

PURCHASED HOME HEALTH CARE SERVICES PROCEDURES

- 1. REASON FOR ISSUE.** This Veterans Health Administration (VHA) Handbook addresses the purchase and monitoring of Purchased Skilled Home Care (PSHC) and Homemaker and/or Home Health Aide Services (H/HHA). Options for purchasing care apply to the Department of Veterans Affairs (VA) Community Hospice Care Program.
- 2. SUMMARY OF MAJOR CHANGES.** This is a new Handbook that incorporates procedural changes for the referral, evaluation and monitoring of veterans in home health care and the purchase of these services.
- 3. RELATED PUBLICATIONS.** VHA Handbook 1140.2, VHA Handbook 1140.3, and VHA Handbook 1140.4.
- 4. FOLLOW-UP RESPONSIBILITY.** The Chief Consultant for Geriatrics and Extended Care Strategic Healthcare Group (114) is responsible for the contents of this Handbook. Questions may be addressed to 202-273-8543.
- 5. RESCISSIONS.** None.
- 6. RECERTIFICATION.** This VHA Handbook is scheduled for re-certification on or before the last working day of July 2011.

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PURCHASED HOME HEALTH CARE SERVICES PROCEDURES

1. PURPOSE

This Veterans Health Administration (VHA) Handbook provides procedures for the implementation of national policy for utilization of home health care services purchased and monitored by VHA; it provides instruction for purchasing an array of necessary and accessible in-home services, and mandates the monitoring necessary to ensure that home care resources utilized by veterans are of high quality and are used effectively and efficiently.

2. BACKGROUND

a. In the past, VHA furnished home care services, both skilled home care and homemaker and/or home health aide (H/HHA) services as well as hospice and palliative care, to a limited number of veterans through Department of Veterans Affairs (VA) Home Based Primary Care (HBPC) programs and a limited fee for service program. Today, all enrolled veterans are eligible for a comprehensive array of medically necessary in-home services as identified in VA's medical benefits package (see Title 38 Code of Federal Regulations (CFR) 17.38 (a) (1) (ix)).

b. VHA's care paradigm has shifted from episodic treatment of illness to managing the medical and psychosocial needs of an enrolled population of aging veterans with a prevalence of complex, chronic, disabling conditions. This shift has mandated an expansion of, and greater commitment to, home and community-based care options for short-term and long-term care.

3. SCOPE

a. VHA is committed to the provision of clinically-appropriate home health care services as an integral component of medical care services. VHA purchases skilled home health care (PSHC), H/HHA services, respite care, hospice and palliative care services, and other in-home services to enhance or build a comprehensive array of resources necessary to address the short-term or long-term care needs of enrolled veterans.

b. All of VHA's 21 Veterans Integrated Service Networks (VISNs) offer a combination of VA-provided, VA-purchased, and VA-arranged home care services. VHA has a long history of coordinating care across settings and payer sources to ensure health care continuity for veterans. However, as VHA increases the amount of purchased care under various payment options, the clinical coordination of services across settings becomes an even greater priority.

c. This Handbook specifies:

- (1) Definitions of community home health care programs,
- (2) Program specific eligibility guidelines for entry into the purchased home care programs,

(3) Processes for administrative management of purchased home health and hospice care, and

(4) Processes for ensuring oversight and monitoring of veterans receiving purchased home health services.

4. GOALS

Goals of the Purchased Home Health Care Services Program are to:

a. Ensure that clinically-appropriate services are available in the home as a component of the medical care necessary to support veterans in restoring or improving their health status, maintaining their independence, or providing them comfort-oriented supportive services at the end of their lives.

b. Ensure that approaches used by VA health care facilities to implement a broad array of home and community based care program alternatives are flexible and innovative with an emphasis on assuring the best of VHA and community resources are accessible to veterans in need of such care.

