Medicare In Light of COVID-19
and an Overview of Medicare’s New Payment Models for Skilled Nursing Facilities and Home Health Services

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With Special Guests:
Eric Panicucci, HHS OIG; and Sandy Morales, CA Senior Medicare Patrol

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

COVID-19

• COVID-19 Fraud Schemes (HHS OIG) (Eric Panicucci)
• COVID-19 and Other Fraud Schemes, e.g. Hospice (CA SMP) (Sandy Morales)
• COVID-19 Related Updates to Medicare (CMA)
  • General Information (Kathy Holt)
  • Hospital and Skilled Nursing Facilities (Toby Edelman)
• COVID-19 Questions and Discussion

Brief Discussion of Other Ongoing Medicare Issues (CMA):

• Skilled Nursing Payment System (PDPM – Effective 10-1-2019) (Toby)
• Home Health Payment System (PDGM – Effective 1-1-2020) (Kathy)
• Questions and Discussion

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COVID-19 Fraud Schemes

ASAC Robb Breeden
SA Eric Panicucci

U.S. Department of Health and Human Services
Office of Inspector General
Office of Investigations
San Francisco Regional Office
Agency Background

- **HHS/OIG**
  - Protect integrity of HHS programs (including Medicare, Medicaid, CDC)
  - Safeguard health and welfare of program beneficiaries

- **Office of Investigations**
  - Criminal, civil, administrative investigations
  - Hotline operations
  - Protective services
  - Emergency operations

Medical Identity Theft Schemes

- Variations of known telemarketing schemes
- Trick beneficiaries into disclosing personal information
- Exploit fear surrounding COVID-19 pandemic
COVID-19 Fraud Schemes

CASE EXAMPLES

Personal Information for Profit

• To a fraudster, personal information is a commodity.
• They use it to bill Medicare for products and services that are either nonexistent or unnecessary.
• This adversely impacts Medicare's financial resources.

These callers will not send you a COVID-19 test kit.
Other Emerging Schemes

• **Treatment Scams** – fake cures or vaccines.

• **Email Phishing Scams** – emails designed to trick recipients into downloading malware or providing information.

• **Supply Scams** – scammers creating fake online stores claiming to sell high-demand supplies. When consumers attempt to purchase supplies, fraudsters pocket the money and never provide promised supplies.

Protect Yourself

• Be cautious of unsolicited requests for personal information.

• Be suspicious of any unexpected calls or visitors offering COVID-19 test supplies.

• Ignore offers or advertisements for COVID-19 testing or treatments on social media sites.
CA SENIOR MEDICARE PATROL

Additional Current Medicare-Related Scams, Including COVID-19 and Hospice

Sandy Morales, CA Senior Medicare Patrol Volunteer Coordinator and Case Manager
Provider Reports

Hospice Fraud

- 93 years, Hispanic woman
- Offered money, milk, food, bus coupons
- Signs paperwork
- Fraudulently enrolled in hospice
- Medicare billed 12/2019 – 3/2020
- Other residents enrolled also
FRAUD TRENDS

Hospice

Not terminally ill:
- Knowingly admitting patients to hospice who are not terminally ill.

- Inflated level of care:
- Fraudulently documenting the patient needs, thus care to receive the highest reimbursement rates.

Gift incentives:
- Using gifts to get beneficiaries to sign up for hospice care, which provides comfort and pain relief, but not take steps to treat the illness.

Services never provided:
- Billing for visits or even inpatient care when the beneficiary is actually at home and no one came for a visit.

If you see it, report it!
- Medicare fraud. Hospice care if you are certified as terminally ill, you accept adequate care, and adequate care is not provided for your illness, make sure a statement charges hospice.

Medicare Fraud Alert

Beware of Scams

1. Do not respond to offers for free medical equipment or services
2. Check your medical statements routinely for services not provided
3. Call us for a FREE fraud prevention presentation or for guidance if you suspect you may be the victim of fraud.
4. Share your Medicare number only with your trusted providers
5. Report Medicare Fraud to California Senior Medicare Patrol
   855-613-7080

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COVID-19 Related Updates to Medicare
General Information

Kathy Holt, Associate Director/Attorney
Center for Medicare Advocacy

MEDICARE AND COVID-19
COVERAGE UPDATES

**Testing:** Physician ordered COVID-19 test is covered with no cost-sharing in either traditional Medicare or an MA plan.
(Provider submit claim to Medicare on/after 4/1/20, use HCPCS U0001 or U0002)

**Hospitalizations:**
- All medically necessary hospitalizations are covered.
- Includes extra days in the hospital for inpatients who would have been discharged but were diagnosed with COVID-19 and had to stay longer under quarantine.
- No differential charge for private room if room medically necessary.

