

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**THE PHYSICIAN'S ROLE IN HOME  
HEALTH CARE**



**JUNE GIBBS BROWN**  
Inspector General

JUNE 1995  
OEI-02-94-00170

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# EXECUTIVE SUMMARY

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## PURPOSE

To describe the current role of the physician in Medicare home health care.

## BACKGROUND

Medicare defines home health care as certain services provided under a physician's plan of care in the residence of a homebound patient. Care can consist of services such as skilled nursing services, home health aide services, physical and occupational therapy, and medical services. Typically, the care is provided by home health agencies, home care aide organizations or hospices.

Little data exist about the current nature of physician involvement in home health care. Services a physician may provide include: managing medical problems, preparing and reassessing the treatment plan, and documenting medical records. Concerns have been raised based on audits of certain home health agencies and anecdotal information that physicians are not appropriately involved in planning and coordinating home health services.

Medicare covers home visits by a physician the same as any other physician visit. Until recently, it did not separately cover the services of physicians for managing the home health care of their patients. In the December 8, 1994 Federal Register, HCFA issued a new regulation providing separate payment for physician care plan oversight services.

The HCFA administrator has asked the Inspector General to assist HCFA in its effort to examine the physician role in home health care. In conducting this inspection we sent a questionnaire to a random sample of 1000 agencies stratified by census regions. The agencies were asked about their relationship with their patients' physicians and the physician role in home health care. We received 700 completed surveys. Subsamples of 96 agencies and 85 physicians were interviewed by telephone to obtain more in-depth answers about the present physician role. Also, we reviewed 1992 beneficiary histories for 191 beneficiaries to determine whether the physician who signed the plan of care billed for visits to the beneficiary and, if so, how often. All of our data collection occurred prior to the regulation providing separate payment for physician plan care oversight services.

## FINDINGS

### *Physicians Are Most Involved in Referring Patients, Approving Plans of Care, and Monitoring the Progress of Complex Patients*

- Physicians are usually involved in initiating referrals to home health agencies.

- Most of the sample physicians had a relationship with the patient for whom they signed a plan of care.
- Physicians review and sign the plans of care.
- Physicians are most involved when caring for complex patients.

***Physicians are Less Involved in Coordinating Services, Visiting Patients At Home and Participating in Interdisciplinary Conferences***

- Physicians feel they coordinate their patients' home care; agencies disagree.
- Physicians do not usually take part in interdisciplinary conferences or make home visits.

***Both Agencies and Physicians Identify Some Obstacles and Issues Related to the Physician Role***

- **Communication.** Most agencies and physicians believe they communicate well with each other. However, physicians feel the agencies could improve communication by calling at scheduled times and having one nurse responsible for contacting the physician. Agencies say having a medical director would improve communication.
- **Plans of Care.** Physicians and agencies generally agree that physicians should continue to sign plans of care; agencies feel it is not always necessary for recertification or for chronic patients. Three-quarters of the physicians consider their arrangement for completing and signing the plans of care satisfactory.
- **Burdensome Paperwork.** Sixty-five percent of agencies and 51 percent of physician respondents find the process of reviewing and signing plans of care burdensome. Physicians indicate that there is too much paperwork and find it difficult to find the information on the plan of care that they consider important.
- **Physician Awareness and Education.** Some agencies feel that physicians' awareness and education in home health care is inadequate, that some physicians lack an understanding of the home health benefit.

**RECOMMENDATIONS**

We support the work of HCFA's home health work group in reviewing and restructuring the home health benefit. As home health care continues to expand, there will be ongoing discussions about the physician role. The HCFA will be pressed

to continue its leadership role to undertake appropriate activity and better define and tell what the physician role should be. Therefore, we recommend:

- The HCFA should continue its efforts to change the plan of care to ensure it conveys critical information to caregivers and relieves unnecessary burden from physicians.
- The HCFA should strengthen its efforts to educate both agencies and physicians about its policies regarding the physician's role in home health care.

### *Issues for Further Study*

Based on our findings and on comments received on our draft report, there are a number of issues about the role of physicians which require further study.

- Should other professionals such as the patient care coordinator, home health nurse, physical therapist, occupational therapist, speech therapist or social worker take on more responsibility for certain aspects of home health care? If so, how does this impact the physician's role?
- Should the complexity of the case determine physician involvement? If so, should the physician be more involved in complex cases and less involved in chronic cases?
- Should home health reimbursement be different for different levels of care? If so, should chronic care cases be reimbursed a lower level than those more complex cases?
- Does payment to physicians for care plan oversight lead to greater physician involvement?

