

Medicare Home Health Care

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The Center for Medicare Advocacy is a national non-profit law organization that works to advance access to comprehensive Medicare, health equity, and quality health care.

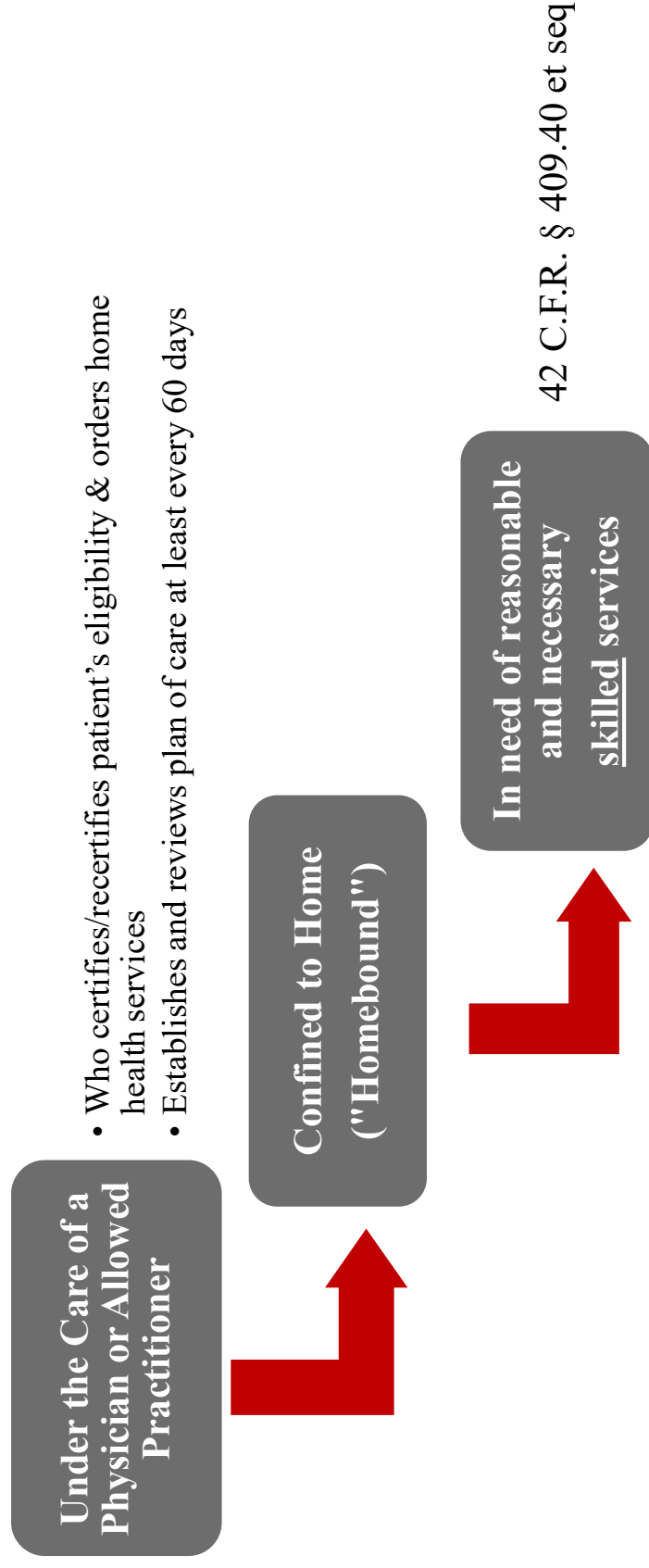
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- Founded in 1986
 - Headquartered in CT and Washington, DC
 - Staffed by attorneys, advocates, a nurse, and technical experts
 - Education, legal analysis, writing and assistance
 - Systemic change – Policy & Litigation
 - Based on our experience with the problems of real people
 - Medicare appeals
 - Medicare/Medicaid Third Party Liability Projects

Agenda

- Review of Medicare Home Health Coverage
- Obstacles to Accessing Covered Care
- Case Study
- Practical Tips
- Resources
- Questions and Discussion

Review of Medicare Home Health Coverage

General Medicare Home Health Coverage Criteria



Important Note: Medicare payment depends upon specific Initial Certification and Recertification requirements (e.g., Face-to-Face encounter) being met.

