

---

March 2017

## The Medicare Home Health Benefit's Need for Reform in Accordance to the Affordable Care Act

Michelle Bedoya

Follow this and additional works at: <https://via.library.depaul.edu/jhcl>



Part of the [Health Law and Policy Commons](#)

---

### Recommended Citation

Michelle Bedoya, *The Medicare Home Health Benefit's Need for Reform in Accordance to the Affordable Care Act*, 18 DePaul J. Health Care L. 57 (2017)

Available at: <https://via.library.depaul.edu/jhcl/vol18/iss1/3>

This Article is brought to you for free and open access by the College of Law at Via Sapientiae. It has been accepted for inclusion in DePaul Journal of Health Care Law by an authorized editor of Via Sapientiae. For more information, please contact [digitalservices@depaul.edu](mailto:digitalservices@depaul.edu).

## THE MEDICARE HOME HEALTH BENEFIT'S NEED FOR REFORM IN ACCORDANCE WITH THE AFFORDABLE CARE ACT

*Michelle Bedoya*\*

### I. INTRODUCTION

There is an exigency for change within the home health care scheme of the United States.<sup>1</sup> The Medicare beneficiary population—those who are older Americans and people with disabilities—is increasing in size at an exponential rate.<sup>2</sup> Furthermore, the Medicare beneficiary boom is accompanied with ever-increasing health care costs.<sup>3</sup> Consequentially, home health care services have become more pertinent than ever.

Providing care in the home is particularly known to improve patient outcomes in a cost-effective and patient-preferred environment. However, there are substantial challenges that inhibit the ability of the Medicare home health care program to meet the growing needs of Medicare's beneficiaries: individuals with disabilities and older Americans. The challenges presented include: (1) Medicare's current payment policy which promotes volume over value; (2) eligibility requirements that prevent optimum care; such as the homebound requirement; (3) lack of sup-

---

\*J.D., Barry University School of Law (2015); B.A. Florida International University. Michelle has over 1 In this article, the term "home health care" is defined as services provided by Medicare certified home health agencies. The Alliance for Home Health Quality & Innovation, *The Future of Home Health Care Project* (May 2014), at (<http://www.ahhqi.org/images/pdf/future-whitepaper.pdf> 2014) [hereinafter, Alliance].

2 *Id.* (citing Carrie A. Werner, U.S. Census Bureau, *The Older Population: 2010, 2010 Census Briefs* (Nov. 2011). According to the U.S. Census Bureau, the population age 65 and older in the United States was 40,267,984 in 2010. The Census Bureau predicts that the 65 and older population will grow to 55,969,000 in 2020, and 72,774,000 in 2030. *Id.*

3 Centers for Medicare & Medicaid Services, *National Health Expenditure Projections 2011-2021*, <http://www.cms.gov/Research-Statistics-data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Proj2011PDF.pdf>. (last visited Mar. 15, 2015). In 2021, total health care spending in the United States is expected to reach \$4.8 trillion up from \$2.6 trillion in 2010 and \$75 billion in 1970. This means that health care spending will account for nearly 20 percent of gross domestic product (GDP), or one-fifth of the U.S. economy, by 2021. *Id.*

port and infrastructure; and (4) reimbursement cuts to home care providers leading to under utilization of services.<sup>4</sup>

Furthermore, the passage of the Affordable Care Act requires a focus on improving the quality of care delivered to patients and increasing access to health care for Americans.<sup>5</sup> It is integral that the home health care program be modeled according to the Triple Aim, developed by the Institute for Healthcare Improvement (IHI).<sup>6</sup> The Triple Aim seeks to (1) improve the patient experience; (2) improve the population's health; and (3) reduce health care costs.<sup>7</sup> It is dire that changes be made to the Medicare home health benefit to better adapt to the legislative, demographic, sociological, and technological changes of modern society. Thus, the Triple Aim lends a progressive framework that is the foundation for a modern approach to the Medicare home health benefit, ultimately leading to the benefit's restructure.

## II. Background

### A. Home health defined:

Modernly, there are health care treatments that at one point were only made available to patients in a hospital or doctor office setting;<sup>8</sup> however, due to technological and medical advances, many of these treatments that can now be done in a patient's home.<sup>9</sup> Home health care is generally

---

<sup>4</sup> *Id.*

<sup>5</sup> Alliance, *supra* note 1.

<sup>6</sup> At, *The IHI Triple Aim*, <http://www.ihl.org/Engage/Initiatives/TripleAim/pages/default.aspx>. (last visited Oct. 14, 2015). The Institute for Healthcare Improvement (IHI), an independent not-for-profit organization. "The IHI Triple Aim is a framework developed by the Institute for Healthcare Improvement that describes an approach to optimizing health system performance. It is IHI's belief that new designs must be developed to simultaneously pursue three dimensions, which we call the Triple Aim."

<sup>7</sup> Alliance, *supra* note 6.

<sup>8</sup> Center for Medicare & Medicaid Services, *What's Home Health Care?*, available at <http://www.medicare.gov/what-medicare-covers/home-health-care/home-health-care-what-is-it-what-to-expect.html>, (last visited Oct. 14, 2015). Examples of skilled home health services include: wound care for pressure sores or a surgical wound, patient and caregiver education, intravenous or nutrition therapy, inject, monitoring serious illness and unstable health status. *Id.*

<sup>9</sup> Centers for Medicare and Medicaid Services, Medicare Benefit Policy Manual, CMS Pub. 100-02, Ch. 7, § 40 (Rev. 208, May 11, 2015)[hereinafter CMS] stating:

Treatments covered by Medicare include: Part-time or intermittent skilled nursing care (other than solely venipuncture for the purposes of obtaining a blood sample); part-time or intermittent home health aide services; physical therapy; speech-language pathology; occupational therapy; medical social services; medical supplies . . . ; durable medical equipment while under the plan of care established by

a more affordable, more effective, and a more convenient option as opposed to receiving care in a hospital or skilled nursing facility.

