Home Health Care for California's Injured Workers

Options for Implementing a Fee Schedule

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Preface

The Official Medical Fee Schedule (OMFS) establishes the maximum allowable fee for medical services provided under California's workers' compensation program unless the payer and provider contract for a different payment amount. California Senate Bill 863 amended the Labor Code to require that the administrative director of the Division of Workers' Compensation (DWC) establish a fee schedule for home health services. Home health services range from skilled nursing and therapy services provided by home health agencies or other home care providers to unskilled personal care or chore services that may be provided by family members or other personal care aides. DWC asked RAND to provide technical assistance in developing the fee schedule and related coverage policies for home health services. The report should be of interest to parties affected by workers' compensation policies for home health services, including injured workers and their representatives, home care providers, and payers, and to policymakers in California and in other states that are considering establishing a fee schedule for home health care services.

The research described in this report was supported by the California Department of Industrial Relations/Division of Workers' Compensation and was conducted in the RAND Center for Health and Safety in the Workplace. Any opinions and conclusions discussed in the report are those of the authors and do not necessarily reflect those of the sponsor.

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Questions or comments about this report should be sent to the project leader, Barbara Wynn (Barbara_Wynn@rand.org). For more information on the RAND Center for Health and Safety in the Workplace, see http://www.rand.org/jie/centers/workplace-health-safety.html or contact the director (chsw@rand.org).

Contents

Preface ... iii
Tables ... ix
Summary ... xi
Current State of Home Health Care for Workers' Compensation ... xii
Findings from Review of Other Fee Schedules ... xiii
Framework for a Home Health Care Fee Schedule ... xv
Recommendations ... xvi
Acknowledgments ... xix
Acronyms ... xxi
Chapter One. Introduction ... 1
Background ... 1
Definition of Home Health Care Services ... 2
Purpose ... 4
Overview of Methodology ... 4
Organization of This Report ... 5
Chapter Two. Current State of Home Health Care for Injured Workers ... 7
Distribution of Payments to Home Health Providers ... 7
Stakeholder Interviews ... 8
Methods ... 8
Results ... 9
Provision of Protective Supervision ... 9
Coverage of Services Provided by Family Members ... 10
Type of Care Provided by Family Members ... 11
Prevention of Fraud and Abuse ... 12
Summary of Issues That Should Be Addressed By DWC Rulemaking ... 12
Chapter Three. Medicare Home Health Services ... 15
Who May Receive Services? ... 15
What Services May They Receive? ... 16
Who May Provide Services? ... 17
Medicare Fee Schedule for Home Health Services ... 18
Fraud and Abuse ... 21
Summary ... 21
Chapter Four. In-Home Supportive Services ... 25
Overview of the IHSS program ... 25
Who Is Eligible For Services? ... 25
What Services May Be Provided? ... 27
Who May Provide Services? ... 29

Contractor Agencies 29
Homemaker Employees 29
Independent Providers 30
What Safeguards Are In Place Against Fraud and Abuse? 31
Summary and Discussion 31
Chapter Five. Other Home Health Services Under California's Medicaid Program (Medi-Cal). 33
Home Health Agency Services 33
Who May Receive Services? 33
What Services Are Covered? 34
Medi-Cal Fee Schedule for Home Health Agency Services 34
Home and Community-Based Services (HCBS) 35
Who is Eligible for Services? 35
Who may Provide Services? 36
What Services Are Covered? 36
What payments are made for covered services? 37
Summary and Discussion 37
Chapter Six. Department of Veterans Affairs 41
Skilled Home Health Care Services 41
Who May Receive Services? 41
What Services May Be Provided? 42
Who May Provide These Services? 42
Homemaker and/or Home Health Aide Services 42
Who May Receive Services? 42
What Services May Be Provided? 43
Who May Provide These Services? 43
Payment Rates for Home Health Agency Services 43
Services for Family Caregivers of Post-9/11 Veterans 44
Who May Receive Services? 44
Who May Provide These Services? 44
What Services May Be Provided? 45
Summary and Discussion 45
Chapter Seven. Review of Policies from Other WC Programs 47
Methodology 47
Review of Policies from Other Jurisdictions 47
Interviews with Administrators from Other Jurisdictions 48
Analysis of Data 48
Results of Review of Other WC Program Policies 49
Calculation of Fee Schedules 49
Rules Related to Home Care of Injured Workers 50
Provision of Services by Family Members 51
Review of Judicially Implemented Policies 54
Results of Interviews 54

Rules Related to Home Care of Injured Workers 54
Calculation of Fee Schedules 55
Provision of Services by Family Members 55
Volume and Cost of Service 56
Summary and Discussion 56
Chapter Eight. Creating a Fee Schedule for California 59
Framework for a Home Health Care Fee Schedule 59
Units of Service Used to Pay for Home Health Services 59
Coding Systems Used to Describe Home Health Services 61
Comparison of Different Fee Schedules for Home Health Services 63
Using the OWCP Fee Schedule to Fill Medicare/IHSS Gaps 65
Assessing the Types and Extent of Needed Services 66
Using a Medicare-Based Fee Schedule for Intermittent or Part-Time Care 67
Integrating IHSS into the OMFS 68
Filling the Gaps with the OWCP Fee Schedule 73
Replacing the Medicare-Based Fee Schedule with an OWCP-Based Fee Schedule 75
Aggregate Payment Levels 75
Codes Included in the Fee Schedule 81
Summary and Discussion 83
Chapter Nine: Summary of Findings and Recommendations for Creating an OMFS for Home Health Care Services 85
Summary of Findings 85
Recommendations 89
Recommended Steps Regardless of How the Fee Schedule Is Established 90
Recommendations for a Fee Schedule Developed from Medicare, IHSS, and OWCP 91
Recommendations for a Fee Schedule Based Only on OWCP 92
Appendix A. Data Collection Methodologies 93
Goal of Data Collection 93
Data Collection 93
Stakeholder Interviews 93
Scan of Policies from Other Jurisdictions 94
State Administrator Interviews 95
Data Analysis 96
Limitations 96
Appendix B. California Academy of Physician Assistants Survey on IHSS Wages as of May 28, 2012 99
Appendix C. Overview of Policies on Attendant Care Services 101
Appendix D. Overview of Policies on Services Provided by Family Members 103
References 105

Tables

2.1 Distribution of Expenditures for Home Health Care Services Exclusive of Payments to Injured Workers 8
2.2: Summary of Considerations that Need to Be Addressed in Implementing an OMFS for Home Health Care Services 13
3.1 Comparison of Estimated Medicare Payments Per Visit and Per Visit Costs: National, 2013 20
3.2. Codes Used to Report Medicare Home Health Services 23
4.1. Tasks Covered and Not Covered by IHSS 27
5.1. Medi-Cal Rates as of January 15, 2014, for Home Health Agency Services 35
5.2. Medi-Cal Rates for HCBS Waiver Services 38
6.1. States with Policies Related to Home Care Services Under Workers' Compensation 47
6.2. Description of Interview Protocol 48
6.3. Types of Home Care Services Covered by Selected Workers' Compensation Programs 50
6.4. Coverage of Home Care Services Provided by Family Members 52
8.1. Summary of Payment Methods for Different Types of Care Used by Medicare. IHSS, Medicaid, and OWCP 64
8.2. BLS Hourly Wages, in Dollars, for Home Health Aides and Personal Care Aides (May 2012) 72
8.3 Estimated OWCP per Visit Times Based on Medicare Mean Length of Follow-Up Visits Compared to 1.2 x Medicare per Visit Rate 76
8.4. 2013 OWCP Fee Schedule for Home Health Services 78
A.2: Description of Interview Protocol 96

Summary

The California Division of Workers' Compensation (DWC) maintains an Official Medical Fee Schedule (OMFS) for medical services provided under California's workers' compensation (WC) program. The OMFS establishes the maximum allowable amount for services unless the payer and provider contract for a different payment amount. Labor Code §5307.1(a)(1) requires that DWC adopt fee schedules for most services, including home health services based on Medicare fee schedules.

The Medicare fee schedule for home health services covers only home health services provided when a homebound individual needs intermittent or part-time skilled care. To date, DWC has not implemented a Medicare-based fee schedule for home health services. Section 74 of Senate Bill 863 added Labor Code §5307.8, which requires that DWC adopt a fee schedule for home health services not covered by Medicare. This fee schedule must establish fees and service provider requirements based on the rules used by the In-Home Supportive Services (IHSS) program, a MediCal-funded program that provides supportive services necessary to enable elderly and disabled individuals to remain safely within their homes.[1] In addition, DWC must ensure that several additional requirements are met: It must ensure that home health care services are provided only if reasonably required to ameliorate the effects of the worker's injury as prescribed by a physician; employers are liable for home health care services only if they receive notice within 14 days of the commencement of services; and family members of the injured workers do not receive payment for services that were customarily performed prior to the injury.[2] Taken together, the Labor Code provisions intend that the OMFS cover the range of activities that might be included within a program of home care for an injured worker.

Under the process put in place by SB-863, the primary treating physician must prescribe and request authorization for home health care services.[3] The payer determines through utilization review whether the services are reasonable and necessary under Labor Code Section 4600 as medical treatment that is reasonably required to cure or relieve the effects of injury. The type, frequency and duration of home health services that are appropriate depend on the injured worker's functional status and type of impairment. An assessment of the patient's needs for home health services typically considers the patient's living environment and need for three types of services: skilled nursing and therapy services, assistance with personal care tasks such

[1] State of California, Senate Bill No. 863, 2011–2012 Regular Session (California 2012). September 19, 2012, Section 76.

[2] State of California, 2012, Section 35.

[3] The requirement that the primary treating physician prescribe home health services was added by SB 863.

as bathing, grooming, dressing and eating, and assistance with activities that allow an individual with impaired functional status to remain at home, such as housework, shopping, and meal preparation, which we term chore services. These services are not inherently medical in nature and do not need to be performed by someone with formal medical training, but they are needed to allow the injured worker to remain in a home environment. These are the types of long-term care services covered by the IHSS that allow an individual who would otherwise require residential care to remain at home.

DWC asked RAND for technical assistance in developing the OMFS for home health care services. We first consulted with stakeholders in the California WC system to outline key concerns that the fee schedule should address. Once we identified the issues, we reviewed home health fee schedule rates and policies used by other payers in order to determine how they had addressed similar problems and conducted interviews with WC administrators from other jurisdictions to elicit their experiences in implementing home health care policies in the WC context. We used this information in order to develop recommendations for the OMFS for home health care services.

Current State of Home Health Care for Workers' Compensation

We conducted nine interviews with selected individuals to obtain an overview of issues and concerns with home health services provided to injured workers. Our interviewees were from stakeholder groups with significant interest in the fee schedule and related issues: applicants' attorneys representing injured workers, payers, home care organization staff, and care management organizations. We identified representatives of each of these groups through conversations with the DWC and the Commission on Health and Safety and Workers' Compensation (CHSWC) at the outset of the project and selected at least two representatives from each group for a telephone interview.

All stakeholder groups identified personal care and chore services (which IHSS terms attendant services) as the underlying reason for the SB-863 provision. Services that are required over a long period of time and over most or all of the day or involve 24-hour protective services were identified as particularly problematic to assess what is reasonable, particularly when family members are providing the services. Prior to SB 863, a payer was often unaware that the services were being provided because there was no physician order and was faced with retroactive payments when the case was settled. SB 863 requires that the physician prescribe home care services and stipulates that the payer is not liable for services provided more than 14 days before being notified of the services being provided; however, determining the scope of appropriate home care services remains an issue in the absence of guidelines delineating an appropriate level of coverage for these services and requirements regarding the specificity of the physician's orders. Also, there is concern that the supplemental income generated by family caregivers creates incentives to overstate an injured worker's need for supportive services and disincentives

to return-to-work. From the applicants' attorney perspective, issues are delays in getting needed home care services for injured workers while disagreements on the type and scope of services are resolved, accommodating an injured worker's preference for caregivers, and obtaining reasonable compensation for family caregivers.

Findings from Review of Other Fee Schedules

We found that neither the Medicare fee schedule nor the IHSS fee schedule would be sufficient to cover the full range of potential home care services provided to injured workers. Medicare's home health benefit is limited to services provided by a Medicare-certified home health agency to individuals with physician certification that they are homebound and need skilled care on a part-time or intermittent basis. The payment is based on 60-day episodes of care specific to the Medicare population and reflect the limited nature of its home health benefit. The most common diagnoses in 2012 for Medicare home health users were chronic conditions such as diabetes, hypertension, heart failure, and chronic skin ulcers rather than injuries. Postacute home health episodes account for 36 percent of Medicare home health clients. Most referrals for home health care under WC follow a surgical procedure (for example, spinal surgeries or hip replacements). Most Medicare patients are elderly with multiple chronic conditions likely to require a more prolonged set of postsurgical rehabilitation services than WC patients, who are younger and more likely to resume activities outside the home (including postsurgical rehabilitative services). For these patients, a Medicare-base episode is likely to provide excessive payments. In contrast, the resource needs for injured workers with major disabilities are likely to be inadequate. Because the 60-day episodes are based only on Medicare patients who need part-time or intermittent skilled care, they do not cover the type of patient receiving the most costly home care under the WC program, i.e., those that need care more extensive than part-time temporary nursing care or long-term support services on more than an intermittent basis.