Medicare Covered Home Health Services

- **Must Need & Receive at Least One Skilled Service:**
- Intermittent Skilled Nursing
- Physical Therapy
- Speech Language Pathology
- Continuing Occupational Therapy

**If Receiving A
Skilled Service**

**"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

Medicare Home Health Coverage is Not Limited in Time

Medicare Home Health Coverage continues to be available
so long as Skilled Care is needed and
other threshold Criteria are met

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

Confined To Home (“Homebound”) Requirement

1st Prong - the patient must **either**:

- Because of illness or injury, need the aid of a supportive device; the use of special transportation; or the assistance of another person to leave their residence; **OR**
- Have a condition such that leaving home is medically contraindicated.

2nd Prong – Two additional requirements:

- There must exist a normal inability to leave home;

AND

- Leaving home must require a considerable and taxing effort.

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

Homebound Requirement (Continued)

- Can 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, occasional trip to barber, walk around the block, family reunion, funeral, graduation, etc.

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

Homebound Requirement (Continued)

Questions To Ask About Absences

- Does individual split time between different residences?
- If electric w/c or scooter: 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.
- Evidence of "taxing effort"
- No physical limitations – but unsafe to or refuses to leave home due to psychiatric or cognitive issues?
- "A patient drives" – Does not always mean not homebound

Look at the individual's overall condition and experience, rather than isolated period(s)

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

Skilled Service Requirement

- To trigger (start) home health coverage, a beneficiary must require a skilled service:
 - Intermittent skilled nursing services; or
 - Skilled Physical Therapy (PT) or Speech Language Pathology (SLP) services
- Occupational Therapy - Sufficient to continue, but not to trigger coverage

42 C.F.R. § 409.40 et seq

Standard for Skill Services

- Skilled = inherent complexity of the service, performed safely and/or effectively only by or under general supervision of qualified professional.
- Must be **medically reasonable and necessary**, based on **individualized assessment** of patient's clinical condition, to:
 - Treat patient's illness or injury **OR**
 - Maintain patient's current condition or prevent or slow further deterioration (SN)
 - Restore or maintain function affected by patient's illness or injury (PT, SLP, OT)

The Need for Skilled Care

ADVOCACY TIP

- Restoration potential is not the deciding factor for deciding whether Medicare coverage is available
 - “**Even if full recovery is not possible, a patient may need skilled services to prevent further deterioration or preserve current capabilities**”
- Improvement is not required in order for a service to be considered skilled

42 C.F.R. § 409.32

Skilled Nursing Must be “Intermittent” or “Part-Time”

1. **Less than daily visits**, but at least once every 60 days or, if less frequently, on a predictable, recurring basis,
- OR
2. **Daily visits**, but less than 8 hours/day, for up to 21 days
 - Extensions to continue daily nursing possible in exceptional circumstances and if the need for daily care is still expected to have a finite and predictable end point

42 U.S.C. §1395x(m)(7)(B)

Medicare Benefit Policy Manual, Ch. 7, Sec. 40.1.3

Skilled Nursing – Intermittent/Part Time

Exception: **Daily insulin injections** when the individual cannot self-inject and no other able & willing person to inject.

Medicare Benefit Policy Manual Ch. 7, Secs. 40.1.2.4A2 & 40.1.3

Specific Skilled Nursing Services Defined

42 C.F.R. § 409.33(a) & (b)

Includes:

- Observation & Assessment of Changing Condition
- Patient Education Services
- Overall Management and Evaluation of Care Plan
- Specific skilled nursing services
 - Includes: IV or intramuscular injections, IV or enteral feeding, suprapubic catheter replacement, treating extensive decubitus ulcers.

