Making the System Work for Home Care Quality

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Abstract: The post-acute and long-term care systems are changing rapidly, with an increasingly important role being played by home care. Under the current system, home care does not consistently meet the needs of older people living in the community. This problem is caused, in large part, by the existing system of financing and regulating home care. This paper examines how the current system funded by Medicare, Medicaid, state programs, private insurance, and out-of-pocket spending affects the delivery and quality of home care services. Specifically, this paper analyzes how financing, coverage of services, reimbursement, quality regulation and assurance, and information coordination affects the quality of home care. The paper concludes by drawing implications for policy.

Keywords
financing
home care
home health
quality
information coordination
reimbursement

Journal for Healthcare Quality
Vol. 31, No. 2, pp. 18–23

The role of home care (home healthcare and other home and community-based services [HCBS]) is growing rapidly. Total expenditures for home care, including home health, for older people and younger persons with physical disabilities increased from $31.7 billion in 1995 to $50.2 billion in 2005 (Wiener, Freiman, & Brown, 2007). In 2002, 14.3% of frail older people in the community received paid home care services, while almost 37% of older people with three or more problems with the activities of daily living used paid home care (Johnson & Wiener, 2006). With the help of home care, more older people with disabilities are remaining at home rather than receiving assistance in hospitals or nursing homes.

Despite these advances, home care quality is not optimal along a number of dimensions (Institute of Medicine, 2008):

- Complex chronic care needs are often not adequately addressed.
- Older people unnecessarily suffer pain because palliative care is not provided.
- Transitions between care settings are not well coordinated.
- Inadequate medication management leaves patients with too many, not enough, or inappropriate prescription drugs.
- The values of patients often are not recognized.
- Information gaps across providers, between acute and long-term care, and across payers impede quality of care and increase costs.

This paper has three premises: First, home care agencies and staff make choices about what they do and how they do it within the options available to them. Second, the options available to them are largely determined by the financing, coverage, reimbursement, quality regulation, and information systems. And, third, the choices that agencies and staff make among those options are consequential for home care quality. The goal of this paper is to analyze the financing and regulatory systems in order to identify ways to improve quality of home care for older persons. The paper concludes by making recommendations for how the system could be reformed.

Financing and Coverage

The home care financing system is highly fragmented, with Medicare, Medicaid, state programs, and out-of-pocket payments all playing important roles (Grabowski, 2007). Although Medicare covers nearly all older people regardless of their financial status, the Medicare home health benefit is limited to mostly short-term, skilled post-acute rather than long-term care services. In contrast, Medicaid home care is long-term care oriented, but covers only people who are low income or became low-income because of high medical expenses. Only about 7.7% of noninstitutionalized older people were Medicaid beneficiaries in 2002 (Johnson & Wiener, 2006).

Under federal law, state Medicaid programs must cover home health services for beneficiaries. Beyond that, states have great flexibility in the amount and type of services covered (Wiener & Tilly, 2003). As a result, people living in Oregon are eligible for a much broader set of services than people living in Alabama.

In addition to home healthcare, states may choose to cover other types of home care services. In 2006, 34 states and the District of Columbia offered personal care services for persons who met the normal Medicaid financial eligibility requirements (Burwell, Sredl, & Eiken, 2008). In addition, virtually all states operate Medicaid HCBS waivers. These waivers allow states to operate their Medicaid programs in ways not normally allowed by federal law (thereby ‘‘waiving’’ normal requirements). Section 1915(c) of the Social Security Act establishes Medicaid waivers to allow states to offer a very broad range of nonmedical services, which are not normally covered, and to provide Medicaid eligibility to people who would normally have too much income to qualify. The Deficit Reduction Act of 2005 established a new Medicaid option that has many characteristics similar to HCBS waivers, but does not require a detailed application and approval process (Kaiser Commission on Medicaid and the Uninsured, 2006).

Several other federal and state programs also finance home care. The Older Americans Act funds modest amounts of home and community services to persons age 60 and over (O'Shaughnessy, 2008; Rabiner, Wiener, Khatutsky, Brown, & Osber, 2007). The Social Services Block Grant and the Rehabilitation Act also fund services. Moreover, most states have small general revenue-funded home care programs (Summer & Ihara, 2004).