5. DEFINITIONS

a. **Purchased Skilled Home Health Care (PSHC).** Skilled home health care services are in-home services provided by qualified personnel that include: skilled nursing, physical therapy, occupational therapy, speech therapy, social work services, clinical assessment, treatment planning, treatment provision, patient and/or family education, health status monitoring, reassessment, referral, and follow-up. A VA primary care provider prescribes skilled home health care services when medically necessary and appropriate for enrolled veterans.

b. **Homemaker and/or Home Health Aide Services (H/HHA).** H/HHA services are personal care and related support services that enable frail or disabled veterans to live at home. Only trained personnel who have successfully completed a competency evaluation and are employed by a home health agency may provide these services. H/HHA services must be provided under the general supervision of a registered nurse. A VA primary care provider prescribes H/HHA services when medically necessary and appropriate for enrolled veterans.

(1) Homemaker services may include assistance with Instrumental Activities of Daily Living (IADLs), such as: light housekeeping, necessary to maintain a safe and sanitary environment in the areas of the home used by the patient; laundering, essential to the comfort and cleanliness of the patient; meal preparation; grocery shopping; escorting the patient to necessary appointments; and ensuring patient safety.

(2) H/HHA services may include assistance with Activities of Daily Living (ADLs), such as: bathing; toileting; eating; dressing; aid in ambulating or transfers; active and passive exercises; assistance with medical equipment; routine health monitoring; and, specific household tasks to maintain environmental safety for the patient.

c. **Community Hospice Care Services.** Hospice is the final stage of the palliative care continuum in which the primary goal of treatment is comfort rather than cure for patients with advanced disease that is life-limiting and unresponsive to disease-modifying treatment. Community hospice agencies provide a comprehensive package of bundled home hospice services utilizing an interdisciplinary team of professionals and volunteers. These programs emphasize relief of suffering and maintenance of functional capacity as long as possible through comprehensive management of the physical, psychological, social, and spiritual needs of the patient. They also provide support for the patient's family or other caregivers including bereavement support following the death of the patient. A VA physician prescribes hospice care services.

d. **Home-based Primary Care (HBPC).** HBPC is a VA-operated home care program in which a physician-supervised interdisciplinary team of VA staff provides comprehensive, longitudinal primary care in the homes of veterans with complex, chronic, disabling conditions for whom routine clinic-based care is not effective.

e. **Respite Care.** Respite care services are personal care and supportive services delivered in the home, nursing home, hospital adult day care center, or assisted living facility, for the express purpose of temporarily relieving the caregiver(s) of caregiving duties. Respite care services may include various VA-provided services, e.g., H/HHA, and non-VA purchased services. In all cases, respite care remains distinct from the routine use of Geriatrics and Extended Care (GEC) services in that the focus and purpose of respite care is providing relief for the caregiver. VHA respite care services are generally limited to 30 days per year total from all settings in which respite is provided. A VA physician prescribes respite care services.

f. **Care Coordination and Home Telehealth (CCHT).** CCHT is the ongoing monitoring and assessment by VA staff of selected patients using telehealth technologies proactively to enable prevention, investigation, and treatment in order to enhance the health of patients and prevent unnecessary and inappropriate utilization of resources. CCHT provides a continuous connection for veteran patients to clinical services from the convenience of their place of residence, and supports formal and informal caregivers in their difficult roles. Care Coordinators facilitate referrals for appropriate services, such as home health care and hospice care, serving as a link between such services and the VA health care system.

g. **Medicare and/or Medicaid Certification.** Medicare and/or Medicaid certification is the process of inspection, certification, and monitoring that home health care agencies undergo to be approved for Medicare and/or Medicaid payment from Centers for Medicare and Medicaid Services (CMS). This process is generally administered by the State in which the home health care agency is licensed.

6. RESPONSIBILITY

a. **VISN Director.** The VISN Director, or designee, is responsible for ensuring that the medical facilities within the VISN develop written policies, procedures, and practices for the referral, planning, and monitoring of home health care services.

b. **Medical Center Director.** The Medical Center Director, or designee, is responsible for ensuring the facility establishes written policy for maintaining the clinical and administrative processes and practices for referral, planning, and monitoring of home health care services.

c. **Office of Geriatrics and Extended Care.** The Office of Geriatrics and Extended Care is responsible for developing policy, monitoring program activity in home health care, and providing reports on compliance and performance.

