Center for Medicare Advocacy

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Health Equity in Medicare

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The Center for Medicare Advocacy is a national, non-profit law organization founded in 1986 that works to advance access to comprehensive Medicare and quality health care. Based in Washington, DC and CT, with additional attorneys in CA, MA, NJ.

- Staffed by attorneys, advocates, communication and technical experts
- Education, legal analysis, writing, assistance, and advocacy
- Systemic change – Policy and Litigation
  - Based on our experience with the problems of real people
- Medicare coverage and appeals expertise
- Medicare/Medicaid Third Party Liability Projects

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HEALTH EQUITY

MEDICARE'S ROLE IN MITIGATING DISPARITIES

- Social insurance program
  - guaranteed coverage, regardless of income, medical history, or health status
  - virtually all Americans age 65 or older are insured
  - Coverage for people with long-term disabilities
- Desegregation of hospitals:
  - the National Institutes of Health Study "The Federal Government's Use of Title VI and Medicare to Racially Integrate Hospitals in the United States, 1963 Through 1967," by P. Preston Reynolds, MD, PhD.
- Despite these successes, disparities remain

COVID-19 AND HEALTH EQUITY

- Research/data on low income, communities of color indicate increased risk of serious illness if infected with COVID-19
  - KFF: Low-Income and Communities of Color at Higher Risk of Serious Illness if Infected with Coronavirus
  - KFF: Communities of Color at Higher Risk for Health and Economic Challenges due to COVID-19
  - KFF:Racial and Ethnic Health Inequities and Medicare (kff.org)
  - Brookings: Why are Blacks dying at higher rates from COVID-19?
  - CDC: COVID-19 in Racial and Ethnic Minority Groups
  - Urban Institute: COVID-19 Racial Health Disparities Highlight Why We Need to Address Structural Racism

DISCRIMINATION IN COVID-19 TREATMENT

- Guidelines for rationing of life saving care
  - Procedures for providers to follow if medical resources must be rationed (ventilators, medication, etc.)
  - Determinations based on individualized assessment of the patient
  - Cannot be based on a patient's perceived "worth" or perceived quality of life
  - OCR Bulletin
  - New England Journal of Medicine
- OCR Complaints
  - Center for Public Representation has analyses, filed complaints and advocacy letters

MEDICARE & COVID-19: OVERVIEW

- Most changes pursuant to CMS action
- Most of the Medicare-related changes are temporary and have been made retroactive to March 1, 2020, and will last until the Public Health Emergency (PHE) related to the COVID-19 crisis is lifted
- Include significant expansion of telehealth
  - Beneficiaries have received a wider range of health services from home, from a broader array of providers, and using more types of technology.

TELEHEALTH

- Protects beneficiaries from exposure to virus
- Discussions of permanently expanding flexibilities
  - Some concerns include:
    - Exacerbating health disparities
    - Equitable access for underserved communities
    - Should supplement, rather than replace, in-person care
    - HIPPA concerns and privacy
    - Fraud concerns
    - Cost-sharing issues
- CMA guiding principles

TELEHEALTH (CONT'D)

- *JAMA* study on telehealth and disparities confirms some of our concerns:
  - the first large-scale study to characterize inequitable access to telehealth care
  - 148,402 patients scheduled for telemedicine visits at a large academic health system during the early phase of the COVID-19 pandemic
  - found that older age, Asian race, and non-English language as the patient's preferred language were independently associated with fewer completed telemedicine visits and that older age, Black race, Latinx ethnicity, and lower household income were associated with lower video use

ACTIONS THAT HELP MITIGATE INEQUITIES

- Increased attention on inequities is important, but just a start:
  - Need for increased data collection
  - Structural Change: policies with equity focus
    - Problem with “color-blind” policies
  - Improve access to health care and improve health outcomes
    - Expansions in ACA, Medicaid enrollment and eligibility, improvements in Medicare

IMPROVEMENTS IN MEDICARE

- Expand Medicare to fill current gaps in coverage
  - Oral Health: Comprehensive oral health benefit included in Medicare Part B as part of overall health
    - Health Affairs Blog: An Oral Health Equity Agenda For The Biden Administration
  - Level playing field with Medicare Advantage

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NURSING HOMES

RACIAL INEQUITY PRE-PANDEMIC

- Disparities in nursing homes have been recognized for a long time.
  - "Lower tier" facilities: serve mostly Medicaid residents, fewer nurses, more quality of care deficiencies; more African American residents
- Vincent Mor, "Driven to Tiers: Socioeconomic and Racial Disparities in the Quality of Nursing Home Care," *The Milbank Quarterly* 2004 Jun; 82(2): 227-256, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2690171/