The Medicare fee schedule also includes per visit rates for skilled services and limited home health services that apply when only a few home visits are required. The per visit rates could be incorporated into the OMFS, but they would need to be supplemented with fee schedule rates for more extensive skilled nursing and home health aide services that would be paid on a time-based unit of service rather than per visit basis.

The IHSS program provides unskilled chore support, personal care services, protective supervision, and other related services to aged, blind, and disabled individuals who need this support to live independently. There are four potential policy areas where the IHSS program might be incorporated into the OMFS: assessing the need for in-home supportive services, limiting the amount of services that are provided, determining who can provide the supportive services, and setting the payment rate for individual covered services. In each of these areas, we reviewed the suitability of the IHSS policies and investigated the policies under other programs

that cover long-term supportive services: Medi-Cal, Veterans Affairs, the Office of Workers' Compensation Program (OWCP) that covers federal workers, and selected state WC programs.

Assessing the need for in-home supportive services. The IHSS assessment and guidelines could be used to determine the supportive services needed to allow the patient to remain at home, but some modifications should be considered. It would be more efficient and less disruptive to the patient to have a single assessment as opposed to multiple assessments, and, unlike the assessment instrument used by Medicare and Medicaid, the IHSS instrument does not cover the full range of services. With respect to the guidelines for service hours, IHSS attendants may perform paramedical services with informed consent that otherwise must be performed by skilled personnel. It is not clear whether it is legal or appropriate to allow home health aides or attendants to provide paramedical services to injured workers. Also, IHSS guidelines preclude coverage for certain spousal services, such as meal preparation. This restriction may not be appropriate if the spouse has taken off work to care for the injured worker.

Determining who may provide the services. IHSS has three different types of arrangements for attendant services. First, the individuals could be employed by a home health agency or other home care organization. Second, the individual might be an independent home care aide who is providing services through a direct agreement with the injured worker. Third, the individual might be a family caregiver. All programs that we reviewed allow the injured worker to approve an individual caregiver, but some limit the arrangements under which care is provided, e.g., the care must be provided through a home health agency or other home care organization responsible for supervising attendant services. The Home Care Services Consumer Protective Act (AB 1217) requires home health aides employed by a health care organization to undergo a background check and register with the California Department of Social Services. Independent home health aides may also register. A WC requirement that only registered home health aides provide personal care services should address several of the concerns expressed by applicants' attorneys regarding payer-placed caregivers as well as payer concerns with caregivers selected by the injured worker. For family caregivers and any other nonregistered home care provider, an evaluation would be needed to verify the ability of the caregiver to furnish the services, whether training is needed, and the level of supervision required by a health care professional.

Limiting the amount of services that are provided. The IHSS has monthly maximums on the amount of services that can be provided to an individual: 195 hours per month for non–severely impaired and 283 hours for severely impaired cases. These limits are budget driven and would result in unmet need for some injured workers. Other public programs have incorporated limitations on coverage for long-term care services provided in the home based on a comparison with the expenses that would otherwise be paid for the appropriate level of care in an institutional setting. We did not identify a WC program that sets this type of limit. More typical among WC programs are dollar limits not expressly linked to the cost of institutional care. For example, the Hawaii WC program limits total home health benefits to four times the maximum weekly benefit rate per month.

Other WC programs establish specific limits on attendant services. For example, OWCP limits attendant care services to a maximum of $1,500 per month, where the need has been medically documented and the services are provided by a home health aide, licensed practical nurse, or similarly trained individual.[4] An appropriately trained family member may provide care up to 12 hours per day under OWCP policies, while Michigan WC limits services by family caregivers to no more than 56 hours per week. Other jurisdictions place limits comparable to the type of restrictions under the IHSS on the type of care that can be provided—for example, excluding household tasks normally provided by members of a family or limiting coverage to personal care services only.

Setting the payment rate for individual covered services. The IHSS fee schedule rates are only for attendant services and are set by each county, generally on the minimum hourly wage rate. The hourly rates vary but are below the statewide median average hourly rate for personal care services set by the VA or the OWCP.

The IHSS fee schedule addresses longer-term attendant services. It does not address the need for temporary but extensive nursing services, nor are these services addressed by Medicare's fee schedule because of its focus on intermittent or part-time care. For administrative simplicity, there are advantages to adopting a single fee schedule that encompasses the full range of home health services. We reviewed the fee schedules for home health services used by Medi-Cal, Veterans Affairs, the OWCP, and selected state workers' compensation programs to assess their suitability as a model fee schedule. We found that both the Medi-Cal fee schedule and the OWCP fee schedule cover the full range of home health care services and are already in use in California. Of these two fee schedules, the OWCP fee schedule has the advantage of providing for annual updates and pricing based on a relative value scale and conversion factor also used under the physician fee schedule. The fee schedule does not incorporate the Medicare per visit rates but rather uses 15-minute time increments to pay for skilled services. When converted to an estimated per visit rate, the amounts are higher than what would be paid based on 120 percent of the Medicare fee schedule for skilled home health care. In contrast, the per visit rates under Medicaid are substantially lower than the Medicare fee schedule rates.

Framework for a Home Health Care Fee Schedule

Based on discussions with DWC, our stakeholder interviews, and review of home health fee schedules used by other programs, we developed the following framework to guide our analysis of potential options for a home health care fee schedule:

[4] Federal Register, Code of Federal Regulations, Title 20, Volume 1, Section 10.314—Will OWCP Pay for the Services of an Attendant?, 2010.

- To cover the home health care needs of the WC patient population, the fee schedule should address the range of home health services including (1) temporary skilled and/or nonskilled supportive care services typically needed on a part-time or intermittent basis for a finite period of time following an acute care medical event (2) more extensive (e.g., full-time or longer-term) skilled care and (3) long-term supportive care services for a seriously injured worker, needed to enable the individual to remain safely at home.
- To reduce administrative burden for providers and for DWC, the fee schedule should build on existing fee schedules policies, coding system and payment amounts. This is the approach that has been taken with respect to other components of the OMFS. Given the SB 863 requirements, priority should be given to adapting the IHSS fee schedules as needed for the WC patient population.
- To establish payment rates that provide access to different types of home care providers and to facilitate monitoring and deter fraud and abuse, there should be standardized codes describing the type and volume of services provided to the injured worker. To the extent feasible, the codes should draw on existing code sets.
- To ensure workers receive high quality medically appropriate care efficiently, the payment rates should be adequate to cover the estimated costs (including a fair return on investment) of providing the services efficiently, and the payment incentives should be structured to safeguard against the under- or overprovision of care.
- To ensure that workers receive needed services required by their work-related conditions and to reduce contention between payers and injured workers over what services are needed, there should be an independent patient needs assessment that considers the services required by the individual's functional status and home environment.
- To balance worker choice with safety and cost considerations, family members should be allowed to provide attendant care services when they have the training to do so and there is appropriate financial accountability and oversight.

Recommendations

The task that DWC faces in establishing a fee schedule for home health services that meets the requirements imposed by the Labor Code is difficult. Weaving multiple fee schedules into a single integrated fee schedule is challenging in itself and is further complicated by the absence of data on the volume and cost of different types of home care services and caregivers providing services to injured workers. In this report, we concentrated on identifying options that would result in a single fee schedule that would cover the full range of home health services furnished to injured workers and identified a number of options that could be considered. We have developed three sets of recommendations. The first set deals with policies and activities that should be undertaken regardless of the actions of the other sets of recommendations. These recommended steps include:

1. Convene an expert panel representing different perspectives on the home care provided to injured workers to consider issues related to an assessment of an injured worker's need for home health services.

2. Evaluate whether the IHSS guidelines can be applied to functional status scores generated with the Medicare/Medicaid assessment instrument and whether the resulting estimates of service needs are comparable to those that are indicated by the IHSS assessment tool.
3. Partner with payer(s) and/or WC case management organizations for a sample of WC patients for whom skilled care is prescribed to obtain a better understanding of the volume and type of home health services currently being provided, the arrangements for providing them, and the "border" issues that are likely to occur if multiple fee schedules are integrated into a single fee schedule.
4. With regard to support services:
    a. Confirm the skill levels required to furnish paramedical services under the WC program, i.e., whether the WC program can adopt IHSS policies in this regard without specific statutory authorization.
    b. Require that any caregiver providing attendant services be either employed by a licensed home health agency or registered with the Department of Social Services unless the payer and worker agree to an unregistered home care aide (who may be a family member) with the necessary skills to provide personal care services.
    c. Require that the physician, the health care professional conducting the assessment, and the injured worker (or representative) participate in the decision regarding whether needed long-term care services can be provided in a home environment safely and the type of arrangements for attendant care services.
    d. Use the IHSS guidelines as a starting place to determine the number of hours needed for supportive services exclusive of the monthly cap. Consider what changes might be necessary in the IHSS policies and guidelines to ensure that workers have access to needed services.
    e. Assume that the IHSS restriction on services provided by spouses or other family members would be a simple but effective way to address the requirement that family members do not receive payment for services customarily performed prior to the injury.
    f. Consider whether to impose a cap on aggregate expenditures, e.g., 120 percent of Medicaid limitations for long-term home care under its waiver program. This would balance worker choice with the cost effectiveness of the arrangement.
5. Standardize the physician prescription forms and billing forms that should be used for home health services to facilitate fiscal responsibility and monitoring of home care services.

The second set of recommendations pertains to implementing a single integrated fee schedule that would draw on three existing fee schedules: Medicare, IHSS, and the OWCP. These recommendations are based on a straightforward reading of the Labor Code requirements for a home health fee schedule under current law and are being made at DWC's request. The fee schedule would be based on using the Medicare per visit rates to pay for intermittent or part-time care, the IHSS hourly rates for unskilled attendant services, and the OWCP rates to fill the gaps between the two fee schedules. The fee schedule allowance would be linked to whether the physician prescribed intermittent or part-time skilled care, more extensive skilled care, or unskilled attendant services only. There are "border" issues regarding which fee schedules

should apply that would need to be addressed and perhaps most importantly, the difference between Medicare's per visit rate and OWCP's time-based rates create incentives to overestimate the level of needed service.

Because we are concerned by the complexities raised by this type of fee schedule and the adequacies of both the Medicare per visit allowances and the IHSS allowances, we also developed a third set of detailed recommendations based on implementing an OWCP-based fee schedule, at least with respect to skilled home health services that would not otherwise be covered under IHSS. We believe that this fee schedule is more likely to accurately match the allowances with the services needed by injured workers, is less prone to payment disputes and potential abuse, and is administratively less complex. Unlike the Medicare or Medicaid fee schedules, it has policies that are tailored to a workers' compensation population, e.g., limiting coverage to services required by the work-related condition.

DWC has authority under Labor Code Section 5307.1(b) to establish different payment parameters from those used in the Medicare payment system to assure that the OMFS allowances are adequate to ensure a reasonable standard of services and care for injured workers as long as the estimated aggregate fees do not exceed 120 percent of the amounts payable in the relevant Medicare payment system for the same class of services. Arguably, the DWC might conclude that this provides sufficient authority to adopt the OWCP fee schedule with appropriate modifications to keep within the 120 percent limitation on aggregate fees for intermittent or part-time services covered by Medicare. If DWC concludes that it does not have the flexibility to implement an OWCP-based fee schedule without changes to the Labor Code, the agency may wish to concentrate in the short run on the IHSS-like services, because these are the most costly and problematic services. However, we would be concerned about putting in place fee schedule features that may not be the most appropriate policies in the long run but may be difficult to change after they are implemented.

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Acronyms

AD	administrative director
ADL	activities of daily living
DIR	Department of Industrial Relations
DWC	Division of Workers' Compensation
H/HHA	homemaker and/or home health aide services
IADL	instrumental activities of daily living
IHSS	in-home supportive services
LUPA	low-income utilization adjustment
LPN	licensed practical nurse
OASIS	Outcome and Assessment Information Set
OMFS	Official Medical Fee Schedule
QA	quality assurance
RN	registered nurse
SB	Senate Bill
VA	Department of Veterans Affairs
VHA	Veterans Health Administration
WC	workers' compensation

Chapter One. Introduction

Background

California's workers' compensation (WC) program provides medical care and wage replacement benefits to workers suffering on-the-job injuries and illnesses. It is a mandatory "no-fault" system in which benefits are paid by the employer without the need to determine whether employer or employee negligence caused the injury. Payments under the WC program for medical care related to treatment of a work-related injury or illness are primary to payments by other health insurance programs. Employers provide workers' compensation coverage by purchasing WC insurance from commercial insurance companies or from the California State Compensation Fund (a public nonprofit carrier) or by setting up a self-insured employer fund. In 2012, an estimated 14 million workers in California were covered by workers' compensation insurance, and 535,000 claims were filed for workplace-related injuries and benefits ranging from minor medical treatment cases to catastrophic traumatic brain injuries and spinal cord injuries (CHSWC, 2013). The systemwide paid cost for 2012 is estimated at $18.3 billion, 40 percent of which was for medical expenses (CHSWC, 2013). Of the nonfatal occupational illnesses and injuries occurring in 2012, 16.5 percent were cases with days lost from work. It takes several years for many workers with serious injuries to reach a "permanent and stationary" status, or maximum medical improvement, at which point a permanent disability rating can be determined. Among workers of insured employers who were injured in 2011, 42,034 have been classified with permanent disabilities, of which 11 percent are classified as having major or total disability (WCIRB, 2014).