### **COMMENTS**

Comments on the draft report were received from HCFA, ASPE and the Acting Assistant Secretary for Management and Budget (ASMB.) Suggestions for additional information and clarifications of the text have for the most part been incorporated into the final report. The actual comments received are included in Appendix A.

The HCFA defers action on our recommendations at this time. Nevertheless, we appreciate their recognition of the importance of our recommendations and support their efforts towards developing a Core Standard Assessment Instrument which would significantly impact on the requirements for the plans of care. We look forward to their decisions on our recommendations after issuance of the final report.

The HCFA, ASPE, and ASMB all commented on physician payment for care plan oversight. We recognize that HCFA is now reimbursing physicians for care plan

oversight. We plan a follow-up study to see whether this has led to greater physician involvement and prudent utilization of the home health benefit as HCFA's comments suggest.

The ASPE suggests that further study is needed to examine the actual behavior of physicians and other providers. We support further study of physicians in home health care that could contribute useful information. We added a new section to our report on issues for further study

Both HCFA and ASPE expressed concerns about specific evaluative issues that fall outside the scope of this study. This report provides descriptive rather than evaluative information. We modified the report to make this clearer.

The ASPE raised concerns about bias in self-reported information. This is always a problem in these kinds of studies. We had addressed it in our original design by obtaining information from many diverse sources. We obtained information from both home health agencies and physicians. We also obtained patient payment records to establish whether a relationship existed between patients and the physicians who signed the plans of care. We provide a methodology section for the reader to draw his/her own conclusions.

The ASPE requested that we include study instruments in our reports. We usually do not do this, but they are available upon request.

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# INTRODUCTION

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## PURPOSE

To describe the current role of the physician in Medicare home health care.

## BACKGROUND

Home health care allows people with limited independence to remain in their homes. The American Medical Association (AMA) defines it as the provision of equipment and services to the patient in the home for the purpose of restoring and maintaining his or her maximal level of comfort, function and health. Medicare defines it as certain services provided under a physician's plan of care in the residence of a homebound patient. Patients may require home care because of acute illness, long-term health conditions, permanent disability or terminal illness.

Home care is one of the nation's fastest growing segments of health care. Patients are living longer, are being discharged from the hospital earlier and receiving more complex care in the home. This care can consist of a variety of services such as skilled nursing care, home health aide services, speech-language therapy, physical and occupational therapy, medical services, medical supplies and durable medical equipment.

Typically, home health care is provided by home health agencies, home care aide organizations or hospices. The National Association for Home Care (NAHC) identified a total of 13,951 home care agencies in the United States as of February 1993. Of this total, more than half are certified Medicare home health agencies or hospices. Approximately 6 million individuals received home care services in 1993. Skilled nursing and aide services were the most frequently offered services by all types of providers, followed by physical therapy and speech therapy.

### *Physician's role*

Little data exist about the current nature of physician involvement in home health care. Literature indicates that they are seen as the "gatekeepers" of service, responsible for planning and supervising most home health care. Concerns have been raised based on audits of certain home health agencies and anecdotal information that physicians are not appropriately involved in planning and coordinating home health services. Some say physicians simply sign the plan of care without reviewing it or without knowing the patient.

Services a physician may provide include: making the medical diagnosis and managing medical problems; preparing a treatment plan with short and long term goals; ordering ancillary personal care; prescribing equipment and supplies; reassessing the treatment plan; documenting medical records, and providing for 24-hour physician coverage.

The AMA formed a Home Care Advisory Panel in 1987 to consider educational efforts to assist physicians in better understanding their role in the delivery of medical care in the home. To increase such physician participation, the panel developed guidelines which outline how the physician should relate to the home care patient. They describe the role of the physician as including medical management, such as evaluation and assessments, and communication and coordination of the services with the interdisciplinary team.

Medicare home health agency regulations require physicians to sign a plan of care specifying all services the patient is to receive. This certification must be updated, according to the regulations, every 60 days, but the doctor is not required to see the patient. To be certified as a Medicare provider, each agency must have a medical advisory board that meets periodically, and each board must have a medical director.

The role of a physician is also discussed in the Medicare Hospice regulations which require hospices to have a physician medical director. As one of his/her responsibilities this physician must be a member of the interdisciplinary team who discusses the plan of care with all involved disciplines, either in person or by teleconference.

### ***Medicare Coverage***

Title XVIII of the Social Security Act, Section 1861, authorizes Medicare payments for home health services under certain conditions. The care must be provided by certified home health agencies, which may be either freestanding or facility-based. They can be voluntary not-for-profit, proprietary or governmental in nature.

