
Date of Approval

Check if applicable  
Copy not approved.  
Objections Attached.

Copy below is hereby certified to be a true and correct  
copy of a document issued, prescribed or promulgated by:

Department of Public Welfare  
\_\_\_\_\_  
(Agency)

LEGAL COUNSEL: Devin Kusen

DOCUMENT/FISCAL NOTE NO. 141-491

DATE OF ADOPTION: \_\_\_\_\_

BY: Estelle B. Pichman

TITLE: Secretary of Public Welfare  
(Executive Officer, Chairman or Secretary)

Copy below is hereby approved as to  
form and legality. Executive or  
Independent Agencies

BY: [Signature]

JAN 19 2007  
Date of Approval

(Deputy General Counsel)  
(Chief Counsel, Independent Agency)  
(Strike inapplicable title)

Check if applicable. No Attorney  
General approval or objection  
within 30 days after submission.

NOTICE OF FINAL-FORM RULEMAKING

DEPARTMENT OF PUBLIC WELFARE

OFFICE OF MEDICAL ASSISTANCE PROGRAMS

[55 Pa.Code Chapter 1249]

Home Health Agency Services

### *Statutory Authority*

The Department of Public Welfare (Department), by this order, adopts the regulation set forth in Annex A pursuant to the authority of the Public Welfare Code, Act of June 13, 1967, P.L. 31, No. 21, 62 P.S. §§ 403, 443.2(2) and 509. Notice of proposed rulemaking was published at 34 Pa.B. 6544 on December 11, 2004.

### *Purpose of the Final-Form Rulemaking*

The purpose of this final-form rulemaking is to remove the requirement that a recipient be homebound to qualify for Home Health Agency (HHA) services and to remove the limits for HHA visits from the regulation.

The final-form rulemaking is needed to conform the regulation to the Department's direction of emphasizing home- and-community-based services, where appropriate, rather than more restrictive and expensive alternatives such as nursing home care, as well as to comply with a Federal directive clarifying Federal regulations regarding the Medicaid home health benefit. Based upon *Olmstead v. L.C.*, 527 U.S. 681 (1999), the Health Care Financing Administration (HCFA), now the Centers for Medicare and Medicaid Services' (CMS), clarified its position that requiring that a person be "homebound" in order to qualify for Medicaid HHA services violates Federal regulatory requirements in 42 CFR 440.230(c) (relating to sufficiency of amount, duration, and scope) and 440.240(b) (relating to comparability of services for groups).

As a result, the Department is removing the requirement that individuals be homebound to receive HHA services.

In addition, the Department is removing the HHA service limits from regulation and placing them on the Medical Assistance (MA) Program Fee Schedule, in order to make those limits consistent with limits on other MA services. The Department is not changing the existing limits.

#### *Affected Individuals and Organizations*

The amendments to Chapter 1249 will have a positive effect on physicians and HHAs enrolled in the MA Program as well as MA recipients of HHA services. The final-form rulemaking permits the attending physician to prescribe medically necessary HHA services to MA recipients who are not homebound if the HHA service would avoid or delay the need for treatment in a hospital or other institutional setting for the condition being treated or if the MA recipient has an illness, injury or mental health condition that justifies providing the service in the home instead of a physician's office, clinic or other outpatient setting. The removal of the homebound requirement does not preclude recipients who are homebound from receiving HHA services.

The removal of the limits on HHA visits from the regulation formalizes a process whereby recipients with a medically necessary and appropriate need for continued care in excess of the Fee Schedule limitations can apply for a program exception as

authorized in 55 Pa.Code § 1150.63 (relating to waivers). It will no longer be necessary to seek a waiver of the regulation from the Secretary of the Department for payment for HHA visits that exceed the service limits.

