Medicare Home Health Care: Coverage Criteria And Tips To Access Services

June 25, 2019

For the NY STATEWIDE SENIOR ACTION COUNCIL

Presented by: Kathleen Holt, Associate Director/Attorney
The Center for Medicare Advocacy

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

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

TODAY'S PROGRAM: MEDICARE HOME HEALTH COVERAGE

- Medicare Home Health Coverage Criteria and Services and a Case Study
- *Jimmo* Settlement Impact on Home Health Care
- Current Obstacles to Getting Care
- Advocacy Tools and Practical Tips

Copyright © Center for Medicare Advocacy

HOW IS HOME HEALTH COVERED IN MEDICARE A&B?

42 C.F.R. § 409.48 Home Health Visits. **(note: "CFR" is Code of Federal Regulations)**

- (a) **Number of allowable visits under Part A**. To the extent that all coverage requirements specified in this subpart are met, payment may be made on behalf of eligible beneficiaries under Part A for an **unlimited number** of covered home health visits. All Medicare home health services are covered under hospital insurance unless there is no Part A entitlement.
- (b) **Number of visits under Part B**. To the extent that all coverage requirements specified in this subpart are met, payment may be made on behalf of eligible beneficiaries under Part B for an **unlimited number** of covered home health visits. Medicare home health services are covered under Part B only when the beneficiary is not entitled to coverage under Part A.

Copyright © Center for Medicare Advocacy

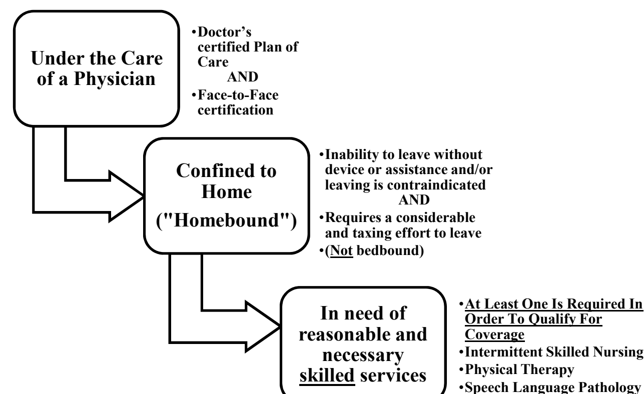
HOW IS HOME HEALTH COVERED IN MEDICARE C?

In Medicare Advantage Plans (Medicare Part C):

- MA Plans are required to cover the same benefits as Medicare Parts A & B
- MA Plans may impose different cost sharing requirements
- **42 C.F.R. § 422.112 Access to services.**
  (a) Rules for coordinated care plans. An MA organization that offers an MA coordinated care plan may specify the networks of providers from whom enrollees may obtain services if the MA organization ensures that all covered services, including supplemental services contracted for by (or on behalf of) the Medicare enrollee, are available and accessible under the plan.

Copyright © Center for Medicare Advocacy

HOME HEALTH COVERAGE CRITERIA



Reference - Federal Regulation: 42 C.F.R. § 409.40 et seq

Copyright © Center for Medicare Advocacy

UNDER THE CARE OF A PHYSICIAN

Certifying physician must:

- Establish a written Plan of Care
  - Order specific medical and therapy treatments, including type of services, and frequency
  - Review at least every 60 days
- Conduct, or sign off on, a "Face-to-Face" meeting

Reference: 42 C.F.R. § 409.40 et seq; 42 C.F.R. § 424.22

Copyright © Center for Medicare Advocacy

CONFINED TO HOME ("HOMEBOUND")

Intent: To provide care at home for people who lack an ordinary ability to leave home

- Because of illness or injury, individual must require assistance of another person or supportive device to leave home; OR
- Have a condition such that leaving home is medically contraindicated; and
- There is a normal inability to leave home; and
- It requires a "considerable and taxing effort" to leave home.

