Regulatory Analysis Form

(1) Agency	This space for use by IRRC
Department of Public Welfare Office of Medical Assistance Programs	RECEIVED 2004 NOV 30 AM 10: 21 INDEPENDENT REGULATORY REVIEW COMMISSION IRRC Number: 2452
(2) I.D. Number (Governor's Office Use)	

(3) Short Title
Home Health Agency Services

(4) Pa. Code Cite	(5) Agency Contacts & Telephone Numbers
55 Pa.Code 1249	Primary Contact: Betty Burris, 772-6161 Secondary Contact: Amy Flaherty, 772-7395
(6) Type of Rule Making (Check One)	(7) a 120-Day Emergency Certification Attached?
_X_ Proposed Rule Making ____ Final Order Adopting Regulation ____ Final Order, Proposed Rule Making Omitted	___ No ___ Yes: By the Attorney General ____ Yes: By the Governor

(8) Briefly explain the regulation in clear and nontechnical language.
The proposed regulation removes the current requirement that in order to qualify for Home Health Agency (HHA) Services an MA recipient must be homebound. The regulation also proposes to delete service limits from the regulation and move them to the Medical Assistance (MA) Fee Schedule.

(9) State the statutory authority for the regulation and any relevant state or federal court decisions.

The Public Welfare Code, Act of June 13, 1967 (P.L. 31, No. 21)(62 P.S. §§ 403, 443.2(2) and 509).

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.

Yes, the deletion of the requirement that an MA recipient must be homebound to qualify for HHA services is based on the U.S. Supreme Court's ruling in Olmstead v. L.C., 527 U.S. 581 (1999) and Federal clarification of 42 CFR 440.230(c) and 440.240 (b).

42 CFR 440.230(c) indicates that the Medicaid agency may not arbitrarily deny or reduce the amount, duration, or scope of a required service to an otherwise eligible recipient solely because of diagnosis, type of illness, or condition. If a State limits home health services to persons who are homebound, it is arbitrarily denying the home health service based on the individual's condition.

42 CFR 440.240(b) states that the plan must provide that the services available to any individual in the following groups are equal in amount, duration, and scope for all recipients within the group: (1) the categorically needy (2) a covered medically needy group. Therefore, if Medicaid home health services are limited to those individuals who are homebound, it is a violation of 440.240(b) by providing the services to some individuals within the eligibility group and not others within the group.

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

Eliminating the homebound requirement to qualify for home health services will meet the documented medical needs of MA recipients in the least restrictive and most cost-effective setting possible.

Moving service limits from regulation to the MA Program Fee Schedule will allow a program exception to be granted to exceed these limits, if so ordered, by the attending physician's plan of care.

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

MA recipients in need of medical care may be required to remain in a hospital, long-term care facility or other institutional setting in order to receive necessary medical care if they do not meet the "homebound" criteria to qualify for home health services. In addition, without the proper follow-up medical care upon discharge from a hospital or other institutional setting, there is increased risk of readmission.

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 the attending physician's plan of care recommends exceeding this limit, a waiver request must be made directly to the Secretary of Public Welfare to waive the applicable regulation on a case-by-case basis. There may be health risks associated with delaying medically necessary home health agency services. If these services are not provided, it is possible that the recipient will be institutionalized in order to receive the care. Approving medically necessary visits under a program exception will provide a means to authorize HHA visits in excess of the fee schedule limits.

Regulatory Analysis Form

(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 proposed regulation will benefit MA participating physicians, MA participating Home Health Agencies and recipients of MA home health 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 regulation.

(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.)

MA participating physicians, MA participating Home Health Agencies and recipients of MA home health care will be required to comply with the regulation.

(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 regulation revision was discussed extensively with the Pennsylvania Homecare Association (PHA). Their comments and recommendations were taken into consideration and they concur with the proposed changes. In addition, the proposed amendments were announced at the October 23, 2003 Medical Assistance Advisory Committee Meeting (MAAC) 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.