The Division of Workers' Compensation (DWC) in the Department of Industrial Relations oversees the workers' compensation program. Section 5307.1 of the Labor Code requires the administrative director (AD) of the DWC to adopt an official medical fee schedule (OMFS) setting forth the maximum allowable amounts for medical services provided under the WC system. The maximum allowable amounts apply unless the payer and health care provider contract for a different amount. To date, no fee schedule has been adopted for home health services, which can range from skilled nursing and therapy services provided by home health agencies and other home health service providers following an acute episode of care, to longer-term unskilled personal care and chore services provided by attendants or family members.[1] In the absence of a fee schedule, there are no standard requirements for reporting and billing for home health services. Payments have been determined through negotiation between the payer

[1] California Department of Industrial Relations, Request for Proposal, DIR/DWC RFP No. 12-008, January 10, 2013.

and home health provider and have often resulted in disputes that require resolution through administrative processes.

Section 5307.8 of the Labor Code (which was added by Section 74 of Senate Bill 863) requires that the AD adopt a fee schedule for home health services that are not covered by Medicare or otherwise covered by the OMFS under Labor Code Section 5307.1. This includes services required on more than an intermittent or part-time basis or supportive services that are not furnished in conjunction with skilled services. The fee schedule must "set forth fees and requirements for service providers, and shall be based on the regulations adopted pursuant to Article 7 (commencing with Section 12300) of Chapter 3 of Part 3 of Division 9 of the Welfare and Institutions Code."[2] These regulations pertain to assistance with in-home supportive services (IHSS) provided to eligible aged, blind, and disabled individuals who are unable to remain safely in their homes without this assistance.

The fee schedule developed by the AD must also satisfy other conditions that pertain to the extent to which specific services are a covered WC benefit. According to the statute, "[n]o fee shall be provided for any services, including any services provided by a member of the employee's household, to the extent the services had been regularly performed in the same manner and to the same degree prior to the date of injury."[3] The statute also specifies that covered home health care services "shall be provided as medical treatment only if reasonably required to cure or relieve the injured employee from the effects of his or her injury and prescribed by a physician and surgeon."[4] Finally, the statute specifies that an employer is not "liable for home health care services that are provided more than 14 days prior to the date of the employer's receipt of the physician's prescription."[5]

Definition of Home Health Care Services

Under California's WC program, the primary treating physician must prescribe and request authorization for home health care services.[6] The payer determines through utilization review whether the services are reasonable and necessary under Labor Code Section 4600 as medical treatment reasonably required to cure or relieve the effects of injury. The type, frequency, and duration of home health services that are appropriate depend on the injured worker's functional status and type of impairment. An assessment of the patient's needs for home health services typically considers the patient's living environment and need for three types of services: skilled

[2] State of California, 2012, Section 74.

[3] State of California, 2012, Section 74.

[4] State of California, 2012, Section 35.

[5] State of California, 2012, Section 35.

[6] S.B. 863 added the requirement that the primary treating physician prescribe home health services.

nursing and therapy services; assistance with activities of daily living (ADL) or personal care tasks such as bathing, grooming, dressing, and eating; and assistance with instrumental activities of daily living (IADLs) that allow an individual with impaired functional status to remain at home, such as housework, shopping, and meal preparation, which we term "chore" services. Some seriously injured workers, such as those with traumatic brain injuries, may require *protective supervision*, or monitoring by someone who is capable of prompting the worker to take basic actions for health and well-being. Currently, there are no policies regarding who should provide the needs assessment and no standard assessment form.

Most programs covering home health services provide coverage for *skilled services*, such as skilled nursing care and therapy services. Skilled nursing care includes activities that require trained judgment and must generally be provided by a licensed nurse. For example, Medicare requires that skilled nursing service be provided by either a registered nurse or a licensed practical (or vocational) nurse supervised by registered nurse.[7] The activities defined as skilled nursing services include administering intravenous drugs and changing dressings. There may also be coverage for skilled therapy services furnished in the home, such as physical therapy, speech-language pathology services, and occupational therapy, and for medical social services. Frequently, these services are provided on a short-term part-time basis to homebound patients following hospitalization or surgery.

Personal care services or assistance with ADLs do not require the advanced skills of a licensed nurse and are often furnished by a home health aide or nursing aide. Most of these tasks are not inherently medical in nature and could be performed by someone with minimal training. For example, IHSS personal care services include bowel and bladder care, feeding, bathing, dressing, and transfer.

In contrast to skilled services and personal care services, *chore services* and other domestic services provide assistance with IADLs, the tasks of everyday living that the individual is no longer capable of performing because of the injury or illness. These services are provided to allow the individual to live as independently as possible and generally do not require any specialized training. For example, IHSS provides coverage for chore services, which include cleaning floors, taking out the garbage, cleaning the kitchen, and even changing a light bulb. IHHS and other programs describe unskilled providers of personal care and/or chore services as *attendants*.

To live independently, some injured workers require *protective supervision*: monitoring by someone who is capable of prompting the worker to take basic actions necessary for health and well-being (such as reminding him or her to eat and bathe) and redirecting the worker when he or she undertakes potentially dangerous activities.

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[7] U.S. Department of Health and Human Services**,** Centers for Medicare & Medicaid Services, *Medicare and Home Health Care*, Baltimore, Md., 2010, p. 8.

Purpose

Labor Code Section 5307.8 requires the AD to develop a fee schedule that covers the full spectrum of home health services. DWC asked RAND to provide technical assistance in implementing the fee schedule. Specifically, DWC asked RAND to address the following questions:

- What types of home care services are provided to individuals covered by the WC program, and what is the volume and cost of these services?
- What features of existing fee schedules for home care services, including Medicare, other WC, and CAL. WIC. CODE § 12300 might serve as a model for the OMFS, keeping in mind the statutory directives to base the schedules on Medicare and IHSS, respectively?
- What options should be considered regarding the services, units of service, and payment amounts for the fee schedule? Could the OMFS be linked to one or more existing fee schedules?
- Are there model rules concerning supportive services provided by relatives that might be adapted for the WC program?
- What has been the experience of other programs in administering fee schedules for supportive services? What program safeguards do they use to protect against fraud and abuse?
- Are there existing billing forms that should be adopted for use under each fee schedule? What billing rules should be considered for adoption?
- What rules should be considered for adoption to clearly delineate the Medicare-based home health agency fee schedule from the IHSS-based home health care services fee schedule and from other workers' compensation fee schedules such as the fee schedule for durable medical equipment, prosthetics, orthotics, and supplies, or the physician fee schedule?[8]

In addition to posing these specific questions, DWC articulated several requirements that should be used to evaluate potential fee schedules. The proposed fee schedules should be easy to implement and update, consider possible abuse, and should allow for itemized costs, with each covered service referenced in the schedule with a unique identifier.

Overview of Methodology

To address DWC's questions, we collected information from three types of sources: (1) interviews with representatives of key stakeholder groups (e.g., payers, applicant attorneys, home care agencies) in the California WC system, (2) an environmental scan for information regarding comparable programs in states with WC policies specific to home health care, and (3) interviews with administrators of those state programs. Our stakeholder interviews consisted of open-ended questions intended to identify the issues related to the provision and payment for home health

[8] CMS, 2010.

care under current policies that should be addressed by the fee schedule regulations. The environmental scan for information describing comparable programs from different states was designed to determine the potential range of alternative polices that the Department of Industrial Relations (DIR) might want to consider going forward. We gathered the information from a review of relevant statutory and regulatory material, published policies, fee schedules, and other documentation. The subsequent interviews with administrators of WC from these states gathered additional information about how each alternative has been implemented, and the perceived failures or successes of different policies. Taken together, these sources of information clarify the issues facing DWC, develop a range of possible alternatives that DWC could use to address these issues, and provide insight into the strengths and weaknesses of each alternative.

We found that we were unable to develop reliable estimates of the total volume and types of home health care services being provided to injured workers and the expenditures for those services. The Workers' Compensation Information System (WCIS) collects data on medical services provided to injured workers, including services provided by home health agencies and other home care providers to workers in their homes, but the reporting is incomplete and inconsistent in the absence of uniform coding rules. Moreover, payments for unskilled services are often made to the injured worker and are not reported in the WCIS medical data. We obtained information from the Workers' Compensation Insurance Rating Bureau and a care management company (One Call Care Management) on home health expenditures made to home care providers (exclusive of payments to injured workers for attendant services). These data provide information on the distribution of payments made to home health providers.

Organization of This Report

Chapter Two provides an overview of current coverage and payment policies and issues for home health care for WC in California. Our understanding of this topic is derived from our interviews with stakeholders in California's WC system. The following four chapters explore the rules for home health care under non-WC programs operating in California: Medicare (Chapter Three), IHSS (Chapter Four), Medi-Cal (Chapter Five) and the Department of Veterans Affairs (Chapter Six). We pay particular attention to how these programs address the concerns identified by both DWC and the California WC stakeholders.

Chapter Seven summarizes how WC programs in other states and the federal Office of Workers' Compensation (OWCP) cover and pay for home health services. Finally, Chapter Eight reviews potential policy options for a fee schedule for home health services. Chapter Nine concludes by summarizing our findings and making recommendations regarding the adoption of an OMFS for home health services and related rules.

Chapter Two. Current State of Home Health Care for Injured Workers

This chapter provides an overview of the home health services provided to California's injured workers that we developed from available data and interviews with selected individuals from stakeholder groups with significant interest in the fee schedule and related issues. Based on the findings from the interviews, it concludes with a summary of the issues that DWC will need to address in implementing a fee schedule for home health care services.

Distribution of Payments to Home Health Providers

We used data provided by the Workers' Compensation Insurance Rating Bureau (WCIRB) and One Call Care Management Company to obtain an understanding of the relative importance of the different types of services provided by home health providers (Table 2.1). Starting in mid-2012, the WCIRB has collected encounter-level medical data from insurers (which represent about 68 percent of the WC market in California). Data provided by the WCIRB varied in terms of number of reporters and the codes that they use to describe services provided in the home. In the aggregate, the largest expenditures were for home health aide/homemaker services, followed by LPN or LVN services, RN services and physical therapy. Minimal speech therapy (< 0.0 percent) and occupational therapy (0.2 percent) were provided in the home (data not shown). The expenditure data do not include payments to injured workers for attendant services.

One Call Care Management Company is a nationwide organization that coordinates the provision of ancillary services for insurers and self-insured employers. For home health services, One Call provides assessments of needed services and arranges for their provision through its network of home care providers. The organization estimates that 10 percent of cases involve only skilled care, while 15 percent involve nonskilled only. The aggregate expenditure data for services provided through One Call in California during 2012 and 2013 show a somewhat different distribution than the WCIRB data, with a higher proportion of expenditures for home health aide services and RN services relative to LPN services.

Table 2.1 Distribution of Expenditures for Home Health Care Services Exclusive of Payments to Injured Workers

Type of Service	Percent of Total Expenditures for Home Health Services Exclusive of Payments to Injured Workers	
	WCIRB April 2012–March 2013	One Call Care Management 2012–2013
Home health aide or certified nursing assistant	62	73
RN nursing services	13	12
LPN or LVN nursing services	19	6
Physical therapy	3	6
Companion services	—	1
Other	3	2

Stakeholder Interviews

Methods

We conducted nine semi-structured interviews with individuals selected from stakeholder groups with significant interest in the fee schedule and related issues: applicant's attorneys representing injured workers, payers, home care organization staff, and care management organizations.[1] We identified representatives of each of these groups through conversations with DWC and Commission on Health and Safety and Workers' Compensation (CHSWC) staff at the outset of the project. We conducted interviews with a convenience sample of at least two representatives from each group to obtain an overview of issues and concerns with home health services provided to injured workers.

Interviewees were contacted and asked a series of open-ended questions designed to elicit their concerns regarding coverage of home health services and attendant care services as it existed before the passage of SB 863. They were asked to identify what problems they had seen regarding both the payment for these services and current policies that regulate the provision of home health care, what they perceive as the potential intended and unintended consequences of the SB 863 provisions, and what mechanisms to prevent fraud and abuse they might find acceptable. More details on the interviews are contained in Appendix A.

[1] Because our goal was to conduct an environmental scan of home care issues under WC, we elected to interview applicants' attorneys who have experience with the issues confronting multiple injured workers rather than a few individual workers receiving home care services whose experiences may not be representative of the broader WC population.

Results

All interviewees suggested that the locus of concern is attendant care services, particularly in situations where attendant care will be required over a long period of time and over most or all of the day. Interviewees noted that the issues are compounded when family members provide the services in question, as it becomes more difficult to determine the scope of services "reasonably required" by the work-related condition and the appropriate payment level for them.

Provision of Attendant Care Services

According to the interviewees, the impetus behind SB 863 was largely to address concerns related to provision of attendant care services. Payers and applicants' attorneys cited specific examples of perceived fraud during the provision of attendant care services that were thought to provoke the passage of SB 863. Prior to SB 863, a payer was often unaware of the services being provided because there was no physician order and was faced with retroactive payments when the case was settled. SB 863 requires that the physician prescribe home care services and stipulates that the payer is not liable for services provided more than 14 days before being notified of the services being provided. While this addresses the issue of retroactive determinations, payers indicated that determining the scope of appropriate attendant care services remains an issue in the absence of policies related to guidelines delineating an appropriate level of coverage for these services and requirements regarding the specificity of the physician's orders.

Payers were concerned that someone competent to perform attendant care services should provide that level of care. Even though attendant care does not require skilled medical training, the caregiver must nonetheless be trained to provide assistance with personal care services. An applicant attorney was concerned that injured workers be able to choose their attendant and suggested that contractor-furnished attendants be bonded and able to communicate in the language most commonly used by the worker.