For Medicare to reimburse the agencies, beneficiaries must be considered homebound, get services under a plan of care established and periodically reviewed by a physician, and receive skilled care. For purposes of qualifying for coverage, skilled care includes: intermittent skilled nursing services, physical therapy or speech therapy services. Only if the patient requires one of these qualifying services may the patient then get the services of an occupational therapist, a medical social worker or a home health aide. If the patient no longer needs intermittent skilled nursing care, physical therapy or speech therapy, but continues to need occupational therapy, the beneficiary remains eligible for Medicare coverage of home health services for the duration of the need for occupational therapy. However, a beneficiary whose sole need is for custodial care does not qualify.

Beneficiaries pay no coinsurance or deductibles for home health care other than for durable medical equipment. Their claims are submitted to one of nine fiscal intermediaries known as Regional Home Health Intermediaries.

Medicare covers home visits by a physician the same as any other physician visit. Until recently, it did not separately cover the services of physicians for managing the home health care of their patients, such as interfacing with the home health agency by

telephone, reviewing medical records or signing plans of care. These services were considered part of the physician's work involved in other services, such as visits or procedures. In the December 8, 1994 Federal Register, HCFA issued a new regulation providing separate payment for physician care plan oversight services.

### ***HCFA Activities***

The HCFA Administrator has formed an internal task force to evaluate the home health benefit. With more home and community-based care, he sees the need to improve and redesign the home health benefit to assure that Medicare beneficiaries receive high quality and affordable home health care.

This task force is expected to recommend both short-term and long-term improvements in all aspects of the benefit. It has discussed restructuring the benefit to better accommodate the differing needs of the patients with complex, post-acute care or long-term custodial needs, and has also discussed the role of the physician in home care.

Other HCFA activities include ongoing research efforts to improve the measurement of quality in home health care, focusing on outcomes; revisions to the current plan of care form; planned improvements to the survey and certification process; and studies related to prospective payment in home health care.

### ***Office of Inspector General (OIG) Home Health Efforts***

The HCFA administrator has asked the Inspector General to join in HCFA's efforts to examine home health care. The OIG has developed a strategic plan in response to issues raised by the HCFA administrator. It focuses on management, costs and payments, compliance with statutes, regulations and policies, utilization, and outcomes of home health services.

The OIG has conducted an audit of home health agency visits in Florida to determine whether payments to these agencies met Medicare reimbursement requirements. The preliminary results show that too often the physician's involvement is limited to signing the plan of care prepared by the agencies without proper evaluation by the physician of the patient's medical needs. This resulted in the agencies' making their own determinations about the types and frequency of services the patients should receive without the guidance of the physician.

### ***Other Surveys***

Aetna in Florida surveyed beneficiaries who had received home health care, primarily in the Southeast, and the physicians who signed their plan of care. Their study reported aggressive marketing by some agencies to maximize visits, overutilization and a concern about the quality of care rendered. The physicians also indicated that many beneficiaries did not need skilled care. Aetna is piloting another survey which will

send an explanation of benefits to the certifying physicians, along with a questionnaire asking if the services the agency billed for were appropriate for that patient.

In 1990, the AMA surveyed and interviewed 1,161 family practice and internal medicine physicians about their involvement in home care. It found that physicians who refer approximately three patients a month to a home health agency spend substantial amounts of time coordinating the care provided by the agency. Rural physicians reported more involvement than their non-rural counterparts. Seventy-five percent of the physicians interviewed regarded a home visit as important, but only half reported making one or more home visits a year. The physicians considered the current payment level for such visits inadequate; 45 percent indicated that they would do more of them if reimbursements were higher. Eighty percent felt that home care agencies should be used more frequently than they currently are.

## METHODOLOGY

We identified the universe of 4,461 home health agencies (agencies) from the certified agencies listed in the Online Survey Certification and Reporting System (OSCAR) that also, according to 1992 National Claims History, filed Medicare claims during 1992 for a 1 percent sample of Medicare beneficiaries. From these, we selected a stratified random sample of 1000 agencies. The agencies were stratified by census regions (Northeast, Midwest, South and West) with 250 in each region. A questionnaire was sent to the sample agencies asking about the agency's relationship with its patients' physicians, its satisfaction with the physician role in home health care, and how the physician role may be strengthened. The questions divided patient care into three categories defined as follows: *complex* - requiring intensive care, using new technologies (such as infusion therapy or ventilators); *acute* - requiring skilled care (such as post hospital care or the exacerbation of a chronic condition); and *chronic* - requiring long term care (less intensive than acute care.) Basic descriptive information on home health agencies was accessed from the OSCAR file as well as from the agencies.

We received 700 completed surveys within approximately one month which we analyzed. There was no response bias with regard to region or ownership. The responses from the agencies were tabulated and cross-tabulated by agency size, region, rural/urban location, ownership, facility type and complexity of the patients they serve. Few statistically significant differences were found. Where differences were found, they are identified in the findings.

