



## **Discharge Planning for Better Health Care**

### **Advocacy Tips for Assisting Medicare Patients in Home Health Care Discharge**

## **Discharge Planning for HOME HEALTH CARE PATIENTS**

### **Introduction**

#### General guidelines and cautions

The following information for Medicare beneficiaries and their advocates is useful in challenging a discharge or reduction in services in hospital, skilled nursing, home health, and hospice care settings:

- Read carefully all documents that purport to explain Medicare rights. If unable to do so, have family members, friends, or other representatives read such document(s).
- Question treating physicians, nurses, social workers, home health care providers, and other care providers about necessary services as the beneficiary's condition improves, remains the same, or requires more services. If the beneficiary has opinions and concerns about care, voice them and participate fully in all care decisions.
- Become familiar with Medicare guidelines about eligibility for hospital and home and community-based care, including nursing facility services and home health services available under the Medicare and Medicaid programs. It is also important to explore options for services that may be available through other state-based sources of coverage for home and community-based services (HCBS).
- Identify and become familiar with available health care services such as visiting nursing services, home health agencies, nursing homes, respite care, friendly visiting services, and religious and civic groups that provide services. An important source of information about services is the Elder Care Locator 1-800-677-1116. In addition, contact the Medicare program's information line B 1-800-MEDICARE (1-800-633-4227) (TTY: 1-877-486-2048 for the hearing impaired).
- Become familiar with discharge planning and its interplay with "transitions," an

activity that includes the preparing for and moving from one care setting to another. See, “Breathing Life Into Discharge Planning,” by Alfred J. Chiplin, Jr., [http://www.medicareadvocacy.org/WAUpdate\\_BreathingLifeIntoDischargePlanning06.22.04.PDF](http://www.medicareadvocacy.org/WAUpdate_BreathingLifeIntoDischargePlanning06.22.04.PDF)

- Use physicians and suppliers who are Medicare-participating providers and, as such, have agreed to accept the Medicare reasonable charge amount, less the 20% beneficiary co-payment, as payment in full for Medicare-covered physician and supplier services (*See, 42 U.S.C §§1395u(b)(3);1395n; 42 C.F.R. §§ 410.152(amounts of payment); 424.55(b)(payment to suppliers); 414.48 (limiting charge for non-participating suppliers); see also, 400.402(definitions specific to Medicare, including payment on an assignment related basis).*
- Beware of using physicians who have opted out of Medicare and the impact of using such physicians and consequent impact on access to Medicare coverage for the services. See, 42 C.F.R. §§405.400 et seq.
- Pay attention to access to coverage concerns that may arise from recently instituted Medicare rules that exclude and limit payment for hospital-acquired conditions (HACs) and incidents that should never happen in hospitals (never events).
- Contact your local Medicare office or the Social Security office for a list of Medicare participating providers and suppliers in your area.

## **Discharge Planning in the Home Health Care Setting**

- Discharge planning rights in the home health care arena are not as well developed as in the hospital and nursing facility context.
- The appropriate focus of advocacy is on keeping services in place. Central to doing so is obtaining notice from the home health provider agency about contemplated denials, reductions, or the termination of services.
- Home health agencies (HHAs) are required to give written or oral notice concerning when Medicare will pay for services and when there is a change. This notice is called a home health advanced beneficiary notice (HHABN). 42 CFR §484.10(a)(1), (2).
- Effective September 1, 2006, home health agencies are to use CMS’s revised HHABN. Instructions for its use are included in CMS Transmittal 1025 (August 11, 2006), Pub 100-04 Medicare Claims Processing, Chapter 30, Section 60.
- The revised notice, also referred to as R1025CP, encompasses broader notice requirements, codified in the Medicare Conditions of Participation (COP). See, [www.cms.hhs.gov/transmittals/downloads/r1025cp.pdf](http://www.cms.hhs.gov/transmittals/downloads/r1025cp.pdf).

