

CENTER FOR MEDICARE ADVOCACY

MEDICARE POLICIES AND COST-SHIFTING TO MEDICAID

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www.MedicareAdvocacy.org

ABOUT THE CENTER FOR MEDICARE ADVOCACY

- Founded in 1986 in CT
- Based in CT, Washington, DC,
Attorneys in CA, MA, NJ
- Work includes direct representation, training,
writing in CT and nationally
 - CT dually eligible appeals & related Medicare
maximization (SNF & HH)
 - Policy (CT and National)
 - Federal litigation

MEDICARE BASICS

- Enacted in 1965
- 50% people \geq 65 years old did not have insurance
- Now, almost **all** do
- Increased access to health care *and* economic security

MEDICARE BASICS (Cont.)

Eligibility:

- Based on age or disability, not income
- 65 or over
- Social Security Disability for 24 months
- End-stage renal disease (ESRD), ALS

Note: Medicare is primary for dually eligibles

MEDICARE BASICS (Cont.)

- Part A - Hospital Insurance
 - Covers inpatient hospital, SNF, home health, hospice care
 - Most beneficiaries do not have to pay for Part A (10-year work history of self or spouse)
- Part B - Medical Insurance
 - Covers physician services, some outpatient services, some preventive services, ambulance services, durable medical equipment
 - Deductible: \$166/Year (2016)
 - “Standard” Monthly Premium: \$104.90 (2016)

MEDICARE BASICS (Cont.)

- Part C – “Medicare Advantage” Program
 - Alternate delivery systems for Medicare coverage
 - Private plans
 - Same coverage rules and at least same benefits as traditional Medicare
- Part D – Prescription Drug Benefit
 - Assistance with outpatient drugs, all through private insurance plans
 - Assistance with cost-sharing for low-income beneficiaries

OBSERVATION STATUS

- Beneficiary is in a hospital bed, receiving medical & nursing care, tests, treatments, drugs, food, supplies, etc.
- But is said to be in “observation status,” not inpatient
- Entire stay may be considered “outpatient”
 - Covered by Medicare Part B
 - Not inpatient, covered by Medicare Part A

OBSERVATION STATUS

- Time spent in observation status prior to (or instead of) an inpatient admission does not count toward the 3-day qualifying inpatient stay need to qualify for SNF care.
 - Medicare Benefit Policy Manual, CMS Pub. No. 100-02, Ch. 8, §20.1.
 - “Inpatient” means someone who has been formally admitted to a hospital – not based on needs or care of patient
 - *Landers v. Leavitt* (2008); *Bagnall v. Burwell* (Current)

OBSERVATION STATUS



“‘When I use a word,’ Humpty Dumpty said in rather a scornful tone, ‘it means just what I choose it to mean--neither more nor less.’”

— Lewis Carroll

OBSERVATION STATUS

- Must have a 3-day prior inpatient (Part A) hospital stay to qualify for Medicare skilled nursing facility (SNF) care, 42 U.S.C. §1395x(i)
 - Part B does not pay all hospital expenses that Part A pays
- **NOTE:** Some Medicare Advantage plans and Accountable Care Organizations (ACOs) waive three-day stay requirement for SNF care

OBSERVATION STATUS

- Consequences for beneficiaries considered observation can include:
 - No Part A coverage for hospital stay
 - No Part A coverage for prescription drugs
 - If no Part B, individual pay “sticker price” for hospital care
 - **No Part A coverage for SNF stay**
 - Some beneficiaries who cannot afford SNF care go home or to assisted living, forgo needed care
- If dually eligible, costs shift to Medicaid**

OBSERVATION STATUS

- “2-midnight policy”: Time-based decisions based on physician expectation.
 - ≥ 2 midnights: appropriate for inpatient admission
 - < 2 midnights: appropriate for outpatient observation
 - Auditors won’t focus on claims meeting these criteria
 - **Doesn’t change 3-day (midnight) requirement for SNF coverage**
 - Effective 10/1/13 but post-payment enforcement delayed
 - Dr. can consider all time in making forecast, but inpatient status only starts with admission order **(2+1 \neq 3)**

CT / OTHER STATE NOTICE LAWS

- CT (MD, NY) now require hospitals to provide notice to patients placed on observation.
- CT:
 - Not later than 24 hours after s/he is designated “observation status”
 - Notice must inform patients they have not been admitted as inpatients and possible implications for Medicare and other insurances, costs and care, and;
 - Recommend patients contact their insurance company or CT Office of Healthcare Advocate for help.

