The Baby Boomers are Booming: The Future of Nursing and Home Health Care

Anthony M. Lopez

Follow this and additional works at: http://via.library.depaul.edu/jhcl

Part of the Health Law and Policy Commons

THE BABY BOOMERS ARE BOOMING: THE FUTURE OF NURSING AND HOME HEALTH CARE

Anthony M. Lopez*

I. INTRODUCTION

The Patient Protection and Affordable Care Act of 2010[1] and the subsequent amendments by the Health Care and Education Reconciliation Act of 2010[2] are referred to, collectively, as the "ACA." The ACA was enacted with the primary purpose of assisting citizens, of the United States, in obtaining affordable healthcare.[3] This nation faces a great challenge of dealing with a large portion of the population, also referred to as the "baby boomers,"[4] reaching retirement age together. This article will focus on the growing concern that, with Medicare already facing solvency issues, once the baby boomers reach retirement age there will be too many individuals needing healthcare services with no way to pay. The United States spends 17.6 percent of its gross domestic product (GDP) or 2.7 trillion dollars a year on health services.[5] Yet the United Kingdom only spent 9.6 percent of its GDP;[6] Canada spent 11.4 percent of its GDP[7] on health care services.[8]

---

[1] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).

[2] Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152, 124 Stat. 1029 (2010).

[3] Stephen Adams, *Understanding the Affordable Care Act*, AMERICAN INSTITUTE FOR ECONOMIC RESEARCH (May 8, 2014), https://www.aier.org/research/understanding-affordable-care-act.

[4] *Baby Boomers*, HISTORY.COM, (2010) http://www.history.com/topics/baby-boomers. The term "baby boomers" refers to a period exactly nine months after World War II ended (1946) and continued on until 1964. By then, there were 76.4 million "baby boomers" in the United States. They made up almost 40 percent of the nation's population.

[5] BARRY R. FURROW ET AL., HEALTH LAW: CASES, MATERIALS, AND PROBLEMS, 527 (2013) (stating $2.7 trillion dollars is roughly $8,233 per capita).

[6] *Id.* (stating 9.6 percent of its GDP is roughly $3,433 per capita).

[7] *Id.* (stating 11.9 percent is roughly $4,445 per capita).

[8] *Id.* at 528.

The first section of this Article will discuss the background of home health. The second section will be a detailed discussion of the laws already implemented to protect the elderly. The third section will propose a switch from traditional home health and nursing home care to a combination of telehealth and Accountable Care Organizations (ACOs) to lower costs, increase access, and improve quality of care.

II. General Background

Home health care is quickly becoming one of the fastest growing issues in health care. For the purposes of this Article, home health care and nursing home care will be used interchangeably to discuss the overarching problem of the baby boomers reaching retirement. The rapid expansion of home health services began in 1988, when widespread changes were made to the Medicare regulations to expand the eligibility for home health care services.[9] The changes, in effect, eliminated any limits on the number of visits by home health care professionals.[10] In the years that followed, the total amount spent on home health care grew from around $2 billion in 1987, to over $18 billion in 1996.[11] The expenditures on home health were not the only area expanding rapidly. By 1996, the number of home health care agencies had grown to more than 10,000 agencies.[12] But with growth rates rapidly rising, demand could not meet the supply.

A nursing home is different from an institution, like a hospital, for several reasons. The most obvious is that a nursing home assumes complete and total control over the environment the residents live in, for a longer period of time than a hospital stay or doctor's visit; a nursing home addresses the day to day needs of their patients, as well as their medical needs. Chronic pain and physical frailty pose challenges that require extensive care.[13] The human race as a whole is living longer, but the later years are fraught with ailments and complications. A hospital is set up to serve a patient, restore them to the most optimal health possible and then discharge them. Yet nursing homes function differently. While hospitals serve a quickly revolving door of patients, when the elderly move into nursing home facilities, it is typically for the final duration of their life.

---

[9] Brian Davis, *The Home Health Care Crisis: Medicare's Fastest Growing Program Legalizes Spiraling Costs*, 6 ELDER L.J. 215, 216 (1998).

[10] *Id.*

[11] *Id.*

[12] *Id.*

[13] BARRY R. FURROW ET AL., HEALTH LAW: CASES, MATERIALS, AND PROBLEMS, 139 (2013).

This is a population with increased vulnerability, as well as an increased need for care and treatment.

While a nursing home operates differently from other medical systems, the incentives driving fraudulent schemes are similar. A prevalent negative incentive stems from Medicare and Medicaid. The government sets the rate of reimbursement for certain services or procedures, as opposed to the doctors setting it on their own. This can result in a lower rate of payment than the doctor or facility would generally need to pay expenses for services.[14] Because doctors and facilities are reaping a lower payment rate from Medicare patients, it creates the incentive to increase the volume of these patients they serve, in an attempt to make up for the deficit created by the lower reimbursement rate. Hospitals and private practices have the luxury of having other patients, under the age of 65, to balance to losses taken for elderly care. Yet nursing homes are often housing only residents covered by Medicare or Medicaid, which carry the same problems. This may increase fraud because doctors bill for visits or procedures they did not perform in an attempt to recoup their losses.

Nursing homes are predominantly staffed by nurses, so doctors and specialty services must be brought in and are not already "in-house." Under Medicare Part B, supplies and services can be furnished by an outside entity other than the nursing home, the opportunity for oversight or unauthorized billing presents itself.[15] If an outside provider is brought into a facility, the nursing home has assessed a need for the services. These services often include wound care, mental health services, or portable x-rays. But service providers often use aggressive marketing techniques to get "in the doors" of the nursing home facilities to overbill a patient's Medicare number. Nursing homes are often understaffed, which makes is almost impossible for them to choose between fraudulent service providers and honest providers. It may be simple to see the danger of fraud that may be present in nursing care, but the real issue is patient care taking a "back seat" to making money.

The older population is also more susceptible to fraud in general. Brain imaging reveals a potential tendency for the elderly to have less

---

[14] Adriana Anderson, *Medicare Reimbursement*, MEDICARE.COM (July 28, 2015), https://medicare.com/administration/how-do-i-get-reimbursed-by-medicare/.