A subsample of 100 agencies (25 within each region) was selected for interviews by telephone to obtain more in-depth answers about the present physician role in home health care and how it can be strengthened. All together, 96 representatives of these agencies were interviewed. Unless otherwise noted, when agency information is reported, it is a result of analysis of the 700 mail surveys. The information from analysis of the agency subsample is noted as such.

From claims filed by the 1000 sample agencies, we identified unique beneficiary physician combinations. These physicians are the ones who signed the plans of care. We picked a random sample of 200 physicians from these combinations to interview by telephone. We asked them about their current role in home health care, their current interaction with home care agencies and their views on how their role could be strengthened. We interviewed 85 physicians. We were unable to obtain the names of 10 physicians from carrier or agency data and were unable to locate 18. This left us with a universe of 172 physicians. Of the remaining non-responding physicians, 25 refused to be interviewed, saying they do not do interviews or were too busy and 62 did not return our calls, even after repeated contact. This is a response rate of 49 percent. While there are no significant differences between the physician respondents and non-respondents relative to region or specialty, we recognize that the low physician response rate is a limitation.

From the random sample of the 200 physicians, we identified the 200 beneficiaries for whom they signed plans of care. Due to the way the sample was selected, we cannot determine whether the plans were initial or recertification. We obtained 1992 beneficiary histories for these beneficiaries. We reviewed them to determine whether the physician who signed the plan of care billed for visits to the beneficiary and, if so, how often. Of the beneficiary histories, nine contained unusable data; thus we reviewed histories for 191. Some of these 191 histories appeared to have missing data. In those cases we contacted the appropriate carriers for additional information.

The confidence interval for the responses to the physician survey using the lowest possible respondent number (79) is plus or minus 11 percentage points at the 95 percent confidence level. The confidence intervals for the agency survey at the 95 percent confidence level are much smaller, always within 5 percentage points.

It should be noted that all of our data collection occurred prior to the regulation providing separate payment for physician care plan oversight services. We conducted our review in accordance with the *Standards for Inspections* issued by the Presidents' Council on Integrity and Efficiency.

# FINDINGS

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## PHYSICIANS ARE MOST INVOLVED IN REFERRING PATIENTS, APPROVING PLANS OF CARE, AND MONITORING THE PROGRESS OF COMPLEX PATIENTS

*Referrals to home health agencies are usually initiated by physicians either alone or in collaboration with someone else*

Agencies and physicians agree that physicians are involved in referrals. Virtually all agencies (99 percent) report that physicians participate in patient referrals, often in collaboration with hospital discharge planners.

Almost all physicians say it is usually their idea, or a combination of their idea and someone else's, to refer patients for home health care. Half of them say the hospital discharge planner or the patient's family assists in the decision.

The number of patients physicians refer varies. Thirty-eight percent of physicians we interviewed refer from one to five; 32 percent refer six to ten, and 31 percent refer 11 to 60 patients per month. Those physicians that refer the most patients are more likely to be specialists in internal medicine and orthopedic surgery.

### *Most of the sample physicians have a relationship with their home health patients*

A review of 1992 beneficiary histories reveals that at least 91 percent of the physicians who signed the plan of care (either initial or recertification) had a relationship with the patient. Some of the remaining patients may have also had such visits, but this information was not available in the histories. For example, the patient may not have had Medicare Part B or may have been in a Medicare HMO.

Of the 91 percent with a relationship, more than three-quarters had four or more visits in 1992. See table below.

Visit Frequency	Percent of Physicians
10 or more visits	29 percent
7-9 visits	21 percent
4-6 visits	29 percent
1-3 visits	21 percent

### *Physicians review and sign the plans of care*

Eighteen percent of physicians report preparing the plans of care themselves. Ninety-three percent of the physicians who do not prepare them say they review the plans of care before signing them. Usually the agency or discharge planner fills them out according to the physician's orders or instructions and sends them to the physician for signature. Almost half of the physicians who review plans of care report sometimes making changes before signing them. Many of those who do not make changes attribute it to the fact the plans of care have been filled out exactly as ordered.

Virtually all of the agencies (99 percent) indicate it is the patient's personal physician who signs the plan of care. Seventy-seven percent of the agencies believe only a physician who has personally seen the patient should sign it.

Seventy-eight percent (66) of the physicians state they usually determine the types of visit the patient gets. Of the remaining 19 physicians who do not make that determination, 17 say they let the agency nurse or other professional make it. A lesser number of physicians, 56 percent, say they determine the number of visits the patient gets. For those who do not, 89 percent allow the agency nurse or other professional to make that determination.