Skilled Therapy (PT, ST, OT)

COVERED IF:

(A) Expectation that condition will improve materially in a reasonable (and generally predictable) period of time

OR

(B) Unique clinical condition requires specialized skills, knowledge, and judgment of a qualified therapy professional to Design or Establish **OR** Perform **a safe & effective maintenance program** required in connection with patient's specific illness or injury

42 C.F.R. § 409.44(c)(2)(iii)

The Need for Skilled Care

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.

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

Dependent Services

- If an individual receives intermittent skilled nursing or PT, SLP, or continuing OT ...
- Then coverage is also available for “Dependent Services” (such as home health aides, medical supplies related to the illness/injury, medical social services)

Note: The amount of skilled services does not determine the amount of dependent services

Home Health Aides

How much can be covered – under the law?

- Combined with skilled nursing, can be covered **up to 28 hours &** any number of days per week as long as provided less than 8 hours each day
- Subject to review on case-by-case basis, coverage may be available for **up to 35 hours** per week

42 U.S.C. § 1395x(m)(7)(b); 42 CFR §409.45(b)

Home Health Aides (continued)

How much is covered – in practice?

- Too often told:
 - Only 1-3 hours a week and only for a bath
 - Agency does not have staff to provide many (or any) aide hours/visits
 - Agency may suggest finding a “private pay” alternative
- This is not all that’s authorized by law

Home Health Aides (Continued)

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

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

Home Health Aides (Continued)

42 CFR §409.45(b)(1) – (4)

What is Hands-on Personal Care?

- Bathing, dressing, grooming, caring for hair, nails, oral hygiene to facilitate treatment or prevent deterioration
- Changing bed linen of incontinent patient
- Feeding, assistance with elimination, routine catheter and colostomy care, skin, foot, ear care
- Help with bed mobility, transfers, ambulation
- Medication assistance & simple dressing changes that don't require skills of licensed nurse

What is Impact of Caregivers At Home?

MEDICARE BENEFIT POLICY MANUAL, CH. 7, SEC. 20.2

- Patient is entitled to have the costs of reasonable and necessary services reimbursed by Medicare without regard to whether someone else is available to furnish the services. But, where someone *is* or *will be providing* services that *adequately* meet patient's needs, it's not reasonable & necessary for HHA to furnish.
- Presumption that there is no able and willing person at home to provide the services unless patient/family indicate otherwise or HHA has first-hand knowledge to the contrary.

Obstacles to Accessing Medicare-Covered Home Care

Medicare Home Health: Law Versus Reality

- Legally covered services are often not available in reality, even for people who qualify.
- CMS policies, payments and practices do not implement coverage law.
- Resulting in narrowed provision of services, favoring people with shorter-term and post-acute care needs.
- Particularly negatively impacts patients who have chronic and longer-term conditions – in conflict with the *Jimmo* Settlement.
- Access to home health aide services has all but disappeared.
- Why is this happening? Cumulative impact of policies/practices:
 - Medicare home health **payment** systems
 - Medicare “**quality measures**” and **home health value-based purchasing** measures
 - **Audits** by Medicare Contractors and Office of the Inspector General

Medicare Home Health: Law Versus Reality

- We hear stories from all over the country about access problems from people with longer-term conditions to otherwise healthy elderly patients who need more time to benefit from services.
- With no substantive changes in the coverage laws, statistics that alarm advocates concerned about access to care, show:
 - As a % of total home health visits, aide services declined from **48%** (1997) to **6%** (2019).
 - Relatively “efficient” providers made a **23.4%** profit on traditional Medicare payments in 2019 (payments total \$19 billion).
 - “Improper” Medicare payments (based on narrowed interpretation of coverage) declined from **59%** (2015) to **9.3%** (2019).