In general, home health care is also considered to improve patient outcomes, be cost-effective, and be preferred by patients.<sup>10</sup> Improvements in patient outcomes occur because Medicare patients usually receive home health care upon discharge from an acute-care setting (such as a hospital). Upon receipt of home health, patients improve with breathing, bathing, wound healing, and experiencing less pain.<sup>11</sup> Moreover, home health care is more economic for a first environment after an acute episode, compared to receiving care at a hospital or other nursing home facility.<sup>12</sup>

In 1965, the legislature enacted the Medicare program, which included a home health benefit.<sup>13</sup> Today, reimbursement to home health care providers is made via a prospective payment system.<sup>14</sup> Under this payment system, Medicare beneficiaries are covered for services that are considered to be reasonable and necessary for treatment of a particular illness or injury.<sup>15</sup>

For a patient to be eligible for the Medicare home health benefit, they must be under the plan of care established and reviewed by their doctor.<sup>16</sup> The doctor must certify that the patient needs one or more of the following: “intermittent” skilled nursing care, physical therapy, speech language pathology services, continued occupational therapy, that the agency

---

physician; medical services provided by an intern or resident-in-training under an approved teaching program of the hospital in the case of an HHA which is affiliated or under common control with a hospital; and services at hospitals, skilled nursing facilities, or rehabilitation centers when they involve equipment too cumbersome to bring to the home. *Id.*

10 See Alliance, *supra* note 6; (citing *A Report to the Nation on Independent Living and Disability*).

According to the AARP, persons 50 and older with disabilities, particularly those age 50 to 64, strongly prefer independent living in their own homes to other alternatives. Preferences for services at home rather than in nursing homes are widespread among persons with disabilities. Even in the event they needed 24-hour care, 73 percent of persons with disabilities prefer services at home. Among the general population of persons 50 and older, 58 percent prefer services at home.

11 *Id.*

12 *Id.* (citing, A. Dobson et al., “Clinically Appropriate and Cost-Effective Placement (CACEP) Project Working Paper Series, Working Paper #2: Baseline Statistics of Medicare Payments by Episode Type for Select MS-DRGs and Chronic Conditions,” at p. 30, October 2012.) Where home health care is the first setting post-discharge, Medicare episode payments are \$5411 less than the overall average. By contrast, where the patient is discharged to SNFs, IRFs and LTCHs, Medicare episode payments are more than the overall average. LTCH first setting episodes are \$34,417 more than the overall average.

13 *Id.*

14 *Id.* at page 1-2.

15 CMS, *supra*, note 9.

16 *Id.*

rendering services be Medicare certified, and lastly, that the patient is *homebound*.<sup>17</sup>

A patient's physician must certify homebound status.<sup>18</sup> For a patient to be considered homebound, it must be found that leaving their home is not recommended due to the patient's medical condition.<sup>19</sup> The medical condition must keep the patient from leaving home without "help."<sup>20</sup> Examples of "help" include using a wheelchair, walker, special transportation, or another person for assistance. Finally, leaving the patient's home must take a considerable and *taxing* effort.<sup>21</sup>

Furthermore, the intent of the Medicare home health care program is to provide treatment for an illness or injury, regain independence, become self-sufficient, and to prevent re-hospitalization.<sup>22</sup> In particular, home health agencies are specialists that serve two kinds of patients: post-acute care patients and community-based management to address chronic conditions.<sup>23</sup> Post-acute care patients are those patients who have been discharged from a hospital and are in recovery from an acute condition. Whereas, community-based management patients are patients who a local doctor may refer to address chronic conditions such as diabetes.<sup>24</sup>

---

17 *Id.*

Some examples of homebound status include: a patient paralyzed from a stroke who is confined to a wheelchair or requires the aid of crutches in order to walk; a patient who is blind or senile and requires the assistance of another person in leaving their place of residence; a patient who has lost the use of their upper extremities and, therefore, is unable to open doors, use handrails on stairways, etc., and requires the assistance of another individual to leave their place of residence. . . . a patient who has just returned from a hospital stay involving surgery who may be suffering from resultant weakness and pain because of the surgery and, therefore, their actions may be restricted by their physician to certain specified and limited activities, such as getting out of bed. . . . *Id.*

18 CMS, *supra*, note 9.

19 *Id.*

20 *Id.*

21 *Id.*

22 Scott R. Talaga, Cong. Research Serv., R42998, Medicare Home Health Benefit Primer: Benefit Basics and Issues, (2013).

Legislative intent: With the establishment of Medicare, the home health benefit has been traditionally categorized as a 'post-acute care' benefit. However, home health coverage is provided to beneficiaries whether or not they had a recent hospitalization. Prior regulatory and legislative changes have expanded Medicare's home health services and eligibility requirements, as well as eliminated cost-sharing requirements. Many of the changes to the home health benefit were in response to efforts of deinstitutionalization, moving individuals out of nursing facilities and back into the community, as well as avoiding hospitalizations. *Id.*

23 Alliance, *supra* note 2.

24 Talaga, *supra* note 22, at 25; *stating*:

"Overall, home health services provide coverage for beneficiaries across a wide variety of conditions and/or diseases. . . . These diseases include diabetes as the most common primary diagnosis, essential hypertension (i.e., high blood pres-

Home health care may include the following: chronic disease management, care to improve functional status, care to improve transitions, behavioral health management, re-hospitalization prevention, and patient and family support to community resources.

### III. CHALLENGES

There are various challenges presented with the Medicare home health program. These challenges ultimately affect the care and treatment a Medicare beneficiary receives. Such challenges include: (1) Medicare's current payment policy which promotes volume over value; (2) eligibility requirements that prevent optimum care, such as the homebound requirement; (3) lack of support and infrastructure;<sup>25</sup> and (4) reimbursement cuts to home care providers leading to under utilization of services.<sup>26</sup>

Despite these challenges, Medicare has certainly moved in a progressive direction to the aid of beneficiaries. In 2012, home health care beneficiaries triumphed with the settlement in *Jimmo v. Sebelius*, a class action challenging the eligibility determinations by Medicare contractors.<sup>27</sup> The holding resulted in a clarification of the Medicare statute that eliminated "the improvement standard" and created a pathway for Medicare beneficiaries to get the care warranted by their condition. Glenda Jimmo and Rosie Berkowitz were two beneficiaries from the class the suit intended to represent.

Glenda Jimmo is a Medicare beneficiary from Bristol, Vermont.<sup>28</sup> She is seventy-six years old and is suffering from complex medical conditions.<sup>29</sup> Glenda has been blind since birth, requires a wheelchair, and is an amputee due to complications related to her chronic illness of diabetes.<sup>30</sup>

---

sure), heart failure, and chronic skin ulcer. The most common diagnoses are diabetes, essential hypertension (i.e. high blood pressure), heart failure and chronic skin ulcer.

<sup>25</sup> Alliance, *supra* note 1.