Eighty-five percent (72) of the physicians believe a physician should see the patient before signing the initial plan of care. Only 28 percent (24), however, believe the physician needs to see the patient before recertifying the plan of care. Physicians report they are more likely to see a patient for recertification if the patient's condition changes, rather than just for routine recertification.

Some physicians, especially orthopedists and surgeons, say that their patients rarely have home health care long enough to require recertification and are usually discharged within 60 days. Both physicians and agencies say some of these patients have unrelated medical problems requiring home care. Some physicians and agencies are concerned because although the specialist has referred the patient to home care, there are other problems that should be managed by a different physician, usually the patient's primary physician. One agency administrator says, "Specialists only want to address one aspect of medical management and often leave the patient without a central physician addressing overall medical issues."

### *Physicians are most involved when caring for complex patients*

Both agencies and physicians have greater involvement with the complex patient. Seventy-nine percent of physicians say their complex patients require more physician involvement than their chronic patients. The agencies agree: 81 percent say they are in contact with the patient's physician 5 or more times a month for complex patients. Communication is more frequent in these cases because it is imperative the physician knows the status of the case in order to prevent problems. Most frequently, the

agency nurse communicates with the physician, but other professionals may communicate once or twice a month.

### **PHYSICIANS ARE LESS INVOLVED IN COORDINATING SERVICES, VISITING PATIENTS AT HOME AND PARTICIPATING IN INTERDISCIPLINARY CONFERENCES**

#### ***Physicians feel they coordinate their patients' home care; agencies disagree***

Eighty-three percent of physicians believe that they serve the coordinating role. Several feel that they provide continuity of care, just like in the hospital.

In contrast, a majority of agencies (61 percent) do not attribute the role of coordination to the physician. The Visiting Nurse Associations are more likely than others to say the physician does not coordinate care. More than half of all agencies say the nurse is usually responsible for coordinating the patient's care. An administrator, when discussing the physician's relationship with other members of the team, says, "I would like to see more of a partnership, more directly related to patient care."

Interviews with the agencies and the physicians suggest these differing opinions are due to the two groups' different perspectives. The agencies view the coordinating role as actively managing the interdisciplinary team, including the physician. The physicians see the coordinating role as overseeing the case, being involved in the medical management of their patient, and determining the number and type of visits. Seventy-two percent of the agencies are satisfied with physician involvement in the medical management of the patient. An agency administrator says, "the physician is the key member in the delivery of care." Agencies agree that the physician determines the number of visits for medical management, but say other professionals make that determination for each discipline. One agency administrator says, "the home care nurse should be responsible for coordination of all home care services." Another says, "I hope you are not reducing the role of the physician because they are responsible for medical management always."

#### ***Physicians do not usually take part in interdisciplinary conferences or make home visits***

Forty-three percent of agencies report that some of their patients' personal physicians participate in agency patient conferences. Although these conferences are not frequent, they are more likely to occur when patients experience problems.

Seventy-nine percent of physicians say they have not participated in such conferences. Both agencies and physicians agree that physicians participating in patient conferences, either in person or by telephone, would be ideal, but many say that physicians' busy schedules makes it impossible and unrealistic.



Fourteen percent of physicians report making home visits; most of them say these visits are infrequent and only when absolutely necessary. They add that since Medicare pays so little for a home visit it is not affordable for them to see patients in their home. They visit only when the patient cannot get to the office. Some physicians feel that physicians should visit patients at home more frequently. Some subsample agencies feel that physicians should make home visits to their patients occasionally. Perhaps, at times, with the home health nurse.

## **BOTH AGENCIES AND PHYSICIANS IDENTIFY SOME OBSTACLES AND ISSUES RELATED TO THE PHYSICIAN ROLE**

### ***Communication***

While all agree that good communication is extremely important for quality patient care, some obstacles are identified. Agencies say they continually work to improve communication with physicians. Ideas they have tried include newsletters, lunch or breakfast meetings to get the physician involved, simplifying requirements, setting a special time for phone calls, hand carrying orders to the physician, providing cellular phones to the visiting nurses, and having a physician from the medical advisory committee communicate with the patient's personal physician, especially in problem cases.

Ninety-two percent of physicians are satisfied with their communication with agencies and seventy-three percent of agencies are satisfied with physician communication with them. Agency satisfaction is somewhat lower with physician communication with other home health professionals, such as the primary care nurse or therapists, with only sixty-three percent of agencies satisfied.

