Minnesota Department of
Human Services

Health Care

Our Mission

The Minnesota Department of Human Services, working with many others, helps people meet their basic needs so they can live in dignity and achieve their highest potential.

Our Values

- We focus on people, not programs.
- We provide ladders up and safety nets for the people we serve.
- We work in partnership with others; we cannot do it alone.
- We are accountable for results, first to the people we serve, and ultimately to all Minnesotans.

We practice these shared values in an ethical environment where integrity, trustworthiness, responsibility, respect, justice, fairness and caring are of paramount importance.

Report to the Legislature

Home Care Reimbursement Methodologies

Report prepared by Stratis Health

Laws of Minnesota 2007
Chapter 147, article 19, section 3, subdivision 6

April 2008

Home Care Reimbursement

Laws of Minnesota 2007
Chapter 147, article 19, section 3, subdivision 6

Report to the Legislature
March 2008

Home Care Reimbursement

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Authorizing Legislation

LAWS OF MINNESOTA FOR 2007 – Ch. 147, Art. 19

(6) $60,000 in fiscal year 2008 is to the commissioner to contract with a Minnesota-based, nonprofit quality improvement organization that collaborates with providers and consumers in health improvement activities, for the purpose of conducting an independent analysis of the reimbursement methodologies for home health services provided to enrollees in the Minnesota senior health options and Minnesota disability health options programs. The analysis of reimbursement methodologies shall include, at a minimum, a review of:
(i) any limitations on flexibility in services or technology for the home health provider;
(ii) the Medicare program reimbursement methodologies, including possible alternatives, and Medicare benefits;
(iii) potential access issues raised by current reimbursement methodologies; and
(iv) incentives, including episodic care reimbursement methodologies, to promote best practices and achieve identified clinical outcomes.
The analysis and any supporting recommendations shall be presented to the commissioner by December 1, 2007, and to the chairs of the appropriate legislative committees by December 15, 2007. In no event shall the study disclose any specific reimbursement amount or methodologies attributable to an individual health carrier.
In conducting its analysis, the organization described in paragraph (a) shall consult with the commissioner, the Minnesota Home Care Association, managed care organizations, and other interested home health entities and advocates, and shall convene the parties to discuss pertinent issues.

Acknowledgements

Stratis Health wishes to thank the members of the Home Health Reimbursement Methodologies Work Group for their patience, perseverance, and commitment to getting it right.

- The Stratis Health Research Team

Executive Summary

This study was conducted in fulfillment of the Department's obligations under Laws of Minnesota, Chapter 147, article 19, section 3, subd. 6. The law requires an independent analysis of reimbursement methodologies for home health services provided to enrollees in the Minnesota Senior Health Options and Minnesota Disability Health Options programs to be conducted, and recommendations to be developed, by Minnesota's Quality Improvement Organization (QIO). The law outlined the following goals:

- Review Medicare reimbursement methodologies, including possible alternatives, and Medicare benefits
- Review limitations on flexibility in services or technology for home health providers attributable to reimbursement methodologies
- Review potential access issues raised by current reimbursement methodologies
- Review incentives, including episodic reimbursement methodologies, to promote best practices and achieve identified clinical outcomes.

This study was initiated in response to Minnesota home health care providers' concerns about how they are being reimbursed by MCOs for the provision of Medicare skilled services. Following is a summary of the research, analysis, conclusions and recommendations reported in this document.

Background Information: Medicare, Medicaid, MSHO, and MnDHO

Most seniors and some people with disabilities in the U.S. receive their health care services through Medicare. In addition to their Medicare benefits, those with low incomes may also receive benefits through Medicaid. Both programs are federally supported and mandated.

The Minnesota Senior Health Options (MSHO) program combines Medicare and Medicaid into one state program serving seniors who are eligible for both programs. The Minnesota Disability Health Options (MnDHO) program combines Medicare and Medicaid into one state program serving people with disabilities who are eligible for both programs. As of January 2008, 35,623 Minnesotans were enrolled in MSHO, approximately 71 percent of all seniors that are eligible for Medicaid. As of the same date, approximately 900 Minnesotans were enrolled in MnDHO. The total dual eligible enrollment of MSHO and MnDHO represents approximately six percent of the state's total Medicare population. The vast majority of Minnesota's Medicare beneficiaries are covered through commercial Medicare Advantage plans.

Medicare Home Health Services and Reimbursement

To qualify for home health care, a Medicare beneficiary must be: 1) confined to his or her residence; 2) require "medically necessary," intermittent skilled nursing, physical therapy, or speech therapy; 3) be under the care of a physician; and 4) have the services furnished under a plan of care prescribed and periodically reviewed by a physician.

In 1965, home health services were included as part of the Medicare benefit as a strategy to shorten inpatient hospital stays. As home care costs increased, significant cutbacks in reimbursement and policy changes were enacted as part of the Balanced Budget Act of 1997 (BBA). The BBA laid the groundwork for the home health reimbursement system that is used today, the Prospective Payment System (PPS).

Medicaid Home Health Services and Reimbursement

Medicaid home care provides medical and health-related services and assistance with day-to-day activities to people in their homes. Medicaid home care services are available to people who are

eligible for Medical Assistance whose care needs meet the Medicaid definition of medical necessity, and whose care is physician ordered and provided according to a written service plan. Medical Assistance, as the payer of last resort, pays for services after the enrollee has used all other potential sources of payment.

Home Health Care and Home Health Agencies in Minnesota
To provide home health care services in Minnesota, a provider must be licensed in one of the following categories: Class A or professional home care agency license, Class B or paraprofessional agency license, Class C or individual paraprofessional license, or Class F or assisted living care provider license. Medicare certification is required for agencies that offer home health services paid by Medicaid and/or Medicare, with the exception of agencies only offering personal care attendant (PCA) services.

As of November 2007, Minnesota has 633 Class A licensed home care providers, 211 of which are Medicare-certified. Since 2000, the number of Medicare-certified home health agencies has declined 17.6% from 256 in 2000 to 211 in 2007.

Most home health technology falls into one of five categories: back office fiscal systems, billing and human resources systems, point-of-care systems for clinicians in the field, electronic medical records, and telehomecare. Medicare and Medical Assistance rules present barriers to home health agencies investing in and using telehomecare technology – Medicare by not counting it as a reimbursable expense, and Medical Assistance by adhering to a narrow definition of what constitutes telehomecare.

The Centers for Medicare and Medicaid Services (CMS) encourages Medicare-certified home health agencies to implement outcome-based quality improvement programs to improve patient outcomes. Medicare Quality Improvement Organizations (QIOs) across the country have been working with home health agencies for the past several years to improve quality of care and patient outcomes.

MSHO Health Plans and County-Based Purchasing Organizations in Minnesota
Six health plans and three county-based purchasing organizations (known collectively as managed care organizations or MCOs) hold contracts with the Department of Human Services to provide reimbursement and care management services for MSHO enrollees. Home care agencies in Minnesota are reimbursed under MSHO using an episodic rate, a per-visit rate, or a blended rate. Four MCOs use the PPS episodic reimbursement methodology, three use a per-visit method and two use both the per-visit and blended methods.

MSHO Home Health Reimbursement and Related Issues and Opportunities
Study participants identified a number of issues and opportunities related to home health reimbursement, largely centered on: communication among home health stakeholders, access to home health services, reimbursement methodologies, billing and coding processes, home health technology, and quality improvement.

Communication. A central finding of this study is that communication among home health stakeholders in Minnesota needs to improve.

Communication Recommendations:

- An ongoing home health stakeholder group should be established to discuss mutually identified issues and work toward solutions. The group should, at a minimum, include representatives of home health agencies, home health consumers, health plans, county-based purchasing organizations, the Minnesota HomeCare Association, and the Minnesota Council of Health Plans.

- The Minnesota HomeCare Association, Minnesota Council of Health Plans, and county based purchasing organizations should pursue a joint research and advocacy agenda that promotes high quality, effective care for home health clients.
- In order to ensure effectiveness, efficiency, and continuity of business operations, MCO staff should make intentional efforts to build relationships with staff of the home health agencies with which their organizations hold contracts.

Reimbursement. Analysis does not point to a particular reimbursement method as the conclusive solution to meet all stakeholders' needs. Home health agencies involved in this study report that reimbursement rates, including Medicare outlier and low-utilization payment adjustment (LUPA) rates, are inadequate to cover the cost of providing home health services. Other study participants, most notably MCO representatives interviewed as key informants, report that their financial analyses show their organizations are reimbursing at a fair level.

Reimbursement Recommendations

- A thorough cost analysis should be conducted by an entity with an understanding of health care finance and no vested interest in the outcome of the analysis.
- The Minnesota HomeCare Association should provide negotiation skills training to home health agency staff.
- MCOs are encouraged to develop pilot projects testing the feasibility of incorporating quality improvement incentives into per-visit and blended home health reimbursement systems used for the MSHO and MnDHO programs.
- Additional research should be conducted – at the state and/or federal level – to better understand the relationship between home health reimbursement methodologies and health outcomes in patients receiving home health services.

Billing and Coding. Billing and coding issues, and receiving timely payment for services delivered, is an area of primary concern for home health agencies in Minnesota. All of the recommendations in this section will be implemented in the context of and should be coordinated with activities related to implementation of the Minnesota Health Care Administrative Simplification Act.

Billing and Coding Recommendations

- MCOs and home health agencies should work together to implement a standardized, electronic process to be used for all home health service authorizations.
- Each MCO that contracts with home health agencies should improve its Website to effectively address its organizational policies and procedures related to home health billing and coding and other information targeted to home health agency staff.
- The Minnesota HomeCare Association, Minnesota Council of Health Plans, county based purchasing organizations, home health agency staff, and MCO staff should build on past joint educational efforts by working collaboratively to design and deliver billing and coding training sessions that meet the needs of home health agency staff.
- The stakeholder group discussed in Communication Recommendation 1 should make discussion, analysis and action on "unclean claims" a high priority.
- The Minnesota HomeCare Association, Minnesota Council of Health Plans, and county based purchasing organizations should work together on state-level advocacy efforts to ensure that no exceptions are granted to requirements of the Health Care Administrative Simplification Act (HCAS).
- Staff from individual MCOs should work with home health agency staff to establish billing and coding pilot projects.

Technology. Although financial and regulatory barriers exist, study participants agree that increased use of technology in the home health arena is an area of great opportunity.

Technology Recommendations

- As part of the access analysis referenced in Access Recommendation 1 below, the Minnesota Department of Health or other appropriate organization should include the availability of information technology infrastructure needed to support telehomecare.
- The Minnesota HomeCare Association, Minnesota Council of Health Plans and county based purchasing organizations should engage in joint advocacy efforts at the state and federal level supporting Medicaid reimbursement for telehomecare visits that do not include a visual component.
- The Minnesota HomeCare Association, Minnesota Council of Health Plans, and county based purchasing organizations should engage in joint advocacy efforts at the federal level supporting Medicare recognition of telehome health services on the Medicare cost report as a reimbursable expense.
- MCOs, in coordination with home health agencies, the Minnesota HomeCare Association, and the Minnesota Council of Health Plans, should seek ways to financially support and develop innovative home health pilot projects which incorporate quality improvement and outcomes measurement components.

Quality Improvement

Quality Improvement/Best Practices Recommendations

- The Minnesota Department of Health or other appropriate entity should conduct a survey of Minnesota home health agencies to determine their level of EHR adoption and use, and provide a platform for further education, adoption, and optimization of home health EHRs to promote improvement in the quality of care.
- The Minnesota Council of Health Plans, the county-based purchasing organizations, and Minnesota's Medicare QIO, in collaboration with the Minnesota HomeCare Association, should explore and develop opportunities for the QIO to share resources, training and education on home health quality improvement with MCO staff.
- The Minnesota Council of Health Plans, the county-based purchasing organizations, and the Minnesota HomeCare Association should review and discuss currently available publicly reported home health quality data, and use that information as a basis for identifying and implementing collaborative quality improvement projects.
- The Minnesota HomeCare Association should work with home care agencies to implement quality improvement projects focused on assessing and improving the accuracy and consistency of their OASIS data.

Access

Access Recommendation

- In order to identify gaps in service availability, and to ensure that it is possible for individuals in need of home health services to receive appropriate, timely, high quality care regardless of where they live, the Minnesota Department of Health or other appropriate entity should conduct a comprehensive, data-based analysis of access to home health services in Minnesota.

INTRODUCTION

This study was conducted in fulfillment of the Department's obligations under Laws of Minnesota, Chapter 147, article 19, section 3, subd. 6. The law requires an independent analysis of reimbursement methodologies for home health services provided to enrollees in the Minnesota Senior Health Options and Minnesota Disability Health Options programs to be conducted, and recommendations to be developed, by Minnesota's Quality Improvement Organization (QIO). The law outlined the following goals:

- Review Medicare reimbursement methodologies, including possible alternatives, and Medicare benefits
- Review limitations on flexibility in services or technology for home health providers attributable to reimbursement methodologies
- Review potential access issues raised by current reimbursement methodologies
- Review incentives, including episodic reimbursement methodologies, to promote best practices and achieve identified clinical outcomes.

A. STUDY METHODS

To conduct this study, Stratis Health used a variety of methods to gather data, discuss issues, and analyze findings, including: conducting a literature review on home health reimbursement and the use of technology, establishing a home health reimbursement workgroup, conducting key informant interviews, developing and administering a survey of home health agencies in Minnesota, conducting a focused interview on home health billing and coding, and collecting home health agency and MSHO data from study participants. Each method is described below.

Literature Review – Stratis Health conducted a review of relevant literature, including articles about changes in home health reimbursement over the past 20 years and the use of technology in home health services. The intent of the literature review was to summarize research findings related to changing reimbursement, and its impact on home health agencies and the clients they serve, as well as the use and impact of technology-based home health services. An overview of the literature reviewed is included in this report as Appendix A.

Home Health Reimbursement Methodologies Work Group — A Home Health Reimbursement Methodologies Work Group was established in September 2007 and included representatives of home health agencies, consumer advocates, health plans, County Based Purchasing organizations[1], the Minnesota Department of Human Services, and the Minnesota HomeCare Association. The work group convened nine times between October 2007 and March 2008. The work group was established to serve as a resource and sounding board for Stratis Health and a forum for presenting and discussing issues, and to review and provide feedback on the study report, in addition to meeting the statutory requirement that Stratis Health consult with and convene specified home health stakeholders. Appendix B includes a list of the individuals and organizations that participated in the work group process and Appendix C includes an overview of activities undertaken in work group meetings.

Key Informant Interviews and Information-Gathering Meetings — Stratis Health conducted key informant interviews with 26 home health stakeholders representing 23 local, state, and national organizations. A list of interviewees is reported in Appendix D. Most of the interviews were conducted via telephone and all were conducted using a structured set of interview questions

[1] Throughout this report, health plans and County Based Purchasing organizations are referred to as managed care organizations, or MCOs.

developed by Stratis Health for the purposes of this study (Appendix E, Interview Questions). Interviews were conducted between November 5, 2007, and January 15, 2008. A summary of interview findings is included as Section H of this report. In addition, Stratis Health held information-gathering meetings with three key stakeholder organizations – the Minnesota Council of Health Plans, Minnesota HomeCare Association, and Minnesota Department of Human Services. A list of participants in information-gathering meetings is included in Appendix D.

Home Care Agency Survey —A Web-based survey developed by Stratis Health, with input from the Minnesota HomeCare Association, the Minnesota Council of Health Plans, and the Department of Human Services, was conducted of Minnesota home care agencies between January 15, 2008, and February 15, 2008. The intent of the survey was to gather information from home health agencies regarding the volume of patients served under different payer sources, to measure the level of technology used in home health care, and to help determine whether billing issues are a widespread problem. Survey questions are included as Appendix F. Providers who serve MSHO clients are required to be Medicare-certified so the study population included only Medicare-certified home care agencies. Agencies for which e-mail contacts could be determined (198 agencies) were sent an e-mail link to the survey, along with e-mail reminders and an e-mail message from the Minnesota HomeCare Association encouraging participation in the survey. The survey resulted in a 37 percent response rate. A summary of the survey findings is included as Section G of this report.

Informational Interview — An informational interview was conducted on January 21, 2008, with staff at REM Health, Inc., to obtain supplemental information on the billing and coding process that home health agencies use to file for reimbursement for the home health services they provide to patients. This information was used to discuss home health services billing and coding issues as part of the work group process and is included as Chart A on page 39.

Data Requests — MSHO, MnDHO, home health agency, and definitions data were requested and obtained from the Minnesota Department of Health, Minnesota Department of Human Services, and the Minnesota HomeCare Association and have been included as part of this study.

B. BACKGROUND INFORMATION: MEDICARE, MEDICAID, MSHO, AND MnDHO

Most seniors (those 65 years and older) and some people with disabilities in the U.S. receive their health care services through Medicare. In addition to their Medicare benefits, those with low incomes may also receive benefits through Medicaid. Both programs are federally supported and mandated and both were established in 1965. Medicare is administered and funded at the federal level through the Centers for Medicare and Medicaid Services (CMS). Medicaid is partially funded by the federal government and includes federal mandates but is administered and partially funded by states. The MSHO program combines Medicare and Medicaid into one state program serving seniors who are eligible for both programs (referred to as dually eligible). Similarly, the MnDHO program combines Medicare and Medicaid into one state program serving people with disabilities who are eligible for both programs.

Medicare

Medicare is the federal government program that provides health care coverage for those 65 years and older and to some persons with disabilities, regardless of income. Medicare-covered services include: inpatient hospital, skilled nursing facility, home health and hospice care (Part A), reasonable and necessary doctors' services, laboratory and x-ray services, durable medical equipment (wheelchairs, hospital beds), ambulance services, outpatient hospital care, home health care, and blood and medical supplies (Part B), and outpatient prescription drugs (Part D).

Medicare is administered using a variety of methods and reimbursement models including fee-for-service, the traditional Medicare program option for reimbursement and service delivery, and Medicare Advantage Plans. Under fee-for-service, the beneficiary makes almost all health care decisions independently without input from health care managers. The Medicare beneficiary receives service, the health care provider submits a claim to Medicare and if the service is covered by Medicare, the health care provider receives reimbursement.

Medicare Advantage Plans are health plan options which allow enrollees to receive their Medicare-covered health care through the health plan they select. The health plan is responsible for managing the care of the patient as well as negotiating costs with the providers of health care services. Medicare Advantage Plan enrollees typically have more health services covered by Medicare as compared to the fee-for-service model; however, beneficiaries need to obtain services within their health plan network or they may be required to pay additional fees.

In 2005, Medicare covered 652,463 enrollees and accounted for 14.6 percent of health care spending in Minnesota as compared to 38,468,030 enrollees and 18.4 percent of health care spending nationally. (SOURCE: "Medicare Enrollment, Centers for Medicare and Medicaid Services, 2005, Retrieved January 2008 and Minnesota Health Care Spending in 2005," Minnesota Department of Health, Health Economics Program, December 2007). In 2007, 206,578 Minnesotans were enrolled in Medicare Advantage Plans (27.5 percent of Minnesota Medicare enrollees) and 8,261,568 (18.5 percent of Medicare enrollees) were enrolled nationally. The average cost of providing health care services to Medicare enrollees is somewhat less in Minnesota than in the nation as a whole. In 2007, the projected cost per enrollee in the fee-for-service sector was $666 per month in Minnesota, compared to $684 per month nationally, while the Medicare Advantage benchmark was $750 per month in Minnesota compared to $796 nationally.[2] (SOURCE: "Medicare Advantage Statistics by State," Congressional Budget Office, April 17, 2007)

As of January 2008, 18 health maintenance organizations (HMOs), preferred provider organizations (PPOs), private fee-for-service plans, and Medicare special needs plans offered 79 Medicare health plan benefit packages and 20 Medicare special needs benefit packages in Minnesota. (SOURCE: "Medicare Prescription Drug Care Finder," U.S. Department of Health and Human Services, Retrieved January 2008)

Medicaid

Medicaid (also known in Minnesota as Medical Assistance) pays for health services for very low income people, some of whom may have no medical insurance or inadequate medical insurance. The federal government establishes general guidelines for Medicaid while states establish specific program requirements. For example, Medicaid eligibility and reimbursement rates are established by each state, while the federal government requires states to include, at a minimum, certain types of individuals or eligibility groups under their Medicaid plans.

Medicaid services provided by all states include:

- Inpatient hospital (excluding inpatient services in institutions for mental disease)
- Outpatient and ambulatory services
- Other laboratory and x-ray
- Nursing facility services for beneficiaries age 21 and older
- Physicians' services

[2] Medicare Advantage benchmarks are the maximum amount that Medicare would pay in each county in 2007 for an average beneficiary.

- Medical and surgical services of a dentist
- Home health services
- Intermittent or part-time nursing services provided by home health agency or by a registered nurse when there is no home health agency in the area
- Home health aides
- Medical supplies and appliances for use in the home
- Home and community based waiver services for eligible enrollees who meet institutional levels of care.

Following are examples of those eligible for Medicaid in Minnesota:

- Pregnant women whose family income is at or below 275 percent of the federal poverty level.
- Adults age 65 years and older that meet income (100 percent of federal poverty level) and asset (e.g., $3,000 for a household of one and $6,000 for two) limits.

