Frequently Asked Questions about the "Home Health Independence" Demonstration

Category	QUESTION	ANSWER
Demo Structure	How long will the Home Health Independence Demonstration operate?	The Home Health Independence Demonstration is scheduled to operate from October 4, 2004, through October 3, 2006.
Demo Structure	In which states are Medicare beneficiaries eligible for participation in the Home Health Independence Demonstration?	Beneficiaries in Colorado, Massachusetts, and Missouri can potentially participate in the demonstration.
Demo Structure	Will beneficiary eligibility (in terms of the three states) be determined based on location of service or on the beneficiary residence information on record with Medicare?	Demonstration eligibility is based on location of service in Colorado, Massachusetts, or Missouri.
Demo Structure	How will the 15,000 beneficiary "cap" on the demonstration be administered?	The cap is being interpreted as a count of beneficiaries who actually use the demonstration benefit - i.e., those who leave home more frequently than would be allowed under the current eligibility rules. The incidence of these beneficiaries in the enrolled demonstration population will be estimated by the evaluation contractor based on data collection from a sample of enrollees. The support contractor will apply this proportion to the entire "ever-enrolled" population to estimate the number that should be counted against the 15,000 cap.
Demo Structure	Will the 15,000 beneficiary "cap" be applied as 5,000 participants per state or 15,000 overall?	The 15,000 beneficiary cap will be applied across all three states, not 5,000 per state.
Eligibility	What are the requirements to be eligible for participation in the Home Health Independence Demonstration?	A patient must meet all of the following conditions: a) Meet ALL of the eligibility criteria for Medicare home health care except the customary homebound requirements related

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		to frequency and duration of absences from home (though leaving home must require "considerable and taxing effort) and b) Be enrolled in Medicare Part B; and c) Be receiving home health services through "traditional" fee-for-service Medicare, not an HMO or hospice; and d) Meet all the eligibility requirements set forth in the legislation: (1) The beneficiary has been certified by one physician as an individual who has a permanent and severe, disabling condition that is not expected to improve; (2) The beneficiary is dependent upon assistance from another individual with at least 3 out of the 5 activities of daily living (eating, toileting, transferring, bathing, and dressing) for the rest of the beneficiary's life; (3) The beneficiary requires skilled nursing services for the rest of the beneficiary's life and the skilled nursing is more than medication management; (4) An attendant is required to visit the beneficiary on a daily basis to monitor and treat the beneficiary's medical condition or to assist the beneficiary with activities of daily living; (5) The beneficiary requires technological assistance or the assistance of another person to leave the home; and (6) The beneficiary does not regularly work in a paid position full-time or part-time outside the home.

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Eligibility	If a Medicare beneficiary has previously been denied home health care, is s/he eligible to participate in the Home Health Independence Demonstration?	If the beneficiary has been denied Medicare home health care solely because of absences from the home, and s/he meets the other qualifications for Medicare home health care and all the eligibility criteria for the demonstration, s/he would be eligible to participate.
Eligibility	To meet conditions 2, 3, 4, and 5 which describe the beneficiary's requirements for assistance, must the beneficiary be currently receiving assistance at this level or only be assessed as needing it for optimal functioning and safety?	To meet conditions 2, 3, 4, and 5 , the beneficiary must be assessed as *requiring* the stated levels of assistance for safety and optimal function. The beneficiary need not be currently *receiving* this level of service.
Eligibility	If a demonstration patient frequently leaves his/her home, will s/he lose his/her home health care?	No, if the Medicare patient meets all of the criteria for enrollment under the demonstration (including the general Medicare home health eligibility requirement that leaving home requires considerable and taxing effort) s/he will be deemed homebound without regard to purpose, frequency, or duration of absences from the home.
Eligibility	What is the definition of "technological assistance?"	"Technological assistance" is defined as use of any device, including a cane or walker.
Eligibility	If a Medicare patient receives assistance with activities of daily living (ADLs) from family members, does s/he still qualify for the demonstration?	Yes, a family member or a friend may be counted as the "attendant" mentioned in the demonstration eligibility criteria. If the beneficiary meets this (as well as all the other eligibility criteria), s/he would be eligible for the demonstration.

