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Economics of Home Health Care in an Accountable Health Care System

Systems Change Project,
Submitted in Partial Fulfillment
of the Requirements for the Degree of
Doctor of Nursing Practice

St Catherine University

St Paul, Minnesota

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May, 2013

ST. CATHERINE UNIVERSITY
ST. PAUL, MINNESOTA

This is to certify that I have examined this
Doctor of Nursing Practice systems change project
written by

Kathleen Valusek

and have found it is complete and satisfactory in all respects,
and that any and all revision required by
the final examining committee have been made.

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Faculty Project Advisor

5/27/13

Date

DEPARTMENT OF NURSING

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Dedication

This project is dedicated to home healthcare patients everywhere. I would like to acknowledge and thank my advisor, Dr. Rozina Bhimani for her support throughout my doctoral program. I would also like to thank my reader, Dr. Susan Hageness, and my site mentor Dr. Alice Swan. Special thanks to my husband for his support in the pursuit of my doctor of nursing practice.

Abstract

Currently in the state of Minnesota, low income individuals have health care costs covered or supplemented through a variety of programs. The 2010 fiscal year-end report to the Minnesota legislature demonstrated that the federal government contributed 4.43 billion dollars to Minnesota Medical Assistance and the state government contributed nearly 2.8 billion dollars. Of this amount only 7% was devoted to providing home care services. This article reviews the economics and outcomes of state and federally funded home health services programs. It identifies how a small increase in the amount provided for home care could significantly decrease the overall cost of healthcare while improving *prevention rather than treatment* services, a goal of healthcare reform. Although this article is based on the experience of one home health agency in the state of Minnesota, barriers are identified that can change the reimbursement system which is relevant to every state.

Key words: Medicare, Homecare, Healthcare, Medical Outcomes, Laboratory Services

Economics of Home Health Care in an Accountable Health Care System

Within the United States (U.S.) health care system there is a constant state of tension between value and cost of care versus outcome of care. If there was one formula to measure value based services or determine that an outcome was worth its cost, the issue would essentially be resolved. However, prioritizing a desired outcome is not only difficult for the patients and providers but also for any third party payer (government and insurance companies). There is no doubt that providers, patients, and payers all have a vested interest in a certain outcome. For example, a provider may wish to take the most expedient course of action in order to save time and have best patient outcome. A patient might prefer the most comprehensive course of action to ensure the best results. Also the third party payer would certainly consider a cost saving course of action. In the realm of home care a potential exists to meet the demands of all three parties.

Background

In the United States there are two public health care reimbursement programs which were developed under the Social Security Act of 1965 (Mason, Leavitt, & Chaffee, 2012): Medicaid and Medicare. Together they are managed by the Centers for Medicare and Medicaid Services (CMS). These two systems work together to provide care to the elderly, disabled and poor population. Medicare is a complex system which includes Parts A (hospitalization coverage), B (outpatient services), C (health maintenance organization coverage), and D (prescription drug coverage). Part A is primarily a medical insurance designed to cover most of the cost of admission to a hospital. Today it also includes coverage for the care provided by home health agencies when a Medicare recipient has been an inpatient in an acute care facility for three or more days, hospice care, and limited stays in a skilled nursing facility. There is no

premium associated with Part A for most people. Part B is an elective supplemental medical insurance which covers a multitude of outpatient services and generally has a premium associated with it. An individual must have Part A and B coverage to participate in Part C. Both Part C and Part D have premiums associated with them (U.S. Social Security Administration, 2011).

At its inception on July 1, 1966, there were approximately 19 million people enrolled in the Medicare program. In 2011, this number increased to almost 49 million individuals who were enrolled in one or both Part A and B of the Medicare programs. Of this number, 12 million individuals elected to participate in a Part C Medicare Advantage plan (U.S. Social Security Administration, 2011).