With the exception of Elderly Waiver services, a Medicaid service is considered "medically necessary" when the health service is consistent with the enrollee's diagnosis or condition and:

- Is recognized as the prevailing standard or current practice by the provider's peer group; and
- Is rendered:
    - In response to a life threatening condition or pain
    - To treat an injury, illness or infection
    - To treat a condition that could result in physical or mental disability
    - To care for the mother and child through the maternity period
    - To achieve a level of physical or mental function consistent with prevailing community standards for diagnosis or condition
    - Is a preventive health service defined under Minnesota Rules, Part 9505.0355.

SOURCE: *Minnesota Rules*, Part 9505.0175, subpart 25, Minnesota Department of Human Services, 2008 MSHO/MSC+/MSC Model Contract

In 2005, Medicaid accounted for 17.8 percent of health care spending in Minnesota and 17.5 percent of health care spending for the nation as a whole. In 2005, seniors accounted for 10.9 percent of Medicaid enrollees and 26.5 percent of Medicaid spending in Minnesota. (SOURCE: "Minnesota Health Care Spending in 2005")

Minnesota Senior Health Options (MSHO)

The MSHO program was started in 1997 through a CMS Medicare demonstration project sponsored by the Department of Human Services (DHS). MSHO combines Medicare and Medicaid financing and services and brings together primary care, acute care, community-based, and long-term care services for seniors 65 years and older who are eligible for both Medicaid and Medicare or eligible for Medicaid only. Seniors enrolled in MSHO can reside in the community or a nursing home. The goals of MSHO are to:

- Align fiscal incentives to support sound clinical practice
- Provide a seamless point of access for both acute and long-term care benefits for the older consumer
- Move toward a single point of accountability for care for this population
- Reduce cost shifting between Medicare and Medicaid

(SOURCE: MSHO Program Description, Minnesota Department of Human Services, 2006)

To establish MSHO, DHS obtained federal waivers from the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services, or CMS) that allowed the state to contract with three health plans that provided a full range of integrated Medicare and Medicaid medical and social services benefits on a capitated risk basis in the metro area. Six additional rural counties were added in 2001. In 2005 and 2006, CMS allowed MSHO to add six additional health plans and county-based purchasing organizations and to expand operations to cover 83 counties. (Hubbard, Clearwater, Lake of the Woods, and Beltrami were not included). In 2006, all MSHO plans were required to transition to Medicare special needs plan status and to provide Part D benefits. The CMS Medicare demonstration was phased out, ending in December of 2007, and MSHO no longer operates under special federal waivers.

MSHO operates as an alternative to Minnesota Senior Care (MSC) or Minnesota Senior Care Plus (MSC+). Enrollment in managed care is mandatory for seniors on Medicaid in Minnesota, either through MSC, MSC+ or MSHO. Enrollment in MSHO is voluntary. In order to facilitate access to Part D benefits without requiring enrollees to change to a different health plan, CMS passively enrolled dually eligible Medicaid enrollees in MSC and MSC+ into their Medicaid plan sponsor's Medicare MSHO plan on January 1, 2006. CMS notified enrollees of their right to "opt out" of this passive enrollment. However, very few chose to exercise this option. As a result, most Medicaid seniors in Minnesota were enrolled into MSHO in January 2006 and have remained enrolled in MSHO throughout the state (with the exception of the four counties listed in the previous paragraph that are not included in MSHO).

Services offered under MSHO include: all Medicare and Medicaid prescription drugs including Part D, medical supplies and equipment, dental care, therapies, medical transportation, home care, hospitalization, physician office visits, and extended home care to the frail elderly who are at risk for nursing home care. In addition, MSHO requires the health plan to be responsible for the first 180 days of care in a nursing facility for those who enroll in MSHO while residing in the community but end up requiring nursing facility care. (SOURCE: MSHO Program Description)

A single enrollment process is used for both Medicare and Medicaid, with MSHO enrollment being processed at the state level. Enrollees are free to change MSHO plans on a monthly basis. MSHO enrollees can also disenroll from MSHO on a monthly basis, and are then transferred back to the MSC/MSC+ program within the same plan in which they have been enrolled in MSHO. As of January 1, 2008, 35,623 Minnesotans were enrolled in MSHO, 71 percent of all seniors that are eligible for Medicaid in the state. The total dual eligible enrollment of MSHO and MnDHO represents approximately six percent of the state's total Medicare population. The vast majority of Minnesota's Medicare beneficiaries are covered through commercial Medicare Advantage plans. (SOURCE: Minnesota Department of Human Services, 2008)[3]

Minnesota Disability Health Options (MnDHO)

MnDHO is a unique managed health care program that is offered as an option to seven-county, Twin Cities metro area residents who are eligible for Medicaid or who are eligible for both Medicare and Medicaid (dually eligible) due to a physical disability. Enrollment in MnDHO is voluntary. MnDHO integrates Medicare and Medicaid services for enrollees who are dually eligible. DHS contracts with a Medicare Advantage special needs plan (UCare) to also provide Medicaid services through the UCare Complete product. UCare contracts with AXIS Healthcare, an organization that specializes in managing care for people with physical disabilities to provide care management. A key feature of

[3] Approximately 52,000 seniors in Minnesota are enrolled in Medicaid; 46,000 of these seniors are required to enroll in managed care (MSC or MSC+), of which 35,623 have voluntarily enrolled in MSHO. (Source: DHS, January 2008)

MnDHO is that all members are assigned a health coordinator, typically a nurse, who helps them navigate the health care system and get the services they need. To be eligible for MnDHO, an individual must meet all of the following:

- Have a physical disability
- Be at least age 18 and under age 65
- Live in a county participating in MnDHO (Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, or Washington)
- Be enrolled in Medicaid. Medicaid enrollees who are also enrolled inMedicare may receive both Medicaid and Medicare services through MnDHO

People who receive home and community-based services through the Community Alternatives for Disabled Individuals (CADI) or the Traumatic Brain Injury (TBI) waiver programs are eligible to enroll in MnDHO. CADI and TBI participants who choose to enroll in MnDHO still receive the waivered services but receive case management services from a health coordinator at AXIS Healthcare instead of a county case manager. (SOURCE: Minnesota Disability Health Options)

As of January 2008, there are approximately 900 MnDHO enrollees in Minnesota. (SOURCE: Minnesota Department of Human Services, January 2008)

A unique feature of the MSHO and MnDHO programs is the assignment of a care coordinator[4] for each enrollee. MCOs are responsible for providing care coordination; they use a variety of models to provide this service. For example, care coordinators may be employed by the health plan or the care system, hospital, clinic or county. Care coordinators may be RNs, social workers, or geriatric nurse practitioners. Care coordinators for enrollees who live in the community are often involved in all aspects of care, such as primary care visits, arranging home and community based services, and checking in on patients on a quarterly basis to determine care needs. (SOURCE: MSHO Program Description)

This legislative study was initiated in response to Minnesota home health care providers' concerns about how they are being reimbursed by MCOs for the provision of Medicare skilled services. Stratis Health determined early in this study that in order to understand home health reimbursement methodologies, it is important to have a broader picture of the context that home health care operates within in Minnesota. The next two sections provide contextual information related to home health care in Minnesota, including:

- A description of Medicare's home health benefit
- Description of reimbursement trends for Medicare's home health benefit
- Description of policy changes over time affecting Medicare reimbursement for home health services
- A description of Medicaid home health services and reimbursement

C. MEDICARE HOME HEALTH SERVICES AND REIMBURSEMENT

Medicare's Home Health Benefit

As noted earlier, Medicare covers those patients that are 65 years and older and some people with disabilities. Medicare's home health care services benefit enables certain beneficiaries with post-acute-care needs (e.g., recovery from joint replacement) and exacerbated chronic conditions (e.g., congestive heart failure) to receive care in their homes rather than in other settings. To qualify for

[4] Under the MnDHO program, the care coordinator is called the health coordinator. The health coordinator works as one of a team of three – including a resource coordinator and a member services representative—to accomplish care coordination.

home health care, a Medicare beneficiary must be: 1) confined to his or her residence ("homebound"); 2) require "medically necessary," intermittent skilled nursing, physical therapy, or speech therapy; [5] 3) be under the care of a physician; and 4) have the services furnished under a plan of care prescribed and periodically reviewed by a physician. If these conditions are met, Medicare will pay for part-time or intermittent skilled nursing; physical, occupational, and speech therapy; medical social services; and home health aide visits. Beneficiaries are not liable for any coinsurance or deductibles for these services and may receive an unlimited number of visits, provided the coverage criteria are met. (SOURCE: "Prospective Payment System Will Need Refinement as Data Become Available," Medicare Home Health Care, Report to Congressional Committees, United State General Accounting Office, GAO/HEHS-00-9, April 2000)

Medicare Home Health Reimbursement: Past and Present

In 1965, home health services were included as part of the Medicare benefit as a strategy to shorten inpatient hospital stays; however, demand for services increased significantly faster than the supply of services. In response, Congress loosened the home health services requirements by allowing for-profit providers to participate, eliminating the requirement for prior hospitalization as a condition of receiving the home care benefit, and removing the limit on the number of visits per episode of care. (Source: Fishman EZ, Penrod JD, Vladeck BC. "Medicare Home Health Utilization in Context." Health Services Research. February 2003). These changes as well as subsequent incentives for hospitals to discharge patients more quickly resulted in increased supply and demand for home health services: in the mid-1980s, Medicare spending for home health services was $3 billion; 10 years later it had increased to $18 billion. (Fishman, 2003) The increases were attributed to an increase in the number of beneficiaries and an increase in the number of home health visits per beneficiary as well as a lack of incentives for home care providers to control costs. (Fishman)

As supply and demand for home health services increased, other changes were also being seen in the home health services marketplace, such as marked variation in home health use across geographic areas and types of agencies and patterns of care. For example, Medicare home health users in Maryland received an average of 37 visits in 1997, with an average payment per user of $3,088 as compared to home health users in Louisiana who received an average of 161 visits, with an average Medicare payment per user of $9,278. (SOURCE: Prospective Payment System Could Reverse Recent Declines in Spending, Report to the Chairman, Subcommittee on Health, Committee on Ways and Means, House of Representatives, United State General Accounting Office, GAO/HEHS-00-176, September 2000) Although Minnesota data is not available for direct comparison, Home Health Reimbursement Methodologies Work Group members report that in 1997, Minnesotans used a lower than average number of home health visits with lower than average payments per user when compared to Medicare beneficiaries nationally.

This wide variation in usage and costs across the U.S. was evident even after controlling for patient diagnosis. Patterns of care also differed across agency types. For example, proprietary agencies tended to deliver more visits and more aide visits per beneficiary than other types of agencies. In 1993, beneficiaries who received care from proprietary agencies were given an average of 69 home health aide visits, compared with 43 and 48 visits from voluntary and government agencies, respectively. (SOURCE: GAO/HEHS-00-176) Reasons for such variation were unknown; however, researchers speculated that it could have been due to provider responses to financial incentives, differences in

[5] "Medically necessary" is defined by Medicare as "services or supplies that are needed for the diagnosis or treatment of your medical condition, meet the standards of good medical practice in the local area, and aren't mainly for the convenience of you or your doctor." Source: http://www.medicare.gov/Glossary

patient needs, regional practice patterns, states' varying Medicaid coverage and eligibility policies, the use of home health care to substitute for services in other clinical settings, and/or a lack of standards for what constitutes necessary or appropriate home health care. According to sources consulted for this study, no national standards existed at that time for determining when home health care was warranted or when services should be stopped. In addition, since many home health users have chronic and multiple needs, the beginning and end of care for a particular problem could overlap with care for another. Further, even the most basic unit of service—the visit—was not well defined. (SOURCE: GAO/HEHS-00-9)

As home care costs increased and became a larger proportion of the Medicare reimbursement pie and questions were raised about the provision of home health services, significant cutbacks in reimbursement and changes in the provision of services were sought through the Balanced Budget Act of 1997 (BBA). The BBA was signed into law on August 5, 1997. It included a two-phased cut-back: first the Interim Payment System (IPS) which included significant cost controls, and then the Prospective Payment System (PPS), which incorporated quality as well as cost controls. Prior to the BBA, home health agencies were paid on the basis of their costs, up to pre-established per-visit limits equal to 112 percent of the national average cost for each type of visit. Although there was a separate payment limit for each type of visit (skilled nursing; physical, occupational, or speech therapy; medical social service; or home health aide), the limits were applied in the aggregate for the agency. That is, costs above the limit for one type of visit would still be paid if costs were sufficiently below the limit for other types of visits. There were no incentives to control the volume of services delivered; as a result, agencies could enhance their revenues by providing beneficiaries with more services. (SOURCE: GAO/HEHS-00-9)

In 1998, **IPS reimbursement** rates were implemented. As a result, per-visit limits were generally lower than in prior years and agencies were subject to a Medicare revenue cap that was based on an aggregate per-beneficiary amount. Generally, the per-beneficiary amount was to reflect each agency's historical average payments for treating a Medicare beneficiary and the regional or national average amount. An agency's revenue cap was the product of its per-beneficiary amount and the number of patients it served. IPS provided incentives for home health agencies to reduce the number of visits made to Medicare beneficiaries and to avoid those whose care plan likely exceeded cost limits. (SOURCE: Liu K, Long SK, Dowling K. "Medicare Interim Payment System's Impact on Medicare Home Health Utilization." Health Care Financing Review. Fall 2003. 25(1):81-97)

Implementation of IPS was viewed by many as extreme and perhaps detrimental to the viability of home care agencies with the likely outcome of home care agencies avoiding high-need patients and special populations. Studies examining the financial impact of IPS found both a significant decline in the home health care services provided and a substantial savings in Medicare home health care expenditures. Studies also examined patient access and outcomes associated with IPS. They found that IPS did not result in access issues; however, the studies had mixed findings when it came to outcomes. For example, even though IPS patients had more functional limitations as compared to pre-IPS patients, some researchers found no evidence of health consequences associated with IPS and reported no increase in the number of hospital re-admissions and emergency visits. Other studies reported possible outcome issues, most likely for the most vulnerable populations. Most of the studies acknowledged that IPS was in place for a short period of time which could have limited its effects in the longer term.

IPS also included the advent of the Outcome and Assessment Information Set (OASIS). The OASIS is a screening and assessment tool that includes standardized definitions and coding categories that are used to determine a patient's need for Medicare home health care services and to measure and track

outcomes. OASIS is mandated for skilled Medicare and Medicaid patients regardless of payer. All home health agencies have been using OASIS since July 19, 1999. Studies suggest that home health agencies have had difficulty implementing the OASIS and that data is often missing from the reports.

The **PPS reimbursement** methodology, which is currently being used by Medicare and was the second phase of the BBA, was implemented in October 2000, with the intent of controlling costs and improving quality of care and health outcomes. PPS replaced IPS and established a 60-day episode of care. Under PPS, Medicare pays home health agencies a predetermined base payment. The payment is adjusted for the health condition and care needs of the beneficiary. The payment is also adjusted for the geographic differences in wages for home health agencies across the country. The adjustment for the health condition, or clinical characteristics, and service needs of the beneficiary is referred to as the case-mix adjustment. The home health PPS provides home health agencies with payments for each 60-day episode of care for each beneficiary. If a beneficiary is still eligible for care after the end of the first episode, a second episode can begin; there are no limits to the number of episodes a beneficiary who remains eligible for the home health benefit can receive. While payment for each episode is adjusted to reflect the beneficiary's health condition and needs, a special outlier provision exists to ensure additional payment for those beneficiaries that have the most expensive care needs. Adjusting payment to reflect the home health agencies' cost of caring for each beneficiary, including the sickest, is intended to ensure that all beneficiaries have access to home health services for which they are eligible.

The home health PPS is composed of five main features:
1) Payment for the 60-day episode. The unit of payment for home health agencies under PPS is a 60-day episode of care. An agency receives half of the estimated base payment for the full 60 days as soon as the fiscal intermediary receives the initial claim. This estimate is based upon the patient's condition and care needs (case-mix assignment). The agency receives the residual half of the payment at the close of the 60-day episode unless there is an applicable adjustment to that amount. The full payment is the sum of the initial and residual percentage payments, unless there is an applicable adjustment. The split percentage payment approach was included as part of the reimbursement formula to provide a more reasonable and balanced cash flow for home health agencies.

2) Case-mix adjustment—Adjusting payment for a beneficiary's condition and needs. After a physician prescribes a home health plan of care, the home health agency assesses the patient's condition and likely skilled nursing care, therapy, medical social services and home health aide service needs, at the beginning of the episode of care. The assessment must be repeated for each subsequent episode of care a patient receives. A nurse or therapist from the home health agency uses the OASIS instrument (as described above) to assess the patient's condition. OASIS components describing the patient's condition, as well as the expected therapy needs (physical, speech-language pathology, or occupational) are used to determine the case-mix adjustment to the standard payment rate. Originally, there were 80 case-mix groups, or Home Health Resource Groups (HHRG), available for patient classification. As of January 1, 2008, there are 153 HHRGs available.

3) Outlier payments—Paying more for the care of the costliest beneficiaries. Additional payments are made to the 60-day case-mix adjusted episode payments for beneficiaries who incur unusually large costs. These outlier payments are made for episodes whose imputed cost exceeds a threshold amount for each case-mix group. The amount of the outlier payment is a proportion of the amount of imputed costs beyond the threshold. Outlier costs are imputed for each episode by applying standard per-visit amounts to the number of visits by discipline (skilled nursing visits, or physical, speech-language pathology, occupational therapy, or home health aide services) reported on the claims. Total national

outlier payments for home health services annually are limited to no more than five percent of estimated total payments under home health PPS.

4) Low Utilization Payment Adjustment (LUPA)—Adjustments for beneficiaries who require only a few visits during the 60-day episode. PPS has a LUPA for beneficiaries whose episodes of care consist of four or fewer visits during the 60-day episode. LUPA payments are calculated by multiplying the labor- adjusted, standardized, service-specific per-visit amount by the number of visits actually furnished during the episode. LUPA rates are considerably lower than episodic rates. Beginning in January 2008, for LUPA episodes that occur as the only episode or the first episode in a sequence of adjacent episodes for a given beneficiary, there is an increase in payment of $87.93 to account for the front-loading of assessment costs and administrative costs.

5) Adjustments for partial episodes. The home health PPS includes a partial episode payment (PEP) adjustment when a beneficiary elects to transfer to another home health agency or when a beneficiary is discharged and readmitted to the same home health agency during the 60-day episode. The intent of the PEP is to take into account key intervening events in a patient's care and ensure that home health agencies are not penalized for admitting a patient who transfers from another agency, or who returns because of a decline in their condition to the same home health agency within a 60-day episode. (SOURCES: Home Health Prospective Payment System. Overview. Department of Health and Human Services. Centers for Medicare and Medicaid Services and *Home Health Prospective Payment System, Payment System Fact Sheet Series.* Department of Health and Human Services. Centers for Medicare and Medicaid Services. November 2007)

D. MEDICAID (KNOWN AS MEDICAL ASSISTANCE IN MINNESOTA) HOME HEALTH SERVICES AND REIMBURSEMENT

Medicaid home care provides medical and health-related services and assistance with day-to-day activities to people in their homes. Medicaid covers short-term care for people moving from a hospital or nursing home back to their home, as well as continuing care for people with ongoing needs. Home care services may also be provided outside the person's home when normal life activities take them away from home.

Medicaid home care services are available to people who are eligible for Medical Assistance whose care needs meet the Medicaid definition of medical necessity, and whose care is physician ordered and provided according to a written service plan. The service plan must be reviewed by the physician at least once every 60 days for the provision of home health services or private duty nursing, or at least once every 365 days for personal care.

Medicaid home care services are provided in a person's residence, not in a hospital or nursing facility. All unskilled home care services and the first nine skilled nurse visits per calendar year covered by Medical Assistance require authorization from DHS except for home care therapy services (physical therapy, occupational therapy, speech therapy and respiratory therapy). Reimbursement for home care services under Medical Assistance is typically made on a per-visit basis.

Medical Assistance covers the following home care services:

- Equipment and supplies, such as wheelchairs and diabetic supplies
- Home health aide
- Personal care assistant
- Private duty nursing
- Skilled nursing visits, either face-to-face or via telehomecare technology

- Therapies (occupational, physical, respiratory and speech)

Prior authorization for home care services is required for:

- All home health aide services
- All private duty nursing services
- Skilled nurse visits above nine visits per recipient, per calendar year
- All telehomecare visits

MCOs are responsible for Medicaid home health for most Medicaid enrollees and each MCO has its own prior authorization requirements; those may differ from the fee-for-service requirements listed above, but are not allowed to be more restrictive.

Reimbursement

Medical Assistance, as the payer of last resort, pays for services after the enrollee has used all other potential sources of payment. Medicaid also has broader coverage criteria than does Medicare, which means that many visits or needs that are not covered by Medicare are covered by Medicaid. The order of payers for Medical Assistance enrollees is:

1. Third party payers or primary payers to Medicare (for example, large and small group health plans, private health plans, workers compensation plans, no-fault or liability insurance policies or plans)
2. Medicare
3. Medical Assistance or MinnesotaCare
4. Waiver programs or Alternative Care (AC) program

Providers must bill all third party payers, including Medicare, and receive payment to the fullest extent possible before billing Medical Assistance. Medical Assistance becomes the payer only after all other payment options (other than a Medicaid waiver program) have been exhausted.

Providers are responsible for staying up-to-date with the specifics of Medicare coverage for home care enrollees. Providers are expected to bill Medicare when Medicare is liable for the service or, if the home health agency is not Medicare-certified, the agency should refer the enrollee to a Medicare-certified provider of the enrollee's choice.

