Home Services vs Home Health Care

1. Welcome

2. Housing continuum:
   - Independent
   - alternative independent
   - assisted living
   - supportive living
   - nursing home

3. Define **Home Services** (also known as custodial care, homemaker services, private duty, home care, non-medical care).

4. Define **Home Health Care** (also known as skilled home health, Medicare home health, home health).

5. Does Medicare Cover Home services?

6. What does Medicare cover?

7. How are home services paid for?

   3 ways to access privately:

   - Independently
   - Registry
   - Company who employes caregivers

   1 government program

   - Community Care Program (CCP)

Supportive Living

What is it?

1. Have you heard of the term "Assisted Living"?

2. Have you heard of the term "Supportive Living"?

3. What is the difference between the two terms?

4. When should you consider moving to a supportive living building?

5. What should you consider when moving to a supportive living building?

Resident Fact Sheet

What:	Affordable assisted living model administered by the Department of Healthcare and Family Services that offers elderly (65 and older) or persons with physical disabilities (22 and older) Home and Community-Based Services as an alternative to nursing facility placement. The goal of the program is to preserve privacy and autonomy while emphasizing health and wellness for persons who would otherwise need nursing facility care.
Who Can be a Resident:	The Supportive Living Program (SLP) is open to any resident who: undergoes pre-admission screening (individuals seeking assistance through the Medical Assistance Program must be found in need of nursing facility level of care according to screening guidelines); Be assessed to determine if functional risks and needs can be met in the SLP setting; has income no less than the current maximum allowable amount of Supplemental Security Income (SSI) (SSI amounts for 2023: $914.00 for a single person; $1,371.00 for a couple); has had a tuberculosis test that indicates the absence of active tuberculosis. The test must be in accordance with the Control of Tuberculosis Code; and is not participating in any other home and community-based services waiver.
Services:	Residents choose from the following menu of services that are provided by the facility: 1. intermittent nursing care 2. social/recreational programming 3. health promotion and exercise programs 4. medication oversight 5. ancillary services 6. 24-hour response/security 7. personal care 8. laundry 9. housekeeping 10. maintenance

	11. meals and snacks Providers must also regularly assess each resident's health status and consult with the resident on an ongoing service plan that promotes health and wellness.
Payment:	Each Medicaid-eligible resident must have income equal to or greater than the current SSI and must contribute all but $90 each month to the provider for lodging, meals and services. The $90 is to be kept by the resident as a personal allowance to use as the resident wishes. When sharing a room, a Medicaid-eligible resident is required to contribute no more than one half of the current SSI rate for a married couple minus the $90 personal allowance.
How Can I Get More Information:	Contact the Department of Healthcare and Family Services, Bureau of Long Term Care, for more information or if you have questions regarding a Supportive Living Program provider . Phone: 217-782-0545 or 844-528-8444 Fax: 217-557-5061 E-Mail: **Illinois Department of Healthcare and Family Services**
Complaint Hotline:	Complaints concerning a supportive living facility may be directed to: Complaint Hotline **1-844-528-8444** No individual participating in the Supportive Living Program (SLP) shall be discriminated against because of race, color, religion belief, political affiliation, sex, national origin or disability. No person shall be improperly excluded from or denied participation in the SLP based solely on the diagnosis of a mental illness if the State's designated screeners find the individual otherwise eligible and appropriate for services within the Program. Following completion of this screening, the SLP Providers shall individually assess each eligible applicant in order to determine whether the SLP Provider can meet the person's needs. The SLP Providers remain subject to all applicable State and Federal law, including the Americans with disabilities Act and Fair Housing Act.

Tips on Finding Appropriate Home Care

Home care agencies differ in many ways. They may be Medicare certified or non Medicare certified, they may be for profit for not-for-profit, they may be independent or affiliated with a larger agency. They differ also in the types of services they provide, how they administer their services and how they collect their fees.

When selecting an agency, it is important to clearly understand what types of services they do provide and what, if any, insurance or reimbursement they accept. Homemaker or non-skilled home care agencies, including

(SASI), provide paraprofessional home care, using experienced caregivers and certified nurses' aides.

When selecting an agency to provide care for a loved one, there are several questions you will want to ask:

1. What is the fee structure? Who do I pay for the services received? Are there extra costs? Is Medicare or private insurance accepted?
2. Is the agency for-profit or non-profit? What other services are provided for helping the older adult?
3. Is the agency bonded and insured?
4. What is the history of the agency?
5. What organizations does the agency work with?
6. How do they hire their caregivers? Do they:
   *conduct a criminal background check?
   *check references?
   *pay the employee?
   *pay the social security taxes and payroll taxes for the employee?
   *require a health screening for the employee?
7. Is a home assessment done prior to the beginning of service?
8. Can the supervisor be reached 24 hours a day?
9. Do I need to sign a contract? How soon can services begin?
10. What is the minimum length of service?
11. Will I get an opportunity to interview or meet the caregiver?
12. What if I am dissatisfied with the worker?
13. What happens if a worker is injured in my home?