RACIAL INEQUITY DURING THE PANDEMIC

- Amil Kumar, et al, "Shifting US Patterns of COVID-19 Mortality by Race and Ethnicity From June-December 2020," *Journal of the American Medical Directors Association* (in press, Mar. 5, 2021), https://www.jamda.com/article/S1525-8610(21)00255-3/fulltext

CONSEQUENCES OF COVID-19 FOR NURSING HOME RESIDENTS AND STAFF

- As of March 21, 2021,
  - 644,247 resident confirmed cases
  - 131,386 resident deaths
  - 558,659 staff confirmed cases
  - 1,632 staff deaths

https://data.cms.gov/stories/s/COVID-19-Nursing-Home-Data/bkwz-xpvg/

MORE CONSEQUENCES OF COVID-19 FOR RESIDENTS AND STAFF

- Loneliness and isolation have also taken a toll on residents' physical and mental health
- Study of long-stay residents in CT's 244 nursing homes
  - Increased depression, unplanned weight loss, incontinence, deterioration in cognitive function

Michael Levere, et al, "The adverse events of the COVID-19 pandemic on nursing home resident well-being," *Journal of the American Medical Directors Association* (2021), https://www.jamda.com/article/S1525-8610(21)00306-6/pdf

NURSING HOMES DURING THE PANDEMIC

- Public health emergency gave federal government authority to waive statutory and regulatory protections, and it did.
  - waived some federal standards of care
    - resident protections, facility reporting requirements
  - waived all standard and complaint surveys
    - instead, limited surveys focused on infection control
  - waived most enforcement (penalties limited to the most serious deficiencies, about 1% of all deficiencies)

NO VISITORS DURING PANDEMIC

- Since March 2020, families have been barred
  - Frequently changing federal guidance
  - Extremely limited visitation
    - "Compassionate care" narrowly interpreted by many facilities to mean very end of life
- Ombudsmen barred, too

CURRENT VISITATION GUIDANCE

- "Facilities should allow indoor visitation at all times and for all residents (regardless of vaccination status), except for a few circumstances . . ."
  - CMS, "Nursing Home Visitation – COVID-19 (REVISED), QSO-20-39-NH (Mar. 10, 2021), https://www.cms.gov/files/document/qso-20-39-nh-revised.pdf
- States and facilities do not necessarily implement the federal guidance

NURSE AIDE TRAINING

- Nurse aides may not work more than 4 months unless they are trained and determined to be competent
  - 42 U.S.C. §§1395i -3(b)(5), 1396r(b)(5), Medicare and Medicaid, respectively
  - 42 C.F.R. §§483.35(d)(1)(i), (ii), 483.35(c)

CMS WAIVER OF 4-MONTH RULE

- CMS waives the 4-month rule, but not competency requirement

CMS, "Long Term Care Facilities (Skilled Nursing Facilities and/or Nursing Facilities): CMS Flexibilities to Fight COVID-19" (Mar. 28, 2020), https://www.cms.gov/files/document/covid-long-term-care-facilities.pdf

WHO'S PROVIDING CARE?

- American Health Care Association created temporary nurse aide (TNA) position
  - Free 8–hour on-line training course
  - A "temporary position intended to address the current state of emergency."

https://educate.ahcancal.org/products/temporary-nurse-aide

MANY STATES ADOPTED AHCA'S TRAINING PROGRAM

- But CMS is not tracking where TNAs are working or anything else about them
  - CMS allows facilities to report TNAs to CMS as if they were fully trained aides
  - CMS reports TNAs as if they were fully trained aides on Care Compare (federal website)

WHAT HAPPENS TO TEMPORARY AIDES WHEN THE PANDEMIC ENDS?

- "Grandfathered in" and become permanent staff?
- Lose their jobs?
- Required to take certified nurse aide training (as mandated by state) and be tested?