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Eligibility	Is a Medicare patient enrolled in the Home Health Independence Demonstration allowed to attend adult day care?	Under the demonstration, a patient will be able to attend adult day care for non-medical services. Under the current rules, the patient may already make frequent visits to adult day care center, if the purpose is to receive medical or psychosocial care.
Eligibility	Will dual-eligible patients (those enrolled in both Medicare and Medicaid) be included in the demonstration?	A dual-eligible patient meeting all of the demonstration eligibility criteria (as well all Medicare home health eligibility criteria except those related to absences from the home) is eligible to participate if Medicare is the primary payer for the home health episode.
Eligibility	The law says, "the beneficiary does not regularly work in a paid position full-time or part-time outside the home." How is "regularly" defined?	Regular employment is "work on a recurring basis performed for remuneration." The work need not be every day or the same number of hours each time to be considered "regular".

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Eligibility	If demonstration eligibility requires that a patient must need skilled nursing care for the rest of his/her life and daily visits to help with activities of daily living (ADLs) and monitoring a medical condition - how can the patient meet the part time/intermittency service criteria for Medicare home health?	The Medicare home health eligibility requirement for intermittency of skilled nursing services is met if the skilled nursing services are provided or needed on fewer than seven days per week OR less than 8 hours per day; demonstration eligibility requires a permanent need for skilled nursing services, but not necessarily every day. Home health coverage guidelines require that skilled nursing and home health aide hours together cannot total more than 8 hours per day or 28 hours per week; demonstration eligibility requires daily visits from an attendant (who could be a home health aide) but not any minimum number of hours of care per day or per week that would exceed the Medicare coverage guidelines. Therefore, a beneficiary would be eligible for both Medicare home health services and for the Home Health Independence demonstration if: > s/he needs skilled nursing visits for the rest of her life - but not daily; > s/he needs daily visits for the rest of her life - but not skilled nursing; > s/he needs less than 8 hours of care per day and less than 28 total hours per week (or 35 hours, subject to case-by-case review); > s/he needs help with at least 3 of the 5 activities of daily living (ADLs) listed in the legislation now, and will need such help for the rest of her life; and > s/he meets all the other eligibility criteria

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Eligibility	Does work in a “sheltered workshop” count as “work outside the home” for the purpose of determining demonstration eligibility?	Daily or regularly scheduled work for pay in a sheltered workshop would disqualify the beneficiary from demonstration eligibility.
Enrollment	Can a home health agency participate in the demonstration for some of a single patient's episodes but not for others?	While an agency's demonstration participation for an individual patient on service can theoretically change from episode to episode if the agency ceases participation in the demonstration, patient management will be greatly simplified if a beneficiary who qualifies for the demonstration and is enrolled by the HHA remains enrolled in the demonstration through any subsequent recertifications with the same agency (assuming that continue to meet both Medicare and the demonstration's eligibility and coverage criteria.)
Enrollment	How/where will the first demonstration criterion ("the beneficiary has been certified by one physician as an individual who has a permanent and severe, disabling condition that is not expected to improve") and the third demo criterion ("the beneficiary requires skilled nursing services for the rest of the beneficiary’s life and the skilled nursing is more than medication management") be documented?	The home health agency should include the wording similar to the "Physician Certification of Eligibility for the Home Health Independence Demonstration" (see below) in the Plan of Care for demonstration beneficiaries. The physician's signature would represent certification that the beneficiary meets the demonstration criteria, and also that the beneficiary is, therefore, deemed "homebound" though s/he may actually be leaving home. Physician Certification of Eligibility for the Home Health Independence Demonstration: Under a mandate created by section 702 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (now more commonly referred to as the Medicare Modernization Act of 2003 (MMA)), the Centers for Medicare & Medicaid Services (CMS) is conducting the “Home Health Independence Demonstration” under which Medicare