FEDERAL NOTICE LAW

- “Notification of Observation Treatment and Implication for Care Eligibility Act” (NOTICE Act) signed August 2015
 - **Effective August 1, 2016**
 - Oral and written notification of observation status within 36 hours
 - Must include reasons and implications of status for hospital costs and subsequent SNF care
 - Says reason will be that the physician decided
- **Does not give right to appeal**

CONGRESSIONAL ACTION?

Improving Access to Medicare Coverage Act of 2015
(H.R. 1571/S. 843)

- **Count all time in hospital towards 3-day stay requirement for SNF coverage**
 - House - Rep. Courtney (D-CT) Lead
 - Senate - Sen. Brown (D-OH) Lead
 - Much Bipartisan Support
- **Eliminate 3-day requirement entirely?**
 - Rep. McDermott bill (D. WA)
 - As do many MA plans/ACOs

OBSERVATION STATUS

Impact for CT Medicaid

- 2015/16: Approximately 50% of the SNF cases closed in the Center's TPL Project due to no prior inpatient hospital stay had a hospital stay, considered "outpatient" Observation
- Stays = Average 4 days
- Majority were 3 days
- Thus far CY2016 the average = 5 days

These costs shift to CT Medicaid with no opportunity to obtain Medicare coverage

JIMMO v. SEBELIUS, NO. 5:11-CV-17
(D. VT., Settlement Approved Jan. 24, 2013)

- Federal class action to eliminate improvement standard in skilled nursing facilities (SNFs), home health (HH), outpatient therapy (OPT).
- Filed Jan. 18, 2011 by CMA and Vermont Legal Aid
- Settled October 2012 (Court approved 1/2013)
- Plaintiffs: 5 individuals and 6 organizations
 1. National MS Society
 2. Alzheimer's Association
 3. National Committee to Preserve Social Security & Medicare
 4. Paralyzed Veterans of America
 5. Parkinson's Action Network
 6. United Cerebral Palsy

WHY LITIGATION?

- “Restoration potential is not the deciding factor in determining whether skilled care is required. Even if full recovery or medical improvement is not possible, a patient may need skilled services to prevent further deterioration or preserve current capabilities.” 42 C.F.R. § 409.32(c)
 - Specifically applied to SNF, HH

WHAT *JIMMO* MEANS

- Service is “so inherently complex that it can be safely and effectively performed only by, or under the supervision of, professional or technical personnel.” 42 C.F.R. § 409.32(a)
- A condition that does not ordinarily require skilled services, may require skill because of special medical conditions. 42 C.F.R. § 409.32(b)
- Must be documented.

WHAT *JIMMO* MEANS

- CMS revised Medicare policy manuals, guidelines, instructions to “clarify”:
 - Coverage does not turn on the presence or absence of potential for improvement but rather on the need for skilled care.
 - Services can be skilled and covered when:
 - Needed to maintain, prevent, or slow decline or deterioration; or
 - Skilled professional is needed to ensure services are safe and effective.

WHAT *JIMMO* MEANS

- Jimmo/ CMS revised Medicare policies apply to:
 - **HH, SNF, and Outpatient Therapy** – PT, ST/SLP or OT, collectively = Outpatient Therapy (OPT)
 - Skilled maintenance therapies and nursing are covered by Medicare
 - **Inpatient Rehabilitation Hospital (Facility) (IRF)**
 - Claim should never be denied because patient:
 - Cannot achieve complete independence in self-care
 - Cannot be expected to return to prior level of functioning

NURSING TO MAINTAIN FUNCTION OR SLOW DETERIORATION

- Maintenance nursing services are Medicare-coverable when skilled nursing is necessary to maintain current condition or prevent or slow deterioration so long as the skills of a nurse are required to ensure the services are safe and effective
 - MBPM Ch. 7, 40.1.1
- Decision regarding coverage should turn on whether skilled nursing is needed, not whether individual is expected to improve.
 - MBPM Ch. 7, 20.1.2 (Home Health)

THERAPY TO MAINTAIN FUNCTION OR SLOW DETERIORATION

Maintenance Therapy –

Where services that are required to maintain current function or to prevent or slow further deterioration are of such complexity and sophistication that the skills of a qualified therapist are required to perform the procedures safely and effectively, the services would be covered physical therapy services.”

Medicare Benefit Policy Manual, Chapter 7, §40.2.2.E
(Home Health Care)

INDIVIDUALIZED ASSESSMENT

- Medicare should not use “rules of thumb”
- Rather, “Determination of whether skilled nursing care is reasonable and necessary must be based solely upon the beneficiary's unique condition and individual needs, without regard to whether the illness or injury is acute, chronic, terminal, or expected to last a long time.”
 - Home Health Fed. Regs. 42 CFR §409.44(b)(3)(iii)

RULES OF THUMB

Certain phrases may indicate Rules of Thumb have been used to deny coverage.