<sup>26</sup> *Id.*

<sup>27</sup> CENTERS FOR MEDICARE & MEDICAID SERVS., *Jimmo v. Sebelius Settlement Agreement Program Manual Clarifications Fact Sheet*, available at [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/jimmo\\_fact\\_sheet2\\_022014\\_final.pdf](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/jimmo_fact_sheet2_022014_final.pdf).

<sup>28</sup> Robert Pear, *In Settlement, Medicare Eases Rules for Some Patients*, THE NEW YORK TIMES Oct. 23, 2012 at A1.

<sup>29</sup> *Id.*

<sup>30</sup> Center for Medicare Advocacy: *The Improvement Standard: Real Stories*, available at <http://www.medicareadvocacy.org/the-improvement-standard-real-stories/>. (last visited Nov. 6, 2015).

Rosie Berkowitz, from Stanford, Connecticut, is a Medicare beneficiary who is eighty-one years old and suffers from multiple sclerosis.<sup>31</sup> Medicare denied both women coverage for services because they did not fit into Medicare's so-called "improvement standard."<sup>32</sup> The improvement standard was a standard applied in determining whether a patient was eligible for coverage. The standard required that if a patient were not improving within a certain period of time, then coverage would be denied. The *Jimmo v. Sebelius* settlement agreement defined the improvement standard as:

The "Improvement Standard" refers to a standard that Plaintiffs have alleged, but that Defendant denies, exists under which Medicare coverage of skilled services is denied on the basis that a Medicare beneficiary is not improving, without regard to an individualized assessment of the beneficiary's medical condition and the reasonableness and necessity of the treatment, care or services in question.<sup>33</sup>

Thus, Jimmo and Berkowitz were plaintiffs in the federal class action of *Jimmo v. Sebelius*, a suit that challenged Medicare's use of an "Improvement Standard" to make coverage determinations.<sup>34</sup> The lawsuit was brought on behalf of six individuals representing a nationwide class of Medicare beneficiaries and national organizations representing people with chronic conditions.<sup>35</sup> According to the complaint, Medicare had failed to make assessments regarding a beneficiary's unique condition and individual needs.<sup>36</sup> It was claimed that the assessment did not rely on the Medicare statute, regulations and manuals, but "relie[d] on more restrictive internal guidelines, policies, and local coverage determinations."<sup>37</sup> As a result, the Centers for Medicare & Medicaid Services (CMS) had agreed to settle the "Improvement Standard" case, *Jimmo v. Sebelius*. The proposed settlement agreement was filed in Federal District Court on October 16,

---

31 Pear, *supra* note 28.

32 Jimmo v. Sebelius Settlement Agreement Fact Sheet, available at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/Jimmo-FactSheet.pdf>.

33 Settlement Agreement, Jimmo v. Sebelius, No. 5:11-CV-17-CR; at <http://www.medicareadvocacy.org/wp-content/uploads/2012/12/Settlement-Agreement-for-Web.pdf>.

34 Sebelius Settlement Agreement Fact Sheet, *supra* note 32.

While an expectation of improvement would be a reasonable criterion to consider when evaluating, for example, a claim in which the goal of treatment is restoring a prior capability, Medicare policy has long recognized that there may also be specific instances where no improvement is expected but skilled care is, nevertheless, required in order to prevent or slow deterioration and maintain a beneficiary at the maximum practicable level of function.

35 Pear, *supra* note 29.

36 Sebelius Settlement Agreement Fact Sheet, *supra* note 33.

37 Amended Complaint for Declaratory, Injunctive, and Mandamus Relief, *Jimmo v. Sebelius*, No. 5:11-CV-17 (D. VT. Mar. 3, 2011).

2012. The Settlement was approved on January 24, 2013.<sup>38</sup> The judgment indicated that as long as a patient requires skills of a therapist or a nurse, a patient would meet the skilled coverage criteria despite not making functional gains.<sup>39</sup>

*Jimmo v. Sibelius* provides an excellent example of one of the many issues confronting beneficiaries receiving benefits under the Medicare home health scheme. Although *Jimmo v. Sibelius* is a huge milestone for Medicare beneficiaries, it is simply a bandage on a home health system that is outdated and unable to meet the needs of its patient beneficiary population.

The amount of older Americans and disabled individuals is growing at an exponential rate.<sup>40</sup> The U.S. Census Bureau expects that the sixty-five and older population will increase by 80%.<sup>41</sup> Chronic illnesses are more widespread than ever and as a result health care costs are on the rise.<sup>42</sup> It is expected for the number of chronic conditions in people to increase by 37%, which is an increase of forty-six million people.<sup>43</sup> Due to the foreseeable challenges ahead, there is pressure on the Centers for Medicare and Medicaid (“CMS”) to address the increasing concerns that the Medicare beneficiary population faces. A solution must take the form of a cost-effective and patient-centered manner. With the recent passage of the Affordable Care Act, there is a legal and social call to address the public health concerns of Americans.

#### *A. Challenge: Medicare’s Current Payment Policy That Promotes Volume over Value*

Due to this fragmentation it is recognized that patients—particularly those with complex medical conditions—routinely experience poor outcomes because care is not coordinated across multiple sites and providers.

Furthermore, a Medicare beneficiary undergoes delivery from different stakeholders across the health care spectrum. Stakeholders include, but are not limited to, hospitals, doctors, skilled nursing facilities, and

---

38 *Jimmo*, *supra* note 34.

39 *Pear*, *supra* note 29.

40 *Alliance*, *supra* note 1.

41 *Id.*

42 *Id.* (citing Shin-Yi Wu and Anthony Green, Projection of Chronic Illness Prevalence and Cost Inflation, RAND Corporation (2000); *stating*: According to RAND, the number of people with chronic conditions is anticipated to increase rapidly over time, with 1% increases each year projected through 2030. Between 2000 and 2030, RAND predicts that the number of Americans with chronic conditions will increase by 37 percent, an increase of 46 million people.

43 *Alliance*, *supra* note 1.

home health agencies.<sup>44</sup> Stakeholders involved in the delivery of care should be incentivized to work together for better health care delivery.<sup>45</sup> Incentivizing providers will result in a more uniform health care delivery system to the Medicare beneficiary with one common purpose apportioned within one common payment system. Incentivized providers should then work together to provide “Targeted care coordination.”<sup>46</sup> Targeted care coordination starts with the physician at the time he/she orders patient care based on the patient’s acuity level. Then, the physician would order services needed for the patient’s maximum rehabilitation; whether it be inpatient rehabilitation facilities, inpatient hospitalization, outpatient services, or home health care. Thus, reforms in payment and health care delivery systems are needed for more uniformity in order to promote more coordinated care across the continuum of care.