7. ELIGIBILITY AND DETERMINATIONS OF NEED FOR VA HOME HEALTH CARE SERVICES

a. **Purchased Skilled Home Health Care.** A veteran is eligible to receive Skilled Home Care (SHC) if the veteran is enrolled in the VA health care system, or if the veteran is not required to be enrolled under 38 CFR 17.37. VA may not furnish SHC in such a manner as to relieve any other person or entity of a contractual obligation to furnish needed services to the veteran. VA must offer SHC to a veteran if VA determines that the veteran needs this care through VA provision (as HBPC) or through purchase. The following factors indicate a medical need for SHC.

(1) A need for intermittent, short-term, or long-term skilled nursing assessment, teaching, treatment services, or monitoring.

(2) A need for intermittent, short-term, or transitional rehabilitative therapies, such as physical therapy, speech and language pathology services, and occupational therapy.

(3) A need for intermittent, short-term, or transitional social work services.

b. **H/HHA.** A veteran is eligible to receive H/HHA if the veteran is enrolled in the VA health care system or not required to be enrolled under 38 CFR 17.37, and is in need of nursing home care. VA must offer H/HHA to a veteran if VA determines that the veteran needs this care. VHA uses the array of home and community-based care services as an alternative to nursing home care, in accordance with the authorizing statute (see Title 38 United States Code (U.S.C.) 1720C). The phrase “in need of nursing home care” means the interdisciplinary team has made a clinical judgment that the veteran would, in the absence of home and community-based care services, need nursing home care. The following criteria identify the target population of eligible veterans who are most in need of H/HHA services as an alternative to nursing home care.

(1) Through an interdisciplinary assessment, the veteran has been determined to have the following clinical conditions:

- (a) Three or more ADL dependencies, or
- (b) Significant cognitive impairment, or
- (c) Require H/HHA services as adjunct care to community hospice services, or
- (d) Two ADL dependencies, and two or more of the following conditions:
 - 1. Has dependency in three or more IADLs;
 - 2. Has been recently discharged from a nursing facility, or has an upcoming nursing home discharge plan contingent on receipt of home and community-based care services;
 - 3. Is seventy-five years old, or older;
 - 4. Has had high use of medical services defined as three or more hospitalizations in the past year or has utilized outpatient clinics or emergency evaluation units twelve or more times in the past year;
 - 5. Has been diagnosed with clinical depression;
 - 6. Lives alone in the community.

(2) It is recognized that every contingency cannot be foreseen. When a veteran who does not strictly meet the preceding criteria and nevertheless is determined by the clinical care team to need H/HHA services, the services may be ordered, but the reason for the variance from these standards must be documented in the patient's record.

c. **Review of Admission Criteria.** The Office of Geriatrics and Extended Care monitors compliance of the application of admission criteria for H/HHA services. The percentage of H/HHA referrals that meet the criteria is highlighted in the semi-annual reports, which the Office of Geriatrics and Extended Care sends to the Deputy Under Secretary for Health for Operations and Management (10N).

8. HOME HEALTH CARE ADMINISTRATIVE ELIGIBILITY AND COST OF CARE

- a. Home health care is a covered benefit for all enrolled veterans, on par with all other medical services included in the medical benefits package.
- b. The receipt of Aid and Attendance (A&A) is not to be considered when placing veterans into home health care services.

c. A veteran who is dually eligible for both VA care and Medicare may elect to have home care services paid for under the Medicare benefit. Veterans who choose Medicare retain their eligibility for VA care and benefits. Veterans should be notified that VA has no authority to pay for any balances or co-payments that may be due after Medicare or any other non-VA source makes payment for care.

d. The total monthly VHA cost of an individual veteran's home and community-based care services, to include skilled home health care, H/HHA services, community adult day health care, and non-institutional respite services, should not exceed 65 percent of the monthly cost per patient in the nearest VA Nursing Home Care Unit (VANHCU). VANHCU rates are available from the Office of Geriatrics and Extended Care (see <http://www1.va.gov/hcbc>). **NOTE:** See paragraph 14 for exemptions.