WAIVER OF STANDARD SURVEYS

- CMS waived standard (i.e., annual) and complaint surveys (except complaints and facility-reported incidents triaged by the state as immediate jeopardy or abuse and neglect)

CMS, "Suspension of Survey Activities," QSO-20-12-All (Mar. 4, 2020), https://www.cms.gov/files/document/qso-20-12-all.pdf; CMS, "Prioritization of Survey Activities," QSO-20-20-All (Mar. 20, 2020), https://www.cms.gov/files/document/qso-20-20-allpdf.pdf-0

LIMITED SURVEYS

- Focused on infection prevention and control requirements

EARLY INFECTION CONTROL SURVEYS CITED FEW DEFICIENCIES

- NYC and Kentucky articles reported
  - Few or no infection control deficiencies cited, even in facilities where many residents and staff had died of COVID-19
  - Questionable survey practices
    - Remote, not on-site, surveys
    - Collaborative approach with facilities

NEW YORK CITY ARTICLE

- Susan Jaffe, "Hundreds Died of COVID at NYC Nursing Homes With Spotless Infection Inspections," *The City* (May 27, 2020),

https://www.thecity.nyc/health/2020/5/27/21273143/hundreds-died-of-covid-at-nyc-nursing-homes-with-spotless-infection-inspections

NEW YORK CITY

- Found more than 600 residents died at 25 NYC facilities whose infection control surveys cited NO infection control deficiencies
  - One facility surveyed twice after families complained about COVID
  - 54 residents at facility died

KENTUCKY ARTICLE

- Bailey Loosemore, "Most Kentucky nursing homes have passed COVID-19 inspections despite widespread outbreaks," *Louisville Courier Journal* (May 28, 2020), https://www.courier-journal.com/story/news/local/2020/05/27/coronavirus-most-kentucky-nursing-homes-pass-covid-19-inspections/5268217002/

KENTUCKY

- Infection control surveys at 154 of state's 285 licensed nursing facilities, "including facilities that have reported some of the highest number of cases," cited infection control deficiencies at 2 facilities (both, deficiencies related to face masks)
- In 2019, 102 Kentucky nursing facilities cited with infection control deficiencies

KENTUCKY

- President of Kentucky Association of Health Care Facilities said facilities "have been pleased with the 'collaborative' process of the COVID-19 inspections, and she hopes facilities can continue to work more closely with state and federal regulators once the virus has passed."

GAO REPORT

- *Infection Control Deficiencies Were Widespread and Persistent in Nursing Homes Prior to COVID-19 Pandemic* (May 20, 2020), https://www.gao.gov/assets/710/707069.pdf

GAO FINDINGS

- 82% of nursing facilities were cited with one or more infection control deficiencies 2013-2017, including
  - 48% of facilities, multiple consecutive years
  - 40% of facilities cited each year

DEFICIENCY CLASSIFICATIONS 2013-2017

- 99% cited as no harm, so
  - 67% did not have penalty imposed or implemented
  - 31% had penalty imposed, but not implemented (they "corrected" the noncompliance)
- CMS implemented enforcement action (financial penalty) for 1% of the infection control deficiencies

CMA'S ANALYSES OF INFECTION CONTROL SURVEYS

- Analyses of CMS's monthly reports of infection control surveys found few deficiencies, most cited as no harm (increasing numbers of jeopardy deficiencies as year progressed)
  - E.g., "More Infection Control Deficiencies Cited in Nursing Homes – Most Considered 'No Harm'" (CMA Alert, Dec. 23, 2020), https://medicareadvocacy.org/more-infection-control-deficiencies-most-considered-no-harm-cited-in-nursing-homes/

CMS GRADUALLY RESTORING SURVEY ACTIVITIES

- While also keeping an extra, ongoing focus on infection control

CMS, "COVID-10 Survey Activities, CARES Act Funding, Enhanced Enforcement for Infection Control deficiencies, and Quality Improvement Activities in Nursing Homes," QSO-20-31-All (June 1, 2020), https://www.cms.gov/files/document/qso-20-31-all.pdf

ENFORCEMENT

- March 2020: CMS suspended all enforcement "with the exception of unremoved IJs" (immediate jeopardy) (QSO-20-20-All)
  - Suspension meant that CMS suspended revisits that would end ongoing enforcement cycles
  - CMS also told facilities they did not need to submit plans of correction

ENFORCEMENT

- Very limited enforcement and limited information about enforcement
- Aug. 2020 guidance:
  - Resolve enforcement cases that were suspended
  - Provide guidance on closing these cases out
  - Provide guidance going forward

CMS, "Enforcement Cases Held during the Prioritization Period and Revised Survey Prioritization," QSO-20-35-ALL (Aug. 17, 2020), https://www.cms.gov/files/document/qso-20-35-all.pdf

ENFORCEMENT REINSTATED

- CMS describes complex reinstatement of survey and enforcement activity, but gives many facilities a pass and limits/reduces the amounts of civil money penalties (CMPs) that may be imposed