Medicare Home Health: Law versus Reality

Three recent reports confirm: **Payment systems, quality measures, and audits impact who gets care, what services, and for how long -**

- **Quality Measures:** January 2023 – CMS is expanding Home Health Value Based Purchasing Program
 - Measures appear to reward improvement in a person's condition or abilities.
 - Adjusts payments to agencies to reward/penalize measurements achieved.
- **Payment System:** – Payment Driven Groupings Model (PDGM)
 - 2020 results - Case mix adjustments for every clinical group decline between 27% and 40% after the first 30 days of home health services,
- **Compliance Audits:**
 - Medicare Administrative Contractors (MAC) apply incorrect standards.
 - OIG audits often based on: Irrelevant and out of context facts, erroneous readings of regulations, lacked restorative potential, unskilled caregivers could provide skilled services, PT and OT are duplicative services, denied prior to reassessment.

Case Example

- Mr. So has ALS and needs all types of services provided through home health care.
- After 6 weeks, HH agency says “Medicare rules require us to leave for 60 days, then we can come back and see how you are.” Dr did not discharge, but care ended.
- Mr. So declined rapidly over 60 days, having no home health services.
- All services then re-started, agency repeats “Medicare only allows 6 weeks care”.
- Agency refuses to show patient/family patient’s plan of care when requested.
- PT originally states, “No point providing PT – just going to lose muscles anyway.”
- Dr. orders aides 2x/day, but agency provides one bath every 2 weeks.
- Agency say they have one aide for 500 cases, with \$16M annual Medicare revenue.
- BUT...agency has a “private pay” department for aide services.
- After advocacy, agency educated - promises to deliver more services & “for life.”

Case Example - Analysis

- As long as a patient qualifies, home health care can continue. There is no cap or limit on length of service.
- Discharge should not happen without the doctor's agreement, under Medicare CoP.
- Patient "Bill of Rights" require patient be provided with plan of care, upon request, under CoP.
- Medicare covers PT to help maintain or slow decline of function, despite any PT or agency unilaterally determining "there's no point."
- HH agency must provide all services as ordered, or arrange for services, although orders are sometimes changed after agency assessment.
- Shifting aide services to a related private-pay "division" allows HH agency to get full Medicare reimbursement (intended to include up to 35 hours of aide services) PLUS the private pay reimbursement generated for the related "division".
- Advocacy to obtain more services for longer: Patient family, CMA, CMS

Questions and Discussion

Medicare Home Health Care

Advocacy Tools And Practical Tips

Review and Refer to Medicare Home Health Law, Regulations & Policies

- **Medicare Act (Law):** 42 USC §1395x(m)
- **Federal Regulations:** 42 CFR §409.40
 - Defines skilled nursing and therapies 42 CFR §§409.32 -33; §§409.42,44
 - Defines home health aide coverage and services 42 CFR §409.45
- **Policies:** Medicare Benefit Policy Manual, Chapter 7 <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c07.pdf>
 - Relied Upon By Medicare-certified home health agencies
 - All significantly revised by *Jimmo v. Sebelius*, N0. 5:11-CV-17 (2013, 2017)
 - Section 20 (Skilled Services); Section 30 (Homebound); Section 40 (Coverage, including for nursing and therapy to maintain or slow decline); Section 50 (Aides); Section 70 (Unlimited duration)

Refer to Medicare Conditions Of Participation

- Require 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
- Mandate 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.

Refer to Medicare Conditions Of Participation

- 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 Websites

- **CMS.gov:** Search for “*Jimmo*” for information about the *Jimmo* case and legal criteria reiterating improvement is not required. (See, *Important Message About Jimmo*)
- **Medicare.gov:** Review the **Care Compare/Home Health** 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

Refer to CMS Medicare & Home Health Care Booklet

- Official CMS Booklet – September 2020 version contains significant updates and clarifications
 - [Medicare & Home Health Care](#)
 - 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 can be helpful advocacy tool

Confirm There's Clear Documentation In Beneficiary's Medical Record

- Be certain orders and goals clearly include maintenance language if that is the intended outcome
- If improvement is initially expected and that goal is reached or changed:
 - **Get new order, with new goals if goal changes from improvement to maintain, deter, or slow decline**
 - Denials occur when this is not done
- Confirm the services are documented as delivered – “If it’s not documented, it didn’t happen”.