Regulatory Analysis Form

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

Not applicable.

(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 which may be required.

It is anticipated that there will be minimal cost to the Department based on the revision of this regulation. The Department has covered and continues to cover medically necessary services.

6-17-04

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)

	Current FY Year	FY +1 Year	FY +2 Year	FY +3 Year	FY +4 Year	FY +5 Year
SAVINGS:						
Regulated Community						
Local Government						
State Government						
Total Savings	$0	$0	$0	$0	$0	$0
COSTS:						
Regulated Community						
Local Government						
State Government	$0	$0	$0	$0	$0	$0
Total Costs	$0	$0	$0	$0	$0	$0
REVENUE LOSSES:						
Regulated Community						
Local Government						
State Government						
Total Revenue Losses	$0	$0	$0	$0	$0	$0

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

N/A

	FY 03-04	FY 04-05	FY 05-06	FY 06-07	FY 07-08	FY 08-09
MA-Outpatient	$0	$0	$0	$0	$0	$0

Regulatory Analysis Form

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

(Dollar Amounts In Thousands)

Program	FY -3	FY -2	FY -1	Current FY
MA-Outpatient	$668,586	$705,750	$666,832	$740,075

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

Currently, MA recipients in need of medical care may be required to remain in a hospital, long term care facility or other institutional setting in order to receive necessary medical care if they do not meet the "homebound" criteria to qualify for home health services. In addition, without the proper follow-up medical care upon discharge from a hospital or other institutional setting, there is an increased risk of readmission. Eliminating the homebound requirement to qualify for home health services will allow the MA Program to meet the documented medical needs of recipients in the least restrictive and most effective setting possible.

(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.

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

(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 amendment will remove the limits from regulation and place it on the MA Fee schedule.

(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 proposed regulation brings Pennsylvania into compliance with Federal standards.

Regulatory Analysis Form

(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 regulations. This regulation 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 regulation will not effect 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 regulation 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.

Not special provisions have been developed. This regulation applies to all MA recipients, and HHA providers.

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 regulation 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 regulations 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.

CDL-1

FACE SHEET
FOR FILING DOCUMENTS
WITH THE LEGISLATIVE REFERENCE BUREAU

(Pursuant to Commonwealth Documents Law)

RECEIVED
2004 NOV 30 AM 10: 21
INDEPENDENT REGULATORY
REVIEW COMMISSION

#2452

DO NOT WRITE IN THIS SPACE

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

BY: Amy Ed. Elliott
(Deputy Attorney General)
NOV 17 2004
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: Ruth O'B

DOCUMENT/FISCAL NOTE NO. 14-491

DATE OF ADOPTION:

BY: Estelle B. Richman

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: Tanya Clarke
11.2.04
Date of Approval

Asst.
~~(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 PROPOSED 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), under the authority of Sections 403, 443.2(2) and 509 of the Public Welfare Code, Act of June 13, 1967 (P.L. 31, No. 21)(62 P.S. §§ 403, 443.2(2) and 509) intends to amend the regulation as set forth in Annex A to this notice.

PURPOSE OF REGULATION

These proposed amendments to 55 Pa.Code Chapter 1249 (relating to Home Health Agency Services) remove the requirement that a recipient be homebound to qualify for Home Health Agency (HHA) services and remove service limits for home health services from the regulation by relocating them to the Medical Assistance (MA) Outpatient Fee Schedule.

NEED FOR REGULATION

In accordance with the Department's move to provide for increased emphasis on home and community based services, rather than providing more restrictive and expensive alternatives such as nursing home care, as well as a Federal directive clarifying Federal regulations relating to the Medicaid home health benefit , the

Department is removing the requirement that individuals must be homebound to receive home health services.[1]

REQUIREMENTS

In accordance with this determination, the Department proposes to amend 55 Pa.Code Chapter 1249 (relating to Home Health Agency Services) to remove the requirement that an MA recipient must be homebound to qualify for HHA services. The Department proposes to eliminate the definition and references to "homebound" in the following sections: 1249.2 (relating to definitions); 1249.42(1)(ii) (relating to the ongoing responsibilities of providers); 1249.52 (relating to payment conditions for various services); and 1249.57(b) (relating to payment conditions for maternal/child services).