However, three-quarters of the agency subsample mention obstacles which get in the way of good communication between the agency and the patient's physician. They include physicians being too busy to do all the paperwork and answer all the agency's phone calls; physicians not getting paid for their time; the physician's office staff making it difficult to reach him/her; the visiting nurse and the physician having difficulty finding convenient times to get together on the phone. Agencies consider it critical that nurses have access to physicians for medical direction and support.

Physicians feel the agencies could improve communication by calling at scheduled times and leaving clearer messages, or having one nurse responsible for contacting the physician so that many different people do not call about the same thing. Paying the physician for the time he/she spends on the phone and doing paper work and reducing the amount of such paperwork are also suggestions made by physicians.

### ***Medical Directors***

Agencies say having a medical director would improve communications. Eighty-six percent of the agencies in the subsample think home health agencies should have a

medical director. They feel this physician would be a good liaison with the patient's personal physician. Physician to physician communication is valuable, especially if there are problems and the medical director would be helpful in educating other physicians. Sixty-eight percent of agencies report currently having a medical director, although in some cases he/she is actually the medical director of the advisory board or the hospice program and not functioning as a full time medical director for the home health agency. Thirty-five percent of physicians feel that agencies should employ physicians, usually in a medical director role.

### *Plans of Care*

Physicians and agencies generally agree that physicians should continue to sign initial plans of care; however, most subsample agencies feel that qualified staff other than the physician can sign the plan of care for recertification or for chronic patients

Almost all (97 percent) agencies indicate that physicians should sign the plan of care for complex patients; ninety-two percent say physicians should sign for acute patients; and sixty-four percent for chronic patients. Sixty-three percent of physicians feel that they should sign all plans of care, regardless of the complexity of the patient's condition.

Three-quarters of the physicians consider their arrangements with the agencies for completing and signing the plans of care satisfactory, although almost half of them find it burdensome. Physicians frequently complained about the amount of paperwork required for home care. Three-quarters of the physicians believe that when they sign the plan of care they are liable for the home health services their patients receive. Some volunteer that there are agencies that try to add too many services, especially home health aide services. They say they stop referring patients to these agencies.

Regardless of the condition of the patient, fifty-three percent of the subsample agencies feel that the physician should always sign the initial plan of care; but a majority (57 percent), think the physician does not need to sign the recertification. These agencies and some physicians say that a qualified person other than the physician should be allowed to sign the plan of care, such as the primary care nurse or nurse practitioner or the treating therapist. They consider it especially appropriate for services to chronic, stable patients, such as those only needing a catheter change once a month, or for the therapist, dietician or social worker services they have evaluated. Most agencies and some physicians suggest support services, such as home health aide or personal care services, may be signed for by a nurse. One agency administrator voices the opinion of others when she says, "Under Medicare we are tied to the medical model which is expensive. We should look to use other professionals to fill some needs."

### *Burdensome Paperwork*

Sixty-five percent of agencies and 51 percent of physician respondents find the process of reviewing and signing plans of care burdensome. The large agencies and the Visiting Nurse Associations are most likely to feel burdened. Agencies feel paperwork is too complex and burdensome for them. An administrator agrees and says that having too many orders for doctors to sign strains the agency - physician relationship. One suggestion is to accept telephone orders for changes in the frequency of visits so that the agency does not have to generate a piece of paper for such minor changes.

Physicians indicate that there is too much paperwork and find it difficult to find the information on the plan of care that they consider important. They suggest paring down the amount of required information and highlighting the medical care. An agency respondent says, "The plan of care as it is today is a compilation of physician, nursing, therapy and social service practices, each of which is specific unto itself, but the physician is expected to sign for all of it." Several respondents suggested the plan be simplified.

### *Physician Awareness and Education*

Some agencies feel that the physicians' awareness and education in home health care is inadequate. They say medical schools usually do not include home health care in their curriculum. Agencies also mention that some physicians lack understanding of the Medicare home health benefit.

### *Overall Role of Physicians*

Forty-six percent of agencies feel the physician role should be stronger than it presently is; thirteen percent feel it should be weaker; and forty-one percent feel it should stay the same. Eighty-eight percent of the agencies believe if the physicians were paid for their home care case management role, they would get more involved; seventy-one percent of the physicians agree. As noted, this data were collected before physicians were paid for care plan oversight.

## **RECOMMENDATIONS**

We support the work of HCFA's home health work group in reviewing and restructuring the home health benefit. As home health care continues to expand, there will be ongoing discussions about the physician role. The HCFA will be pressed to continue its leadership role to undertake appropriate activity and better define and tell what the physician role should be.

Therefore, we recommend:

- The HCFA should continue its efforts to change the plan of care to ensure it conveys critical information to caregivers and relieves unnecessary burden from physicians.
- The HCFA should strengthen its efforts to educate both agencies and physicians about its policies regarding the physician's role in home health care.

