Moving Through Care Settings
(Don't Send Me to a Nursing Home)

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At-Home Care Getting More Attention

- Many federal programs, as will be discussed in session.

- Bi-partisan popularity.
  - G.W. Bush Administration promoted long-term care at home.

Olmstead v. L.C. (1999)

- Obligation is strong but not unlimited:
  - State's treatment professionals determine that such placement is appropriate;
  - Affected persons do not oppose such treatment; and
  - Placement can be reasonably accommodated, considering state's resources and needs of others.

Limitations to LTC at Home

- Quality of care standards generally non-existent or minimal.
- Programs don’t cover housing costs.
- Care coordination can be difficult.

Discharge Planning

HOSPITAL DISCHARGE PLANNING SERVICES

(42 USC 1395x(ee)) (42 U.S.C. §1395x(ee); 42 C.F.R. §482.43. Condition of participation: Discharge planning)

Identify at an early stage of hospitalization, patients who are likely to suffer adverse health consequences upon discharge in the absence of discharge planning services.

Conduct on a timely basis a discharge planning evaluation for all patients identified by their physicians as needing discharge planning services as well as any patient requesting a discharge planning evaluation.

Medicare Discharge Planning

GENERAL GUIDELINES AND CAUTIONS

The following is useful in challenging a discharge or reduction in services in hospital, skilled nursing, home health, and hospice care settings:

- Read or have some one read to you all documents that purport to explain Medicare rights
- Question treating personnel and other care providers about your care as your condition improves, remains the same, or requires more services.
- Explore other options for services that may be available through state-based sources, including home and community-based services (HCBS).

Medicare Discharge Planning

Place the discharge planning evaluation in the patient's medical record

Discuss the evaluation with the patient (and representatives)

Review the elements of the discharge plan evaluation.

Medicare Discharge Planning

Arrange, when requested by a patient's physician, for the development and the initial implementation of a discharge plan for the patient.

Assure that discharge planning evaluations and discharge plans are developed by, or under the supervision of, a registered professional nurse, social worker, or other appropriately qualified personnel.

Transitions and Discharge

Moving Toward Transitional Care

The scope of care transitions is broader than the discharge process and embraces preparation of the patient to optimize continuity and coordination of practitioners and services across settings.

Generally, transitional care is defined as a set of actions designed to ensure the coordination and continuity of care as patients transfer between different locations or different levels of care within the same location.

Transitional care encompasses the sending and receiving aspects of the transfer, includes logistical arrangements, education of the patient and family, and coordination among health professionals involved in the transition.

Skilled Nursing Facility (SNF) Coverage

Threshold Criteria

- 3 day prior inpatient hospital stay that has been Medicare covered
- Transfer to the SNF within 30 days of discharge from the hospital (unless it is not *medically appropriate* to begin a course of treatment until beyond 30 days)
- Physician must certify that the beneficiary needs SNF care

MEDICARE COVERED SNF CARE

- Care must be reasonable and necessary.
  - 42 USC §1395y(a)(1)(A)
- Care must require the skills of technical or professional personnel such as registered nurses…physical therapists, occupational therapists, and speech pathologists. 42 CFR § 409.31
  - Care must be daily.
  - Nursing 7 days a week
  - Therapy 5 days a week
  - Combination of nursing and therapy 7 days a week.

MEDICARE COVERAGE OF SNF CARE

- **Daily skilled nursing or rehabilitation services**
  - …services must be furnished for a condition for which the beneficiary received inpatient hospital…services; *or*
  - Which arose while the beneficiary was receiving care in a SNF… 42 C.F.R. § 409.31(b)(2).

SKILLED NURSING

- **Skilled nursing services** 42 CFR § 409.33(a)
- Observation and assessment of changing condition
  - Management of overall care plan
  - Patient education services

SNF PROSPECTIVE PAYMENT SYSTEM (PPS)

- Mandated by the Balanced Budget Act of 1997.
- Sets a per diem rate for the Medicare SNF benefit.
- Payment based on Resource Utilization Groups, -- RUGs), with the payment premised upon the type and intensity of the care required by each patient and the amount of resources utilized to provide the care provided.