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		beneficiaries with chronic conditions" (as described below) "are deemed to be homebound for purposes of receiving home health services under the Medicare program." I certify that in addition to meeting all of the eligibility criteria for Medicare home health services (other than confinement to the home), this beneficiary is "deemed to be homebound without regard to the purpose, frequency, or duration of absences from the home" (by meeting ALL of the criteria in section 702, specifically): (1) The beneficiary has been certified by one physician as an individual who has a permanent and severe, disabling condition that is not expected to improve; (2) The beneficiary is dependent upon assistance from another individual with at least 3 out of the 5 activities of daily living (*) for the rest of the beneficiary's life; (3) The beneficiary requires skilled nursing services for the rest of the beneficiary's life and the skilled nursing is more than medication management; (4) An attendant is required to visit the beneficiary on a daily basis to monitor and treat the beneficiary's medical condition or to assist the beneficiary with activities of daily living; (5) The beneficiary requires technological assistance or the assistance of another person to leave the home; and (6) The beneficiary does not regularly work in a paid position full-time or part-time outside the home. (*) The term ''activities of daily living'' means eating, toileting, transferring, bathing, and dressing.

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		This eligibility must be certified at the start of each episode of Medicare-covered home health care. In addition to the criteria listed above, demonstration participation is limited to Medicare beneficiaries who: > Are enrolled in Medicare Part B; > Receive their Medicare home health care in Colorado, Massachusetts, or Missouri; > Receive their Medicare home health care services during the operational period of the demonstration (October 4, 2004, through October 3, 2006); and > Do not receive their home health services through an HMO or Medicare Advantage plan, or through the Hospice benefit.)
Enrollment	Are home health agencies in the demonstration states required to accept demonstration patients?	Certified home health agencies in the demonstration states have the opportunity to serve demonstration patients but are not required to do so. The demonstration affords home health agencies the opportunity to provide home health care services to Medicare beneficiaries in need of home health care who otherwise would not be eligible for home health care because they would not be considered homebound.
Enrollment	Can an HHA participate in the demonstration for some patients, but not for others?	Participation in the Home Health Independence Demonstration is voluntary for home health agencies, and they will make the decision to enroll qualifying beneficiaries in the demonstration based on their situation at the time. However, agencies cannot "cherry pick" patients to admit based on perceived cost of care or other characteristics. CMS would like home health agencies who decide to participate in the demonstration to do so throughout the

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		demonstration period. However, an agency can admit demonstration patients at one point in time and choose not to admit demonstration patients at a later point in time.
Enrollment	If a beneficiary is already receiving Medicare home health services and their condition changes such that s/he becomes eligible for the Home Health Independence Demonstration, how can s/he enter the demonstration?	A patient who is already on service can enter the demonstration if (a) the patient's physician provides the certification that the beneficiary meets the demonstration eligibility criteria and (b) the home health agency places "HHDEMO" in the remarks field on the final claim for the episode (even though it was not on the Request for Anticipated Payment (RAP). The date of demonstration participation will be set to the start date of the episode (or October 4, 2004, whichever is later.)
Enrollment	What happens after a Medicare patient is referred for home health care under the Home Health Independence Demonstration?	The referral and home health enrollment process is largely the same under the Home Health Independence Demonstration as under non-demonstration home health care intake. However, after the beneficiary is identified as meeting the criteria for participation in the demonstration, the home health agency should inform the beneficiary and provide information describing the demonstration and the fact that the beneficiary can leave home more frequently than would be allowed outside the demonstration. Suggested materials for beneficiaries can be downloaded from the demonstration web site, http://www.cms.gov/researchers/demos/homehealthindependence.asp. The home health agency then submits a claim with the demonstration code ("HHDEMO"), in the remarks field, and a copy of that claim is forwarded to the support contractor,

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		which generates a letter to the beneficiary confirming that s/he may participate in the demonstration and that s/he has the opportunity to leave the home more often than would be the case outside the demonstration.
Enrollment	What should a Medicare patient do if s/he believes s/he meets the criteria to participate in the Home Health Independence Demonstration?	The beneficiary should ask his/her physician if s/he can certify that the beneficiary meets the criteria. If the beneficiary is already receiving Medicare home health services, the physician can make the certification and arrange for the home health agency to enroll the beneficiary in the demonstration, so that the beneficiary will be able to leave home more frequently without risk of losing benefits. If the beneficiary is not currently receiving Medicare home health services, the physician would need to determine that Medicare home health services are needed and appropriate as well as certifying demonstration eligibility.