E. HOME HEALTH CARE AND HOME CARE AGENCIES IN MINNESOTA

Home health care in Minnesota includes a wide array of services provided to patients in their homes. According to Minnesota Statutes, Section 144A.43, home health care services are defined as any of the following services when delivered in a place of residence to a person whose illness, disability, or physical condition creates a need for the service:

- nursing services, including the services of a home health aide
- personal care services not included under sections 148.171 to 148.285
- physical therapy
- speech therapy
- respiratory therapy
- occupational therapy
- nutritional services
- home management services when provided to a person who is unable to perform these activities due to illness, disability, or physical condition. Home management services include at least two of the following services: housekeeping, meal preparation, and shopping;
- medical social services

- the provision of medical supplies and equipment when accompanied by the provision of a home care service and
- other similar medical services and health-related support services identified by the commissioner in rule.

In addition, Minnesota Statutes, Section 144A.43, Subdivision 4, defines "home care provider" as an individual, organization, association, corporation, unit of government, or other entity that is regularly engaged in the delivery, directly or by contractual arrangement, of home care services for a fee. At least one home care service must be provided directly, although additional home care services may be provided by contractual arrangements.

To provide home health care services in Minnesota, a provider must apply for and receive licensure in any of the following licensing categories:

- **Class A** or professional home care agency license. Provider may provide all home care services, at least one of which is nursing, physical therapy, speech therapy, occupational therapy, nutritional services, medical social services, home health aide tasks, or the provision of medical supplies and equipment when accompanied by the provision of a home care service. These may be provided in a place of residence, including a residential center, and a housing with services establishment.
- **Class B** or paraprofessional agency license. Under this license, a provider may perform home care aide tasks and home management tasks in a place of residence.
- **Class C** or individual paraprofessional license. Under this license, a provider may perform home health aide, home care aide, and home management tasks in a place of residence.
- **Class F** or assisted living care provider license. Under this license, a provider may perform home care services solely for residents of one or more registered housing with services establishments, as provided by Minnesota Statutes 144A.4605. "Assisted living home care provider" means a home care provider who provides nursing services, delegated nursing services, other services performed by unlicensed personnel, or central storage of medications solely for residents of one or more housing with services establishments. Some Class F home care providers and/or the housing with services establishments they serve may choose to call themselves or their services "assisted living" and must then meet the requirements for the use of the term assisted living as defined in Minnesota Statutes 144G.

(Source: "A Guide to Home Care Services," Minnesota Department of Health, January 2008)

Medicare certification is required for home care agencies that offer health services paid by Medicaid and/or Medicare with the exception of agencies only offering PCA services. If an agency is Medicare-certified it must also have a Class A home care license but a Class A agency is not required to be Medicare-certified. (SOURCE: Minnesota Home Care/Hospice Licensure and Medicare Certification, Tip Sheets, Minnesota Board on Aging, Retrieved December 2007)

As of November, 2007, Minnesota has 633 Class A licensed home care providers, 20 Class B providers, 56 Class C, and 591 Class F providers (Map 1). Of the 633 Class A licensed home care providers, 211 are Medicare-certified and are therefore able to provide care for both Medicare and Medicaid enrollees (Map 2). The remaining 422 Class A agencies are not Medicare-certified and while they can provide either skilled or non-skilled care, they can be reimbursed by a more limited array of payers, including private pay, PCA, home infusion companies, and some third party payers.

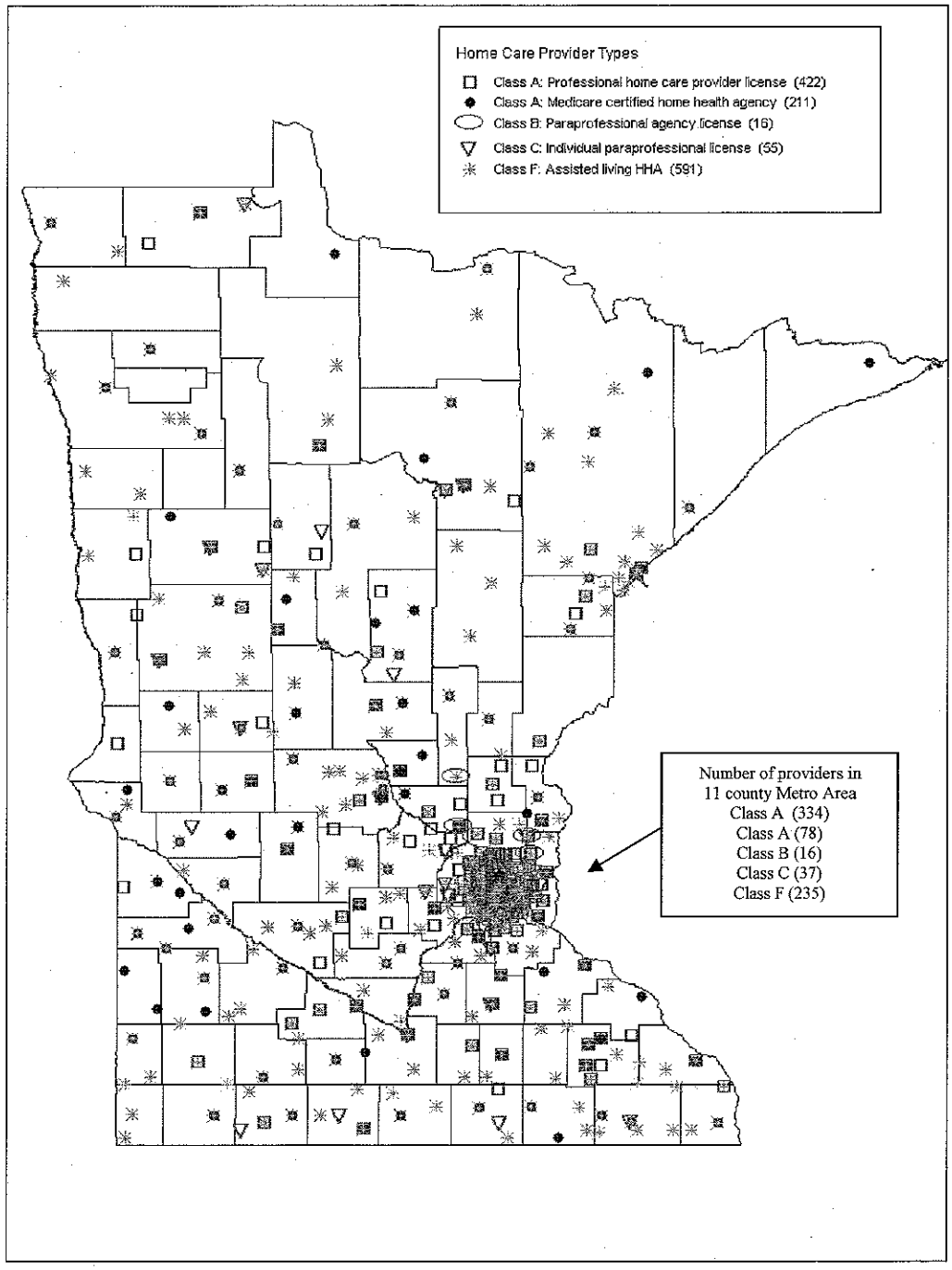
Since 2000, the number of Medicare-certified home health agencies has declined 17.6 percent—from 256 in 2000 to 211 in 2007. (Sources: *Senior Health Services in Minnesota: A System Approach.*

Minnesota Department of Health, Office of Rural Health and Primary Care, 2001 and Minnesota Department of Health Division of Compliance and Monitoring, Licensing and Certification Program December 2007) Data describing how much of this decline can be attributed to closures, mergers, or absorptions and any resulting changes in service areas for the remaining 211 agencies is not readily available.

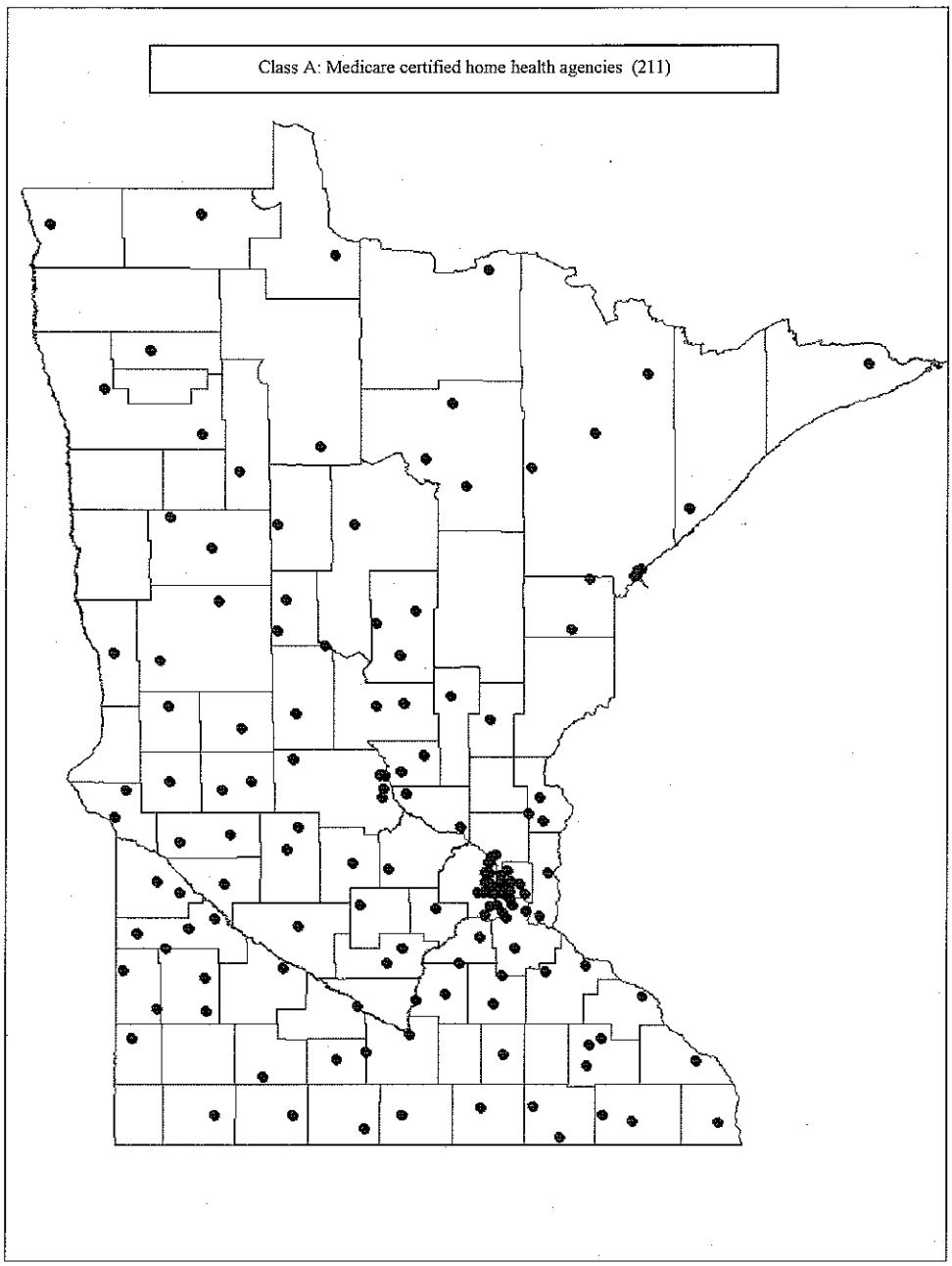
As displayed in Map 1, the majority of home health agency offices are located in the 11-county metropolitan area of Minneapolis and St. Paul. Several regions in Minnesota have counties with no home health agency office. However, because home care services are not provided at agency offices but rather in a patient's place of residence, a complete understanding of home health geographic access can only be gained through a thorough analysis of each agency's service area, array of services offered, and acceptable payers. For example, home health agencies located in bordering states may provide care to residents of Minnesota who live nearby. In addition, there are counties in Minnesota without a home health agency, but in some of those instances there is a home health agency office located just across the county line.

In 2001, the Minnesota Department of Health's Office of Rural Health and Primary Care published a report entitled, *Senior Health Services in Minnesota: A System Approach.* In that study, the researchers reported, "It appears that all Medicare recipients in the state have access [geographic] to at least two home care providers [agencies]." This may or may not be true in 2008, given the decline in the number of Medicare-certified agencies over the past several years. In addition, *Senior Health Services in Minnesota* pointed out: "Given the current workforce crisis in Minnesota, just because there is a home health agency willing to serve clients, it does not necessarily mean the agency has the staff available to do the work. And for current staff, the issues of driving long distances to care for clients in remote or isolated parts of counties can lead to minimal care time, staff burnout and turnover, as well as high costs for mileage." Those issues – workforce shortages and the necessity of driving long distances to serve clients who live in isolated areas – are just as relevant today as they were in 2001.

Map 1 – Minnesota Home Care Providers



Map 2 – Minnesota Medicare Certified Home Health Agencies



Reimbursement

Home care agencies in Minnesota are reimbursed for MSHO using either a per-visit rate (the most common form of reimbursement), an episodic rate (the current method used by Medicare and some health plans as part of MSHO), or a blended rate. A per-visit rate is a predetermined rate, specific to a particular health care program (e.g., Medicaid), paid for a set of services rendered during each home health visit. The Medicare episodic rate can be defined as payment for a 60-day episode of care, with a predetermined base payment rate that is adjusted for the health condition and care needs of the beneficiary and the geographic differences in wages for home health agencies across the country. The blended rate is a predetermined, per-visit rate that is based on a combination of rates (e.g., Medicare and Medicaid fee schedules). This single rate may be used to reimburse home health services

regardless of whether they constitute Medicare or Medicaid-covered skilled or Medicaid-covered unskilled care.

Billing

All home care agencies bill various payers for the provision of home care services. For example, agencies bill Medicaid directly through an electronic billing tool on the Web; they bill MCOs through an electronic billing system or by submitting paper claim forms. Minnesota Statutes 62Q.75 governs the claims processing and submission timeline, stating that health plans and other third party payers have 30 days to pay or deny claims from home health services, and health services providers must submit claims to a health plan or third party administrator within six months of providing services. Health plans that are not in compliance are required to reimburse home health agencies 1.5 percent of the claim for each month of delay. Home health agencies that do not comply with claims submission time limits will not be reimbursed for the affected charges. As part of the Medicare and Medicaid programs, CMS also requires that Medicare Advantage organizations (including MCOs) pay 95 percent of the "clean claims" within 30 days of receipt. (SOURCE: 42 *CFR* 422.520)

Home Health Technology

Most home health technology currently in use falls into one of five categories: back office fiscal systems, billing and human resources systems, point-of-care systems for clinicians in the field, electronic medical records, and telehomecare. (SOURCE: Fazzi R, Ashe T, Doak L. *Philips National Study on the Future of Technology and Telehealth in Home Care*. Phillips Medical Systems. October 2007) Back office technology refers to tools used by the home health agency to improve business operations and performance. Billing and human resources systems are used to track services provided to patients so the data can be submitted for billing purposes. Point-of-care technology refers to the exchange of information between a home health care provider working in a patient's residence and a health care provider located at another site. This may include completing a patient assessment and transmitting the data to a physician for review and approval or transmitting patient care information from the patient to the physician. Electronic medical records, or electronic health records, are tools used to track patient care and patient outcomes.

Telehomecare refers to services that allow for the monitoring of patients and/or patient education using two-way communication devices. These devices may facilitate digital, audio, and/or visual communication between patients and home health care providers and can include regular, on-going patient monitoring (e.g., blood pressure and blood sugar levels) and scheduled televisits. Home health care providers typically use telehomecare to decrease administrative costs, increase efficiency, reduce transportation expenses, improve patient access to specialists (including mental health providers), improve quality of care, and increase communications among providers, and between providers and patients.

Although home health technology is increasingly being used by home health agencies in the U.S. and Minnesota, limited incentives exist for home health agencies to adopt these new technologies. In particular, reimbursement for the provision of telehealth services is limited. CMS has not formally defined telemedicine for the Medicaid and Medicare programs, and Medicaid does not recognize telemedicine as a distinct service.

Telehealth services are considered to be outside the scope of the Medicare home health benefit and home health PPS. Specifically, the law "does not permit the substitution or use of a telecommunications system to provide any covered home health service paid under home health PPS, or any covered home health service paid outside of home health PPS." (SOURCE: Medicare Home Health Agency Manual (HCFA Pub. 11) However, "there is nothing to preclude a home health

agency from adopting telemedicine or other technologies that they believe promote efficiencies, but these technologies will not be specifically recognized or reimbursed by Medicare under the home health benefit." Therefore, although PPS does not directly reimburse for telehomecare, neither does it prohibit its use. Under Medicare, telehomecare is seen as an optional tool that home care agencies can choose to use to improve patient care and create efficiencies.

Within the context of Minnesota's Medical Assistance program, telehomecare is defined as "the use of telecommunications technology by a home health care professional to deliver home health care services, within the professional's scope of practice, to a patient located at a site other than the site where the practitioner is located." (SOURCE: Minnesota Statutes 256B.0651). The following summarizes the state's Medical Assistance policies regarding telehomecare:

> Medicaid home health skilled nurse visits are reimbursed by Medicaid if the services are "provided via telehomecare...do not require hands-on care between the home care nurse and recipient. The provision of telehomecare must be made via live, two-way interactive audiovisual technology and may be augmented by utilizing store-and-forward technologies. Store-and-forward technology includes telehomecare services that do not occur in real time via synchronous transmissions and that do not require a face-to-face encounter with the recipient for all or any part of any such telehomecare visit. A communication between the home care nurse and recipient that consists solely of a telephone conversation, facsimile, electronic mail, or a consultation between two health care practitioners, is not to be considered a telehomecare visit. Multiple daily skilled nurse visits provided via telehomecare are allowed. Coverage of telehomecare is limited to two visits per day. All skilled nurse visits provided via telehomecare must be prior authorized by the commissioner or the commissioner's designee and will be covered at the same allowable rate as skilled nurse visits provided in-person." (SOURCE: Minnesota Statutes 256B.0653 Home Health Agency Covered Services)

Home Health Quality Improvement

CMS encourages Medicare-certified home health agencies to implement outcome-based quality improvement programs to improve patient outcomes. Using data collected from the OASIS assessment, CMS provides agencies with monthly outcome reports that display the percentage of the agency's patients that showed improvement over time on each of 41 measures. Measures include physiologic, functional, cognitive, emotional and behavioral health, as well as utilization measures of acute care hospitalization, emergency room visits, and discharges to the community. Twelve of the measures are publicly reported on http://www.medicare.gov, under "Compare Home Health Agencies in Your Area."

Medicare QIOs across the country, including Minnesota's Stratis Health, have been working with home health agencies to improve quality of care and patient outcomes. Stratis Health has worked with home health agencies over the past five years to encourage and support the use of evidence-based best practices to improve the outcome measures, by providing education, tools and resources, and individual technical support to help providers set improvement goals, implement intervention strategies, and measure results.

In 2005, CMS set a national priority for home health agencies to reduce the number of patients hospitalized while receiving home care. Unnecessary hospitalizations create financial and emotional burdens for patients and their families, and can negatively impact the health care delivery system.

In January 2007, CMS in conjunction with the Home Health Quality Improvement Organization Support Center, Quality Insights of Pennsylvania, launched the Home Health Quality Improvement

National Campaign. The goal of the campaign was to unite the home care community under the shared vision of reducing avoidable hospitalizations to improve quality of care. Sixty percent of Minnesota's Medicare-certified home health agencies participated in the campaign.

During the campaign, best practice intervention packages – including educational tools and resources, guidelines, success stories, and best practice education – were provided monthly.[6] Examples of the best practice intervention package topics included hospitalization risk assessment, emergency care planning, medication management, telemonitoring, immunization, physician relationships, fall prevention, patient self-management, and transitional care coordination. Agencies were encouraged to review best practices, prioritize needs, and implement appropriate interventions in their agency.

F. MSHO HEALTH PLANS AND COUNTY-BASED PURCHASING ORGANIZATIONS IN MINNESOTA

Six health plans and three county based purchasing organizations (which are collectively referred to in this report as managed care organizations, or MCOs) in Minnesota hold contracts with the state Department of Human Services to provide reimbursement and care management services for MSHO enrollees. Participating MCOs include: Blue Cross Blue Shield of Minnesota, FirstPlan of Minnesota, HealthPartners, Itasca Medical Care, Medica, Metropolitan Health Plan, PrimeWest Health, South Country Health Alliance, and UCare. Below are Tables 1, 2, and 3 which highlight key characteristics of each MCO—membership, service area, and MSHO reimbursement methods being used by each MCO; and breakouts of MSHO and MnDHO enrollment.

Table 1: Key Characteristics of Minnesota MCOs

MCO	Health Plan/County-based Purchasing Organization	Total Plan Membership	Service Area for All Products	Reimbursement System Used for MSHO
Blue Cross Blue Shield of Minnesota	Health Plan	2.7 million members	Statewide	Uses Medicare's PPS episodic rate. Moved to the episodic rate January 1, 2006.
FirstPlan	Health Plan	17,000	Seven Minnesota counties (Cook, Carlton, Itasca, Koochiching, Lake, northern Pine and St. Louis counties)	Uses a per-visit rate.
HealthPartners	Health Plan	662,000	Minnesota, North Dakota, parts of South Dakota, Iowa, & Wisconsin	Uses a per-visit rate and less frequently, a blended rate.