Medicaid provides health care coverage to approximately 55 million low-income Americans. Through a complicated formula, states receive contributions from the federal government for the state's Medicaid program. However, Medicaid is not solely federally funded; each state contributes towards this funding. Some individuals are eligible for both Medicaid and Medicare. Because dual eligibility is permitted, another nine million Americans are enrolled in both programs. Together these two programs consume nearly \$1 trillion of the taxpayer revenue (Medicare, 2012)

The United States healthcare system is changing as a result of the Affordable Care Act (ACA) of 2010. The ACA is in the process of implementation and is expected to be fully implemented in 2014. The ACA will expand coverage to 32 million people (Patient Care Forum, 2012). Implementation of the Affordable Care Act includes major insurance reforms allowing 94% of the U.S population to have health coverage. Other provisions of ACA include promotion

of prevention and wellness, promotion of primary care, increase in value and quality for health dollar, and increase in affordability for many (Purcell, & Webb, 2013).

All of these objectives will impact the provision of home health care and ultimately third party payers, including Medicare and Medicaid, will need to accommodate changes in reimbursement in order to control costs and improve service. Both Medicare and Medicaid contribute to the problem of waste due to restrictive policies which preclude the provision of services which would save money and improve quality of care, particularly to the homebound individual.

Current Practice

Most western nations use a combination of community health workers and formal home health agencies to reach and provide health care to families and communities. Wide variations within Europe regarding how home care is provided have been reported (Nadine et al., 2011). In most cases, the United States may be setting the highest standard in the regulation of care because other western nations are more fragmented in the determination of how and to whom care will be delivered. However, most European nations demonstrate immense concern for their elderly through the delivery of significant healthcare financial resources. This delivery includes, in a number of countries, a voucher system which can be utilized to purchase homecare services. Also these home health agencies are not limited to providing only skilled care and home health aides but also offer homemaker services (Nadine et al., 2011).

In the United States, like European nations, skilled homecare services are provided by home health agencies. In order to meet state licensing requirements and certification by Medicare or Medicaid, a home health agency must meet standards of care which requires homebound status and preclude the provision of “as needed services.” The home health agency is required to

admit the individual into care and then monitor the ongoing needs of the patient (Quan, 2009). While these requirements may be effective care for very ill or recently discharged community dwelling homebound population, they are not effective for everyone.

Everyone who is a Medicare or Medicaid recipient is not eligible for home health agency services in the United States. CMS has imposed strict guidelines regarding eligibility. In order to be eligible for home health service reimbursement under part A or B an individual must have spent three or more days as an inpatient in a hospital and/or meet other eligibility criteria which include homebound status (which must be certified by a physician), intermittent skilled care needs, and the provision of care by a Medicare certified agency. Home health agencies are not entitled for reimbursement from CMS for care of an individual unless the criteria for home care and homebound status are met. Restriction of certain services to the elderly and disabled because they don't meet other criteria is tantamount to refusal of care. Conversely, some patients may meet the CMS criteria but are not homebound, which once again leads to refusal of care. If a disabled or elderly individual does not meet the criteria for home care or is not homebound and requires lab collection services, they must be transported to the emergency room or clinic to receive these services unless they have been admitted by a Medicare Certified Home Health Agency.

Exemplar of Waste of Health Care Resources

Currently, a licensed home health agency in Minnesota provides laboratory specimen collection services to home bound individuals. Laboratory specimen collection includes phlebotomy blood specimen collection, finger sticks, throat cultures and urinary specimen collection. These are collected by laboratory technicians and delivered to a reference laboratory for processing. Nurses may also collect (Meyer, 2009) specimens from wounds, urinary

catheterization and central lines. All laboratory technicians operate under a waiver granted by the state for home health aides. There are no predetermined competencies needed for the laboratory technicians providing home health care (The Office of the Revisor and Statutes, 2008). With this in mind, their competency is checked every six months and if the supervisory RN has concerns at any point, there is a formal competency review. Those individuals who are eligible for care through a home health agency are fortunate because they either have Medicare or Medicaid coupled with Health Maintenance Organization (HMO) insurance which covers the cost of home care. However, since the 1997 Balance Budget Act (Meyer, 2009), individuals who receive Medicaid but are not enrolled in the Medicaid-HMO option are no longer eligible for home care. Therefore, if a disabled or elderly individual requires lab collection services they must be transported to the emergency room to receive these services.