[15] George F. Grob, *Testimony on Fraud, Waste, and Abuse in Nursing Homes*, ASSISTANT SECRETARY FOR LEGISLATION DEPARTMENT OF HEALTH AND HUMAN SERVICES (Apr. 16, 1997), http://www.hhs.gov/asl/testify/t970416a.html.

activity in the area of the brain that processes risks and subtle danger.[16] This makes them more susceptible to scams and being taken advantage of.[17] An elderly resident may be the victim of a fraud and abuse Medicare scam and not be aware of it or unable to catch it; but that doesn't make it less important to monitor this area as thoroughly as others. Not only do these instances of fraud harm the patient financially, but it also hinders recovery.

III. The Elder Justice Act

Elder abuse is defined as "intentional actions that cause harm or create a serious risk of harm to an other person," (whether or not harm is the intended outcome) and includes such acts as physical abuse and neglect, financial exploitation, and mental abuses.[18] Because abuses do not fit a single pattern, but are multifaceted, a coordinated and sustained response across multiple disciplines is required. Elderly residents exist in a strong interplay between Medicare and government coverage, the nursing home and its staff, other residents and doctors, or specialized staff that comes from beyond the in-house facility. For elder abuse to be combatted, there must be communication and collaboration among all active parties.

In 2002, the first comprehensive legislation geared specifically to combat elder abuse was introduced.[19] The need was identified by the Government Accountability Office, who noticed both weaknesses in nursing home oversight, as well as state level enforcement and insufficient safeguards to protect residents against abuse. The Elder Justice Act, enacted as part of the ACA on March 23, 2010, [20] authorizes $100 million to be provided as state and local funding to implement and ensure the elderly population is protected. Further, the Elder Justice Coalition was

---

[16] Patti Neighmond, *Why It's Easier to Scam the Elderly*, NATIONAL PUBLIC RADIO (Dec. 6, 2012) http://www.npr.org/sections/health-shots/2012/12/06/166609270/why-its-easier-to-scam-the-elderly.

[17] *Id.*

[18] Nora Super, *Elder Justice Policy Brief*, 2015 WHITE HOUSE CONFERENCE ON AGING (May 8, 2015) http://www.archive.whitehouseconferenceonaging.gov/blog/post/elder-justice-policy-brief.aspx.

[19] *Elder Justice Act*, NATIONAL ADULT PROTECTIVE SERVICES ASSOCIATION, http://www.napsa-now.org/policy-advocacy/eja-implementation/.

[20] *The Elder Justice Act: Addressing Elder Abuse, Neglect, and Exploitation*, NATIONAL HEALTH POLICY FORUM (Nov. 30, 2010), https://www.nhpf.org/uploads/announcements/Basics_ElderJustice_11-30-10.pdf.

created to promote the process of the Elder Justice Act. The group has since expanded to support the passage of other legislation governing elder abuse. Such legislation includes the Elder Abuse Victims Act,[21] geared to advance the rights of the victims of elder abuse and increase resources for investigation and prosecution of crimes. The Elder Protection and Abuse Prevention Act, was seeking to create a statute requiring the National Adult Protective Service Center to implement screening and reporting of elder abuse, in order to improve overall coordination between agencies. The Home Care Consumer Bill of Rights Act, sought to extend the rights and protections of residents in long-term care facilities to those receiving long-term care at home. Unfortunately, none of these bills passed through Congress, and the Elder Justice Act remains the only law specifically governing elder abuse.

Advisory boards were created within the Department of Health and Human Services to monitor elder abuse with the purpose of making recommendations to the Secretary regarding coordination of activities related to abuses covered by the Elder Abuse Act. The Elder Abuse Act recognized the rights of an elder person to be free of abuse, neglect and exploitation. The creation of forensic centers to development methodologies to determine the presence of elder abuse, and the collection of such evidence, was another medium through which the Elder Justice Act sought to work.

In 2014, the Elder Justice Coordinating Council, acting within the Health and Human Services, put forth eight recommendations to improve awareness of, and engage prevention of and response to elder abuse:[22]

1. Support the investigation and prosecution of cases by providing training and resources to federal, state, and local entities;
2. Enhance services available for victims by improving identification of abuses and outreach to its victims;
3. The development of a national audit protective services system based on standardized data collection;
4. Development of a federal elder justice research agenda to identify the best practices available fro prevention and intervention in abuse, making the issue more of a priority;

---

[21] Elder Abuse Victims Act of 2008, 110 H.R. 5352 (2008).

[22] WHCOA Staff, *Elder Justice Policy Brief*, 2015 WHITE HOUSE CONFERENCE ON AGING (May 8, 2015), http://archive.whitehouseconferenceonaging.gov/blog/policy/post/elder-justice-policy-brief.

5. The development of a broad public awareness campaign, to raise awareness and understanding;

6. Encourage cross-disciplinary training on elder abuse to educate the various stakeholders in multiple sectors that interact with nursing homes, so that more may be able to identify and respond to instances of abuse;

7. Combat elder financial exploitation by collaborating with the financial industry to enhance fraud detection and provide resources for victims; and

8. Improve first responders' ability to identify a diminished capacity (mental or financial), and vulnerability to financial exploitation.

Some steps have been taken to put these recommendations into place, including a 2016 budget proposal of $25 million to support the enhancement of state level adult protective services and a nationwide implementation of a mistreatment reporting system.[23] The Department of Health and Human Services is also beginning the design of a national adult maltreatment reporting system, which is hoped to be in full functioning capacity by February 2017.[24] But the reporting by states is not mandatory and, as any self-reporting data, must be taken with a "grain of salt" in its status as a reliable and honest representation of the elder justice activity in the area. The Consumer Financial Protection Bureau has produced several resource manuals for a variety of individual who may come in contact with elder abuse (i.e. for older adults, to help them identify and avoid scams; for those who manage elder estates or operate nursing facilities, etc.).[25]

The Department of Justice launched a website in September of 2014, with resources for victims of elder abuse and their family members to assist in reporting the abuse and finding help.[26] The website contains links to law enforcement agencies, local practitioners, and the ability to quickly locate support by zip code. Another legislative advancement is under each States' "Long-Term Care Ombudsman programs," which serve as advocates for residents of nursing homes, working to resolve individual

---

[23] *Id.*

[24] *National Adult Maltreatment Reporting System*, DEPARTMENT OF HEALTH AND HUMAN SERVICES (Dec. 31, 2014), http://www.aoa.acl.gov/AoA_Programs/Elder_Rights/NAMRS/index.aspx.

