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

- 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
Senior Medicare Patrol (SMP)

CMA Webinar:
Help Available for Lower Income Beneficiaries

Catherina Isidro
Executive Director
California Health Advocates

Tatiana Fassieux
Training and Education Specialist
California Health Advocates

February 23, 2023
The mission of the SMP program is to empower and assist Medicare beneficiaries, their families, and caregivers to prevent, detect, and report health care fraud, errors, and abuse through outreach, counseling, and education.

Located in all 50 states plus:
- District of Columbia
- Guam
- Puerto Rico
- U.S. Virgin Islands

To Find your state SMP:
- Toll Free: 877-808-2468
- Visit: www.smpresource.org
Providing quality Medicare and related healthcare coverage information, education and policy advocacy.

**Advocacy & Policy**
Improving rights and protections for Medicare beneficiaries and their families

**Education**
Website, fact sheets and educational workshops

**Senior Medicare Patrol**
Fraud prevention education

California Health Advocates
www.cahealthadvocates.org

SMP
Senior Medicare Patrol

Preventing Medicare Fraud
Three Roles of SMP

Provide
• Provide Medicare fraud prevention education via health fairs, presentations, etc.

Address
• Address complaints reported via our SMP State-wide fraud hotline 1-855-613-7080.

Refer
• Refer potential Medicare fraud cases to appropriate investigative entities.
<table>
<thead>
<tr>
<th>PREVENT</th>
<th>DETECT</th>
<th>REPORT</th>
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<tr>
<td>PREVENT: SMPs provide focused outreach and messaging designed to protect Medicare beneficiaries from Medicare fraud.</td>
<td>DETECT: As local trusted connections in the community the SMPs are often the first to hear of new issues as they begin to emerge.</td>
<td>REPORT: SMPs provide in-depth one-on-one assistance to Medicare beneficiaries and other complainants.</td>
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SMP Materials

Medicare Fraud Alert
Beware of Scams

Do not respond to offers for free medical equipment or services.

Check your medical statements routinely for services not provided.

Call us for a FREE fraud prevention presentation or for guidance if you suspect you may be the victim of fraud.

Share your Medicare number only with your trusted providers.

Report Medicare Fraud to California Senior Medicare Patrol
855-613-7080

Reminder! Return for a second dose! ¡Recuerdalo! ¡Regrese para la segunda dosis!

Contact Porsha Avila at:

pavila@cahealthadvocates.org
Join Us for Our Upcoming Webinars Partnered with Center for Medicare Advocacy!

Help Available for Lower Income Beneficiaries

19 Jan.

Medicare Home Health Coverage and Updates

23 Feb.

Medicare Skilled Nursing Facility Coverage & Updates

23 Mar.

Voices of Medicare - Pressing Beneficiary Issues

25 May
Sign up for our newsletter

First Name
First Name

Last Name
Last Name

Email address:
Your email address

Choose the news you’d like to receive

☐ Medicare Updates and More

☐ Fraud Alerts

☐ Upcoming Webinar Announcements

Sign up
Tri-fold mailer
Unemployment Benefits
Guide??
Bait & Switch!
Fine print:
Insurance solicitation!

Looks like an IRS form!

Misleading Marketing
Top Complaints:

1. Medicare Part C/D Communications & Marketing Violations
2. Billing Issues
3. Deceptive Hospice Enrollments
4. DME Brace Scams
5. Genetic Testing Scams
6. Medicare Card Phone Scam
What to Look Out For:

- **Keep track of medical appointments**
  - Use journal or calendar

- **Medicare Summary Notice (MSN)**
  - Sent to FFS Medicare beneficiaries

- **Explanation of Benefits (EOB)**
  - Sent to MA members and beneficiaries with a prescription drug plan

Check statements for accuracy. Look for:

- Charges for services not rendered
- Charges for services different than those rendered (upcoding)
- Services/items charged twice
- Charges for services not ordered by primary care physician
# Red Flags on an MSN

Help prevent Medicare fraud by checking these things

## November 28, 2019

**Leo Zygelman, CH, (555) 555-123**

200 West Center St, Manchester CT 06040-0000

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<th></th>
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<td>Chiropractic manipulative</td>
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</tr>
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### Questions

- Is this a provider you know?
- Did you receive services on this day?