[6] All of these resources are now available on http://www.medqic.org, to assist home care agencies in keeping their patients at home.

MCO	Health Plan/County-based Purchasing Organization	Total Plan Membership	Service Area for All Products	Reimbursement System Used for MSHO
Itasca Medical Care	County-based Purchasing Organization	5,400	Itasca, northern Aitkin, and southern Koochiching Counties	Uses a per-visit rate.
Medica	Health Plan	1.3 million	Minnesota, select counties in Wisconsin, and all of North Dakota and South Dakota	Uses a blended rate and a per-visit rate. Exploring making an episodic payment rate available
Metropolitan Health Plan	Health Plan	16,940	Anoka, Carver, Hennepin, Mower, Polk, & Scott counties	Has used Medicare's PPS episodic rate since 2005.
PrimeWest Health	County-based Purchasing Organization	10,500	Beltrami, Big Stone, Clearwater, Douglas, Hubbard, Grant, McLeod, Meeker, Pipestone, Pope, Renville, Stevens, and Traverse counties	Uses Medicare's PPS episodic rate plus 15 percent for Medicare-covered services, and the DHS Medical Assistance fee-for-service payment methodology/rate plus 15 percent for Medicaid or HCBS.
South Country Health Alliance	County-based Purchasing Organization	24,000	Brown, Cass, Crow Wing, Dodge, Freeborn, Goodhue, Kanabec, Morrison, Sibley, Steele, Todd, Wabasha, Wadena, and Waseca counties	Has used Medicare's PPS episodic rate since January 1, 2006.
UCare	Health Plan	130,000	Minnesota and 23 counties in western Wisconsin	Uses a per-visit rate. Does not currently have the claims processing software to support a PPS episodic reimbursement method but is exploring options that may lead in this direction.

SOURCES: Key informant interviews, MCO websites, and MCO staff.

Table 2: Minnesota MSHO Enrollment and MSHO Payment Methodology by MCO, January 2008

MCO	MSHO Enrollees			MN Counties Served	MSHO payment method
	Metro	Non-Metro	Program Total		PPS, Per-Visit, Blended
BLUE PLUS	1,683	8,364	10,047	56	PPS
FIRST PLAN BLUE	0	941	941	5	Per-Visit
HEALTH PARTNERS	2,582	0	2,582	7	Per-Visit, Blended
ITASCA MEDICAL CARE	0	451	451	3	Per-Visit
MEDICA	4,755	3,736	8,491	33	Per-Visit, Blended
METROPOLITAN HEALTH PLAN	793	12	805	5	PPS
PRIMEWEST HEALTH SERVICE	0	2,046	2,046	10	PPS +
SOUTH COUNTRY HEALTH ALLIANCE	0	1,985	1,985	9	PPS
UCARE	4,688	3,587	8,275	55	Per-Visit

SOURCE: Minnesota Department of Human Services, February 2008, and MCOs February 2008.

Table 3: Statewide MSHO and MnDHO Enrollment and MSHO Reimbursement Methodology, January 2008

		MSHO Enrollees		
		Metro	Non-Metro	Program Total
Statewide MSHO Enrollment		14,501	21,122	35,623
MSHO Reimbursement Method	PPS	2,476	12,407	14,883 (42%)
	Per-Visit/Blended	12,025	8,715	20,740 (58%)
TOTAL MSHO		**14,501**	**21,122**	**35,623**
TOTAL MnDHO		**921**	**0**	**921**

SOURCE: Minnesota Department of Human Services, February 2008, and MCOs February 2008.

As noted in Tables 2 and 3, there are 921 MnDHO enrollees in the Twin Cities metro and all of them are enrolled in UCare.

As indicated in Table 2, all of the Minnesota MCOs discussed in this report serve MSHO enrollees. Four MCOs use the PPS episodic reimbursement methodology, three use a per-visit method and two use both the per-visit and blended methods. This translates into 14,883 MSHO enrollees (42 percent) having their home health services reimbursed using the PPS episodic rate and 20,740 MSHO enrollees (58 percent) having their home health services reimbursed using the per-visit or blended rates. See Appendix G for a map of MCOs' MSHO service areas.

Following are brief descriptions of each MCO, its reimbursement method for MSHO and any planned changes, a description of quality improvement and technology-related home health services projects the MCO is currently supporting or developing, and a description of the MCO's methods for providing care coordination services to MSHO enrollees.

Blue Cross and Blue Shield of Minnesota (BCBS) — BCBS, a not-for-profit, taxable organization, and its affiliates—under the parent corporation Aware Integrated Inc.—provides health coverage to more than 2.7 million members, including 10,047 MSHO enrollees.

BCBS' MSHO service area is 56 counties. The company contracts with 60 home health agencies and over 200 PCA agencies to provide home care services to MSHO enrollees. BCBS contracts with counties to provide the bulk of their care coordination services for MSHO enrollees.

BCBS reimburses for MSHO home health services using Medicare's PPS episodic rate. BCBS moved to the episodic rate January 1, 2006. BCBS has not implemented any home health technology-based projects but is currently exploring telehome health options.
(SOURCES: BCBS, 2008 http://www.bluecrossmn.com/ and key informant interviews)

FirstPlan — FirstPlan is a non-profit health plan that is affiliated with BCBS. FirstPlan serves over 17,000 Minnesotans, in their seven-county service area (Cook, Carlton, Itasca, Koochiching, Lake, northern Pine and St.Louis counties).

FirstPlan serves 941 MSHO enrollees in five counties. The company contracts with 24 home health agencies to make home care services available to MSHO enrollees. FirstPlan provides care coordination services through FirstPlan employees; by contracting with St. Luke's Hospital, St. Mary's Duluth Clinic, and North Star Physicians; and by contracting with four counties. FirstPlan reimburses for MSHO home health services using a per-visit rate. FirstPlan has not implemented any home health technology-based projects; however, the organization contracts with some home health agencies that provide telehome health services. (SOURCES: FirstPlan, 2008 http://www.firstplan.org and key informant interviews)

HealthPartners — HealthPartners is an independent, non-profit health plan that provides services to approximately 662,000 members, including 2,582 MSHO enrollees. Health Partners' service area includes Minnesota and North Dakota and parts of South Dakota, Iowa, and Wisconsin.

HealthPartners' MSHO service area is the seven-county metro area. The company contracts with more than 71 home health agencies and 68 PCA agencies to provide home health services. HealthPartners provides care coordination services through its own case managers. HealthPartners reimburses for MSHO home health services using a per-visit rate and less frequently, using a blended rate. HealthPartners has not implemented any home health technology-based projects.
(SOURCES: Health Partners, 2008 www.healthpartners.com and key informant interviews)

Itasca Medical Care (IMCare) — IMCare is administered by Itasca County. IMCare is a county based purchasing organization that provides services to approximately 5,400 Minnesotans, including 451 MSHO enrollees.

IMCare's service area is three counties (Itasca, northern Aitkin, and southern Koochiching Counties). IMCare contracts with 15-20 home health agencies and PCA agencies to provide home health services to MSHO enrollees. IMCare provides care coordination services through county employees (some based at IMCare and some based at the local public health agency). IMCare reimburses for MSHO

home health services using a per-visit rate. IMCare has not implemented any home health technology-based projects. (SOURCES: IMCare, 2008 and http://www.co.itasca.mn.us/hhs/imcare/)

Medica — Medica is a non-profit, taxable corporation that provides health coverage to 1.3 million members, including 8,491 MSHO enrollees. Its coverage is available in Minnesota, select counties in Wisconsin, and all of North Dakota and South Dakota.

Medica's MSHO service area includes 33 Minnesota counties. Medica contracts with 30 home health agencies and 60 PCA agencies to provide home health services to MSHO enrollees. Medica uses a variety of methods to provide care coordination services to MSHO enrollees, including Medica employees; contracts with care systems (Evercare, Fairview Partners, North Memorial Hospital, Saint Mary's Duluth Clinic, Health East, and North Star Family Physicians); and contracts with counties.

Medica reimburses for MSHO home health services using a blended rate and a per-visit rate. The company is exploring making an episodic payment rate available; however, United Health Group, which manages claims processing for Medica, is in the process of developing a new claims system. Medica has requested use of the episodic payment rate as a systems development requirement, but it is unclear whether that will be a priority in the systems development process.

Medica has implemented home health technology pilot projects over the past two years. The pilot projects include remote units and a video component in patient homes. Medica is also exploring other telehomecare options. (SOURCES: Medica, 2008, http://www.medica.com and key informant interviews)

Metropolitan Health Plan (MHP) — is a not-for-profit, state-certified HMO. MHP provides health coverage to approximately 16,940 members, including 805 MSHO enrollees.

MHP's MSHO service area is five counties—Anoka, Carver, Hennepin, Polk, and Scott. MHP contracts with 58 home health agencies and 29 PCA agencies to make home care services available to MSHO enrollees. MHP provides care coordination services through MHP employees as well as through contracts with counties. MHP reimburses for MSHO home health services using Medicare's PPS episodic rate. MHP moved to an episodic rate in 2005. MHP has not implemented any home health technology-based projects.(SOURCES: MHP, 2008 http://www.co.hennepin.mn.us/ and key informant interviews)

PrimeWest Health (PrimeWest) — PrimeWest is a county-based purchasing organization owned by a group of 13 counties in southwestern, west-central, and northern Minnesota—Beltrami, Big Stone, Clearwater, Douglas, Hubbard, Grant, McLeod, Meeker, Pipestone, Pope, Renville, Stevens, and Traverse. PrimeWest has over 10,500 members, including 2,046 in MSHO.

PrimeWest maintains an "any willing provider" network. This allows all qualified health care providers that enter into a provider contract with PrimeWest to provide covered services to PrimeWest members without first requiring service authorization, and to receive a higher reimbursement rate than non-contracted providers.

PrimeWest's MSHO service area is 10 counties. PrimeWest contracts with 37 home health agencies and 38 PCA providers to make home care services available to MSHO enrollees. PrimeWest's care coordination program utilizes county public health and social services case managers. PrimeWest has an internal billing and claims processing system and reimburses for MSHO home health services using Medicare's PPS episodic rate plus 15 percent for Medicare-covered services, and the DHS

Medical Assistance fee-for-service payment rate plus 15 percent for Medicaid (Medical Assistance) or HCBS. PrimeWest has not implemented any home health technology-based projects. (SOURCES: PrimeWest, 2008, http://www.primewest.org and key informant interviews)

South Country Health Alliance (SCHA) — SCHA is a county-based purchasing organization that is owned by a group of 14 counties—Brown, Cass, Crow Wing, Dodge, Freeborn, Goodhue, Kanabec, Morrison, Sibley, Steele, Todd, Wabasha, Wadena, and Waseca. SCHA has over 24,000 members, including 1,985 MSHO enrollees.

SCHA's MSHO service area includes nine counties. SCHA contracts with BCBS to use its provider network, including home health agencies and PCA agencies that provide home health services to MSHO enrollees. SCHA also has contracts with BCBS for patient authorizations and billing and claims processing. SCHA contracts with counties to provide care coordination services to MSHO enrollees. Since January 1, 2006, SCHA has reimbursed for MSHO home health services using Medicare's PPS episodic rate. SCHA has not implemented any home health technology-based projects. (SOURCES: SCHA, 2008, http://www.mnscha.org and key informant interviews)

UCare — UCare is an independent, non-profit health plan that provides services to more than 130,000 Minnesotans, including 8,275 MSHO enrollees and 921 MnDHO enrollees. It provides health plan coverage in Minnesota and 23 counties in western Wisconsin. UCare is the only health plan in Minnesota that holds a contract to serve MnDHO enrollees. (SOURCES: UCare, 2008 http://www.ucare.org)

G. HOME HEALTH REIMBURSEMENT SURVEY: METHODS AND FINDINGS

Methods

A Web-based survey was developed by Stratis Health with input from the Minnesota HomeCare Association, the Minnesota Council of Health Plans, and the Department of Human Services. The intent of the survey was to gather information from home health agencies regarding the volume of patients served under different payer sources, to measure the level of technology used in home health care, and to determine the prevalence of billing and coding issues, which emerged from key informant interviews as a major topic. The questions were developed to help clarify information gathered during the key informant interviews.

The study population included only Medicare-certified home health agencies. Agencies for which e-mail addresses could be determined (198 agencies) were sent an e-mail link to the survey, along with e-mail reminders and an e-mail message from the Minnesota Home Care Association encouraging participation in the survey. The survey was administered between January 15, 2008, and February 15, 2008.

Results

Eighty home health agencies responded to the survey, resulting in a 37 percent response rate. Three questions were asked related to agency characteristics. The first question asked home health agencies to describe their agency structure. Of the 80 home health agencies that responded, 23 (28.8 percent) identified their agencies as free-standing, 36 (44.4 percent) identified as hospital-based, 12 (15 percent) as public health-affiliated, and the remaining nine (11.3 percent) as other types of agencies, such as nursing home-based or a visiting nurse association.

The next question asked respondents to indicate if their agency is part of a multi-agency organization or chain (more than one agency owned by the same organization). Only eight (10 percent) reported

that their home health agency is part of a chain; the remaining 72 (90 percent) reported that they are an independent agency.

Finally, respondents were asked if their agency is part of a health care system (two or more organizations under the same ownership that are different provider types such as a hospital, nursing home, home care agency, clinic, working together for the aim of the system). Of those who responded, 43 (53.8 percent) reported that their agency is part of a health care system. It is unknown to what extent the demographics of responding home health agencies are representative of the demographics of home health agencies statewide.

Respondents reported that their agencies employ on average 77 people (range four to 500, median 34). The total number of clients served per month ranged from 10 to 1500 with an average of 216 and a median of 117.

The survey included a question that asked respondents to indicate the Minnesota MCOs (listed in Table 4) with which they currently have contracts. The purpose of the question was to determine how many different MCOs home health agencies are working with and therefore how many different billing systems they must accommodate. In this question, "contract" was not limited to MSHO contracts. Since the purpose of this question was to determine how many MCOs home health agencies work with overall, this question included any type of contract a home health agency might have with an MCO.

Table 4: For each Minnesota MCO, the Number and Percent of Home Health Agency Respondents that Report Current Contracts in Place (n = 80 respondents)

MCO	Number	%
IMCare	5	6.20%
First Plan	6	7.40%
MHP	15	18.50%
PrimeWest	17	21.00%
South Country	18	22.20%
Health Partners	40	49.40%
UCare	61	75.30%
Medica	62	76.50%
BCBS	78	96.30%

Home health agencies can also have contracts with entities other than the nine Minnesota health plans and county based purchasing plans listed in Table 4. As of January 2008, 18 HMOs, PPOs, private fee-for-service plans, and Medicare special needs plans offered 79 Medicare health plan benefit packages and 20 Medicare special needs benefit packages in Minnesota (SOURCE: Medicare, 2008). Even though the survey did not ask respondents to quantify the number of contracts they hold with entities other than the Minnesota MCOs, if home health agencies are working with out-of-state plans or other insurance groups that have their own unique billing systems, the complexity home health agencies face is even greater than these results show.

Survey results show that nearly all of the home health agencies that responded have a contract with BCBS but relatively few have contracts with IMCare and First Plan (Table 4). The distribution in Table 4 is reflective of the health plan service areas in Minnesota with respect to home health agencies.

Figure 1 shows the number of Minnesota MCOs with which each home health agency reported having a current contract. For example, one home health agency has zero contracts in place, three home health agencies have one contract in place and 14 agencies have two contracts in place. The results show that the majority of home health agencies (71.65 percent) reported having contracts with three to five Minnesota MCOs. The home health agency that reported zero contracts is currently negotiating a

contract with an MCO. The home health agency with seven MCO contracts was a large home health agency with many employees. However, the home health agencies that reported six MCO contracts were not all large (in fact, one reported six employees and serves an estimated 25 clients a month). Other demographic characteristics (such as agency structure or being part of a chain) were not associated with high or low numbers of contracts.

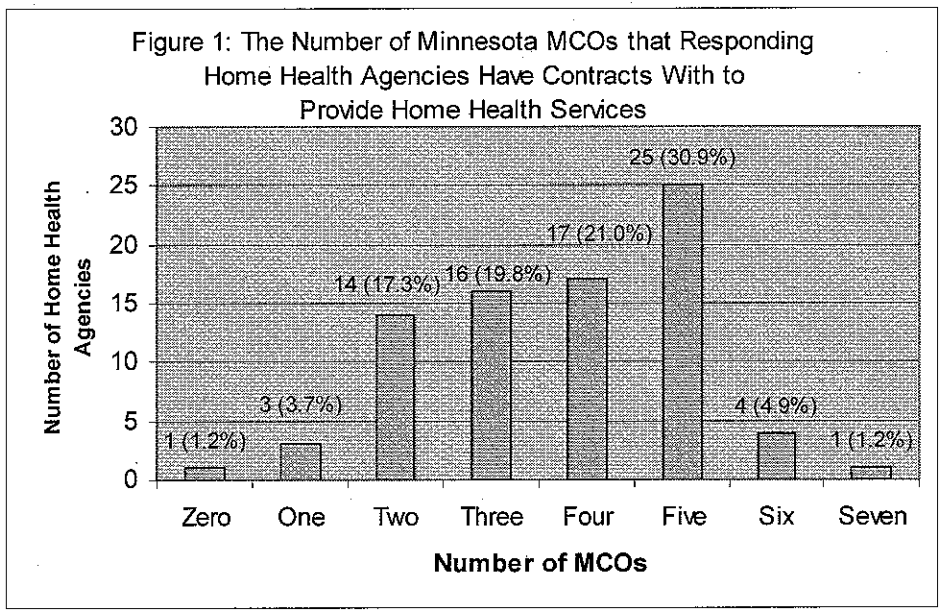


Table 5 shows the number of home health agencies that reported claims returned for further processing. Over half (57.2 percent) reported that claims are returned occasionally or often. The average number of clients for the home health agencies that reported claims returned never or rarely was 164 compared to 264 for those that reported claims returned occasionally or often. A One-Way Anova procedure was used to test if the difference between the two means is statistically significant. Although the difference appears large, it is not statistically significant (p=0.078). The average number of employees for the home health agencies that reported claims returned never or rarely was 37 compared to 110 for those that reported claims returned occasionally or often. This difference was statistically significant (p=0.0005).

Table 5: In the last month, how often were claims returned to your agency for further processing? (n = 80 respondents)

Response	Number	%
Never	7	9.1%
Rarely	26	33.8%
Occasionally	32	41.6%
Often	12	15.6%

Hospital-based home health agencies were less likely to report claims returned for further processing than other types of home health agencies; 44.1 percent of hospital-based home health agencies reported claims returned occasionally or often, compared to 78.2 percent of freestanding home health agencies and 55 percent for all other types of home health agencies. This difference may be because hospital-based home health agencies have more experience submitting claims to MCOs, or they may have more effective software products that result in fewer claims returned.

Home health agencies were asked to estimate the average number of days it took each payer to process claims in the last month. Table 6 shows the mean and median days to process claims by payer

type grouped into managed care, fee-for-service (FFS) and other payer types. The mean number of days to process claims was the highest for managed care plans: Medicare managed care (59 days), Medicaid managed care (31.6 days), and MSHO (35.9 days). The lowest means were for Medicare FFS (23.6 days) and Medicaid FFS plans (20.5 days).

The median number of days was lower than the mean for all plan types because the distribution of responses was skewed toward low average numbers of days, with a few outlier home health agencies reporting high average numbers of days. Although the outlier agencies' responses lie well outside the norm, their responses should not be discounted because they represent actual, if unusual, circumstances. In addition, a look at the medians reveals similar results; managed care claims are associated with the highest median number of days to process claims compared to FFS claims (with the exception of MnDHO). This question did not distinguish between Minnesota payers and non-Minnesota payers.

Table 6: The Average and Median Number of Days to Process Claims Reported by Home Health Agency Respondents (n = 80 respondents)

Payer Type	Mean	Median
Managed Care Claims		
Medicare managed care	59.0	32.5
Medicaid managed care	31.6	30.0
MSHO	35.9	30.0
MnDHO	25.6	18.0
FFS Claims		
Medicare FFS	23.6	20.0
Medicaid FFS	20.5	14.0
Other Claims	35.2	30.0

Finally, questions were asked about staffing and technology (Table 7). Twenty-five percent of home health agencies responded that they currently provide PCA services. Free-standing home health agencies were more likely to report PCA services provided (39.1 percent) compared to hospital-based (20 percent) and all other agency types (19 percent).

Overall, home health agencies have staff recruiting needs, especially for registered nurses (RNs) and nursing assistants (NA/Rs). Many home health agencies responded that they recruit for these positions on a continuous or ongoing basis or have been recruiting for longer than nine months. For those agencies currently recruiting NA/Rs, 67 percent are doing so on a continuous basis or have been doing so for more than nine months. Hospital-based home health agencies were less likely to report recruiting needs compared to other types of agencies. Only 22.9 percent of hospital-based home health agencies are recruiting RNs or licensed practical nurses (LPNs), compared to 77.3 percent of free-standing and 62 percent of all other types of agencies.