[25] WHCOA Staff, *supra* note 22.

[26] *The Elder Justice Website*, U.S. DEPARTMENT OF JUSTICE, http://www.justice.gov/elderjustice/.

[26] *State Long-Term Care Ombudsman Programs*, FEDERAL REGISTER (Feb. 11, 2015), https://www.federalregister.gov/articles/2015/02/11/2015-01914/state-long-term-care-ombudsman-programs.

resident problems and bring about improvements in quality.[27] A regulation set to take hold on July of 2016, would seek to strengthen these programs, to fill gaps in efficiency and stabilize consistency in the programs across the board. The changes to the existing rules governing the programs seek to clarify confusions brought up in public comments, to make these programs easier to implement. Other legislative advancements have been the Patient Safety and Abuse Prevention Act, passed in 2010, and instated a comprehensive national system of criminal background checks to prevent those with a history of violence or abuse from being employed in long-term care facilities.[28] In it's pilot stages, the Act had been ruled as a success, and has stopped at least 7,000 improper applicants from passing through the employment system unnoticed. It now requires nationwide compliance with the screening provisions and the penalty for failure to comply exclusion from Medicare or Medicaid participation.[29]

A. In-House Solutions

Turning from legislative tactics to prevent elder abuse and exploitation in nursing homes, there are also in-house internal systems in place to monitor care and quality. The Office of the Inspector General has developed numerous compliance programs—specialized for nursing homes or other healthcare facilities—tailored to the governing regulations and overall purpose of improving quality.[30] The compliance guidelines identify areas where there is danger of fraud and abuse and how to alleviate the danger.[31] The detailed explanations on sufficient staffing, comprehensive care plans for residents, resident safety and proper reporting are meant to encourage the development and use of internal

---

[27] *State Long-Term Care Ombudsman Programs*, FEDERAL REGISTER (Feb. 11, 2015), https://www.federalregister.gov/articles/2015/02/11/2015-01914/state-long-term-care-ombudsman-programs.

[28] Matthew White, *What is the Patient Safety and Abuse Prevention Act?*, GRAY AND WHITE, http://www.grayandwhitelaw.com/faqs/what-is-the-patient-safety-and-abuse-prevention-act-psapa.cfm.

[29] *The Society for Post-Acute and Long-Term Care Medicin*e, THE SOCIETY FOR POST-ACUTE AND LONG-TERM CARE MEDICINE (Sept. 10, 2008) http://www.amda.com/advocacy/legal/congress110/s1577.cfm.

[30] *Compliance Guideline*, OFFICE OF THE INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES (Sept. 30, 2008), http://oig.hhs.gov/compliance/compliance-guidance/index.asp.

[31] *Supplemental Compliance Program Guidance for Nursing Facilities*, FEDERAL REGISTER (Sept. 30, 2008), http://oig.hhs.gov/compliance/compliance-guidance/docs/complianceguidance/nhg_fr.pdf.

controls; so that the facility will be self-sufficient in policing itself for violations and adhering to all the relevant statutes. The guidelines are entirely comprehensive, so nursing homes can adopt and rely on them completely and be assured that its explicit compliance with the guidelines would simultaneously ensure compliance with all relevant law governing elder care. Yet the downfall to the Office of the Inspector General's programs are that they are not mandatory; but as merely voluntary guidelines, there is no incentive or penalty for not following them.

The Centers for Medicare/Medicaid Services (CMS) take a less passive step in combatting poor treatment of patients in nursing home facilities. CMS created the Medicaid Integrity Program to prevent and reduce fraud and abuse and increase patient safety in facilities using Medicaid.[32] Through this program, CMS hires contractors to monitor the activity of Medicaid providers, audit claims and identify instances of abuse. The Medicaid Integrity Program also provides state level auditing and fraud policing systems with the assistance and educational tools they require, seeking to strengthen the fraud combatting powers as a whole.

CMS also promulgates its own regulations, with more enforced mandatory compliance than the Office of the Inspector General's guidelines. CMS requires that skilled nursing and nursing facilities be certified by unannounced surveys conducted by the state, and a possible follow up or confirmation needed from the regional office.[33] If a facility is found to be unsatisfactory and not up to the proper standards, Medicare or Medicaid participation will be revoked. More famously, is the CMS's promulgation its list of serious reportable events, or "never events."[34] The purpose of singling out these "never events" is to address common medical errors, which can total to more than $4.5 billion in additional health spending per year, and which are completely preventable.

CMS exercised its authority to announce that Medicare will no longer pay the extra cost of treating occurrences off of the "never events" list, including: pressure ulcer stages III and IV; falls and trauma; surgical

---

[32] *dicaid Integrity Program: General Information*, Centers for Medicare & Medicaid Services (Apr. 28, 2015), https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/MedicaidIntegrityProgram/index.html?redirect=/medicaidintegrityprogram/.

[33] *Nursing Homes*, Centers for Medicare & Medicaid Services (Dec. 17, 2015), https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/NHs.html.

[34] Herb B. Kuhn, *State Medicaid Director Letter*, Centers for Medicare and Medicaid Services (July 31, 2008), https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/smd073108.pdf.

site infections after bariatric surgery, bypass surgery and certain orthopedic procedures; vascular-catheter associated infection; catheter-associated urinary tract infection; administration of incompatible blood; air embolism; and the unintentional retention of a foreign object from surgery. Combined with this steeper penalty for selected never events, CMS continues to monitor the other hospital-acquired conditions on the full list, totaling 28 "never events," and requires that an instance of any one of them be reported.

B. Too Little Too Late

Several strategies have been put in place to combat against issues specific to the nursing home landscape; but there is still the question of whether these safeguards and active measures are enough to sufficiently stop the problem. In late September 2015, the Inspector General admitted that nursing homes are still billing for more therapy than patients need, for the purpose of exploiting the billing system.[35] While the legislation and regulations in place to protect elderly residents are not foolproof, some may work better than others; and there could be tweaks made to ensure a more efficient and comprehensive protection of the elderly. It is especially important that this group be sufficiently protected, not just for the value the elderly possess and the honor due to their contributions to society, but because the frailty of those in the later stages of life makes fraud and abuse to this class more dangerous.