### *Accomplishments and Benefits*

The final-form rulemaking benefits MA recipients because it will enable the MA Program to prior authorize medically necessary HHA services for recipients who are not homebound but who are in need of medical care that can be provided more cost effectively in their own homes, rather than in a hospital, long-term care facility or other institutional setting. In addition, MA recipients of HHA services and their physicians will benefit from the final-form rulemaking because the amendments to § 1249.59 (relating to limitations on payment) permit the attending physician to prescribe and the MA recipient to receive medically necessary HHA visits beyond the existing service limits, if approved through a program exception.

### *Fiscal Impact*

It is anticipated that the final-form rulemaking will result in no additional cost to the Department. Allowing providers to prescribe medically necessary HHA services for MA recipients who are not homebound and those MA recipients to receive medically necessary HHA services will result in more MA recipients qualifying for HHA services, but additional costs associated with increased HHA services utilization will be offset by

decreased utilization of hospital and other institutional services. The Department anticipates no fiscal impact on the private sector or the general public as a result of this rulemaking.

### *Paperwork Requirements*

No additional reporting, paperwork or record keeping is required to comply with the rulemaking.

### *Public Comment*

Written comments, suggestions and objections regarding the proposed rulemaking were requested within a 30-day period following publication of the proposed rulemaking. No public comments were received within the 30-day timeframe; however, the Department received two comments from the Independent Regulatory Review Commission (IRRC). The Department also received comments from the Disabilities Law Project (DLP) and Pennsylvania Protection and Advocacy (PP&A) after the 30-day comment period closed.

### *Discussion of Comments and Major Changes*

Following is a summary of the comments received following publication of the proposed rulemaking and the Department's response to those comments. A summary of major changes from the proposed rulemaking is also included.

## *GENERAL PROVISIONS*

*§ 1249.2a. Clarification of conditions under which MA recipients may be considered homebound-statement of policy.*

### *Comment*

The IRRC stated that it understood that the Department will be rescinding § 1249.2a and replacing it with a statement of policy that is consistent with the changes to this regulation. The IRRC recommended that the Department publish the final-form version of this regulation and the updated statement of policy concurrently to avoid inconsistencies in Chapter 1249.

### *Response*

Because MA recipients must no longer be homebound to receive HHA services, a statement of policy clarifying when a recipient may be considered homebound is no longer necessary. Therefore, the Department will be rescinding the statement of policy and will not replace it with another statement of policy.

*PAYMENT FOR HOME HEALTH SERVICES*

*§ 1249.52. Payment conditions for various services.*

*Comment*

The IRRC commented that it understood that all MA recipients who reside or are eligible to reside in a nursing home, rehabilitative facility or a mental institution qualify for HHA services and therefore recommended that the term “hospitalization” in proposed § 1249.52(a)(2)(i) be replaced with a broader term that encompasses all institutional care settings.

DLP and PP&A commented that Federal Medicaid regulations prohibit a State from requiring that a person be in or qualify for institutional care to receive HHA services and recommended that proposed § 1249.52(a)(2)(i) be deleted.

*Response*

The Department disagrees with the IRRC’s statement that eligibility for HHA services depends on whether an MA recipient resides or is eligible to reside in a nursing home, rehabilitative facility or mental institution. The Department agrees with DLP and PP&A that eligibility for HHA services may not be based on whether the recipient has



received or is eligible to receive care in an institutional setting. Eligibility is based on an MA recipient's health care benefits package, irrespective of whether the recipient has been or may be institutionalized.

The intent of the Department's initial statement in § 1249.52(a)(2)(i) ("The only alternative to home health agency services is hospitalization") was to explain one of the conditions that the Department would have considered in determining the medical necessity of HHA services, not to establish eligibility for the services. The Department agrees that this section requires clarification and that the alternatives to HHA services need to be expanded beyond hospitalization. The section has been rewritten as follows: "The specific HHA service(s) would avoid or delay the need for treatment in a hospital or other institutional setting for the condition being treated."