9. USE OF COMMUNITY AGENCIES FOR HOME HEALTH CARE

VHA referrals for home health care services are made to community agencies that are state-licensed or CMS-certified for the level of care provided (SHC, H/HHA), and in good standing with state licensing bodies in the states where the agency provides care. **NOTE:** *Accreditation by other organizations is neither necessary nor sufficient for VA to use an agency for home care placements.*

b. Whenever possible, patient preference in the selection of the home care agency is a priority consideration.

NOTE: See paragraph 14 for exemptions to the licensure and CMS certification requirement.

10. HOME HEALTH CARE REFERRALS

a. Referral for home health care services must be initiated by the veteran's VA health care team. This interdisciplinary team must complete an appropriate assessment and VA Form 10-0415, Geriatrics and Extended Care (GEC) Referral. This determination of need must be completed before a veteran is referred for service.

b. When veterans are placed with home health care or home hospice agencies outside the Primary Service Area, the VA facility or VISN making the placement must authorize care and must obligate funds for a period of time not to exceed 30 days. If home health care or hospice care services are expected to exceed 30 days, veteran responsibility transfers to the VA facility and/or VISN where the veteran is placed.

c. It is the responsibility of the placing facility to contact the receiving VA facility to:

(1) Assist in placement with an appropriate agency.

(2) Arrange the transfer of obligations, including veteran follow-up and financial requirements after the initial 30 days with the receiving VA facility. The receiving VA facility is responsible for obligations and follow-up services after the initial placement period.

d. The guidance in subparagraph 10b does not apply in the following cases:

(1) When the placing VA facility provides primary care for the veteran, that VA facility maintains financial and follow-up for the episode of home health care.

(2) When the receiving VA facility has been paying for home health care, or hospice care, prior to the episode of care at the placing VA facility, the receiving facility maintains financial and follow-up responsibility from the time of placement.

(3) When the VISN has a written policy on intra-VISN placement, transfers, and financial responsibility.

11. HOME HEALTH CARE WAITING LISTS AND WORKLOAD REPORTS

The Medical Center Director, or designee, is responsible for ensuring that:

a. Current VHA policy is followed in utilizing an electronic waiting list (EWL) of veterans in need of and seeking home health care services when budget resources are not sufficient to meet all identified home health care needs of veterans. For eligible veterans who are determined to be in need of H/HHA, VA gives priority to veterans who are in receipt of, or are in need of, nursing home care primarily for the treatment of a service-connected disability, or who have a service-connected disability rated at 50 percent or more. A waiting list process for hospice care services is not to be utilized, as VA must provide or purchase needed hospice services without delay. **NOTE:** *DSS Stop Code 682 is to be utilized for both PSHC and H/HHA.*

b. Workload related to the purchase and clinical oversight of home health care services is to be entered into the appropriate reporting systems for local and national tracking.

12. PURCHASE OPTIONS FOR HOME HEALTH CARE AND HOSPICE SERVICES

a. Processes for purchasing home health care and hospice services must be jointly developed by Acquisition and Materiel Management Services (A&MMS) and appropriate clinical staff at each VISN or VA health care facility level. The purchasing options ensure that a broad array of home and community-based care options are accessible to veterans, and that the veteran's preference for specific resources is considered when facilitating referrals.

b. All VHA purchases of home health care will be made only from licensed and appropriately-certified community agencies in good standing with state licensing bodies. VHA purchases hospice services only from agencies that are licensed, or otherwise state-approved, or are certified by Medicare or Medicaid as hospice agencies.

c. Options for the purchase of home health and hospice care include:

(1) Contracts for services established at the VA facility, VISN, or multi-VISN level. "Contract" for the purpose of this definition, means a competitively attained, mutually binding

legal relationship obligating the seller to furnish the supplies or services and the buyer to pay for them. It includes all types of commitments that obligate the Government to an expenditure of appropriated funds and that, except as otherwise authorized, are in writing.