Provision of Protective Supervision

One interviewee described protective supervision as the level of care that would be required for a nine-year-old child. While the individual under protective supervision would generally be able to care for him- or herself, the presence of a responsible adult would be required in case an emergency arose. Protective supervision can be costly because it is provided continuously. When protective supervision is needed, the worker cannot be left entirely alone even though he or she can operate independently some of the time. Therefore, although a low level of skill is required to provide protective supervision, it can become expensive if the fees for these services are calculated on an hourly basis. There are substantial disagreements between payers and injured workers over the need for protective supervision and the appropriate payment rate, particularly if provided by a live-in companion or family member.

Some payers were somewhat skeptical of the circumstances under which injured workers claimed to need protective supervision. According to them, prototypical situations where protective supervision is requested include instances where the worker is suicidal, needs external motivation to leave the home and perform activities, or may need help in case of an emergency, such as monitoring to avoid choking. While these interviewees wanted to ensure that the injured worker receives needed care, they were aware of seemingly "outrageous" requests and wanted guidelines for ensuring that the services requested were actually necessary.

An interviewee with experience in the area of protective supervision described his experience in determining appropriate payment for protective supervision. He noted that the cost of services increases at a diminishing rate when care is required for longer periods of time; it should not be significantly more expensive to provide 24-hour care than it is to provide 12-hour care.

Coverage of Services Provided by Family Members

Concerns regarding the provision of attendant care services are magnified when a family member provides such services. Payers and applicants' attorneys alike expressed their concern over provision of attendant care services by family members for several reasons, including the calculation of payment rates for a family caregiver, the number of hours of care authorized, and the type of care provided by the family members. A representative from a care management organization suggested that the incentives for efficient delivery of care and return to work are distorted when family members are paid for their services.

Payment for Services Provided by Family Members

Some payers were concerned that family members appeared to be exploiting the payer to obtain a level of payment incommensurate with the services either required or provided. However, this concern was by no means universal. According to one interviewee, family members providing care to injured workers are usually not seeking to make a profit, and the worker is generally reimbursed between $10–25 per hour for this care.

One applicants' attorney we interviewed was adamant that family members should be paid based on the type and level of care being provided, not the skills and experience of the individual caregiver. For this interviewee, the characteristics of the person providing the care, such as training level or employment opportunities forgone to provide care, are irrelevant to the calculation of the appropriate payment rate. Instead, the payment should be based on the rate that would otherwise be paid to an appropriately trained individual for the service. This interviewee was very concerned that a family member might not be paid appropriately for the level of care actually provided: for example, receiving an hourly rate commensurate with attendant care

services when the caregiver is actually providing paramedical services.[2] Another interviewee echoed this concern, stating that rates calculated for unskilled attendant care might not be appropriate for the type of care actually required after a catastrophic injury. For example, a family member tending to a worker who has been badly burned might be supplying services that an RN would receive $50/hour for providing, while the IHSS rate for those services would only be $9–$12/hour.

Determination of Number of Hours of Care Provided by Family Members

Calculation of payment to family members is further complicated when care must be provided on a 24-hour basis. One applicants' attorney described a situation when payment to family members for 24-hour care had to be negotiated. In that situation, the family members were paid the same amount that would have been paid to an institution for providing comparable care. Similarly, a payer noted that there used to be a "live-in rate" for continual care, calculated on a daily or weekly basis rather than an hourly basis. Although this interviewee had not seen this practice in a while, he thought it might be a promising option.

The applicants' attorneys suggested that a family member providing 24-hour protective supervision must be paid for all of those hours, including the hours spent sleeping but "on call." According to them, to do otherwise would allow the payer to benefit from the marital or familial relationship by paying less than they would have had to pay an unrelated employee. However, payers seemed to consider that providing 24-hour care on a continuous basis did not reflect the reality of the care provided, as the family member would have to also engage in other activities (such as sleeping).

Type of Care Provided by Family Members

Some interviewees discussed their concerns regarding the type of care provided by family members, both to ensure that they are paid appropriately for the level of care provided and to ensure that they are qualified to provide that level of care.

Relatedly, some payers are concerned that family members may not be capable of providing the level of care they are often asked to provide. Several discussed the strain on both injured workers and their familial caregivers caused by attempting to provide a level of care that they are not trained to provide, particularly when this care is required for most of the day. While family members may receive training in care from a hospital or nursing care facility before the injured worker is discharged into their care, this training may be inadequate preparation for the realities of providing home care.

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[2] As defined by the IHSS program, paramedical services include administration of medications, injections, and other services that require the judgment of a health care professional.

Prevention of Fraud and Abuse

Both payers and applicants' attorneys suggested that a mechanism for consistent and independent assessment of needs provides primary protection against fraud and abuse. According to them, there is currently no consistent pattern in how injured workers' needs are assessed within the WC system. Interviewees identified several concerns that must be addressed if assessment of needs is to be required when home health services are provided.

The first source of concern is who should perform the need assessment. All interviewees identified the need for an independent assessor, preferably with significant medical training and a thorough understanding of the issues related to home health care services. One interviewee discussed a preference for engaging a nurse case manager chosen by both parties to perform the assessment.

In addition to determining who should perform the assessment, interviewees were concerned about what type of assessment would be performed. One interviewee suggested that proper assessment would require both a review of medical charts and an extended period of observation, not just a brief visit. This thorough assessment was meant to counteract the possibility that a worker could be observed on a particularly "good" or "bad" day, and the level of need incorrectly determined. However, a payer noted that assessors were often refused access when they attempted to perform assessments, severely limiting the ability of assessors to perform their duties thoroughly.

Summary of Issues That Should Be Addressed By DWC Rulemaking

The representatives of the stakeholder groups that we interviewed raised a variety of issues related to implementation of the OMFS for home health care. While the interviewees' concerns were often divergent, and sometimes even contradictory, the potential issues identified in the interviews tended to involve four questions: who may receive services, what services may be provided, who may provide these services, and what is a reasonable allowance for these services. To successfully implement an OMFS for home health care, DWC will have to find satisfactory answers to these four questions.

Table 2.2 contains a list of the considerations that DWC may wish to address during the rulemaking process, as identified both by DWC and by the individuals we interviewed. We use the four categories of questions to frame our review of how non-WC public programs pay for home health services in Chapters Three through Six.

Table 2.2: Summary of Considerations that Need to Be Addressed in Implementing an OMFS for Home Health Care Services

Key Questions	Specific Considerations to Be Addressed
Who may receive services?	Who is eligible to receive attendant care services? What information should be included in a doctor's recommendation for attendant care services? Who should perform an independent assessment of needs? What types of analysis and observation should be included in the independent assessment of needs? When and how often should the assessment be repeated?
What services may they receive?	What types of activities are included as part of attendant care services? When should protective supervision be available? When should continuous protective supervision be available?
Who may provide services?	What qualifications must a person have to provide attendant care services? Can family members provide attendant care services, and if so, how many hours of home care services provided by family members should be covered? Should family members be allowed to provide 24/7 protective services, or should relief providers be required? Should family members receive training before providing care?
What is a reasonable allowance for needed services?	What is a reasonable allowance for attendant care services and, if applicable, continuous protective supervision? Should a different allowance apply when a family member provides needed services?

Chapter Three. Medicare Home Health Services

We start our review of how various programs pay for home health care services with the Medicare program. This is because Labor Code Section 5307.1 requires that with certain exceptions (e.g., pharmaceutical services) the maximum allowable fees under the OMFS be in accordance with the fee-related structure and rules of the relevant Medicare payment system. Under the fee schedules adopted by the AD under this provision, the maximum allowable fees are limited to no more than 120 percent of estimated aggregate Medicare fees for the same class of services. As amended by SB 863, Labor Code Section 5307.8 requires the AD to adopt a fee schedule based on IHSS policies for home health care services not covered by a Medicare fee schedule or otherwise covered by the OMFS under Section 5307.1. One implication of these two provisions is that the OMFS for home health care services should be based on the Medicare fee schedule to the extent that such services are covered by Medicare fee schedules. Thus, it is important to understand both the nature of home health care services covered by the Medicare program and how its fee schedule rates are established.

Medicare is a federally funded health insurance program available to U.S. citizens over the age of 65, and U.S. citizens under the age of 65 who have certain disabilities.[1] This program is intended to ensure that these populations are able to obtain necessary health services and is currently utilized by 54 million beneficiaries.[2] As discussed below, the home health benefits are limited in scope relative to those that are available under the workers' compensation program. Specifically, the Medicare home health benefit is limited to homebound beneficiaries who need intermittent or part-time skilled care. Medicare's payment is based on 60-day episodes of care that do not reflect the full range or mix of home health care services that might be needed by an injured worker, particularly with respect to personal care services and chore services. Nevertheless, there are elements of the Medicare fee schedule that the AD may wish to incorporate into the OMFS.

Who May Receive Services?

Persons with Medicare are eligible to receive home health services as part of their plan of care if a doctor certifies that they are homebound and need particular types of skilled care on a part-time or intermittent basis. An individual is considered homebound if a doctor attests that leaving the home is either inadvisable due to health, impossible without assistance, or possible

[1] Centers for Medicare & Medicaid Services, *What is Medicare?*, website, undated.
[2] Centers for Medicare & Medicaid Services, *CMS Fast Facts*, Medicare and Medicaid Populations.

only with a large amount of effort.[3] An individual who leaves home for medical treatment or occasionally for nonmedical reasons, including attending religious services, may still be considered homebound.

To qualify for Medicare home health coverage, the beneficiary must need intermittent part-time skilled nursing care, physical therapy, or speech-language pathology services. A beneficiary who needs full-time skilled nursing care is not covered, nor is a beneficiary who needs only occupational therapy or medical social services. Medicare defines intermittent part-time care as "care that is needed or given on fewer than 7 days each week or less than 8 hours each day over a period of 21 days (or less)."[4] These restrictions on covered services explicitly eliminate situations where around-the-clock or daily care is required. Exceptions may be made in special circumstances, provided that the recipient's doctor can anticipate when the need for care will end.

What Services May They Receive?

Medicare covers a narrow range of skilled services provided within the home, including intermittent skilled nursing care, physical therapy, speech-language pathology services, certified occupational therapy, and medical social services.[5] When a Medicare beneficiary qualifies for home health care coverage by needing skilled care on an intermittent, part-time basis, Medicare will also cover limited personal care and chore services by a part-time home health aide if needed as support services for the skilled care. If the beneficiary requires only unskilled services, Medicare does not cover them. Patient and caregiver education may also be covered, so that the patient and caregiver can be trained to provide care they are currently incapable of providing.[6] The goal of home health care services is to help the recipient become independent and self-sufficient,[7] and education can be a vital component of fulfilling this goal.

Skilled nursing services are defined to explicitly exclude personal care services that would traditionally be provided by home health aides, including assistance with bathing, dressing, and homemaking. "Any service that could be done safely by a non-medical person (or by [the beneficiary]) without supervision of a nurse, isn't skilled nursing care."[8] These supportive services are covered only when they are provided in conjunction with skilled nursing services, as

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[3] Centers for Medicare and Medicaid Services, *Medicare and Home Health Care*, 2010, p. 5.

[4] CMS, 2010, p. 6.

[5] CMS, 2010. Occupational therapy and medical social services are not home health qualifying services but are covered if the beneficiary needs one of the qualifying skilled services on an intermittent, part-time basis.

[6] Centers for Medicare and Medicaid Services, *Home Health Care: What It Is and What to Expect*, website, undated.

[7] CMS, *Home Health Care,* undated.

[8] CMS, 2010, p. 8.

part of a plan of care authorized by a physician.[9] Covered home health aide services include personal care services, simple dressing changes that do not require the skills of a nurse, and assistance with medications that are ordinarily self-administered and do not require the skills of a licensed nurse to be provided safely and effectively.

Medicare may cover other skilled services provided within the home, including physical therapy, occupational therapy, and speech-language pathology services. To be covered by Medicare, these treatments must be safe, effective, and capable of being provided only by trained professional therapists.[10] These services are available only if the individual's condition is expected to improve within a reasonable time frame, or intervention by a skilled therapist is necessary to "establish a maintenance program" or "perform maintenance therapy."[11] An individual may receive only a reasonable amount of therapy. Medical social services may also be covered if a doctor certifies that they are necessary to help the patient cope with the emotional and social aspects of the condition.[12]

Medicare-certified home health agencies and California Medicaid-licensed home health agencies are required to meet the Medicare conditions of participation. One requirement is that they perform a comprehensive assessment of all patients at the start of care, other than patients who need only chore services. For Medicare and Medicaid patients, a standard assessment tool (Outcome and Assessment Information Set, OASIS) must be used and reported to the Centers for Medicare and Medicaid Services (CMS). Use of OASIS for other patients requiring skilled care is optional as long as a comprehensive assessment is performed. Medicare uses this form to establish the beneficiary's eligibility for home health care and the level of services required for Medicare payment purposes. This form could also be used to assess the functional status and home health care service needs of injured workers. However, IHSS uses a different tool to assess the needs of individuals requiring long-term supportive services to remain at home (see Chapter Four). Chapter Eight discusses how the two assessment tools might be used consistent with the Labor Code requirements that services not covered under a Medicare fee schedule be based on IHSS program requirements.

Who May Provide Services?