Table 7: Responses to technology and staffing questions (n = 80 respondents)

	Yes
Is your agency currently providing personal care attendant (PCA) services?	20 (25%)
Is your agency currently recruiting RNs or LPNs?	38 (49.4%)
Is your agency currently recruiting physical therapists?	23 (28.4%)
Is your agency currently recruiting occupational therapists?	10 (12.5%)
Is your agency currently recruiting nursing assistants (NA/Rs)	27 (35.9%)
Is your agency currently using telemonitoring in the homes of your clients?	27 (33.3%)
Do you currently use a point-of-care system to electronically collect data in your patients' homes (NOT including OASIS assessment data)?	38 (48.1%)

Of all respondents, 33 percent are currently using telemonitoring in the homes of their clients. There were statistically significant differences in the use of telemonitoring by agency structure. Hospital-based home health agencies were more likely to use telemonitoring (47.2 percent) than free-standing (30.4 percent) or all other types of agencies (14.3 percent) (p=0.013). Notably, none of the 12 public health-affiliated home health agencies included in the "all other types of agencies" category reported that they use telemonitoring in the homes of their clients.

Finally, nearly half (48.1 percent) of home health agencies reported that they currently use a point-of-care system to electronically collect data. There were no differences in the use of electronic systems between agency types. Since this survey was Web-based and responding required a certain amount of technological capacity and competence, it is possible that the survey results overstate the actual statewide rate at which home health agencies use electronic data collection systems. In other words, those agencies that did not respond to the survey may have made that choice in part because they lack or are not comfortable with the technological tools required to respond; they may also lack the technological tools to do electronic data collection.

H. HOME HEALTH KEY INFORMANT INTERVIEWS: METHODS AND FINDINGS

Key informant interviews were conducted with 26 home health stakeholders representing 23 local, state, and national organizations, including representatives of: nine home health agencies, seven health plans, two county based purchasing organizations, Stratis Health, state agencies outside of Minnesota that manage MSHO-like products, the National Association for HomeCare and Hospice, and the Medicare Payment Advisory Commission (MedPAC). A list of the key informants is reported in Appendix D. Most of the interviews were conducted via telephone and all were conducted using a structured set of interview questions developed by Stratis Health for the purposes of this study (Appendix E, Key Informant Interview Questions). Interviews were conducted between November 5, 2007, and January 15, 2008.

The intent of key informant interviews was to: 1) obtain background information on each organization, 2) develop a better understanding of the MCO and home health agency contracting process for MSHO, 3) understand the impact of MSHO expansion on key home health stakeholders, 4) understand the different ways that care coordination services are being provided around the state,

within the home health context, 5) identify the different reimbursement methods that MCOs are using, their rationale for selecting the reimbursement methods they have, and any reimbursement method changes that are occurring and/or planned, 6) develop a better understanding of Minnesota's home health marketplace and the impact of marketplace issues on home health reimbursement, and 7) identify quality improvement and home health technology activities that are occurring through MCOs and home health agencies.

Key informant interviews uncovered a number of issues affecting home care agencies and MCOs related to reimbursement, home health technology, and quality of care that extend beyond MSHO and MnDHO. Consequently, this discussion may include concerns about other Medicare managed care plans, and was not restricted to discussion of MSHO/MnDHO. Stratis Health's analysis revealed that these issues fall into a number of themes, including: communication, billing and coding, rate negotiations, care coordination, PCAs, workforce shortages, barriers to technology use, and quality improvement. Following is an overview of each issue along with related quotes from stakeholders:

Communication and Information

- Home care agencies and health plans report lack of knowledge and understanding of the MSHO program. Stakeholders attribute this to staff turnover (a problem throughout the health care industry), lack of training, and lack of consistent information resources.
- Most home care agency staff interviewed do not understand that DHS is not responsible for contracting with MCOs to provide the Medicare portion of services provided through MSHO. (CMS is responsible for the Medicare portion of MSHO.)
- Home care agency staff and MCO staff report limited face-to-face contact between them; this has a negative impact on organizational communications and issues resolution. Both MCOs and home care agencies report a desire to have more regular face-to-face communication opportunities. For example, one stakeholder stated, "I wish we could get together even just once a year."
- Home health agencies and MCOs report an overall need to improve communications and relations between health plans and home health agencies. This includes relations pertaining to care decision making and contract negotiations. The following comments by those interviewed reflect this finding, "Why can't we just talk – I don't understand it." And "Relationships are everything, so how did it get to this point?"
- Although most MCOs report that meetings between MCOs and home health agencies can be scheduled upon request, home health agencies are either not aware of this option, do not believe it is a real option that will result in open dialogue, and/or have tried this option with limited success.
- Home care agencies report that their definitions of skilled and unskilled visits do not always coincide with MCO definitions.
- Frequent staff turnover has a significant impact on MCOs' and home health agencies' ability to establish consistent communication channels between them, which can in turn have a negative impact on business continuity.

Billing and Coding

- All but one home care agency interviewed discussed reimbursement and billing issues. Most related to long delays in getting paid, problems with resolving billing concerns, MCOs not having a designated billing contact for home health agencies, the many different billing procedures required of home care agencies to accommodate MCOs' differing systems, and the overall financial impact of billing issues on home health agencies' cash flow and ability to provide services. Examples of comments made by key informants include:

- "It's not only the days that we are not getting paid, but we can be on the phone for hours, which demands a lot of staff time, and we still don't get paid."
- "Why they [MCOs] can't figure out one way to bill everything is beyond me."
- "We just added an eleventh person to our billing staff because we are having so many issues. These are just extra costs that we cannot afford."
- "At this point, I don't care how we are getting paid; we just need to get paid."
- "I'm taking profitability from last year to make payroll this year."
- "The only thing that saves us is the backing of a company that can help with our on-going cash flow issues."
- "Blended benefits are great for patients and they are an administrative burden for providers."
- "Try to imagine training your nursing workforce on how to submit information for billing purposes."

- All of the health plans and county-based purchasing organizations stated they have mechanisms in place to address billing issues; however, home care agencies perceive there are limited mechanisms in place.
- Although home care agencies reported billing and coding as one of their greatest concerns, no MCO reported awareness of on-going home care billing and coding problems.

Rate Negotiations

Some home health agencies report MCOs do not provide an opportunity to negotiate rates. Some MCOs confirmed this by stating they have set reimbursement rates for certain geographic areas of the state. Home health agencies also report they are at a disadvantage when it comes to negotiation because they do not have the financial or organizational capacity to have staff trained in this area, health plans are significantly larger organizations with designated contracting staff, and often, the contracts between MCOs and home health agencies do not include reimbursement rates and/or updated rates. Examples of comments from home health agencies that reflect their perceptions of the negotiation process include:

- "Health plans are multi-million dollar companies. How can we negotiate with something like that?"
- "Why should my agency be paid differently when supposedly, we are providing the same services?"
- "They pretty much send a contract and the expectation is to sign it or leave it."
- "For many of the contracts, we don't know the rate because it's not even included in the contract. MSHO was just incorporated into the existing contracts and the renewals were signed before we even knew the rates."

Care Coordination

A unique feature of MSHO is the assignment of a care coordinator for each MSHO enrollee. MCOs use a variety of models to provide this service.

- Key informants, particularly home care agencies, report confusion about the roles and responsibilities of care coordinators and say there are inconsistencies in how care coordination is carried out. In particular, home health agencies report that they often serve as the care coordinator; they just don't get paid to do it.
- Health plans and some home health agencies report care coordination has improved care by providing regular contact between care coordinators and MSHO enrollees. This gives MSHO enrollees an important avenue for communication, and makes them more comfortable raising concerns about their care.

- Some home health agencies report care coordinators have just created another layer between the health care providers and consumers. For example, one stated, "It seems like the care coordinators are really just the gatekeepers managing the money."

Personal Care Attendants (PCAs)

Throughout the key informant interviews, it was clear that there is general agreement among MCOs, home health agencies, and state and national stakeholders that issues PCA rules and regulations need attention. More research in this area is needed.

Workforce

Home health care agencies report shortages of physical therapists and occupational therapists. They also report that when the state unemployment rate is low, recruitment of home health aides is more difficult. These staffing constraints affect not only the care that home health agencies are able to provide, but also the cost of providing services.

Home Health Technology

- Some home health agencies report they are using in-home telemonitoring systems for patients. Those using in-home monitors are primarily using them for congestive heart failure (CHF), cardio-obstructive pulmonary disease (COPD), diabetes, and heart disease and some are reporting their use with wound care. Those that are using telemonitoring for COPD and wound care report they have realized positive outcomes.
- Some of the home health agencies interviewed report they are using laptops for point-of-care data collection to integrate into their home health agency electronic medical record.
- While no health plan has a home health technology project currently in place, one reports it has piloted in-home monitoring systems.

Quality Improvement

All of the key informants were asked about home health quality improvement activities they are involved in, in particular as they relate to MSHO. Home care agencies and MCOs report they are not working together to addressing quality improvement needs except on a case-by-case basis when issues arise. Some home care agencies report they are concerned about OASIS and other quality improvement related data being collected, in particular because of data quality and consistency issues. For example, one home care agency reports, "I can have two nurses go out and do the same initial OASIS assessment on a patient and come back with two very different assessments. It's too difficult to interpret quality using this."

I. MSHO HOME HEALTH REIMBURSEMENT AND RELATED ISSUES AND OPPORTUNITIES

The research team, key informants, and work group members involved in this study identified a number of challenges and opportunities related to home health reimbursement. Most centered on: communication among home health stakeholders, access to home health services, reimbursement methodologies, billing and coding processes, home health technology, and quality improvement. This section focuses on these issues and opportunities and related recommendations that grew out of the study process.

Communication

Home health agency staff and representatives, MCO representatives, and other stakeholders identified a number of communication-related issues that, if resolved, could contribute greatly to resolving pressures and challenges the home health community in Minnesota is currently experiencing. Some of these issues are related to high rates of staff turnover, both at home health agencies and MCOs. Others appear to be related to differences in organizational culture between home health agencies and MCOs, lack of opportunities for relationship-building due to geographic distances, and heavy workloads. Work group members have verbally agreed to continue meeting beyond the close of this study to address these communication issues. The work group identified the following as a sampling of potential areas of focus for future work together:

- Training
    - Identify home health training and outreach approaches that meet the needs of home health agency staff, including targeted approaches for different types of staff (e.g. coders and billers, administrators).
    - Develop a "frequently asked questions" tool that can be used as a training tool for new staff MCO and home health agency staff.
    - Communicate training opportunities to the Minnesota HomeCare Association for posting on the Association's education calendar.
- Technology
    - Explore opportunities to enhance Medicare and Medicaid reimbursement for the use of home health technology in meeting the needs of home health clients.
- Billing and coding
- Data collection
- Research related to access issues, health workforce shortages, demographic changes
- Quality improvement
    - Develop tools, including quality measurement tools
    - Develop pilot projects to measure and improve quality of care

Communication: Conclusions and Recommendations

A central finding of this study is that communication among home health stakeholders in Minnesota needs to improve. This study confirmed that home health agencies face a variety of challenges and operate in an environment that is extremely complex. It is clear, however, that those challenges and environmental factors will more likely be recognized and addressed if communication among stakeholders increases. This includes communication between and among MCOs, including health plans and county-based purchasing organizations), home health agencies, the Minnesota Council of Health Plans, the Minnesota HomeCare Association, the Department of Human Services, and consumer representatives.

Communication Recommendation 1:

- An ongoing home health stakeholder group should be established to discuss mutually identified issues and work toward solutions. The stakeholder group should, at a minimum, include representatives of home health agencies, home health consumers, health plans, county-based purchasing organizations, the Minnesota HomeCare Association, and the Minnesota Council of Health Plans.
    - Facilitation of the stakeholder group should be provided by a neutral party with a basic understanding of the home health system and how MCOs operate in Minnesota, but no vested interest in the outcome of stakeholder discussions.
    - Stakeholder group discussions should begin by focusing on issues identified through this study.

Communication Recommendation 2:

- The Minnesota HomeCare Association, Minnesota Council of Health Plans, and county-based purchasing organizations should pursue a joint research and advocacy agenda that promotes high quality, effective care for home health clients. Potential topics of focus for these joint research and advocacy efforts include quality improvement and the increased use of technology in the home health sector.

Communication Recommendation 3:

- In order to ensure effectiveness, efficiency, and continuity of business operations, MCO staff should make intentional efforts to build relationships with staff of the home health agencies with which their organizations hold contracts. These relationship-building efforts should include efforts to improve the transfer of organizational knowledge when personnel changes occur at MCOs and home care agencies, and whenever feasible, should include face-to-face contact.

Reimbursement

As stated earlier in this report, home care agencies in Minnesota are reimbursed for Medicare skilled services under MSHO using either a per-visit rate (the most common form of reimbursement), a PPS episodic rate (the current method used by Medicare and some health plans as part of MSHO), or a blended rate. Four MCOs use the PPS episodic rate, two use per-visit rates, and two use both per-visit and blended rates.

Most home care agencies contacted through this study have a strong preference for the PPS episodic rate as it: 1) provides half of the payment up front, 2) most often results in a higher payment (as compared to per-visit and blended rates) for care provided to each patient, 3) allows them to front-load visits and provide high cost services such as physical therapy sooner versus later, and 4) requires only one authorization for each 60-day episode of care. Home care agencies report that episodic reimbursement also allows them to provide patients with some enhanced services (e.g., more aggressive wound care services that include the use of advanced and more costly supplies can be provided), complete more thorough patient assessments, more effectively plan for and provide care, and cover some of the financial losses they incur through providing Medicaid services.

Home health agencies that are paid a per-visit and/or blended rate for Medicare skilled services under MSHO report the rates are inadequate to cover their costs. Agencies have come to rely on payments received from more generous payers to help cover costs not covered by less generous payers; per-visit or blended rates generally allow for smaller margins and so make the practice of agency level cost shifting more difficult. For example, through key informant interviews, home health agencies reported, "We used to say we could take a loss here because we could make up for it over there. That

is no longer possible," and "We lose money when we provide physical therapy and occupational therapy services to Medicaid patients. It has to come from somewhere." Regarding negotiation, although it is accepted and intended that home care agencies negotiate reimbursement rates with MCOs, most agencies contacted through this study report that they choose not to negotiate rates (in some cases, because they do not believe the opportunity to negotiate is available to them), or are offered a rate without the opportunity for negotiations. Two MCOs confirmed that they have predetermined rates for some areas of the state, in particular the Twin Cities metro area.

As part of the key informant interviews, MCOs were asked to report the reimbursement method(s) they use for MSHO home health patients and the rationale for the method selected. Examples of responses from key informants include, "Home health agencies don't feel that the other payment methods cover their costs, so we selected one that does;" "It's not that we don't want to pay PPS, it's that we don't really have a choice," and "We're not terribly interested in PPS because we saw a lot of cost shifting out of Medicare into Medicaid. Instead, we need to reimburse agencies for the work they provide." Based on the differing perceptions and viewpoints of home care agencies and MCOs and the lack of unbiased financial analysis clarifying the financial impact of each method, it is clear that an in-depth analysis of each reimbursement methodology is needed before conclusions can be made.

Table 8 below describes the three basic reimbursement methodologies and outlines the strengths and weaknesses of each from the perspective of MSHO stakeholders represented on the work group, including home health agencies, MCOs, and the state Department of Human Services.

Table 8: Home Care Reimbursement Methodologies Strengths and Weaknesses

Type of Reimbursement	Strengths	Weaknesses
Medicare PPS Episodic Payment Method: a 60-day, episode of care, predetermined base payment that is adjusted for the health condition and care needs of the beneficiary and the geographic differences in wages for home health agencies across the country.	1) Simplifies the negotiations/contracting process between health plans and home health agencies 2) Provides more flexibility in managing patients care (e.g., front-loading visits) 3) No additional authorizations are needed within the episode of care. 4) Facilitates the use of telehome health care because home care agencies can recover the costs 5) Decreases the potential for billing, coding problems 6) Allows for administrative efficiencies 7) Allows for a more thorough patient assessment 8) Creates incentive for home care agencies because the higher the quality of care, the less likely that more care is needed 9) Greater ability to cost shift (strength from home health agency perspective)	1) MCOs perceive it limits their oversight ability. 2) Incentive for home care agencies to only meet the needs of patients that need care beyond four visits but not high need care 3) Incentive for referring agencies that own home health agencies: refer patients needing a high level of care to other agencies 4) Greater ability to cost shift (weakness from state and MCO perspective)

Type of Reimbursement	Strengths	Weaknesses
Per-Visit Method: Involves a predetermined rate, specific to a particular health care program (e.g., Medicaid), paid for a set of services rendered during each home health visit.	1) Ability to negotiate reimbursement rates based on local costs and availability of services 2) Limited ability to cost-shift (strength from state and MCO perspective) 3) Greater level of oversight for services provided (strength from MCO perspective) 4) Easier to administer (for MCOs) 5) All MCOs have systems capacity to reimburse under this method.	1) More frequent authorizations required 2) Lack of consistency in authorizations across MCOs 3) Limited ability to cost shift (weakness from home health agency perspective) 4) More potential for billing and coding problems 5) Greater level of oversight for services (weakness from home health agency perspective) 6) No current incentives for outcome-based care 7) Limited focus on patient assessments
Blended Method: Involves a predetermined, per-visit rate that is based on a combination of rates (e.g., Medicare and Medicaid home health fee schedules). This single rate is used to reimburse home health services regardless of whether they were for skilled or unskilled care.	1) Ability to negotiate rates based on local costs and availability of services 2) No need to differentiate between skilled and unskilled services for payment 3) Lower administrative costs for home health agencies 4) More oversight for services provided (strength from MCO perspective) 5) Potential to be financially beneficial for high volume home care agencies 6) Easier to administer once the payment rate is set 7) Allows for cost shifting (strength from home health agency perspective)	1) More frequent authorizations may be required 2) Lack of consistency in authorization requirements across MCOs 3) Difficult to establish rates because of changing variables 4) No current incentives for outcome-based care 5) Disincentive for home care agencies to provide high skilled care 6) Difficult to monitor cost-sharing from a state perspective 7) Allows for cost shifting (weakness from state and MCO perspective)

As noted in Table 8, some of the strengths of a particular reimbursement method can also be considered weaknesses, depending on one's perspective. For example, the Medicare episodic rate provides a greater opportunity to shift costs from one payer to another. From a payer and policy perspective, cost-shifting is not desired as it means that one payer is paying for some of the care for patients that are covered by another payer (e.g., Medicare paying for Medicaid services). From a provider or home care agency perspective, the ability to cost-shift is a benefit as it allows agencies to make internal financial adjustments as necessary to ensure that all their costs are covered and to provide services to patients regardless of payer.

Following is additional description of selected strengths and weaknesses discussed in Table 8.

Medicare PPS Episodic Payment Method

- Weakness #2: Patient Selection. The PPS episodic reimbursement methodology could be seen as creating an incentive for home care agencies to only meet the needs of patients that require care beyond four visits, but not high need care. Home health agencies contacted through this study report that some agencies "select" patients in this way either because they do not have the capacity (e.g., trained staff) to care for high need patients or they are seeking to maximize their reimbursement and minimize their costs. This could create an access issue for high need clients.
- Strength #7: Patient Assessments. An advantage of the PPS episodic methodology is that it allows for a more thorough OASIS assessment. This method allows providers more than one visit to complete the assessment, which allows the nurse to have more time, greater interaction with the patient, and a better understanding of the patient's condition.

Per-Visit Method

- Weakness #1: Authorizations. The need for multiple authorizations is a significant weakness of the per-visit method from the perspective of home health agencies. Each MCO uses a different authorization process under the per-visit rate method, and authorizations are required starting with the first visit and at varying intervals for subsequent visits, depending on the rules of the MCO. This increases the administrative burden of home care agencies with limited benefit in terms of patient outcomes. It is possible that increased administrative burdens could result in access issues for client that need multiple visits.

Blended Method

- Weakness #3: Rate-setting. Developing a blended Medicare/Medicaid reimbursement rate can be challenging due to the complexity and variability of the factors that determine the rate. This is true both from an MCO and a home health agency perspective.

All of the reimbursement methods discussed above have strengths and weaknesses and the potential to foster improvements in quality and outcomes; how the particular rate is determined and whether the formula is tied to health outcomes will ultimately determine how well a method meets the needs of home health agencies, health plans, and ultimately of consumers. For example, Medicare PPS reimbursement is currently based on a national formula; the intent is that the formula will be changed to reflect outcomes data collected through the OASIS. This same model could be applied to per-visit rates or blended rates by, for example, providing an enhanced per-visit rate for agencies that decrease their re-hospitalization rate or decrease visits to the emergency room. One of Minnesota's health plans is considering piloting this model with some of its home care agencies.

It should also be noted that reimbursement methodologies are simply that – methodologies – and the way they are operationalized can and will change in the future. Medicare has changed the PPS methodology in the past and has proposed further changes. So although one method may appear to be the best today, that could easily change in the future. In addition, no method of payment has shown that it leads to improved health outcomes. Over time, the Medicare episodic method may prove to move care in that direction, but additional research is needed in this area. Given that three distinct reimbursement methods are currently being used in Minnesota, this is an opportune time to research the impact of these methods on a state level. This would provide a unique and needed perspective and make an important contribution to the health care reform discussions that are currently underway at the state level.