Accordingly, Medicare is currently testing health care reforms to address the preceding issue.<sup>47</sup> One such potential reform is the requirement for Accountable Care Organizations (“ACO”). The ACO model is essentially able to provide “targeted care coordination”. According to CMS, “Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients.”<sup>48</sup>

An ACO’s coordinated high quality care goals seek to ensure a patient’s efficient care at the proper time, while also preventing medical errors and avoiding extraneous duplication of health care services.<sup>49</sup> The ACO model is designed to incentivize providers to deliver high-quality care and also use health care dollars more consciously.<sup>50</sup> The incentive is precisely that the ACO will *share* in the savings it achieves for the Medi-

---

44 Alliance, *supra* note 1.

45 *Id.*

46 DEP’T OF HEALTH & HUMAN SERVS., *The Roles of Patient-Centered Medical Homes And Accountable Care Organizations in Coordinating Patient Care*, (Dec. 2010) *noting*:

Targeted areas of coordination include six specific activities: 1. Determine and update care coordination need; 2. Create and update a proactive plan of care; 3. Communicate: Exchange information, preferences, goals, and experiences among participants in a patient’s care; 4. Facilitate transitions: Share information among providers and patients when the accountability for some aspect of a patient’s care is transferred between two or more health care entities; 5. Connect with community resources: Provide, and if necessary, coordinate services with additional resources available in the community that help support patients’ health and wellness or meet their care goals; 6. Align resources with population needs: At a system-level, assess the needs of populations to identify and address gaps in services. *Id.*

47 Alliance, *supra* note 1.

48 CENTERS FOR MEDICARE & MEDICAID SERVS., *Accountable Care Organizations*, (2015) at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html?redirect=/ACO>.

49 *Id.*

50 *Id.*

care program.<sup>51</sup> Although only currently voluntary, the Medicare Shared Saving Program is the agent that seeks to promote the value of services and improve patient care by helping providers become an Accountable Care Organization.<sup>52</sup>

*B. Challenge: Eligibility Requirements That Prevent Optimum Care*

*1. The Homebound Eligibility Requirement*

One of the requirements for home care coverage under the Medicare benefit requires that a patient be homebound. The homebound requirement: (1) imposes limits on Medicare beneficiaries due to the “must” requirement in establishing homebound status; and (2) restricts the ability for beneficiaries to receive continuous, long-term support.

a. Limitations imposed on Medicare beneficiaries due to the “must” requirement to establish homebound status

Currently, the homebound requirement limits the ability for Medicare beneficiaries to benefit from medically reasonable and necessary services to which they are legally entitled.<sup>53</sup> As outlined in the policy manual for CMS, the intent of the home health care benefit statute states that a patient does not have to be bedridden to be considered as homebound, or confined to the home.<sup>54</sup> Rather homebound status exists when the patient's condition creates a normal inability to leave their home and that it would be a considerable and taxing effort.<sup>55</sup> The policy manual further explains that leaving the home is expected to occur for purposes of receiving medical treatment.<sup>56</sup> The policy continues to state that non-medical absences from the home would not necessarily create a finding that the patient is not home bound.<sup>57</sup> However, non-medical absences must take place on an infrequent basis and be relatively short in time.<sup>58</sup> Furthermore, a patient “*must* require the assistance of another, require an assistive device, or special transportation to leave home or that it is medically contraindicated for

---

<sup>51</sup> *Id.*

<sup>52</sup> *Id.*

<sup>53</sup> Center for Medicare Advocacy, *New CMS Proposed Homebound Policy Would Leave Medicare Beneficiaries Without Coverage*, at <http://www.medicareadvocacy.org/new-cms-proposed-homebound-policy-will-leave-medicare-beneficiaries-without-coverage/> (Last accessed on March 17, 2015). (hereinafter *New CMS Proposed Homebound Policy*).

<sup>54</sup> *Id.*

<sup>55</sup> Medicare Benefit Policy Manual Chapter 7, *supra* note 16.

<sup>56</sup> *Id.* at 20.

<sup>57</sup> Benefit Policy Manual, *supra* note 16, at 20.

<sup>58</sup> *Id.*

the person to leave home”, for the taxing effort standard to be established.<sup>59</sup>

Although the statute states that an individual’s condition *must* “be such that there exists a normal inability to leave home and that leaving home requires a considerable and taxing effort...”; the statute should not contain the specific requirements that a patient “*must* require the assistance of another, require an assistive device, or special transportation to leave home or that it is medically contraindicated for the person to leave home.”<sup>60</sup>

The “*must*” requirement, introduced into the CMS transmittal in October of 2013, should be removed.<sup>61</sup> The original intent of the benefit under the statute is for beneficiaries *who lack an ordinary ability to leave home*.<sup>62</sup> Therefore beneficiaries who need “assistance of another or an assistive device or who require special transportation to leave home or people who should not leave home because it is medically contraindicated” are simply *examples* of “people who lack an ordinary ability to leave the home.” Yet, those beneficiaries are *not the only* individuals who are to be considered homebound in order to qualify for Medicare coverage of home health care.<sup>63</sup>

There are beneficiaries who may not meet the “*must*” requirement and still meet the requirements under the original intent of the statute, which is *lack of ordinary ability to leave home*.<sup>64</sup> An example of a patient who may lack an ordinary ability to leave home and who does not meet the “*must*” requirement is a patient who suffers from chronic obstructive pulmonary disease, or COPD.<sup>65</sup> Also, patients who undergo symptoms such as dizziness upon exertion, shortness of breath, or inability to climb stairs, are patients who may very well have an ordinary inability to leave the home. These patients do not “require the assistance of another, require an assistive device, or special transportation to leave home or that it is medically contraindicated for the person to leave home”.<sup>66</sup> The current “*must*” requirement undermines the original intent of the Medicare statute and has resulted in entitled beneficiaries to non-coverage of home care services.<sup>67</sup> Thus, home care services are currently non-covered for beneficiaries to re-

---

<sup>59</sup> *Id.*

<sup>60</sup> New CMS Proposed Homebound Policy, *supra* note 53, at 3.

<sup>61</sup> *Id.*

<sup>62</sup> *Id.*

<sup>63</sup> New CMS Proposed Homebound Policy, *supra* note 53, at 3.