## December 25, 2019

**Joshua Richards, M.D., (555) 555-1234**

848 Scioto St, Urbana, OH 43078-2255

<table>
<thead>
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### Questions

- If you live in CT, did you really receive services in OH?
- Do any services appear twice when they shouldn’t?
“Guard the Medicare Card”

Scammers do not discriminate between Original Medicare and Medicare Advantage enrolled beneficiaries. Their target is anyone with this Medicare card.
THANK YOU!

• Remember to report Medicare fraud to your local SMP

• SMP Resource Center and SMP Locator link:
  • https://www.smpresource.org/Default.aspx

• If in California, call our CA SMP Hotline at 855-613-7080
Medicare Home Health Updates

Sponsored by California Health Advocates
February 23, 2023

Presented by Center for Medicare Advocacy
Judy Stein, Executive Director/Attorney
Kathy Holt, Associate Director/Attorney
Medicare Home Health Updates

Agenda

I. Overview of Home Health Coverage
II. 2023 CMS Updates Affecting Beneficiaries
III. Public Health Emergency Ending Impact
IV. Review Common Home Health Misinformation
V. Advocate for Home Health Coverage
VI. CMA Home Health Aide Litigation
VII. Questions and Discussion
I. OVERVIEW OF MEDICARE
HOME HEALTH COVERAGE
General Medicare Home Health Coverage Criteria

- Under the Care of a Physician or Allowed Practitioner
  - Who establishes a Plan of Care
  - Reviews it at least every 60 days

- Confined to Home ("Homebound")

- In need of reasonable and necessary skilled services

42 C.F.R. § 409.40 et seq

Note: Medicare payment is conditioned upon specific Initial Certification and Recertification requirements (Example: “Face-to-Face encounter” with authorized provider),
Medicare-Covered Home Health Services

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

If Receiving A Skilled Service

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

"Dependent" Services Can Be Covered
Home Health Aides

- HH aide services are 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 (Con’t.)
As Defined in Regulation at 42 CFR §409.45(b)(1) – (4)

What is “Hands-on Personal Care”?

- Specifically defined to include:
  - 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
  - Assistance with ambulation, changing position in bed, help with transfers
  - Assistance with Rx that doesn’t require nurse
Underlying Coverage Principles

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 Home Health Benefit Policy Manual, Ch. 7, Sec. 40.1.1
Coverage Does Not Hinge On Improvement

- 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” 42 C.F.R. § 409.32

- Improvement **is not required** in order for a service to be considered skilled
Medicare Home Health Coverage Is Not Limited In Time/Visits

- Coverage is available… “without regard to whether… it is expected to extend over a long period of time.”
  - Medicare Benefit Policy Manual, Ch. 7, Sec. 40.1.1

- Coverage for skilled nursing is available so long as the beneficiary requires skilled care for services to be safe and effective
  - Medicare Benefit Policy Manual, Ch. 7, Sec. 40.1.1

- Payment can be made for an unlimited number of covered visits
  - 42 C.F.R. § 409.48(a)-(b); MBPM, Chapter 7, § 70.1
Congressional History Of Medicare Home Health (HH) Coverage

- Reviewed multiple times in Congress since Medicare enacted in 1965
- Originally limited to 100 visits of HH care, after 3-day inpatient hospital stay, with a deductible and co-insurance.
- 1972: Added coverage for certain people with disabilities, repealed Part B co-insurance for HH
- 1980: Removed 100-visit limit, prior hospital stay requirement, and the Part B deductible for HH
- 1997: Moved payment for HH after 100 visits to Part B if individual has Parts A & B, but did not reduce total # of coverable visits
- 2000: Clarified Homebound requirement still met if individual attends Adult Day Care or religious services
- 2015/18: Introduced new payment models, but did not scale back eligibility or scope of benefit
CMS Jimmo Reminder
(December 2, 2021)

“Skilled Nursing Care & Skilled Therapy Services to Maintain Function or Prevent or Slow Decline: Reminder

Medicare covers skilled nursing care and skilled therapy services under skilled nursing facility, home health, and outpatient therapy benefits when a beneficiary needs skilled care to maintain function or to prevent or slow decline, as long as:

- The beneficiary requires skilled care for the services to be provided safely and effectively
- An individualized assessment of the patient's condition demonstrates that the specialized judgment, knowledge, and skills of a qualified therapist are needed for a safe and effective maintenance program

Visit the Jimmo Settlement Agreement webpage for more information.”

Link: Skilled Nursing Care & Skilled Therapy Services to Maintain Function or Prevent or Slow Decline: Reminder
Summary of Key Coverage 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:
   • Maintain current capabilities
   • Prevent or slow further deterioration
5. Coverage can continue so long as qualifying criteria are met

   • Note: 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)
II.

