Home Care Alliance of Massachusetts
Home Health 101

Webinar Series
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Orientation to Home Health

- Introduction to Home Health Care
- Home Health Conditions of Participation
- Health Insurance Coverage/Medicare Requirements
  - Certification – Face to Face, Homebound, Skilled Care, Under Care of Physician, Plan of Care
- Requirements for Patient Notices
  - ABN, NOMNC, HHCCN
- Survey Process
- OASIS Basics
Introduction to Home Health Care

History of Home Care in the US
History of Home Care in the US

- Industrial Revolution/ Immigration to the US in late 1800
- Medicare Benefits added to Social Security-1965
- Medicaid 1965
  - jointly funded, Federal-State health insurance program for low-income and needy people.
  - It covers children, the aged, blind, and/or disabled and other people who are eligible to receive federally assisted income.
Coverage for Home Health Services

**Health Insurance Plans** - have specific criteria for coverage and payment

- Medicare - Medicare Benefit Policy Manual - Chapter 7 (e.g. Homebound required) Prospective Payment System
- Medicare Advantage Plans
- Medicaid - MassHealth - Home Health Agency Manual (Do not need to be homebound) Paid per visit rate
- Medicaid HMO/ACO
- Private Insurance

**Private Pay**
Health Insurance - Medicare

- Medicare is a health insurance program for:
  - People age 65 or older.
  - People under age 65 with certain disabilities.
  - People of all ages with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).
Medicare - Health Insurance

- **From 1965-1999** home health was paid per visit.
- **October 1999-September 2000** - Interim Payment System (IPS) Mandated by the 1997 Balance Budget Act (BBA)
  - The IPS reduced per-visit payment rates and established an average beneficiary cost limit for Medicare HHAs.
  - Very strong incentives for HHAs to reduce the number of visits provided to each patient and to avoid patients whose plan of care was likely to exceed the average beneficiary cost limit.
- **Prospective Payment System (PPS)** effective October 1, 2000.
Health Insurance - Medicare

• **Prospective Payment System (PPS) 2000**
  • Payment includes all covered home health services
  • 60-day episodes of care
  • The 60-day payment amount is adjusted for case-mix and area wage differences.
  • The case-mix adjustment under this system included:
    • a clinical dimension;
    • a functional dimension;
    • and a service dimension, payment would increase if certain therapy visit thresholds were met.

• **Patient-Driven Groupings Model (PDGM) January 1, 2020**
Health Insurance- Medicare

Patient-Driven Groupings Model (PDGM)

New case-mix classification model relies heavily on clinical characteristics, and other patient information to determine payment categories.

- Admission source (two subgroups): community or institutional admission
- Timing of the 30-day period (two subgroups): early or late
- One case-mix variable is the assignment of the principal diagnosis to one of 12 clinical groups to explain primary reason for HH services.
PDGM

- **Clinical grouping**
  - musculoskeletal rehabilitation;
  - neuro/stroke rehabilitation;
  - wounds;
  - Medication Management, Teaching, and Assessment (MMTA)
  - surgical aftercare; MMTA
  - cardiac and circulatory; MMTA
  - endocrine; MMTA
  - gastrointestinal tract and genitourinary system; MMTA
  - infectious disease, neoplasms, and blood-forming diseases; MMTA
  - respiratory; MMTA-
  - Other-behavioral health; or
  - complex nursing interventions
- **Functional impairment level** - low, medium, or high
- **Comorbidity adjustment** (none, low, or high based on secondary diagnoses.)
• There are now two 30-Day Periods of Care
• Unit of payment is now 30-days, instead of 60-days, HHAs may have more frequent contact with physician and get the POC/orders sign and dated timely in order to bill for home health services.
• Plan of Care and OASIS remain 60 days
Health Insurance- Medicaid

- Medicaid provides health coverage to millions of Americans, including
  - eligible low-income adults,
  - children,
  - pregnant women,
  - elderly adults, and
  - people with disabilities.
- Medicaid is administered by states, according to federal requirements. The program is funded jointly by states and the federal government.
- Massachusetts’ Medicaid=MassHealth
Centers of Medicare and Medicaid
CMS

- Responsible for Medicare and Medicaid Program
- Administrative simplification standards from Health Insurance Portability and Accountability (HIPAA)
- Quality standards through survey/certification process
- Oversight Healthcare.gov
Medicare Eligibility Criteria for Home Health

*The physician who certifies the need for home health and establishes the plan of care must sign and date “the certification”*

1. Confined to Home
2. Under the Care of a Physician/NPP
3. Beneficiary is under a plan of care established and periodically reviewed by a physician
4. Need Skilled nursing care on an intermittent basis or physical therapy or speech-language pathology or have a continuing need for Occupational therapy
5. Face-to-Face Encounter Requirement
   *(If POC not dated, claim will not be paid)*
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Patient Confined to the Home

(Benefit Policy Manual Chapter 7-Home Health Services)

Section 30.1.1
An individual is considered “confined to the home” (homebound) if the following two criteria are met:

Criteria One

One Must Be Met

- Because of illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person to leave their place of residence

OR

- Have a condition such that leaving his or her home is medically contraindicated.

Criteria Two

Both Must Be Met

- There must exist a normal inability to leave home.

AND

- Leaving home must require a considerable and taxing effort.
More on Homebound…..

• The patient may be considered homebound if absences from the home are infrequent;
  • for periods of relatively short duration;
  • for the need to receive health care treatment;
  • for religious services;
  • to attend adult daycare programs; or
  • for other unique or infrequent events (e.g., funeral, graduation, trip to the barber).
Allowed Absence- From the Home

Absences attributable to the need to receive health care treatment include:

- Attendance at adult day centers to receive medical care;
- Ongoing receipt of outpatient kidney dialysis; or
- The receipt of outpatient chemotherapy or radiation therapy.

