MLN Matters® — Information for Medicare Fee-For-Service Health Care Professionals

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MMA - Demonstration Project to Clarify the Definition of Homebound

Note: This article was updated on May 9, 2013, to reflect current Web addresses. All other information remains unchanged.

Provider Types Affected

Home health agencies (HHAs)

Provider Action Needed

This article is chiefly informational but may be of particular interest to (HHAs) that serve beneficiaries taking part in the demonstration effort.

Background

In accordance with Section 702 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (also known as the Medicare Modernization Act, or MMA), the Centers for Medicare & Medicaid Services (CMS) will be conducting a two-year demonstration in Massachusetts, Missouri, and Colorado. The demonstration will be commonly referred to as the Homebound Demonstration.

The purpose of the demonstration is to study the efficacy and cost of providing home health services to Medicare beneficiaries with chronic conditions of a specific nature who otherwise would not be deemed homebound under the Medicare program. HHAs can identify a patient as a demonstration candidate between the period of October 4, 2004 and October 5, 2006.

Eligibility

Treatment under this demonstration program is limited to no more than 15,000 beneficiaries. Beneficiaries eligible for this demonstration are those with

permanent, severe disabilities who need assistance on a continuing basis with three of five Activities of Daily Living (ADLs), permanent skilled nursing care, and daily attendant visits to monitor, treat, or provide ADL assistance. Beneficiaries must also require technological or personal assistance to leave home, and may not be working outside the home.

The business requirements specified in this CR apply only to the Medicare home health benefit and only affect those Regional Home Health Intermediaries (RHHIs) providing payments to HHAs serving Medicare patients within the states covered under the demonstration. In addition, implementation of this demonstration will not require any changes in payments or payment processing under the Home Health Prospective Payment System.

Additional Information

Eligibility for Consideration as Homebound

Upon implementation of the demonstration, providers will be informed that, for the duration of the demonstration in their state, a Medicare patient will be eligible to be considered homebound, without regard to the purpose, frequency, or duration of absences from the home, if the Medicare patient meets all of the following conditions:

- Is certified by one physician as an individual with a permanent and severe, disabling condition that is not expected to improve;
- Is dependent upon assistance from another individual with at least three out of the five ADLs specified in the act (eating, toileting, transferring, bathing, and dressing) for the rest of the beneficiary's life;
- Requires skilled nursing services for the rest of his or her life, and the skilled nursing is more than medication management;
- Requires an attendant to visit on a daily basis to monitor and treat a medical condition or to assist the beneficiary with ADLs;
- Requires technological assistance or the assistance of another person to leave the home; and
- Does not regularly work in a paid position full-time or part-time outside the home.

If a Medicare beneficiary meets these conditions during the demonstration period, providers may refer/enroll this patient for home care whether or not the patient meets the homebound definition.

Enrollment

At enrollment, if the HHA or physician believes that the patient meets the criteria for a demonstration patient, the physician, in signing the Plan of Care (POC), will indicate in the open text remark section that he or she certifies that the patient has a severe and permanent condition and satisfies the requirements of the demonstration.

The HHA and/or physician will enroll and provide services to the patient, inform the patient that he or she is being admitted under a demonstration project of limited duration, and specify the parameters that allow more freedom to leave the home.

The HHA will inform the patient that he or she may take advantage of the more liberal homebound policy only during the demonstration period.

Under the demonstration, the HHA will be encouraged to keep a log of the patients who meet the criteria and were enrolled, and also those who meet the criteria who, for whatever reason, were not enrolled.

Request for Anticipated Payment

For each identified demonstration patient, the HHA will submit to the RHHI a Request for Anticipated Payment (RAP) entering a special code of "HHDEMO" in the remarks field of the claim identifying the patient as part of the demonstration. The HHA will place the same code of "HHDEMO" in the remarks field on any interim claim and end-of-episode claim for that patient as long as the patient meets the demonstration criteria. The HHA will process the RAP and subsequent end-of-episode claim(s) in accordance with standard Medicare claims processing rules.

The RHHI will receive and process the RAP and subsequent claims for payment in accordance with standard Medicare rules. The claim is transmitted to Medicare's Fiscal Intermediary Standard System (FISS), which provides pertinent feedback to the RHHI.

Weekly File

For each identified demonstration patient, the RHHI or FISS will provide the following information on a weekly basis to a designated file address at the CMS data center:

- Home health agency provider number;
- Home health agency location;
- Patient name;
- Medicare health insurance identification number with alphanumeric suffix; and
- Patient address.

Each new weekly file will be appended to the existing file to create a cumulative file on all beneficiaries served under the demonstration.

CMS Demonstration Support Contractor

A CMS Demonstration Support Contractor will access the designated CMS data center file on a regular basis to access information on new demonstration patients. The Support Contractor will notify the patient that he or she has been identified as meeting the requirements of the demonstration, and advise the patient of the opportunity during the demonstration period to leave home frequently and for longer duration than normally allowed while receiving home care under Medicare.

The patient will be encouraged to take advantage of this opportunity and informed that taking advantage of the opportunity will not affect his or her Medicare benefits. The patient will be asked to keep a log of absences from home for the purpose of the evaluation of the demonstration and will be told that he or she may be contacted by the evaluation contractor. The patient will be provided with a toll-free number to answer questions about the demonstration.

After the patient is discharged from home care, the Support Contractor will contact the HHA to request a copy of the plan of care and medical record for each patient. Depending on the evaluation design and number of patients entering the demonstration, the number of records requested may be limited to a number below the 15,000 maximum.

The Support Contractor will monitor enrollment of demonstration patients across the three designated states and will inform CMS when the number of patients nears 15,000. At this point, CMS will inform providers and RHHIs of the cessation of enrollment under the demonstration, if it is before the end of the two-year demonstration period.

The RHHI will provide notification to HHAs in the three states of the cessation of enrollment under the demonstration at the end of the demonstration treatment period, which will be the earlier of the following:

- Notification that the 15,000 enrollment limit has been reached;
- Two years after the start of the demonstration; or
- Such other date as provided by CMS.

Beneficiaries enrolled into the demonstration within 60 days of the 2-year end date of the demonstration (October 5, 2006) will be allowed to continue under the demonstration until the end of that 60-day episode of care.

When informed that the demonstration is complete, RHHIs will no longer identify patients and tag claims with “HHDEMO” in the remarks field as described above.

The official instruction issued to your RHHI carrier regarding this change may be found by going to *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R3DEMO.pdf* on the CMS website.