**Vaccine:**
- None yet. Under current law, when vaccine available all Part D plans (and MAPD) required to cover.
MEDICARE AND COVID-19
COVERAGE UPDATES

Telehealth:
- Medicare beneficiaries allowed to receive a wider range of healthcare services without having to travel to a facility.
- Covers doctors, nurse practitioners, clinical psychologists, and licensed clinical social workers.
- Deliver telehealth via phone and video chat at home or any health care facility (office, hospital, nursing home, clinic).
- Includes routine visits, mental health counseling, preventive health screenings for cancer and other illnesses.
- During emergency, paid at same rate as in-person services.
- Waive requirement that patient had to see doctor within past 3 years.

MEDICARE AND COVID-19
INITIAL ENROLLMENT

Medicare Enrollment through Social Security (SSA)
- Local Social Security offices are closed to the public, although some continue to provide services over the phone.
- SSA extending deadlines for filing “whenever possible”.
- Beneficiaries who need to apply for Medicare Parts A & B
  - Suggest creating an account on www.ssa.gov to allow those in Medicare’s initial enrollment period to apply for both A & B.
  - To locate telephone number to local SS office: https://secure.ssa.gov/ICON/main.jsp
MEDICARE AND COVID-19
SPECIAL ENROLLMENT

Medicare Part B and Special Enrollment through SSA

Scenario – Individual wishes to enroll immediately because:
  • Job is unavailable at the current time
  • Not going to work due to fear of contracting virus
  • Lost job and employer sponsored health insurance

  ▪ Must file 2 Forms to enroll in Part B
    • CMS 40B Application for Enrollment in Medicare Part B, AND
    • CMS L564 Request for Employment Information

  ▪ BUT what if workplace has closed or no access to records?
  ▪ OR what to do if Social Security offices aren’t open?

MEDICARE AND COVID-19
MEDICARE ADVANTAGE

  ▪ “We must remove barriers that could prevent or delay beneficiaries from receiving care.” CMS on 3-10-2020
  ▪ 42 C.F.R. 422.100(m) authorizes special requirements during a disaster or emergency related to Medicare.
  ▪ MA plans must:
    • Cover benefits at non-contracted facilities as long as those facilities have participation agreements with Medicare.
    • Waive, in full, gate-keeper referral requirements.
    • Provide same cost-sharing for in and out-of-network.
    • Make changes immediately without 30-day notification, e.g. reductions in cost sharing, waiver of prior-authorization.
MEDICARE AND COVID-19
MEDICARE ADVANTAGE

- Examples of possible MA Plan waivers:
  - Remove prior-authorization requirements
  - Waive cost-sharing for COVID-19 treatments in Dr. office or emergency room
  - Waive prescription refill limits; relax restrictions on home delivery
  - Expand access to telehealth
  - Loosen provider-enrollment requirements
  - Suspension of nursing home pre-admission reviews
  - Reimbursement to providers for care delivered in alternate settings

- Telephone Confirmation: Beneficiaries should contact their Medicare Advantage plan to confirm specific waivers – recommend getting full name of customer service individual and note date/time of the call.

- On-line Confirmation: Beneficiaries should copy or electronically save waiver information on-line that they rely on, in case it should change.

MEDICARE AND COVID-19
PRESCRIPTION REFILLS

- Medicare Contractor consideration criteria to pay for a greater than 30-day supply of drugs:
  - Nature of the drug (including Part B immunosuppressive drugs);
  - Patient’s diagnosis;
  - Extent and likely duration of disruptions to the drug supply chain during an emergency;
  - Other relevant factors to determine if extended supply is reasonable and necessary.

- Up to a 3 month supply (?) (If it remains in today’s law)

- CMS permits plans to relax restrictions on use of preferred retail or mail-order pharmacy, but does not require.
MEDICARE AND COVID-19
AMBULANCE TRANSPORTATION

Typically, Medicare covers ground ambulance transportation
• To hospital, critical access hospital, skilled nursing facility
• When transport in other vehicle could endanger health
• Also covers flight if immediate and rapid transport required that
ground transport cannot provide

In a public emergency, should a facility be unavailable
• Medicare may pay for transport to another facility so long as that
facility is nearest facility available and equipped to provide needed
care for illness or injury involved

Medicare may pay for limited, nonemergency transport if
physician writes an order stating medically necessary (cost
sharing apply)