When doctors order and administer unnecessary procedures, it can be detrimental to those who can no longer bounce back and recover. After the opportunity to generate finances through employment has been foreclosed, protection of the assets an individual has left carries greater weight than the protection of a young adult with a secure job and good health. Because the elderly tend to be less adapt to technology and more mentally susceptible to scams and exploitation, security measures that work in typical healthcare facilities and systems may not be sufficient.

Beginning with an evaluation of the legislative safeguards in place, the Elder Justice Act serves as an important focal point to counteract the problems of elder abuse. With the overall goals of improving coordination and collaboration among all various members who participate in the operation and servicing of nursing homes, the Elder Justice Act has the right goals in mind. But the execution has not taken off so quickly. Federal

---

[35] Robert Pear, *Nursing Homes Bill for More Therapy Than Patients Need, U.S. Says*, N.Y. TIMES (Sept. 30, 2015), http://www.nytimes.com/2015/09/30/us/nursing-homes-bill-for-more-therapy-than-patients-need-us-says.html?_r=1.

advisory board recommendations have been presented, but the comprehensive adoption of these recommendations has yet to occur. There appears to be a heavy reliance on websites and other virtual mediums in where resources and explanations are contained. Many of the manuals and resources available to victims of elder abuse are contained online. The reporting databases that are touted as a way for residents to review potential nursing homes require the use and knowledge of a computer. For generations who were born before the invention of the computer, the second-nature of current persons to navigate and utilize the Internet may not be translating well into feasible means for the elderly. If addressing the problem of making services and resources available to victims of elder abuse is done primarily through technology, this is not adequately or efficiently addressing the problem or the ability of residents to become informed.

But what the Elder Justice Act implementations do best might serve as a guide for how to better solve some of these other types of problems. Extra funding and resources have been appropriated for the Long-Term Care Ombudsman Programs. These programs work with individual residents and their specific situations and harms. This interpersonal and face-to-face communication is a much more efficient and high quality approach to assisting members of the elderly population. The care and personal affect of an individualized visit from an advocate allows the individual to feel more comfortable; they are given the opportunity to ask questions and feel a sense of comfort from the problem solving experience with someone who they can get to know and talk too - not just an empty presence on a computer screen. To utilize this method on a larger problem solving scale would require a greater database of advocates. It would require an increase of interest in elder rights, as well as an incentive for would-be advocates.

To inspire such an increase in advocates, an option for the Elder Justice Coordinating Council would be to allocate a portion of funding to set aside as grants or scholarships. This would incentivize young people, in colleges or graduate school or even in the workforce, who have the energy and passion for elder rights to donate their time and care to combating instances of abuse for a small amount of compensation. The sum could not be large for a two-fold reason: first, is that there are not the resources to sustain a broad extension of funds to the extent of people needed to increase the advocate database; and secondly, if the grant allocation offered is too high, it could incentivize the wrong people for the wrong reasons. But a slight stipend of a couple hundred dollars or less for year's commitment as an advocate to provide this facial assistance to a larger number of the elderly community would be a benefit matching the expense extension. To become an advocate would not require a vast

amount of training or qualification. The goal of bridging the gap between the individual elder person and the ability to identify and combat fraud in a predominantly technological setting merely requires an intelligent individual, with a patient temperament and a working knowledge of computers.

The theme of increased personal presence can carry over into enhancing the in-house internal controls of quality and efficiency. The Office of the Inspector General has already created compliance programs, tailor made to fit the exact needs of nursing homes. These are programs that are updated to stay current with regulations and are entirely thorough and comprehensive. The purpose of these programs is to capitalize on efficiency, improve quality overall, and save money through fewer mistakes and less opportunities for fraudulent claims. Therefore, the cost of implementing these programs would not be extreme and theoretically would save money. It would just be requiring that nursing homes do what they're already supposed to be doing. An easy fix appears to be the mandate of explicit compliance, nationwide, with the nursing home program guidelines.

However, while there would be numerous benefits, increased efficiency, and a rise in quality, the largest impact from this implementation would come from the substantial increase in needed manpower for enforcement purposes. And this need could not be met with volunteers, touting some minimal training and their best intentions. A radical change of this scale would require an increase in highly trained professionals, and would require much more than a small stipend to incentivize the necessary increase to the workforce. While this would be possibly the most effective way to combat fraud and abuse in the nursing home sector, it doesn't seem like a feasible option in the face of the current financial system of America. A change of this scale would require almost constant vigilance, at least in the early stages, in the form of new training, assistance with the program implementation, large scale internal reorganization, and then a consistent presence to monitor enforcement.

Where would the money for all these new jobs come from to enforce the regulations? Would they work for the nursing homes, for the government, or from an outside source like private companies? How regularly would enforcement inspections be expected and what kind of timetable would facilities be given to rectify their violations? These are just some of the big questions that would need to be answered in order to shift the Inspector General's compliance programs from voluntary to mandatory. The largest challenge would be the funding of such an extreme shift, as the need for a larger enforcement base combined with the financial toll on nursing homes to get up to code would be substantial. Ideally, nursing homes would be provided with grants or subsidies to assist in their

restructuring to meet the more comprehensive compliance expectations, but the funding provided through the Elder Justice Act would be stretched far too thinly to be very beneficial. The benefits would be a boost to overall quality, a uniform expectation of standards across the board, more efficient and cost-effective measures and most importantly tangible benefits of improved care and consistency for the residents. But with the current healthcare system draining government and state resources, this implementation could not be reasonably adopted in the near future—without substantial change.

So while it looks like internal measures of quality cannot be radically elevated for the time being, it is feasible to provide elderly residents with the comfort an increased presence of personal assistance and a greater voice to advocate for quality elder care. A shift away from what has become a typical reliance on technology and an increase in interpersonal, face-to-face assistance will better suit the needs and natures of elderly residents of nursing homes. This will increase the individual resident's clarity, as well as provide them with a resource they will know how to use and be able to get their questions sufficiently answered. With the baby boomers entering the nursing home community in higher numbers each day, the potential for fraud and abuse is increasingly heightened. It is important not to let this population be swept under the rug; we must commit to ensuring safeguards are in place to meet their needs. The health and happiness of our elderly population is not only a sign of character for the country, but a reminder of where each individual inevitably will end up. The choices made today will effect their future selves and situations, so it pays to be thoughtful, as well as thorough, when it comes to evaluating the protection against fraud and abuse for elderly residents of nursing homes.