Reference: Medicare Benefit Policy Manual (MBPM), Ch. 7, Sec. 30.1.1

Copyright © Center for Medicare Advocacy

HOMEBOUND (continued)

- May leave home for:
  - Health care
    - Medical appointments, therapy not available at home, adult day care for the purpose of therapeutic, psychosocial, or medical treatment
  - Infrequent absences or absences of short duration
    - Religious services deemed OK
    - Occasional trip to barber, walk around the block, family reunion, funeral, graduation, etc.

Reference: Medicare Benefit Policy Manual, Ch. 7, Sec. 30.1.1

Copyright © Center for Medicare Advocacy

HOMEBOUND (continued)
QUESTIONS TO ASK ABOUT ABSENCES

- Is a walker, wheelchair or other assistive device needed?
- Special transportation arrangements? Equipment needs?
- Can't transfer self? Can't dress self? Look for issues like poor grip, upper body paralysis, incontinence, poor vision, mental status, requires escort/another person's assist.
- Is there evidence of a "taxing effort"
- "Patient drives" – Does not automatically mean not homebound

Look at individual's overall condition & experience, rather than isolated period(s).

Reference: Medicare Benefit Policy Manual, Ch. 7, Sec. 30.1.1

Copyright © Center for Medicare Advocacy

WHAT SERVICES QUALIFY AN INDIVIDUAL FOR COVERAGE?

- To begin coverage, the beneficiary must require a **skilled** service:
  - Intermittent skilled nursing services; or
  - Skilled physical therapy (PT) or speech language pathology (SLP) services
- To continue coverage, also:
  - occupational therapy (OT) - not to begin coverage

Reference: 42 C.F.R. § 409.40 et seq

Copyright © Center for Medicare Advocacy

SKILLED SERVICES

- "Skilled" means a qualified professional is needed for the care to be safe & effective to provide or supervise the care (nursing or therapy)
- Skilled nursing/therapy are defined at 42 C.F.R. §409.33
  - List of services that = skilled nursing/therapy (42 C.F.R. §409.42)

No duration of time limit. Medicare home care coverage is available so long as skilled care required

Reference: Medicare Benefit Policy Manual, Ch. 7, Sec. 40.1.1

Copyright © Center for Medicare Advocacy

SKILLED NURSING MUST BE "INTERMITTENT" TO BEGIN COVERAGE

Intermittent nursing means care provided:

1. Fewer than 7 days per week; or
2. 7 days per week but less than 8 hours each day, for up to 21 days or less; but
   - Extensions possible to continue daily nursing in exceptional circumstances if the need for daily care is still necessary and is expected to have a finite and predictable end point

References: 42 U.S.C. §1395x(m)(7)(B) (note: "USC" is United States Code); Medicare Benefit Policy Manual, Ch. 7, Sec. 30 - 30.1.3

Copyright © Center for Medicare Advocacy

INTERMITTENT NURSE (continued)

- Dr. can recertify if need for daily skilled nursing doesn't end after 21 days as expected, but there must be an expectation that daily nursing need will end.
- Exception: Daily Insulin injections can continue when the individual can not self-inject

  Reference: MBPM Ch. 7, Sec. 40.1.2.4A2
- Must have medically predictable recurring need for skilled nursing services (at least once every 60 days, but there are exceptions). Reference: MBPM Ch. 7 Sec. 40.1.3

Copyright © Center for Medicare Advocacy

SKILLED NURSING DEFINED

- Overall Management and Evaluation of Care Plan
- Observation and Assessment of Changing Condition
- Patient Education Services
- Specific skilled nursing services

Reference: 42 C.F.R. § 409.33(a)

Copyright © Center for Medicare Advocacy

SKILLED NURSING - OVERALL MANAGEMENT -

Management and Evaluation of Care Plan

- When patient requires nurse to manage a combination of non-skilled services
  - Considered reasonable & necessary "when underlying conditions or complications are such that only a registered nurse can ensure that essential non-skilled care is achieving its purpose". (42 C.F.R. § 409.42(c)(1)(i))
  - Requirement for <u>payment</u> for these services is that in the patient's care plan "the physician includes a brief narrative describing the clinical justification for this need". (42 C.F.R. § 424.22(a)(1))