With the removal of the homebound requirement throughout the regulations, and the specific exemption to this requirement in section 1249.57(b) (relating to payment conditions for maternal/child services) it is no longer appropriate to list

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[1] On July 25, 2000, the Health Care Financing Administration (HCFA), now the Centers for Medicare and Medicaid Services (CMS), issued "Olmstead Update No. 3". See Attachment 3-g: Prohibition of Homebound Requirements in Home Health [http://www.cms.hhs.gov/states/letters/smd725a0.asp] . Based upon Olmstead v. L.C., 527 U.S. 581 (1999), this document clarified CMS's position that the use of a "homebound" requirement to qualify for Medicaid HHA services is a violation of Federal regulatory requirements at 42 CFR 440.230 (c) and 440.240 (b).

prenatal care in this section. Since the remainder of section 1249.57 (b) only deals with postpartum and child services, the Department proposes to remove the term "Prenatal" from this section. The amount and scope of the Medical Assistance Fee Schedule prenatal services are not changed by this revision.

The Department also proposes to amend section 1249.59(2) (relating to limitations on payment), which currently provides that, after the first 28 days of unlimited home health care, payment is limited to 15 home visits per month, per treatment plan. The Department proposes to remove this limit on service from regulation and, instead, place it in the MA Fee Schedule, consistent with limits on other MA services. The existing limits will not be altered, however, by removing this requirement from the regulation. A program exception may be granted to exceed this limit if ordered by the attending physician's plan of care and deemed medically necessary. The purpose of this amendment is to allow the flexibility to meet the documented medical needs of recipients in the least restrictive and most cost-effective setting possible.

AFFECTED ORGANIZATIONS, INDIVIDUALS

The proposed amendments to Chapter 1249 will have a positive affect on MA participating physicians, Home Health Agencies and recipients of MA HHA services. These amendments will permit the attending physician to prescribe medically necessary home health services to recipients who are not homebound. In addition the proposed removal of home health agency visit limitations from regulation will improve access to

medically necessary care. This formalizes a process whereby individuals with medically necessary and appropriate need for continued care in excess of the MA Fee Schedule limitations, will be able to apply for a program exception to the fee schedule limitations rather than seeking a waiver from the Secretary of Public Welfare.

ACCOMPLISHMENTS/BENEFITS

The proposed amendments benefit MA recipients who meet medically necessary criteria and prior authorization requirements for home health services. There are times when MA eligible individuals are in need of medical care that can be provided cost-effectively in their own homes, rather than in a hospital, long-term care facility or other institutional setting. The proposed regulation allows for medically necessary treatment to be provided in the home for clients who normally remain in the home, but who from time to time may, with assistance, be able to go to a doctor's appointment or to visit family for a holiday.

In addition, recipients of MA HHA services and their physicians will benefit from the regulation. This proposed amendment to section 1249.59 (relating to limitations on payment) would permit the attending physician to prescribe, and the MA recipient to receive, medically necessary home health services beyond the existing service limits, if approved through a program exception.

FISCAL IMPACT

Public Sector

Commonwealth

It is anticipated that there will be minimal cost to the Department based on the amendment of this regulation. The Department has covered and continues to cover medically necessary services. This amendment will allow those services to be provided in a home setting, as opposed to a hospital or institutional setting, offsetting any increase in the number of MA recipients qualifying for home health care.

Political Subdivisions

There will be no fiscal impact on political subdivisions as a result of this proposed rulemaking.