MEDICARE AND COVID-19
DURABLE MEDICAL EQUIPMENT

• If durable medical equipment, prosthetics, orthotics or supplies are
lost, destroyed, irreparably damaged or otherwise unusable or
unavailable, contractors can waive the following requirements:
  • Face-to-face encounter
  • New physician’s order
  • New medical necessity documentation
• Suppliers must still include a narrative description on the claim
explaining the reason why equipment must be replaced
• Suppliers must maintain documentation indicating DMEPOS was lost,
destroyed, irreparably damaged or otherwise unusable or unavailable
as a result of the emergency.
MEDICARE AND COVID-19
APPEALS – PARTS A, B, C & D

- Extension to file an appeal
- Waive timeliness for request for additional information to adjudicate the appeal
- Processing the appeal even with incomplete Appointment of Representation forms but “communicating” to the other party (beneficiary to provider or provider to beneficiary)
- Process requests for appeal that do not meet the required elements using information that is available
- Using all flexibilities available in the appeals process as if good cause requirements are satisfied.

MEDICARE AND COVID-19
INFORMATION RE: PROVIDERS

- Locations: CMS to waive requirements that out-of-state providers be licensed in the state where they are providing services when they are licensed in a different state. This applies to Medicare and Medicaid.
- Enrollment:
  - CMS to establish toll-free hot-line for non-certified Part B suppliers, physicians and non-physician practitioners to enroll and receive temporary Medicare billing privileges.
  - Waive the following screening requirements:
    - Application fee (42 C.F.R. 424.514)
    - Criminal background checks associated with FCBC (42 C.F.R. 424.518)
    - Site visits (42 C.F.R. 424.517)
  - Postpone all revalidation actions.
  - Allow licensed providers to practice outside their state of enrollment.
  - Expedite pending or new applications from providers.
MEDICARE AND COVID-19
HOME HEALTH AGENCIES

- Regulations and guidance support home health agencies taking appropriate action to address potential and confirmed COVID cases.
- Agencies will mitigate transmission including screening, treatment, and transfer to a higher level of care, when appropriate. The Guidance applies to Medicare and Medicaid providers.
- When patients refuse home health visits (for COVID-19 related reasons and fear of possibly infected home health staff coming into their home) many agencies are replacing visits with telephonic teaching and training.
- Patients should not be discharged for refusing in-person care.
- Alternate care optional, e.g. Cardiocom units (shipped directly) left in the home taking patient vitals which are clinically assessed remotely.

MEDICARE AND COVID-19
GENERAL RESOURCES

MEDICARE AND COVID-19
GENERAL RESOURCES

- Testing is Covered: https://www.medicare.gov/coverage/coronavirus-test?emci=b1f91b3e-8168-5a11-a94c-00155d3b5dd&emd=bc9d7933-9768-aa11-a94c-00155d3b5dd&ceid=4142489

COVID-19

COVID-19 Related Updates to Medicare Skilled Nursing Facilities

Toby Edelman, Senior Policy Attorney
Center for Medicare Advocacy
FEDERAL GUIDANCE

• Changing constantly.
• Often, broad statements without details.
• One day’s CMS guidance superseded the next day.
• Focus today at CMS guidance on changes to Medicare coverage, discharges, admissions, visitors, survey and enforcement.

MEDICARE COVERAGE OF CARE IN SKILLED NURSING FACILITIES

  • Waives 3-day inpatient hospital stay requirement for Part A coverage.
  • Authorizes extension of SNF benefits for residents who have exhausted Part A benefits.
INFECTION CONTROL GUIDANCE FOR NURSING HOMES


NEW AS OF MAR. 13

- Communal dining and all group activities cancelled.
- Active screening of residents and staff, including staff who work at multiple facilities.
- Recommendations for social distancing.
DISCHARGE PRACTICES

- If resident suspected of having COVID-19, facility should contact local health department.
- Transfer to hospital is not required, even if facility does not have an airborne infection isolation room (AIIR), if facility can follow CDC infection prevention and control practices.
- Resident may need hospital for higher level of care.

DISCHARGE HOME

- If resident does not require hospitalization, can be discharged home, in consultation with state or local public authorities, “if deemed medically and socially appropriate.”
- Facility should put facemask on resident and isolate resident in room with door closed until discharged home.
ADMISSIONS PRACTICES

- Facility may admit from hospital a person diagnosed with COVID-19 as long as it follows CDC guidance for transmission-based precautions.
- If facility cannot follow these precautions, it should not admit a person with COVID-19.
  - Who decides?