Home health care services must be provided through a Medicare-certified home health agency, and an individual can choose which agency provides care. To become a Medicare-certified home health agency, an organization must be principally engaged in providing health

[9] CMS, 2010, p. 10.

[10] CMS, 2010, p. 9.

[11] CMS, 2010.

[12] CMS, 2010.

services, ensure that these services are supervised by a health professional, obtain a state license, and meet federal requirements.[13]

By definition, skilled nursing care must be provided by a licensed nurse, either a registered nurse or a licensed practical (or vocational) nurse working under the supervision of a registered nurse. Examples of skilled nursing services include wound care, taking vital signs, administration of IV treatments and injections, and monitoring the recipient's health.[14] A skilled nurse is also responsible for managing care and coordinating his or her caregiving efforts with care provided by the individual's doctor and other caregivers. With reference to personal care and chore services, Medicare by statute excludes payment for any services provided by an immediate relative or members of the beneficiary's household.

Medicare Fee Schedule for Home Health Services

Medicare makes a prospective payment covering all services other than durable medical equipment, during a 60-day episode of care provided by a home health agency, which reflects the limited nature of the Medicare home health benefit. The 2014 60-day base payment rate is $2,869 for home health agencies in urban areas and $2,955 for home health agencies in rural areas. The payment is case-mix adjusted for clinical severity, functional severity, and therapy service needs defined by 153 home health resource groups (HRRGs) based on the information reported through OASIS and for wage variation across geographic areas. The case-mix adjustment is determined through a comprehensive patient assessment using the OASIS tool at the outset of care and periodically thereafter. If the beneficiary requires additional care at the end of an episode, payment is made for an additional 60-day episode.

We do not have data on the home health services provided WC patients that are needed to make a direct assessment of the suitability of incorporating the 60-day episode fee structure into the OMFS. However, there are several indications that caution against adopting the per episode rates. Medicare's per episode payment reflects the cost of providing a typical mix of Medicare-covered services during the 60-day episode and does not reflect the type and duration of home care that might be furnished to injured workers. The most common diagnoses in 2012 for Medicare home health users were for chronic conditions such as diabetes, hypertension, heart failure and chronic skin ulcers rather than injuries. Postacute aftercare or rehabilitation in the home setting account for 36 percent of Medicare home health clients but are the predominant reasons for home health in the injured worker population. Even when the reason for the postacute episode is similar (e.g., following a knee replacement), the volume and mix of services are likely to be different. Most Medicare patients are elderly with multiple chronic conditions, and are

[13] CMS, *Home Health Providers*, website, April 2013.

[14] CMS, *Home Health Care*, undated.

likely to require a more prolonged set of postsurgical rehabilitation services than WC patients, who are younger and more likely to resume activities outside the home (including postsurgical rehabilitative services). For these patients, a Medicare-base episode is likely to provide excessive payments. This issue is further exacerbated by the Medicare per episode payments substantially exceeding the costs of the care provided to Medicare beneficiaries. Since the per episode payment was implemented in 2000, agencies have responded to the payment incentives by reducing the number of visits per home health episode by 8.2 percent while increasing the number of episodes per health patient by 20 percent.[15] Home health agency Medicare margins have averaged 17.5 percent between 2001 and 2011[16]. In theory, an overall reasonable level for an episodic-based allowance could be addressed through adopting a lower OMFS multiplier, but data to do so are not available, and the issues of whether the HRRGs appropriately capture the relative home care resources required for different types of WC patients and how home care providers would respond to the payment incentives would remain. The HRRGs are likely to overstate the resources required for postsurgical rehabilitation care relative to those required for WC patients with serious disabilities. Because the 60-day episodes are based only on Medicare patients who need part-time or intermittent skilled care, they do not cover the type of patient receiving the most costly home care under the WC program, i.e., those who need more extensive but temporary nursing care or long-term support services.

Rules that try to define the "border" between the services covered by the episodic payment and the other services would be problematic and could lead to significant changes in how home care is delivered to injured workers. Medicare pays only for home care provided by Medicare-participating home health agencies, while WC is currently paying for care provided through other home care agencies and independent caregivers that is typically less costly than home health agency services, which have higher overhead costs. Medicare maintains the integrity of the episodic payment by requiring the home health agency to provide all the services required by the beneficiary during the episode of care. If this policy were adopted when the injured worker requires intermittent or part-time care, home care organizations and independent providers would no longer be able to furnish these services. If they were permitted to continue to furnish services, incentives would be created for the home health agency to furnish only enough services to qualify for the episodic payment and for the remainder to be furnished by other organizations. This would create a duplicate payment for the services, once in the episodic payment to the home health agency and again to the other home care organization or independent caregiver.

Although Medicare's episodic payment is not appropriate, another feature of the payment system might be. If fewer than five visits are provided during a 60-day episode, Medicare makes

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[15] Medicare Payment Advisory Commission, *A Data Book: Health Care Spending and the Medicare Program*, 2014b.

[16] Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, 2014a.

a low-income utilization adjustment (LUPA) and pays the home health agency a per visit amount rather than the per episode amount. The LUPA per visit payment varies by discipline but does not vary by the length of the visit. However, there is an additional add-on to recognize that the initial visit is longer than subsequent visits.[17]

These wage-adjusted rates might be a suitable basis for a per visit fee schedule for skilled services delivered to homebound patients. However, policies to reduce the excessive per episode payments through limitations on allowable updates for inflation have also applied to LUPA and created a gap between the reported average cost per visit and the per visit payment rate (see Table 3.1).[18] For skilled services, the gap ranges from 19 percent for skilled nursing visits to 33 percent for physical therapy. This suggests that even with a 1.2 multiplier to the Medicare per visit rates, the allowances would not be sufficient to cover the estimated cost of an average visit. For home health aide services, the gap is 33 percent. The home health aide rates are problematic also because of considerable variation in the length of WC-covered visits. It is likely that a more extensive range of personal care and chore services would be provided to injured workers during a home health aide visit than the services that Medicare covers.

Table 3.1 Comparison of Estimated Medicare Payments Per Visit and Per Visit Costs: National, 2013

Discipline	2013 Estimated Per Visit Payment Rate ($)	2013 Estimated Per Visit Average Cost ($)	Percentage Difference
Skilled nursing	117.28	140.13	19.48
Home health aide	53.12	70.69	33.08
Physical therapy	128.24	170.70	33.11
Occupational therapy	129.11	169.50	31.28
Speech-language pathology	139.34	181.29	30.11
Medical social services	188.01	231.69	23.23

Home health agencies use the billing form for institutional services (UB04) to bill for home health services. Billing occurs at least every 60 days and includes an HHRG code that describes

[17]The initial assessment is not separately counted or paid as a visit. Instead, the costs are included as an overhead cost. If the care requires a low-volume payment adjustment, the payment for the initial visit is multiplied by an adjustment factor to recognize that the overhead cost of the assessment visit is spread over fewer visits. The add-on adjustment factors to the first visit in calendar year 2014 are: skilled nursing, 1.8451; physical therapy, 1.6700; and speech-language pathology, 1.6266.

18 CMS, "Home Health Prospective Payment System Rate Update for CY 2014, Home Health Quality Reporting Requirements, and Cost Allocation of Home Health Survey Expenses; Final Rule," *Federal Register,* Vol. 78, No. 231, 2013. Home health agencies file an annual cost report with CMS that the agency uses to determine the average cost per visit by discipline.

the patient's case-mix classification and line-item information on the actual services provided during the billing period. Each HHRG has a unique code used to determine the payment for the 60-day episode. In addition, revenue codes and Healthcare Common Procedures Coding System (HCPCS) alphanumeric G-codes are reported for each visit by discipline (Table 3.2). Only one HCPCS G-code is reported for each visit. If more than one nursing or therapy service is provided in a visit, the home health agency reports the G-code for the service that required the most time. Services are reported in 15-minute increments based on the time spent with the beneficiary.

Fraud and Abuse

Medicare bills for home health services are processed by regional Medicare Administrative Contractors (MACs) who specialize in home health services. As with other services, the MACs monitor utilization patterns to identify providers with aberrant patterns for possible fraud and abuse. Medicare also contracts with Zone Program Integrity Contractors to prevent improper payments and identify potential fraud and abuse situations. Further, CMS uses a predictive analytics system that analyzes all billings to identify potential fraud and builds home health agency profiles that are used to create risk scores estimating the likelihood of fraud and identify potentially fraudulent claims and billing patterns. WC has multiple payers, which makes this type of profiling difficult for them to do, but assuming a standardized coding system were implemented, it might become feasible using the Workers Compensation Information System medical data.

The Office of Inspector General in the Department of Health and Human Services also monitors home health services and has concluded that they vulnerable to fraud, waste, and abuse. The issues have included home health agencies billing for home health services that were not medically necessary or not provided, for periods the beneficiary was in hospital or other institutional care, or for services on dates after beneficiaries' death.[19] These types of analyses could be undertaken by payers and applied to supportive services as well as home health agency services.

Recent legislation permits Medicare to implement temporary moratoriums on the enrollment of agencies in geographic areas believed to have a high incidence of fraud. The moratorium was implemented in the Miami-Dade County and Chicago areas in July 2013.

Summary

The Medicare program home health benefit is designed to provide services needed to treat an illness or injury to homebound beneficiaries. It provides coverage for a narrow range of services over a limited period of time while the beneficiary regains self-sufficiency. It is not intended as a

[19] U.S. Department of Health and Human Services and U.S. Department of Justice, *Health Care Fraud and Abuse Control Program, Annual Report for Fiscal Year 2011*, February 2012.

long-term care benefit. Custodial care is specifically excluded, and home health aide services are covered only when they are part of a plan of care requiring intermittent, part-time skilled services.

There is a standard assessment form that could be used to determine the type and duration of needed home health services. However, Medicare's 60-day episode rates reflect the limited nature of Medicare-covered home health services and are unlikely to reflect the type and mix of services required by injured workers. To the extent rates are needed for skilled care delivered to patients in their homes, such as care provided following a discharge from a hospital after a surgical stay, the Medicare per visit rates for these services might be considered. Given the gap between the estimated average cost per visit and the payment rate for the visits, however, allowances set at 1.2 times the Medicare per visit rates are unlikely to be sufficient to cover the cost of care. Most importantly, however, the home health aide visit rates do not reflect the full range and mix of personal care and chore services provided to injured workers with major disabilities. Because the Medicare program does not cover custodial care, its fee schedule for home health care services does not provide rates for the attendant care and protective services that are the major issue under California's workers' compensation program.

Table 3.2. Codes Used to Report Medicare Home Health Services

Discipline	Revenue Center Code	HCPCS Code
Physical therapy	042x	**G0151** Services performed by qualified physical therapist in home health or hospice setting, each 15 minutes. **G0157** Services performed by qualified physical therapist assistant in home health or hospice setting, each 15 minutes. **G0159** Services performed by qualified physical therapist, in home health setting, in establishment or delivery of a safe and effective physical therapy maintenance program, each 15 minutes.
Occupational therapy	043X	**G0152** Services performed by qualified occupational therapist in home health or hospice setting, each 15 minutes. **G0158** Services performed by qualified occupational therapist assistant in home health or hospice setting, each 15 minutes. **G0160** Services performed by qualified occupational therapist, in home health setting, in establishment or delivery of a safe and effective occupational therapy maintenance program, each 15 minutes.
Speech-language pathology	044X	**G0153** Services performed by qualified speech-language pathologist in home health or hospice setting, each 15 minutes. **G0161** Services performed by qualified speech-language pathologist, in home health setting, in establishment or delivery of a safe and effective speech-language pathology maintenance program, each 15 minutes.
Skilled nursing	055X	**G0154** Direct skilled services of licensed nurse (LPN or RN) in home health or hospice setting, each 15 minutes. **G0162** Skilled services by licensed nurse (RN only) for management and evaluation of plan of care, each 15 minutes (the patient's underlying condition or complication requires an RN to ensure that essential nonskilled care achieves its purpose in the home health or hospice setting). **G0163** Skilled services of licensed nurse (LPN or RN) for observation and assessment of patient's condition, each 15 minutes (the change in the patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment in the home health or hospice setting). **G0164** Skilled services of licensed nurse (LPN or RN), in training and/or education of patient or family member, in the home health or hospice setting, each 15 minutes.
Medical social services	056X	**G0155** Services of clinical social worker under home health plan of care, each 15 minutes.
Home health aide	057X	**G0156** Services of home health aide under home health plan of care, each 15 minutes.

Chapter Four. In-Home Supportive Services

Overview of the IHSS program

SB 863 requires that DWC base the OMFS for home care services not otherwise covered by Medicare or other OMFS fee schedules on the regulations adopted for the IHSS program administered by California Department of Social Services. Given this mandate, a thorough understanding of the IHSS program is a necessary prerequisite to any analysis of fee schedule issues.

The IHSS program provides the supportive services necessary to enable elderly and disabled individuals to remain safely within their homes.[1] To be eligible for services, individuals must qualify for Medi-Cal (California's Medicaid program) on the basis of being aged, blind, or disabled, unable to live in their own homes safely without care, and meeting certain financial requirements. Funding is primarily provided by Medi-Cal through a combination of federal, state, and local funding. California's program is administered at the county level by the county welfare (or social services) department. Each county is required to evaluate potential recipients, determine their eligibility and need, and process requests for service.[2] All but two counties have created a public authority (a corporation empowered to contract for home care services and provide payment to providers) to assist with the administration of IHSS.[3] IHSS services that can be provided to a single individual are limited to 195 hours per month for non–severely impaired cases or 283 hours per month for severely impaired cases.[4]

Who Is Eligible For Services?