### *Issues for Further Study*

Based on our findings and on comments received on our draft report, there are a number of issues about the role of physicians which require further study.

- Should other professionals such as the patient care coordinator, home health nurse, physical therapist, occupational therapist, speech therapist or social worker take on more responsibility for certain aspects of home health care? If so, how does this impact the physician's role?
- Should the complexity of the case determine physician involvement? If so, should the physician be more involved in complex cases and less involved in chronic cases?
- Should home health reimbursement be different for different levels of care? If so, should chronic care cases be reimbursed a lower level than those more complex cases?
- Does payment to physicians for care plan oversight lead to greater physician involvement?

### **COMMENTS**

Comments on the draft report were received from HCFA, ASPE and the Acting Assistant Secretary for Management and Budget (ASMB.) Suggestions for additional information and clarifications of the text have for the most part been incorporated into the final report. The actual comments received are included in Appendix A.

The HCFA defers action on our recommendations at this time. Nevertheless, we appreciate their recognition of the importance of our recommendations and support their efforts towards developing a Core Standard Assessment Instrument which would significantly impact on the requirements for the plans of care. We look forward to their decisions on our recommendations after issuance of the final report.

The HCFA, ASPE, and ASMB all commented on physician payment for care plan oversight. We recognize that HCFA is now reimbursing physicians for care plan oversight. We plan a follow-up study to see whether this has led to greater physician

involvement and prudent utilization of the home health benefit as HCFA's comments suggest.

The ASPE suggests that further study is needed to examine the actual behavior of physicians and other providers. We support further study of physicians in home health care that could contribute useful information. We added a new section to report on issues for further study.

Both HCFA and ASPE expressed concerns about specific evaluative issues that fall outside the scope of this study. This report provides descriptive rather than evaluative information. We modified the report to make this clearer.

The ASPE raised concerns about bias in self-reported information. This is always a problem in these kinds of studies. We had addressed it in our original design by obtaining information from many diverse sources of data. We obtained information from both home health agencies and physicians. We also obtained patient payment records to establish whether a relationship existed between patients and the physicians who signed the plans of care. We provide a methodology section for the reader to draw his/her own conclusions.

The ASPE requested that we include study instruments in our reports. We usually do not do this, but they are available upon request.

# APPENDIX A

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## COMMENTS




DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care  
Financing Administration

**Memorandum**

**DATE** MAR 27 1995

**FROM** Bruce C. Vladeck  
Administrator 

**SUBJECT** Office of Inspector General Draft Reports: "The Physician's Role in Home Health Care," (OEI-02-94-00170) and "Home Health Agencies: Alternative Coverage and Payment Policies," (OEI-12-94-00180)

**TO** June Gibbs Brown  
Inspector General

We reviewed the subject draft reports which examine home health care provided under the Medicare program. Our comments are attached for your consideration.

Thank you for the opportunity to review and comment on these reports. Please advise us if you would like to discuss our position on the recommendations.

Attachment

Comments of the Health Care Financing Administration (HCFA)  
on Office of Inspector General (OIG) Draft Reports:  
"The Physician's Role in Home Health Care," (OEI-02-94-00170)  
and "Home Health Agencies: Alternative Coverage and Payment  
Policies," (OEI-12-94-00180)

OIG Recommendations on "The Physician's Role in Home Health Care"

1. The HCFA should continue its efforts to change the plan of care to ensure it conveys critical information to caregivers and relieves unnecessary burden from physicians.
2. The HCFA should further communicate its expectations about physician involvement and take steps to assure that it is more clearly understood by home health agencies and physicians.

HCFA Response

HCFA defers action on the above recommendations at this time. We are in the process of examining issues related to plans of care and the physician's role and recognize the importance of both recommendations. However, we believe it would be premature to make immediate changes.

Clearly one of the most important problems facing the Medicare home health benefit is utilization. OIG is commended for its attempts to better understand the appropriate role of the physician in monitoring utilization and appropriateness and duration of care.

HCFA has addressed the issue of physician involvement through regulations. In the December 8, 1994 Federal Register, HCFA issued a new regulation providing separate payment for physician care plan oversight services. Reimbursing physicians for care oversight services should lead to greater physician involvement and prudent utilization of the home health benefit.

HCFA has also established a Medicare Home Health Care Work Group which is currently drafting revised Home Health Agency Conditions of Participation. HCFA is also developing a Core Standard Assessment Instrument. Requirements for the assessment instrument could significantly impact the information requirements on the plan of care. The work group expects to develop recommendations after it completes its research. Until then our operational plans are to continue using HCFA Forms 485 and 486 (Medicare Collection of Medical Information on Home Health Services).