(SASI) is one of the few non-profit home care providers in the community and we welcome the opportunity to provide committed care to older adults. We work with parish nurses and those that do outreach from all faiths. As a mission based non-profit provider of care, our fee structure is set to cover our costs of operation as opposed to a for-profit organization whose pricing structure needs to generate profit in order to cover owner or stock-holder profits. Please do not hesitate to call us at **(847) 864-7274** with any questions about this article or our services. Thank you.

Should you hire a private caregiver or an agency?

Hiring private caregivers may seem like a less costly alternative than using an agency, but in reality, you are putting yourself at risk. Individual employers have a number of challenges including:

Taxes The IRS states individual employers are liable for:

*Social Security taxes not paid
*Unemployment compensation taxes not paid
*Payroll taxes not withheld, including an additional tax assessment of up to 100% of the amount owed the IRS if the employer is considered to have "willfully" failed to withhold the taxes
*Interest on underpayments
*Possible civil fines of up to $100
*Possible criminal penalties, including imprisonment for up to five years

* **Worker's Compensation** Worker's Compensation is the most serious risk. If your employee strains her back while lifting, she may expect you to pay medical expenses and disability coverage.

* **Negligent Hiring** The shortage of qualified applicants and your own immediate needs may compromise your hiring procedures. Careful background checks and thorough interviews are performed by all reputable home care organizations. In addition, an outside agency can train and supervise the caregiver to ensure maximum quality standards are met.

* **General and Professional Liability** Private caregivers rarely carry general or professional liability insurance. If the caregiver fails to perform her duties adequately or if she injured at your home **you** may be the party with the major liability.

* **Insurance** Insurance protects you from theft or breakage. Without insurance, you may have limited or no protection. Bonding typically does not provide coverage for a broad array of problem situations.

Please know the risks!
Call SASI

847-864-7274

JCL

National Council on Aging

Home Health Care vs. Custodial Care

Understanding the difference and how to help your clients with Medicare

Benefits counselors often get asked whether Medicare will pay for care at home. There is a distinct difference between the skilled, intermittent care (home health care) that Medicare covers and help with household chores and custodial care that it does not, and it is important for you and your clients to understand the difference.

What is home health care?

Home health care (HHC) encompasses a wide range of services and supplies that a person receives at home under a plan of care established by a doctor. HHC can include skilled nursing and home health aide services, physical therapy, occupational therapy, speech-language pathology services, medical social services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers), medical supplies, and other services provided in the individual's home.

When does Medicare cover HHC?

There are very specific criteria for when Medicare will cover HHC services. First, the individual must be considered "homebound." The Centers for Medicare & Medicaid Services (CMS) have established the following criteria for homebound:

Criteria 1 (individual must meet <u>one</u> of these)

- A person, because of illness or injury, cannot leave home without the assistance of another person, use of special transportation, or supportive device (e.g., wheelchair, cane) OR
- The person has a condition such that leaving home is medically contraindicated (i.e., medically advised against).

Criteria 2 (must meet <u>all</u> of these in addition to one of the Criteria 1 points above)

- There must exist a normal inability to leave home, AND
- It must require a considerable and taxing effort to leave home.

Note: Homebound individuals may leave the home infrequently or for relatively short periods of time, including to attend adult day care or to receive other health care treatment. In addition, they may leave the home for non-medical purposes, for example, to go to the barber or attend religious services.

The individual must also:

- Be under the care of a doctor (or nurse practitioner working with the doctor), who completes and documents a face-to-face visit with the beneficiary up to three months before the start of HHC or within one month after the HHC benefit has begun.
- Need skilled care on a part-time or intermittent basis from a registered nurse; licensed nurse practitioner; skilled physical, speech, or language therapist; or have a continuing need for occupational therapy.
- Receive HHC from a Medicare-approved home health agency.

If your client receives Medicare through a private health plan (Medicare Advantage), she should check with the plan to find out how it provides for Medicare-covered home health benefits.

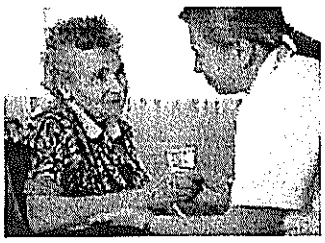
Does the patient need to have a condition that will get better in order to receive HHC?

No. Following a recent nationwide lawsuit (*Jimmo vs. Sebelius*), CMS revised its Medicare coverage manuals to clarify that a person's condition does not need to improve in order for a person to get continued skilled care coverage. Skilled care may be necessary to improve, maintain, prevent, or further slow the individual's condition.

What does HHC cost?

Generally, someone with Original Medicare pays $0 for covered HHC services, and 20% of the Medicare-approved amount for durable medical equipment.

Don't Let Health Care Providers Use the Improvement Standard to Deny Medicare Coverage



Have you or a loved one been denied Medicare-covered services because you're "not improving"? Many health care providers are still not aware that Medicare is required to cover skilled nursing and home care even if a patient is not showing improvement. If you are denied coverage based on this outdated standard, you have the right to appeal.