The fragmentation of financing has five adverse implications for the quality of home care:

- While almost all seniors are eligible for Medicare post-acute care services, the vast majority of seniors are not eligible for Medicaid long-term care services.
- Because Medicaid home care services vary by state, the services that people receive vary by where they live as well as by what they need.
- Multiple sources of financing increase the difficulty of assembling a comprehensive care package and divert attention from client-centered care.
- Funders provide little coverage for client education, assessment, or care coordination.
- Many older people receive their long-term home care services through Medicaid, but their acute care through Medicare, making coordination across payers difficult. Efforts to integrate acute and long-term care services financed by Medicare and Medicaid are difficult to develop and have not been widely replicated. This lack of replication is due to the inherent difficulty of integrating care compounded by: (1) the differing philosophies and requirements of the two programs, (2) fears of cost-shifting between the federal and state governments, (3) consumer reluctance to join managed care organizations, and (4) fears of the medicalization of long-term care (Grabowski, 2007; Institute of Medicine, 2008; Master & Eng, 2001; Wiener, 1996).

Reimbursement

Compared with hospital and physician services, home care is very dependent on public financing (CMS, 2008a). Medicare and Medicaid reimbursement policies are critical to the level of resources available to providers, and to the extent that more resources translate into better quality, public reimbursement is a key factor in determining quality. Reimbursement constrains what can be paid to staff, which can affect turnover as well as the educational level of staff that agencies can afford to hire (Institute of Medicine, 2008). Incentives and disincentives embodied in reimbursement methodology also can influence the numbers of people served, the type of services provided, and the level of quality.

Medicare and Medicaid reimbursement is particularly important as a policy lever because policymakers control both the level and methodology of payment. Changes in Medicare reimbursement, for example, have shaped the types of services provided over time. The current payment system was established in response to explosive increases in Medicare home health expenditures during the early and mid-1990s (MedPAC, 2007). As a result of reimbursement changes between 1997 and 2000, the number of Medicare home health beneficiaries fell by about one million persons and the number of visits fell by 65% (MedPAC, 2008). In particular, home health aide visits fell from about 125 million visits in 1997 to about 20 million in 2006.

Although the federal government sets Medicare reimbursement policy, states have complete freedom in setting Medicaid payment rates (Wiener & Tilly, 2003). Little systematic information is available about how Medicaid pays home care providers, but anecdotal evidence suggests that rates vary substantially and are often low and unadjusted for inflation or casemix. According to 2008 data collected by the National Association for Home Care, the average Medicaid home health reimbursement for an RN visit in Alabama is $28, but $142 in Mississippi (personal communication, Mary St. Pierre, National Association for Home Care, July 12, 2008). State-funded home care programs have their own reimbursement systems, which are typically different from Medicaid.

Prospective payment systems create incentives to reduce costs because reimbursement does not fall when providers' costs decrease. However, this incentive to reduce costs can conflict with desired improvements in quality of care. ''Pay for performance'' initiatives integrate quality incentives directly into the reimbursement methodology to buffer the incentive to decrease costs at the expense of quality. To explore this concept, the CMS has started several pay-for-performance demonstrations that link high quality or improvements in quality to higher payments (CMS, 2005).

The Medicare home health pay-for-performance demonstration began in January 2008 in seven states. Participating providers will be evaluated on seven quality indicators from Home Health Compare (http://www.medicare.gov/HHCompare), a CMS Web site providing consumers with quality of care information on individual agencies. Agencies that volunteer will be randomly assigned to an experimental or control group. For the experimental group, agencies in the top 20% of performance and 10% of improvement will be eligible for an incentive payment.

Critics point to several possible problems with these demonstrations:

- Measuring quality is technically difficult and not everyone agrees that the proposed indicators are good measures of quality. Thus, there is a risk that agencies providing average or even low quality may qualify for financial incentives.
- The size of the bonus payment is based on factors that may be unrelated to quality. To comply with federal rules requiring budget neutrality for Medicare demonstrations, the funds for the incentive payments will be based on savings attributable to presumed lower cost growth for the experimental group. If there are no savings, there will be no incentive payments even if quality improves. The uncertainty about bonus payments could discourage agencies from improving quality.
- Quality incentive payments may ''guild the lily'' by providing additional funds to agencies that already are doing well financially. Thus, the demonstration may inefficiently target public resources.
- If adjustment for patient casemix is inadequate, paying for good outcomes may be the result of treating ''healthier'' patients, which could have the perverse effect of providing an incentive for agencies to restrict care to less difficult patients.