(2) Basic Ordering Agreements (BOA) based on geographic location or low-frequency of use (fewer than 30 referrals per year for each service to that agency).

d. By June 30, 2008, existing Memoranda of Understanding, or other purchase arrangements, must be replaced by the purchase options in subparagraph 12c.

e. Guidelines for reimbursement rates for purchased home health care and hospice care services are found in VHA Directive 1140.3.

NOTE: Under the Health Insurance Portability and Accountability Act (HIPAA), the National Provider Identifier (NPI) final rule requires that Covered Entities use NPIs in standard transactions by the compliance date of May 23, 2007, or by May 23, 2008, for small health plans. Covered Entities are health plans, health care clearinghouses, and those health care providers who transmit any health information in electronic form in connection with a transaction for which the Secretary of Health and Human Services has adopted a standard. The NPI is a standard health care provider identifier maintained by the CMS. VHA plans to perform bulk enumeration for existing providers, and policy will be developed for future providers joining the VHA system. The implications are that VHA would not be able to bill for services of providers who have not been enumerated and will also incur penalties if its providers are not in compliance by the compliance dates.

13. QUALITY OVERSIGHT AND MONITORING

VA health care facilities must integrate into their overall quality management program a system of oversight and monitoring for VA-purchased home health care services. At a minimum these systems must ensure that:

a. All veterans receiving VA-purchased home health care services have their need for service reviewed at least every six months for the first year of placement and annually thereafter. This review process must consist of a review of pertinent VA clinical documentation to substantiate the continued clinical need for service, and documentation of the extension of service(s). **NOTE:** The VA Form 10-0415, *Geriatrics and Extended Care (GEC) Referral* will be updated or a new one completed in CPRS, if indicated.

b. Each year, one third of all veterans receiving VA-purchased home health care are contacted to ensure they are receiving the services according to the home health care agency's plan. Patient and family satisfaction with these services may also be discussed. **NOTE:** These contacts are normally completed by phone.

c. Clinical and administrative program quality elements are routinely measured and analyzed with action plans developed if necessary. Annual reports to VA health care facility leadership

include a summary of the findings, as well as the outcome of any corrective action plans on identified quality issues. The minimum quality elements that must be monitored include:

(1) Patient and/or family concerns, if discussed, see subparagraph 13b.

(2) Annual verification that the agencies utilized by the VA health care facility remain in good standing with state licensing and certifying agencies.

(3) For Medicare-certified home health care agencies only, the performance of the home health agency against state, regional, and national standards of quality as monitored and reported through CMS systems (Home Health Compare) is reviewed. Agencies under VA contract must perform better than the state average on at least 50 percent of the CMS quality measures. A separate verification of license under subparagraph 13c(2) is not required for Medicare-certified agencies.

d. A Contracting Officer's Technical Representative (COTR) progress report is completed on an annual basis for each Contract or BOA and sent to appropriate leadership for review and action as necessary.

e. Appropriate VA health care facility staff review local reports automatically generated by VA Form 10-0415 on H/HHA placements for compliance with the clinical admission criteria for this service (see paragraph 7).

NOTE: *VHA refers and provides information for home health care placements and does not control the patient's plan of care, which is developed and implemented by the community agency. As a result, PSHC and H/HHA are not subject to Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) survey as part of the VA health care facility's JCAHO accreditation process.*

14. EXEMPTIONS

Requests for exemptions to the policies in paragraphs 8d and 9 may be developed by each VA health care facility. VHA's Office of Geriatrics and Extended Care may grant exemptions on the cost of maximum care, license, or accreditation of community agencies on the recommendation of a VISN Director.