2023 CMS UPDATES AFFECTING BENEFICIARIES
Home Health Updates
New CMMI Reporting Model

• Expansion of **Home Health Value Based Purchasing Model** (HHVBP)
• Effective 1/1/2023
  • All Medicare-certified programs established before 1-1-2022 are required to participate
  • Benchmarks, achievement thresholds, improvement thresholds formulas allow risk-adjustments for maintenance patients
Home Infusion Therapy Services

- Established by the 21st Century Cures Act (2016)
- 1-1-2021 implements permanent home infusion therapy services benefit and supplier enrollment requirements.
- Rule excludes home infusion therapy services from home health services. (No homebound requirement)
- Covers: professional services (including nursing) - furnished in accordance with a plan of care, patient training and education (not otherwise covered under the DME benefit), remote monitoring, monitoring services for the provision of home infusion therapy, and home infusion drugs furnished by a qualified home infusion therapy supplier.
III. IMPACT ON HOME HEALTH OF THE PUBLIC HEALTH EMERGENCY, ENDING MAY 11, 2023
Permanent Regulatory Updates

From the *Home Health Care Planning Improvement Act* (S. 296/H.R. 2150), included in the *Coronavirus Aid, Relief, and Economic Security Act* or the “*CARES Act*” (H.R. 748) Codified at 42 C.F.R. 409.43:

- The *CARES Act* permanently authorized PAs (physician assistants), NPs (nurse practitioners) and CNSs (clinical nurse specialists), in a manner consistent with state law (the top of their state licensure), to perform the following services for Medicare patients:
  - Order home healthcare services for Medicare patients,
  - Establish a plan of care, and
  - Certify and re-certify services.
Permanent Regulatory Updates

- **Occupational Therapists** are allowed to perform initial and comprehensive assessments, when there are other therapists in initial plan of care. (But not for an RN only case.)
  
  *42 C.F.R. 484.55(a)(2), (b)(3)*

- The *Consolidated Appropriations Act of 2021* clarified that OTs still **cannot** be the sole skilled service to start home health care and establish eligibility.
Permanent Regulatory Updates
Telehealth

• Care can be provided via telecommunications technologies (remote monitoring, telecommunications system, or audio-only) **if included in the plan of care.**
• Must be tied to patient-specific needs identified in comprehensive assessment.
• No requirement for how technology will help achieve goals (unlike PHE waiver)
• Medical records should explain how services are facilitating outcomes.
• Use of technology **can not substitute for an in-person home visit ordered in the plan of care.**
• Use of technology cannot be considered a “visit” for eligibility or payment.
• CMS states “efficiencies” may result due to less frequent in-person visits.
• Agencies may report telecommunications technology costs as allowable administrative costs on the HHA cost report.
Permanent Regulatory Updates

Homebound

▪ Will still consider COVID diagnosis (confirmed or suspected) to be a satisfying criteria for homebound status.

OR

▪ If an authorized practitioner certifies it is medically contraindicated for an individual to leave home due to potential COVID exposure and meets all other homebound criteria.

Required Face-to-Face Encounter by Telehealth

▪ Allowed if completed by two-way audio-video.

▪ Will revert to pre-PHE requirements (still allowed in some circumstances) as of the 1st day after 151st day following PHE end.
Home Health Updates
PHE Waivers Ending

Discharge Planning

- Home health agencies are required to share quality and resource use measures with patients prior to discharge to another health care setting.

- Settings include: other home health agencies, skilled nursing facilities, inpatient rehabilitation facilities, and long-term care hospitals.

- Waiver of discharge planning rules was intended to expedite discharges between health care settings.

- Waiver ends on May 11, 2023
Home Health Updates
PHE Waivers Ending

Home Health Aide Training

- Waived the requirement for each home health aide to certify 12 hours of in-service training every 12 months.

- Training certification must be completed by the end of the first full quarter after the PHE ends (September 30, 2023).
Home Health Updates
PHE Waivers Ending

Home Health Aide Assessments

- Waived the requirement for a registered nurse or other appropriate skilled professional (physical therapist/occupational therapist, speech language pathologist) to make an annual onsite supervisory visit (direct observation) for each aide that provides services on behalf of an agency.
  
