

PART I

Home Health Administration

Chapter 1

Status of Home Health Care: 2015 and Beyond

Chapter 2

Home Health Care: A Historical Perspective and Overview

Status of Home Health Care: 2015 and Beyond

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Home health care has a long and complex history, and nurses and nursing were historically the leaders in the field, which will be covered in the next chapter, entitled “Home Health Care: A Historical Perspective and Overview.” The current environment suggests that health care and home care may be going back to their roots in the next decades—and during our practice lifetime. For clarity, the term *home care* will be used throughout this chapter. There are many definitions of *home care*, but for the purposes of this chapter, the definition will be a classic one taken from the U.S. Public Health Service:

... that component of a continuum of comprehensive health care whereby health services are provided to individuals and families in their places of residence for the purpose of promoting, maintaining, or restoring health, or maximizing the level of independence, while minimizing the effects of disability and illness, including terminal illness. Services appropriate to the needs of the individual patient and family are planned, coordinated, and made available by providers organized for the delivery of home care. (Warhola, 1980)

This is where we are going, and in some ways it is returning to the past of community-based care. This definition clearly specifies terms that

support an organized, coordinated approach to care for patients and their families. In addition,

this classic definition provides a good framework for three reasons: it is not prescriptive as to the services provided, it does not limit services, and it refers to “individuals and families.” It acknowledges that in home care, patients are cared for in the context of the family whose members, when capable, and willing to provide care, can contribute significantly. The definition uses the words *promotion* and *restoring*. In *promotion*, health is a lifestyle choice with certain preventive components that are under the individual’s control and that empower healthcare. Because the majority of home care patients are older adults, *restoring* refers to efforts directed toward the restoration or maintenance of safe, independent functioning. (Marrelli, 2012)

■ MEDICARE HOME CARE 101

It has been well-documented that Medicare is in a financial crisis and that older adults wish to remain at home and age in place. Historically, home care is the lowest cost setting for health care. Medicare is the largest payer for home

care services (MedPAC, 2004), and the home care patient population will continue to grow exponentially. According to a 2014 report commissioned by the National Institutes of Health, the United States' older adult population is "now over 40 million and expected to more than double by mid-century, growing to 83.7 million people and one-fifth of the U.S. population by 2050" (Cire, 2014). Taken together, these factors indicate that home care will be the preferred setting for much of the health care in the future.

Home care at present is a blend of numerous kinds of programs and services that are primarily driven by the payer. First there are Medicare-certified home care programs and providers, which must meet certain standards to receive reimbursement for care provided to their patients. In 2012 there were 12,311 home health agencies participating in Medicare (MedPAC, 2014). There are also private duty agencies. These include both medical and nonmedical home care programs that might primarily provide personal care or assistance to older adults that is generally privately paid or reimbursed by long-term care insurance. In addition, there are home care organizations who care for Medicaid patients in their homes. This care can be highly skilled (e.g., a registered nurse caring for a patient at home with a ventilator) or unskilled (e.g., an aide providing respite for a family caregiver who has a child with autism), depending on the state and the requirements.

For purposes of illustration, let's look at the Medicare program. For specific information about Medicare home care, readers are referred to the Centers for Medicare and Medicaid Services (CMS) Manual System (Chapter 7) and its Transmittals for the most up-to-date policies and changes. The Medicare home care program has undergone many changes since the inception of the home health benefit, and as the delivery of health care has changed, so too has the home benefit over the past five decades. Having worked at the Medicare central office in Baltimore for 4 years on Medicare home care and hospice policy and operations, I came away with an understanding of the complexity and sometimes byzantine processes of the program. And I thought I knew something about home care and

hospice at the time, from having been a visiting nurse and a director of home care and hospice programs for a number of years and having written many books on the topics! Because Medicare is also a law, as a result of being included in specific sections of the Social Security Act, some aspects of it are formally structured and not easily changed. In addition to the law, there are the Medicare Conditions of Participation (called the CoPs), which are mandated for Part A Medicare providers. Like all payers, there are specific qualifying and/or coverage criteria that must be covered in order for services to be reimbursed by Medicare. These fundamentals include that the patient be "homebound," have medically necessary care, be under the care of a physician, and need skilled nursing or therapy services, along with others. At the same time, the payers—who are the contractors the government works with to have home care and other claims processed, paid, or denied—and all these components can lead to a daunting process with seemingly endless layers of complexity. The Medicare payers are called MACs, which stands for Medicare administrative contractors. In the past, these government contractors were called the regional home health intermediaries (RHHIs).