Copyright © Center for Medicare Advocacy

SKILLED NURSING
- OBSERVATION & ASSESSMENT -

Observation and Assessment of Changing Condition

- The likelihood of change in a patient's condition requires skilled nursing to identify and evaluate the patient's need for possible modification of treatment, or
- Skilled nursing initiation of additional medical procedures is necessary until the medical regimen is essentially stabilized
- Information from the patient's medical history may support the likelihood of a future complication or acute episode and may justify the need for continued skilled observation and assessment beyond a 3 week period

Reference: Medicare Benefit Policy Manual, Ch. 7, Sec. 40.1.2.1

Copyright © Center for Medicare Advocacy

SKILLED NURSING
- OBSERVATION -

"Where a patient was admitted to home health care for skilled observation because there was a reasonable potential of a complication or further acute episode, but did not develop a further acute episode or complication, the skilled observation services are still covered for three weeks or so long as there remains a reasonable potential for such a change, complication or further acute episode."

Reference: Medicare Benefit Policy Manual, Chapter 7, Sec. 40.1.2.1

Copyright © Center for Medicare Advocacy

SKILLED NURSING
- PATIENT EDUCATION SERVICES -

- Reasonable and necessary until "it is apparent, after a reasonable period of time, that the patient, family, or caregiver could not or would not be trained." (42 C.F.R. § 409.42(c)(1)(ii))

"We believe it inappropriate to assign specific timeframes for patient education services because the length of time a patient or family or caregiver needs should be determined by assessing each patient's individual condition and other pertinent factors such as the skill required to teach the activity and the unique abilities of the patient. It is important to know that teaching activities must be related to the patient's functional loss, illness, or injury."

Reference: 74 Fed. Reg. 58115 (Nov. 10, 2009)

Copyright © Center for Medicare Advocacy

SKILLED NURSING
- SPECIFIC SERVICES DEFINED-

- Specific skilled nursing services defined:
  - Intravenous or intramuscular injections
  - Intravenous & enteral feedings
  - Insertion and sterile irrigation of supra pubic catheters
  - Application of dressing involving prescription medications and aseptic techniques
  - Treatment of extensive decubitus ulcers and other widespread skin disorders
  - Nasopharyngeal / tracheostomy aspirations

Reference: 42 C.F.R. § 409.33(b)

Copyright © Center for Medicare Advocacy

SKILLED NURSING (continued)

IMPORTANT ADVOCACY TIP

- 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.

Reference: Medicare Benefit Policy Manual, Ch. 7, Sec. 40.1.1

Copyright © Center for Medicare Advocacy

SKILLED NURSING (continued)

IMPORTANT ADVOCACY TIP BASED ON *JIMMO v. SEBELIUS*

- 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 for a service to be skilled**.**

Copyright © Center for Medicare Advocacy

SKILLED THERAPY

- Physical Therapy
- Speech Language Pathology
- Occupational Therapy (sufficient to continue care, but not to trigger coverage)

Reference: 42 C.F.R. § 409.44(c)

Copyright © Center for Medicare Advocacy

SKILLED THERAPY (continued)

- Must relate directly and specifically to a treatment regimen (established by the physician, after any needed consultation with the qualified therapist) that is designed to treat the individual's illness or injury
- Must be reasonable and necessary

Reference: 42 C.F.R. § 409.44(c)

Copyright © Center for Medicare Advocacy

SKILLED THERAPY (continued)

"…There must be an expectation that the beneficiary's condition will improve materially in a reasonable (and generally predictable) period of time …**or the skills of a therapist must be necessary to perform a safe and effective maintenance program**."

