



2019 SMP/SHIP NATIONAL CONFERENCE

RECENT AND UPCOMING CHANGES TO MEDICARE HOME HEALTH CARE

AND HOW ADVOCATES & COMMUNITY PARTNERS CAN HELP BENEFICIARIES

Center for Medicare Advocacy

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July 22–25, 2019 • San Diego, CA



Center for
Medicare Advocacy

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

- Headquartered in CT and Washington, DC
- Staffed by attorneys, advocates, nurse, paralegal, and technical experts
- Education, legal analysis, writing and assistance
- Systemic change – Policy & Litigation
 - Based on our experience with the problems of real people
- Medicare appeals
- Medicare/Medicaid Third Party Liability Projects

OVERVIEW OF HOME HEALTH COVERAGES AND SERVICES

- Medicare Home Health Coverage Criteria and Services
- *Jimmo* Settlement Impact on Home Health Care
- Current Obstacles to Getting Care
- Advocacy Tools and Practical Tips

HOME HEALTH COVERAGE CRITERIA



Reference - Federal Regulation: 42 C.F.R. § 409.40 et seq

UNDER THE CARE OF A PHYSICIAN

Certifying physician must:

- Establish a written Plan of Care
 - Order specific medical and therapy treatments, including type of services, and frequency
 - Review at least every 60 days
- Conduct, or sign off on, a “Face-to-Face” meeting

Reference: 42 C.F.R. § 409.40 et seq; 42 C.F.R. § 424.22

CONFINED TO HOME (“HOMEBOUND”)

Intent: To provide care at home for people who lack an ordinary ability to leave home

- Because of illness or injury, individual must require assistance of another person or supportive device to leave home; OR
- Have a condition such that leaving home is medically contraindicated; and
- There is a normal inability to leave home; and
- It requires a “considerable and taxing effort” to leave home.

Reference: Medicare Benefit Policy Manual, Ch. 7, Sec. 30.1.1

HOMEBOUND (CONT.)

- May leave home for:
 - Health care
 - Medical appointments, therapy not available at home, adult day care for the purpose of therapeutic, psychosocial, or medical treatment
 - Infrequent absences or absences of short duration
 - Religious services deemed OK
 - Occasional trip to barber, walk around the block, family reunion, funeral, graduation, etc.

Reference: Medicare Benefit Policy Manual, Ch. 7, Sec. 30.1.1

HOMEBOUND (CONT.)

QUESTIONS TO ASK ABOUT ABSENCES

- Is a walker, wheelchair or other assistive device needed?
- Special transportation arrangements? Equipment needs?
- Can't transfer self? Can't dress self? Look for issues like poor grip, upper body paralysis, incontinence, poor vision, mental status, requires escort/another person's assist.
- Is there evidence of a "taxing effort"
- "Patient drives" – Does not automatically mean not homebound

**Look at individual's overall condition & experience,
rather than isolated period(s).**

Reference: Medicare Benefit Policy Manual, Ch. 7, Sec. 30.1.1

WHAT SERVICES QUALIFY AN INDIVIDUAL FOR COVERAGE?

- To **begin** coverage, the beneficiary must require a **skilled** service:
 - Intermittent skilled nursing services; or
 - Skilled Physical Therapy (PT) or Speech Language Pathology (SLP) services

- To **continue** coverage, also:
 - Occupational Therapy (OT) - not to begin coverage

Reference: 42 C.F.R. § 409.40 et seq

SKILLED SERVICES

- “Skilled” means a qualified professional is needed for the care to be safe & effective
 - To provide or supervise the care (nursing or therapy)
- Skilled Nursing / Therapy defined at 42 C.F.R. §409.33
 - List of services that = skilled nursing/therapy
(42 C.F.R. §409.42)

No duration of time limit. Medicare home care coverage is available so long as skilled care required

Reference: Medicare Benefit Policy Manual, Ch. 7, Sec. 40.1.1

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SKILLED NURSING DEFINED

- Overall Management and Evaluation of Care Plan
- Observation and Assessment of Changing Condition
- Patient Education Services
- Specific skilled nursing services

Reference: Code of Federal Regulations 42 C.F.R. § 409.33(a)

SKILLED NURSING (Cont.)