<sup>64</sup> *Id.*

<sup>65</sup> *Id.*

<sup>66</sup> *Id.*

<sup>67</sup> *Id.*

ceive care at their home under the preceding circumstances. Consequently beneficiaries turn to costly alternatives and institutions.

*b. The homebound requirement restricts the ability for beneficiaries to receive continuous, long-term support*

The homebound status requirements of the Medicare home health benefit limits beneficiaries from experiencing the long-term value of homecare.<sup>68</sup> Thus, the structure of the benefit does not enable optimal patient care.<sup>69</sup> When a patient qualifies for homecare coverage due to a finding of homebound status, that patient is qualified to receive skilled care from a home health care professional. In many instances, once the patient receives skilled services and improves mobility, they will no longer qualify for skilled care since they will no longer be considered homebound.<sup>70</sup> When the patient is no longer homebound, the provider is then lawfully required to discharge the patient from services.<sup>71</sup> Upon discharge, it is not uncommon to find that the patient's condition worsens.<sup>72</sup> As a result, transfer to a hospital may ensue. An example of such a case may ensue when a beneficiary receives physical therapy. The beneficiary may be covered for home health because they demonstrate rehabilitation potential. Yet, once the physical therapy services are complete, many of these patients usually decline back to their prior level of function because they need ongoing monitoring and education. Another example of a type of beneficiary that would likely require monitoring and education is a patient diagnosed with Congestive Heart Failure (CHF).

Congestive Heart Failure (CHF) is the most common reason for admission of Medicare patients to a hospital. Sadly, 40 percent of Medicare patients discharged after admission for CHF are readmitted within ninety days, even though well-designed demonstration projects have shown for years that that rate can be reduced by more than 80 percent with proper management of patients. Patients experience this reactive system as one providing poor service and lacking memory.<sup>73</sup>

---

68 Alliance, *supra* note 1.

69 *Id.* at 11.

70 *Id.*

71 *Id.*

72 *Id.*

73 Donald M. Berwick et al., *The Triple Aim: Care, Health, and Cost*, 27 HEALTH AFFAIRS 759, 759 (2008).

Thus, continuous long-term support is needed to keep the Medicare population from health declination and to prevent costly readmissions to acute care settings.

## 2. The “Skilled Care” Requirement and the Face-To-Face Requirement

The Medicare statute outlines further requirements, other than homebound status requirement, for a patient to be eligible for home health care coverage. These other requirements include the requirement for skilled care and face-to-face encounters.

The skilled care requirement<sup>74</sup> obliges home health providers to provide skilled care.<sup>75</sup> However, the skilled care requirement care averts coverage for patients who need behavioral and social support, not skilled care.<sup>76</sup> Behavioral and social home care services are critical to avoiding hospitalizations.<sup>77</sup> A patient may have trouble affording or forgetting to take medications.<sup>78</sup> Medication adherence is important to achieving the Triple Aim, however Medicare does not cover these kinds of services, in and of itself.

Moreover, the face-to-face requirement impedes a home care provider’s ability to provide thorough coordinated care.<sup>79</sup> The implementation of the face-to-face requirement was intended to engage physicians with pa-

74 Home Health Compare Glossary, available at <http://www.medicare.gov/homehealthcompare/Resources/Glossary.html> (last visited Feb. 1, 2015). CMS defines skilled care as “[a] type of health care given when you need skilled nursing or rehabilitation staff to manage, observe, and evaluate your care. Nursing, physical therapy, occupational therapy, and speech therapy are considered skilled care by Medicare.” *Id.* (emphasis added).

75 See Medicare Benefit Policy Manual, *supra* note 9; stating:

Conditions Patient Must Meet to Qualify for Coverage of Home Health Services: To qualify for the Medicare home health benefit, under §§1814(a)(2)(C) and 1835(a)(2)(A) of the Act, a Medicare beneficiary must meet the following requirements: • Be confined to the home; • Under the care of a physician; • Receiving services under a plan of care established and periodically reviewed by a physician; • Be in need of skilled nursing care on an intermittent basis or physical therapy or speech-language pathology; or • Have a continuing need for occupational therapy.

76 Alliance, *supra* note 2, at 11.

77 *Id.*

78 *Id.*

79 See Medicare Benefit Policy Manual, *supra* note 9, at §§ 30.5.1, 30.5.1.1; explaining:

The certifying physician must document that he had a face-to-face encounter with the patient. The documentation must include (1) the date when the physician or allowed NPP saw the patient; (2) a brief narrative composed by the certifying physician who describes how the patient’s clinical condition as seen during that encounter supports the patient’s homebound status and need for skilled services; and (3) the certifying physician’s documentation of the encounter either on the certification, which the physician signs and dates, or a signed addendum to the certification. Regarding, timeframe Requirements, The encounter must occur no more than 90 days prior to the home health start of care date or within 30 days after the start of care.”

tient care.<sup>80</sup> Yet, the requirement has only resulted in an unnecessary administrative burden and delay of patient care.<sup>81</sup> The burden in delay is due to the requirements for physician review and signature, which in turn hinders delivery of compliant and timely care.<sup>82</sup>

However, in 2015 CMS announced changes to the face-to-face encounter requirements that would “foster greater efficiency, flexibility, payment accuracy, and improved quality,” by removing the narrative requirement for physicians.<sup>83</sup> However, the change in requirements will probably create an adverse reaction.<sup>84</sup> The new requirement would likely place a greater burden on home health agencies to obtain physician documentation that supports a need for home health care. These changes do not address the root of the challenge. The root is accountability and communication between the different stakeholders in the healthcare spectrum: physician and home health provider.

### *C. Challenge : Lack of Support and Infrastructure*

Medicare beneficiaries lack the infrastructure and support to healthily age in the United States.<sup>85</sup> There is no single comprehensive system in place to address the multidimensional needs of older Americans and individuals with disabilities.<sup>86</sup> These multidimensional needs include: “personal care services and caregiving supports; appropriately designed housing; meals/nutrition; and transportation.”<sup>87</sup> Without a single uniform system to address the needs, beneficiaries must turn to patchwork fill-in-the-blank means such as Medicaid<sup>88</sup>, states, local programs or paying their

---

80 Alliance, *supra* note 2.

81 *Id.*

82 *Id.* at 12.

83 CENTERS FOR MEDICARE & MEDICAID SERVS. *CMS proposes payment changes for Medicare home health agencies for 2015*, (July 1, 2014), available at <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2014-Fact-sheets-items/2014-07-01.html>.