The IHSS program assists aged, blind, and disabled individuals who would be unable to continue living in their homes without this support. Individuals qualifying for the services must be eligible for Medicaid. To determine whether an individual is eligible to receive IHSS, county staff rank the individual's functioning across 11 different physical functions and three different mental functions required for independent living, including the ability to do housework, prepare meals, bathe and dress him- or herself, remember things, and use judgment.[5] The ranking process

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[1] State of California, Welfare and Institutions Code, Sections 12300–12330, 2013.

[2] California Department of Social Services, *Social Services Standards*, Chapter 30-700, Service Program No. 7: In-Home Supportive Services. October 12, 2006, 30-760.2.

[3] California Department of Social Services, 2006, 30-701(7).

[4] California Department of Social Services, 2006, 30-757.1(a)(4).

[5] A complete list of activities can be found in California Department of Social Services, 2006. at 30-756.2.

is based on the individual's functional abilities, including the ability to care for him- or herself and complete normal household chores, not the medical diagnosis.[6] This assessment is conducted within the individual's current environment and takes into consideration the assistive tools and devices available to the patient.[7] Mental function is evaluated on a three-point scale based on the degree to which the individual's mental functioning impairs physical functions, considering the need for human intervention to allow for functioning.[8]

After the individual has been evaluated and ranked, the rankings are used to determine the amount of time per month that the individual should receive assistance under IHSS to perform various tasks related to independent living. To determine the amount of time per task that should be covered, the counties take into account the recipient's functional index ranking as a contributing factor, although not as the sole factor.[9] Unless an exception is necessary, this determination is based in part on a standardized set of time guidelines.[10] However, other factors may be considered, including the recipient's living arrangements and the variation in the recipient's functioning on a daily basis.[11] These other factors may be used to revise the allowable amount of assistance either up or down.

The amount of IHSS services that can be provided to a single individual is limited. Reflecting California state budget issues, there is an absolute maximum of 195 hours per month for non–severely impaired cases, or 283 hours per month for severely impaired cases.[12] Additionally, some services have a specific time guideline, which must be followed unless the recipient has unusual needs that necessitate an exception.[13] The county IHSS worker fills out a form that includes the unmet need for IHSS, which is the amount of care needed by the individual over the maximum number of allowable hours.[14] There may be additional social services available to help fill that unmet need, such as personal care services covered under a Medicaid home and community-based waiver (see Chapter 5).[15]

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[6] California Department of Social Services, 2006, 30-756.3.

[7] California Department of Social Services, 2006, 30-756.33.

[8] California Department of Social Services, 2006, 30-756.37.

[9] California Department of Social Services, 2006, 30-757.1(a)(1).

[10] California Department of Social Services, 2006, 30-757.1(a).

[11] California Department of Social Services, 2006, 30-757.1(a)(1).

[12] California Department of Social Services, 2006, 30-757.1(a)(4).

[13] California Department of Social Services, 2006, 30-757.1(a).

[14] Disability Rights California, *In Home Supportive Services: Nuts and Bolts*, May 2008.

[15] Disability Rights California, 2008, p. 19.

What Services May Be Provided?

Under the California Welfare and Institutions Code, the supportive services provided through IHSS include: (1) chore and cleaning services, (2) personal care services, (3) accompaniment for necessary travel, (4) paramedical services (5) protective supervision, and (6) teaching and demonstration services.[16] These services include a range of activities across a variety of different categories. Table 4.1 contains a list of specific tasks included and not included within each category.

Table 4.1. Tasks Covered and Not Covered by IHSS

Category	Tasks Covered	Tasks Not Covered
Chore and cleaning services	Miscellaneous chore services Light and heavy cleaning Light yard work, including removal of snow and grass	
Personal care services	Assistance with feeding, bathing, dressing, ambulation, and bowel and bladder care	Insertion of enemas and catheters, which are considered part of paramedical services
Accompaniment for necessary travel	Travel to doctor's appointments and other health appointments	
Paramedical services	Administration of medications, injections, and services that require the judgment of a health care professional	
Protective supervision	Behavioral observation for mentally ill or mentally impaired persons who cannot redirect their own activities	Monitoring of suicidal or self-destructive person or medical conditions that require medical supervision; monitoring in anticipation of a medical emergency
Teaching and demonstration services	Instruction to enable recipients to fulfill the tasks currently provided by IHSS	Teaching services that are not cost effective: i.e., where the cost to train would not be offset by a reduction in the need for services

Chore and personal care services form the core of the assistance provided by IHSS. Chore services include general light housekeeping duties, such as sweeping, washing counters, changing sheets, and taking out the garbage.[17] IHSS also covers more thorough cleaning services[18] and light yard work, such as the removal of snow or excessive grass.[19] Personal care services are nonmedical assistance with the basic bodily necessities of everyday life, including

[16] California Welfare and Institutions Code, 2013, §12300(b).

[17] California Department of Social Services, 2006.

[18] California Department of Social Services, 2006, 30-757.12.

[19] California Department of Social Services, 2006, 30-757.16.

assistance with bathing, feeding, dressing, ambulation, and bowel and bladder care.[20] IHSS also provides assistance with travel under certain circumstances, including travel to doctor's appointments, and fitting of health-related appliances.[21]

Certain paramedical services, defined as activities required for health maintenance that would normally be provided by the recipient, may be covered. These are activities persons would ordinarily perform for themselves but cannot because of functional limitations. Covered paramedical services include the administration of medication, injections, and insertable medical devices, sterile procedures, and "other activities requiring judgment based on training given by a licensed health care professional."[22] To be covered, there must be a written order by a licensed health professional that includes the patient's informed consent to have the services provided by an IHSS caregiver trained to provide the service rather than a skilled professional, and the caregiver must provide the paramedical services under the direction of a licensed health professional.

Supportive services may also include protective supervision: the monitoring of the recipient's behavior in order to protect him or her against harm.[23] To obtain protective supervision, the recipient must demonstrate he or she is: (1) mentally ill or mentally impaired, (2) confused or otherwise incapable of self-directing behavior to ensure personal safety, and (3) in need of 24-hour daily supervision in order to remain within his or her home.[24] Deliberately aggressive, self-destructive, or suicidal persons may not receive protective supervision.[25] Protective supervision is not available to assist in social activities, or when the recipient needs to be monitored for medical reasons.[26] A recipient who is eligible for protective supervision receives the highest allocation of IHSS services: 195 hours for non–severely impaired persons or 283 hours for severely impaired persons.[27]

Supportive services also include services intended to enable the recipient to provide services for him- or herself. Coverage is provided for teaching and demonstration services, where the recipient is instructed on how to perform personally services currently provided under IHSS.[28] However, this coverage must be cost effective: it is available only when it is expected that the

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[20] California Department of Social Services, 2006, 30-757.14.

[21] California Department of Social Services, 2006. 30-757.15.

[22] California Department of Social Services, 2006, 30-757.19.

[23] California Department of Social Services, 2006, 30-757.17.

[24] California Department of Social Services, 2006, 30-757.171-173; Disability Rights California, *In Home Supportive Services Protective Supervision*, December 2010, p. 2.

[25] California Department of Social Services, 2006, 30-757.171–172.

[26] California Department of Social Services, 2006, at 30-757.172.

[27] Disability Rights California, 2010, p. 1.

[28] California Department of Social Services, 2006, 30-757.18.

instruction will result in a lessened need for IHSS services commensurate with the cost of the instructive services.[29]

Who May Provide Services?

Three types of providers can provide the supportive services covered by the IHSS program: contractors or agencies that arrange for IHSS services, homemaker employees of the county, and independent providers hired by the IHSS recipient. Counties can elect to provide IHSS though any or all of these methods and may choose to select the methods that best suit the demographic makeup of their county.[30] However, recipients cannot be compelled to accept services from any individual provider, unless the recipient's guardian or conservator has chosen that provider.[31]

Contractor Agencies

Under the IHSS rules, a county may contract with an agency to provide supportive services to recipients. This contract must specify that the contractor will maintain a roster of recipients within the state, the hours authorized for each recipient, the actual hours provided, and the amount the contractor is paid for providing these hours.[32] If a county has contracted with an agency to provide supportive services, the caregiver is sent directly from the agency to the recipient's home.[33] Under this scheme, contractors are paid directly by the county for the provision of services to individual recipients.

Homemaker Employees

The county may choose to employ service providers directly, provided that it verifies that the caregiver is both competent to provide services and does in fact provide the authorized services.[34] The county trains and supervises the homemaker employees,[35] and homemaker employees are hired under the county civil service system and paid directly by the county. The county may consider homemaker employees as temporary employees if it is acceptable under its civil service system.[36]

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[29] California Department of Social Services, 2006, 30-757.184.

[30] California Department of Social Services, 2006, 30-767.

[31] California Department of Social Services, 2006, 30-767.3.

[32] California Department of Social Services, 2006, 30-767.12.

[33] California Advocates for Nursing Home Reform, *IHSS—In Home Support Services*, website, September 2014.

[34] California Department of Social Services, 2006, 30-767.11.112.

[35] California Advocates for Nursing Home Reform, 2014.

[36] California Department of Social Services, 2006, 30-767.111.

Independent Providers

Finally, most IHSS services are provided by independent providers. In the independent provider mode, the recipient directly hires and supervises the caregiver.[37] Often, family members of the recipient are employed to supply care as independent providers.[38] California law explicitly allows certain categories of IHSS services to be provided by a spouse of the recipient, including personal care services and paramedical services.[39] A spouse may also be paid for transportation or protective supervision if these activities have required him or her to forgo full-time employment because another suitable caregiver cannot be found.[40]

However, the services that may be provided under IHSS are limited when the recipient lives with a spouse assumed to be capable of regular household activities. Absent medical reasons he or she cannot do so, it is assumed that a spouse not receiving IHSS services is capable of regular household activities[41] Under those circumstances, neither the spouse nor any other IHSS provider will receive payment for chore and related services, yard work, teaching and demonstration, and heavy cleaning.[42] Payment for meal preparation, transportation, and protective services is available only if these services are needed in the spouse's absence.[43] These limitations are in place whether or not the spouse provides paid IHSS services. Furthermore, when a recipient is residing with a member of his or her family in order to receive care, chore services will be provided only for living areas used only by the recipient, and yard services will not be provided.[44] The number of IHSS hours allocated to the recipient and the county's base payment rate determine payment to independent providers.[45] The same hourly rate is paid regardless of the training and skills of the individual and the types of services provided. The base payment rate varies from county to county but is generally close to the California minimum wage. However, some Bay Area counties have both set a higher base payment rate and provided medical and dental insurance.[46] Results from a California Association of Physician Assistants (CAPA) survey to determine hourly wage rates are in Appendix A. All but two counties have

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[37] California Advocates for Nursing Home Reform, 2014.

[38] California Advocates for Nursing Home Reform, 2014.

[39] California Department of Social Services, 2006, 30-763.415.

[40] California Department of Social Services, 2006, 30-763.416.

[41] California Department of Social Services, 2006, 30-763.412.

[42] California Department of Social Services, 2006, 30-763.413. Teaching and demonstration services are provided by IHSS providers to enable recipients to perform for themselves services that they currently receive from IHSS.

[43] California Department of Social Services, 2006, 30-763.414.

[44] California Department of Social Services, 2006*,* 30-763.414.

[45] California Department of Social Services, 2006*,* 30-764.1.

[46] California Advocates for Nursing Home Reform, 2014.

established Public Authorities, which act as an intermediary between the recipient and the provider for purposes of payment.[47]

What Safeguards Are In Place Against Fraud and Abuse?

Safeguards against fraud and abuse begin during the evaluation process, which is intended to allow an impartial county official to evaluate the need for care.[48] This assessment process is repeated yearly, and the number of hours of services a recipient may receive may change as a result of this reassessment.[49] Counties take other proactive steps to prevent fraud, including checking Medi-Cal records to determine whether IHSS providers received payment for days the recipient was in institutional care, such as a hospital or nursing home.[50] Effective September 2013, a standard timesheet has been required of all independent caregivers, and the county pays them directly for their services.

Counties are also required to have a Quality Assurance Unit that reviews a sample of supportive services cases to guarantee that they meet the appropriate standards for the IHSS program.[51] This process begins with a desk review and, for a subsample of reviewed cases, will also include a home visit to determine whether IHSS services are needed and whether the services currently provided are appropriate.[52] As part of this process, the county is required to look into possible incidents of fraud and, when necessary, pursue repayment of overpayments.[53] Consequently, the quality assurance process serves a secondary function of combating fraud and abuse within the context of improving health care services.

Summary and Discussion

The IHSS presents one model for addressing the issues raised with regard to unskilled personal care and chore services. IHSS services are based on a standardized assessment of the individual's needs and may be provided by a recipient's family member. Furthermore, a wide variety of home care services may be provided, including protective supervision and paramedical service as well as personal care and chore services.

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[47] California Advocates for Nursing Home Reform, 2014, p. 4.

[48] California Department of Social Services, 2006.

[49] California Welfare and Institutions Code, 2013, §12301.1(b).

[50] Disability Rights California, 2008, p. 74.

[51] California Department of Social Services, 2006, 30-702.12.

[52] California Department of Social Services, 2006, 30-702(b).

[53] California Department of Social Services, 2006, 30-702.14.