IMPORTANT ADVOCACY TIP

- A patient's overall medical condition, without regard to whether the illness or injury is acute, chronic, terminal, or expected to extend over a long period of time, should be considered in deciding whether skilled services are needed. A patient's diagnosis should never be the sole factor in deciding that a service the patient needs is either skilled or not skilled. Skilled care may, depending on the unique condition of the patient, continue to be necessary for patients whose condition is stable.

Reference: Medicare Benefit Policy Manual, Ch. 7, Sec. 40.1.1

NURSING TO MAINTAIN FUNCTION OR SLOW DETERIORATION

- **Maintenance nursing services are Medicare-coverable when skilled nursing is necessary to maintain current condition or prevent or slow deterioration so long as the skills of a nurse are required to ensure the services are safe and effective**

(Medicare Benefit Policy Manual, Ch. 7, Sec. 40.1.1)

- **Decision regarding coverage should turn on whether skilled nursing is needed, not whether individual is expected to improve**

(Medicare Benefit Policy Manual, Ch. 7, Sec. 20.1.2)

SKILLED THERAPY

- Physical Therapy
- Speech Language Pathology
- Occupational Therapy (sufficient to continue care, but not to trigger coverage)

Reference: 42 C.F.R. § 409.44(c)

SKILLED THERAPY (continued)

- Must relate directly and specifically to a treatment regimen (established by the physician, after any needed consultation with the qualified therapist) that is designed to treat the individual's illness or injury
- Must be reasonable and necessary

Reference: 42 C.F.R. § 409.44(c)

SKILLED THERAPY (continued)

“...There must be an expectation that the beneficiary’s condition will improve materially in a reasonable (and generally predictable) period of time ...or the skills of a therapist must be necessary to perform a safe and effective maintenance program.”

Reference: 42 C.F.R. § 409.44(c)(2)(iii)

SKILLED MAINTENANCE THERAPY

- **Maintenance Therapy Is A Covered Service** – “...when the specialized knowledge of a qualified therapist is required to design and establish a maintenance program based on an initial evaluation and periodic assessment of a patient’s needs...” (42 C.F.R. § 409.33(c)(5))
- **Maintenance Therapy** – Where services that are required to maintain the patient’s current function or to prevent or slow further deterioration are of such complexity and sophistication that the skills of a qualified therapist are required to perform the procedure safely and effectively, the services would be covered... .”

Reference: Medicare Benefit Policy Manual, Ch. 7, Sec. 40.2.2.E

IMPORTANT KEY POINTS

1. An individualized assessment regarding eligibility for coverage is required
 2. Restoration potential is not the deciding factor
 3. Medicare should not be denied because the beneficiary has a chronic condition or needs services to maintain his/her condition
 4. Skilled therapy and other services can be covered to:
 - Preserve current capabilities
 - Prevent further deterioration
 5. Home Care can continue so long as qualifying are criteria met
-
- Home health agencies must submit claims to Medicare if a beneficiary requests (but the individual is responsible for payment until/unless Medicare coverage is granted)

“DEPENDENT” COVERED SERVICES

- **Must Need/Receive at Least One Skilled Service:**
- Intermittent Skilled Nursing
- Physical Therapy
- Speech Language Pathology
- Occupational Therapy (To continue, not trigger coverage)

If Receiving Skilled Services

"Dependent" Services Can Be Covered

- **IF a Skilled Service is Required and Received, Then Coverage is Available for:**
- Home Health Aides (Part-time or Intermittent personal care)
- Medical Social Services
- Medical Supplies

DEPENDENT SERVICES (continued)

Home health aides (can be Part-time or Intermittent)

Home health aides, combined with skilled nursing, can be provided up to 28 hours per week and any number of days per week as long as they are provided less than 8 hours each day

- Subject to review on case by case basis, they may be available up to 35 hours per week

Reference: 42 U.S.C. § 1395x(m)(7)(b)

DEPENDENT SERVICES (continued)

- Home Health Aides
 - HH Aides must provide personal, hands-on-care
 - Homemaker services alone are *not* covered
 - Only allowed if incident to personal hands-on care
- “Custodial” Care
 - Medicare Act specifically establishes home health aide (custodial care) as a covered service under the Medicare benefit

Reference: 42 U.S.C. § 1395x(m); 42 C.F.R. § 409.45

IS COVERAGE AVAILABLE IF CAREGIVERS ARE AT HOME?