84 CY 2015 Home Health Prospective Payment System Rate Update; Home Health Quality Reporting Requirements; Survey and Enforcement Requirements for Home Health Agencies, 79 Fed. Reg. 215 (proposed Nov. 6, 2014) (to be codified at 42 C.F.R. pts. 409, 424); *proposing*:

The goal of the Affordable Care Act provision is to achieve greater physician accountability in certifying a patient’s eligibility and in establishing a patient’s plan of care. We believe this goal is better achieved if the face-to-face encounter occurs close to the start of home health care, increasing the likelihood that the clinical conditions exhibited by the patient during the encounter are related to the primary reason the patient needs home health care.

85 Alliance, *supra* note 2, at 12.

86 *Id.*

87 *Id.*

88 *See generally* Medicaid at <http://www.medicare.gov/your-medicare-costs/help-paying-costs/medicaid/medicaid.html> (Accessed on 2/1/2015). “Medicaid is a joint federal and state program that

own expenses out of pocket, to address any pending needs not covered by the Medicare benefit.<sup>89</sup>

*D. Challenge: Reimbursement Cuts to Home Care Providers Leading to Under Utilization of Services*

In 2015, CMS introduced changes that finalized approximately \$60 million in cuts to home health.<sup>90</sup> These cuts reduced Medicare reimbursement to home health agencies by 3%.<sup>91</sup> In 2013, it was estimated that 3.5 million beneficiaries received home health services from nearly 12,000 home health agencies. These services cost Medicare \$18 billion.<sup>92</sup> Cutting reimbursement has an adverse effect on patient outcomes and care because it may lead to under utilization of services.

#### IV. REFORM ACCORDING TO THE “TRIPLE AIM”

The Affordable Care Act (ACA), comprising of The Patient Protection and Affordable Care Act (H.R.3590) and the Health Care Education and Reconciliation Act (H.R.4872), aims to achieve the Triple Aim.<sup>93</sup> The Triple Aim seeks to accomplish the following: (1) improve the patient experience of care; (2) improve the health of populations; and (3) reduce the per capita cost of healthcare.<sup>94</sup> The Institute for Healthcare Improvement (IHI) developed the aim, which seeks to outline a simple approach to ameliorate health system performance.<sup>95</sup> In order to achieve the goals of the Triple Aim, present payment models and health care delivery systems must undergo necessary reforms. The Triple Aim was developed due to “[t]he need to control the ever-increasing spiral of health care costs, to reduce the fragmentation of the delivery of care in this country, to focus on

---

helps with medical costs for some people with limited income and resources. Medicaid also offers benefits not normally covered by Medicare, like nursing home care and personal care services.”

<sup>89</sup> Alliance, *supra* note 1, at 12.

<sup>90</sup> CY 2015 Home Health Prospective Payment System Rate Update; Home Health Quality Reporting Requirements; Survey and Enforcement Requirements for Home Health Agencies, 79 Fed. Reg. 179, 38414 (proposed July 7, 2014) (to be codified at 42 C.F.R. pts. 409, 424, 484).

<sup>91</sup> *Id.*

<sup>92</sup> Cassandra Dowell, *CMS Outlines \$58 Million in Medicare Home Health Cuts for 2015*, SENIOR HOUSING NEWS (Jul. 1, 2014), <http://seniorhousingnews.com/2014/07/01/cms-outlines-58-million-in-medicare-home-health-cuts-for-2015/>.

<sup>93</sup> Jerome F. Levine, Betty Herbert, Jan Mathews, & Valinda Rutledge, *Use of the Triple Aim to Improve Population Health*, 72 N.C. MED. J.No. 3 (2010).

<sup>94</sup> Alliance, *supra* note 1, at 21.

<sup>95</sup> *Id.* at 6.

prevention and wellness, and to improve the quality of care . . . is certainly not a new concept.”<sup>96</sup>

The intent of the Triple Aim is to have an improved, more effective health care system in the United States. With the passage of the Affordable Care Act, health providers must be mandated to conform to the goals of the Triple Aim. [However,] the outcomes of this current delivery model are in need of improvement.

Due to the need for a focus on the Triple Aim and health care reform, an emphasis on the home health benefit is a particularly viable choice. Home health is a valuable means for achieving the Triple Aim because it offers the chance of delivering cost-effective care within a patient-preferred environment: the home. It offers the ability to improve outcomes by focusing on patient-centered care, which in turn accomplishes the three goals of the Triple Aim: patient experience, population health, and lower costs.<sup>97</sup>

A focus on patient outcomes within home health would establish home care’s value and ability to achieve the Triple Aim. Patients receiving home health care after hospital discharge are found more likely to improve in self-care.<sup>98</sup> Additionally, there are improved outcomes in the area of wound, pain, bathing, and breathing.<sup>99</sup> These improved patient outcomes consist of 89% of wounds healed or improved after an operation, 67% had reduced pain when moving, 64% had improved breathing, and 66% improved in bathing.<sup>100</sup>

Moreover, a focus on home health care is needed because it is a cost-effective alternative to healthcare.<sup>101</sup> Medicare beneficiaries may receive post-acute care in a wide variation of settings. These settings include: home health, skilled nursing facilities, inpatient rehabilitation facilities, and long-term acute care hospitals. Yet, across all Medicare diagnosis groups, Medicare expenditures for a patient treated in their home after a discharge from a hospital averaged around \$20,345.<sup>102</sup> Compared to an average of \$28,294 across all other post-acute care settings.<sup>103</sup>

The preceding outcomes act as compelling evidence that a focus on home health care is a means of achieving the Triple Aim’s goal of pa-

---

<sup>96</sup> Levine, *supra* note 93, at 201.

<sup>97</sup> Alliance, *supra* note 1, at 6.

<sup>98</sup> *Id.*

<sup>99</sup> *Id.* at 6-7.

<sup>100</sup> *Id.*

<sup>101</sup> *Id.* at 7.

<sup>102</sup> *Id.*

<sup>103</sup> *Id.*

tient experience, overall health of populations, and reduction of costs. Thus, the goal for patient centered care<sup>104</sup> is an obtainable objective via a refined home health model.

