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Anthony H. Szczygiel

University at Buffalo School of Law

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Clinic Helps Elderly Get Home Health Care

By Anthony H. Szczygiel

The current system of health care coverage, while a practical headache, offers a rich educational experience for our law students. Our Legal Services for the Elderly Clinic, part of the Law School's Legal Assistance Program, primarily focuses on the problems of access to and payment for medical care. This year, the clinic worked extensively with one legal issue in particular: Medicare's newly expanded coverage of home health care services.

The clinic is based in the offices of Legal Services for the Elderly, Disabled and Disadvantaged, located at 200 Delaware Ave. Students must first familiarize themselves with the variety of medical coverage programs available — Medicare, VA, private insurance, CHAMPUS, CHAMPVA, Medicaid, Hill-Burton, EISEP and EPIC, to name a few — and the various ways these programs interrelate or conflict. The law students then are assigned "live client" cases which are chosen from the caseload of the Legal Services for the Elderly, Disabled and Disadvantaged office. The cases can involve a full range of practice skills, including client counseling, factual development, negotiation and administrative hearings.

Long-term care is a major problem for our elderly and disabled clients, both in terms of finding appropriate modes of care and paying for the care. Recently there has been a dramatic improvement in Medicare coverage for one aspect of long-term care. Home health care benefits were included in the 1965 legislation creating Medicare, the federal medical insurance program for the





Photo courtesy of SPS Home Health Care.

elderly and disabled. 42 U.S.C. 1395. Under Medicare Part A, an individual confined to the home, in need of intermittent skilled nursing services or the services of a therapist (physical, speech or, for continuing care cases, occupational), qualifies for the home health benefit. The amount of care covered includes these qualifying services plus the services of a home health aide. 42 U.S.C. 1395x (m) (1) and (4).

For many elderly or disabled individuals, this combination of therapy and/or nursing services and aide services provided in the familiar surroundings of their own home can prevent or significantly postpone institutionalization. Studies have shown that appropriate home care results in better health achieved at a lower cost than institutional care.

The use of home health services steadily increased in the early 1980s, reflecting an aging population, a greater number of chronic medical problems and a renewed interest in non-institutional care for budgetary and health reasons. However, some people viewed this increased usage merely as an undesirable rise in the costs of a federal social program. In 1984, and again in 1986, Medicare coverage of home health services was substantially reduced via informal "transmittals" issued by Medicare officials. These transmittals changed a number of Medicare policies and substantially restricted coverage.

Here's how it works: A home health agency which meets the certification requirements of Medicare (known as a CHHA, certified home health agency) makes the initial determination of

Medicare coverage and implements the physician-ordered plan of care prior to submitting that claim to Medicare for review. A claim that is disallowed can result in a complete loss of payment for the services already provided. And even though CHHAs were becoming increasingly conservative in their initial authorizations, the national disallowance rate approached 10 percent in 1986. Most home health agencies operate on a low-profit margin and are badly hurt by such revenue cuts.

The Medicare appeals process allows a beneficiary to contest a denial, and the system worked for those who had the knowledge, energy and persistence to utilize it. An astounding 80 to 90 percent of home care denials were reversed at the Administrative Law Judge level, the first level at which an "impartial" decision-maker had a chance to review. The Health Care Financing Agency, however, maintained a policy of non-acquiescence whereby anything less than a U.S. Supreme Court decision was seen as binding only for that case, with no precedential value for other similar cases.

Thus, these initial victories helped only the individual involved and some successful appellants found that such a victory was short-lived, as they promptly received a new denial notice after winning their first appeal.

Few home care providers could continue to provide services on the hope of payment a year or more later if a successful appeal were taken. For most sick elderly or disabled Medicare beneficiaries, the initial denial forced them to decide between forgoing needed.

physician-ordered care or becoming institutionalized.

The informal policy changes that restricted Medicare coverage of home care were challenged in federal court. *Duggan v. Bowen*, 691 F. Supp. 1487 (D.D.C. 1988). Out of a number of claims presented in their complaint, plaintiffs first focused the court's attention on one key issue. The claim was that defendants had rewritten the statutory coverage standard by replacing "part time or intermittent" with an effective requirement that care be "part time and intermittent." The judge was forced to hold a full factual hearing, since defendants denied that they had changed their policy. The judge found that there had been a substantive policy change, and held it to be arbitrary and capricious since it "produces absurd results" and "is without basis in reality."

