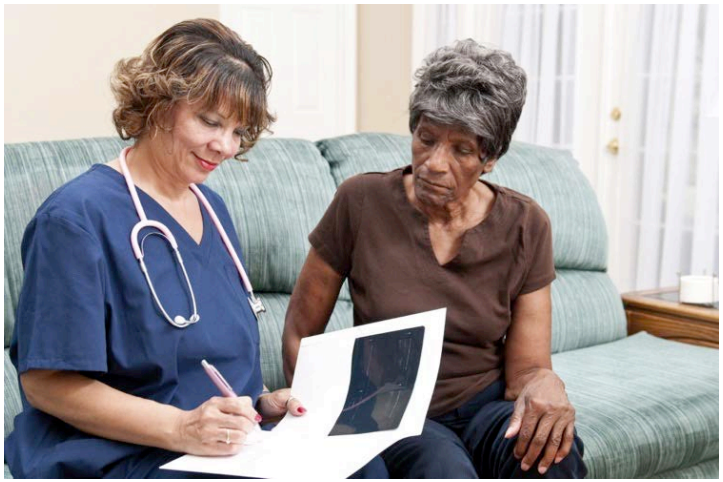
Interprofessional Geriatrics Training Program

Community Services for the Older Adult: Access and Payment Systems



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Introduction

Introduction

- The purpose of this module is to inform health care providers serving older adults with complex needs about the services available to support them living at home or in independent housing with adequate support services
- While most people prefer to live their final years in the familiar setting of their homes with their families and in their communities, most state and federal funding has been directed to caring for people in institutions: generally, for this population, facilities licensed as nursing homes
- This module examines the types of home- and community-based services available and how to access those services on their behalf

Learning Objectives

Upon completion of this module, learners will be able to:

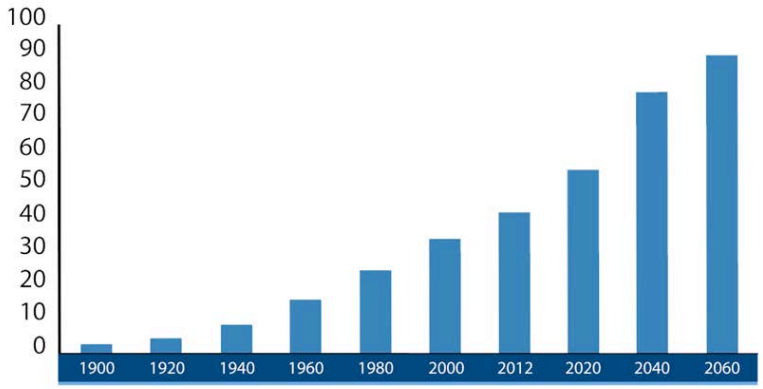
1. Identify national programs that support older adults in the community
2. Describe the overall system of care available through federal and state programs and how older adults and their families can access those programs locally
3. Discuss variations in long-term supports and services and how they are financed

Role of the Health Care Provider

The Aging Population

- With the large number of older adults aging into their 80s, 90s, and beyond, and the percentage of the older adult population increasing rapidly, health care providers will see more of them in their practices

NUMBER OF PERSONS 65+ (NUMBERS IN MILLIONS)