Home health care typically takes place in a patient's daily environment, thus care in that setting is more conducive to the patient's improvement and well-being.<sup>105</sup> Care in the home also enables respect for the values and needs of each individual patient.<sup>106</sup>

It is in the best interest of Medicare's beneficiaries that a focus be placed on home health in the United States. With the passage of the Affordable Care Act, there is no better time to initiate a reform. Home health outcomes thoroughly achieve the Triple Aim and it is in society's best interest to have beneficiaries receive home health care when it is clinically needed and appropriate. The Medicare home health program must accept the responsibility of all three aims for its beneficiary population.

## V. ESTABLISHED EVIDENCED PROGRAMS WITH POTENTIAL REFORM INFLUENCE

The challenges surrounding home health care are evident. The Medicare home health care benefit is in need of reform in the form of new models. These new models should "leverage finite resources" by reimbursing providers in accordance to patient outcomes.<sup>107</sup> Opportunely, demonstration projects and programs that evaluate different approaches to delivery and payment have been established to address the issues of health care delivery, cost, and outcomes. These projects have emphasized "targeted care coordination" and value over volume of services in order to accommodate the Triple Aim.<sup>108</sup> Established programs such as the Veterans Affairs Home Based Primary Care program and Medicare's Program of All-inclusive Care for the Elderly, or PACE, are valuable because of their

---

104 See Alliance, *supra* note 1, at 7 (citing Institute of Medicine, Executive Summary, Crossing the Quality Chasm: A New Health System for the 21st Century 3 (2001); *stating*: The Institute of Medicine (IOM) defines patient centered care as "providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all decisions."

105 *Id.* at 7-8.

106 *Id.* at 8.

107 *Id.* at 4.

108 Alliance, *supra* note 1, at 13.

The Triple Aim is a framework developed by the Institute for Healthcare Improvement (IHI) that describes an approach to optimizing health system performance. It is IHI's belief that new designs must be developed to simultaneously pursue three dimensions, which we call the 'Triple Aim': [i]mproving the patient experience of care (including quality and satisfaction); [i]mproving the health of populations; and [r]educing the per capita cost of health care. *Id.* at 6.

demonstrations of compelling evidence regarding patient outcomes. As a result, the models underlying the preceding programs may potentially influence future reform policy by evidencing quality outcomes.<sup>109</sup>

The Veterans Affairs Home Based Primary Care program (VA HBPC)<sup>110</sup>, operated by the United States Department of Veterans affairs, is “a home care program that specifically targets individuals with complex chronic disabling disease, with the goal of maximizing the independence of the patient and reducing preventable emergency room visits and hospitalizations.”<sup>111</sup> The program confers “comprehensive longitudinal primary care by an interdisciplinary team in the homes of veterans with complex chronic disease, who are not effectively managed by routine clinic-based care.”<sup>112</sup> The interdisciplinary team consists of the physician, social worker, nurses, therapists, pharmacists, dietician, and psychologist.<sup>113</sup> The HBPC program is a prime example of a model that contrives weighty improvement in outcomes and cost saving.

In 2007, the VA HPBC procured a “59 percent reduction in hospital bed days of care, 89 percent reduction in nursing home bed days of care, and a combined reduction of 78 percent in total inpatient days of care.”<sup>114</sup> Also, the program secured 21 percent reduction in 30-day hospital readmissions rates.<sup>115</sup>

Furthermore, a 2002 study observed discovered that 11,335 veterans procured a “62 percent reduction in hospital bed days of care, 88 percent reduction in nursing home bed days of care, and an increase in home care visits by 264 percent.”<sup>116</sup> Likewise, the VA HBPC cost of care per patient decreased a striking 24 percent, from \$38,000 to \$29,000 a year.<sup>117</sup>

In order for the Medicare Home health program to achieve similar results, there must be a pressing analysis on the differences between the VA HBPC program and the Medicare program. A physician medical director in direct coordination with an interdisciplinary team leads the VA

---

109 *Id.*

110 Julie Leftwich L. Beales & Thomas Edes, *Veteran's Affairs Home Based Primary Care*, 25 *CLINICS IN GERIATRIC MED.* 25, 149-54 (2009), at 149, available at [http://www.geriatric.theclinics.com/article/S0749-0690\(08\)00068-2/fulltext](http://www.geriatric.theclinics.com/article/S0749-0690(08)00068-2/fulltext); stating: VA HBPC is a model to emulate for the care of persons with complex, chronic disabling conditions, improving quality without added cost, and maximizing their independence through comprehensive longitudinal interdisciplinary care delivered in their homes).

111 *Id.* at 149.

112 Alliance, *supra* note 1, at 13.

113 *Id.*

114 *Id.*

115 *Id.*

116 *Id.*

117 *Id.*

HBPC program, whereas the Medicare program is led by a plan of care that is reviewed and approved by the patient's physician.<sup>118</sup> The Medicare method is scarcely ever coordinated since a plan of care is often reviewed and approved *after* an evaluation of a patient.

Moreover, under the VA HBPC program, a patient is not required to obtain skilled care and the patient is not required to be homebound. The standard for homecare under the VA HBPC program is for a patient "for whom routine clinic-based care is not effective."<sup>119</sup> In contrast, the Medicare program only allows coverage to patients who require skilled nursing or therapy, and who are homebound.

Additionally, the VA HBPC targets patients who have chronic diseases where as Medicare home health focuses on "remediable conditions due to Medicare contactor interpretations".<sup>120</sup> The VA HBPC provides care through the end of life and still provides care despite the declination of patient's health.<sup>121</sup> Thus, the VA HBPC provides longitudinal care, in contrast to the Medicare home health time frame of care, 60-day short-term episodes.

Also, the VA HBPC delivers services that support and educate patient caregivers. These services also ensure that the home is adapted as a safe and therapeutic environment, and if needed, contracts with the following programs: adult day health services, homemaker, and home hospice.<sup>122</sup> However, the Medicare home health program does not cover services such as homemakers in the same way. Medicare may provide home health services, yet they are limited in nature and are only incident to skilled care needed.<sup>123</sup> Also, homemaker and adult day health services are not covered.