*Cannot provide home health at the adult day center
Must be the patient’s place of residence*
A Closer Look at Homebound

- Any other absence from home shall not disqualify an individual if absence is of an **infrequent or relatively short duration**.
  - Any absence for attending a religious service shall be deemed to be an absence of infrequent or short duration. **It is expected that in most instances, absences from the home that occur will be for receiving health care treatment.**
  - However, occasional absences from home for nonmedical purposes: e.g., occasional trip to the barber, attendance at a family reunion, funeral, graduation, or other infrequent or unique event
The law does not permit HHA to furnish a Medicare covered billable service to a patient under a HH plan of care outside the home except in those limited circumstances where the patient needs to use medical equipment that is too cumbersome to bring to a home.

A person’s residence is wherever she/he makes her home.
- temporarily stay at son/daughter home
- shelter
Certifying Patients for the Medicare Home Health Benefit

Some examples of persons confined to the home are:

- A patient who is blind or senile and requires the assistance of another person in leaving their place of residence;
- A patient who has just returned from a hospital stay involving surgery, who may be suffering from resultant weakness and pain and therefore their actions may be restricted by their physician to certain specified and limited activities such as getting out of bed only for a specified period of time or walking stairs only once a day; and
- A patient with a psychiatric illness that is manifested, in part, by a refusal to leave home or is of such a nature that it would not be considered safe for the patient to leave home unattended, even if they have no physical limitations.

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Physician and Non-Physician Practitioner (NPP)

Patient must be under the care a physician/NPP, who and will establish POC and follow patient in the community

- **Physician** - A doctor of medicine, osteopathy or podiatry legally authorized to practice medicine and surgery by the State in which such function or action is performed.

- **Non-Physician Practitioners -NPP**
  - Nurse practitioner or a clinical nurse specialist working in collaboration with physician authorized to practice in the state
  - Certified nurse midwife or physician assistant under the supervision of the certifying physician authorized to practice in the state
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Skilled Care

- Intermittent Skilled Nursing
- Physical Therapy
- Speech-language Pathology or
- Have a continuing need for Occupational Therapy

Specifically defined in Medicare Benefit Policy Manual- Chapter 7
Medicare Eligibility Criteria for Home Health

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5. **Face-to-Face Encounter Requirement**
Face-to-Face Encounter

- **When Must Encounter Occur?**
  - No more than 90 days prior to the home health start of care
  - Within 30 days of the SOC

- **Related reason**
  - Encounter must be related to primary reason for home health
  - Not necessarily the primary reason for the encounter
  - During the encounter- the primary reason for home health is addressed
Who Can Perform a Face-to-Face Encounter?

- According to 42 CFR 424.22(a)(1)(v)(A), the F2F encounter can be performed by:
  - Certifying physician
  - Physician who cared for patient in acute or post-acute care facility (from which the patient was directly admitted to home health);
  - Nurse practitioner or a clinical nurse specialist working in collaboration with certifying physician or the acute/post-acute care physician; or
  - Certified nurse midwife or physician assistant under the supervision of the certifying physician or the acute/post-acute care physician.

*F2F encounter cannot be performed by any physician or allowed NPP (listed above) who has a financial relationship with the HHA.*
Face to Face Encounter

- Physician responsible for documentation of F2F and eligibility requirements
- Documentation must be in the certifying physician’s medical records or the acute/post-acute care facility’s medical records
- Certifying physicians and acute/post-acute care facilities must provide HHA with MR documentation that supports the certification of patient eligibility for Medicare HH benefit-

*If documentation used as the basis for certification is not sufficient to demonstrate the patient is or was eligible to receive services under the Medicare HH benefit, payment will not be rendered for home health services provided.*
Face to Face Encounter

- Information from the HHA can be incorporated into the certifying physician/acute/post-acute care facility’s MR for patient.
- Certifying physician must review and sign off on anything incorporated into the patient’s medical record that is used to support the certification of patient eligibility.
Home Health Agency Survey
HHA- Standard Survey

- Conducted by:
  - State Agency- Department of Public Health or
  - Accrediting Organization-
    - Joint Commission (JC)
    - Community Health Accreditation Partner (CHAP),
    - Accreditation Commission for Health Care (ACHC)
HHA- Standard Survey

• Evaluate HHA every 3 yrs for:
  • Compliance with Conditions of Participation - COPs, federal and state regulations
  • Emergency Preparedness Plan
  • Quality Care Compliance
  • Infection Control
  • Timely transmission of OASIS
  • Potentially avoidable events (adverse events)
HHA- Standard Survey

• Surveyors utilize “Interpretive Guidelines”
• Directs them in survey process

State Operations Manual (SOM) - Guidance to Surveyors:
Conditions of Participation Interpretive Guidelines
HHA- Standard Survey

Survey and certification process:

- Joint home visits with clinicians
- Evaluates organizational structure
- Compliance with state and federal laws
- Review of Human Resource records
- Review of patient records
- Review of agency policies and procedures
- Interviews with clinicians and patients to determine if COPs have been met
Conditions of Participation-COPs
§ 42 CFR Part 484
Section Sign 42 of the Code of the Federal Register
Part 484 Home Health

COPs: the “cookbook” for starting and operating a home health agency!

- **Regulations** certified HHA must comply with to participate in Medicare/Medicaid program
- **Guidelines** for State Surveyor and accrediting organizations to conduct surveys
  - Aimed at improving quality of care,
  - Protecting rights of patients
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QUESTIONS

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