  42 CFR §484.80(h)(1)(iii)

- All postponed onsite assessments must be completed by skilled professional no later than 60 days after May 11, 2023.
Home Health Updates
PHE Waivers Ending

Home Health Aide Supervision

- Waived the requirement for a nurse to conduct an on-site visit every 2 weeks for aide supervision. (Virtual supervision was encouraged.) **Waiver ending on May 11, 2023.**
  
  42 C.F.R. 484.80(h)(1)

- **2022 Final Rule (CMS 1747-F) permanently allows for one virtual visit every 60 days** to assess quality of care and services provided by home health aide to ensure services meet patient needs.
Home Health Updates
PHE Waivers Ending

- Waiver allowed home health agencies 10 business days to provide a patient’s clinical medical record to the patient at no cost, when requested by the patient, instead of 4 business days. **Waiver ending on May 11, 2023.**

- Waiver allowed a home health comprehensive assessment to be completed within 30 days (extended the regulatory 5-day completion requirement). **Waiver ending on May 11, 2023.**

- Waiver allowed home health agencies to submit assessment data any time prior to submitting a final claim (extended the regulatory 30-day submission requirement). **Waiver ending on May 11, 2023.**
Home Health Updates
Appeals and PHE Waivers

- **Appeal Filings:** Waiver allowed for extensions to file appeals with good cause to the MACs, QICs, (traditional Medicare, Part C MA plans, Part D plans) and IREs (Part C MA plans and Part D plans). These good cause flexibility extensions for appeals will continue.

- **Providing Additional Information:** Waiver allowed for extensions for additional information to support appeals in MA plans.
  - Up to 14 more days to process appeals (but not for Part B drugs)
  - When enrollee requests, when justified, AND when in enrollee’s best interest to get information from a noncontracted provider, OR
  - When an extension is justified, “given the circumstances”.
  - These extensions will continue.
Home Health Updates
Appeals
and PHE Waivers (continued)

▪ Incomplete Appointment of Representative form (AOR): Waiver allowed for flexibility in processing when elements of AOR were not complete. At PHE end, flexibility will continue for Medicare Parts A & B, but will NOT continue for Parts C and D plans.

▪ Required Elements Lacking: Waiver allowed for processing appeals that don’t contain all required elements, but instead used best available information. At PHE end, appeals processed must meet all regulatory requirements.
IV.

REVIEW COMMON HOME HEALTH MISINFORMATION
Examples of Misinformation About Medicare-Covered Home Health Services

Patients who can drive are not homebound.
Driving a car does not preclude homebound status. The frequency of absence and duration of absence from the home is the over-arching question to determine homebound status.

A patient’s condition must decline/change immediately prior to entering home health in order for the patient to be considered homebound.
No! “Normal inability” to leave the home is NOT based on the patient’s own individual ability, or inability, that is “normal” to the patient immediately prior to assessment (rather than what we generally consider to be “normal”, out in the world). “Normal” should not be evaluated based on an individual’s “prior level of function” before home health. Eligibility for services is not based on what is new or what has changed from that individual’s prior normal.
Examples of Misinformation About Medicare-Covered Home Health Services

Skilled services should be amenable to treatment and must be given only for a “reasonable amount of time”. “Amenable to treatment” is not necessary to receive home health services. Skilled service needs are equally covered for improvement, maintenance, and to prevent condition decline. Also, Medicare-covered home health is an unlimited services benefit for those who qualify so it is incorrect to say services “must be given only for a reasonable amount of time”.

Homebound criteria must be met through the last day of Medicare covered services, rather than as part of the full POC.

This is incorrect. Example: Patient is homebound in part because he uses a cane. 4 therapy visits are ordered in the plan of care, the final therapy visit will be to help him walk without the cane but because he isn’t using the cane, the agency states that he isn’t homebound. The 4th therapy visit is appropriate and should not be denied. Given the agency’s logic, the person’s plan of care would always be inappropriate for the last visit (not homebound).
Examples of Misinformation About Medicare-Covered Home Health Services

The patient must be seen by the allowed practitioner when there are changes to the plan of care.

*42 CFR 424.22 does not require a practitioner to see a patient in order to change a plan of care.*

Only a practitioner allowed to order services may sign the required face-to-face encounter document.

Certified nurse midwives (CNM) are permitted by *Section 1861(gg) of the Social Security Act* to perform a face-to-face encounter, if authorized by state law. CNM are not authorized to order home health services.