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Enrollment	Does a Medicare beneficiary have to consent to participate in the demonstration before the home health agency can consider them enrolled and submit a claim with "HHDEMO" in the remarks field? How does that work?	Because participation in the demonstration is merely being identified as having increased options available while receiving home health care, beneficiary consent is not required. The home health agency is not obtaining information beyond what it would normally obtain in the course of a comprehensive assessment and development of the care plan, and by placing “HHDEMO“ on the claim, the home health agency informs Medicare that the beneficiary meets the demonstration eligibility criteria. It does not place any requirement on the beneficiary to do anything s/he would not do in the absence of the demonstration. The beneficiary may eventually be contacted by the evaluation contractor and asked to participate in an interview to discuss his/her experiences; this will be voluntary and the beneficiary will be asked for consent at that time. This type of data collection is similar to activities that are already conducted by Medicare, such as the Medicare Current Beneficiary Survey (MCBS). While it will be suggested that the patient consider keeping a record of absences from the home to help facilitate the (optional) interview for the evaluation, this is not required.
Beneficiary Activities	If a patient is enrolled in the Home Health Independence Demonstration, what will s/he have to do to for the demonstration?	The evaluation contractor may contact the patient during and after the Home Health Independence Demonstration and request an interview, which the beneficiary can accept or decline. It will be suggested that the patient consider keeping a record of absences from the home to help facilitate the (optional) interview for the evaluation, but this is not required.

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Category	QUESTION	ANSWER
Leaving the Demonstration	If a beneficiary is a participant in the Home Health Independence Demonstration and the demonstration ends, is there a danger of them no longer being considered homebound?	During the demonstration, beneficiaries must meet ALL criteria for home health eligibility EXCEPT that absences from home are not restricted to being "infrequent and of short duration." The beneficiary must have functional limitations that make it impossible to leave home without "considerable and taxing effort." According to the Home Health Agency Manual: "Generally speaking, a patient will be considered to be homebound if s/he has a condition due to an illness or injury that restricts his/her ability to leave his/her place of residence except with the aid of supportive devices such as crutches, canes, wheelchairs, and walkers, the use of special transportation, or the assistance of another person or if leaving home is medically contraindicated." "After the demonstration, if the patient meets all of the Medicare home health eligibility requirements, including being confined to the home as defined in 1814(a)(2), s/he would presumably be considered homebound and eligible for home health services. Home health agencies are NOT to consider the beneficiary's pattern of absences from the home during their participation in the demonstration when making a determination of eligibility for post-demonstration home health care. If the beneficiary continues to leave home more frequently than allowed under non-demonstration Medicare guidelines, s/he would not be considered homebound and would not be eligible for Medicare home health care.

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Leaving the Demonstration	What happens to a participating Medicare patient after the Home Health Independence Demonstration ends?	If a beneficiary is in the midst of a home health care episode on the demonstration's end date, s/he will be allowed to complete that episode under the demonstration rules concerning absences from home. (The episode would end when it reaches its 60th day, or earlier if there is a transfer or readmission with a partial episode payment (PEP) adjustment.) For any SUBSEQUENT episodes of Medicare home health care, the beneficiary will be subject to the "regular" (non-demonstration) eligibility criteria for Medicare home health services as related to frequency or duration of absences from home.
Leaving the Demonstration	If someone is receiving Medicare home health services and is enrolled in the Home Health Independence Demonstration and his/her condition changes such that s/he is NO LONGER eligible for the demonstration (e.g., the need for assistance in activities of daily living (ADLs) drops to 2 ADLs, or a new technology allows him/her to do without daily attendant visits), what happens?	That patient may complete the current home health care episode under the demonstration eligibility criteria for home health services (i.e., s/he would be allowed to leave home and retain Medicare home health eligibility.) The episode would end when it reaches its 60th day, or earlier if there is a transfer or readmission with a partial episode payment (PEP) adjustment. Both the initial Request for Anticipated Payment (RAP) and the final claim for that episode would show "HHDEMO" in the remarks field.
Demo Structure	Will out-of-state home health agencies which have Medicare patients in the demonstration states be able to participate in the demonstration?	Claims for Medicare beneficiaries receiving home health care in Missouri, Colorado or Massachusetts, that are submitted to any RHHI with the proper demonstration code will be recognized as demonstration claims regardless of the location of the home office of the home health agency.