Medicare and Medicaid recipients are in an all or nothing dilemma regarding home health care. The entitlement is for a period of time rather than a specific service. This means if an elderly or disabled individual does not meet the Medicaid/Medicare guidelines and is in a need of immediate services, they are unable to access home care services. As long as the individual's status meets the guidelines, the provision of services continues. However, those who don't qualify or whose status changes are left with no home health care. There is no assistance for the elderly or the disabled when there is a need (Ceci, 2006). It is simply too expensive and unjust to continue to eliminate an entire segment of the population from home care service when doing so will drive up costs and diminish positive outcomes.

Future Recommendations for Change: A Cost Benefit Analysis

The direct medical cost of the care for the homebound individual who is transported to the emergency department for a specimen collection for urinary tract symptoms includes: the

transport fee which will range from \$40 (for a taxi) to \$1000 (for an ambulance) based upon the distance to the facility which is used (Cost Helper, 2011). According to an estimate emergency room visit charges may be over \$1000 (Blue Cross Blue Shield, n.d.). Because most third party payers probably have a negotiated price with both the transportation service and the facility, the cost may be substantially less. The negotiated fees between facilities and insurance companies are *not* available in the public domain. However, even if services are discounted by 50%, the cost far exceeds that of the home health agency which would be approximately \$75 for the laboratory specimen collection, including a blood draw and urine specimen collection (\$20 extra for the weekend service).

The direct nonmedical cost to the patient when treated in the emergency room includes: 1) the disruption of the normal routine; 2) discomfort with transportation to the emergency room; 3) exposure to a system which is not prepared to provide optimal care to a non-emergent patient and 4) a delay in treatment. A delay in treatment of UTIs is a risk factor for reflux nephropathy in adults (Mattoo, 2011).

According to Minnesota Hospital Association (2011) the average stay on a medical unit in a hospital in Minnesota is \$6,818. A delay in treatment may lead to the patient being admitted for three days of IV antibiotics, the admission alone will have a direct cost of \$ 6,818. In this scenario, the recipient of care is not only greatly inconvenienced by the treatment but is also put at a higher risk for complications of urinary tract infection. Additionally the third party payer has an additional financial burden estimated to be \$1900 at a minimum for the initial services and possibly, if admitted, an additional cost as much or more than \$6,000. Based on the cost benefit analysis it is obvious that provision of home laboratory specimen collection services should be available for both straight Medicaid and Medicare populations in Minnesota. Therefore, this

common sense change in CMS policy is recommended to decrease healthcare cost and improve patient outcomes.

Discussion

The average stay in a United States non-government hospital is 4.9 days (Center for Disease Control 2009). When considering the cost of an admission of \$1853 per day, the cost of the average stay in the U.S. equals \$9,080. If instead of being admitted, an individual was seen by a nurse or lab technician for a lab specimen collection which costs \$75, the savings to the third party payer would range from \$6830 - \$9005. This calculation is very simple math and yet the disturbing fact is that in this climate of budgetary shortfall and deficit spending, this simple decision has not been considered.

The United States health care system is changing. The Affordable Care Act is a reality where changes are being instituted to reduce cost and improve patient outcomes; it is inevitable that accountability for services provided will be monitored closely. This change in Medicaid/Medicare policy to increase access to needed services in a timely manner may impact immensely on the cost of health care. When considering the savings associated with laboratory collection services for homebound individuals who are unable to pay; the most significant issue is not only the decrease in cost, but also a decrease in needless human suffering.

Laboratory services at a clinic or hospital are always an option for Medicare homebound non-home health agency patients. However, it is the lack of transportation and the difficulty associated with presenting to a clinic that leads to an emergency room visit. The immense cost of an emergency room visit and/or being admitted to the hospital calls in question the credibility of the current policy. Hence, it is incumbent upon the decision makers at CMS to reconsider those individuals who struggle because they live on the fringes of eligibility.

The fringes of eligibility are analogous to the fringes of poverty. Assistance is not available to those in either case. Like an individual who lives slightly above the poverty line and is not eligible for welfare but struggles daily to get by; the Medicare recipient who is not allowed to access home health agency services but has home health needs, is also in a daily struggle. The most difficult element of this dilemma is that the individual, who needs only a little help, may ultimately be the one that costs CMS the most.