  CMS, "Enforcement Cases Held during the Prioritization Period and Revised Survey Prioritization," QSO-20-35-ALL (Aug. 17, 2020), https://www.cms.gov/files/document/qso-20-35-all.pdf

CHANGES NEEDED GOING FORWARD

- Reinstatement of Requirements of Participation (standards of care)
- Reinstating complaint and standard (annual) surveys
- Reinstating and strengthening enforcement
  - Reversing the dismantling of enforcement (e.g., identifying per instance civil money penalties (CMPs) as default instead of per day CMPs

THREE ADDITIONAL CHANGES NEEDED

- Staffing: Registered nurses 24 hours/day; better salaries, benefits, conditions for aides
- Increased attention on how facilities spend their Medicare and Medicaid reimbursement
- More control at federal and state levels over who owns, operates, manages facilities

REGISTERED NURSES

- Decades of research: RNs correlated with better health outcomes for residents
- Pandemic: more RN coverage, fewer COVID-19 cases and deaths in CT

Yue Li, et al, "COVID-19 infections and deaths among Connecticut nursing home residents: facility correlates," *Journal of the American Geriatrics Society* (Jun. 18, 2020), https://onlinelibrary.wiley.com/doi/10.1111/jgs.16689.

AIDES

- Aides need higher salaries and better benefits (e.g. paid sick leave)
  - Aides transmitted COVID-19 across facilities because they work multiple jobs
  - LeadingAge, *Making Care Work Pay: How Paying at Least a Living Wage to Direct Care Workers Could Benefit Care Recipients, Workers, and Communities*, https://leadingage.org/sites/default/files/Making%20Care%20Work%20Pay%20Report.pdf?_ga=2.118488393.1154178586.1601481977-1021098696.1598989890

DIRECT CARE RATIO

- Requirement that facilities spend designated portions of reimbursement on direct resident care (i.e., limits on administrative costs, management fees, profits)
- NJ enacted a direct care ratio
  - A4482/S2758 authorizes direct care ratio, limiting percentage of reimbursement that can be spent on administrative costs, profits https://www.njleg.state.nj.us/2020/Bills/A4500/4482_R2.PDF

OWNERSHIP/MANAGEMENT

- Need tighter, more stringent and enforceable rules for
  - who gets state license to operate a facility
  - who gets federal certification (Medicare and Medicaid)

CONCERN ABOUT PRIVATE EQUITY

- Senate and House hearings
- Atul Gupta, et al, "Does Private Equity Investment in Healthcare Benefit Patients? Evidence from Nursing Homes," Becker Friedman Institute, Working Paper No. 2021-20 (Feb. 2021)
  - 20,000 more deaths, higher Medicare payments

https://bfi.uchicago.edu/wp-content/uploads/2021/02/BFI_WP_2021-20.pdf

SENATE FINANCE COMMITTEE

- "A National Tragedy: COVID-19 in the Nation's Nursing Homes," hearing, Mar. 17, 2021
  - Hearing video, opening statements, written statements of witnesses, https://www.finance.senate.gov/hearings/a-national-tragedy-covid-19-in-the-nations-nursing-homes

HOUSE WAYS & MEANS COMMITTEE

- Oversight Subcommittee, "Private Equity's Expanded Role in the U.S. Health Care System," Hearing, Mar. 25, 2021
  - Hearing video and written testimony of witnesses, https://waysandmeans.house.gov/legislation/hearings/oversight-subcommittee-hearing-examining-private-equity-s-expanded-role-us

KENTUCKY

- Bailey Loosemore, "Most Kentucky nursing homes have passed COVID-19 inspections despite widespread outbreaks," *Louisville Courier Journal* (May 28, 2020), https://www.courier-journal.com/story/news/local/2020/05/27/coronavirus-most-kentucky-nursing-homes-pass-covid-19-inspections/5268217002/

MEDICARE & INDIVIDUALS WITH CHRONIC CONDITIONS

OVERVIEW

- Beneficiaries with longer-term and chronic conditions – such as diabetes, stroke, paralysis, multiple sclerosis, Parkinson's, ALS, heart disease, pulmonary disorders and more – are too often denied ongoing care for which they legally qualify.