Thus, "[t]he VA's HBPC program offers an example of how home-based care can be optimized to deliver improved outcomes for Americans who are older and have disabilities, simultaneously generating considerable cost savings to the health care system."<sup>124</sup>

---

118 *Id.*

119 Beales, *supra* note 110, at 150.

120 Alliance, *supra* note 5, at 14.

121 *Id.*

122 *Id.*

123 See CMS, *supra* note 9. An example of home health aide visits provided on an intermittent basis contingent on skilled care provided:

EXAMPLE 1: A physician has ordered home health aide visits to assist the patient in personal care because the patient is recovering from a stroke and continues to have significant right side weakness that causes the patient to be unable to bathe, dress or perform hair and oral care. The plan of care established by the HHA nurse sets forth the specific tasks with which the patient needs assistance. Home health aide visits at an appropriate frequency would be reasonable and necessary to assist in these tasks. *Id.*

124 Alliance, *supra* note 1, at 14.

In addition, the Program of All Inclusive Care for the Elderly (PACE), like the VA HBPC, is a federal program that has provided value home health care to improve outcomes and lower costs. PACE integrates the Medicare program and Medicaid state option to provide acute and long-term care for those 55 or over. The program was essentially created to keep eligible participants in the community receiving care at home, as opposed to a nursing home (a more costly option). A participant would acquire coordinated care from an interdisciplinary team of health care professionals and receive following services: nursing, physical, occupational, nutrition, means, recreational therapies, social work, personal care, physician care, home health care, personal care, prescription drug supply, social services, specialist care, respite care, along with hospital and nursing home care as needed.<sup>125</sup>

The PACE program has improved care quality, decreased mortality rates, promoted preservation of function, increasingly met patient needs, provided patient and caregiver satisfaction, lower hospital and nursing home usage, and ultimately lowered Medicare expenditure among its participants.<sup>126</sup> Although PACE groups undertake a financial risk by combining all aspects of patient care, the affirmative outcomes reflect the PACE program as a means to avoiding futile hospital and nursing home admissions. Avoidance of unnecessary admissions substantially lower costs and spending. “In one study at a PACE site in Seattle, Wash., those enrolled in PACE had a 13 percent mortality rate as compared to 19 percent for those enrolled in home and community based services alone.”<sup>127</sup>

Thus, there is evidence of established models of care that effectively meet the goals of the Triple Aim. However, these programs are limited to a specific class of individuals and not available to Medicare beneficiaries.<sup>128</sup>

## VI. EMERGING PROJECTS

Currently, there are emerging projects and programs that reflect novel delivery and payment models. These projects include accountable care organizations (ACOs) and bundled payment arrangement projects.<sup>129</sup>

---

125 Alliance, *supra* note 1, at 15; (citing Centers for Medicare and Medicaid Services, “Quick Facts about Programs of All-inclusive Care for the Elderly (PACE),” CMS Publication No. 11341 (January 2008)).

126 *Id.*

127 *Id.*

128 *See Id.* at 12. The VA HBPC program is limited to veterans and by geography and the PACE organizations only offer services to those in PACE care areas and those who are Medicaid eligible.

129 Alliance, *supra* note 1 at 4, 15.

These emerging models seek to lower costs by incentivizing providers to improve coordination of care.<sup>130</sup> The coordination of care shall extend to all providers involved in care such as hospitals, physicians, and home health providers.<sup>131</sup> Coordination of care is therefore expected to result in achieved quality measures.<sup>132</sup> Most of the emerging models have a primary focus on post-acute care along with home care as a leveraging agent to yield quality measures – and of course – cost saving.<sup>133</sup>

Moreover, emerging projects are expected to coincide with the Triple Aim because of a significant focus on: (1) Patient care after discharge to prevent avoidable readmissions to a hospital; and (2) developing population health management.<sup>134</sup>

Thus, emerging projects foster their focus by leveraging the Medicare home health benefit after hospital discharge with the ultimate goal of keeping the patient safe and independent at home.<sup>135</sup> In other words, a less costly alternative for post-acute care is using Medicare home health as a partner in reducing readmissions. Under the emerging models, home health care may be provided outside of the Medicare benefit for those patients who do not qualify as homebound. This outlier coverage is accomplished by providing crucial services, such as reconciliation and physician follow-up, in order to support care transitions. Also, under these emerging models home health professionals provide care coordination and management within the home.

## VI. CONCLUSION

---

130 *Id.* at 15.

131 *Id.*

132 *Id.*

133 *Id.* at 16 (citing IOM Consensus Report, Report Brief at p. 2-3, Variation in Health Care Spending: Target Decision Making, Not Geography” (Released July 24, 2013); *stating*:

This focus is consistent with the findings of a consensus report issued by the Institute of Medicine in July 2013 on “Variation in Health Care Spending: Target Decision Making, Not Geography”, which identified post-acute care variation as the main driver of variation in Medicare spending. The report found that if there were no variation in PAC spending, variation in total Medicare spending would fall by 73 percent. *Id.*

134 *Id.*

135 See Alliance, *supra* note 1, at 21.

“Community based care transitions programs are recognizing how home health providers are able to contribute to achieving reductions in 30-day readmission rates. One example is the program at Wake Forest Baptist Medical Center.” *Id.* (citing *Connecting Home Health Care to the Care Continuum*) “These efforts are not limited to such programs, however. Home health agencies today are better managing care transitions from hospital to home using techniques such as the ones advanced by Sutter Care at Home.” *Id.* (citing Paula Suter, *Putting the Patient at the Center of Care*, Alliance for Home Health Quality and Innovation, available at <http://ahhqi.ilgwebservices.com/images/pdf/innovation-paula-suter.pdf>.)

The quality and cost effectiveness of these emerging models have not yet been fully evaluated and are still being analyzed today. Regardless of full evaluation, there are models that align incentives across the health care spectrum, among multiple health care providers. These incentives reward providers for aligning themselves with the goals of the Triple Aim. Now more than ever, it is critical that reforms be made to Medicare home health benefits so that home care can be used to provide care to patients within the home, which is a patient preferred and cost effective environment. Care within the home has shown to improve overall health and keep health care costs low.

Yet, there are substantial challenges that inhibit the ability of the Medicare home health care program to meet the growing needs of Medicare's beneficiaries. Evidence demonstrates the need for changes to Medicare home health benefits to better adapt to the legislative, demographic, sociological, and technological changes of modern society. The Triple Aim lends a progressive framework that is the foundation for a modern approach to Medicare home health benefits, ultimately leading to the benefits' restructure. In conclusion, "[t]he country needs and, unless . . . mistake its temper, the country demands bold, persistent experimentation. It is common sense to take a method and try it: if it fails, admit it frankly and try another. But above all, try something."<sup>136</sup>

---

136 Franklin D. Roosevelt, *Commencement Address at Oglethorpe University (May 22, 1932)*, available at <http://newdeal.feri.org/speeches/1932d.htm> (last accessed September 24, 2015).