Home Health Coverage

Coverage Criteria – 42 CFR § 409.40 et seq

- Services must be ordered by a physician
  - A doctor of podiatric medicine may establish a plan of care only if consistent with the functions he or she is allowed to perform under state law.
- Services must be provided under a written plan of care
- The beneficiary must be “confined to home”

Home Health Coverage Criteria

42 CFR § 409.40 et seq.

Beneficiary must require:

- Intermittent skilled nursing services;
- Skilled PT or ST services (or, in limited circumstances, OT services)

Home Health Coverage Criteria

42 CFR § 409.40 et seq

Services must be:

- Medically reasonable and necessary
- Provided by, or under arrangements with, Medicare certified agency

"Triggering" Nurse Services

Intermittent Skilled Nursing

- *Intermittent* means:
  - Less than 7 days per week
  - Exception: 7 day per week services may be covered if for no more than 21 consecutive days (with "renewable" 21 consecutive day periods)
  - *and* finite and predictable end to need for daily skilled nursing services
    - Insulin injections when individual can not self-inject

Medicare Home Health Covered Services

Amount of Coverable Services

- No more than 28-35 hours per week *combined* nursing and aide services
- Use of provider formulas prohibited

MEDICARE COVERED HOSPICE CARE

- Designed to provide palliative care of a terminal illness. 42 U.S.C. § 1395y(a)(1)(C).
- Terminally ill: the individual has a medical prognosis that his or her life expectancy is six months or less if the terminal illness runs its normal course. 42 C.F.R. § 418.3.
- Hospice election periods: an initial 90 day period; a subsequent 90 day period; or an unlimited number of subsequent 60 day periods. 42 C.F.R. § 418.21.

MEDICARE HOSPICE
Four Levels of Care

1. **Routine Home Care**: 93% of hospice care is provided at the routine home care level. It is provided where the person resides.

2. **Continuous Home Care**: Nursing care may be covered on a continuous basis for as much as 24 hours a day during periods of crisis as necessary to maintain an individual at home. The nursing care can be supplemented by home health aides and homemakers, but the care must be predominantly nursing. A period of crisis is a period in which the individual requires continuous care to achieve palliation or management of acute medical symptoms. 42 C.F.R. § 418.204(a)

MEDICARE HOSPICE
Four Levels of Care

3. **Respite Care** is short-term inpatient care provided to the individual only when necessary to relieve the family members or other persons caring for the individual. Respite care may be provided only on an occasional basis and may not be reimbursed for more than five consecutive days at a time. 42 C.F.R. § 418.301(b).

4. **General Inpatient** care day is a day on which an individual who has elected hospice care receives general inpatient care in an inpatient facility for pain control or acute or chronic symptom management that cannot be managed in other settings.
   42 C.F.R. § 418.302.

MEDICARE HOSPICE

- Hospice Election
  - Hospice patients waive their right to curative treatment of the terminal condition.
    - Artificial nutrition and hydration
    - End stage renal disease
    - Distrust of the medical establishment based on real and perceived discrimination
  - Need for a Signature
    - A legal representative is “an individual who has the authority under State law (whether by statute or pursuant to an appointment by the courts of the State) to authorize or terminate medical care or to elect or revoke the election of hospice care on behalf of a terminally ill patient who is mentally or physically incapacitated. This may include a legal guardian.” 42 C.F.R. § 418.3
    - Only a small percentage of the American population engages in healthcare planning.

Programs of All-inclusive Care for the Elderly (PACE)

- 71 Fed. Reg. 71244 (Dec. 8, 2006) ,42 CFR Parts 460, 462, 466, 473, and 476, et al. http://www.cms.hhs.gov/PACE/Downloads/pacereg.pdf
- 42 U.S.C. 1395eee .

Programs of All-inclusive Care for the Elderly (PACE)

- PACE uses an interdisciplinary team of professionals to coordinate and provide services.
- PACE provides all the care and services covered by Medicare and Medicaid
- PACE provides coverage for prescription drugs, doctor care, transportation, home care, check ups, hospital visits, and nursing home stays whenever necessary.

Programs of All-inclusive Care for the Elderly (PACE)

- QUALIFICATIONS to join PACE:
  - 55 years old or older.
  - **Live** in the service area of a PACE organization.
  - **Certified** by the state in which you live as meeting the need for a nursing home level of care
  - Are able to live safely in the community with the help of PACE services.
  - Participants can leave a PACE program at any time.