Although the IHSS program does provide a model for addressing paramedical and unskilled services, the model is limited in some respects and raises several issues to consider in establishing the OMFS fee schedule:

- There is variation across the counties in how the program is implemented, particularly with respect to eligible caregivers and the hourly rates. One issue is whether this variation should be built into the OMFS or whether uniform policies should apply across the state.
- Under the IHSS program, each county can choose different modes of service delivery. Under the WC program, the contract agency and independent provider models are feasible service delivery options. However, the rules would need to address whether one or both options should be available to an injured worker and how much choice the worker has regarding the individual providing IHSS-like services.
- County social services departments are responsible for doing the needs assessment for each client at the time of application and yearly thereafter. The WC rules would need to address who is responsible for the needs assessment and how frequently it should occur. Where family caregivers are involved, the assessment would need to consider whether they are able to provide the necessary care, and the types of care that should be covered.
- The IHSS program is a public benefits program that provides resources to individuals who otherwise would be unable to obtain those services. Limits on the benefits that one person can receive may be needed in order to ensure that there are some benefits available to all appropriate recipients within available funding. However, these limits counter the requirement that WC pay for all medical care reasonably required to cure or relieve the effects of a worker's injury or illness. While most services under IHSS are nonmedical, they are required by the injured worker’s medical condition and enable him or her to remain at home safely.

Chapter Five. Other Home Health Services Under California's Medicaid Program (Medi-Cal)

In this chapter, we discuss the policies and payment rates for the other Medi-Cal–covered home health care services. Medi-Cal, the name for the Medicaid program in California, is a health care program for low-income individuals. It is jointly funded by the federal government and the state and is administered by the state. The Department of Health Care Services administers the Medi-Cal program other than the IHSS program discussed in Chapter Four. The other home health services covered by the Medicaid program have a medical component. We include these services in our assessment of potential OMFS fee schedule options because Medicaid covers a broader range of home health care services than the Medicare program, notably long-term care services for individuals with chronic illnesses or disabilities, such as skilled nursing services. It also provides home and community-based services to eligible individuals who would otherwise need to be institutionalized in a medical facility. This is in contrast to the IHSS program, which pays for home care services that are not necessarily medical in nature and covers individuals who may or may not be at risk of institutionalization.

Home Health Agency Services

Who May Receive Services?[1]

Home health agency services are covered for Medi-Cal beneficiaries in two situations: (1) during the convalescent phase following discharge from a hospital or other institution, and (2) when a homebound patient can be maintained at home in lieu of institutional placement with skilled nursing or other care. If the cost of continuing home health agency care exceeds the monthly cost of institutional care, consideration is given to requiring institutionalization unless there are overriding social considerations against such placement.

Unlike Medicare, Medi-Cal does not stipulate that the patient require skilled care as a prerequisite for receiving other therapeutic home health services. Rehabilitation services are terminated when the patient's condition has plateaued and no significant functional benefit is likely to occur with continued therapy. The patient or family is expected to provide services requiring minimal professional skill, e.g., passive range of motion, assistance with ambulation, and routine activities of daily living.

[1] California Department of Health Care Services, *Manual of Criteria*, "Chapter 9.1, Criteria for Home Health Agency Services," 2014.

What Services Are Covered?

Medicaid-covered home health benefits are similar in design to Medicare-covered benefits. They include part-time or intermittent skilled nursing services, therapy services, medical social services, and home health aide services. The services must be provided in accordance with a written treatment plan approved and signed by a physician. For each discipline, the plan must identify the types of services that will be provided, the therapeutic goals, and the time frame for achieving them. A description of the home situation and whether assistance is available from household members, homemakers, attendants, or others is also required. Special rules apply to coverage of home health psychiatric nursing.

Personal care and household services may be covered if the services are part of a physician-approved treatment plan and supervised by a registered nurse or therapist. Household services such as changing the bed and light cleaning to facilitate the patient's self-care may also be included in the visit if they are incidental to medically necessary services and do not substantially increase the service time of the home health aide. However, home health aide services are not covered if they more appropriately qualify as personal care or chore services under IHSS.

Physician services, nutritionist services, podiatrist services, drugs, and biologicals are not covered home health agency services.

Medi-Cal Fee Schedule for Home Health Agency Services

Medi-Cal uses California-specific alphanumeric codes for home health agency billing and reimbursement (Table 5.1) on a per visit basis. For home health services, each "per visit" allowance represents a minimum of two hours of service. According to the Department of Health Care Services, the Medi-Cal rates are established in part by reference to the Medicare rates, which include medical supplies used during the visit—for example, bandages used in changing a dressing. The only supplies that are separately reimbursable are supplies left with the patient (which require prior authorization).

Table 5.1. Medi-Cal Rates as of January 15, 2014, for Home Health Agency Services

Code	Description	Rate ($)
Z6900	Skilled nursing services	74.86
Z6902	Home health aide services	45.75
Z6904	Physical therapy services	68.84
Z6906	Occupational therapy services	71.36
Z6908	Speech therapy services	78.43
Z6910	Medical social services	96.22
Z6914	Initial or six-month case evaluation and treatment plan	30.13
Z6916	Monthly case evaluation	15.19
Z6918	Unlisted services	By report
Z6920	Home health agency early discharge follow-up visit	74.86

Home and Community-Based Services (HCBS)

For frail elderly and the disabled, Medi-Cal has waiver programs to provide cost-effective alternatives to institutionalized care by ensuring that a beneficiary's medical needs can be met appropriately and safely in a home environment. The waiver allows the state to cover under its Medicaid program long-term nursing care and support services not ordinarily covered in the home setting. To qualify for federal matching funds the care must be less costly than the institutional alternative.

Who is Eligible for Services?

HCBS are designed to provide in-home care to Medicaid beneficiaries who otherwise would require prolonged institutionalization in an acute care hospital or nursing facility (subacute, skilled, or intermediate care levels). HCBS authorization depends on the agreement of the recipient (or authorized representative), primary care physician, and the HCBS service provider in the decision to provide services in the home. Medi-Cal provides each party with a notice outlining their respective roles and responsibilities as well as the benefits and limitations of the services provided under the HCBS waiver. The criteria that must be met before an individual is enrolled in the waiver program are listed in Figure 5.1.

Figure 5.1. Requirements for Authorization of HCBS Waiver Services

Waiver enrollment and authorization of HCBS are approved only under the following conditions:

- The recipient's medical care needs meet the HCBS waiver's level of care.
- The total cost of providing waiver services and all other medically necessary Medi-Cal services is less than the total cost incurred by the Medi-Cal program for providing institutional care to the recipient.
- The requested waiver services are prescribed by the recipient's primary care physician based on medical necessity and in accordance with meeting the criteria for the identified institutional alternative.
- The recipient's home is medically appropriate as determined by DHCS.
- A responsible adult, trained and available to perform the tasks necessary to care for the recipient, should be prepared to ensure that care is not interrupted by an unforeseen event (for example, the inability of a home health agency to provide nursing services due to staff illness, temporary staff shortage, or natural disaster).
- The HCBS waiver provider is able and willing to commit to providing the number of nursing hours and waiver services requested.

SOURCE: Medi-Cal, *Outpatient Services for HHA and HCBS*, January 2012.

Who may Provide Services?

All individuals must be licensed and provide services within their scope of practice. The services may be provided by a home health agency. In addition, licensed professionals (registered nurses, vocational nurses, social workers, marriage and family therapists, and psychologists) who are not employees of a home health agency or otherwise affiliated with a health care organization may provide services as an HCBS provider. An individual HCBS provider may not be a parent, stepparent, foster parent, spouse, or legal guardian of the patient. Unlicensed individuals employed by a home health, employment, or personal care agency that meets the HCBS waiver provider requirements may provide personal care services.

What Services Are Covered?

Services include private duty nursing by a registered or licensed vocational nurse, case management, home health aide and waiver personal care services, minor home modifications and personal emergency response systems, utility coverage for life-sustaining equipment, and respite care. These services and IHSS services are not mutually exclusive as long as they are supplementary rather than overlapping. For example, an individual entitled under the HCBS program may receive needed personal care services that exceed the IHSS limits.

What payments are made for covered services?

Payment is set at an hourly rate for most services. Generally, the rates for home health agency–employed services are higher than for individual HCBS providers. Table 5.2 provides a summary of the key services and payment rates for services.[2]

Summary and Discussion

Taken together, the Medi-Cal home health services and HCBS waiver services provide a full range of home care services that are integrated with the IHSS program. The IHSS program provides personal care and chore services needed for individuals to remain safely in their homes. Other Medi-Cal services have a medical component, and when the medical services are needed, other supportive services may also be provided. Home health agency services are paid on a per visit basis, while HCBS waiver services are paid on time-based units with the rate determined by whether the services are provided by an organization or an individual HCBS provider. The time-based units are appropriate when the skilled nursing services are more prolonged than intermittent skilled nursing care. Personal care services are payable only when the aide is employed, but they may also be provided under the IHSS program by family caregivers.

Medi-Cal's payment policies for other home care services raise two issues that merit consideration by the DWC. The first is whether there should be any cost-effectiveness criteria in deciding on the appropriateness of paying for long-term home health care. Under the terms of the Medi-Cal waivers, the costs of providing HCBS cannot exceed the costs of providing care in the institutional setting based on the institutional level of care required to meet the patient's medical needs. Currently, there are no regulatory policies specific to when long-term care services in a home setting are appropriate for injured workers. This issue is typically addressed through the administrative dispute resolution process and at case settlement.

The second issue relates to the actual levels of payment and is pertinent only if DWC decides to adopt a Medicaid-based fee schedule. Medi-Cal rates are substantially less than the Medicare rates for comparable services. For example, the national average Medicare skilled nursing rate in 2014 is $121.10, compared to $74.86 for Medi-Cal skilled nursing visits. As discussed in Chapter Three, the Medicare rates are already below the estimated cost of providing home health services.

[2] The full set of rates is available at the Medi-Cal website.

Table 5.2. Medi-Cal Rates for HCBS Waiver Services

Procedure Code and Service Definition	HHA, Professional Corporation, or Nonprofit Agency ($)	Individual HCBS Provider ($)
G9012 Transitional Case Management (TCM), per hour. Coordinated care fee, risk-adjusted maintenance, other specified care management: services provided to transition an HCBS waiver–eligible individual from a hospital facility to a home and community-based setting. This includes the assessment of the individual's medical and nonmedical needs, supports in the home, and funding. TCM services may be provided up to 180 days before discharge from an institution. Providers may be reimbursed for a maximum of 24 hours per day (24 units).	45.43	35.77
S5111 Home care training, family, per session. Family training services provided for the families of individuals served under the IHO HCBS waivers. Training includes instruction about treatment regimens and use of equipment specified in the plan of care, and shall include updates as necessary to maintain the individual's safety at home. Session = one hour.	45.43	35.77
S5190 Wellness assessment, performed by nonphysician. Conduct a Preference Interview with potential demonstration participants.	100.00	100.00
S9122 Home health aide or certified nurse assistant, providing care in the home, per hour. Individual private duty services provided by a certified home health aide (CHHA) who is employed by a Home Health Agency and supervised by a registered nurse. Per hour.	18.90	Not applicable
S9123 Nursing care, in the home; by registered nurse, per hour (use of general nursing care only, not to be used when CPT-4 codes 99500–99602 can be used). Individual private duty nursing services provided by a registered nurse for individual and shared nursing care.	40.57	31.94
S9124 Nursing care, in the home; by licensed practical nurse, per hour. Individual private duty nursing services provided by a licensed vocational nurse (LVN) for individual and shared nursing care.	29.41	24.42
T1016 Case management, each 15 minutes. Consists of the development of a treatment plan, ongoing case management activities, and HCBS registered nurse supervisory activities of private duty services (individual or shared) provided by an HCBS LVN. 1 unit = 15 minutes.	11.36	9.94
T1019 Personal care services, per 15 minutes, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant). Supportive services to assist an individual to remain at home and includes assistance to independent activities of daily living and adult companionship. 1 unit = 15 minutes.	3.62	Not applicable

Procedure Code and Service Definition	HHA, Professional Corporation, or Nonprofit Agency ($)	Individual HCBS Provider ($)
T2017 Habilitation, residential, waiver; 15 minutes. Services to assist in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in a participant's natural environment. Providers may bill a maximum of 24 hours per day (96 units).	11.36	8.94

Chapter Six. Department of Veterans Affairs

The provision of home health care has become an integral part of the services provided by the Department of Veterans Affairs (VA) to enrolled veterans. The services provided are intended to meet both the short- and long-term needs of injured or ill veterans and may include skilled home health care, homemaker and/or home health aide services, and other services. Recently, the "Caregivers and Veterans Omnibus Health Services Act of 2010" made additional VA services available to seriously injured post-9/11 veterans and their family caregivers. Several aspects of the VA policies inform potential WC home health fee schedule policies, including the rates paid for intermittent home health services and the policies and rates for family caregivers.

This chapter discusses how the Veterans' Health Administration (VHA) determines who may receive home health care services, what services may be provided, who may provide these services, and how payments are determined for the services. As the VHA makes these determinations separately for skilled home health care and homemaker and/or home health aide services, this discussion will address each of these situations separately. It is followed by a discussion of the new Comprehensive Assistance for Family Caregivers program.

Skilled Home Health Care Services

Who May Receive Services?