*Comment*

DLP and PP&A expressed concern that proposed § 1249.52(a)(2)(ii) continued to require a person to have a physical or mental condition that justifies that the service must be provided in the home rather than in an outpatient clinic, which they believe is another way of requiring that recipients of HHA services be homebound. DLP and PP&A also commented that because occupational, physical and speech therapies are not covered for adult MA recipients in an outpatient setting, adult MA recipients can receive these services outside of an institution only through HHA visits. Therefore, requiring that a recipient must have a condition that justifies receiving the therapy in the

home will effectively prevent adult MA recipients who are not homebound from receiving medically necessary therapies.

*Response*

The Department disagrees with DLP's and PP&A's comment that occupational, physical and speech therapies are not covered for adult MA recipients in outpatient settings other than through HHA. The Department covers medically necessary occupational, physical and speech therapies for adult MA recipients in outpatient clinics as well as through HHA.

Nonetheless, the Department agrees with DLP and PP&A that the language of the regulation needs to be revised so that it is clear that an MA recipient does not have to be homebound to qualify for HHA services. In addition, the requirement for documentation in the medical record has been deleted from this subparagraph and added to the introductory sentence in § 1249.52(a). As a result, the Department has revised § 1249.52(a)(2)(ii) as follows: "The recipient has an illness, injury or mental health condition that justifies providing the service at the recipient's residence instead of a physician's office, clinic or other outpatient setting."

*Comment*

DLP and PP&A recommended that the Department remove all references to the homebound requirement from Medical Assistance Bulletin 23-94-04, Procedures for Prior Authorization of Home Health Services, issued June 10, 1994, and effective July 5, 1994.

*Response*

The Department agrees and will obsolete MA Bulletin 23-94-04 and issue an updated bulletin removing the requirement that a recipient be homebound to qualify for HHA services.

*Discussion of Additional Changes*

In addition to the changes explained above, after additional internal review and in preparation for final-form rulemaking, the Department made the following changes:

*§ 1249.42. Ongoing responsibilities of providers.*

After additional internal review of proposed § 1249.42(1)(ii), the Department realized that the proposed language inadvertently did not require an initial assessment of need for HHA services. Accordingly, § 1249.42(1)(ii) has been revised to remove the word "continued" to make clear that the need for HHA services must be assessed and documented both initially and on a continuing basis.

*§ 1249.59. Limitations on payment.*

After additional internal review of proposed § 1249.59, the Department realized that the proposed language did not make it possible to request services above the service limits through a program exception. Accordingly, § 1249.59(2) and (4) (redesignated as paragraph 3) have been revised to remove the limits on HHA visits and place them on the Fee Schedule.

As a result of the revision to § 1249.59(2), proposed subparagraph (6) to § 1249.52 is unnecessary and has been deleted. Proposed subparagraph (7) has been redesignated as subparagraph (6).

In addition to the changes discussed above, the Department made several technical revisions in preparing the final-form rulemaking, including correcting typographical errors and revising language to enhance clarity.

*Regulatory Review Act*

Under § 5.1(a) of the Regulatory Review Act (71 P.S. § 745.5a(a)), on **FEB 16 2007** the Department submitted a copy of this regulation to the IRRC and to the Chairpersons of the House Committee on Health and Human Services and the Senate Committee on Public Health and Welfare. In compliance with the Regulatory

Review Act the Department also provided the Committees and the IRRC with copies of all public comments received, as well as other documentation.

In preparing the final-form regulation, the Department reviewed and considered comments received from the Committees, the IRRC and the public.

In accordance with § 5.1 (j.1) and (j.2) of the Regulatory Review Act, this regulation was [deemed] approved by the Committees on . The IRRC met on and approved the regulation.

In addition to submitting the final-form rulemaking, the Department has provided the IRRC and the Committees with a copy of a Regulatory Analysis Form prepared by the Department. A copy of this form is available to the public upon request.

*Order*

The Department finds:

- (a) That public notice of intention to amend the administrative regulation by this Order has been given pursuant to §§ 201 and 202 of the Commonwealth Documents Law (45 P.S. §§ 1201 and 1202) and the regulations at 1 Pa.Code §§ 7.1 and 7.2.

(b) That the adoption of this regulation in the manner provided by this Order is necessary and appropriate for the administration and enforcement of the Public Welfare Code.