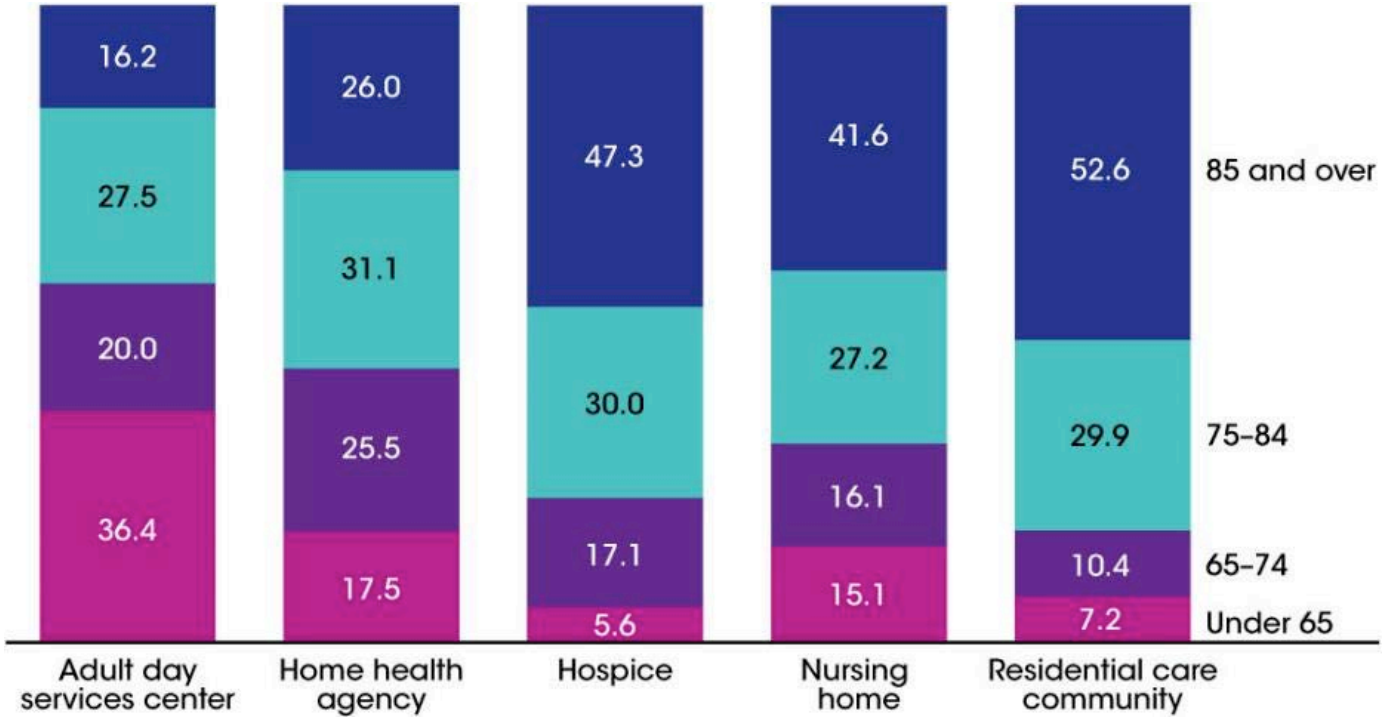
Adapted from U.S. Census Bureau, Decennial Census, Population Estimate and Projection
These 2010-2060 are projections of the resident population

(Administration for Community Living, 2014)

Providing Care to the Aging Population

- The costs to care for these large numbers of older adults in nursing homes would be unaffordable for society
- Americans prefer to live as long as possible in their own homes, with their families and friends nearby (for more information, view the "Community-Based Interprofessional Home Care of the Older Adult" module)
- Providers need to know how to help these patients find the appropriate services and supports when patients need assistance to continue living independently
- Additionally, we need to support their family and friends in informal caregiving networks

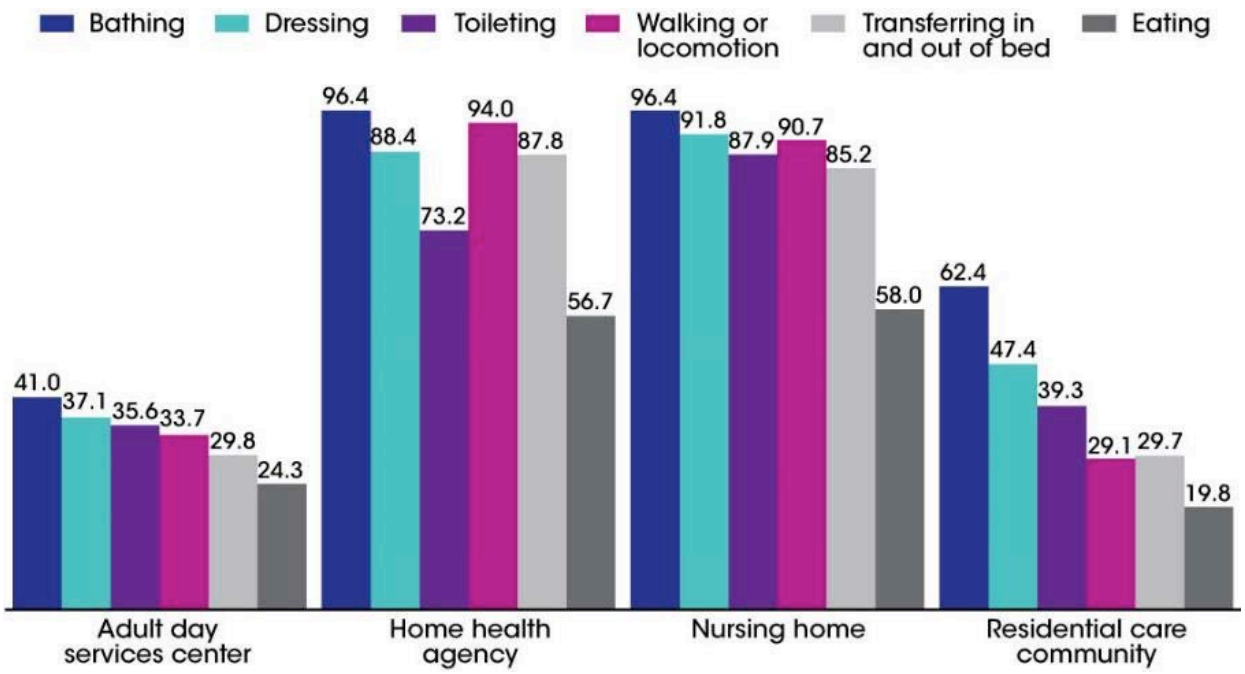
Percent Distribution of Long-Term Care Services Users, by Sector and Age Group: United States, 2013 and 2014