IV. MOVING TO THE FUTURE OF HEALTH

A. New Regulations and Statutes May Create More Trouble Than They Are Worth

As of 2015, there were 15,700 operational nursing homes in the United States, with 1.7 million licensed beds.[36] Unfortunately, the number of residents nearly fills the bed allotment, with the latest number totaling 1.4 million. With only over 300,000 beds left to be used, how will nursing

---

[36] *Nursing Home Care*, CENTERS FOR DISEASE CONTROL AND PREVENTION (Feb. 6, 2015), http://www.cdc.gov/nchs/fastats/nursing-home-care.htm.

care facilities grow at a rate fast enough to house this increasing number of elderly?

The primary concern is that many home health agencies lack the staff or equipment to keep up with the demand for home health services. This may have been a small proportion of the population in the past, but with the baby boomers set for retirement the number of elderly individuals using home health services is set to increase exponentially. The increase in demand for services will likely lead to an increase in fraud and abuse of the elderly. The fraud and abuse problems that exist in hospital settings and in private practices are just as numerous as in home health, but they are not as closely guarded due to the consigned nature of thought surrounding elder care and its occupants. One reason for this increased likelihood for fraud is that long-term care facilities are so different from institutions like hospitals—or doctor's offices—and many of the systems in place to protect against fraud and abuse are not as efficient or effective for home health services. While there has been some specialized action taken for the protection of elder care, has it really been enough to combat the levels of patient mistreatment in the home healthcare system?

Congress and State legislatures can implement as many reforms and laws as they want, but unless there is implementation of these regulations they system fails. As previously discussed, the nursing home industry already has issues with availability of services. Whether the nursing facility lacks beds, staff, or proper equipment, there is a real issue that senior citizens will not be able to find affordable care in the near future when the baby boomers come of age. Simply put, nursing homes are out of money. Without money to fund their facilities the patients suffer. Claudia Lennhoff, the executive director of Champaign County Health Care Consumers stated, "[j]ust, very frankly, I would not want to be in a nursing home," and "I would do everything I could do to try to keep my parents out of a nursing home."[37] The common sentiment amongst the medical community is that nursing homes are a place with insufficient medical care and a "last resort" for your loved ones. Yet money, time, and health restrictions often forces people's hands into placing their loved ones in a "home."

B. Telemedicine

The differences between telehealth, telemedicine, and telecare must be understood before diving deeper into the subject. First, telehealth is a

---

[37] Robert Holly and Claire Everett, *Reports: Nursing Home Troubles Continue*, THE NEWS-GAZETTE (Dec. 26, 2014, 7:00 AM), http://www.news-gazette.com/news/local/2014-12-26/reports-nursing-home-troubles-continue.html.

broad term used to describe the delivery of health care services, health care education, and health information services over a distance.[38] Next, telecare refers to technology that allows patients to remain in the safety of their homes by using "telecommunications technology including telephones, computers and mobile monitoring devices such as warden alarms, automatic gas shut-off devices and home entry videophones."[39] Further, telecare involves remotely monitoring a patient to help manage the patient's comfort and care at home. Finally, telemedicine is defined as "the use of electronic communications and information technologies to provide clinical services to patients in other locations."[40] Telemedicine is much narrower in scope than telehealth because it refers to the delivery of health care services—and education—over a distance, through the use of telecommunications technology.[41]

Typically, telemedicine and telecare are covered under the broad scope of telehealth. However, The American Telemedicine Association (ATA) uses telehealth interchangeably with either telemedicine or telecare.[42] As a general matter, telehealth and telemedicine both allow for a variety of treatment options like virtual doctor-patient consultations, remote monitoring of blood pressure, ECG or other vital signs, and health education services.[43] Through telehealth technology, physicians are able to monitor any fluctuations in the patient's health and take corrective action by adjusting the therapy or medical treatment being administered to the patient. Allowing patients to stay in their home or a home health care facility greatly reduces cost and improves recovery rates.[44] For the purposes of this paper, I will be using both telehealth and telemedicine interchangeably.

---

[38] Telehealth, Telecare and Telemedicine. . .What's the Difference?, GLOBALMED.COM http://www.globalmed.com/additional-resources/telehealth-telecare-and-telemedicine-whats-the-difference.php.

[39] *Id.*

[40] *Id.*; Reid, Jim, *A Telemedicine Primer: Understanding the Issues* (1996) (Examples of telemedicine include video consultations with specialists, remote medical evaluations and diagnoses and the digital transmission of medical imaging).

[41] *Id.*

[42] Telemedicine Frequently Asked Questions (FAQs), AMERICANTELEMED.ORG, http://www.americantelemed.org/about-telemedicine/faqs#.Vl3H77zw_Vo.

[43] *Id.*

[44] Hospital & Home Care Recovery, PEARLCARROL.COM, http://pearlcarroll.com/csea/Hospital_Home_Care_Recovery_27_product.htm (Typically less expensive than nursing home or hospital stays, in-home care can bring more personalized service and help people recover more quickly.)

a. General Background

Telemedicine and telehealth are undoubtedly gaining quick support in the United States, and internationally, due to the incredible medical benefits of diagnosing patients without needing the doctor to be physically present. To help facilitate the growing demand for telehealth services in the United States, the Centers for Medicare & Medicaid Services (CMS) included a provision to expand telemedicine coverage. This expansion increases coverage to include the remote monitoring of chronic care management for patients. This allows for patients to remain in the safety and comfort of their own home and receive the care they need.[45]

b. The Government's Impact

On April 15, 2015 Congress passed the "doc fix" Bill, originally titled Medicare Access and CHIP Reauthorization Act (H.R. 2).[46] The question we are left wondering is: does this bill actually help progress telemedicine in the United States? The short answer is yes.[47] The "doc fix" bill is a glaring indication to medical providers that adopting innovative procedures, such as telemedicine, can increase their organizations likelihood of obtaining new payment prospects. "Doc fix" completely changes the reimbursement system and financing of health care in the United States. The most notable shift is the departure from the traditional fee-for-service model and towards accountable care organizations (ACOs), risk-based payment, and a focus on quality and population health.[48]

Further, on July 1, 2015, third party payors are now required to reimburse medical providers on the same basis for telemedicine and telehealth programs as they would for face-to-face consultations. Indiana is just one of twenty-nine states that have passed Parity Laws for private

---

[45] By reducing traveling for patients with chronic illnesses, telehealth can save the government and the patient money. In addition, allowing a patient to be seen in a comfortable setting can also help speed recovery and make their condition less unpleasant.