Private Sector

There will be no fiscal impact on the private sector as a result of this proposed rulemaking.

General Public

There will be no fiscal impact on the general public as a result of this proposed rulemaking.

PAPERWORK REQUIREMENTS

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

EFFECTIVE DATE

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

SUNSET DATE

There is no sunset date.

PUBLIC COMMENTS

Interested persons are invited to submit written comments, suggestions or objections regarding the proposed regulation to the Department of Public Welfare,

Office of Medical Assistance Programs, Attention: Regulations Coordinator, c/o Deputy Secretary's Office, Room 515, Health and Welfare Building, Harrisburg, Pennsylvania 17120, within 30 days after the date of publication of this Notice in the Pennsylvania Bulletin. Persons with a disability may use the AT&T Relay Service at 1-800-654-5984 (TDD users) or 1-800-654-5988 (Voice users).

REGULATORY REVIEW ACT

Under Section 5(a) of the Regulatory Review Act (71 P.S. § 745.5(a)), on [illegible] the Department submitted a copy of this proposed rulemaking to the Independent Regulatory Review Commission (IRRC) and to the Chairpersons of the House Committee on Health and Human Services and the Senate Committee on Public Health and Welfare. In addition to submitting the proposed 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.

Under Section 5(g) of the Act (71 P.S. § 745.5(g)), if the IRRC has any comments, recommendations or objections to any portion of the proposed regulation, it may notify the Department and the Committees within 30 days after the close of the public comment period. Such notification shall specify the regulatory review criteria that have not been met. The Act specifies detailed procedures for review by the Department, the General Assembly and the Governor of any comments, recommendations or objections raised, prior to final publication of the regulation.

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.]

* * * * *

§ 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:

(i)An evaluation visit in the recipient's residence to consider the physical facilities available, attitudes of family members and the availability of family members to help in the care of the patient.

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

* * * * *

(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 the only alternative to home health agency services is hospitalization or the recipient has an illness, injury or mental health condition, documented in the recipient's medical records, which justifies that the service 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] speech therapist or home health aide. If the recipient requires only home health aide services, the physician shall certify the need for these services.

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(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.

* * * * *

§ 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).] 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)] (3) For prenatal and postpartum care, the following limits apply:

(i) [Payment for prenatal care is limited to one visit per month.] Complications [attributable to] of pregnancy are not counted as prenatal care [part of the one visit per month limit] but are classified for invoicing purposes as acute illness.

(ii) Payment for a postpartum visit includes payment for care provided the newborn child.

[(5)] (4) Payment for hypodermic or intramuscular therapy provided during a home visit is included in the visit fee. If this service is provided during a recipient's visit to the home health agency, the agency will be paid at the rate specified in the MA Program Fee Schedule.

* * * * *

TRANSMITTAL SHEET FOR REGULATIONS SUBJ REGULATORY REVIEW ACT

IRRC
14th Floor
HARRISTOWN II

I.D. NUMBER:	14-491
SUBJECT:	Office of Medical Assistance Programs - Home Health Agency Services
AGENCY:	DEPARTMENT OF PUBLIC WELFARE

TYPE OF REGULATION

X Proposed Regulation

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

RECEIVED
2004 NOV 30 AM 10: 21
INDEPENDENT REGULATORY REVIEW COMMISSION

FILING OF REGULATION

DATE	SIGNATURE	DESIGNATION
11/30	A. Luck	HOUSE COMMITTEE ON HEALTH & HUMAN SERVICES
11/30	N Thompson	
11/30/04	Jeremy Mohler	SENATE COMMITTEE ON PUBLIC HEALTH & WELFARE
11/30/04	MW	
11/30/04	D. Gelwicks	INDEPENDENT REGULATORY REVIEW COMMISSION
	N/A	ATTORNEY GENERAL (for Final Omitted only)
11.30		LEGISLATIVE REFERENCE BUREAU (for Proposed only)

November 18, 2004