ADMISSIONS PRACTICES
MORE

- Facility can follow its normal admissions practices.
- If possible, dedicate wing/unit for residents coming or returning from hospital – and have residents stay there for 14 days.
VISITORS

Now banning all visitors, except for certain compassionate care situations, such as end-of-life situations.

Visitors should perform hand hygiene and use personal protective equipment, such as facemasks, and restrict visit to resident’s room “or other location designated by the facility.”

MORE

- CMS restricts ombudsman except in compassionate care situations (and case-by-case review by facility).
- CMS advises visitors to monitor themselves for 14 days after leaving facility.
NURSING HOME GUIDANCE

- CMS recommendations that are still valid after March 13 revisions:
  - Offer alternative means of communication – phone, videoconference.
  - Create listserve to update families.
  - Assign staff member as primary contact to communicate with families.
  - Offer phone line with voice recording, updated at set times daily.

CONCERNS ABOUT VISITOR BANS

MORE CONCERNS ABOUT VISITOR BANS

- Bans of family, ombudsmen, surveyors (unless they have personal protective equipment, as discussed later).
- Who is overseeing care for residents?

SURVEY AND ENFORCEMENT

  - Supersedes prior guidance (Mar. 4, 2020).
  - Addresses surveys and enforcement for next 3 weeks (the prioritization period).
SURVEY

- Limited surveys to be conducted:
  - Complaints/facility-reported incidents (FRI) surveys triaged to immediate jeopardy (IJ) level.
    - These surveys will include a streamlined infection control review.
  - Targeted infection control surveys of providers identified by CDC and HHS (no more detail about criteria for facility identification).

PERSONAL PROTECTIVE EQUIPMENT

- BUT, surveyors will conduct on-site surveys only if they have personal protective equipment (PPE).
IF SURVEYOR IDENTIFIES ACTIVE COVID CASE DURING SURVEY

- Surveyor reports the case and facility to the state agency.
- State health department to coordinate with CDC and CMS Regional Office, which decide what to do (no further detail).

SURVEYS THAT ARE NOT AUTHORIZED FOR NEXT 3 WEEKS

- Standard surveys, including Life Safety Code and emergency preparedness.
- Complaint or FRI triaged to non-IJ level.
  - Surveyors enter complaints in ASPEN Complaints/Incidents Tracking system; more guidance will be provided in few weeks.
- Revisit surveys that are not associated with IJ deficiencies.
ENFORCEMENT

- CMS suspends remedies – denial of payment for new admissions (DPNA), per day civil money penalties (CMPs), and terminations – during 3-week prioritization period.

SELF-ASSESSMENT

- CMS encourages facilities to perform “voluntary self-assessment of their ability to prevent the transmission of COVID-19.”
- CMS “reminds” facilities of existing federal requirement to have “a system to identify possible communicable diseases or infection” to prevent their spreading.
CMA CONCERNS

  Expresses concerns that infection control is most frequently cited deficiency (2 of 3 facilities), 99+% cited as no harm, no enforcement; health and safety rules viewed as burden on facilities.

LIFE CARE CENTER AT KIRKLAND

MORE

- CMS announces
  - federal surveyors conducted on-site survey at facility, Mar. 16, 2020
    - CMS cited 3 IJ deficiencies (failure to rapidly identify and manage ill residents; to notify state of respiratory infections; to possess a sufficient back-up plan after facility doctor became ill).
  - new survey and enforcement rules discussed above.

MORE

- CMS announces 147 nursing homes in 27 states have at least 1 resident with COVID-19.
CHARLENE HARRINGTON

- “I think it is criminal not to disclose to families and the public which facilities have the virus. CMS should put a L&C nurse on site in those homes and monitor the staffing and care on a daily basis. I think these NHs need to stop all admissions and see which patients could be sent home or moved to another facilities. Families should be allowed to remove patients if they can and want to do that. Without proper gowns, masks etc, and infection control procedures and adequate staffing, there is no way to stop the spread of the virus throughout the facility. It seems like this is worse than Katrina.”

CENTER FOR MEDICARE ADVOCACY RESOURCES

- Website for COVID-19 (Coronavirus and Medicare), updated daily with materials from CMS and others

“COVID-19 and Medicare – Where We Stand Today 3/19/2020),”
MEDICARE PAYMENT SYSTEMS

Skilled Nursing Facility Payment System
Patient Driven Payment Model (PDPM) Effective 10-1-2019

PATIENT-DRIVEN PAYMENT MODEL

- Patient-Driven Payment Model (PDPM) bases payment on resident characteristics, rather than on services provided. 83 Fed. Reg. 39162, 39183-39265 (Aug. 8, 2018).
PDPM

- Enormous change in financial incentives for SNFs from prior system, RUGs.
- Initial primary concern was therapy, but admissions, assessment practices, and transfer/discharge practices are also changing, reflecting PDPM’s financial incentives.