Data source reprinted: CDC/NCHS, National Survey of Long-Term Care Providers, 2013-2014

(Harris-Kojetin et al., 2013, p. 36)

Percentage of Long-Term Care Services Users Needing Any Assistance with Activities of Daily Living, by Sector and Activity: United States, 2013 and 2014

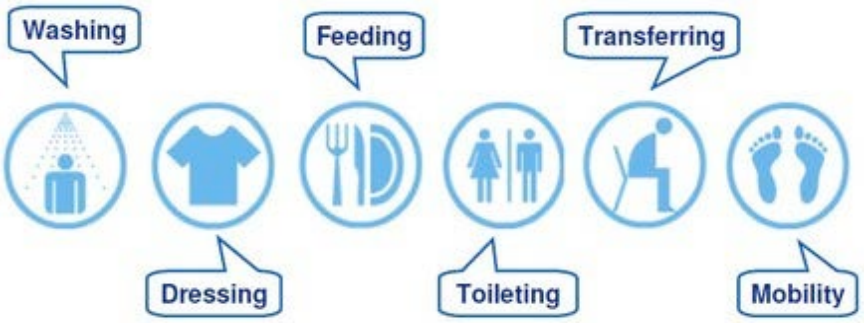


Data source reprinted: CDC/NCHS, National Survey of Long-Term Care Providers, 2013-2014

(Harris-Kojetin et al., 2013, p. 36)

Long-Term Care Support Services: Activities of Daily Living

- Most of us will experience declining health as we age and will lose sensory and physical capabilities necessary to live independently
- Specifically, the long-term services and supports (LTSS) field has identified six functions essential for living independently
- These "Activities of Daily Living" (ADLs) include: feeding, bathing, dressing, grooming, toileting and continence, and mobility



Instrumental Activities of Daily Living

- LTSS may also be needed by older adults who need assistance with what are called "Instrumental Activities of Daily Living" (IADLs):
  - Housework
  - Preparing meals
  - Taking medications as prescribed
  - Managing money
  - Shopping for groceries or clothing
  - Errands
  - Use of telephone or other form of communication
  - Transportation within the community

(Centers for Medicare & Medicaid Services, n.d.)

Providing ADL and IADL Services

- A patient with significant limitations in any of these areas will need supports and services to compensate for their individual deficiencies
- Some services may be available from family members, some from friends and neighbors
- Others will have to be purchased from private individuals or for-profit or not-for-profit service providers

Funding Questions

- Before helping, the provider may want to know how the family will pay for any needed long-term supports and services
  - Is it going to be an out-of-pocket expense?
  - Is the patient eligible for Medicare with its limited coverage?
  - Or Medicaid, whose benefits and income and asset eligibility criteria vary from state to state?

(Medicare.gov, n.d.)