Programs of All-inclusive Care for the Elderly (PACE)

PACE services include:

- Adult Day Care •Recreational therapy •Meals •Dentistry •Nutritional Counseling •Social Services •Laboratory / X-ray Services • Social Work Counseling •Transportation

- PACE also includes all other services determined necessary by your team of healthcare professionals to improve and maintain your overall health.

- Primary Care (including doctor and nursing services) • Hospital Care • Medical Specialty Services • Prescription Drugs • Nursing Home Care • Emergency Services • Home Care • Physical therapy • Occupational therapy

Programs of All-inclusive Care for the Elderly (PACE)

- PACE Covers Prescription Drugs
- PACE organizations offer Medicare Part D prescription drug coverage. Through PACE program, one gets Part D-covered drugs and all other necessary medication from the PACE program.

Programs of All-inclusive Care for the Elderly (PACE)

- **Information about PACE :**
- www.npaonline.org (the National PACE Association
- www.medicare.gov/Nursing/Alternatives/PACE.asp
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- PACE Provider Organizations list: http://www.cms.hhs.gov/PACE/LPPO/list.asp#TopOfPage

Medicare Special Needs Plans (SNPs)

- Medicare **S**pecial **N**eeds **P**lans (SNPs)

42 USC 1395w-28(b)(6); 42 CFR 422.52

  - A type of Medicare Advantage (MA) Plan (Medicare Part C) tailored for people with certain chronic diseases and conditions, or who have special needs, including people who have both Medicare and Medicaid, or people who live in certain institutions such as nursing homes.
  - SNPs provide all Medicare Part A (Hospital Insurance), Medicare Part B (Medical Insurance) services, and Medicare prescription drug coverage (Part D).

Medicare Special Needs Plans (SNPs)

Restricting Enrollment. An SNP must restrict future enrollment to only special needs individuals as established under §422.2.

Exceptions. As specified in §422.4, CMS may designate certain MA plans that disproportionately serve special needs individuals, as defined in §422.2 as SNPs.

Individuals already enrolled in an MA plan that CMS subsequently designates as an SNP may continue to be enrolled in the plan and may not be involuntarily dis-enrolled because they do not meet the definition of special needs individuals in §422.2.

Medicare Special Needs Plans (SNPs)

Medicare SNPs, approved by CMS and run by private companies, are to provide all Medicare hospital and medical health care services through the SNF, including Medicare prescription drug coverage.

- Medicare SNPs are to manage the services and providers that patients need, and to help members get assistance from community resources, and coordinate Medicare and Medicaid services.

- In a Medicare SNP, members see providers in the plan, go to certain hospitals for covered services. The Medicare SNP will still provide coverage for emergency or urgently needed care, even if out of the plan's service area. The plan may also require referrals to see specialists.

Medicare Special Needs Plans (SNPs)

If you join a Medicare SNP and you move out of your plan's service area, you can switch plans when you move, or you will automatically be returned to Original Medicare.

If you belong to a Medicare SNP that leaves the Medicare Program, you can switch plans when your Medicare SNP notifies you that it is leaving the Medicare Program.

If you are involuntarily dis-enrolled from your Medicare SNP, you have 3 months to join a new Medicare SNP, or a Medicare health or drug plan, starting from the time your plan notifies you that your Medicare SNP coverage ends.

Medicaid Home and Community-Based Services (HCBS) Waivers

- Designed explicitly as alternative to nursing facility care.
  - Beneficiary must have care needs that would warrant nursing facility care.
  - Medicaid-funded expenses must not exceed those that would have been incurred had the beneficiary received care in a nursing facility.

Broad Package of Services

- Case management
- Home health aide services
- Personal care services
- Respite care
- Adult day health
- Environmental accessibility adaptations
- Private duty nursing

Services (cont.)

- Transportation
- Specialized medical equipment and supplies
- Chore services
- Personal Emergency Response Systems
- Adult Residential Care (e.g., assisted living)
- Extended State plan services (e.g., therapy, medication)

HCBS Care Has More Uncertainties Than Nursing Facility Care

- Negligible quality of care standards.
- Housing costs not covered by Medicaid.
  - Minimal allocations for housing costs.