HOW RUGS WORKED

- Two case-mix adjusted categories
  - Nursing (nurse staffing and non-therapy ancillary services [chiefly, drugs]).
  - Rehabilitation
    - The more minutes of therapy per day, the higher the daily reimbursement rate.
- Perceived overuse of therapy; definitely over-billing.
PDPM OVERCOMPENSATES FOR CONCERNS ABOUT RUG-IV

- PDPM pays less for residents who receive any therapy and more for residents who receive no therapy (according to CMS’s Impact Analysis, Resident-Level, 83 Fed. Reg., 39257-39259, Table 37).
  - However, under Medicare statute, beneficiaries qualify for Part A coverage of SNF stay if they need rehabilitation services 5 days/week (or skilled nursing services 7 days/week).

HOW PDPM WORKS

- Instead of RUGs’ two case-mix adjusted components, PDPM creates six federal base payment rates:
  - Five components are case-mix adjusted (physical therapy, occupational therapy, speech language pathology, nursing, non-therapy ancillaries [primarily drugs]).
  - One component is not case-mix adjusted.
MODE OF THERAPY

- PDPM allows up to 25% of therapy to be provided in group or concurrent settings (instead of as individual therapy, as 99% of therapy under RUG-IV was billed).
  - Group may have 6 residents, 84 Fed. Reg. 38728, 38745-38750 (Aug. 7, 2019).
- But exceeding 25% cap leads only to “a non-fatal warning edit” – no penalty.

CMS’S ASSESSMENT OF IMPACT OF PDPM

- Final rules describe financial impact of new reimbursement system and include two tables illustrating impact of PDPM’s changes on residents and on facilities. 83 Fed. Reg., 39257-39259, Table 37 (Impact Analysis on Residents), and 83 Fed. Reg., 39160-39161, Table 38 (Impact Analysis on Facilities).
CMS’S ANALYSIS OF IMPACT ON RESIDENTS

- CMS writes, “we project that for residents whose most common therapy level is RU (ultra-high therapy) – the highest therapy level, there would be a reduction in associated payments of 8.4% percent, while payments for residents currently classified as non-rehabilitation would increase by 50.5 percent.”


OCT. 1, 2019
(EFFECTIVE DATE OF PDPM)

- Impact of PDPM is immediate, with loss of thousands of therapy jobs nationwide and SNF demands that therapists use group and concurrent therapy instead of individual therapy.
  - Genesis Healthcare laid off 585 therapists (almost 6% of its rehabilitation employees).
- As much as we were anticipating significant changes, the speed was shocking and the behavior, brazen.
PDPM DID NOT CHANGE ELIGIBILITY AND COVERAGE RULES

- Eligibility: daily skilled care (generally, skilled nursing 7 days/week or skilled therapy 5 days/week, or a combination), 42 U.S.C. §1395f(a)(2)(B).
- Therapy should be provided as assessed and ordered in care plan.
- Baseline care plan, 42 C.F.R. §483.21(a), must be developed within 48 hours of admission.
  - Baseline care plan includes therapy, §483.21(a)(1)(ii)(D).
  - Baseline care plan may be especially important because length of stay is reduced under PDPM and comprehensive care plan is not required for 21 days after admission.

WHAT BENEFICIARIES AND THEIR ADVOCATES CAN DO ABOUT THERAPY

- Request care planning meeting and say
  - Medicare eligibility and coverage rules have not changed.
  - Therapy should be provided as assessed and ordered in care plan.
  - Individual therapy is default; SNF must justify group or concurrent therapy.
AT CARE PLANNING MEETING

  - “[W]e believe that individual therapy is usually the best mode of therapy provision as it permits the greatest degree of interaction between the resident and the therapist, and should therefore represent, at a minimum, the majority of therapy provided to the resident.”
  - “group and concurrent therapy should not be utilized to satisfy therapist or resident schedules.”
  - “all group and concurrent therapy should be well documented in a specific way to demonstrate why they are the most appropriate mode for the resident and reasonable and necessary for his or her individual condition.”

CMS made many similar additional points in preamble.

AT CARE PLANNING MEETING

- Use preamble to 2019 regulations, 84 Fed. Reg. 38728, 38726 Aug. 7, 2019), which says
  - “SNFs should include in the patient’s plan of care an explicit justification for the use of group rather than individual or concurrent therapy.”
  - Description in care plan should identify “the specific benefits to that particular patient of including the documented type and amount of group therapy.”