Reference: 42 C.F.R. § 409.44(c)(2)(iii)

Copyright © Center for Medicare Advocacy

SKILLED THERAPY (continued)

- **Occupational Therapy** (OT) can be the only skilled service when:
  - OT is ordered along with some other skilled services (Example: Nursing, PT, or SLP) and
  - The other skilled service(s) are discontinued but OT continues to be necessary and provided

Copyright © Center for Medicare Advocacy

SKILLED MAINTENANCE THERAPY

- **Maintenance Therapy Is A Covered Service –** "…when the specialized knowledge of a qualified therapist is required to design and establish a maintenance program based on an initial evaluation and periodic assessment of a patient's needs…" (42 C.F.R. § 409.33(c)(5))
- **Maintenance Therapy** – Where services that are required to maintain the patient's 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 procedure safely and effectively, the services would be covered… ."

Reference: Medicare Benefit Policy Manual, Ch. 7, Sec. 40.2.2.E

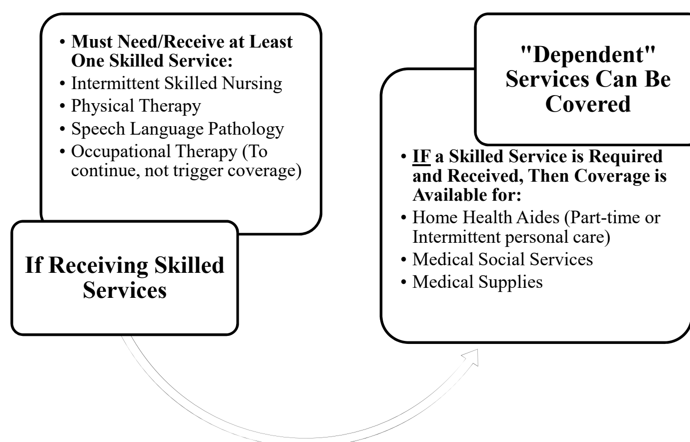
Copyright © Center for Medicare Advocacy

IMPORTANT KEY 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 nursing, therapy and other services can be covered to:
   - Preserve current capabilities
   - Prevent further deterioration
5. Home Care can continue so long as qualifying are criteria met

Copyright © Center for Medicare Advocacy

"DEPENDENT" COVERED SERVICES



Copyright © Center for Medicare Advocacy

DEPENDENT SERVICES

- If an individual receives intermittent skilled nursing or PT, SPL or continuing OT…
- Then coverage is also available for "Dependent Services" (such as home health aides)

Note – The amount of skilled services does not determine the amount of dependent services

Copyright © Center for Medicare Advocacy

DEPENDENT SERVICES (continued)

- Home health aides
- Medical social services
- Medical supplies (related to the illness/injury)
  - Examples: catheters, ostomy supplies
  - Not DME/Prosthetics & Orthotics → Covered separately under Part B

Reference: 42 U.S.C. § 1395x(m)(7)(b)

MedicareAdvocacy.org
Copyright © Center for Medicare Advocacy

DEPENDENT SERVICES (continued)

Home health aides

Home health aides, combined with skilled nursing, can be provided up to 28 hours per week and any number of days per week as long as they are provided less than 8 hours each day

- Subject to review on case by case basis, they may be available up to 35 hours per week

Reference: 42 U.S.C. § 1395x(m)(7)(b)

MedicareAdvocacy.org
Copyright © Center for Medicare Advocacy

DEPENDENT SERVICES (continued)

- Home Health Aides
  - HH Aides must provide personal, hands-on-care
  - Homemaker services alone are *not* covered
    - Only allowed if incident to personal hands-on care
- "Custodial" Care
  - Medicare Act specifically establishes home health aide (custodial care) as a covered service under the Medicare benefit

Reference: 42 U.S.C. § 1395x(m); 42 C.F.R. § 409.45

MedicareAdvocacy.org
Copyright © Center for Medicare Advocacy

IS COVERAGE AVAILABLE IF CAREGIVERS ARE AT HOME?