For decades Medicare, skilled nursing facilities, and visiting nurse associations applied the so-called "improvement" standard to determine whether residents were entitled to Medicare coverage of the care. The standard, which is not in Medicare law, only permitted coverage if the skilled treatment was deemed to contribute to improving the patient's condition, which can be difficult to achieve for many ill seniors.

Three years ago in the case of ***Jimmo v. Sebelius*** (https://www.elderlawanswers.com/medicare-to-end-improve-or-youre-out-standard-for-coverage-of-skilled-services-10018) the Centers for Medicare & Medicaid Services (CMS) agreed to a settlement in which it acknowledged that there's no legal basis to the "improvement" standard and that both inpatient skilled nursing care and outpatient home care and therapy may be covered under Medicare as long as the treatment helps the patient maintain her current status or simply delays or slows her decline. In other words, as long as the patient benefits from the skilled care, which can include nursing care or physical, occupational, or speech therapy, then the patient is entitled to Medicare coverage.

Medicare will cover up to 100 days of care in a skilled nursing facility following an inpatient hospital stay of at least three days and will cover home-based care indefinitely if the patient is homebound.

Unfortunately, despite the *Jimmo* settlement, the word hasn't gotten out entirely to the hospitals, visiting nursing associations, skilled nursing facilities, and insurance intermediaries that actually apply the rules. As a result, the *Jimmo* plaintiffs and CMS have now agreed to a court-ordered corrective action plan, which includes the following statement:

> The Centers for Medicare & Medicaid Services (CMS) reminds the Medicare community of the *Jimmo* Settlement Agreement (January 2014), which clarified that the Medicare program covers skilled nursing care and skilled therapy services under Medicare's skilled nursing facility, home health, and outpatient therapy benefits when a beneficiary needs skilled care in order to maintain function or to prevent or slow decline or deterioration (provided all other coverage criteria are met). Specifically, the *Jimmo* Settlement required manual revisions to restate a "maintenance coverage standard" for both skilled nursing and therapy services under these benefits:
>
> Skilled nursing services would be covered where such skilled nursing services are necessary to maintain the patient's current condition or prevent or slow further deterioration so long as the beneficiary requires skilled care for the services to be safely and effectively provided.
>
> Skilled therapy services are covered when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a qualified therapist ("skilled care") are necessary for the performance of a safe and effective maintenance program. Such a maintenance program to maintain the patient's current condition or to prevent or slow further deterioration is

> covered so long as the beneficiary requires skilled care for the safe and effective performance of the program.
>
> The *Jimmo* Settlement may reflect a change in practice for those providers, adjudicators, and contractors who may have erroneously believed that the Medicare program covers nursing and therapy services under these benefits only when a beneficiary is expected to improve. The Settlement is consistent with the Medicare program's regulations governing maintenance nursing and therapy in skilled nursing facilities, home health services, and outpatient therapy (physical, occupational, and speech) and nursing and therapy in inpatient rehabilitation hospitals for beneficiaries who need the level of care that such hospitals provide

"The CMS Corrective Statement is intended to make it absolutely clear that Medicare coverage can be available for skilled therapy and nursing that is needed to maintain an individual's condition or slow deterioration," says Judith Stein, Executive Director of the Center for Medicare Advocacy (http://www.medicareadvocacy.org) and a counsel for the plaintiffs. "We are hopeful this will truly advance access to Medicare and necessary care for people with long-term and debilitating conditions."

While this doesn't change the rights Medicare patients have always had, it should make it somewhat easier to enforce them. If you or a loved one gets denied coverage because the patient is not "improving," then appeal.

To read the court order implementing the new corrective action plan, click here (http://www.medicareadvocacy.org/wp-content/uploads/2017/02/Jimmo-v.-Sebelius-Corrective-Action-Order.pdf).

Article Last Modified: 07/27/2017 (http://attorney.elderlawanswers.com/admin/cms/article/id/16225)

Chicago Methodist Senior Services

125 Years of Care

Senior Connections

Building intergenerational friendships and reducing loneliness.

Senior Connections is a no-cost program that matches trained volunteers with older adults to create mutually beneficial friendships that reduce loneliness and social isolation.

Volunteers visit older adults weekly for an hour of conversation and connection. If phone calls are preferred over in-person visits, we also offer that option.

Senior Connections is one of numerous programs and services offered by CMSS, a non-profit and non-sectarian organization, providing a continuum of care to older adults and their families around Chicagoland.

Call: 847-869-0682
Email: SeniorConnections@cmsschicago.org
Visit: cmsschicago.org/connections

Join Senior Connections

Interested older adults must

- Be 55 years of age or older
- Live in the northern suburbs or Chicago's northside neighborhoods
- Live independently (not in a nursing home or assisted/supportive living residence)
- Desire friendship with a volunteer

Interested volunteers must

- Be 18 years of age or older
- Commit to a weekly visit/call for a minimum of one year
- Be able to travel, if visiting in person
- Desire friendship with an older adult