The Department acting pursuant to the Public Welfare Code, Act of June 13, 1967, P.L. 31, No. 21, 62 P.S. §§ 403, 443.2(2) and 509 orders:

(a) The regulation of the Department is amended to read as set forth in Annex A of this Order.

(b) The Secretary of the Department shall submit this Order and Annex A to the Offices of General Counsel and Attorney General for approval as to legality and form as required by law.

(c) The Secretary of the Department shall certify and deposit this Order and Annex A with the Legislative Reference Bureau as required by law.

(d) This Order shall take effect upon final publication in the *Pennsylvania Bulletin*.

Annex A

TITLE 55. PUBLIC WELFARE

PART III. MEDICAL ASSISTANCE MANUAL

CHAPTER 1249. HOME HEALTH AGENCY SERVICES

GENERAL PROVISIONS

§ 1249.2. Definitions.

The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise:

\* \* \* \* \*

[*Homebound*--A condition due to illness or injury that restricts the individual's ability to leave his residence without assistance or makes leaving medically contraindicated. The term does not relate to maternal/child services.]

\* \* \* \* \*

**PROVIDER PARTICIPATION**

**§ 1249.42. Ongoing responsibilities of providers.**

Ongoing responsibilities of providers are established in Chapter 1101 (relating to general provisions). The home health agency shall:

(1) Have written policies concerning the acceptance of recipients and the feasibility of meeting the recipient's needs in the home care setting, which include, but are not limited to:

\* \* \* \* \*

(ii) [The homebound status of the recipient.] Assessment and documentation of the need for ~~continued~~ home health agency services.

\* \* \* \* \*

**PAYMENT FOR HOME HEALTH SERVICES**

**§ 1249.52. Payment conditions for various services.**



(a) Home health agencies are reimbursed for services furnished to MA recipients within the MA Program Fee Schedule limits if the following conditions are met and documented in the recipient's medical record:

\* \* \* \* \*

(2) [The attending physician certifies that the recipient is homebound and as part of the treatment plan review certifies that the recipient continues to remain homebound. To be considered homebound, the recipient shall have a condition due to illness or injury that restricts the individual's ability to leave his residence without assistance or makes leaving medically contraindicated.] The attending physician certifies that the recipient requires care in the home and either of the following conditions exist EXISTS:

(i) The only alternative to home health agency services is hospitalization. THE SPECIFIC HOME HEALTH SERVICES WOULD AVOID OR DELAY THE NEED FOR TREATMENT IN A HOSPITAL OR OTHER INSTITUTIONAL SETTING FOR THE CONDITION BEING TREATED.

(ii) The recipient has an illness, injury or mental health condition THAT, documented in the recipient's medical records, which justifies PROVIDING that the services must be provided at the recipient's residence instead of a physician's office, clinic or other outpatient setting.

(3) The attending physician certifies that the recipient requires the skilled services of a nurse, physical therapist, occupational therapist [or] OR, speech therapist or THE SERVICES OF A home health aide. ~~If the recipient requires only home health aide services, the physician shall certify the need for these services.~~

\* \* \* \* \*

~~(6) A new treatment plan may be started with the onset of a new primary diagnosis or the exacerbation of an existing diagnosis which causes a significant change in the recipient's condition and requires a change in the treatment. If home health services are provided following the onset of an illness which does not involve a hospitalization, the initial evaluation home health visit begins a new treatment plan.~~

~~(7) The Department has determined that prior authorization requirements have been met AUTHORIZED THE SERVICES.~~

\* \* \* \* \*

**§ 1249.57. Payment conditions for maternal/child services.**

\* \* \* \* \*

(b) [*Prenatal, postpartum*] Postpartum and child services. [A recipient is not required to be homebound to receive these services.] When the mother no longer requires

postpartum visits for medical reasons, but the child continues to need medical services, payment will be made for the additional visits for care of the child only if the services are ordered by the attending physician and are part of a written plan of care written specifically for the child.