Examples:

- Individual has “plateaued”
- Individual has “reached baseline”
- Individual is “chronic and stable”
- Individual needs “maintenance therapy only”
- New Phrases developing since *Jimmo*?
 - Or just: “Not reasonable and necessary”

JIMMO SUMMARY

- Coverage turns on whether skilled care is required (This is key to *Jimmo*)
- Restoration potential is not the deciding factor
- Medicare should not be denied because the beneficiary has a chronic condition or needs services to maintain his/her condition
- An “Individualized Assessment” of each claim is required
- Rules of thumb should not be used

JIMMO SUMMARY

Questions to Ask:

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

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

UPDATE

- Center has been pressing CMS for further education since 2014
- We created a *Jimmo Implementation Council* to help monitor
- *Jimmo Council* survey: 46% did not know about CMS Ed. Campaign
- CMS' Settlement case sample: 40% wrongly decided

UPDATE

- Notice of Dispute Resolution submitted to government attorneys per Settlement
 - Could not agree on resolution
- 3/1/2016: Back to Court to seek better CMS implementation of Settlement (*Motion to Compel*)
 - Seeking Education and direction from CMS
 - Further correction of Medicare Policy Manual
- 5/26/2016: Oral Argument held
 - Decision expected Summer 2016

JIMMO

Impact on Medicaid

- Should be particularly helpful to dually eligible individuals who have disproportionately more long-term and chronic conditions
 - Should open access to more Medicare and more care to maintain/slow deterioration

If not fairly, accurately implemented, these costs remain with and/or shift to Medicaid

QUICK VIEW

- Outpatient Therapy Caps
- Appeals
- Medicare “Reform”

OUTPATIENT THERAPY \$ CAP

Part B

- OT and PT/ST combined
- **\$1,940 / Year**
 - Exception up to \$3,700
 - Then Further review
 - Difficult, time-consuming process, providers resist
- Can apply to therapy in SNFs
 - After Part A denied or not available

OUTPATIENT THERAPY \$ CAP

- Repeal of Cap sought in Congress
- What would replace it?
 - Prior Authorization?
 - Could create more problems
 - Prior Auth. Often means earlier denial

Impact on Medicaid

**Costs above \$1,940 / Year often shift to Medicaid
for dually eligible people**

MEDICARE APPEALS

- **Problem #1: “Rubber-stamp” denials at lower levels of appeal**
 - Redetermination, Reconsideration –
 - Not meaningful review
 - Only about 2% of denials are reversed
 - Have to appeal to ALJ for due process (60+%)
 - Center for Medicare Advocacy represents:
 - DSS in thousands of SNF and HH appeals (TPL Project)
 - Beneficiaries challenging lack of meaningful appeals in court

MEDICARE APPEALS

- **Problem #2: Backlog at ALJ level**
 - Largely due to “RAC” appeals by hospitals (mostly of observation cases)
 - ≥ 600 day average processing time / FY 2015
 - Law requires 90 days
 - *Lessler v. Burwell*, (D. Conn.) Settlement pending.
 - Beneficiary-initiated appeals will be prioritized – closer to 90 days. Very small part of caseload.
 - Does not apply to cases brought by Medicaid Commissioners

MEDICARE APPEALS

- “Reform” possible:
 - Senate Finance Committee, GAO Report, AFIRM Act
 - Will not change lower level appeal denials,
 - Will likely create Sub-AIJs for cases with \leq \$1,500
 - Will not improve delays of DSS Commissioner appeals

Impact on CT Medicaid:

Erroneous Medicare denials are very difficult to reverse. Costs remain with T19 unless fair decision-making can be obtained. Usually now at 3rd, ALJ level-of-review. Important to “push back”.

WHAT'S IN STORE?

— On The One Hand —

- **“Premium Support” / Vouchers**
 - No more guarantee of health coverage
 - Flat payment/voucher to buy insurance plan – amount not likely to change to match cost of health care
 - Increases costs to beneficiaries
- **Increase age of eligibility (to 67?)**
 - Saves federal government \$
 - Increases costs for:
 - 65-66 year olds; employers; younger people; states/Medicaid
- Often “grandfathers” current/impending beneficiaries

— On The Other Hand —

- **Enhance Traditional Medicare**
 - Coverage/Benefits
 - OOP Limit
 - Medigap access
 - Parity with Medicare Advantage
- **Decrease Age of eligibility**
 - Buy-In at 50/55?
 - Eligible at 50/55?
 - Adds income to Medicare
 - Decreases costs employers/ACA?
- Medicare as Public Option/ ACA
- Medicare for All

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