- A patient is entitled to have the costs of reasonable and necessary services reimbursed by Medicare without regard to whether there is someone available to furnish the services ...
- Ordinarily it can be presumed that there is no able and willing person at home to provide services rendered by the home health aide or other HH personnel

Reference: Medicare Benefit Policy Manual, Ch. 7, Sec. 20.2

Jimmo Case Settlement

Impact On Medicare Home Health Care

JIMMO V. SEBELIUS

SETTLEMENT APPROVED 1/24/2013

- **Federal class action brought to end Medicare denials based on an “Improvement Standard” for skilled nursing facility (SNF), home health (HH), and outpatient therapy (OPT) care.**

- **Plaintiffs: 5 individuals and 6 organizations**
 1. National MS Society
 2. Alzheimer’s Association
 3. National Committee to Preserve Social Security & Medicare
 4. Paralyzed Veterans of America
 5. Parkinson’s Action Network
 6. United Cerebral Palsy

WHAT *JIMMO* MEANS

Care that meets Medicare level-of-care criteria (i.e. homebound for home health), and is needed to maintain an individual's condition or slow decline, is just as coverable as care intended to improve an individual's condition.

WHAT *JIMMO* MEANS

Settlement required CMS to revise its Medicare home health and other policy manuals, guidelines, instructions and education to “clarify”:

- **Coverage does not turn on the presence or absence of potential for improvement but rather on the need for skilled care**
 - Including Nursing and Therapy

Services can be skilled and covered when:

- Skilled professional is needed to ensure services are safe and effective
- To maintain, prevent, or slow decline

Medicare Benefit Policy Manual, Ch.7, Sec. 20.1.2

JIMMO SUMMARY

Questions to Ask:

- Is a skilled professional needed to ensure nursing or therapy is safe and effective? Yes - Medicare coverable
- Is a qualified nurse or therapist needed to provide or supervise the care? Yes - Medicare coverable

Regardless of whether the skilled care is needed to improve, or maintain, or slow deterioration of the condition. Or if condition is “chronic” or “stable” or has “plateaued.”

***JIMMO* AND PRIOR LAW REQUIRE AN ASSESSMENT OF EACH INDIVIDUAL'S SITUATION**

- Medicare should not use “rules of thumb”
- Rather, “Determination of whether skilled nursing care is reasonable and necessary must be based solely upon the beneficiary's unique condition and individual needs, without regard to whether the illness or injury is acute, chronic, terminal, or expected to last a long time.”

Reference: 42 C.F.R. §409.44(b)(3)(iii); See also, 42 C.F.R. §409.44(a)

MEDICARE HOME HEALTH CARE SERVICES

Current Obstacles to Care

OBSTACLES TO CARE: NARROW (MIS)INTERPRETATION OF COVERAGE LAWS

- By Home Health Agencies, Medicare Contractors, CMS, MedPAC, and the Office of the Inspector General
- A lack of understanding about the *Jimmo* case
- Agencies fear of Medicare audits

“Service to the few jeopardizes service to the many.”