Reimbursement: Conclusions and Recommendations

This study resulted in three main conclusions related to home health reimbursement:

- Analysis conducted for this study does not point to a particular reimbursement method as the conclusive solution to meet all stakeholders' needs. As discussed earlier in the report, episodic reimbursement methodologies allow home health agencies greater flexibility to meet client needs than other methodologies, and are therefore generally preferred by home health agencies. While MCOs that have not yet switched to episodic payment should consider doing so, for some MCOs this shift will require major computer systems changes or upgrades. Those changes will be expensive, and related costs will need to be recovered.
- Home health agencies involved in this study report that reimbursement rates, including Medicare outlier and LUPA rates, are inadequate to cover the cost of providing home health services. Other study participants, most notably MCO representatives interviewed as key informants, report that their financial analyses show their organizations are reimbursing at a fair level. A thorough analysis of the cost structure of Minnesota's home health agencies and the level of reimbursement agencies receive was outside the scope of this study.
- Research conducted for this study and discussions that took place within the Home Health Reimbursement Methodologies Work Group revealed that billing and coding issues are a major concern—for many of those interviewed as key informants, their greatest concern.

Reimbursement Recommendation 1:

- In order to ascertain whether reimbursement rates paid to Minnesota home care agencies are fair, a thorough cost analysis should be conducted by an entity with an understanding of health care finance and no vested interest in the outcome of the analysis. In the short term, Minnesota MCOs that are reimbursing at per-visit rates comparable to the Medicare LUPA rate should re-examine those rates to determine whether they are appropriate, given the level of care being provided and the ultimate goal of improving health outcomes.

Reimbursement Recommendation 2:

- The Minnesota HomeCare Association should provide negotiation skills training to home health agency staff on an ongoing basis, in order to better prepare home health agencies to engage in business negotiations with MCOs. Training would improve the effectiveness and efficiency of these negotiations for both the home health agencies and the MCOs.

Reimbursement Recommendation 3:

- MCOs are encouraged to develop pilot projects testing the feasibility of incorporating quality improvement incentives into per-visit and blended home health reimbursement systems used for the MSHO and MnDHO programs.

Reimbursement Recommendation 4:

- Additional research should be conducted – at the state and/or federal level – with a goal of better understanding the relationship between home health reimbursement methodologies and health outcomes in patients receiving home health services. State-level research should be conducted by a neutral party selected by mutual agreement of home health stakeholders involved in the stakeholder group referenced in Communication Recommendation 1. A legislative appropriation or other source of funding will be needed to support this research.

Billing and Coding

Billing and coding are processes used for the monitoring, provision, and payment of all health services, including home health services. Coding is the process of attaching diagnosis and payment codes to the services being provided to each patient. Billing is the process of sending the coding information to the payer so they know what services were provided, to whom, when, and by whom so they can in turn pay the provider for the services rendered.

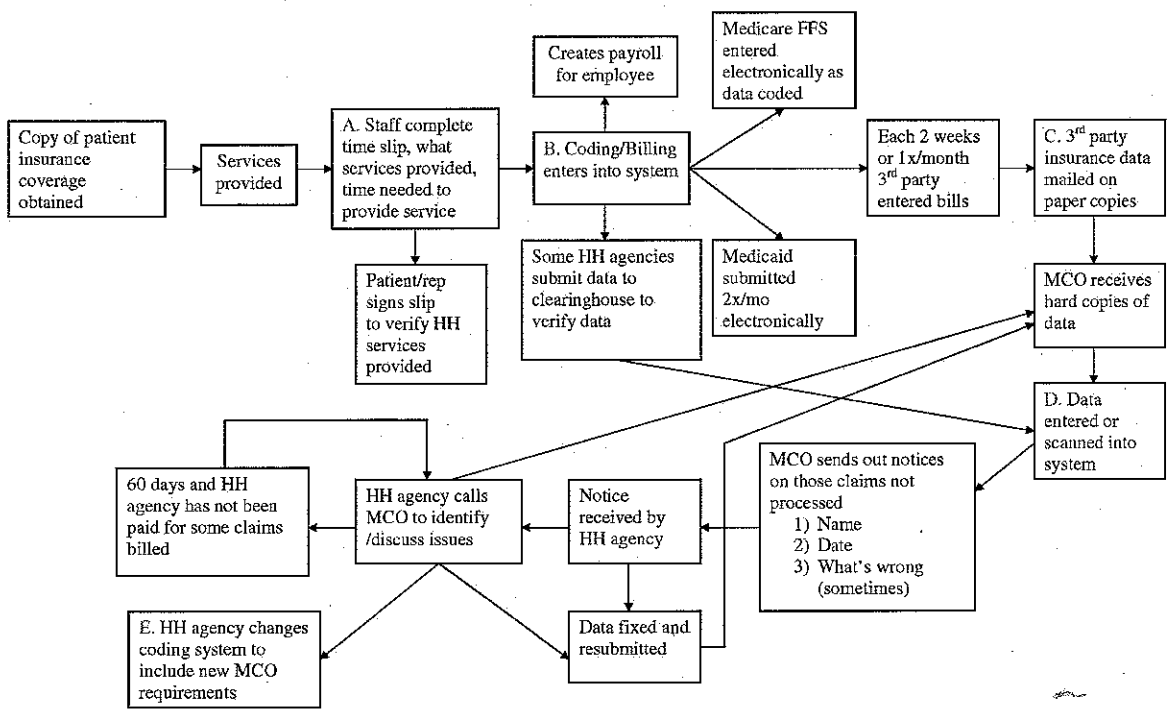
In the process of conducting this study, Stratis Health conducted nine key informant interviews with home health agency personnel representing a range of agency types. Agency employees interviewed for the report identified billing and coding issues as their "greatest concern." In fact, most reported they are currently more concerned about billing and coding and "getting paid" for the services they provide as compared to the reimbursement method for getting paid. Their rationale for this level of concern stems from the impact of delayed payment and in some instances, no payment, on home health agencies' cash flow and ability to stay in business. Delayed payment has an even greater impact on smaller and independent agencies as they have limited cash reserves, cannot borrow funds or cost shift from other parts of their organizations as larger agencies or those that are part of a system or chain might be able to do. Several home health agencies interviewed for this study highlighted the administrative cost of managing billing and coding issues, both in terms of clinical and administrative staff time.

To better understand the scope and scale of billing and coding issues, Stratis Health took the following steps as part of this study (in addition to key informant interviews, mentioned above): 1) included billing and coding questions in an on-line survey of home health agencies, 2) conducted an in-depth interview with one home health agency's billing and coding staff in order to better understand and outline the process, and 3) discussed billing and coding issues as part of a meeting of the Home Health Reimbursement Methodologies Work Group. Information gathered through these methods affirmed what was learned through key informant interviews – that billing and coding issues, and receiving timely payment for services delivered, is an area of primary concern for home health agencies in Minnesota.

Several opportunities exist for problems to arise in the billing and coding process. Some of these problems can be resolved through intentional changes in the process, some are due to human error and can be addressed through training and retention efforts, and some may be eliminated as the state implements the Health Care Administrative Simplification Act of 1994, Minnesota Statutes 62J.51. Implementation of HCAS is intended to provide "significant savings throughout the health care industry by implementing a set of administrative standards and simplified procedures and by setting forward a plan toward the use of electronic methods of data interchange." The Administrative Uniformity Committee (http://www.health.state.mn.us/auc/index.html) is working to develop agreement on standardized processes. The deadline for implementation is January 15, 2009.

As Chart A below illustrates, there are many opportunities throughout the billing and coding process for issues and problems to occur.

Chart A: Home Health Billing and Coding Process



The most common types of issues and errors include:

1) Data issues
   - Variations in system design
   - Lack of synchronization in system updates between MCOs and home health agencies
   - Use of batch processing systems which may not allow for all errors in the batch to be identified and/or may reject all subsequent claims from a batch, once an initial unclean claim is identified.
   - System complexity

2) Human error issues
   - Data submission and entry errors
   - Mishandled hard copies of claims reports
   - System complexity

3) Communication-related issues
   - Home health staff may have incomplete information regarding changes and updates to billing, coding and claims processing. This can result from lack of training, high rates of turnover, excessive workloads, lack of understanding of how to access information, etc.
   - Authorizations for agencies to provide home health services are often conducted via telephone with no formal or standardized verification process. If authorizations are questioned later, no documentation exists and related claims may be denied.

As discussed earlier, many of the identified billing and coding issues should be resolved through implementation of HCAS; however, it should be noted that if exceptions or exclusions are made for

certain payers, billing and coding issues will remain for those home health agencies contracting with those payers. Other issues can be overcome through improved communications between MCOs and home health agencies, including establishing formalized, electronic, authorization documentation.

Clean Claims

Minnesota Statute, 62Q.75 (Appendix H) requires that MCOs pay or deny a "clean claim" within 30 days of submission. According to the Minnesota Department of Human Services, Minnesota MCOs are in compliance with this statute. As part of the Medicare and Medicaid programs, CMS also requires that Medicare Advantage organizations (including MCOs) pay 95 percent of the clean claims within 30 days of receipt. (SOURCE: 42CFR 422.520) However, it became clear through conducting this study that the handling of "unclean claims," or claims that are submitted to MCOs and returned to home health agencies because they are determined to be incomplete or incorrect, can cause delays in payment and financial distress for home health agencies. Home health agencies involved in this study indicated that dealing with unclean claims is a significant and costly issue in their day-to-day operations.

Billing and Coding: Conclusions and Recommendations

All of the recommendations in this section will be implemented in the context of and should be coordinated with activities related to implementation of the Minnesota Health Care Administrative Simplification Act.

Billing and Coding Recommendation 1:

- Recognizing the constraints of the Health Insurance Portability and Accountability Act (HIPAA), MCOs and home health agencies should work together to implement a standardized, electronic process to be used for all home health service authorizations. Further, the Minnesota HomeCare Association should work with home health agencies to ensure that they are able to comply with electronic billing and coding reporting requirements, which take effect in January and July 2009.

Billing and Coding Recommendation 2:

- Each MCO that contracts with home health agencies should improve its Website to effectively address its organizational policies and procedures related to home health billing and coding and other information targeted to home health agency staff. MCOs should consult with home health agency staff as they develop and improve these Websites, to ensure that the information included is responsive to the business needs of home health agencies. Regular updates, e-mail alerts, and other reminder systems should be employed to ensure home health agency staff are notified of changes in a timely, effective manner.

Billing and Coding Recommendation 3:

- The Minnesota HomeCare Association, Minnesota Council of Health Plans, county-based purchasing organizations, home health agency staff, and MCO staff should build on past joint educational efforts by working collaboratively to design and deliver billing and coding training sessions that meet the needs of home health agency staff. While it may not be feasible for MCOs to work together on all elements of these training sessions, they are encouraged to seek opportunities to collaborate in the areas in which it is feasible, and to look for opportunities to increase efficiencies in scheduling and delivering training. For example, it may be possible for all MCOs to agree to deliver billing and coding training on the same day at a single site.

Billing and Coding Recommendation 4:

- Given that the handling of "unclean claims" can cause considerable financial distress for home health agencies, the stakeholder group discussed in Communication Recommendation 1 should make discussion, analysis, and action on this issue a high priority.

Billing and Coding Recommendation 5:

- The Minnesota HomeCare Association, Minnesota Council of Health Plans, and county-based purchasing organizations should work together on state-level advocacy efforts to ensure that no exceptions are granted to requirements of the HCAS, even for insurers headquartered outside of Minnesota who operate within Minnesota.

Billing and Coding Recommendation 6:

- Staff from individual MCOs should work with home health agency staff to establish billing and coding pilot projects. In these pilot projects, MCO and home health agency staff would work intentionally to establish close working relationships, understand the billing and coding process from both the MCO and agency perspective, and collaborate to identify and address problems in the system and increase the efficiency of the process. Lesssons learned through these pilot projects could be shared with other MCOs and home health agencies, using the home health stakeholder group referenced in Communication Recommendation 1 as a forum for discussion.

Technology

As stated earlier in this report, home health technology falls into three main categories—back office, point-of-care, and telehealth. Study participants discussed and reported on the use of home health technology and the challenges and opportunities they encounter in acquiring or using it. The survey conducted for this study found:

- Of the 80 home health agencies that responded, 33 percent currently use telemonitoring in the homes of their clients.
- Hospital-based home health agencies were more likely to use telemonitoring (47.2 percent) than free-standing (30.4 percent) or all other types of agencies (14.3 percent).
- None of the 12 responding public health-affiliated home health agencies reported that they use telemonitoring in the homes of their clients.
- 48.1 percent of respondents currently use a point-of-care system to electronically collect data.

Although a number of home health agencies included in the study report they would be interested in adopting home health technology, there are financial barriers and few financial incentives for them to make that investment. Technology is expensive, requires regular updating and maintenance, and includes training costs. In addition, although Medicaid will reimburse for telehomecare services, it is only considered reimbursable when the visit includes a video component and is authorized by a physician. Some rural communities, those that could make best use of telehealth because of their remote locations, do not have the connectivity infrastructure (e.g., T1 lines) in place to offer a video component. Medicare does recognize telehealth as an allowable service, but using telehealth is not considered a visit and is therefore not reimbursable on a home health agency's Medicare cost report. Federal Medicare policy states, "There is nothing to preclude a home health agency from adopting telemedicine or other technologies that they believe promote efficiencies, but those technologies will not be specifically recognized or reimbursed by Medicare under the home health benefit." [7]

Although video encounters may be the appropriate telehealth approach for some patients, the majority are in need of in-home monitoring of vital statistics and daily activities, which does not require a video component. Home health agencies that have used or are using telemonitoring for home health patients report they have realized improved outcomes, in particular for CHF, COPD, and wound care.

[7] Medicare Home Health Agency Manual (HCFA Pub. 11)

Study participants agree there is a need to support the adoption of Medicaid and Medicare home health reimbursement for all telehealth services, in particular telemonitoring. Some MCOs represented on the work group indicated their organizations may have the capacity, through foundation grants and other sources, to assist in covering up-front costs of telemonitoring and other telehomehealth equipment.

Technology: Conclusions and Recommendations

Technology Recommendation 1

- As part of the access analysis referenced in Access Recommendation 1 referenced later in the report, the Minnesota eHealth Advisory Committee, Minnesota Department of Health or another appropriate organization should assess the availability of information technology infrastructure needed to support telehome health services.

Technology Recommendation 2

- The Minnesota HomeCare Association, Minnesota Council of Health Plans and county-based purchasing organizations should engage in joint advocacy efforts at the state and federal level supporting Medicaid reimbursement for telehomecare visits that do not include a visual component.

Technology Recommendation 3

- The Minnesota HomeCare Association, Minnesota Council of Health Plans, and county-based purchasing organizations should engage in joint advocacy efforts at the federal level supporting Medicare recognition of telehome health services on the Medicare cost report as a reimbursable expense.

Technology Recommendation 4

- MCOs, in coordination with home health agencies, the Minnesota HomeCare Association, and the Minnesota Council of Health Plans, should seek ways to financially support and develop innovative home health pilot projects which incorporate quality improvement and outcomes measurement components, including through the Minnesota Legislature and the eHealth Advisory Committee.

Quality Improvement

All stakeholders involved in the study process report that they support efforts to improve quality of care. Although many agreed that the OASIS assessments are an administrative burden, they also agreed that they are a necessary step in the right direction.

Quality Improvement/Best Practices: Conclusions and Recommendations

Current federal and Minnesota state policy reflects a convergence around the belief that adoption of electronic health records (EHR) is necessary in order to ensure continued progress in the area of improving quality of care. Recent Minnesota legislation requires that all Minnesota health care providers adopt an interoperable electronic health record by January 1, 2015. Although 48 percent of the home health agencies responding to the survey conducted for this study report using a point-of-care system to electronically collect data in their patients' homes, little is known and documented about the level of EHR adoption and use by home health agencies.

For the past several years, Stratis Health, as Minnesota's Medicare QIO, has provided quality improvement-related information, resources and education to home health agencies across Minnesota. Opportunities exist to expand this education and support to include MCOs.

Quality Improvement/Best Practices Recommendation 1

- The Minnesota Department of Health or other appropriate entity should conduct a survey of Minnesota home health agencies to determine their level of EHR adoption and use, and provide a platform for further education, adoption, and optimization of home health EHRs to promote improvement in the quality of care.

Quality Improvement/Best Practices Recommendation 2

- The Minnesota Council of Health Plans, the county-based purchasing organizations, and Minnesota's Medicare QIO, in collaboration with the Minnesota HomeCare Association, should explore and develop opportunities for the QIO to share resources, training and education on home health quality improvement with MCO staff.

Quality Improvement/Best Practices Recommendation 3

- The Minnesota Council of Health Plans, the county-based purchasing organizations, and the Minnesota HomeCare Association should review and discuss currently available publicly reported home health quality data, and use that information as a basis for identifying and implementing collaborative quality improvement projects.

Quality Improvement/Best Practices Recommendation 4

- The Minnesota HomeCare Association should work with home care agencies to implement quality improvement projects focused on assessing and improving the accuracy and consistency of their OASIS data.

J. OTHER IMPORTANT ISSUES IDENTIFIED THROUGH THIS STUDY

Access to Home Health Services

While a comprehensive analysis of geographic access to home health services across Minnesota is beyond the scope of this study, this section briefly describes some access-related issues that arose during this study. As of November 2007, there are 633 Class A, licensed home care providers in Minnesota. Of these, 211 are Medicare certified home health agencies. This is a decline of 45 agencies or 17.6 percent as compared to the 256 Class A Medicare certified home care agencies that were in operation in 2000. (Sources: Minnesota Department of Health, Office of Rural Health and Primary Care and Licensing and Survey Compliance) As displayed in Map 1, the majority of home health agency offices in Minnesota are located in the Twin Cities metropolitan area. Some border areas within Minnesota are served by home health agencies whose offices are based across the state line, in particular North and South Dakota.

Since home care services are not provided at home health agency offices but rather in the patient's place of residence, any assessment of geographic access to home care services must take into account detailed knowledge of the service area, array of services provided, and acceptable payers for each home health agency. Past state and national research studies and current reports from MCOs do not identify significant geographic access issues; supporting those findings is the fact that Minnesota MCOs report having no issues finding home care agencies to serve their members, including those enrolled in MSHO. Reports from Minnesota home health agencies, however, indicate that access issues are emerging in some areas, and some health plans acknowledge that a small number of home care agencies (primarily in the sparsely populated far north) travel beyond their typical service areas to meet the needs of patients that would otherwise be without care. Reports from home health agencies and work group members indicate there are geographic access issues along the borders of Roseau County, in parts of Dakota County, and around Lake Mille Lacs. Work group members also report that some home health agencies have recently reduced the size of their service areas, reduced

the number and type of services offered, and made other service adjustments that are having a subtle but noticeable impact on access.

Access: Recommendations

Access Recommendation 1:

- In order to identify gaps in service availability, and to ensure that it is possible for individuals in need of home health services to receive appropriate, timely, high quality care regardless of where they live, the MDH or other appropriate entity should conduct a comprehensive, data-based analysis of access to home health services in Minnesota.
    - The analysis should take into account the types and quantity of home health services available, including those licensed in other states and providing care in Minnesota; the service areas of home health agencies; the staffing and resource capacity of home health agencies; the current and projected demand for home health services; the availability of information technology infrastructure needed to support telehome health services, and the roles and impact of other health care providers, such as personal care attendants.
    - The organization charged with conducting this analysis should, in designing and carrying out this study, consult with the stakeholder group described in Communication Recommendation 1.

Care Coordination: Conclusions and Recommendations

As noted earlier in this report, a unique future of MSHO is the assignment of a care coordinator for each MSHO enrollee. MCOs use a variety of models to provide this service. Within the home care setting, care coordination can be particularly important as patients may not have the capacity to serve as their own care coordinator and may have limited access to providers that can assist them with meeting and coordinating their care needs.

While care coordination is not directly related to home health reimbursement methodologies, it was identified early in the study process as a topic that should be addressed because of its relevance to the MSHO program and to home health stakeholders. Through key informant interviews, MCOs and home health agencies were asked to describe their use of and experience with care coordinators within MSHO. Most of the MCOs report using one or more of a variety of methods to provide care coordination services, including contracting with county staff or employing their own staff as care coordinators. They also report that care coordinators play a critical role in meeting the health care needs of patients and managing patient care. Use of care coordinators has resulted in improved patient satisfaction, personalized health care, improved continuity of care, and a single point of contact for case management. A few MCOs report varying levels of success using care coordinators; however, care coordinators have been viewed very positively by patients. Work group members pointed to some instances they are aware of where communication between care coordinators and home health providers could be improved to ensure that patients' needs are effectively met.

While a comprehensive analysis of care coordination services offered to MSHO enrollees is outside the scope of this study, interviews and work group discussion indicate it could be beneficial to pursue further work in this area.

Care Coordination Recommendation 1

- The home health stakeholder group described in Communication Recommendation 1 should review the analysis and recommendations contained in DHS's recently published report on care coordination and determine whether further action or study is needed in the area of home

health care coordination. Any further action or study should be coordinated with the DHS Care Coordination Work Group. The care coordination report can be found on-line. (http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-4986-ENG)

Care Coordination Recommendation 2

- The stakeholder group referenced in Communication Recommendation 1 should explore opportunities for care coordinators to enhance communication and feedback between the MCOs and home health agencies with which they work.

Personal Care Attendants (PCAs): Conclusions and Recommendations

All study participants acknowledged that extensive regulatory and oversight issues exist related to PCAs and that they need to be resolved. Examples of these issues include:

- PCA costs are increasing at a significantly faster rate compared to other health services.
- Populations that were originally considered the primary beneficiaries of PCA services (e.g. those with physical disabilities) are beginning to experience access issues and are no longer the primary beneficiaries.
- MCOs plans have limited ability to manage care provided by PCAs.
- Some attempts have been made to address PCA concerns, but little progress has been made.