**Medicare Part A coverage is different than Medicare Part B.**

There is no difference in coverage for the beneficiary. The only difference is which pot of money Medicare pays a home health agency from.
Examples of Misinformation About Medicare-Covered Home Health Services

If fluctuating signs and symptoms are a “normal” part of a patient’s baseline then there is no reason to have a skilled service to “observe and assess” the patient because it isn’t new. This is contrary to CMS policy in the Medicare Benefit Policy Manual, Chapter 7, Section 40.1.2.1. The logic to this statement would lead to a conclusion that the sickest Medicare beneficiaries should never qualify for services because their “normal” is not “new”.

Discharge always begins at admission.
Some beneficiaries may qualify for Medicare-covered home health services for the remainder of their lives. Discharge planning requirements at admission may indicate discriminatory application of unlimited Medicare coverage.
Misinformation About Medicare-Covered Home Health Services

Sometimes, agencies give misinformation about Medicare-covered services as a justification to not serve patients.

Medicare-certified agencies are not required to serve patients, even if they meet Medicare coverage qualifications.

But agencies are not allowed to discriminate against an individual due to Medicare status.

42 CFR 489.53(a)(2)
V.

ADVOCATE FOR

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

- Medicare Act (Law): 42 USC §1361(m); §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
  - Relied Upon By Medicare-certified home health agencies
  - All significantly revised by Jimmo v. Sebelius, No. 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 measurable 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 for Proof of Coverage to Share with Providers

• **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](https://www.medicare.gov/homehealthcompare/search.html)

  • Contact agencies, including those that do **NOT** have 5 Star Ratings

• **CMS.gov**: Search for “Jimmo” for information about the Jimmo case and legal criteria reiterating improvement is **not** required. (See, *Important Message About Jimmo*)
Refer to CMS Official

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 either improvement OR maintenance language to clarify 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”.

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Last Resort: Accept Less Than Individual Qualifies For

• To the greatest extent possible, exhaust all advocacy resources previously discussed.

• Contact Medicare and Congressional offices.

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

Please join us!
VI.

CMA HOME HEALTH AIDE LITIGATION
CMA Home Health Aide Litigation

- Medicare-covered home health aide visits declined by 90% from 1998 to 2019 with no changes to Medicare-covered services.
- October 2022, *Johnson v. Becerra* case filed in federal district court for the District of Columbia as a class action against the Secretary of Health and Human Services for failing to properly administer the Medicare home health benefit.
- The plaintiffs are three individuals and two organizations.
- Medicare law authorizes coverage for up to 35 hours per week of home health aide services for personal, hands-on care, but plaintiffs have struggled to obtain anywhere close to that. They face serious health consequences as a result.
CMA Home Health Aide Litigation

- Plaintiffs challenge the Secretary’s policies and practices that violate Medicare law, as well as Section 504 of the Rehabilitation Act, which prohibits discrimination on the basis of disability. Section 504 imposes a duty on federal agencies to avoid unjustified institutionalization of people with disabilities.

- Plaintiffs seek changes to address these violations that will remove barriers to necessary, Medicare-covered home health aide care for individuals who qualify under law.

- Read the Complaint in Johnson v. Becerra, No. 1:22-cv-03024.
Resources From the Center For Medicare Advocacy

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
Additional Resources From the Center For Medicare Advocacy

www.MedicareAdvocacy.org

- Home Health - Center for Medicare Advocacy
- New Resource | Home Health FAQs - Center for Medicare Advocacy
- CMA Home Health Survey | Medicare Beneficiaries Likely Misinformed and Underserved (medicareadvocacy.org) (2021)
- Issue Brief | Medicare Home Health Coverage: Reality Conflicts with the Law (April 7, 2021)
- Issue Brief: Medicare Payment vs. Coverage for Home Health & Skilled Nursing Facility Care (March 3, 2020)
- Plans to Address and Resolve the Medicare Home Care Crisis (October 18, 2018)
- Statistical Trends and Published Articles with Studies and Research from 2002-2017 (August 23, 2018)
VII.

QUESTIONS AND DISCUSSION
State Health Insurance Assistance Program (SHIP)

- A **Trusted** community resource
- Provides one-on-one counseling and enrollment assistance including screening for Medicare Savings Programs (MSPs)
- Virtual outreach and educational events

State Health Insurance Assistance Program (SHIP)

[Home](#) | [State Health Insurance Assistance Programs (shiphelp.org)](#)
For further information, to receive the Center’s free weekly electronic newsletter, *CMA Alert*, update emails and webinar announcements, contact:

Communications@MedicareAdvocacy.org

Or visit

MedicareAdvocacy.org

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