- HHABNs are required more frequently for reductions and terminations as a result of the court’s decision in *Lutwin v. Thompson*, 361 F.3d 146 (2d Cir. 2004), for example, changes in non-covered home care.
- HHABNs are required in some situations where qualifying requirements for Medicare benefits are not being met, such as when there is a lack of physician orders for home care; and
- HHABNs are required in many of circumstances where covered care is reduced or terminated.
- Medicare provides for a two-day, expedited notice procedure to be used when services are terminated because they are no longer reasonable and necessary (see discussion below).
- Notice should provide an opportunity for discussion and negotiation with the HHA, necessary appeals, and collaboration with the beneficiary’s physician.
- Beneficiaries should also explore other sources of coverage when Medicare home health coverage is in question. Private health care coverage, services under the Older Americans Act, Medicaid, and other home and community-based health care may be useful options.
- Advocates and beneficiaries should contact the Eldercare Locator (identified at the beginning of this writing) for an exploration of local options.
- We are experiencing an up-tick in termination of services of severely ill patients who need chronic, on-going care. Often, these patients are expensive to treat. HHAs express concern about the cost of these cases and about their patient mix. Many are terminating services for “business reasons.” This will be an on-going area of advocacy.

### **Prospective payment and access to service**

- The Medicare program uses a Prospective Payment System (PPS) as its methodology to in paying for home health care. Under this system, HHAs are paid on the basis of a 60-day episode of care in accordance with standard payment amounts (42 U.S.C. §1395fff; 42 C.F.R. §484.200 et seq.).
- The PPS for home health relies on a patient assessment instrument, the Outcome and Assessment Information Set (OASIS), as part of the process of determining the PPS amount the home health agency will be paid for each patient (42 C.F.R. §§484.210, 484.220).
- When an HHA accepts a patient, it must perform an OASIS assessment of the patient (42 C.F.R. §484.250).

- Each patient is assigned to a home health resource group (HHRG) based on the combination of his or her severity levels on the three OASIS data point elements: clinical severity, functional severity, and services utilization.

### **Home health agency requirements to inform beneficiaries**

- The Medicare program requires each participating HHA to provide its Medicare home health patients with:
- Information in advance about the care and treatment to be provided by the agency;
- Full information in advance of any changes in the care or treatment to be provided by the agency that may affect the individual’s well-being;
- The right to participate in planning care and treatment or changes in care or treatment;
- The right to be fully informed orally and in writing (in advance of coming under the care of the agency) of any changes in the charges for items or services to be provided, as well as to be fully informed of the beneficiary’s rights and entitlements under Medicare.

42 U.S.C. §1395bbb (a)(1)(A), 42 C.F.R. §484.10(c)(1) and (2).

### **Legal protections against loss of home health care coverage**

- The Secretary of Health and Human Services is obligated to enforce notice and appeal rights of home health beneficiaries through several means, including intermediate sanctions and terminating the HHA as a Medicare-certified agency (42 U.S.C. §1395bbb(e)(2)).
- Medicare beneficiaries are entitled to an explanation of the circumstances in which a beneficiary has the right to have a “demand bill” submitted. (CMS online manual system, Pub. 100-4, Medicare Claims Processing, [www.cms.hhs.gov/manuals](http://www.cms.hhs.gov/manuals), Chapter 30, §50).
- An expedited review process is available for a beneficiary when the provider plans to terminate services or to discharge the beneficiary.
- The provider must give notice 2 days before loss of services occur.
- The beneficiary must file for expedited appeal with a QIO by noon of the day of receipt of notice from the provider.
- The QIO must inform the provider of the appeal, and the provider must supply the beneficiary with a more detailed notice.
- The QIO has 72 hours to make a determination.

### **Notice under Prospective Payment System**

- Under PPS, beneficiaries and their advocates should remain vigilant. Changes in health status or other patient circumstances occurring within a 60-day episode of care should trigger notice to the beneficiary.
- CMS responded in its pleadings in Healey v. Shalala that notice and appeal rights are not affected by PPS; that the same notice and appeal processes currently in place apply, including the demand bill process. 186 F. Supp.2d 105 (D. Conn. 2001).

### **Final reminders for discharge planning advocates in the home health care setting**

- Advocates should work with physicians and advocacy groups to assure that detailed orders for home health care services are prepared; that physicians fully understand that physician-ordered services are not to be terminated by home health agencies without the consent of the treating physician.
- Advocates should demand that home health agencies provide the HHABNs and should report agencies to the Regional Home Health Intermediary when they do not.
- To the extent possible, advocates should provide physicians and home health agencies with information about Medicare coverage that support coverage when coverage issues may be questioned and before a notice of non-coverage is submitted.
- Advocates should encourage patients to use the demand bill process where feasible. They should keep in mind that the issue of paying for services pending an appeal will be difficult for many beneficiaries.
- When appeals are necessary, advocates should assist beneficiaries in filing an appeal of home health care coverage denials and enlist physician support in the form of detailed statements about the need for coverage.

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