Quality Regulation and Assurance

Quality regulation and assurance in home care is uneven across the system, lessening its impact. It focuses on monitoring compliance with minimum standards rather than encouraging optimal performance, provides a narrow range of information on provider quality to consumers, and lacks sufficient standards for training, especially for home health aides and personal care attendants.

Home care quality regulation and assurance are also not coordinated across payers or programs. Medicare and Medicaid establish uniform national certification standards for home health agency participation, but the federal Medicaid statute does not include quality standards for personal care providers and requires only state assurances that a quality of care system is in place for HCBS waivers (Wiener & Tilly, 2003). While most states license home health agencies, fewer states license or certify other types of home and community-based services.

The Medicare and Medicaid home health conditions of participation establish minimum requirements for participating in the programs, but they are largely structural- and paperwork-oriented and do not directly measure quality of care. Because it focuses on meeting minimum standards, the survey process lacks mechanisms or a mandate to encourage high-quality care. In addition, there is a paucity of research about how states monitor other home and community-based services.

Providing information about the quality of care of individual providers to consumers, their families, and hospital discharge planners is a widespread approach to quality improvement (Harrington, O'Meara, Kitchener, Simon, & Schnelle, 2003; Mukamel & Spector, 2003). However, the research literature on consumer responsiveness to quality of care information in healthcare is mixed (Barr et al., 2002; Hibbard, Stockard, & Tusler, 2002; Vaiana & McGlynn, 2002). Few studies have examined whether publicly reported quality measures change consumer or provider behavior or improve the quality of care provided.

Outcome and Assessment Information Set (OASIS) data on individual home health patients are used to develop quality indicators reported on the Home Health Compare Web site (CMS, 2008b). Twelve measures provide information on changes in the ability of patients to perform basic daily activities (e.g., the percentage of patients who improve in bathing). Several factors may make information on home health agencies ineffective in influencing consumer choice. For example, this information may not be what consumers want to know, may be too technical for consumers to understand, or may be irrelevant to consumers who have limited choice of providers.

The quality measures on the Home Health Compare Web site provide clinical information, but do not incorporate consumer perspectives. In 2010, CMS will begin reporting consumer views of home healthcare using the Home Health Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. Measures will assess consumer perspectives on various process measures of care (e.g. pain management). CMS plans to link higher Medicare reimbursement with better performance on the Home Health CAHPS. Similar provider-specific information for consumers receiving Medicaid-covered services is not available, although some states, including Texas, Maine, and Nebraska, conduct consumer surveys on home care to provide information at the program level (Wiener, Anderson, & O'Keeffe, 2008).

The availability and competency of the home care workforce affects the ability of home health agencies to provide high-quality geriatric home care (Institute of Medicine, 2008). Home health agencies face a shortage of registered nurses, with 3.8% of the total nursing workforce working in home health agencies in 2004 (Health Resources and Services Administration, 2006). Home health nurses typically come from other service settings, and are seldom trained in geriatrics, adult education, or chronic disease management (Institute of Medicine, 2008). Home health aides and personal care attendants are also in short supply, and the aging of the population over the next generation will produce greater shortages of these workers (Stone & Wiener, 2001).

The limited training requirements for home health aides and personal care assistants also potentially affect quality outcomes (Wiener et al., 2007). Federal regulations (42 CFR 483.152) require that nurse aides receive a minimum of 75 hr of training, with at least 16 hr of supervised practical or clinical training. States vary widely on the length of minimum training, ranging from 75 to 175 hr (PHI, 2007). Consumer-directed home care, in which consumers may hire family or friends to provide unskilled personal care services, may help to bring additional paraprofessional workers into the workforce, but these programs typically lack minimal training standards, depending on the competitive marketplace and family relationships to ensure quality (Coleman, 2003).