[46] Peter Sullivan & Sarah Ferris, *Senate overwhelmingly approves 'doc fix'* (04/14/15 09:45 PM) http://thehill.com/policy/healthcare/238871-senate-overwhelmingly-approves-house-doc-fix-bill.

[47] Nathaniel M. Lacktman, *Does the "doc fix" bill help telemedicine and telehealth?* (April 20 2015) http://www.lexology.com/library/detail.aspx?g=4e507667-8b8d-4cc8-8e95-8521146bbc06&utm_source=Lexology+Daily+Newsfeed&utm_medium=HTML+email+-+Body+-+Federal+section&utm_campaign=Chicago+Bar+Association+subscriber+daily+feed&utm_content=Lexology+Daily+Newsfeed+2015-04-22&utm_term=.

[48] *Id.*

insurance coverage of telemedicine.[49]   An additional ten states have proposed legislation that should be voted on shortly.

The United States spends more per capita[50] than any other developed country. However, the—sometimes absurd—spending may be warranted with advances in technology. One of the most prevalent technologies in the medical field today is telehealth.[51] Telehealth is a broad term used to describe the delivery of health care services, health care education, and health information services over a distance.[52] In addition, telecare—another area of telehealth—refers to technology that allows patients to remain in the safety of their homes by using "telecommunications technology including telephones, computers and mobile monitoring devices such as warden alarms, automatic gas shut-off devices and home entry videophones."[53] Telehealth and telemedicine both allow for a variety of treatment options like virtual doctor-patient consultations, remote monitoring of blood pressure, ECG or other vital signs, and health education services.[54]

Through telehealth technology, physicians are able to monitor any fluctuations in the patient's health and take corrective action by adjusting the therapy or medical treatment being administered to the patient. Allowing patients to stay in their home or a home health care facility greatly reduces cost and improves recovery rates.[55] Telemedicine and telehealth are undoubtedly gaining quick support in the United States, and internationally, due to the incredible medical benefits of diagnosing patients without needing the doctor to be physically present. To help facilitate the growing demand for telehealth services in the United States, the Centers for Medicare & Medicaid Services (CMS) included a provision to expand telemedicine coverage. This expansion increases coverage to include the remote monitoring of chronic care management for patients.

[49] *Telemedicine Frequently Asked Questions (FAQs)*, AMERICANTELEMED.ORG, http://www.americantelemed.org/about-telemedicine/faqs#.Vl3H77zw_Vo.
[50] Adriana Anderson, *supra* note 14.
[51] Telehealth may also be referred to as telemedicine, interchangeably.
[52] *What is Telemedicine?*, GLOBALMED, http://www.globalmed.com/additional-resources/telehealth-telecare-and-telemedicine-whats-the-difference.php.
[53] *Id.*
[54] *Id.*
[55]   *Hospital   &   Home   Care   Recovery*,   PEARLCARROL, http://pearlcarroll.com/csea/Hospital_Home_Care_Recovery_27_product.htm
(discussing that in-home care is typically less expensive than nursing home or hospital stays, and can bring more personalized service and help people recover more quickly).

This allows patients to remain in the safety and comfort of their home and receive the care they need.[56]

On April 15, 2015 Congress passed the "doc fix" Bill, originally titled Medicare Access and CHIP Reauthorization Act (H.R. 2).[57] The question we are left wondering is: does this bill actually help progress telemedicine in the United States? The short answer is yes.[58] The "doc fix" bill is a glaring indication to medical providers that adopting innovative procedures, such as telemedicine, can increase their organizations likelihood of obtaining new payment prospects. "Doc fix" completely changes the reimbursement system and financing of health care in the United States. The most notable shift is the departure from the traditional fee-for-service model and towards accountable care organizations (ACOs), risk-based payment, and a focus on quality and population health.[59]

The benefits of telemedicine have been prevalent since it first began in the 1960's.[60] But to understand how telemedicine truly benefits patients we will look at three different categories: access, quality, and cost. It is without question that some home health facilities in the United States provide their patients with greater access to medical care than others. However, what happens for those families that lack the financial stability to place their loved ones in nursing homes capable to make the correct judgment in life or death situations? The answer, unfortunately, is that

---

[56] By reducing traveling for patients with chronic illnesses, telehealth can save the government and the patient money. In addition, allowing a patient to be seen in a comfortable setting can also help speed recovery and make their condition less unpleasant.

[57] Peter Sullivan & Sarah Ferris, *Senate Overwhelmingly Approves 'Doc Fix,'* THE HILL (Apr. 14, 2015, 09:45 PM), http://thehill.com/policy/healthcare/238871-senate-overwhelmingly-approves-house-doc-fix-bill.

[58] Nathaniel M. Lacktman, *Does the "Doc Fix" Bill Help Telemedicine and Telehealth?*, CHICAGO BAR ASSOCIATION (Apr. 20, 2015), http://www.lexology.com/library/detail.aspx?g=4e507667-8b8d-4cc8-8e95-8521146bbc06&utm_source=Lexology+Daily+Newsfeed&utm_medium=HTML+e mail+-+Body+-
+Federal+section&utm_campaign=Chicago+Bar+Association+subscriber+daily+fee d&utm_content=Lexology+Daily+Newsfeed+2015-04-22&utm_term=.

[59] *Id.*

[60] Telemedicine had its beginning in the 1960's when the National Aeronautics and Space Administration (NASA) began to put people into space; Teresa Smith Welsh, *Current Trends in Telemedicine*, (June 6, 1999), http://ocean.st.usm.edu/~w146169/teleweb/telemed.htm; BASHER, R.L., P.A. ARMSTRONG, & Z.I. YOUSSEF,
TELEMEDICINE: EXPLORATIONS IN THE USE OF TELECOMMUNICATIONS IN HEALTH CARE (1975).

without proper or specialized medical attention, some individuals do not survive; although, with the rise of telemedicine, doctors can more easily make qualified decisions over a computer monitor.[61] For instance, a drug called Tissue Plasminogen Activator ("TPA")—administered a few hours after a stroke—can break up blood clots and reduce damage to the brain.[62] Yet if administered incorrectly, the drug can cause fatal hemorrhages.[63] Only a stroke specialist would have the medical expertise to decide when to administer TPA with fewer complications. By implementing telemedicine programs in all nursing facilities, a stroke specialist in Chicago can diagnose symptoms of a nursing home patient in the suburbs of Illinois—effectively administering TPA.