- A patient is entitled to have the costs of reasonable and necessary services reimbursed by Medicare without regard to whether there is someone available to furnish the services …
- Ordinarily it can be presumed that there is no able and willing person at home to provide services rendered by the home health aide or other HH personnel

Reference: Medicare Benefit Policy Manual, Ch. 7, Sec. 20.2

MedicareAdvocacy.org
Copyright © Center for Medicare Advocacy

JIMMO V. SEBELIUS SETTLEMENT APPROVED 1/24/2013

- Federal class action brought to end Medicare denials based on an "Improvement Standard" for skilled nursing facility (SNF), home health (HH), and outpatient therapy (OPT) care.

- 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

Copyright © Center for Medicare Advocacy

WHAT *JIMMO* MEANS

Care that meets Medicare level-of-care criteria and is needed to maintain an individual's condition or slow decline, is just as coverable as care intended to improve an individual's condition.

Copyright © Center for Medicare Advocacy

WHAT *JIMMO* MEANS

Settlement required CMS to revise its Medicare home health and other policy manuals, guidelines, instructions and education to "clarify":

- **Coverage does not turn on the presence or absence of potential for improvement but rather on the need for <u>skilled care</u>**
  - Including Nursing and Therapy

Services <u>can</u> be skilled and covered <u>when</u>:

- <u>Skilled</u> professional is needed to ensure services are safe and effective
- <u>To maintain, prevent, or slow decline</u>

Medicare Benefit Policy Manual, Ch.7, Sec. 20.1.2

MedicareAdvocacy.org
Copyright © Center for Medicare Advocacy

JIMMO SUMMARY

Questions to Ask:

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

<u>Regardless</u> of whether the skilled care is needed to improve, <u>or</u> maintain, or slow deterioration of the condition. Or if condition is "chronic" or "stable" or has "plateaued."

MedicareAdvocacy.org
Copyright © Center for Medicare Advocacy

JIMMO AND PRIOR LAW REQUIRE AN ASSESSMENT OF EACH INDIVIDUAL'S SITUATION

- 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."

Reference: 42 C.F.R. §409.44(b)(3)(iii); See also, 42 C.F.R. §409.44(a)

MedicareAdvocacy.org
Copyright © Center for Medicare Advocacy

CASE STUDY
Meet Mrs. Drew

- Mrs. Drew has Parkinson's disease. She is a widow and lives alone. Her two adult daughters and their families live about an hour away from her.
- Mrs. Drew is enrolled in a Medicare Advantage (MA) plan. She has been receiving home health coverage for PT 1 time per week, OT 1 time per week, nursing 2 times per week, and home health aides 2 times a day Mon – Fri.
- The home health agency told Mrs. Drew her home health coverage was ending because she was not improving and the agency did not believe Medicare would pay for her care.

MedicareAdvocacy.org
Copyright © Center for Medicare Advocacy

CASE STUDY
Questions an Advocate Should Ask

- Can the home health agency be persuaded to continue care – as ordered by the physician?
- Did Mrs. Drew get a written denial notice?
  - If so, get a copy
- Did the physician who ordered home health discharge the care?
- Will the physician support continued home health care?
  - If so, obtain the physician's active support
  - If possible in writing
- Try to speak to nurse, PT and OT about the care they've been providing and get their support for the need to continue that care

Copyright © Center for Medicare Advocacy

CASE STUDY
Goal: Keep Care In Place

- After speaking to physician and home health nurse and/or therapists, contact the home health agency to try to keep care in place
- If HH agency can't be convinced to continue care, appeal the denial
  - Be certain appeal deadline is met
  - Get written support from Dr. to include with appeal

Copyright © Center for Medicare Advocacy

CASE STUDY
Issues Presented

- Medicare is available to maintain/slow decline equally to improve
- Medicare is available when condition is stable or declining
- Coverable care/services must be "reasonable & necessary"
- Length of time Medicare home health coverage can continue is based on meeting basic criteria and needing skilled care
- Responsibility/ability of family to provide care is not relevant to Medicare coverage determination
- Medicare Advantage v. traditional Medicare
  - Application of Medicare law
  - MA plans must provide adequate access to Medicare-covered services (42 C.F.R. § 422.112)

