MEDICARE PAYMENT VS. COVERAGE

FOR HOME HEALTH & SKILLED NURSING FACILITY CARE

I. Introduction

The Centers for Medicare & Medicaid Services (CMS)—the federal agency responsible for administering the Medicare program—has begun implementing new Medicare payment models for both home health and skilled nursing facility care. These payment models create a different set of financial incentives for Medicare providers. Although the payment models pose a substantial risk to beneficiaries, especially those with chronic conditions and longer-term needs, CMS has made clear that PDGM and PDPM do not change Medicare coverage criteria. Thus, Medicare beneficiaries who meet the coverage criteria for home health and skilled nursing facility care must continue to receive medically reasonable and necessary services tailored to their individual needs.

II. Home Health Care

Payment. On January 1, 2020, CMS began implementing the Patient-Driven Groupings Model (PDGM) for Medicare-covered home health care. Under PDGM, home health agencies will receive higher reimbursement for admitting beneficiaries after an inpatient institutional stay, such as in a hospital or skilled nursing facility. As a result, home health agencies will have less of a financial incentive to admit beneficiaries from the community. (The "community" category includes hospital outpatients and hospital patients in Observation Status, as well as those who start care from their home, without a prior hospital or SNF stay.) Further, payment is expected to be higher for the first 30 days of home health services, then drop by over 30% thereafter, which will create access obstacles for beneficiaries who have longer-term and chronic conditions.

PDGM also removes the therapy service utilization payment thresholds, thereby lowering the financial incentives for agencies to provide therapy to beneficiaries. In fact, PDGM has already started harming beneficiaries. According to Home Health Care News, "[s]tories of widespread layoffs of PTs, OTs and SLPs persist — and now new reports of agencies incorrectly telling their patients that Medicare no longer covers therapy under the home health benefit . . . ."

Coverage. On February 10, 2020, CMS released a special edition *Medicare Learning Network (MLN) Matters* article to address continued care and therapy under PDGM. The MLN article makes clear that, while the reimbursement system has changed, "eligibility criteria and coverage for Medicare home health services remain unchanged." CMS adds that, "as long as the individual meets the criteria for home health services as described in the regulations at 42 CFR 409.42, the individual can receive Medicare home health services, including therapy services." In light of the *Jimmo v. Sebelius* Settlement Agreement, the MLN article also states "there is no improvement standard under the Medicare home health benefit and therapy services can be provided for restorative or maintenance purposes."

Therefore, according to CMS, the following remain true under PDGM:

- Medicare eligibility and coverage rules have not changed;
- Home health services can continue as long as individuals meet the Medicare coverage criteria; and
- Beneficiaries can receive home health services to improve their condition, to maintain their current condition, or to slow or prevent further decline.

III. Skilled Nursing Facility Care

Payment. On October 1, 2019, CMS began implementing the Patient Driven Payment Model (PDPM) for Medicare-covered skilled nursing facility care. Most notably, under PDPM, skilled nursing facilities have a greater financial incentive to provide little to no therapy to beneficiaries. Furthermore, PDPM allows skilled nursing facilities to provide 25 percent of a resident's total therapy regimen, by discipline, in group and concurrent therapy settings; there is no penalty for exceeding this limit. As a result, PDPM not only incentivizes skilled nursing facilities to provide less therapy overall but also less individualized therapy in particular. Within days of PDPM's implementation, stories began to verify concerns about the payment model. For example, Modern Healthcare reported "[s]killed-nursing chains have terminated or 'transitioned' many of their therapists. Those who remain have been asked to boost their productivity and quickly cycle through patients as well as increase their use of group and concurrent therapy rather than one-on-one sessions."

Coverage. While CMS has not released a comparable MLN article on PDPM (as of the date of publication), the agency has made clear that Medicare coverage criteria has not changed. In FAQs, CMS notes that "[w]hile PDPM does change the manner in which patients are classified into payment groups under the SNF PPS, it does not change any of the coverage criteria . . . ." CMS adds that "PDPM 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." Therefore, according to CMS, patient care needs must still be based on clinical standards and judgment related to individual care needs.

IV. Conclusion

Medicare providers, contractors, and adjudicators must not be confused about the impact of PDGM and PDPM. CMS makes clear that the new payment models have no effect on Medicare coverage of home health and skilled nursing facility services. Medicare beneficiaries who meet the setting-specific coverage criteria continue to be entitled to care based on their individual needs.

Additional Information

For more information about PDGM and PDPM, please read "Potential Impacts of New Medicare Payment Models On Skilled Nursing Facility and Home Health Care."