This is just one example of how increased access can improve medical outcomes for nursing home patients. In addition, nursing home patients can also benefit from these services by easily obtaining specialty services. Further, patients can stay in their home health organizations or nursing homes and no longer have to travel long distances for medical attention. Patients can also receive a variety of specialty services to include, stroke, trauma, and intensive care services that healthcare providers are able to expand their "reach" through telemedicine.[64]

c. Benefits of Telemedicine

Telemedicine can also improve the quality of medical care for patients. Earlier diagnoses and treatment, can further contribute to improved outcomes by addressing patient's illnesses before it escalates. Also, telemedicine supported ICU's can reduce mortality rates, complications, and hospital stays for patients in critical care situations.[65] Telemedicine also allows physicians to guide and control therapy sessions with much more ease. This allows patients in nursing facilities to receive updated therapy treatment at a much faster rate, increasing the likelihood of recovery and care for patients. Therapy and rehabilitation is a key component to any medical treatment. Survival rates tend to decrease for

---

[61] Neel V. Patel, *The Science of Telemedicine: A Lifesaver in the Right Place*, WIRED (May 30, 2015, 9:00 AM), http://www.wired.com/2015/04/science-of-telemedicine/?mbid=social_twitter.

[62] *Id.*

[63] *Stroke Treatments*, AMERICAN STROKE ASSOCIATION (May, 23, 2013), http://www.strokeassociation.org/STROKEORG/AboutStroke/Treatment/Stroke-Treatments_UCM_310892_Article.jsp#.Vl3RELzw_Vo.

[64] *Benefits of Telehealth/Telemedicine?*, SETRC.US, http://www.setrc.us/index.php/what-is-telehealth/benefits-of-telehealth-telemedicine/.

[65] *Id.*

patients with longer than normal hospital stays. By allowing a patient the ability to rehab in a nursing care facility or an in-home monitored program, the patients have much more happiness and increased chances of healing.

The last area that telehealth can help improve is cost, for both the consumer and government. Transportation cost can sometimes be a hurdle for patients, especially if the commute is far or they need to pay for transport. In nursing homes, a lack of access to a specialist can result in high transportation costs and higher cost if the patient is required to stay at a hospital overnight. However, with telemedicine, the patient can remain in their home using home monitoring programs or nursing home, which can reduce high cost hospital visits.[66] Further, specialists can be costly. For example, you have a patient with a lung condition in a nursing facility with limited access to medical specialists. After visiting the local physician, the condition progresses, which leads to lessened blood flow, resulting in the patient having a stroke. Telemedicine, allows specialists to "team up" with local healthcare providers to improve disease management and reduce complications and hospitalizations.[67] [68]   Telemedicine also helps save the government money because better health for the patients leads to less use of medical services. This means the patient will not need constant care and therefore less billings to Medicare or Medicaid.

While some say that the benefits of telemedicine far outweigh the negatives, they cannot be ignored. One of the biggest issues with telemedicine is that it is relatively unproven. This means that the error rate may be higher than in other medical fields, leading to a decrease in quality. Some potential issues that will be addressed are electronic glitches, physician resistance, tricky reimbursement models, and fewer in-person consultations.[69]

Without a doubt, technology has limitations. Computer malfunctions, Internet connection issues, poor video quality, weather complications, power outages, or lack of face-to-face consultation all attribute to a long list of potential lawsuits. Using the TPA example above, if the doctor in Chicago was to misdiagnose the patient via video messaging because of poor Internet connection, who would be at fault? Potentially the doctor, hospital, insurance company, the telemedicine

---

[66] *Id.*

[67] *Id.*

[68] This concept of "teaming up" is also discussed later in this paper as the need to switch to an ACO based health care system.

[69] Jessica Harper, *Pros and Cons of Telemedicine for Today's Workers*, U.S. NEWS (July   24,   2012,   4:15   PM),   http://health.usnews.com/health-news/articles/2012/07/24/pros-and-cons-of-telemedicine-for-todays-workers?page=2.

program, the internet provider would all carry some blame in this situation, but who would be liable? With the rise in technology, accountability is blurred. In coming years, the judicial system may see a staggering rise in telemedicine cases, especially because of the incentives to implement Parity Laws for private insurance coverage of telemedicine.[70]

The majority of physician resistance comes from the doctors that cannot adjust to the use of technology in their practices. At times the equipment may be costly, difficult to use, or not readily available. Yet telemedicine is also intriguing to the newest generation of doctors, who see a way to better manage patients with chronic illnesses and expand access to rural areas.[71] The divide between incoming doctors and doctors that have been in practice for years is still a very real issue for telemedicine. Unless there can be a compromise, the telemedical field will face more serious problems than just financing the programs.

One of the biggest hurdles for physicians, old and young, is the struggle with payment for services when using new telemedicine services; primarily because there has been a slow transition into the payment options. Even after "doc fix," Medicare reimbursement for telemedicine services is limited.[72] Medicaid reimbursement varies from state-to-state. About 20 states have enacted statutes that either recognize or require reimbursement for certain telemedicine services by commercial insurers.[73] As of now, Medicare reimburses only services that include consultation, office visits, individual psychotherapy and pharmacologic management delivered via a telecommunications system.[74] The expansion to Medicare in recent years hopes to also expand the reimbursement models for telehealth providers, offering incentives to continue these services. But reimbursement is still often tied to in-person consultations or contact

---

[70] *Telemedicine Frequently Asked Questions (FAQs)*, American Telemedicine Association,   http://www.americantelemed.org/about-telemedicine/faqs#.Vl3H77zw_Vo.

[71] Jessica Harper, *Pros and Cons of Telemedicine for Today's Workers*, U.S. News (July   24,   2012,   4:15   PM),   http://health.usnews.com/health-news/articles/2012/07/24/pros-and-cons-of-telemedicine-for-todays-workers?page=2.

[72] Mark A. Kadzielski & Jee-Young Kim, *Telemedicine Expansion-Navigating Potential   Pitfalls*,   Pepper   Hamilton   LLP   (Feb.   25,   2014), http://www.pepperlaw.com/publications/telemedicine-expansion-navigating-potential-pitfalls-2014-02-25/.