Quote from Texas agency

OBSTACLES TO CARE: NARROW (MIS)INTERPRETATION OF COVERAGE LAWS – OIG EXAMPLES

Recent Office of Inspector General audit reports from across the country, denying claims for “lack of homebound status”, described 4 beneficiaries as follows:

1. Beneficiary had an uncomplicated procedure, independent in self-care, no barriers in apartment, had declined PT
2. Beneficiary outside when PT arrived, he had already wheeled himself to the corner of his street two times
3. Beneficiary lived in an accessible residence with an elevator and his oxygen level was over 90%
4. Beneficiary can ambulate 300 feet with no taxing effort

OBSTACLES TO CARE: PAYMENTS TO AGENCIES INFLUENCE DELIVERY OF CARE

- Current payment case-mix weights are not strong for people living with a chronic condition.
- Medicare certified home health agencies are not required to provide services to all Medicare patients.
- However, Medicare certified home health agencies are not allowed to discriminate by payer source.
- Agencies receive no additional payments for home health aides, despite # of hours needed. Home health aide visits have declined 87% under the PPS since 1998.

OBSTACLES TO CARE: QUALITY RULES

- Impact of the current Home Health Quality Reporting Program (HHQRP) and the “star rating” system - measures include these “improvement” measures:
 - How often patients got better at walking around
 - How often patients got better at getting in and out of bed
 - How often patients got better at bathing
 - How often patients had less pain when moving around
 - How often patients’ breathing improved
 - How often patients’ wounds improved or healed after an operation

OBSTACLES TO CARE: ARBITRARY DISCHARGE

- The patient continues to meet qualifications for Medicare home care, but the home health agency says:
 - Medicare won't pay for your care any more
 - Medicare doesn't cover long term services
 - Medicare doesn't cover maintenance therapy
 - We don't have the staff to meet your needs
 - You only need custodial care and Medicare doesn't pay for that
 - You are not homebound

OBSTACLES TO CARE: CHANGES EFFECTIVE 2020

PATIENT DRIVEN GROUPINGS MODEL (PDGM)

CHANGES TO HOME HEALTH THERAPY VISITS

EFFECTIVE 1-1-2020

- Currently there are 9 “service use” thresholds (# of therapy visits) 0-5, 6, 7-9, 10, 11-13, 14-15, 16-17, 18-19, 20+ therapy visits
- As of 1-1-2020, therapy thresholds will be eliminated
- Recent survey by National Home Care and Hospice (NAHC) 685 agencies responded – up to a third of agencies will reduce therapy staff

CHANGES TO HOME HEALTH THERAPY VISITS

EFFECTIVE 1-1-2020

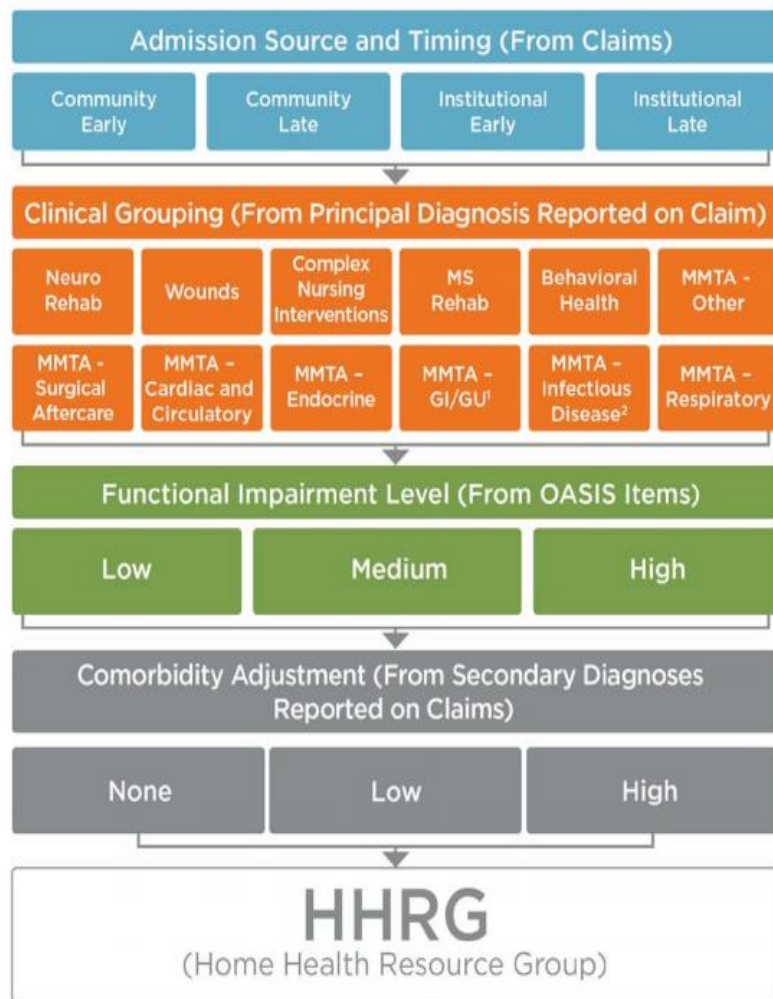
- From NAHC June 2019 Survey results:

How do you anticipate PDGM will impact therapy utilization in your agency?	For Profit	Nonprofit
Stay the same	17.4%	48.6%
Decrease less than 10%	22.8%	22.4%
Decrease more than 10%	41.3%	9.1%

PATIENT DRIVEN GROUPINGS MODEL (PDGM) COMPONENTS

EFFECTIVE 1-1-2020

- *Admission Source* – Post-inpatient stay admission or community admission
- *Timing* – Changes “early” episodes from 120 days (Two 60 day episodes) to 30 days
- *Clinical Grouping* - (12 categories)
- *Functional Impairment Level* - Low/Medium/High
- *Co-Morbidity Adjustment* - None/Low/High



How the Patient-Driven Groupings Model Works

- **Five main case-mix variables—**

1. Admission Source
2. Timing
3. Clinical Grouping
4. Functional Impairment Level
5. Comorbidity Adjustment

- A 30-day period is grouped into **one** subcategory in each color category

- This results in **432 possible case-mix adjusted payment groups** into which a 30-day period can be placed:
 $(2 \times 2 \times 12 \times 3 \times 3 = 432 \text{ HHRGs})$

¹ Gastrointestinal tract/Genitourinary system

² The infectious disease category also includes diagnoses related to neoplasms and blood-forming diseases

PATIENT DRIVEN GROUPINGS

MODEL (PDGM) EXAMPLE

MEDICATION MANAGEMENT, TEACHING, ASSESSMENT

Clinical Group + Functional Need Level	Timing + Admission Source	Comorbidity Adjustment	CY 2019 Case Mix Adjusted Weight
MMTA – Other - High	Early – Institutional	2	1.6261
MMTA – Other – High	Late – Institutional	2	1.4870
MMTA – Other – High	Early – Community	2	1.4442
MMTA – Other - High	Late – Community	2	1.0401

PATIENT DRIVEN GROUPINGS

MODEL (PDGM) EXAMPLE

COMPLEX NURSING INTERVENTIONS

Clinical Group + Functional Need Level	Timing + Admission Source	Comorbidity Adjustment	CY 2019 Case Mix Adjusted Weight
Complex – High	Early – Institutional	2	1.5633
Complex – High	Late – Institutional	2	1.4241
Complex – High	Early – Community	2	1.3813
Complex – High	Late – Community	2	0.9772

MEDICARE HOME HEALTH CARE SERVICES

Advocacy Tools and Practical Tips

USE THE MEDICARE BENEFIT POLICY MANUAL

- Relied Upon By Medicare-certified Home Health Agencies <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c07.pdf>
- Medicare Benefit Policy Manual, Chapter 7
 - All significantly revised by *Jimmo*
 - Section 20 (Medicare decisions should be based on whether skilled care is needed, not on whether individual will improve)
 - Section 30 (Homebound)
 - Section 40 (Coverage, including for nursing and therapy to maintain or slow decline)

USE THE CMS *MEDICARE & HOME HEALTH CARE BOOKLET*

- Official CMS Booklet - October 2017 version contains significant updates and clarifications
 - <https://www.medicare.gov/Pubs/pdf/10969-Medicare-and-Home-Health-Care.pdf>
- Topics include:
 - Medicare Coverage of Home Health Care
 - Choosing a Home Health Agency
 - Getting Home Health Care – including plan of care and a checklist for care needs
- Not perfect, but a strong advocacy tool