Additionally, there are two sets of benefits which are managed by CMS. There are those benefits which are available to the beneficiary of Medicaid and are determined and managed by the state. Conversely, there are benefits which Medicare provides and are federally mandated. Thus, an individual who receives Medicaid services may have a personal care attendant, while the individual who has Medicare with same health problems will not qualify (Elliot, 2011). This dichotomy in care is confusing to the individual; further, it is unjust. The basis for care through the public sector is currently more reflective of how funds are distributed and less on the availability of funds or the needs of the beneficiary.

Now as this nation approaches a health care system which more closely replicates other western nations, some remodeling of the home health care system will be inevitable. It is simply too expensive and unjust to continue to eliminate an entire segment of the population from home care service when doing so will drive up costs and diminish positive patient outcomes.

Summary

The Centers for Medicare and Medicaid Services has demonstrated that it is able to monitor home health agencies they certify. However, the restrictions that have been embedded into their policies preclude the use of troubleshooting ideas when problems related to the health and well-being of the aging or disabled population arises. Therefore, it is incumbent upon those

who drive health care policy to reconsider policies which restrict access and waste resources.

Restricting care inappropriately often leads to more care and increase waste in healthcare. Obviously the limited care is much less costly but it may also lead to better patient outcomes. In order to provide the beneficiaries of Medicaid and Medicare with optimal services which permit them to live at their fullest capacity and also to prevent waste, changes in home health care policies and reimbursement need to be made. Therefore, it is reasonable to consider allowing short-term services without admitting a beneficiary into a certification period. In addition, non-Medicare Certified Home Health Agencies should be able to provide non-skilled services to meet patient's short-term need. Bringing the Medicare and Medicaid services that are responsive to changing needs of patients allow for decreased waste and increased access to healthcare services.

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Use of Outcomes and Assessment Information Set in Home Care: A Call for Reform

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Dedication

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Abstract

Most people who are admitted into a home health agency program are above the age of 65 and thus receive Medicare funding in some form. Since 1999, Medicare has required that the Outcome and Assessment Information Set (OASIS) instrument be completed for the measurement of outcomes data in home health agency patients. This instrument with 79 items is utilized for various reasons, including determining the level of reimbursement to the agency.

The OASIS assesses physical, mental, functional, and psychosocial status of all patients receiving the services of Home Health Agencies (HHAs) that are approved to participate in the Medicare and/or Medicaid programs. This instrument which is intended to improve services to senior citizens may have the opposite impact and be a barrier to the provision of care.

Keywords: Healthcare Reform, Affordable Care Act, Medicare, OASIS, Home Health Care.

Use of Outcomes and Assessment Information Set in Home Care: A Call for Reform

Most people who are admitted into a home health agency program are usually elderly (above the age of 65) and thus receive Medicare Part A (CMS, n.d.). About 40 million individuals are served by Medicare today (Kaiser Family Foundation, 2012). Since 1999, the Center for Medicare and Medicaid Services (CMS) has required completion of the Outcome and Assessment Information Set (OASIS) instrument for the measurement of outcomes in home health agency patients. In January 2010, OASIS was revised as OASIS C to better reflect home health quality outcomes (CMS, n.d.).

Home Health Care and OASIS

The CMS has adopted the Institute of Medicine's call for quality improvement through efficiency, effectiveness, equity, safety, timeliness, and patient centeredness approach (Center for Medicare and Medicaid services, 2012). To meet this quality improvement focus, the OASIS tool has been used as an outcome measure. CMS states that "the instrument assesses: physical, mental, functional, and psychosocial status of all patients receiving the services of Home Health Agencies (HHAs) that are approved to participate in the Medicare and/or Medicaid programs" (Department of Health and Human Services, 1999).

To monitor these quality outcomes, OASIS is the main tool used by CMS when a patient is admitted to the home health agency and every 60 days until the patient is discharged. According to the Medicare guidelines (OASIS Guidebook, 2008) a reassessment using the OASIS must be completed again during the final five days of each 60 day period of care. If an individual does not demonstrate ongoing problems which require home health care services, a discharge from home care is anticipated.