The MACs replaced the specialized RHHIs, who provided administrative oversight, processed claims, provided medical review, and provided other services to/for home care and hospice providers. At the same time, the government seeks (and this is mandated by law) to identify fraud in the Medicare program to preserve federal dollars funded by taxpayers, which are public monies. Remember, these monies belong to us all. Sadly, there has been an increase in fraud related to Medicare, in certain parts of the country more than others. What this means for home care agency administrators and clinicians operationally and practically is varying levels of scrutiny and types of review of their patients, documentation, and medical records. Some of these reviews are performed by Zone Program Integrity Contractors (ZPICs). The primary goal of the ZPICs is to investigate suspected fraud, waste, and abuse in the Medicare program. They are charged with ensuring that Medicare trust fund monies are not spent for inappropriate care. Instances where ZPICs

or other reviewers will investigate or audit agencies include billing for services not furnished; performing medical review of clinical records; performing an analysis of agency data such as billing for duplicative payment; altering claims or clinical records to obtain a higher payment amount; soliciting, offering, or receiving a kick-back or rebate for patient referrals; and generally investigating potential fraud or abuse. Other reviews can be performed by the MACs or the RACs (recovery audit contractors). What all this means to home care and hospice providers who are “doing the right things right” is that they must be aware of these reviews and have complete and effective clinical and other documentation should they be targeted for an in-depth review. These reviews are very serious; based on the findings of these reviews, administrative action can be taken including denial of specific patient encounters and payment suspension, a request for repayment, and other serious consequences. In addition, the appeals process used to refute denials is complex, and writing appeals and the like takes the management and clinical team away from caring for patients. A strong and effective compliance program and an understanding and operationalization—on a daily basis—of the rules and the fundamentals is more important than ever for all these reasons.

The complexity continues because some states have licensure whereas others do not. Some states have a certificate of need (CON) process whereas others do not. Simply stated, if a state has a very tough CON in place, it is very difficult to open a home health agency (HHA) or other program. In states without a CON process, there are a plethora of new agencies—regardless of whether they are needed from a population/feasibility viewpoint. Some states and certain counties have placed a moratorium on new provider types, including HHAs, meaning no new agencies are allowed.

■ THE OASIS-C1: PART OF A COMPREHENSIVE ASSESSMENT

Medicare HHAs are mandated to use the OASIS-C1 (the Outcome and Assessment Information Set) upon patient admission and at recurring, defined intervals. This lengthy tool

is part of a comprehensive assessment that predicts payment for a 60-day episode and measures outcomes of care provided. It must be completed for patients when they are admitted for home care services. The face-to-face (F2F) requirement has also been implemented, though at this time it is undergoing more changes related to the completion of forms and data that the patient’s physician must complete for Medicare home care patients. We will have to see what happens with the final decision about F2F.

Taken together, Medicare home care—and it is the Medicare home care program that other payers generally mirror—is a very complex and always changing program. Interestingly, the assessment tool itself may be changing at some point as well. In 2014, the Medicare Payment Advisory Commission (MedPAC) finalized a recommendation to create a common postacute assessment instrument for home health, skilled nursing facilities (SNFs), and some other provider types in 2016. This makes sense—that the same assessment tool be used across care settings, regardless of care site. Currently, SNFs use the Minimum Data Set, similar to how HHAs use the OASIS-C1 tool. Having just one assessment tool could also help with the standardization of definitions, care, and related processes for patients. We will see more of this “harmonization” in health care—meaning that terms and structures will go across care settings and there will be more uniformity for patients and providers. The Continuity Assessment Record and Evaluation (CARE) Item Set has been studied and can be accessed at www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/CARE-Item-Set-and-B-CARE.html. Moving to one assessment tool may also help in transitions of care—those defined risk areas across/between care settings when patients must move from one setting to another setting, such as being discharged from the hospital and going to an SNF or returning home. These transition points can be problematic for patients and support the need for effective care coordination, communication, and transitional care instruments and processes.

Another area that all providers must address is how to decrease hospitalizations, particularly

for older adults. In the same 2014 meeting mentioned previously, the MedPAC recommended the creation of a penalty to home health payments for home health readmissions to hospitals that exceed a specified target. For these and other reasons, it is very important to stay up-to-date on the regulatory changes that impact home care.

■ THE FUTURE MAY BE HERE SOON: HOLD ON!