Medicare

- Covers cost of skilled home health services under Part B as a temporary benefit
- Skilled services limited to nursing, physical therapy, occupational therapy, speech therapy, and home health aide support
- Generally only covered by Medicare for a limited time
- Intended for individuals recuperating from an acute problem, such as a stroke, and who need those services to regain their previous level of functioning
- Ordered by qualified provider documenting Medicare home health requirements
- Home health agencies providing services are certified by Medicare and licensed by the state

Provider Reimbursement

- Centers for Medicare and Medicaid Services (CMS) recognizes the role of providers in assisting with care needs at home
- Acknowledges care management as critical component of primary care
- January 2015: Medicare pays separately under the Medicare Physician Fee Schedule, Current Procedural Terminology (CPT) code 99490, for non-face-to-face care coordination services for multiple chronic conditions

(Centers for Medicare and Medicaid Services, n.d.)

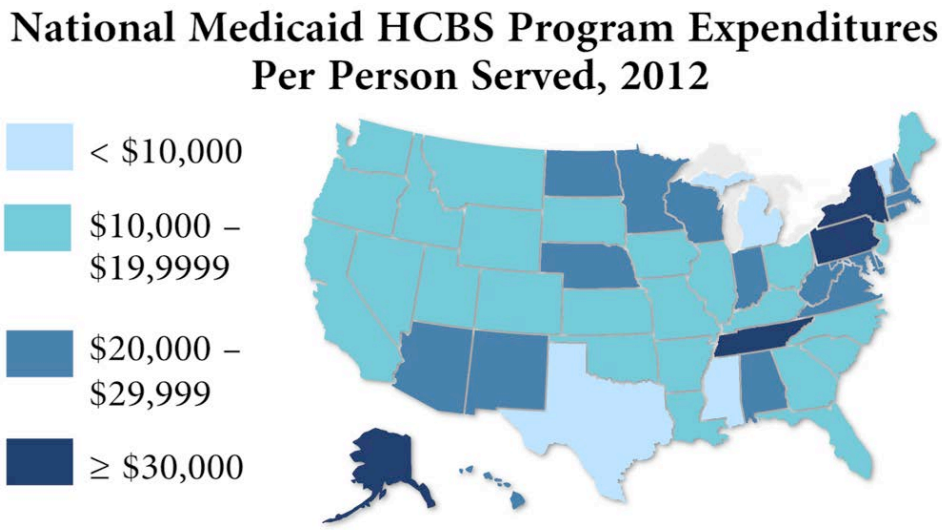
Medicare Payments for Chronic Conditions

- Alzheimer's disease
- Autism spectrum disorders
- Depression
- Cancer
- Chronic obstructive pulmonary disease (COPD)
- Asthma
- Diabetes
- Heart disease (heart failure, hypertension, atrial fibrillation, ischemic disease)
- Arthritis (OA, RA)
- Osteoporosis

(Centers for Medicare & Medicaid Services, n.d.)

State Medicaid Home and Community-Based Services Spending

- Unfortunately, there is no national program that pays for all of these services
- Because many are available through a state's Medicaid waiver program, the range and amount of state support depends on the state where the patient resides



(Ng et al., 2015)

State Community-Based Services Spending

- Without several different payers, service definitions differ, as well as eligibility thresholds, both for client income and assets, but also level of need to qualify
- Difficult to find any single organization that can provide all of the services any patient might need
- Some entities, such as the federally funded and state designated Area Agency on Aging, provide information and referral assistance
- Local social service agencies provide some services
- State, county, townships, and municipalities may provide certain services to residents who meet their specific criteria
- A team of caregivers will be required to meet the patient's needs

(Ng et al., 2015)

Medicaid

- Medicaid administered by each state under terms of federal law and rules
- States pay the medical costs for eligible persons
- Federal Medicaid law established mandatory services and offers optional service
- Note: the detailed services listed on the next two slides are not included in the video narration

(Centers for Medicare & Medicaid Services, n.d.)

Medicaid

Mandatory Services	Optional Services
Inpatient hospital	Prescription drugs
Outpatient hospital	Clinic services
Early and Periodic Screening, Diagnostic and Treatment (EPSDT)	Physical therapy
Nursing facility services	Occupational therapy
Home health	Speech, hearing and language disorder
Physician	Respiratory care
Rural health clinic	Diagnostic, screening, preventive, and rehabilitative

(Centers for Medicare & Medicaid Services, n.d.)