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General Medicare/ Home Health	If a Medicare patient currently has home health services but has not yet been identified as meeting the criteria for the Home Health Independence Demonstration, is s/he allowed to leave home?	Under the non-demonstration criteria for Medicare home health eligibility, a beneficiary must be homebound, or normally unable to leave home unassisted. To be homebound means that leaving home takes considerable and taxing effort. A person may leave home for medical treatment or short, infrequent absences for non-medical reasons, such as a trip to the barber or to attend religious services. Once participating in the demonstration, a beneficiary may leave home more frequently and for longer periods without risking the loss of the home health benefits.
General Medicare/ Home Health	Where can I find a Medicare-approved home health agency?	A beneficiary can consult the web site: www.medicare.gov/hhcompare/home.asp or call 1-800-MEDICARE to find a Medicare-certified home health agency in the local area.
General Medicare/ Home Health	Where can a Medicare patient find information on which home health services are covered by Medicare?	A Medicare beneficiary can obtain information about covered home health services in the Medicare publication found at the following web site: http://www.medicare.gov/Publications/Pubs/pdf/10969.pdf or by calling 1-800-MEDICARE.
General Medicare/ Home Health	Where can a Medicare patient get help with home health care questions (not the Home Health Independence Demonstration)?	The beneficiary can call 1-800-MEDICARE or consult http://www.Medicare.gov to obtain answers to questions about home health care services.
General Medicare/ Home Health	What should a Medicare patient do if s/he wants to change home health agencies?	A Medicare beneficiary can ask his/her physician for a referral or s/he can look at Medicare's "Home Health Compare" web site at http://www.medicare.gov OR s/he can call 1-800-MEDICARE to find another home health agency in the local

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		area.
Data	What information will a home health agency have to provide for the demonstration?	The home health agency will submit claims to the RHHI and OASIS assessments to the state repository as usual. The only difference is that the claim will show "HHDEMO" in the remarks field (FL84). An evaluation contractor hired by Medicare may later contact the home health agency to discuss its experience screening beneficiaries for demonstration eligibility. The home health agency will be encouraged (but not required) to keep a log of the patients who meet the demonstration criteria and are enrolled, and also those meeting the criteria who, for whatever reason, were not enrolled, so that they will have data for reference during these discussions. The support contractor may at a later point request home health agencies to submit clinical records for a sample of demonstration beneficiaries and their episodes of care to provide information for the evaluation of the Home Health Independence Demonstration. These requests will likely follow the format of the Clinical Data Abstraction Center (CDAC) record requests that agencies already receive in relation to quality improvement activities by the Quality Improvement Organizations (QIOs) in each state. Agencies that submit records will be reimbursed for copying at the current rate established for CDAC record requests.

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Service Provision	If a prospective demonstration enrollee meets the demonstration eligibility criteria by being *assessed* as requiring the levels of assistance described in conditions 2, 3, 4, and 5 in section 702 but is not currently receiving these services, is the home health agency required to provide the required assistance?	Development of the care plan would proceed exactly as it currently does. The demonstration modifies only the "homebound" eligibility criterion for home health as far as absences from the home are concerned; the home health agency's process for developing the care plan is not affected. Under the Conditions of Participation, an agency must provide the services ordered by the physician, and the agency should accept a patient only if there is a reasonable expectation that it can provide all of the services that the patient needs (unless the patient specifically declines the services).
Coordination	Will the HMOs and insurance companies need to know that Medicare coverage should be applied to demonstration patients, when Medicare would normally deny coverage under the current definition of homebound?	In some cases, the change in eligibility for Medicare home health services may be important to other payors as it affects coordination of benefits. Of course, they would need to know not only that the beneficiary qualifies for the demonstration but also that a home health agency has formally identified the patient as a demonstration eligible by submitting a claim with "HHDEMO" in the remarks field. Once beneficiaries are participating in the demonstration and receiving Medicare home health services, other insurers would treat them the same as any other beneficiaries receiving Medicare home health services. (It should be noted that beneficiaries enrolled in HMOs/Medicare Advantage plans are not eligible for participation in the demonstration.)
Operations	What should a Medicare patient do if s/he has questions regarding the demonstration?	We have posted a list of Frequently-Asked Questions (FAQ) on the demonstration web site: http://www.cms.gov/researchers/demos/homehealthindependence.asp