Initially the OASIS was an outgrowth of the efforts by CMS to reduce fraud among homecare agencies (Quan, 2009). During the 1980s and 1990s, home health care was reimbursed

by CMS on a fee for service basis. CMS deemed the OASIS tool as the reporting mechanism to reduce fraud (Buto, 1999). With the initiation of OASIS as the basis for the provision of home health services, thousands of home health agencies were forced to surrender their Medicare certification and ultimately closed their doors. The loss of Medicare certification was a result of the changes that were implemented by CMS (Buto, 1999).

CMS pays prospectively based on a case mix which is determined by the OASIS tool, but this has not always been the case. William & Weissert (1994) described concerns regarding the Medicare Home Health financing debate (during the transition from fee for services to prospective payment) that a segment of the vulnerable population would not be included in the funding. Eventually, those individuals who did not receive specific long term health care services for a measurable long-term problem were excluded in the fiscal planning during Medicare home health reform.

After home health reform, Medicare continues to require use of the OASIS tool for home health. Through the use of the OASIS tool, home health agencies cannot ever meet the needs of the Medicare patient who only has “spot trouble.” This means that the occasional need for a blood draw in a home-bound individual who is not eligible for homecare per the OASIS guidelines must be excluded from service. Also excluded will be the disabled individual who is doing well until he/she has a urinary tract infection and needs someone to collect a urine sample and transport it to the clinic. In addition, not included are the frail men/women who painfully walk on corns which require occasional debridement. These are all services which the Medicare certified agency must turn away due to CMS guidelines. Even if the individual chooses to pay privately, all services provided by a Medicare certified agency must be consistent with Medicare

guidelines. Therefore, more and more agencies are dividing into Medicare certified and non-Medicare certified agencies to respond to patients who are falling through Medicare gaps.

The non-Medicare certified home health agency must still have a license in the state in which it provides home care even though it cannot receive any funds through Medicare. Thus the state licensed non-Medicare certified home health agency must follow guidelines which in some cases are more restrictive than those imposed by CMS. These guidelines further restrict access to care on an as-needed basis for individuals who require it most.

For most individuals who have only Medicare as insurance or for those who participate in a Medicare HMO, to have care through a non-Medicare home health agency requires out-of-pocket payment. This type of service has given rise to some “concierge” agencies which include everything from shoveling the back patio to care attendants. This type of service stands ready for “spot trouble” but few can afford it.

Cohen-Mansfield et al (2010) point out that people do better if they are able to function somewhat independently and most importantly if they are able to leave their home at least twice weekly. This concept is contrary to the strict CMS guidelines which prohibit care to anyone who is not homebound. This means improving mobility while continuing to receive care to optimize health is restricted by CMS (OASIS) measurement. Such restrictions on mobility are in direct conflict with the call by Institute of Medicine to improve access, efficiency, safety and equity. Therefore, a closer look at OASIS tool is needed.

Issues with OASIS

OASIS is a 79 items instrument, which is utilized for not only patient assessment but also for determining the level of reimbursement to the agency. If the individual is deemed to be appropriate for home health agency services, the instrument is used again to evaluate the status

of the individual at specific intervals. At the time of its inception, the OASIS was criticized for privacy issues. One concern, voiced by the Citizens Council for Health Freedom, (Brase, 1999) was that it limited the privacy of the individual by asking questions that were not germane to the care that was needed. Another concern which was voiced more recently by the same organization is that the OASIS does not limit the personal identifiers to prevent information from being easily traced back to the individual.

The validity of the OASIS has been called into question for a variety of reasons. In a study done by Schneider, Barkauskas, and Keenan (2008) it was demonstrated that the OASIS is not sensitive to the effect of home health agency nursing care when measured by the intensity of the interventions, and furthermore, the tool was not effective in measuring clinically discernible changes in patient outcomes. O'Connor & Davitt (2012) concurred that the validity and the reliability of the OASIS varied from low to moderate depending upon the item studied. Similarly, Kinatukara, Rosati, and Huang, (2005) were concerned regarding validity, reliability and usefulness of OASIS for home health care measurement.