Medicaid

Mandatory Services	Optional Services
Federally qualified health center	Podiatry
Laboratory and X-ray	Optometry
Family planning	Dental
Nurse midwife	Dentures
Certified pediatric and family nurse practitioner	Prosthetics
Freestanding birth center	Eyeglasses
Transportation to medical care	Chiropractic
Tobacco cessation counseling for pregnant women	

(Centers for Medicare & Medicaid Services, n.d.)

Medicaid

- Federal government pays as much as three-quarters costs in poorer states and one-half in wealthier states
- States must cover hospital and nursing home costs
- Personal care services are optional

Veterans' Services

- In addition to qualifying for Medicare and Medicaid, ask your patient:
  - Is he/she a veteran?
  - Do they meet the Veterans Administration criteria for services?
- They may be qualified for additional VA benefits

(U.S. Department of Veterans Affairs, n.d.-b)

- Resources:
  - Veterans benefits: http://benefits.va.gov/benefits/
  - Veterans resources (by need): http://www.dvnf.org/veterans-programs/veterans-resources/

(Disabled Veterans National Foundation, 2016)

Funding Questions

- There are many privately and publicly funded services and supports for patients for older adults:
- Long-Term Services and Supports (LTSS) are:
  - Labor-intensive
  - Last for the rest of the patient's life
  - Are very expensive

Service Payment Sources

- Cost of services may be covered by:
  - State Medicaid waiver programs (examples presented later in the presentation):
  - https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/waivers_faceted.html (Centers for Medicare & Medicaid Services, n.d.)
  - Private long-term care insurance
  - Veterans benefits:

    http://www.benefits.va.gov/persona/veteran-elderly.asp
    (U.S. Department of Veterans Affairs, n.d.-b)

Other Payment Sources

- Private pay
- Area agencies on aging
  - www.n4a.org (National Association of Area Agencies on Aging, 2016)
- State or local social service programs
- Religious support groups: church, mosque, synagogue, or other religious support groups

Assessment Question 1

Medicare Part B covers the cost of skilled home health services to qualified individuals:

a) For a limited period of time

b) For an unlimited period of time

c) Limited to skilled nursing care only

d) Limited to skilled nursing and home health aide care

Assessment Question 1: Answer

Medicare Part B covers the cost of skilled home health services to qualified individuals:

a) For a limited period of time (Correct Answer)

b) For an unlimited period of time

c) Limited to skilled nursing care only

d) Limited to skilled nursing and home health aide care

Assessment Question 2

Medicaid is a joint federal and state program which:

a) Offers the same services as Medicare, such as long-term nursing home care
b) Is available to every older adult regardless of income
c) Has mandatory services only
d) Offers benefits not normally covered by Medicare, like nursing home care and personal care services

Assessment Question 2: Answer

Medicaid is a joint federal and state program which:

a) Offers the same services as Medicare, such as long-term nursing home care

b) Is available to every older adult regardless of income

c) Has mandatory services only

d) Offers benefits not normally covered by Medicare, like nursing home care and personal care services (Correct Answer)

Determining the Care Plan

Determining the Care Plan

- The challenge is finding the right pieces of a jigsaw puzzle and arranging them so the patient and any engaged family members or close friends have a recognizable picture of the assistance needed to continue living safely at home or on their own in a facility that offers services, also called assisted living

Determining the Care Plan

- Families often play a key role in determining the care plan
- Family roles include:
  - Providing some or all of the assistance
  - Paying for it
  - Arranging and coordinating the array of service providers

Determining the Care Plan Services

- Deciding what services are needed based on:
  - Number of ADLs needing assistance
  - Intensity of that assistance
  - Determine the appropriate setting, such as home, adult day health center, assisted living facility, or nursing home
  - Two or more deficiencies in ADLs qualify older adults for certain private and public benefit programs
  - Some programs have a more extensive assessment that also takes into account the supports available from families and friends and tries to fill the gaps

Role of the Primary Care Provider (PCP)

How to Arrange for Services

- Primary care provider should:
  - Be aware of how much support is needed
  - Help the patient and family arrange for services
  - Recognize the high cost of support at home and offer assistance to help them learn what benefits for which they may qualify