Coordination

One of the cornerstones of beneficiary-centered care is service coordination built on integrated, accessible information on each person's service needs, treatments, and options. Today, however, coordination is rare, and available information is usually limited to the setting in which care is received. Moreover, the current bifurcation between acute medical coverage and long-term care exacerbates the problem.

Medicare is currently implementing a number of initiatives to address these problems. One Medicare coordination initiative is payment to physicians for case management services. Another is a demonstration encouraging primary care physicians to create ''medical homes'' for beneficiaries with multiple chronic or prolonged illnesses. The goal of these ''homes'' is to coordinate care across providers and settings.

The importance of home care as a potential vehicle for bridging gaps in care coordination for older people with medical, rehabilitation, and personal care needs is widely recognized. To support coordination in post-acute care, Medicare is testing the Continuity Assessment and Record Evaluation (CARE) tool, which is designed to collect longitudinal patient-level information that bridges the continuum of care and is not specific to any one individual type of provider. This tool will standardize the types of information collected across the Medicare program, while an electronic record system will permit key information transfers across different providers. The tool currently captures information from home health and institutional providers but potentially can be used in physician and outpatient offices as well. Fully implemented, the CARE tool would provide home health providers with access in ''real time'' to hospital and nursing home data on medical, functional, and cognitive status and on social support before patients are admitted to home healthcare.

While the CARE tool should be useful for improving information coordination for Medicare-covered services, home care agencies also provide services to many populations with less skilled care needs. The type of information collected in the CARE tool, and the system developed for its use, hold the potential for expanding its use into the broader aging and disability communities. The CARE initiative is designed to be expanded as the federal government moves towards developing interoperable data standards to allow communication across provider and insurance networks.

Conclusions

The problems of home care quality do not exist in a vacuum. Rather, they are caused or influenced by the financing, coverage, reimbursement, and quality assurance systems in which home care providers and clients function. Much needs to be done to better align the incentives in home care financing and regulatory systems to improve quality. While there are many possible recommendations, we offer four for consideration.

First, the current highly fragmented financing system results in administrative complexity and gaps in coverage. Greater integration of financing would improve quality. While controversial, more experimentation with capitation and managed care is needed.

Second, with population aging, the future demand for home care is likely to outstrip the available workforce. Low reimbursement levels, especially for lower-skilled staff such as home health aides and personal care attendants, make it difficult to attract and retain high-quality staff. Although it translates directly into larger public costs, higher reimbursement may be critical for improving care quality.

Third, public reporting through the Home Health Compare Web site was a major step forward in providing information about clinical quality of care. The addition of the Home Health CAHPS will help to add the consumer perspective and should be supported, as should the provision of information in a more ''consumer-friendly'' format. In addition, Medicaid is expanding home and community-based services, but little information is available on provider or systems performance. More monitoring and data collection would help to ensure that low-income older adults receive high-quality care.

Fourth, and finally, separate and sometimes conflicting assessment and data collection requirements across payers and providers makes transitions across settings and funders difficult and results in duplicative tests and inadequate information transfer. CMS should continue to support the development and testing of integrated data collection systems like the CARE tool, and should aim to encompass all providers.

Given population aging, the demand for home care likely will increase substantially over the next 30 years. By one projection, the number of older people receiving home care will triple between 2000 and 2040 (Johnson, Toomey, & Wiener, 2007). In order to ensure that home care meets its potential, greater attention needs to be given to making the system work for home care quality.

Acknowledgments

Financial support for this paper was provided through a grant to the Center for Home Care Policy and Research at the Visiting Nurse Service of New York from the John A. Hartford Foundation entitled ''Establishing a National Framework for Geriatric Home Care Excellence.'' More information on this initiative is available at http://www.champ-program.org/framework/home.html.

The authors gratefully acknowledge helpful comments on earlier drafts from Penny H. Feldman, Ph.D., Annette Totten, Ph.D., and Ellen Kurtzman, M.P.H., R.N.

The views expressed in this paper are those of the authors and are not necessarily those of RTI International, the Visiting Nurse Service of New York, or the John A. Hartford Foundation.

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