USE THE MEDICARE CONDITIONS OF PARTICIPATION (COP) (REVISED EFFECTIVE 1/13/2018)

- First major update to CoP in over 25 years
- Generally expands beneficiary protections
- Affords greater protections for patients from arbitrary transfer or discharge from home health care
- Establishes an updated Patient Bill of Rights that must be clear and accessible to patients and home health staff
- Enhances patient assessment requirements to include psychosocial, functional and cognitive components
- Requires more significant consideration of patient preferences

USE THE MEDICARE CONDITIONS OF PARTICIPATION (REVISED EFFECTIVE 1-13-2018)

- Requires more patient involvement in care planning:
 - Includes patients, representatives and aides on an interdisciplinary care team
 - Establishes more communication between patients, care representatives and the home health agency
- Mandates home health agencies identify caregivers and their willingness/ability to assist with care (not assume it's available).
- Require coordination/integration with all patient's physicians.

Reference: 42 C.F.R. § 484.2 et. al.

USE THE MEDICARE CONDITIONS OF PARTICIPATION (REVISED EFFECTIVE 1-13-2018)

- Discharge and Transfer of Patients
 - Discharge is appropriate only when a physician and home health agency both agree that the patient has achieved measureable outcomes and goals established in the individual plan of care. (Note: Goals may include slowing deterioration of a condition or maintaining a condition.)
 - Home health agencies are responsible to make arrangements for safe and appropriate transfer of a patient to another agency.

Reference: 42 C.F.R. § 484.50(d)(1); 42 C.F.R. § 484.50(d)(3)

VISIT MEDICARE.GOV

- Search for “*Jimmo*” for information about the *Jimmo* Settlement and lawfully required Medicare coverage for people with conditions such as ALS
- Review the **Home Health Compare** tool, it will provide contact information for all Medicare certified home health agencies that serve your zip code.
<https://www.medicare.gov/homehealthcompare/search.html>
- Contact agencies, including those that do NOT have 5 Star Ratings.

CONFIRM THERE'S STRONG DOCUMENTATION IN THE BENEFICIARY'S MEDICAL RECORD

- The skilled nursing and/or therapy is medically reasonable and necessary - and is provided.
- Homebound requirements are met.
- Face-to-Face requirements are met.
- The need for dependent services (home health aides) is justified.
- The services are documented as delivered – “If it’s not documented, it didn’t happen”.

APPEAL MEDICARE DENIALS

- Continue to receive care, if possible. Request an expedited appeal in a timely manner.
- If an expedited appeal is denied, continue with a standard appeal.
- See our website MedicareAdvocacy.org for self-help appeals information.
- Ask the agency to submit a “Demand Bill” to Medicare for all the coverable services on the Plan of Care.

LAST RESORT: ACCEPT LESS THAN YOU QUALIFY FOR

- To the greatest extent possible, exhaust all of the resources previously discussed.
- The Center for Medicare Advocacy is working for fair access. In the meantime, the reality may be that you can only get access to limited Medicare-covered home care.
- Let us know! Your stories will help us remove unfair barriers to Medicare-covered home care.

CREATE COMMUNITY PARTNERSHIPS

- To promote wider-spread understanding of Medicare's coverage of home health care benefits as HCBS.
- Educate community groups, including institutional discharge planners, professional practitioner groups (e.g. medical societies), advocacy groups, senior center staff, federally qualified health centers, placement agencies, faith-based groups, and home health agencies.
- Gather and share stories about barriers to home care to discover, and seek to resolve, systemic problems with access to legally covered care.

ADDITIONAL RESOURCES FROM THE CENTER FOR MEDICARE ADVOCACY

Available at:

<http://www.medicareadvocacy.org/medicare-info/home-health-care/>

- *Jimmo* Settlement and materials
- Medicare Home Health Benefit Policy Manual
- Health Tool Kit
- Revised Home Health Brochure
- Self-Help Packets
- Articles on Home Health Topics

Questions and Comments



**Please, Send Questions and Stories (Challenges and Successes)
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