Care Strategies

Care Strategies

- Provider should:
  - **Understand** how the chronic or acute condition that is being treated is impacting the patient's function and ability of the patient to perform ADLs
  - **Anticipate** the trajectory and timing of improvements and decline in functioning
  - **Engage** the patient and family with end of life planning at the earliest stage of illness and functional disability
  - **Share** appropriate information about underlying medical conditions and their impact on functional ability with caregivers
  - **Facilitate** accepting information from the care team that can influence the treatment or caregiving plans

Comprehensive Care Plan

- The federal government, the Center for Medicare and Medicaid Services (CMS), has established a CPT code 99490 for billing for case management services so that PCPs can bill for developing a care plan with a patient and family
- A comprehensive care plan for all health issues typically includes but is not limited to:
  - Problem list
  - Expected outcome and prognosis
  - Measurable treatment goals
  - Symptom management

(Centers for Medicare & Medicaid Services, n.d.)

Comprehensive Care Plan

- A comprehensive care plan for all health issues includes (continued):
  - Planned interventions and identification of the individuals responsible for each intervention
  - Services and supports to help ensure patients adhere to the medication regime prescribed by their providers through medication management
  - Community and social services to complement health care and maximize quality of life
  - A description of how services of agencies and specialists outside the practice will be directed or coordinated; schedule for periodic review and, when applicable, revision of the care plan

(Centers for Medicare & Medicaid Services, n.d.)

Comprehensive Care Plan

Resource:

- CMS Comprehensive Primary Care Fact Sheet:
  - https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus

(Centers for Medicare & Medicaid Services, n.d.)

Service Care Options:
Nursing Homes/Home and Community-Based Services (HCBS)

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Nursing Homes

- Licensed by the state and meet standards set by the state health department as well as Medicare and/or Medicaid
- Accredited by private organizations such as The Joint Commission or the National Committee for Quality Assurance (NCQA)
  - Such accreditation may also be a requirement for homes to receive patients covered by Medicaid-managed care or Medicare Advantage
- Began adapting to changing expectations from the current population of older adults and are now integrated into the caregiving process
- Services include short rehabilitation stay and residential chronic care

Evaluating Nursing Homes

- Word-of-mouth is the most common form of communication about individual nursing homes, as well as HCBS providers
  - Reflection on that person's experience
- Discussions with social workers, hospital discharge planners, the local Area Agency on Aging, or other community-based resources

Resources:

- Use the Medicare "Nursing Home Checklist" when you visit a nursing home: https://www.medicare.gov/files/nursing-home-checklist.pdf
- Find and compare nursing homes: https://www.medicare.gov/nursinghomecompare/search.html?

(Centers for Medicare & Medicaid Services, n.d.)

Paying for Nursing Home Care

- Medicare does NOT cover long-term care but covers post-acute rehab services
- Private long-term care insurance
- Private pay
  - When assets are exhausted, patient may qualify for state Medicaid

Assessment Question 3

Long-term nursing home care can be paid for by all the of the following <u>EXCEPT</u>:

a) Medicaid

b) Private long-term care insurance

c) Medicare

d) Private pay

Assessment Question 3: Answer

Long-term nursing home care can be paid for by all the of the following <u>EXCEPT</u>:

a) Medicaid

b) Private long-term care insurance

c) Medicare (Correct Answer)

d) Private pay

Home and Community-Based Services (HCBS)

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Home and Community-Based Services (HCBS)

- This phrase covers a wide variety of supports and services to assist with ADL limitations and assist older adults to continue to live in their homes
- Federal CMS pays for HCBS under the joint state-federal partnership of the Medicaid program
- CMS defines HCBS as person-centered care programs
  - Delivered in the home and community setting
  - Address the needs of persons with functional limitations and in need of assistance with activities of daily living

(Centers for Medicare & Medicaid Services, n.d.)

HCBS Populations

- HCBS “waivers” provide services to qualified Medicaid:
  - Persons with acquired or traumatic brain injury
  - Persons with HIV/AIDS
  - Persons who are aged/elderly
  - Persons with autism
  - Persons with intellectual and/or developmental disabilities
  - Persons who are medically fragile and/or technology-dependent
  - Persons with mental illness
  - Persons who are physically or otherwise disabled

(Centers for Medicare & Medicaid Services, n.d.)