CMS made many similar additional points in preamble.
AT CARE PLANNING MEETING

- Use CMS’s FAQs for PDP, #12.1 (Aug. 2019)
  - “PDP does not change the care needs of SNF patients, which should be the primary driver of care decisions, including the type, duration, and intensity of skilled therapies, made on behalf of SNF patients.”

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM/ (click on the FAQ link).

TRANSFER/DISCHARGE

- If SNF proposes to discontinue therapy 5 days/week, threatening Medicare eligibility,
  - Use expedited appeals process.
  - Resident should not leave if there is another source of payment (e.g., private-pay, Medicaid); use Nursing Home Reform Law.
TRANSFER/DISCHARGE

- If resident does not receive therapy 5 days/week, resident may not qualify for a Medicare-covered Part A stay.
- Facilities may give transfer/discharge notices.
- BUT, residents are entitled to 2 notices.
  - Notice of Medicare noncoverage (NOMC).
  - Nursing Home Reform Law, transfer and discharge, 42 C.F.R. §483.15(c).


(still accurate information, except for citation to federal transfer/discharge rules, now 42 C.F.R. §483.15(c)).

Updating the Alert with a new one.
ADMISSIONS

- New admissions practices are likely.
- SNFs may “specialize” in new areas, such as ventilator care, dialysis.
  - Residents who had been hard to place (e.g., residents needing ventilators) are easier to place as some SNFs actively recruit them.
    - Special Focus Facility candidate recruiting ventilator patients.

FINANCIAL ADVANTAGES OF VENTILATOR CARE FOR SNFS

- Highest case mix group for nursing component (remember: nursing does not decline with length of stay).
- Greater chance of 100 days of Medicare coverage.
- (Just (at least) 15 minutes of time for therapist or nurse with resident/day).
- As much as $1200-$1800 extra reimbursement/week.

DRUG-RESISTANT INFECTIONS FOR RESIDENTS USING VENTILATORS

- Drug-resistant infections prevalent in residents using ventilators (because of low staffing levels, poor infection control practices).


DIALYSIS

- “Dialysis services have recently been highlighted as a major growth area” under PDPM, “both financially and clinically.”
  - Article highlights 2 SNFs
    - One facility is 1-star facility (much below average);
    - Other is 3 star (because 5-star quality measures boosts 2-star health surveys (below average) to 3 star rating).

RESIDENT ASSESSMENTS

- How will assessments change?
- Will depression be identified and treated?
  - Trade press suggests identification and treatment of depression can boost payment by $43/day and support longer lengths of stay.
- Will cognitive impairment be identified?
  - Trade press suggests $21/day and longer lengths of stay are justifiable.


NURSE STAFFING

- Medicare reimbursement should more fully fund nurse staffing because of PDPM’s stated focus on resident acuity.
- Staffing documentation will be critical to getting high rates.
  - BUT, will RN staffing increase? Will staffing increase on weekends, when many admissions occur?
  - Will new RNs be assigned solely/primarily to assessment?
NURSE STAFFING

- RUG nursing component covered both nursing and non-therapy ancillaries (drugs).
- In PDPM,
  - 57% of RUG nursing component is devoted to nursing;
  - 43% of RUG nursing component goes to drugs.
- So is sufficient reimbursement even recognized in PDPM for nursing?

OTHER IMPLICATIONS OF PDPM

- CMS anticipates shorter lengths of stay under PDPM.
  - RUGs: 20 days (large co-payment begins day 21).
- If Medicare no longer paying, residents then
  - Leave the SNF, or
  - Use Medicaid (if they are eligible for Medicaid), or
  - Pay out-of-pocket, becoming Medicaid-eligible sooner than if Medicare had continued paying.
HOW SNFS HAVE DONE FINANCIALLY WITH PDPM

- Laid off therapists across the country; did not hire additional nurses (first 6 weeks).
- SNFs made $52/resident/day more than under RUGs (even without artificial inflation because of new assessments done on Oct. 1, $26 more).


INDUSTRY ANALYSTS

- Some analysts predict that CMS will recalibrate rates to reduce such large increase in per day payments (in what CMS intended to be a budget-neutral change in reimbursement).
  - American Health Care Association CEO trying to tamp down that concern.
SUMMARY
CONCERNS ABOUT PDPM

- Enormous change in financial incentives.
- SNFs are changing practices to maximize profits.
- Lot of concerns about therapy, admissions, assessments, transfer/discharge, staffing, gaming.
- Need for careful monitoring and advocacy.