We note that the report recommendations do not address the two main questions listed on page 3: "Are physicians effectively fulfilling their gatekeeper role in initiating and monitoring the plan of care?" "Do physicians rubber stamp the plan of care?" While the report recognizes that there are discrepancies in how physicians and agencies view the



physician's role in coordinating care, it does not address whether physicians are an effective gatekeeper. Perhaps the study might more effectively address "Does greater physician involvement result in a more cost-effective utilization of the home health benefit?"

Additionally, we would be interested in any specific suggestions OIG may be able to offer on the following:

- o After interviewing both agencies and physicians, does OIG have any specific suggestions of ways the plan of care can be changed?
- o Does OIG have specific suggestions on how the role of physicians should be better communicated?
- o Does OIG feel that, after talking to agencies and physicians, there is a consensus on what the physician role ought to be?

Comments on "Home Health Agencies: Alternative Coverage and Payment Policies"

The report appears to assume that other agencies are more effective than Medicare in controlling costs. However, there are no data in the report comparing the average number of visits or expenditures per beneficiary. While the report identifies other plans' limits on utilization, there may be other factors, such as age, health status, and income, that could explain differences in utilization, if they exist.

We are in the process of developing our approach to revitalizing the coverage and payment policies for home health agencies. The Points of Further Analysis in this report raise interesting alternatives that will be considered by HCFA as it formulates its plan to revitalize the home health benefits.



MAY 1 1995

TO: June Gibbs Brown  
Inspector General

FROM: Assistant Secretary for  
Planning and Evaluation

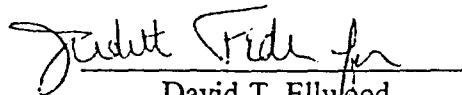
SUBJECT: OIG Draft Reports on Home Health Care -- COMMENTS

The following are our comments on the draft inspection report, "The Physician's Role in Home Health Care," OEI-02-94-00170. There are no comments on the second report, "Home Health Agencies: Alternative Coverage and Payment Policies," OEI-12-94-00180.

#### GENERAL COMMENTS

- **The purpose of the report needs clarification.** The purpose is stated as "to describe the current role ... and obtain suggestions as to how this role can be strengthened". We agree that this report describes the current role of physicians, based on physician and provider perceptions. However, since the effectiveness of the physician's role is not evaluated in this study, we recommend eliminating references to strengthening the physician's role.
- **The study's limitations should be stated.** The report describes what conclusions can be drawn from the study but does not define what inferences are outside the study's scope. For example, since the study does not include a comparison of the perceived role to current regulatory requirements, interpretations related to current law are outside the scope of this study. Furthermore, because the measurements of physician involvement may be biased due to self-report, the findings should be interpreted with caution. Finally, the low physician response rate to the telephone interview (43%) should be noted as a limitation.
- **References to gatekeeping should be revised.** Since the effectiveness of the physician's role as a gatekeeper is not evaluated in this study, references to this as part of the study's purpose should be eliminated (see p.3 paragraph 4). Instead, the report's findings should suggest further study of this issue because they indicate that other professionals (e.g. nursing, therapy, social work) determine the amount and type of care, (with rare changes by the physician) and that the physician does not routinely see the patient to recertify care.

- **Revisions to the recommendations are needed.** Since the study is based on perceptions versus actual behavior, a further study that examines the actual behavior of physicians and other providers should be recommended. Additionally, the report should recommend that HCFA consider revising its expectations about physician involvement to reflect current practice. For example, the report states that physicians are most involved in complex medical cases. Since current law allows reimbursement to physicians for care plan oversight in **all** cases, this should be considered a highly relevant finding.
- **The report should include the study instruments.** It is difficult to interpret these findings without knowing the actual questions that were asked. We recommend you include the questionnaires in an appendix.

  
David T. Ellwood

Prepared by: HP:Susan Manfredi 690-7862/DALTCP:Ruth Irwin 260-0370



MAR 6 1995

Washington, D.C. 20201

To: Inspector General  
Attn: George Grob

From: Elizabeth M. James *Elizabeth M. James*  
Acting Assistant Secretary for Management and Budget

Subject: Draft OIG Report--Physician's Role in Home Health Care  
(OEI-12-94-00170)--Concur with comment  
*52-94-00170*

We recommend that the final report acknowledges that, effective this calendar year, Medicare now makes separate payments to physicians for their work in providing home health care plan oversight. Because the draft report finds that lack of payment was one obstacle to improving physician involvement in the ongoing care of home health patients, we believe it is appropriate that the new payment policy be discussed in the final report.

We appreciate the opportunity to review the draft report.