Categories of Home and Community-Based Services

- Case/care management
- Personal care (i.e., assistance with ADLs)
- Nutrition
- Transportation
- Medication management
- Chores/housekeeping
- Socialization
- Money management
- Adult day services
- Rehabilitation
- Respite

HCBS: Adult Day Services, Informal Caregiving, and Formal Caregiving

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Adult Day Services (ADS)

- Bridge the gap between home services and those requiring older adult to travel to a location
- Provide safe and secure setting
- Provide services:
  - Meals
  - Medication management
  - Socialization
  - Exercise
  - Social work or nursing oversight

Paying for Adult Day Services (ADS)

- **Medicare:** Does NOT pay for any form of adult day care
- **Medicaid:** Does pay for adult day services
- Each state has several Home and Community-Based Services (HCBS) Medicaid Waivers or 1915 Waivers offered as alternatives to nursing home care
  - Help individuals remain living in their homes and communities by providing the necessary support services
    - Very often, this includes adult day care and transportation assistance to and from the community
    - Unfortunately, waivers are not entitlements, and wait lists may exist

Assessment Question 4

Home and community-based services include all of the following:

a) Case/care management

b) Dental care

c) Chores/housekeeping

d) Financial support

e) Money management services

f) Nutrition (Meals on Wheels)

g) Transportation to medical appointments

Assessment Question 4

Home and community-based services include all of the following:

a) Case/care management (Correct Answer)

b) Dental care

c) Chores/housekeeping (Correct Answer)

d) Financial support

e) Money management services (Correct Answer)

f) Nutrition (Meals on Wheels) (Correct Answer)

g) Transportation to medical appointments (Correct Answer)

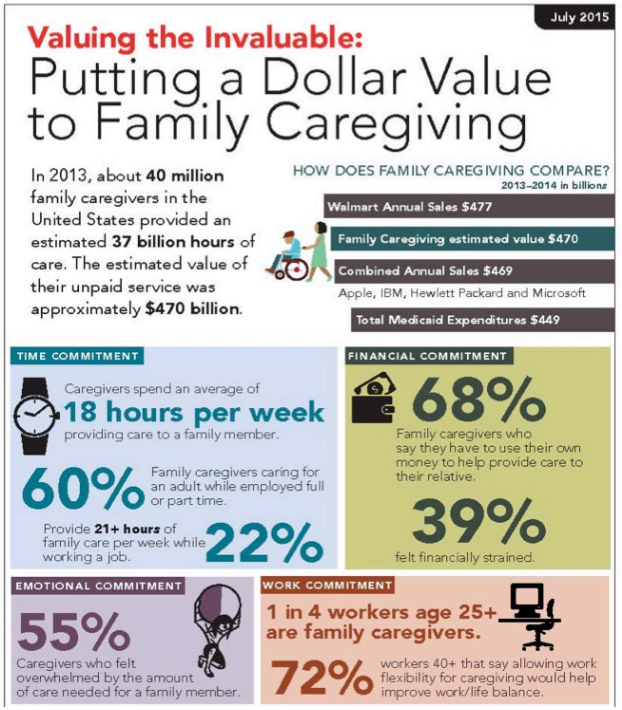
Service Care Options

Informal Caregivers

- Informal caregivers (family, friends, neighbors) provide care without compensation
- Provider should assess whether caregiver is capable
- Provider may refer patient and family to entity that can assist if informal caregiving system breaks down

Informal Caregiving

- Resources available at Family Caregiver Alliance
- https://www.caregiver.org/



(Reprinted from Reinhard, 2015)

Formal Supports and Services

In-Home Care Services and Companionship

- Enrichment activities go beyond keeping individuals safe and independent
- Medication reminders can help avoid unnecessary hospitalization

Live-In Home Care Services Customized to Meet Individual Needs

- 24-hour home care services
- Respite care and relief provides a much-needed break for family caregivers

Physical Assistance for Older Adults

- Transferring and positioning
- Mobility assistance helps individuals get out of their homes

Private Staffing Agencies

- When needs exceed what the family member(s), friends, and neighbors can accommodate, the family may look to pay others for the necessary supports and services
- While there are many service options established by state and local governments, as well as private social service agencies, most often the patient or responsible family member will assemble the resources needed on his or her own through word-of-mouth references or through a private agency

Private Staffing Agencies

Private Staffing Agency

- Higher sense of confidence about caregiver qualifications
- Screen and identify workers
- Agency paid by family; agency pays worker and manages payroll functions
- Identify and approve the qualifications of those clients interested in personal care
- Fill orders when called on
- Agency may or may not be licensed by state; quality difficult to ascertain

Home and Community-Based Service Providers
Aging Network

- Home and community-based service providers that exist specifically to serve older adults with complex needs in their homes
- Despite independent ownership, access routes, financing options, etc., these services are collectively referred to as the "aging network"
- Key element is care management
  - May also be called case management or care coordination
  - http://www.eldercare.gov/Eldercare.NET/Public/Index.aspx

(Administration on Aging, n.d.)