PCA Recommendation 1

While thorough analysis of issues related to personal care attendant services in Minnesota was outside the scope of this study, Home Health Methodologies Work Group members recommend further research into oversight, regulation, and payment changes that may be needed in this area.

K. RECOMMENDATIONS

For ease of reference, all recommendations referenced earlier in the report are included in this comprehensive recommendations section. Broad topic areas are listed in the same order in which they appear in the body of the report. Within topical sections, recommendations are not listed in priority order.

Communication

Communication Recommendation 1:

- An ongoing home health stakeholder group should be established to discuss mutually identified issues and work toward solutions. The stakeholder group should, at a minimum, include representatives of home health agencies, home health consumers, health plans, county based purchasing organizations, the Minnesota HomeCare Association, and the Minnesota Council of Health Plans.
    - Facilitation of the stakeholder group should be provided by a neutral party with a basic understanding of the home health system and how MCOs operate in Minnesota, but no vested interest in the outcome of stakeholder discussions.
    - Stakeholder group discussions should begin by focusing on issues identified through this study.

Communication Recommendation 2:

- The Minnesota HomeCare Association, Minnesota Council of Health Plans, and county based purchasing organizations should pursue a joint research and advocacy agenda that promotes high quality, effective care for home health clients. Potential topics of focus for these joint research and advocacy efforts include quality improvement and the increased use of technology in the home health sector.

Communication Recommendation 3:

- In order to ensure effectiveness, efficiency, and continuity of business operations, MCO staff should make intentional efforts to build relationships with staff of the home health agencies with which their organizations hold contracts. These relationship-building efforts should include efforts to improve the transfer of organizational knowledge when personnel changes occur at MCOs and home care agencies, and whenever feasible, should include face-to-face contact.

Reimbursement

Reimbursement Recommendation 1:

- In order to ascertain whether reimbursement rates paid to Minnesota home care agencies are fair, a thorough cost analysis should be conducted by an entity with an understanding of health care finance and no vested interest in the outcome of the analysis. In the short term, Minnesota MCOs that are reimbursing at per-visit rates comparable to the Medicare LUPA rate should re-examine those rates to determine whether they are appropriate, given the level of care being provided and the ultimate goal of improving health outcomes.

Reimbursement Recommendation 2:

- The Minnesota HomeCare Association should provide negotiation skills training to home health agency staff, in order to better prepare home health agencies to engage in business negotiations with MCOs.

Reimbursement Recommendation 3:

- MCOs are encouraged to develop pilot projects testing the feasibility of incorporating quality improvement incentives into per-visit and blended home health reimbursement systems used for the MSHO and MnDHO programs.

Reimbursement Recommendation 4:

- Additional research should be conducted – at the state and/or federal level – with a goal of better understanding the relationship between home health reimbursement methodologies and health outcomes in patients receiving home health services. State-level research should be conducted by a neutral party selected by mutual agreement of home health stakeholders involved in the stakeholder group referenced in Communication Recommendation #1. A legislative appropriation or other source of funding will be needed to support this research.

Billing and Coding

Billing and Coding Recommendation 1:

- Recognizing the constraints of the HIPAA, MCOs and home health agencies should work together to implement a standardized, electronic process to be used for all home health service authorizations. Further, the Minnesota HomeCare Association should work with home health agencies to ensure that they are able to comply with electronic billing and coding reporting requirements, which take effect in January and July 2009.

Billing and Coding Recommendation 2:

- Each MCO that contracts with home health agencies should improve its Website to effectively address its organizational policies and procedures related to home health billing and coding and other information targeted to home health agency staff. MCOs should consult with home health agency staff as they develop and improve these Websites, to ensure that the information included is responsive to the business needs of home health agencies. Regular updates, e-mail alerts, and other reminder systems should be employed to ensure home health agency staff are notified of changes in a timely, effective manner.

Billing and Coding Recommendation 3:

- The Minnesota HomeCare Association, Minnesota Council of Health Plans, county based purchasing organizations, home health agency staff, and MCO staff should build on past joint educational efforts by working collaboratively to design and deliver billing and coding training sessions that meet the needs of home health agency staff. While it may not be feasible for MCOs to work together on all elements of these training sessions, they are encouraged to seek opportunities to collaborate in the areas in which it is feasible, and to look for opportunities to increase efficiencies in scheduling and delivering training. For example, it may be possible for all MCOs to agree to deliver billing and coding training on the same day at a single site.

Billing and Coding Recommendation 4:

- Given that the handling of "unclean claims" can cause considerable financial distress for home health agencies, the stakeholder group discussed in Communication Recommendation 1 should make discussion, analysis and action on this issue a high priority.

Billing and Coding Recommendation 5:

- The Minnesota HomeCare Association, Minnesota Council of Health Plans, and county based purchasing organizations should work together on state-level advocacy efforts to ensure that no exceptions are granted to requirements of the HCAS, even for insurers headquartered outside of Minnesota who operate within Minnesota.

Billing and Coding Recommendation 6:

- Staff from individual MCOs should work with home health agency staff to establish billing and coding pilot projects. In these pilot projects, MCO and home health agency staff would work intentionally to establish close working relationships, understand the billing and coding process from both the MCO and agency perspective, and collaborate to identify and address problems in the system and increase the efficiency of the process. Lesssons learned through these pilot projects could be shared with other MCOs and home health agencies, using the

home health stakeholder group referenced in Communication Recommendation 1 as a forum for discussion.

Technology

Technology Recommendation 1

- As part of the access analysis referenced in Access Recommendation 1 below, the Minnesota Department of Health or other appropriate organization should include the availability of information technology infrastructure needed to support telehome health services.

Technology Recommendation 2

- The Minnesota HomeCare Association, Minnesota Council of Health Plans and county based purchasing organizations should engage in joint advocacy efforts at the state and federal level supporting Medicaid reimbursement for telehomecare visits that do not include a visual component.

Technology Recommendation 3

- The Minnesota HomeCare Association, Minnesota Council of Health Plans, and county based purchasing organizations should engage in joint advocacy efforts at the federal level supporting Medicare recognition of telehome health services on the Medicare cost report as a reimbursable expense.

Technology Recommendation 4

- MCOs, in coordination with home health agencies, the Minnesota HomeCare Association, and the Minnesota Council of Health Plans, should seek ways to financially support and develop innovative home health pilot projects which incorporate quality improvement and outcomes measurement components.

Quality Improvement/Best Practices

Quality Improvement/Best Practices Recommendation 1

- The Minnesota Department of Health or other appropriate entity should conduct a survey of Minnesota home health agencies to determine their level of EHR adoption and use, and provide a platform for further education, adoption, and optimization of home health EHRs to promote improvement in the quality of care.

Quality Improvement/Best Practices Recommendation 2

- The Minnesota Council of Health Plans, the county-based purchasing organizations, and Minnesota's Medicare QIO, in collaboration with the Minnesota HomeCare Association, should explore and develop opportunities for the QIO to share resources, training and education on home health quality improvement with MCO staff.

Quality Improvement/Best Practices Recommendation 3

- The Minnesota Council of Health Plans, the county-based purchasing organizations, and the Minnesota HomeCare Association should review and discuss currently available publicly reported home health quality data, and use that information as a basis for identifying and implementing collaborative quality improvement projects.

Quality Improvement/Best Practices Recommendation 4

- The Minnesota HomeCare Association should work with home care agencies to implement quality improvement projects focused on assessing and improving the accuracy and consistency of their OASIS data.

Other Important Issues Identified Through This Study

Access

Access Recommendation 1:

- In order to identify gaps in service availability, and to ensure that it is possible for individuals in need of home health services to receive appropriate, timely, high quality care regardless of where they live, the MDH or other appropriate entity should conduct a comprehensive, data-based analysis of access to home health services in Minnesota.
    - The analysis should take into account the types and quantity of home health services available, including those licensed in other states and providing care in Minnesota; the service areas of home health agencies; the staffing and resource capacity of home health agencies; the current and projected demand for home health services; the availability of information technology infrastructure needed to support telehome health services, and the roles and impact of other health care providers, such as personal care attendants.
    - The organization charged with conducting this analysis should, in designing and carrying out this study, consult with the stakeholder group described in Communication Recommendation 1.

Care Coordination

While a comprehensive analysis of care coordination services offered to MSHO enrollees is outside the scope of this study, interviews and work group discussion indicate it could be beneficial to pursue further work in this area.

Care Coordination Recommendation 1

- The home health stakeholder group described in Communication Recommendation 1 should review the analysis and recommendations contained in DHS's recently published report on care coordination and determine whether further action or study is needed in the area of home health care coordination. Any further action or study should be coordinated with the DHS Care Coordination Work Group. The care coordination report can be found on-line. (http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-4986-ENG)

Care Coordination Recommendation 2

- The stakeholder group referenced in Communication Recommendation 1 should explore opportunities for care coordinators to enhance communication and feedback between the MCOs and home health agencies with which they work.

Personal Care Attendants (PCAs)

PCA Recommendation 1

While thorough analysis of issues related to personal care attendant services in Minnesota was outside the scope of this study, Home Health Methodologies Work Group members recommend further research into oversight, regulation, and payment changes that may be needed in this area.

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Appendix A: Literature Review

Introduction:
Medicare home health services and reimbursement methodologies have changed significantly over the past ten years: first through the Interim Payment System (IPS) and then the Prospective Payment System (PPS) as part of the Balanced Budget Act of 1997. Initial changes were directed primarily at reducing costs while more recent changes have been aimed at constraining costs, maintaining access, and improving quality of care. Within this context, home health agencies have also begun exploring and using telehomecare tools to address quality improvement needs, workforce issues, and the changing needs of the populations they serve. This literature review looks at the history of home health reimbursement, focusing primarily on changes in the past ten years with the intent of summarizing research findings related to changing reimbursement, its impact on home health agencies and the patients they serve, as well as the use of and impact of telehomecare services.

Reimbursement Discussion:
In 1965, home health services were included as part of the Medicare benefit. (Fishman et al February 2003) The intent of this added benefit was to shorten inpatient hospital stays; however, demand for services increased significantly faster than the supply of services. In response, Congress loosened the home health services requirements by allowing for-profit providers to participate, eliminating the requirement for prior hospitalization as a condition of receiving the home care benefit, and removing the limit on the number of visits per episode of care. (Fishman 2003) These changes, as well as subsequent incentives for hospitals to discharge patients more quickly, resulted in increased supply and demand for home health services: in the mid-1980s Medicare spending for home health services was $3 billion, 10 years later Medicare spending had increased to $18 billion. (Fishman 2003) The increases are attributed to an increase in the number of beneficiaries and an increase in the number of home health visits per beneficiary as well as the lack of incentives for home care providers to control costs. (Fishman 2003)

As home care costs increased and became a larger proportion of the health care reimbursement pie, significant cutbacks in reimbursement were sought through the Balanced Budget Act of 1997 (BBA). The BBA included a two-tiered cut-back: first the IPS with significant cost controls and then PPS, the intended long-term reimbursement formula with both cost and quality controls. IPS, implemented in 1998, provided incentives for home health agencies to reduce the number of visits made to Medicare beneficiaries and to avoid those whose care plan likely exceeded cost limits. (Liu et al fall 2003) Implementation of IPS was viewed by many as extreme and perhaps detrimental to the viability of home care agencies with the likely outcome of home care agencies avoiding high-need patients and special populations. Studies examining the financial impact of IPS found both a significant decline in the home health care services provided and a substantial savings in Medicare home health care expenditures. (OIG1999, Cheh et al June 2003, Fitzgerald et al September 2006, McCall et al February 2003). Many of these studies also examined the outcomes associated with IPS and while the researchers were in agreement that the IPS resulted in cost savings and did not result in access issues, there were mixed findings related to the resulting health care outcomes. For example, even though IPS patients had more functional limitations as compared to pre-IPS patients, Cheh found no evidence of health consequences associated with IPS and the OIG1999 reported no increase in the number of hospital re-admissions and emergency visits. Other studies (McCall, Fitzgerald, and OIG2000) report possible outcome issues, most likely for the most vulnerable home health care populations.

IPS also included the advent of the Outcome and Assessment Information Set (OASIS). The OASIS is a screening and assessment tool that includes standardized definitions and coding categories that is

used to determine a patient's need for Medicare home health care services and to measure and track outcomes. Studies suggest that home health agencies are having difficulty implementing the OASIS and that data is often missing from the reports. (Cheh)

The PPS reimbursement methodology was implemented in October 2000, with the intent of controlling costs and improving quality of care and health outcomes. PPS replaced IPS and established a 60-day episode of care. Given that this is a newer payment methodology, few studies have been conducted to determine the resulting costs and outcomes. Some early studies under PPS indicate that hospitalization and emergency care rates have decreased, community discharge rates have declined, and emotional/behavioral outcomes have increased. (Schlenker et al February 2005) Other studies indicate no changes due to PPS and report that overall hospital readmission rates for Medicare home health beneficiaries discharged from hospitals remained at 47 percent from 2000 through 2003. (Office of the Inspector General – OIG- 2006) They also report the overall rate of emergency department visits for Medicare home health beneficiaries discharged from hospitals increased slightly, from 29 to 30 percent, from 2000 through 2003. (OIG)

Given the significance of PPS, it appears that the impact of PPS goes well beyond Medicare and affects the health care system as a whole, including other payment streams such as Medicaid and commercial payment. (Kulesher et al September 2006) This may be attributed to the increasing complexity of the health care system as a whole, the role of managed care organizations in the provision of health services, changing demographics, as well as the on-going cross subsidization of health services between payers. In general, studies indicate that additional time implementing PPS as well as further research and analysis are needed to better understand the full implications of PPS and whether early indicators reflect long-term outcomes. (Kulesher 2006).

To further test the implications of PPS and the concept of pay-for-performance, the Centers for Medicare and Medicaid Services (CMS) has implemented a Home Health Pay-for-Performance Demonstration. This demonstration is being implemented in each of the seven CMS regions across the U.S. in seven states. All Medicare-certified home health agencies are eligible to participate (Minnesota is not a demonstration site). The intent of the demonstration is to determine whether financial rewards for providing high quality services or for significant improvements in quality result in an overall increase in quality of care. (CMS 2007), and to determine whether financial incentives for quality care result in a decrease of total Medicare costs for patients who use home health services. (CMS). Demonstration enrollment began in October 2007 while operations began January 1, 2008, and are scheduled to continue for two years. (CMS)

Reimbursement Conclusions

Although reimbursement methodologies continue to evolve and change and the health care marketplace responds, research indicates that no reimbursement panacea has been identified and proven and cost and quality issues contine. It is clear; however, that cost-based reimbursement for home health services, the system that was in place prior to implementation of IPS and then PPS, was neither efficient nor effective and resulted in an unsustainable home health care system. It is also clear that regardless of the reimbursement methodology, the decline in inpatient hospital utilization rates; a growing Medicare, frail elderly, and disabled population; and an increasing preference by consumers for in-home care will drive consumer demand for home health services. As new reimbursement models are tested, implemented, and measured there may be beneficial outcomes; however, given the research on past reimbursement methods, the complexity of the health care system and the unique, state-specific policies, populations, health system features, and cost shifting between payers, outcomes will likely vary by state, populations served, and will likely change over time.

Therefore, extensive state-specific research is needed to determine the long-term benefits of any changes in reimbursement methods.

Telehomecare Discussion:
With the advent of technology, reimbursement constraints, a tighter health care workforce marketplace, and a push towards improved quality of care and health outcomes, home care agencies, the federal government, and some states are looking to telehomecare to better meet the needs of patients. Although telehomecare definitions vary from study to study, the Philips National Study on the Future of Technology and Telehealth in Homecare (Fazzi October 2007) provided a definition that captured the intent of many of the definitions used by other researchers: "backroom fiscal, billing and HR systems, point-of-care systems for clinicians in the field, electronic medical records, and telehealth and remote patient monitoring systems." A few researchers take telehomecare to the next step by defining it within the context of a robotic environment.

Fazzi, the largest telehomecare study reviewed as part of this telehomecare literature review, examined the use of telehomecare in 976 home care agencies across the U.S., 24 representing Minnesota. They found that less then 50 percent of reporting home care agencies were "very satisfied" with their billing/fiscal systems and over 21 percent are in the process of upgrading their systems, 61 percent of home care agencies use a point of care system to collect data in patients' homes, and again less than 50 percent were "very satisfied" with their point-of-care system, almost 60 percent of home care agencies are using some sort of an electronic medical record to store and retrieve patient data, and over 17 percent of home care agencies presently have some form of a remote patient monitoring system. Fazzi went on to report that over 70 percent of participating home health care agencies reported patient satisfaction scores improved with patients that receive telehomecare services. Almost all home health agencies using telehomecare reported using it for congestive heart failure (93.2 percent) as well as for other diseases and 42.8 percent reported it has resulted in reduced costs.

While Fazzi examined the use, satisfaction, and perceived benefits of telehomecare, a limited number of other telehomecare research studies have been conducted that examine the financial, health outcomes, and hospitalization rates due to the use of telehomecare. Many of these studies have been conducted by stakeholders in the telehomecare industry; fewer have been conducted by independent research organizations and/or universities. Most of the studies that appear to have been conducted by a more independent entity have found that use of telehomecare can have a positive financial impact on the home care agencies and can improve outcomes for specific health care issues. (Rumberger 2006, Frey 2005) They go on to report that much of the financial impact of telehomecare ties back to the change from a cost-based, fee-for-service payment methodology to implementation of PPS. This is because prior to PPS, the incentive for home health care agencies was maximizing home health visits whereas under PPS, the incentive is maximizing the number of patients and managing the patients' episodes of care.

Considering the impact of telehomecare and more specifically telemonitoring on patients, studies again indicate positive results; however, most of these studies have very limited sample sizes and were short in duration. For example, Jaana et al studied the impact of telemonitoring on patients with diabetes. This study found that telemonitoring reduced patient HbA(1C) and other complications and patients were receptive to and empowered by the technology used. Bowles et al took a similar approach, finding that telehomecare appears to have a positive effect on chronic illness outcomes, rehospitalizations, and length-of-stay and appears to reduce costs. Both of these studies concluded that sample size and study duration were issues; therefore, additional research is needed to better understand the long term benefits and costs telehomecare.

The Department of Veterans Affairs (VA) has launched and/or has completed a number of telehomecare studies. For example in 2004, the VA launched a study specifically targeting veterans with chronic heart failure. This study included data on 73 patients and found that telehomecare was associated with improved early outcomes such as improved blood pressure and reduction in inpatient hospital days. (Schofield 2005) A second VA study that focused on changes in home health patients' quality of life due to the use of telehomecare found limited to no changes in patients' physical health but found improvements in patients' mental health and fewer overall outpatient visits. (Hopp 2006)

Beyond the telehomecare that is already being used and tested is the adaptive technology that is being tested and will soon be available. This includes technology that will assist people with their "activities of daily living" – getting dressed, meal preparation, cleaning, and medication administration. These technological tools include things such as, "LifeShirt, a vest that monitors cardiac, pulmonary and respiratory activity as well as posture; the M2A capsule, a pill that when ingested reports on the functioning of patient intestines; a nurse robot named Pearl that takes vital signs and retrieves basic items; and the Health Dashboard, inspired by the dashboard in a car, which displays everything from environmental metrics like the pollen index and flu trends to personal data like blood pressure, cholesterol levels, exercise patterns and drug compliance." (Weil 2004) Most of this telehomecare is still in the development and testing phases but it too will need to be assessed for its impact on cost, quality, and outcomes.

Telehomecare Conclusions:
Telehomecare is a tool that is increasingly showing it has the potential to improve health outcomes, decrease costs, and allow people to live more independently in their homes; particularly with the advent of PPS. Additional research is needed; however, to determine the best and most cost-effective uses for telehomecare. This includes conducting studies that use larger sample sizes and occur over longer periods of time and more specifically, with consideration to the payment method being used for the telehomecare services being provided. In addition, it is clear that we are only beginning to realize the potential uses of telehomecare services, particularly given the growing aging population and their home-based care preferences and the strains being placed on the health workforce.

Issues that were not resolved: Almost all of the research reviewed as part of this literature review was limited to national research projects or those outside the state of Minnesota. Therefore, it is unclear whether the research reflects the home health care marketplace in Minnesota. In addition, the number of home health research studies available is limited when compared to other service providers and most lack longitudinal analysis and/or have relatively small sample sizes. It is unclear whether the short-term impacts of reimbursement changes and use of telehomecare are similar to the long-term impacts and whether the impacts affect different home health care providers in unique ways.