President John F. Kennedy said, “Change is the law of life. And those who look only to the past or present are certain to miss the future” (John F. Kennedy Presidential Library and Museum, n.d.). The world view of health care has changed dramatically over the past few years, and this section seeks to summarize the larger trends. This may bode well for those home care providers and others who can effectively work across care settings and communicate and coordinate effectively. In any case, home care is undergoing, and will continue to undergo, significant change as the entire healthcare system undergoes change. Whatever the change looks like, Medicare providers should perhaps consider offering other services and products—the Medicare program we know now may be very different in the future.

The Affordable Care Act (ACA) will continue to change the macro level of health care in all settings. At some point we may have a more effective healthcare “system” with a process that works for both providers and payers. There is a movement toward more transparency across varying levels of health care—this was demonstrated when, in 2014, for the first time CMS made public data about what Medicare paid to individual healthcare providers (physicians and other professionals who billed Medicare). This story made national news when it was noted that around 4000 providers received more than \$1 million from Medicare in 2012, and some received even more (Whoriskey, Keating, & Somashekhar, 2014). Such transparency may help decrease the variations seen across the country in care, costs, and related health services. The models are all seeking to improve quality and help control/reduce costs.

Controlling costs and increasing quality are the primary drivers for now and into the future.

Innovation will be the watchword for the coming years. We are seeing innovative models being introduced to help create a healthcare system that is rational and works more effectively from both the financial and quality perspectives. Some of these models/programs and changes include:

- The state of Maryland and CMS announced a joint initiative to improve care and lower costs. This will be the benchmark as CMS moves away from traditional fee-for-service and paying for volume and services instead of quality and desired outcomes. This will “allow the state to adopt new policies that reduce per capita hospital expenditures and improve health outcomes as encouraged by the Affordable Care Act” (CMS, 2014). It is hoped that other states will learn from this Maryland model.
- Emergency medical personnel in some states are making home visits to help decrease hospitalization rates. There are programs like this in Maine, Texas, North Carolina, Minnesota, and Pennsylvania (Hallman, 2014).
- In 2014, CMS issued 41 pages of accountable care organization (ACO) contractors. Home care agencies need to partner with hospitals, physicians, and other systems-based colleagues to be integrated into these ACOs. The goal of the ACOs is to provide higher quality care at less expense. Home care providers can contribute greatly to this goal.
- Some hospital organizations are following patients from the hospital into the home using unit nurses or patient navigators.
- Technology and its use in clinical and operational systems will be more important than ever in order to provide the basis for care with improved standardization, decision making, and data collection.
- Consolidations and collaborations will continue.
- Look at the care provided and the quality—not quantity. How is it measured? What are your performance improvement projects that continually seek to improve care

EXHIBIT 1-1 Web Resources

American Nurses Association (ANA): www.nursingworld.org
 ANA's *Essential Principles for Utilization of Community Paramedics*: www.nursingworld.org/principles
 ANA's *Home Health Nursing: Scope and Standards of Practice* (2nd ed.): www.nursesbooks.org
 International Home Care Nurses Organization: www.ihcno.org
 Marrelli and Associates: www.marrelli.com
 VNAA: www.vnaa.org

and processes related to decreasing rehospitalization rates, infection control, safety, falls, and other area of risk?

- Home care providers know their communities and can offer unique services to ACOs and others seeking collaborations. For this to happen there must be ongoing and positive communications with hospitals and other stakeholders in the community. They have the patients and will be looking for the highest quality HHAs to safeguard their patients once transitioned back to the home setting.

■ CONCLUSION

Whatever the future holds, the healthcare system will be moving toward value-based purchasing—in essence, making sure that the government and other payers get the best value for limited dollars spent. This will be reflected in metrics such as improved outcomes, decreased rehospitalization rates, increased patient and family satisfaction, and others. Whether the model that emerges as the most successful is an ACO where the ACO (for instance, a hospital) takes the risk to provide care from hospitalization through and including home and other community-based care (bundling) or another model, there will be significant changes for providers. This may mean more consolidation and collaboration among and across providers and varying provider groups. It will mean more engaged patients and families and an increased value placed on patient satisfaction. Improved, effective technology will be imperative for providing the best evidence-based and science-based care to

help us do our jobs and to effectively document that care. The model of delivery that cuts costs and improves care and patient satisfaction will be the model that survives and brings health care—and home care—into the next decades.

One of the major goals of the ACA was to move care out of the hospital and back into the community. Who is better positioned to provide this care than experienced home care clinicians and managers? It will be clear that home care practitioners are best able to answer this call if we can prove our value through data and science.

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