Copyright © Center for Medicare Advocacy

CASE STUDY
Coverage When Condition Is Stable Or Not Improving

- **Restoration potential is not a basis for denial of coverage**
  - "Even if full recovery is not possible, a patient may need skilled services to prevent further deterioration or preserve current capabilities" (42 CFR § 409.32)
- **Improvement is not required for a service to be skilled – and covered**
  - *Jimmo v. Sebelius* Settlement (See MedicareAdvocacy.org and CMS.gov\Jimmo)

Copyright © Center for Medicare Advocacy

CASE STUDY

How Much And How Long Can Care Be Covered?

- Up to 28 to 35 hours per week combined of nursing and home health aide services (Medicare Act: 42 USC § 1395x(m))
  - In practice, difficult to find an agency to provide
- And PT, SLP, OT as medically necessary and reasonable
  - Note: OT can qualify as the skilled service to continue coverage, but not to trigger it
- **No duration of time limit**. Coverage is available so long as skilled care required.

  Medicare Benefit Policy Manual, Chap. 7, § 40.1.1

Copyright © Center for Medicare Advocacy

CASE STUDY

Impact Of Family Or Caregivers On Coverage

- Home health agency should not presume care is actually available
- Or refuse Medicare coverage on grounds it is (or should be) when it is not
- Is there actually an able and willing available caregiver who can provide the needed care safely and effectively?

Medicare Policy Manual, Chap. 7 § 20.2

Copyright © Center for Medicare Advocacy

CASE STUDY
Medicare Advantage Concerns

- MA is supposed to provide at least as much coverage as traditional Medicare
  - Same coverage rules apply
  - MA plans must provide adequate access to covered services (42 C.F.R. § 422.112)
  - In practice…
- With MA plans, it is harder to work directly with a home health agency to continue care

MedicareAdvocacy.org
Copyright © Center for Medicare Advocacy

OBSTACLES TO CARE: NARROW (MIS)INTERPRETATION OF COVERAGE LAWS

- By Home Health Agencies
- By Medicare Contractors
- Lack of understanding about *Jimmo* case
- Fear of Medicare Audits by the Office of Inspector General (OIG)

MedicareAdvocacy.org
Copyright © Center for Medicare Advocacy

OBSTACLES TO CARE: PAYMENTS TO AGENCIES

- Payment case-mix weights are not strong for people living with a chronic condition.
- Medicare certified home health agencies are not required to provide services to all Medicare patients.
- However, Medicare certified home health agencies are not allowed to discriminate by payer source.
- Office of Inspector General audits are pressuring agencies to discharge patients.

Copyright © Center for Medicare Advocacy

OBSTACLES TO CARE: QUALITY RULES

- Impact of the current Home Health Quality Reporting Program (HHQRP) and the “star rating” system, measures include these “improvement” measures:
  - How often patients got better at walking around
  - How often patients got better at getting in and out of bed
  - How often patients got better at bathing
  - How often patients had less pain when moving around
  - How often patients’ breathing improved
  - How often patients’ wounds improved or healed after an operation

Copyright © Center for Medicare Advocacy

OBSTACLES TO CARE: ARBITRARY DISCHARGE

- The patient still qualifies for care, but the home health agency says:
  - Medicare won't pay for your care any more
  - Medicare doesn't cover long term services
  - Medicare doesn't cover maintenance therapy
  - We don't have the staff to meet your needs
  - You only need custodial care and Medicare doesn't pay for that
  - You are not homebound

Copyright © Center for Medicare Advocacy

OBSTACLES TO CARE: MEDICARE ADVANTAGE PLANS

- Limited networks give beneficiaries less choice of providers.
- Provider contracts may be discontinued during services.
- Plans may impose beneficiary cost sharing for services.
- Plans may limit authorization for home health services despite the plan of care, order, and OASIS assessments.
- Plan reimbursement to providers may be lower than the traditional Medicare bundled rate payment, possibly creating further access problems for beneficiaries.