ADDITIONAL RESOURCES FROM CENTER FOR MEDICARE ADVOCACY

- Weekly Alerts (free emails),
  https://www.medicareadvocacy.org/join/.
- Self-help materials (free),
- Monthly newsletter on nursing home enforcement issues (subscription, $250/year),
  https://secure.everyaction.com/LduW4G7pT0in77zVpBo4UQ2
  Center for Medicare Advocacy, 
  https://www.medicareadvocacy.org/.
MEDICARE PAYMENT SYSTEMS

Home Health Care Payment System
Patient Driven Groupings Model (PDGM) Effective 1-1-2020
REVIEW - HOME HEALTH COVERAGE CRITERIA

Under the Care of a Physician
- Doctor’s certified Plan of Care AND
- Face-to-Face certification

Confined to Home ("Homebound")
- Inability to leave without device or assistance and/or leaving is contraindicated AND
- Requires a considerable and taxing effort to leave (Not bedbound)
- At Least One Required in Order To Qualify For Coverage
  - Intermittent Skilled Nursing
  - Physical Therapy
  - Speech Language Pathology

In need of reasonable and necessary skilled services

42 C.F.R. § 409.40 et seq

REVIEW - HOME HEALTH ADDITIONAL COVERED SERVICES

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

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

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HOME HEALTH COVERAGE RESOURCES

Resources for additional information about Medicare home health care coverage:

- Law: 42 U.S.C. § 1361(m)
- Regulations: 42 C.F.R. § 409.42-409.45
- Policy: Medicare Benefit Policy Manual, Chapter 7
- [https://www.medicareadvocacy.org/medicare-info/home-health-care/](https://www.medicareadvocacy.org/medicare-info/home-health-care/)
- [https://www.medicare.gov/coverage/home-health-services](https://www.medicare.gov/coverage/home-health-services)

NEW MEDICARE HOME HEALTH PAYMENT SYSTEM

- **Patient Driven Groupings Model (PDGM)**
  - Medicare payment to home health agencies changes from a 60-day *episode* to a 30-day *period* effective for 30-day periods beginning on or after 1/1/2020.
REFER TO NEW CMS MLN MATTERS, 2/10/2020

- CMS MLN Matters, No. SE200005, The Role of Therapy under the Home Health Patient-Driven Groupings Model (PDGM), 2/10/2020
- “…eligibility criteria and coverage for Medicare home health services remain unchanged. That is, as long as the individual meets the criteria…, the individual can receive Medicare home health services, including therapy.”

PAYMENT CHANGES FOR HOME THERAPY UNDER PDGM

- Before 1/1/2020, there were 9 “service use” thresholds based on # of therapy visits in an episode: 0-5 visits, 6, 7-9, 10, 11-13, 14-15, 16-17, 18-19, 20+.
- Each threshold increased allowable reimbursement.
- As of 1/1/2020, therapy thresholds were eliminated.
- 2019 survey by National Association of Home Care and Hospice (NAHC) (685 agencies responded)
  - Up to 1/3 of agencies planned to reduce therapy staff.
IMPACT OF PDGM VARIABLES ON CASE-MIX ADJUSTMENT

- **Early vs. Late Period**: Payment is approximately 32% higher for the first 30 days of care.
- **Functional Impairment**: Payment is approximately 16% higher for high versus low.
- **Admission Source**: Payment is approximately 13% higher for institutional versus community.
- **Co-morbidities**: Payment is approximately 10% higher for 2 or more versus none.
**HOW IS TYPICAL PDGM PAYMENT CALCULATED?**

- National, Standardized 30-day Period Payment Rate = $1,864.03 multiplied by the Case-Mix Adjustment for the Payment Group
- Multiply that result by the labor portion **76.1%** x the Wage Index Value of the city/region (e.g. Jacksonville = .8703)
- Add that result to non-labor portion **23.9%** (This is the total Case-Mix and Wage-Adjusted 30 day Period Payment for 3DC31)
- Equals payments between $1,000 to $3,000 for 30 days

**NON-PDGM PAYMENTS AND OTHER PAYMENT ISSUES**

- Low Utilization Payment Amounts (LUPA) – As of 2020, per 15 minute unit. Depending on the HIPPS code, 2 to 6 visits.
- Outlier Payments – For significantly high resource use patients (pays base PDGM plus 80% of cost). 2.5% cap.
- Request for Anticipated Payment (RAP) changing from 60% up front payment for first episode, to 20% up front for all periods (as of 1-1-2020), phasing out RAPs as of 2022.
- Rural “add-on” categories:
  - High Utilization: .5% (2020); none (2021); none (2022)
  - Low Population Density: 3% (2020); 2% (2021); 1% (2022)
  - All Other: 2% (2020); 1% (2021); none (2022)
BEHAVIORAL ADJUSTMENT TO HOME HEALTH PAYMENTS