A nationwide class was certified, over defendants' objections. "Indeed, it is only through the vehicle of a class action that meaningful relief can be obtained by those needy and elderly citizens who can hardly any longer stand up to the defendants' insensitive and improper tactics." *Duggan*, 691 F. Supp. 1502.

After this decision was released, the attorneys for both sides entered into negotiations to resolve all the issues in the case. New guidelines were announced in April 1989 in the form of a rewritten Health Insurance Manual for fiscal intermediaries and home health care providers (HIM-11).

Medicare's policy of covering home health care was changed dramatically. Under the restrictive guidelines, clients could rarely receive more than nine hours a week of combined nursing and home health aide services, and then only for a limited number of weeks. If they needed more than that, Medicare denied all coverage.

Medicare coverage now extends to all needed therapy, and/or the combination of skilled nursing services and home health aides up to 35 hours a week or more in exceptional circumstances. If

more hours of skilled care or aide care are necessary each week, Medicare can cover all of the services for up to three weeks, then other payors are expected to assume the excess over the Medicare coverage. Services up to 35 hours a week can continue to be covered indefinitely.

Under the HIM-11 standards, the reversal rate by Medicare has dropped to .5 percent for substantive denials, and 1 percent for technical denials which often can be readily corrected by submitting proper forms, signed by proper persons.

This dramatic improvement could be seen as an almost unqualified success, except for two factors. First, the case and the new guidelines couldn't help most of the individuals who suffered unnecessary denials or limitations in the five years from 1984 to 1989. As already noted, most denied individuals had to choose between forgoing the care and becoming institutionalized. Either choice severely limited their capacity to benefit from home care years later.

Second, the new guidelines are not self-effectuating. Much wrong information is still being given out, even by those who should know better. This discourages individuals from applying, leaving them with the pre-*Duggan* benefit reductions.

The home care providers were literally traumatized by the five years of restricted coverage that the *Duggan* attorneys described as "a standardless system of ad hoc decision making which leads to irrational, contradictory and unexplained home health care coverage determinations." Even after HIM-11 came out, the providers continued to inform applicants for home care that they could get only nine hours a week for a limited number of weeks under Medicare.

The Law School's Legal Services for the Elderly Clinic has taken on the task of helping to realize the promise of the new HIM-11.

In individual cases, law students have worked with the clients, their physicians and the selected home health agency to see that cases involving 28 to 35 hours of combined nursing and home health aide

services are accepted and serviced by the provider. As each case at that level of care is approved, the next one is somewhat easier to arrange.

We have sought to educate the important players in the home care process — the home health agency personnel, social workers, discharge planners, case managers, nurses, attorneys and other advocates or representatives of potential beneficiaries. In conjunction with Neighborhood Legal Services and Legal Services for the Elderly, the Legal Services for the Elderly Clinic has organized and presented two major conferences on the new Medicare home care benefit. The first, a full-day session, attracted a standing-room-only crowd of 150 attendees. The keynote speaker was William Dombi, the lead attorney in *Duggan*.

A half-day version of that conference was presented in June to 200 social workers, discharge planners, case managers, nurses, attorneys and family members.

We are seeing a slow and cautious transition to the post-*Duggan* world. The client benefits are substantial. Up to the Medicare coverage limit, the care is fully paid for. There are no deductibles or co-payments for the individual. The program is available to many persons who are not eligible for the other major payor of home care services — Medicaid. Medicare coverage avoids the necessity of reducing one's assets to meet the stringent financial guidelines of Medicaid.

For clinic students, the case combines an example of excellent legal work in *Duggan* with some feel for the power, and limitations, of litigation.

Anthony H. Szczygiel joined the faculty in 1982 as a clinical instructor. In 1987 he was appointed an assistant professor of law. Szczygiel has developed several clinical offerings, including his current clinic, Legal Services for the Elderly. His teaching interests are in the areas of health law and administrative law.