JIMMO & THE MYTH OF IMPROVEMENT

- Pervasive belief among health care professionals, providers, Medicare reviewers, and contractors that Medicare pays for skilled nursing or therapy in certain settings only if beneficiary is expected to improve
- Not true and never has been true
- See CMA website at: https://www.medicareadvocacy.org/medicare-info/improvement-standard/ including *Jimmo* Issue Brief (June 2019) at: https://www.medicareadvocacy.org/wp-content/uploads/2019/06/Jimmo-Improvement-Standard-Issue-brief-June-2019.pdf

WHAT *JIMMO* SETTLEMENT MEANS: NO DENIALS BASED ON IMPROVEMENT STANDARD

- Medicare coverage is improperly denied for skilled nursing or rehabilitation services when the denial is based on:
  - Individual's stable or chronic condition.
  - No expectation of improvement in a reasonable period of time.
- Services can be skilled and covered even when:
  - Individual has "plateaued"
  - Services are "maintenance only"

CARE SETTINGS *JIMMO* APPLIES TO

- Skilled nursing facility (SNF)
- Home health (HH)
- Outpatient therapy
- Inpatient rehabilitation facilities (IRFs)
  - (To a lesser extent)

BIGGEST OBSTACLES TO IMPLEMENTATION

- Continuing belief among providers and adjudicators that beneficiary must be improving before Medicare will pay (we still get frequent calls about patient who has “plateaued”)
- SNFs, HH agencies, therapists in outpatient setting refusing to provide therapy, regardless of what surgeon or other physician says

MLN ARTICLE RE: MAINTENANCE THERAPY

- On May 1, 2020, CMS issued an MLN article which **reconfirms that therapy to maintain** an individual's function **is a Medicare-covered service**. Further, the MLN **authorizes therapist assistants to perform** maintenance therapy as a covered Medicare home health benefit, if the therapy is initially assessed, and is supervised, by a qualified physical therapist.
  - See MLN Matters # MM-11721 (May 1, 2020): https://www.cms.gov/files/document/mm11721.pdf

HH BENEFIT

- Growing disconnect between coverage available under the law and what is actually provided
  - Law says, eg, no duration limitation; up to 28 to 35 hours a week of home health aide (personal hands-on care) and nursing services combined
  - In practice, diminishing access to home health aides, and most coverage short-term
- See CMA Medicare & Family Caregivers paper (June 2020)

MEDICARE ADVANTAGE (MA) PLANS & PAYMENT

- MA plans have incentives to make people appear more sick/have more diagnoses because payment is risk adjusted
- *NEJM* article (2018) noted MA enrollees "appear to be somewhat healthier than beneficiaries in traditional Medicare"
- December 2019 HHS OIG report stated that risk-adjusted payments "may create financial incentives for [MA plans] to make beneficiaries appear as sick as possible to obtain higher payments. **CMS estimates that from 2013 through 2016, Medicare paid $40 billion in overpayments that resulted from plan-submitted diagnoses that were not supported by beneficiaries' medical records**."

QUALITY OF CARE IN MA PLANS

- Several studies (including those sponsored by insurance industry) say that people with chronic conditions generally fare better in Medicare Advantage (MA) plans, however …
- *New England Journal of Medicine (NEJM)* "Medicare Advantage Checkup" (2018)
  - Evidence is mixed – e.g., generally higher rates of preventive care and screenings among MA recipients, but "[s]omewhat counterintuitively, there seems to be no difference between Medicare and [MA] plans with respect to care coordination"
  - "[s]everal studies have flagged concerns about the quality of care received by high-need, high-cost enrollees, on the basis of disenrollment rates and other measures."

QUALITY OF CARE IN MA PLANS

- *Health Affairs* (May 2020) - "people with greater levels of disability were more likely to switch to traditional Medicare, compared to those with lower levels […] the highest-need older adults with disability may experience lower-quality care in Medicare Advantage and thus leave before accessing the program's expanded benefits."
- Flawed quality star ratings - MedPAC (March 2020): because of the way data is reported/collected, "Medicare and beneficiaries lack important information about the quality of care of MA plans in their market. As a result, the Commission can no longer provide an accurate description of the quality of care in MA"

MA DENIALS & APPEALS

- The number of enrollees in plans that require prior authorization for one or more services increased from 2019 to 2020, from 79% in 2019 to 99% in 2020 (KFF)
- 2018 HHS Office of Inspector General (OIG) report found "'widespread and persistent problems related to denials of care and payment in Medicare Advantage' plans": https://go.usa.gov/xPW2c
  - Findings include: when beneficiaries and providers appealed preauthorization and payment denials, MA plans "overturned 75 percent of their own denials."

Q&A

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