Confirm There's Clear Documentation In Beneficiary's Medical Record

- Need for and receipt of skilled care must be evident
 - Document skilled care was needed and provided
- There are no magic words required in documentation:
 - But vague phrases like “patient tolerated treatment well,” “continue with Plan of Care,” “patient remains stable” are not sufficient to establish coverage.
 - Include language stating skilled nursing and/or therapy are required to maintain or slow and deter and why
- If improvement does occur, document it!

Last Resort: Accept Less Than Individual Qualifies For

- To the greatest extent possible, exhaust all advocacy resources previously discussed.
- Contact Congressional offices
- The Center for Medicare Advocacy is working for fair access. In the meantime, the reality may be that individual can only access limited Medicare-covered home care.
- Let us know! Stories help us remove unfair barriers to Medicare-covered home care.

If Home Health Agency Says Medicare Won't Cover

- Continue receipt of care, if possible.
- Ask the agency to submit a “Demand Bill” to Medicare for all the coverable services included on the plan of care. (Agencies must do so if the beneficiary insists. But, beneficiary payment for services is not waived.)
 - For up to 28-35 Hrs/Wk of home health aide and nursing combined and PT, SLP, OT, HH aides and other “dependent services”
 - Home Health Agency should use “Code 20” on *demand bill* claim form to ensure a medical review is done (rather than get an automatic denial)

Appeal Medicare Denials

Fast Track / Expedited Appeals

- When an agency plans to end all home health services, the beneficiary has a right to a fast (“expedited”) appeal.
- The agency must give the beneficiary a written notice, a Notice of Medicare Non-Coverage (NOMNC) at least 2 days before all covered services end.
- The NOMNC includes rights to get more details about why discharge is happening and how to ask for a fast appeal.
- Appeal by noon of the day after receiving the NOMNC.
- In appealing, the beneficiary should show why care should continue. Include support from physicians & providers.
- Note: No appeal rights unless all services are stopped.

Reference: 42 CFR §§ 405.1200 - 405.1204, MCPM Chapter 30 (Traditional);

42 CFR §§ 422.624 - 422.626, MMCM Chapter 13 (Medicare Advantage)

Appeal Medicare Denials

Standard Appeals

- Appealing to obtain coverage for continued, subsequent services and for claim payment for those services.
- A beneficiary must receive services in order to appeal. Appeals are not available for care that “should have happened”.
- Standard Appeal levels in **Traditional Medicare**: Initial Determination, Medicare Administrative Contractor (MAC) Redetermination, Qualified Independent Contractor (QIC) Reconsideration, Administrative Law Judge (ALJ) Hearing, Medicare Appeals Council Review
- Standard Appeal levels in **Medicare Advantage**: Organization Determination, Health Plan Reconsideration, Independent Review Entity (IRE) Reconsideration, ALJ hearing, Medicare Appeals Council Review
- Appeal must be for at least \$180 (2022) for ALJ Hearing & Council Review.
- Thereafter, a claim can be appealed to Federal Court, if appeal is for at least \$1,760 in 2022.

Resources From the Center For Medicare Advocacy

Available at: MedicareAdvocacy.org

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

- *Jimmo* Settlement, materials, factsheets
- Medicare Home Health Infographic/Factsheets
- Home Health Tool Kit
- Home Health Brochure
- Self-Help Packets
- Articles on Home Health Topics

Why Continue Fighting for Coverage?

- People need the care.
- It's the law.
- People who qualify for coverage should not have to pay themselves, go without care, or shift costs to Medicaid.
- Advocacy can open doors to this important coverage and care.
- It's our mission.

Please join us!



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