[73] *Id.*

[74] *Telemedicine and Telemedicine Services*, American Telemedicine Association (Jan. 2013), https://www.americantelemed.org/docs/default-source/policy/medicare-payment-of-telemedicine-and-telehealth-services.pdf?sfvrsn=14.

between patients and providers, which creates a whole new set of barriers for telehealth providers.

It is hard to argue that telemedicine would worsen a patient's care. Still, when expanding a program that limits face-to-face encounters with physicians, we must proceed with caution. Raymond Christensen, assistant dean for rural health at the University of Minnesota Medical School, points out the main inconsistency with telehealth when he stated, "I think there a lot of good uses for it, I don't think you can start an IV with it. There are places where we still have to have people touching people. But it brings a higher level of care . . . than we've been able to provide before."[75] With less in-person consultations, there is a greater chance that a physician will miss a critical assessment or misdiagnose the patient. Saving money and time are two of the biggest factors leading the way for telemedicine, but is the cost of losing someone's life worth saving a few dollars?

C. Accountable Care Organizations

Telehealth can provide the much needed access to health professionals, that home health and nursing facilities lack, at a reduced cost to both the government and the consumers. However, without a system that promote synergy amongst health professionals, the patients will suffer. One model that would lead use away from a fee-for-service payment structure would be an Accountable Care Organization (ACO or ACOs). The Center for Medicare and Medicaid Services (CMS) defines and ACO as "groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to the Medicare patients they serve."[76] The main function of an ACO is to provide coordinated care and management while lowering costs to health care consumers.[77]

ACOs seem like the perfect solution to a growing problem in our Country. Then why have they not gained large popularity? For starters, only a few years ago most medical professionals saw ACOs as "mythical unicorns."[78] Not only were ACOs unpopular because of the profits produced form a fee-for-service system, but ACOs were not thought possible by the medical professionals supposed to be administrating care

---

[75] Jessica Harper, *supra* note 59.

[76] *ccountable Care Organizations (ACOs): General Information*, CENTERS FOR MEDICARE   &   MEDICAID   SERVICES   (June   27,   2016), https://innovation.cms.gov/initiatives/aco/.

[77] *Id.*

[78] Justin Kearns, *Rural Roads to ACOs: Inter-Community Collaboration is Key to Rural Accountable Care Organizations' Success Under Medicare's Shared Savings Program*, 116 W. VA. L. REV. 425, 426 (2013).

through them.   Why is this?   ACOs, unlike the Medicare covered counterparts, are not covered for claims that fall in excess of the set budgets they set out. Given the incredible costs of healthcare, this could lead to substantial losses for the ACO, which in turn will be felt by consumers, through increased premiums or more cost-cutting in terms of their care. Doubters of ACOs are a constant struggle to their success on a large scale.

Another issue facing the private financing of health care is its quality of care.   Privately funded Healthcare systems can be quite profitable and quickly amass top quality hospitals and staff. The cost of employing only the best and brightest leads to a number of issues. This may incentivize doctors who want to make money to pursue specialized fields thus thinning the availability of general specialists and quality doctors. This effectively would create a system where only those with high incomes could receive quality care and the full array of treatments while leaving others entirely excluded. To combat this, the government could mandate that privately funded entities have to allow those outside their plans access for specific treatment which may be unavailable if sought elsewhere.   At balance, the government would have to reimburse the private entity at a fixed cost.

All of these changes and issues facing health care in the United States has slowly allowed ACOs to prove their worth. As of February 2013, 428 ACOs were operating in forty-nine states and had more than doubled in number since 2011. The quality-based incentives of ACOs is imperative to the success of each model. Quality metrics, ultimately, decide the fate of these "unicorns." Nursing homes and home health facilities will be one of the main benefactors of doctors being placed on a quality metric system. First, the quality based system requires doctors to not only focus on the primary care of the patient, but also the secondary or rehabilitation care. Second, the ACO model is one that, allegedly, will reduce costs overall for the health care provider and the patient. Finally, ACOs have the benefit of increasing access to a variety of specialists within a network that work well together. This level of coordinated care will increase the overall health outcomes and life of patients in nursing or long term facilities.

ACOs will allow the physicians, specialists, and nursing care to come together as one cohesive units to provide the best service at the lowest possible price. Yet there is one downfall. ACOs are relatively untested in a large scale. There is no guarantee that this payment model will 1) be adopted universally or 2) work at a large scale to truly help nursing home and home health patients. But a combination of telehealth and ACO care may just be the solution needed. With this combination, the doctors in the ACO can seamlessly communicate with one another and the

patient at the touch of a button saving time, money, and unnecessary distress caused by travel.

V. CONCLUSION

Overall, if health care was an easy solution, then we would already have a system that grants free health care to all regardless of financial situation or insurance. However, as it as been shown in the history of the United States we have an imperfect model. What this means is that those who do not have as strong of a voice in the community or lack resources get left out. Historically the elderly are, as a group, susceptible to being mistreated, undertreated, or subjected to fraudulent schemes. This will be changing in the next ten to fifteen years. Not only are the elderly one of the most represented groups, due to their voting, they also will be adding an increasing number to their ranks.

The fact is that nursing facilities and home health facilities are already being over consumed. This will only increasingly get worse as the next decade unfolds. The issue with overconsumption will be solved by market forces. Any increase in need for nursing homes will be met by those people or groups looking to make a profit.   Yet even if the consumption issues are corrected, there is no guarantee that the patients will receive the level of care they need. This Article has proposed two ways to not only decrease the prices for the elderly, but to increase the quality of care.

First, by implementing telemedicine and telehealth programs into nursing facilities, nursing home patients can benefit by easily obtaining specialty services; allowing patients to stay in their home health organizations or nursing homes. Thus eliminating the long travel distances for medical attention. Travel and hospital stays are leading contributors to worsened health outcomes for the elderly. And telehealth will drastically reduce the cost for health care consumers. These savings can be used in other ways, such as other medical costs or vacation.

Second, ACOs can be a helpful tool to change the very landscape of healthcare. These quality based programs place the pressure on the doctors to secure the best health outcomes for their patients. ACOs are still relatively untested, but the projections for ACOs show a system that drives the quality metric model in order to reduce costs and improve quality. The implementation of both a telehealth program and the ACO model of health care will allow the government to adjust spending to meet the demand on Medicare, which already is facing solvency issues.