Home Health Service Requirements

- For a patient to be eligible to receive covered home health services under both Medicare Part A, which is hospital insurance coverage, and Part B, the law requires that a physician certify in all cases that the patient is confined to his/her home

The Following Two Criteria Must be Met:

- Criterion one – patient must either:
  - Need the aid of supportive devices, such as crutches, canes, wheelchairs, and walkers; the use of special transportation; the assistance of another person in order to leave their place of residence because of illness or injury
  - OR have a condition such that leaving his or her home is medically contraindicated
  - Must ALSO meet two additional requirements defined in Criterion Two

(Centers for Medicare & Medicaid Services, n.d.)

Home Health Service Requirements

- Criterion two:
  - Normal inability to leave home
  - AND leaving home requires a considerable and taxing effort

(Centers for Medicare & Medicaid Services, n.d.)

Home Health Service Requirements

Medicare Regulation

- Patient may leave the home and still be considered homebound if absences are infrequent, for short duration, or are attributable to the need to receive health care
- Provides specific examples of permitted absences from the home, including:
  - Therapeutic, psychosocial, or medical treatment in an adult day care program licensed or certified by a state
  - Outpatient dialysis, outpatient chemotherapy, or radiation therapy
  - Attending religious services, occasional trip to the barber, a walk around the block or a drive, attendance at a family reunion, funeral, graduation or other infrequent or unique events

(Centers for Medicare & Medicaid Services, n.d.)

Home Health Care Plan

- If a referral for Home Health is made, the home health aide (HHA) will conduct an initial comprehensive assessment
- If warranted, the HHA will determine a care plan for the 60-day eligibility period, which will be sent to the referring doctor for written approval

Home Health Care Plan

- The care plan will include:
  - Start date
  - Home care provider name, provider number
  - Diagnoses, surgical procedures, medications, allergies
  - Durable medical equipment or other supplies needed
  - Nutritional requirements, fluid needs and restrictions, parenteral or enteral nutrition
  - Safety measures, functional limitations, and activity level
  - Mental status and prognosis
  - Types of service required, measurable therapy goals, frequency and duration of visits for each home health discipline
- The ordering doctor can request certification for an additional 60-day period if the patient still has a need for skilled therapy covered by Medicare

Working with a Managed Care Organization (MCO)

- Another important consideration for the health care provider is the role a managed care organization might play for the patient
- Across the country, more than 75 percent of Medicaid clients are enrolled in a managed care plan
- In many states, however, clients who are older adults and those with disabilities may be “carved out” of the managed care program
- If the client (patient) is not enrolled in a managed care plan, then the provider should help patient pursue other Medicaid-funded services

Working with Managed Care

- If the patient (client) is enrolled in a managed care plan and the plan covers long-term services and supports, then the PCP must make sure that the MCO is aware of the patient's needs and follow their procedures for connecting managed care plan procedure for connecting him/her to appropriate service covered by the MCO
- The MCO will likely have its own care management function, but not always, called a care manager
  - Who will assess their client and determine what services and supports they are required to provide
  - This will vary from state to state; even within a state, the process can vary from MCO to MCO

Working with Managed Care: Medicare Advantage

- Medicare Advantage (MA or Medicare Part C)
  - Managed care plans for older adults and people with disabilities who qualify for Medicare
  - Will have their own care managers who are responsible for assessment and referral for covered long-term supports and services
  - Unfortunately, the extent of coverage and service options will vary among MA plans
- Among public providers, The Veterans Administration covers these services

Summary
(Included on Film Only)

Resources

http://www.acl.gov/ Accessed November 1, 2016

http://benefits.va.gov/benefits/ Accessed November 1, 2016

http://www.benefits.va.gov/persona/veteran-elderly.asp Accessed November 1, 2016

https://www.caregiver.org/ Accessed November 1, 2016

http://www.cdc.gov/nchs/nhhcs/ Accessed November 1, 2016

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