- CMS proposed a -8.01% behavioral adjustment for 2020, but the finalized behavioral adjustment is -4.36%.
- CMS cited 3 underlying assumptions to determine the behavioral adjustment:
  - 1. HHAs will change documentation and coding practices and put the highest paying diagnosis code as the principle diagnosis code, placing a 30-day period of care in a higher-paying clinical group.
  - 2. By taking into account ICD-10-CM diagnosis codes listed on the HH claim, more 30-day periods of care will receive a co-morbidity adjustment than if CMS had used the OASIS diagnosis codes for payment.
  - 3. For one-third of LUPAs that are one to two visits away from the LUPA threshold, HHAs will provide one to two extra visits to receive the full 30-day payment.

BENEFICIARY ADVOCATE CONCERNS

- New payment system is impacting/further limiting access to care.
- PDGM provides incentives to serve people w/ shorter term needs.
- PDGM provides incentives to serve people w/ prior inpatient stays.
- Some home health agencies and Medicare contractors are providing misinformation about Medicare coverage.
- Some beneficiaries who qualify for Medicare coverage and need services can’t get them.
- Under PPS, nursing and aide services were unfairly reduced. Under PDGM, therapist services are unfairly reduced.
- Provider “behavioral adjustments” only address concerns re gaming system for higher payment, not for under-serving patient needs.
MEDICARE HOME HEALTH CARE

Advocacy Tools
and Practical Tips

REFER TO MEDICARE HOME HEALTH LAW & REGULATIONS

- Medicare Act: 42 USC §1395x(m)
- Federal Regulations: 42 CFR §409.40
- Visit: www.MedicareAdvocacy.org
REFER TO NEW CMS
MLN MATTERS, 2/10/2020

- CMS MLN Matters, No. SE200005, The Role of Therapy under the Home Health Patient-Driven Groupings Model (PDGM), 2/10/2020
- “…eligibility criteria and coverage for Medicare home health services remain unchanged. That is, as long as the individual meets the criteria…, the individual can receive Medicare home health services, including therapy.”

MEDICARE CONDITIONS OF PARTICIPATION
(Revised 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
REFER TO THE MEDICARE CONDITIONS OF PARTICIPATION

• 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.

REFER TO THE 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)
REFER TO THE MEDICARE BENEFIT POLICY MANUAL

- Relied Upon By Medicare-certified Home Health Agencies
- Medicare Benefit Policy Manual, Chapter 7
  - All significantly revised by Jimmo vs. Sebelius
  - 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)

VISIT CMS MEDICARE WEBSITES

- CMS.gov: Search for “Jimmo” for information about the Jimmo case and legal criteria reiterating improvement is not required. Skilled care to maintain or slow deterioration of individual’s condition is covered.
- Medicare.gov: 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
REFER TO THE CMS MEDICARE & HOME HEALTH CARE BOOKLET

- Official CMS Booklet - October 2017 version contains significant updates and clarifications
- 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

CONFIRM CLEAR DOCUMENTATION IN THE MEDICAL RECORD

- Be certain orders and goals clearly indicate 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 CLEAR DOCUMENTATION IN THE 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!

IF HOME HEALTH AGENCY SAYS MEDICARE WON’T COVER

- Continue to receive 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 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 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 an expedited (fast) 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 and other relevant providers.
- Note: No appeal rights unless all services are stopped.

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.
- 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 $170 (2020) for ALJ Hearing & Council Review.
- Thereafter, a claim can be appealed to Federal Court, if appeal is for at least $1,670 in 2020.
LAST RESORT: ACCEPT LESS THAN INDIVIDUAL QUALIFIES 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 individual can only access limited Medicare-covered home care.

Let us know! Stories help us remove unfair barriers to Medicare-covered home care.

RESOURCES FROM THE CENTER FOR MEDICARE ADVOCACY

Available at: MedicareAdvocacy.org

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

- Jimmo Settlement and materials
- Medicare Home Health Infographic/Factsheets
- Health Tool Kit
- Home Health Brochure
- Self-Help Packets
- Articles on Home Health Topics
Questions and Comments?

For further information, to receive the Center’s free weekly electronic newsletter, CMA Alert, update emails and webinar announcements, contact:

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Or visit

MedicareAdvocacy.org

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