**§ 1249.59. Limitations on payment.**

The following limits apply to payment for covered services:

\* \* \* \* \*

(2) [After the first 28-days of unlimited home health care, payment is limited to 15 home visits per month per treatment plan. A new period of unlimited care begins following hospitalization, the onset of a new primary diagnosis or the exacerbation of an existing diagnosis which causes a change in the recipient's conditions and requires a change in the plan of treatment, subject to § 1249.52(a)(4) (relating to payment conditions for various services).] AFTER THE FIRST 28 DAYS OF UNLIMITED HOME HEALTH CARE, PAYMENT IS LIMITED TO THE NUMBER OF HOME VISITS SPECIFIED ON THE MA PROGRAM FEE SCHEDULE. A NEW PERIOD OF UNLIMITED CARE BEGINS FOLLOWING HOSPITALIZATION, THE ONSET OF A NEW PRIMARY DIAGNOSIS OR THE EXACERBATION OF AN EXISTING DIAGNOSIS WHICH CAUSES A CHANGE IN THE RECIPIENT'S CONDITION AND REQUIRES A CHANGE IN THE PLAN OF TREATMENT, SUBJECT TO § 1249.52(A)(4) (RELATING TO

PAYMENT CONDITIONS FOR VARIOUS SERVICES). ~~Home visits which exceed the MA Program Fee Schedule maximums are not compensable. If a new treatment plan is instituted, the payment limitations begin with the first service provided in the new treatment plan.~~

(3) [If home health services are provided following the onset of an illness which does not involve a hospitalization, payment is made for the initial evaluation home health visit which will begin the 28-day period of unlimited service.

(4)] For prenatal and postpartum care, the following limits apply:

(i) [Payment for prenatal care is limited to one visit per month.] PAYMENT FOR PRENATAL CARE IS LIMITED TO THE NUMBER OF VISITS SPECIFIED ON THE MA PROGRAM FEE SCHEDULE. Complications [attributable to] of pregnancy are not counted as [part of the one visit per month limit] prenatal care but are classified for invoicing purposes as acute illness.

\* \* \* \* \*

[(5)] (4) \* \* \*

Comments Received BEFORE Deadline

#	NAME	ORGANIZATION	ADDRESS
1	NONE	NONE	NONE

Comments Received AFTER Deadline

#	NAME	ORGANIZATION	ADDRESS
1	Chava Kintisch	Disabilities Law Project	The Philadelphia Building 1315 Walnut Street, Suite 400 Philadelphia, PA 19107-4798
2	Ilene Shane	Pennsylvania Protection and Advocacy	The Philadelphia Building 1315 Walnut Street, Suite 400 Philadelphia, PA 19107-4798

**TRANSMITTAL SHEET FOR REGULATIONS SUBJECT TO THE  
REGULATORY REVIEW ACT**

I.D. NUMBER: 14-491  
 SUBJECT: HOME HEALTH AGENCY SERVICES  
 AGENCY: DEPARTMENT OF PUBLIC WELFARE

**TYPE OF REGULATION**

- Proposed Regulation
- X Final Regulation
- Final Regulation with Notice of Proposed Rulemaking Omitted
- 120-day Emergency Certification of the Attorney General
- 120-day Emergency Certification of the Governor
- Delivery of Tolled Regulation
  - a. With Revisions
  - b. Without Revisions

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**FILING OF REGULATION**

DATE	SIGNATURE	DESIGNATION
2-16-07	<i>[Signature]</i>	HOUSE COMMITTEE ON HEALTH & HUMAN SERVICES
2-16-07	<i>[Signature]</i>	
X 2/16/07	<i>[Signature]</i>	SENATE COMMITTEE ON PUBLIC HEALTH & WELFARE
X 2/16/07	<i>[Signature]</i>	
	<i>[Signature]</i>	INDEPENDENT REGULATORY REVIEW COMMISSION
		ATTORNEY GENERAL (for Final Omitted only)
		LEGISLATIVE REFERENCE BUREAU (for Proposed only)