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Appendix B: Home Health Reimbursement Methodologies Work Group Members

Managed Care Representatives

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Appendix C: Work Group Meetings Summary

Meetings Date	Meeting Goals
October 2, 2007	• Establish a common understanding of the roles of Stratis Health and the work group in the Home Health Reimbursement Study. • Establish a common preliminary understanding of the issues and opportunities facing home care in Minnesota. • Establish a common understanding of the plans to move forward with the Home Health Reimbursement Study.
November 26, 2007	• Update members on project status. • Establish a common preliminary understanding of quality improvement activities and expectations of home care agencies. • Establish a common preliminary understanding of health plans' issues, opportunities, quality improvement goals, and use of technology as they relate to home health reimbursement methodologies in Minnesota. • Develop a draft report outline.
January 8, 2008	• Update members on project status. • Update members on themes and issues identified through key informant interviews. • Discuss and define communication and information-related issues as they relate to home health reimbursement.
January 15, 2008	• Discuss and define various home health reimbursement methodologies; identify strengths and weaknesses of each approach. • Discuss personal care attendant (PCA) issues and identify recommendations/next steps as appropriate. • Discuss definitions for key terms planned for inclusion in the study report.
January 29, 2008	• Discuss billing and coding issues and identify recommendations/next steps as appropriate. • Discuss potential opportunities that may exist for Minnesota's home health community related to technology and quality improvement.
February 5, 15, 25, and March 5, 2008	• Review and make changes to the draft report and recommendations.

Appendix D: Participants in Key Informant Interviews and Information-Gathering Meetings

Key Informant Interview Participants

Name	Organization	Name	Organization
Kristy Bourassa	HealthEast Home Care, Inc.	Hannah LaMere	Metropolitan Health Plan
Stacia Cohen	First Plan	Vickie Lynch	Preston Good Samaritan Home Care
Bill Dombi	National Association for Home Care	Amelia Mata	Hennepin Home Health Care, Inc.
Denise Edgett	Integrated Home Care	Ned Moore	Metropolitan Health Plan
Julie Faulhaber	Medica	Maureen Murray	South Country Health Alliance
Diane Flanders	Massachusetts Division of Medical Assistance	Kelly O'Neill	Stratis Health
Pamela Halvorson	REM Health, Inc.	Julie Pahlen	Roseau County Home Health Care
Marge Hannon Pifer	Wisconsin Department of Health and Family Services	Nadine Paitich	HealthEast Home Care, Inc.
Candy Hanson	Chisago County Health and Human Services	Jim Przybilla	PrimeWest Health
Sean Heath	Blue Cross and Blue Shield of Minnesota	Richard Raihle	HealthPartners
Pat Jump	Acorn's End Training and Consulting	Nancy Scholl	Vikingland Home Health, Inc.
Jeff Stensland	MedPAC	Janelle Shearer	Stratis Health
Julie Stone	First Plan	Ghita Worcester	UCare

Information-Gathering Meeting Participants

Name	Organization	Name	Organization
Cara Bailey	Minnesota Department of Human Services	Pam Parker	Minnesota Department of Human Services
Julie Brunner	Minnesota Council of Health Plans	Barbara Burandt	Minnesota HomeCare Association
Neil Johnson	Minnesota HomeCare Association	Kathryn Kmit	Minnesota Council of Health Plans

Appendix E: Home Health Study Interview Questions

Health Plans & County-Based Purchasing Organizations

1. What is your title and role in NAME OF ORGANIZATION?
2. How long have you worked for NAME OF ORGANIZATION?
    a. Are you familiar with the legislature's Home Health Reimbursement Study that we are conducting at Stratis Health? IF NOT, BRIEF OVERVIEW.
3. Did your organization have any involvement in the discussions that led up to the Home Health Reimbursement study? If so, please talk about how the study evolved and your organization's role.
4. What is your organization's overall impression of MSHO and MDHO? Has this changed since the expansion of MSHO?
5. With how many home health agencies does your organization contract?
6. Describe the contracting process, in particular as it relates to establishing MSHO contracts with home health providers.
7. Did this contracting process change as a result of the expansion of MSHO? Explain.
8. Describe the care coordinators that your organization uses to implement MSHO.
    a. Does your organization have its own care coordinators/do you contract with a care coordination organization/local public health?
    b. If you do contract, with whom?
    c. What is your overall impression of the value/impact of having care coordinators engaged in the provision of health care services?
9. Does your organization reimburse home health agencies using the PPS, FFS, both or another reimbursement methodology?
    a. When was the methodology adopted?
    b. Why was the methodology selected?
    c. What (if any) changes in reimbursement have occurred?
    d. Are there any reimbursement related issues/challenges that you are working on?
10. What is the current home care marketplace?
    a. Have health plans – home health agency relations changed?
    b. Are there new/evolving factors impacting the contacting process, services, service providers, access, technology, quality of care, reimbursement?
    c. Are there geographic differences?
    d. Has it changed because of MSHO expansion?
    e. The role of MSHO in the marketplace.
11. What are the current reimbursement methodologies available to home care agencies through your organization, are changes needed/being considered, and are there other reimbursement options available/being developed?
    a. How would changes affect home care agencies?
    b. How would changes affect health plans?
    c. What would the impact be on the broader reimbursement system (e.g., Medicaid, private pay)
    d. What would the impact be on the health care system as a whole?
12. How are payment rates negotiated?
    a. Are there differences in payment rates for different home care agencies? If so, how and why do they vary?
13. How does quality improvement fit into this discussion?
    a. Is home health quality improvement being discussed?

b. What, if anything, is your organization doing to improve health care quality?
c. Are there any factors/issues that may/are impacting home health quality improvement?

14. How does the use of technology fit into the discussion?
15. Is there anything else Stratis Health should be aware of as we conduct this study?
16. Other thought or comments?

Home Health Agencies

1. What is your title and role in NAME OF ORGANIZATION?
2. How long have you worked for NAME OF ORGANIZATION?
3. Are you familiar with the legislature's Home Health Reimbursement Study that we are conducting at Stratis Health? IF NOT, BRIEF OVERVIEW.
4. Did your organization have any involvement in the discussions that led up to the Home Health Reimbursement study? If so, please talk about your organization's role in establishing the study.
5. What is your organization's overall impression of MSHO and MDHO? Has this changed since the expansion of MSHO?
6. Describe your organization's experience with MSHO's expansion.
7. With how many health plans/BCP organizations does your home care agency have contracts?
8. Describe the contracting process, in particular as it relates to establishing MSHO contracts with health plans.
9. Did this contracting process change as a result of the expansion of MSHO? Explain.
10. Describe the care coordinator process that your organization uses to implement MSHO.
    a. Does your organization provide care coordinators/do you contract for services; are care coordinators provided as part of the health plans?
    b. What is your overall impression of the value/impact of having care coordinators engaged in the provision of health care services?
11. How is your home health agency reimbursed for MSHO (PPS, FFS, both or another reimbursement methodology)?
    a. How are payment rates negotiated?
    b. Are there differences between health plans? Describe.
    c. When was the methodology adopted and why was it selected?
    d. Is it your agencies preferred methodology and why?
    e. Are reimbursement changes needed, if so, what and what would the impact be on home care agencies, health plans, and the people they serve?
    f. Are there any reimbursement related issues/challenges that you are working on?
12. What is the current home care marketplace?
    a. Have health plans – home health agency relations changed?
    b. Are there new/evolving factors impacting the contacting process, services, service providers, access, technology, quality of care, reimbursement, workforce?
    c. Has it changed because of MSHO expansion?
    d. The role of MSHO in the marketplace and changing the marketplace.
13. How does quality improvement fit into this discussion?
    a. Is home health care quality improvement being discussed between health plans and home care agencies?
    b. What, if anything, is your organization doing to improve health care quality?
    c. Are there any factors/issues that may/are impacting home health quality improvement?
14. How does the use of technology fit into the discussion?
15. Is there anything else Stratis Health should be aware of as we conduct this study?
16. Other thought or comments?

Appendix E (Continued)

Stratis Health – Kelly O'Neill and Janelle Shearer, Program Managers

1. What is your relationship/role in Stratis Health in regards to home care agencies and health plans?
2. Talk about the projects you are currently working on that relate to home care agencies and health plans.
3. How would you describe the current home care marketplace?
4. Has it changed/is it changing because of MSHO/MDHO expansion?
5. Has it changed/is it changing because of other factors?
6. Have health plans – home health agency relations changes?
7. Are there new/evolving factors impacting the contacting process, services, service providers, access, technology, quality of care, reimbursement?
8. Impact of PCAs?
9. Impact, role, and relations of case management organizations and home care agencies and health plans?
10. Are there geographic differences?
11. Do reimbursement issues exist?
12. Describe the health plan/home care agency relationship.
13. How are payment rates negotiated?
14. Are there differences in payment rates across organizations? If so, how and why do they vary?
15. What else about the health plan/home health agency relationship, other than reimbursement, is important to consider?
16. Describe the home care reimbursement/
17. What are the current reimbursement methodologies available to home care agencies and how should these change?
18. Should this change?
19. How would changes affect home care agencies?
20. What would the impact be on the broader reimbursement system (e.g., Medicaid, private pay)
21. What would the impact be on the health care system as a whole?
22. Other thought or comments?
23. Recommendations for home care agencies to interview?

Appendix E (Continued)

Home Health National/State Experts

1. What is your title and role in NAME OF ORGANIZATION?
2. How long have you worked for NAME OF ORGANIZATION?
3. Are you familiar with Minnesota's Home Health Reimbursement Study that we are conducting at Stratis Health? IF NOT, BRIEF OVERVIEW.
4. Did your organization have any involvement in the discussions that led up to the Home Health Reimbursement study? If so, please talk about your organization's role in the study.
5. Are you familiar with the MSHO program in MN? If so, what is your overall impression of MSHO and has this changed since the program's expansion?
6. Are you familiar with programs in the U.S. (in your state) that are similar to MSHO? Describe these programs.
7. Brief history of the programs, statewide or regional
8. Contracting process for reimbursement
9. Reimbursement methodologies that are used and being considered
10. Care coordination aspects of the program
11. Relations with health plans and the contracting process
12. What is the current home care marketplace nationally/in your state?
13. Have health plans – home health agency relations changed?
14. Are there new/evolving factors impacting the contacting process, services, service providers, access, technology, quality of care, reimbursement, workforce?
15. Has it changed because of your state's use of an MSHO-like product?
16. How does quality improvement fit into this discussion?
17. Is home health care quality improvement being discussed between health plans and home care agencies?
18. Are there any factors/issues that may/are impacting home health quality improvement?
19. How does the use of technology fit into the discussion? How is your state/nation responding to changes in technology?
20. Is there anything else Stratis Health should be aware of as we conduct this study?
21. Other thought or comments?

Appendix F: On-line Survey Questions

Home Health Reimbursement Survey

This survey is being conducted by Stratis Health under contract with the Minnesota Department of Human Services (DHS). The purpose of the survey is to gather information for an independent analysis of reimbursement methodologies for home health services provided to enrollees in the Minnesota Senior Health Options (MSHO) program.

Please complete this survey by **Friday, January 25th.** The survey will take approximately 10-15 minutes to complete. Participation in this survey is voluntary. Survey data will be combined and reported in aggregate form only. Individual responses will remain confidential and will not be released outside of Stratis Health.

Any questions regarding completion of this survey or inquiries for further information about the survey can be directed to Cathy Carlos at 952-853-8560, ccarlos@stratishealth.org.

Thank you for completing this survey.

1) Describe your Home Health Agency structure (choose one):

- ○ Hospital Based
- ○ Nursing Home Based
- ○ Public Health
- ○ Visiting Nurse Association
- ○ Free Standing
- ○ Other (please specify)

If you selected other, please specify:

2) Is your home health agency a part of a **multi-agency organization** or **chain** (more than one agency owned by the same organization)?

- ○ Yes
- ○ No

3) Is your agency a part of a **health care system** (two or more organizations under the same ownership that are different provider types such as a hospital, nursing home, home care agency, clinic, working together for the aim of the system)?

- Yes
- No

4) How many people are employed by your Home Health Agency?

5) Estimate the total number of clients your agency serves per month.

6) Which health plans does your agency currently have contracts with (check all that apply):

- Blue Cross Blue Shield of Minnesota (BCBS)
- First Plan of Minnesota
- Health Partners
- Itasca Medical Care (IMCare)
- Medica
- Metropolitan Health Plan (MHP)
- PrimeWest
- South Country Health Alliance (SCHA)
- UCare

7) In the last month, how many clients did your agency serve that are covered under each plan (please give the total number of clients in all products for each plan)?

Blue Cross Blue Shield of Minnesota (BCBS)
First Plan of Minnesota
Health Partners
Itasca Medical Care (IMCare)
Medica
Metropolitan Health Plan (MHP)
PrimeWest
South Country Health Alliance (SCHA)
UCare

8) In the last month, how many clients did your agency serve from each plan that are enrolled in **Minnesota Senior Health Options (MSHO)**?

Blue Cross Blue Shield of Minnesota (BCBS)
First Plan of Minnesota
Health Partners
Itasca Medical Care (IMCare)

Medica

Metropolitan Health Plan (MHP)

PrimeWest

South Country Health Alliance (SCHA)

UCare

9) For your total patient population, please indicate the number of clients you served for each payer type in the last month.

Medicare Managed Care (Medicare Advantage)

Medicare Fee For Service (FFS)

Minnesota Senior Health Options (MSHO)

Minnesota Disability Health Options (MnDHO)

Medicaid Managed Care

Other state reimbursed services such as Medicaid Fee For Service (FFS)

All other payer types

Next Page

10) In the last month, what was the average number of days to process a claim from each payer source?

Medicare Managed Care (Medicare Advantage)

Medicare Fee For Service (FFS)

Minnesota Senior Health Options (MSHO)

Minnesota Disability Health Options (MnDHO)

Medicaid Managed Care

Other state reimbursed services such as Medicaid Fee For Service (FFS)

All other payer types

11) In the last month, how often were claims returned to your agency for further processing because they were determined, by the payer, to have not been submitted in the proper format (or "unclean" claims)?

○ Never ○ Rarely ○ Occasionally ○ Often ○ Always

12) Is your agency currently providing personal care attendant (PCA) services?

○ Yes ○ No

13) Is your agency currently using telemonitoring in the homes of your clients?

○ Yes ○ No

14) Is your agency currently recruiting RNs or LPNs?

○ Yes ○ No

15) If yes, for how many months have you been recruiting RNs or LPNs?

16) Is your agency currently recruiting Physical Therapists?
○ Yes ○ No

17) If yes, for how many months have you been recruiting Physical Therapists?

18) Is your agency currently recruiting Occupational Therapists?
○ Yes ○ No

19) If yes, for how many months have you been recruiting Occupational Therapists?

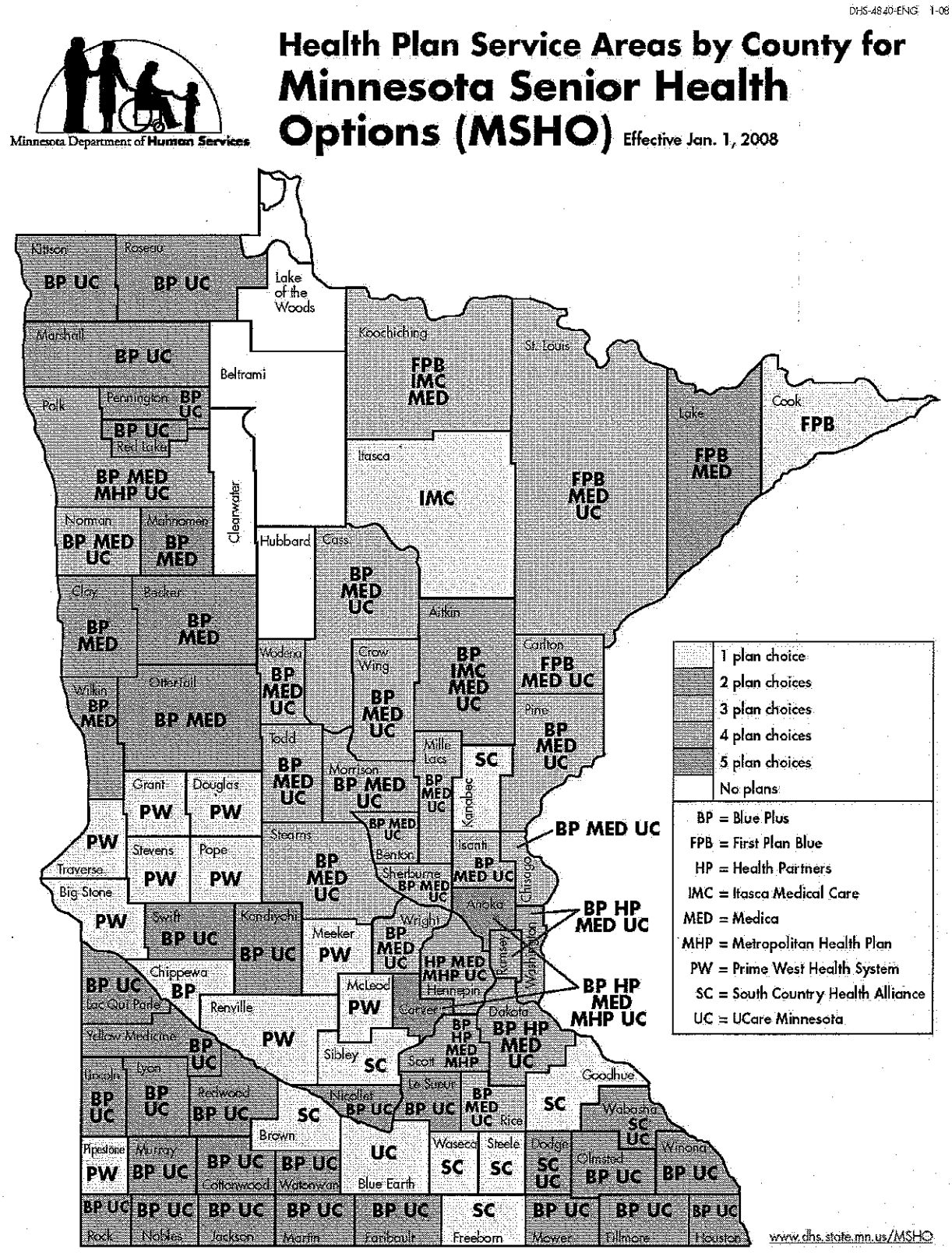
20) Is your agency currently recruiting Nursing Assistants (NRAs)?
○ Yes ○ No

21) If yes, for how many months have you been recruiting Nursing Assistants?

22) Do you currently use a Point of Care system to electronically collect data in your patients' homes (**NOT** including OASIS assessment data)?
○ Yes ○ No ○ Don't Know

23) Please provide any comments you have about billing or reimbursement methodologies.

Appendix G: MSHO Service Areas Map



Appendix H: Minnesota Statutes 62Q.75

62Q.75 PROMPT PAYMENT REQUIRED.

Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms have the meanings given to them.(b) "Clean claim" means a claim that has no defect or impropriety, including any lack of any required substantiating documentation, including, but not limited to, coordination of benefits information, or particular circumstance requiring special treatment that prevents timely payment from being made on a claim under this section. Nothing in this section alters an enrollee's obligation to disclose information as required by law.(c) "Third-party administrator" means a third-party administrator or other entity subject to section 60A.23, subdivision 8, and Minnesota Rules, chapter 2767.

Subd. 2. **Claims payments.** (a) This section applies to clean claims submitted to a health plan company or third-party administrator for services provided by any:(1) health care provider, as defined in section 62Q.74, but does not include a provider licensed under chapter 151;(2) home health care provider, as defined in section 144A.43, subdivision 4; or(3) health care facility.All health plan companies and third-party administrators must pay or deny claims that are clean claims within 30 calendar days after the date upon which the health plan company or third-party administrator received the claim.(b) The health plan company or third-party administrator shall, upon request, make available to the provider information about the status of a claim submitted by the provider consistent with section 62J.581.(c) If a health plan company or third-party administrator does not pay or deny a clean claim within the period provided in paragraph (a), the health plan company or third-party administrator must pay interest on the claim for the period beginning on the day after the required payment date specified in paragraph (a) and ending on the date on which the health plan company or third-party administrator makes the payment or denies the claim. In any payment, the health plan company or third-party administrator must itemize any interest payment being made separately from other payments being made for services provided. The health plan company or third-party administrator shall not require the health care provider to bill the health plan company or third-party administrator for the interest required under this section before any interest payment is made. Interest payments must be made to the health care provider no less frequently than quarterly.(d) The rate of interest paid by a health plan company or third-party administrator under this subdivision shall be 1.5 percent per month or any part of a month.(e) A health plan company or third-party administrator is not required to make an interest payment on a claim for which payment has been delayed for purposes of reviewing potentially fraudulent or abusive billing practices.(f) The commissioner may assess a financial administrative penalty against a health plan company for violation of this subdivision when there is a pattern of abuse that demonstrates a lack of good faith effort and a systematic failure of the health plan company to comply with this subdivision.

Subd. 3. **Claims filing.** Unless otherwise provided by contract, by section 16A.124, subdivision 4a, or by federal law, the health care providers and facilities specified in subdivision 2 must submit their charges to a health plan company or third-party administrator within six months from the date of service or the date the health care provider knew or was informed of the correct name and address of the responsible health plan company or third-party administrator, whichever is later. A health care provider or facility that does not make an initial submission of charges within the six-month period shall not be reimbursed for the charge and may not collect the charge from the recipient of the service or any other payer. The six-month submission requirement may be extended to 12 months in cases where a health care provider or facility specified in subdivision 2 has determined and can substantiate that it has experienced a significant disruption to normal operations that materially affects the ability to conduct business in a normal manner and to submit claims on a timely basis. This subdivision also applies to all health care providers and facilities that submit charges to workers' compensation payers for treatment of a workers' compensation injury compensable under chapter 176, or to reparation

obligors for treatment of an injury compensable under chapter 65B.
History: *2000 c 349 s 1; 2004 c 246 s 10; 2005 c 77 s 4*