Copyright © Center for Medicare Advocacy

PATIENT DRIVEN GROUPINGS MODEL (PDGM) COMPONENTS

MEDICARE PAYMENTS TO PROVIDERS EFFECTIVE 1-1-2020

- ***Changes Timing*** – "early" episodes from 120 days (two 60 day episodes) to 30 days
- ***Adds Admission Source*** – Post-inpatient stay admission or community admission
- ***Clinical Groupings***
- ***Functional Need Level*** – High, Medium or Low
- ***Co-Morbidity Adjustment***

Copyright © Center for Medicare Advocacy

USE THE MEDICARE BENEFIT POLICY MANUAL

- Relied Upon By Medicare-certified Home Health Agencies https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c07.pdf
- Medicare Benefit Policy Manual, Chapter 7
  - All significantly revised by *Jimmo*
  - 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)

Copyright © Center for Medicare Advocacy

USE THE CMS *MEDICARE & HOME HEALTH CARE BOOKLET*

- Official CMS Booklet - October 2017 version contains significant updates and clarifications
  - https://www.medicare.gov/Pubs/pdf/10969-Medicare-and-Home-Health-Care.pdf
- 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

Copyright © Center for Medicare Advocacy

USE THE MEDICARE CONDITIONS OF PARTICIPATION (COP) (REVISED EFFECTIVE 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

Copyright © Center for Medicare Advocacy

USE THE MEDICARE CONDITIONS OF PARTICIPATION (REVISED EFFECTIVE 1-13-2018)

- 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.

USE THE MEDICARE CONDITIONS OF PARTICIPATION (REVISED EFFECTIVE 1-13-2018)

- 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)

VISIT MEDICARE.GOV

- Search for "*Jimmo*" for information about the *Jimmo* Settlement and lawfully required Medicare coverage for people with conditions such as ALS
- 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.

Copyright © Center for Medicare Advocacy

CONFIRM THERE'S STRONG DOCUMENTATION IN THE BENEFICIARY'S MEDICAL RECORD

- The skilled nursing and/or therapy is medically reasonable and necessary - and is provided.
- Homebound requirements are met.
- Face-to-Face requirements are met.
- The need for dependent services (home health aides) is justified.
- The services are documented as delivered – "If it's not documented, it didn't happen".

Copyright © Center for Medicare Advocacy

IF HOME HEALTH AGENCY SAYS MEDICARE WON'T COVER

- Ask the agency to submit a "Demand Bill" to Medicare for all the coverable services included on the plan of care (they must do so if the beneficiary insists)
  - For up to 35 hrs/wk of home health aide and nursing combined and PT, SLP, OT, other "dependent services"
  - Home Health Agency should use "Code 20" on the claim form so a medical review is done

Copyright © Center for Medicare Advocacy

APPEAL MEDICARE DENIALS

- Continue to receive care, if possible.
- Contact the Center for Medicare Advocacy for assistance with appeals.

Copyright © Center for Medicare Advocacy

LAST RESORT: ACCEPT LESS THAN YOU QUALIFY 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 you can only get access to limited Medicare-covered home care.
- Let us know! Your stories will help us remove unfair barriers to Medicare-covered home care.

Copyright © Center for Medicare Advocacy

ADDITIONAL RESOURCES FROM THE CENTER FOR MEDICARE ADVOCACY

Available at:

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

- *Jimmo* Settlement and materials
- Medicare Home Health Benefit Policy Manual
- Health Tool Kit
- Revised Home Health Brochure
- Self-Help Packets
- Articles on Home Health Topics

Copyright © Center for Medicare Advocacy

Questions and Comments

Please, Send Questions and Stories (Challenges and Successes) To: HomeHealth@MedicareAdvocacy.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**

Follow us on Facebook and Twitter!