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		A patient can also call 1-800-MEDICARE with general questions about the demonstration. Providers can call 1-888-443-3665 (1-888-HHDEMO-5) with specific questions.
Operations	Will there be any adjustment to home health agency payments to reflect the possibly heavy service needs of demonstration participants?	The legislation does not provide for any special adjustment to home health agency payments.
Operations	How will a home health agency avoid being cited by survey/certification surveyors (or private accreditation agencies, such as JCAHO or CHAP) for providing services to beneficiaries who leave home?	Survey agencies in the participating states have been apprised of the demonstration criteria and will not expect demonstration beneficiaries to meet customary "homebound" criteria related to absences from home. State surveyors will NOT be reviewing medical records for demonstration beneficiaries to validate demonstration eligibility based on the legislative criteria..
Operations	Will the home health agency be "second guessed" by Medicare after identifying the patient as a demonstration candidate?	Neither the RHHI medical review staff nor state survey staff will review demonstration cases for demonstration eligibility. Private accreditation organizations have also been informed about of the demonstration and possible changes in patient mix and home health eligibility at agencies in the three demonstration states. If a beneficiary is found at reassessment to be ineligible for the demonstration and, therefore, found to be ineligible for Medicare home health services due to frequency /duration of absences from the home, and the beneficiary disagrees, the beneficiary may request that the home health agency submit a “demand bill.” In this situation only, the RHHI medical review staff would review the case to determine if the beneficiary

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		appears to meet the criteria for Medicare home health eligibility AND the criteria for demonstration eligibility.
Operations	Would an ABN be required if the agency decides to discharge a patient from Medicare home health services because it decides to stop participating in the demonstration and the beneficiary does not qualify for Medicare home health services? Can the patient request that a demand bill be submitted?	Since the patient would be discharged from Medicare home health services, a notice to the beneficiary would be required. However, no demand bill can be submitted based on an agency discontinuing its participation in the demonstration because no coverage or eligibility determination is at issue. Note that to be eligible for the demonstration, the beneficiary must meet ALL of the eligibility and coverage criteria for the Medicare home health care benefit with the sole exception of the frequency, duration, and purpose of absences from the home. Therefore, if nothing affecting his/her eligibility and coverage has changed and the beneficiary is prepared to limit his/her absences from home, s/he would presumably be eligible for non-demonstration Medicare home health care. If the beneficiary feels that s/he is eligible to receive non-demonstration Medicare home health care (i.e., s/he still meets all the Medicare criteria and is prepared to limit absences from home) but the HHA disagrees, a demand bill could be requested by the beneficiary. Note that an agency MAY NOT use a beneficiary's pattern of absences from the home while s/he was enrolled in the demonstration as evidence of failure to meet the customary "homebound" criteria once s/he is no longer enrolled.

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Operations	If an agency realizes that it has erroneously submitted a claim identifying the wrong beneficiary as meeting the demonstration eligibility criteria, what should it do?	The agency should do three things. 1) Submit a cancellation claim (still with "HHDEMO" in the "Remarks" field) and submit a replacement claim WITHOUT "HHDEMO" in the “Remarks” field. 2) Since the initial claim submission may already have triggered a letter to be sent to the beneficiary confirming their enrollment in the demonstration, the agency must provide a written notification to the beneficiary that (a) s/he was erroneously reported to be eligible for the demonstration and may, therefore, receive a letter to that effect from "Medicare" (the support contractor) but (b) s/he is NOT in fact part of the demonstration and must conform to Medicare's usual eligibility criteria regarding absences from home. 3) The home health agency should send a copy of the notification to the support contractor so that the beneficiary can be identified in (and deleted from) the support contractor's database. The notification should include: > home health agency provider number > home health agency name > beneficiary HIC number > beneficiary last name > from-date of episode and should be sent to the support contractor at: Home Health Independence Demonstration Abt Associates Inc.

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		55 Wheeler Street Cambridge, MA 02138 This beneficiary episode will be dropped from the participant database and the beneficiary will not be contacted for future data collection by the evaluation contractor.