The OASIS provides a wealth of information on the population of individuals who receive home health agency services, but it only looks at a small percentage of the overall population of the Medicare eligible age group. It does not, for example, look at the homebound population who are not currently eligible for Medicare home health agency services. These individuals are the cost-savers in a system which is financially strained. The limitation of OASIS suggests that the tool itself is in question and the barriers that it imposes may be unnecessary.

The independently living older person will help keep the cost of Medicare stable if an admission to a long-term or acute-care facility is avoided. The majority of Medicare beneficiaries who have chronic health conditions have conditions which can be managed without admission

and require simple community care. These chronic conditions are: high blood pressure (58%), high cholesterol (45%), heart disease (31%), arthritis (29%) and diabetes (28%) (CMS, 2012). Management of these chronic conditions is costly. The intervention for the reduction of hypertension is not reimbursed by Medicare if the individual does not qualify for care by OASIS results. Consequently the simple teaching and monitoring that a registered nurse could provide to better manage high blood pressure is not available for most Medicare beneficiaries.

The Surgeon General's (2012) report states that a mere five percent reduction in the prevalence of hypertension would save \$25 billion in 5 years. It is notable that at least four of the five chronic conditions listed above are affected by high blood pressure. Home health agencies continue to use OASIS despite the call from IOM to radically decrease cost and improve patient access to health services.

A Call for Reform

The OASIS is the single greatest barrier in preventing the provision of needed services by home health agencies to seniors who do not qualify by the conventional method of assessment through CMS guidelines. There are multiple issues in the current systems that marginalize care a home health care agency can provide. An individual who may choose to pay out of pocket is not allowed to do so based on the current system. Elders who may occasionally get out of their home risk losing the "homebound" status, while "spot troubles" are not accounted for in the OASIS tool. Most elders when their healthcare needs are not met end up in hospitals. The average cost per stay for hospital admission in the United States is \$15,734 (Rodak 2012); usually followed by an admission to a rehabilitation center or home health agency. Admissions can be avoided if there were a provision for "spot trouble" (Ceci, 2006). Provision of services when needed, without facing these barriers may potentially decrease healthcare costs rather than continue to

escalate. Therefore, CMS focus must shift from covering curative treatments to preventive services.

The IOM (1999) report and the inception of Affordable Care Act (2010) call for new models of health care delivery. Home health care provides a venue for improved health care quality and decrease cost. Recommendations to reform home health care access calls for (a) removing OASIS as a basis for quality monitoring and reimbursement mechanism; (b) allowing “spot trouble” to be covered under CMS guidelines; (c) eliminating homebound criteria for Medicare recipients for the provision and care; and (d) providing access to home health care services who may not qualify under Medicaid or Medicare services. Eliminating these barriers has economic implications for small home health agency, which may be able to compete in the free market without static rules and regulations imposed by CMS. The Affordable Care Act of 2010 is anticipated to provide access to 30 million more people during the coming year. As these individuals seek medical assistance from health care professionals in the community, resources will be increasingly strained. This increased demand coupled with the advancing median age of the country will place a new financial burden on the current system of care including Medicare. This may be the time to look at alternatives within this system. Home health care provides a suitable, cost effective solution where care can be provided at home, which ultimately will lead to patient satisfaction.

Summary

Services of home health care are underutilized and restricted from having meaningful impact due to cumbersome CMS guidelines and OASIS. As 30 million people enter the subsidized health care arena due to Affordable Care Act and over 40 million are already eligible for Medicare, the time has come to look at how health care is delivered. Rethinking decisions of

the past, that may have been complicit in driving up costs, can have an impact in stabilizing or decreasing costs to the taxpayers. The current system is not working and yet revamping it in its entirety is unrealistic because the political system moves too cautiously. Therefore, a call for reform in the existing system provides a pragmatic solution through use of home health care to individuals who need it most. As a civilized society it is imperative that we infuse social justice into market justice in order to decrease cost, but above all, honor human dignity.

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