The VHA determines if the veteran has a medical need for skilled home care.[1] A medical need is indicated if the veteran requires assessment, treatment, or monitoring from a skilled nurse; rehabilitation or occupational therapy; or assistance from a social worker.[2] Skilled nursing services may be received on either an intermittent, short-term, or long-term basis; both rehabilitation services and social work services can be received only on an intermittent, short-term, or transitional basis.[3] Coverage for these services is intended to supplement any other medical insurance the veteran might have and cannot be used to provide services that another entity is contractually required to provide.[4]

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[1] U.S. Department of Veterans Affairs, Veterans Health Administration, *VHA Handbook*, *1140.02, Respite Care*, Washington, D.C., 2008, 1140.7(a).

[2] U.S. Department of Veterans Affairs, 2008, 1140.7(a).

[3] U.S. Department of Veterans Affairs, 2008.

[4] U.S. Department of Veterans Affairs, 2008.

What Services May Be Provided?

The VA provides skilled home health care similar to care provided under Medicare. Skilled health care encompasses a variety of services provided by an individual with medical training. While the prototypical case might concern skilled nursing care, the term can also include other related medical disciplines, including physical, occupational, and speech therapy.[5] Social work and patient education also fall under the umbrella of skilled health care.[6] These services are available when a physician has prescribed them as medically necessary and appropriate.[7]

Who May Provide These Services?

A qualified nurse or other medical professional provides skilled health services within the veteran's home. The VHA contracts with a home health care agency to provide these services.[8] These home health care agencies must be either licensed by the state or certified by CMS to provide the appropriate level of services,[9] although individual VHA facilities can choose to waive this requirement.[10] "Whenever possible, patient preference in the selection of the home care agency is a priority consideration."[11]

Homemaker and/or Home Health Aide Services

Who May Receive Services?

To receive services, a veteran must either be enrolled in the VA health care system or fall within an exception to the enrollment requirement.[12] Assuming this requirement has been met, a veteran may receive homemaker and/or home health aide services if eligible to receive care in a nursing home environment and if it is cost effective to provide the home health care.[13] The homemaker and/or home health aide services are therefore intended to provide an alternate source of services for veterans who would otherwise require residential care. This cap is

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[5] U.S. Department of Veterans Affairs, 2008*,* 1140.6(5)(a).

[6] U.S. Department of Veterans Affairs, *Purchased Skilled Home Health Care Services*—FAQs, VA Palo Alto Health Care System, January 2014.

[7] U.S. Department of Veterans Affairs, January 2014.

[8] U.S. Department of Veterans Affairs, *Geriatrics and Extended Care: Skilled Home Health Care*, September 2014.

[9] U.S. Department of Veterans Affairs, 2008, 1140.9.

[10] U.S. Department of Veterans Affairs, 2008*,* at 1140.14.

[11] U.S. Department of Veterans Affairs, 2008*,* at 1140.9.

[12] See California Department of Social Services, 2006, 30-702.12, for a discussion of circumstances where a veteran may receive services without being enrolled in the VA health system.

[13] U.S. Department of Veterans Affairs, 2008.

somewhat analogous to the types of caps used under Medicaid's HCBS waiver programs for individuals who would otherwise be institutionalized.

Because limited resources are available to provide homemaker and/or home health aide services, the VHA must prioritize who may receive such services. Under federal law, it is required to give preference to those veterans who have three or more disabilities that prevent them from performing the activities of daily living, have substantial cognitive impairment, or require services to supplement hospice care.[14] Veterans may also receive priority if they have two disabilities that affect their ability to perform the activities of daily living and are elderly, have heavily used medical resources over the past year, have difficulty performing tasks necessary to maintain a healthy living environment, suffer from clinical depression, or reside alone. These guidelines may be waived if the veteran's medical providers determine he or she requires homemaker and/or home health aide services, provided that the medical providers document why these services are needed.

What Services May Be Provided?

The VA provides both personal care services and chore services similar in scope to those discussed for the IHSS and other Medi-Cal programs.

Who May Provide These Services?

The rules determining who may provide homemaker and/or home health aide services are substantively similar to the rules determining who may provide skilled health care services; that is, the homemaker and/or home health aide services must be provided by a home health agency under contract with the VA.[15] This agency must be either licensed under state law or certified by the CMS to provide the level of care. However, as it is plausible that an agency may be licensed to perform homemaker and/or home health aide services while not licensed to perform skilled health care services, agencies may be qualified to provide one type of home health care services while not qualified to provide the other.

Payment Rates for Home Health Agency Services[16]

Payment rates for VA-purchased home health care are negotiated at the local level but are subject to maximum levels by discipline based on the Medicare LUPA rates described in Chapter Three. The VA's use of these per visits rates is unrelated to how they are used in Medicare

[14] U.S. Department of Veterans Affairs, *Geriatrics and Extended Care: Skilled Home Health Care*, September 2014.

[15] U.S. Department of Veterans Affairs, September 2014.

[16] U.S. Department of Veterans Affairs, Veterans Health Administration, *VHA Handbook 1140.3, Home Health and Hospice Care Reimbursement Handbook*, Washington, D.C., August 2004.

(when fewer than five visits are provided in the episode). Multiple skilled visits provided by a single provider or discipline on a single day are paid at 80 percent of the per visit maximum after the first visit is paid at the full rate.

The limit applies to home health aide services as well as skilled visits. The VHA's use of the Medicare per visit rate for homemaker/home health services is based on two hours of care per visit. Moreover, if the state has a separate Medicaid rate for homemaker services, VHA's rate is capped at 110 percent of the established Medicaid rate for that home care agency or geographic area.

Additionally, the costs of all home-based services must not exceed 65 percent of the cost of providing these services at the nearest VA nursing home.[17] This policy suggests that the VA system makes some attempt to ensure that care is provided in a cost-effective way while still respecting the preferences of the veteran receiving services. However, exemptions to this policy may be made by either the individual VA facility or the VHA's office of Geriatrics and Extended Care pursuant to a recommendation of a VISN director.[18]

Services for Family Caregivers of Post-9/11 Veterans

Who May Receive Services?

Additional services are available to veterans who sustained a serious injury incurred or aggravated in the line of duty on or after September 11, 2001. The injuries include traumatic brain injury, psychological trauma, and other mental disorders. To receive the additional services, the veteran must need at least six months of personal care services because of an inability to perform one or more activities of daily living and/or need supervision or protection based on neurological impairment. Participation in the program must be in the best interest of the veteran, and the veteran must agree to receive ongoing Home Based Primary Care (HBPC) or similar VA services. HBPC is long-term comprehensive care provided to veterans with complex medical needs by a multidisciplinary team under the supervision of a VA physician.

Who May Provide These Services?

An eligible veteran may designate one primary family caregiver and up to two secondary family caregivers. The caregiver must be at least 18 years of age and must be either (1) an immediate or extended family member or (2) someone who lives with the veteran. The caregiver is provided with training and must be able to assist the veteran with personal care functions required in everyday living. Training can be completed in a classroom, online, or by self-study

[17] U.S. Department of Veterans Affairs, 2008, 1140.8(d); United States Code, Title 38, Part II, Chapter 17, Subchapter II, Section 1720C—Noninstitutional Alternatives to Nursing Home Care, 2011, paragraph (d).

[18] U.S. Department of Veterans Affairs, 2008, 1140.14.

using a workbook and DVD provided by the VA. After the training is completed, a member of the HCPC team visits the home to assure that the family caregivers and veteran have what they need to be safe and successful in the home setting.

What Services May Be Provided?

The personal care services provided by the family caregiver cannot be simultaneously provided through another individual or entity. The additional assistance is provided to the family caregiver and includes a monthly stipend, travel expenses to accompany veterans undergoing care, health insurance, mental health services, and counseling and respite care (not less than 30 days per year).

The monthly compensation is monetary compensation paid to the primary family caregiver. The VA maintains it is not intended to replace career earnings, nor does it create an employment relationship between the VA and the primary caregiver. The amount is based on the weekly number of hours of personal care services that a veteran requires during the month. The VA health care team provides a clinical evaluation of the veteran's level of dependency as follows:

High tier: maximum of 40 hours of care per week;

Medium tier: maximum of 25 hours of care per week;

Low tier: maximum of 10 hours of care per week.

The number of hours the veteran requires each week is multiplied by 4.35 to estimate the number of hours of care in a month. The hourly rate is based on the Bureau of Labor Statistics' hourly wage for a home health aide at the 75th percentile in the geographic region in which the veteran resides, updated for inflation using the consumer price index. As of May 20132012, the 75th percentile for California home health aide hourly earnings was $13.98.[19]

Summary and Discussion

While the policy choices available to the VA might be somewhat different from the policy choices available to DWC, the VHA policies for home care services nevertheless have features that might be adaptable to WC. First, consistent with the Labor Code requirement pertaining to the use of relevant Medicare-based fee schedules, the VHA's rates for home health agency services are capped at the Medicare LUPA rates discussed in Chapter Three. The VHA addresses Medicare's limited homemaker/home health aide coverage by counting each two hours of aide services as a visit and by capping the maximum fee for homemaker services at 110 percent of any applicable Medicaid rate for homemaker services. Second, VHA policies cap total payments for home care services at 65 percent of the cost of nursing home care. Further, the VHA's services for family caregivers of post-9/11 veterans have features that DWC might consider. For

[19] U.S. Department of Labor, Bureau of Labor Statistics, Occupational Employment Statistics, *Occupational Employment and Wages*, website, May 2013.

example, assistance is limited to seriously injured veterans who will require at least six months of personal care services. The family caregivers must demonstrate an ability to provide the personal care needed by the veteran. It must be in the veteran's best interests to receive care in the home, and a VHA home care team oversees the veteran's health care. The monthly stipend is pegged to the number of hours of personal care the veteran needs and the 75th percentile of average hourly home health aide earnings.

Chapter Seven. Review of Policies from Other WC Programs

Methodology

Review of Policies from Other Jurisdictions

To identify policy alternatives from other jurisdictions, we searched state statutes and administrative codes using LEXIS to identify jurisdictions that have policies in this area. We found that while some states have statutes and regulations that specifically address the issue of WC and home care services, others have created policy only through judicial interpretation of WC statutes that did not explicitly address home care services. Table 6.1 contains a listing of states that we identified as having policies pertaining to home health care services. In addition, we reviewed the policies of the federal Office of Workers' Compensation Program (OWCP).

Table 6.1. States with Policies Related to Home Care Services Under Workers' Compensation

States with Legislatively Created Policies	States with Judicially Created Policies
Florida	Arizona
Hawaii	Arkansas
Massachusetts	Colorado
Michigan	Connecticut
Montana	Iowa
North Carolina	Nebraska
Ohio	New Mexico
Pennsylvania	New York
Rhode Island	Pennsylvania
Tennessee	Vermont
Texas	Virginia
Washington	

We focused our review on WC programs in states that have established home health policies through legislatively created policies. We searched for appropriate documentation from each state. We began our search with the state's statutes and regulatory codes and then expanded it to include other sources of information from the state agencies involved in implementing WC policies. While we were particularly interested in finding WC medical fee schedules or related rules from each state, we also paid attention to other types of documentation provided to injured workers and providers within each state, including publications describing the state's policies and responses to "frequently asked questions." The goal of this research was to be able to characterize how each state had or had not enacted policies that addressed the concerns of DWC and the California stakeholders. We conducted a similar review for the OWCP.

Interviews with Administrators from Other Jurisdictions

After we had identified states with policies on WC home care services that might inform the DWC during the upcoming rulemaking process, we contacted administrators from each state that had legislatively created policies. We began by contacting a high-ranking leader within each agency by email, either directly where the appropriate contact information was available or indirectly though the general email directory where it was not. We asked to be directed to the most appropriate person to interview regarding the implementation of home care policies within the state.

Once we had identified the appropriate contacts within each agency, we interviewed them about the state's experiences in implementing policies related to WC and home care services. We utilized a standard interview protocol but allowed for flexibility where the subject identified additional issues or concerns. Specifically, we asked questions regarding composition of the fee schedule, limitations on coverage, provision of services by a family member, and the volume and costs of services. Table 6.2 describes the interview protocol used to elicit this information.

Table 6.2. Description of Interview Protocol

Policy Area	Questions
Fee schedule and related rules	• How does your state determine who is eligible to receive home health care services? • How is the fee schedule calculated?
Limitations on coverage	• Are there any other conditions that must be met before receiving home health care services? • Is there a cap on reimbursement?
Provision of services by family members	• Does your state allow for reimbursement of home health care services provided by a spouse or family member? – If so, are there any conditions that must be met? – What services can the spouse or family member provide? – Are there any additional limitations? – How is payment to the spouse or family member calculated? – What has been your experience in implementing these rules? Have you experienced any major problems, or had any significant push-back from key stakeholders? – Have there been systematic problems with fraud or abuse of this program? – What, if any, safeguards do you have in place against fraud and abuse? – What sort of notice must be given the employer?
Cost and volume of services	• What is the volume and cost of these services?

Analysis of Data

After we completed our environmental scan of WC home health policies in other jurisdictions, we organized the information into a matrix, with the key issues identified by both the DWC and the key California stakeholder groups across the horizontal axis and the alternative policies identified through the research of other jurisdictions down the vertical axis. This matrix enables analysis of various policy options both within and across jurisdictions and makes it

possible to understand how different state policies addressed different issues that are currently facing DWC. These matrices are available in Appendix C (Overview of Policies on Attendant Care Services) and Appendix D (Overview of Policies on Family Caregivers).

Results of Review of Other WC Program Policies

Our policy review was designed to elicit information regarding the home care policies utilized by WC programs in other states. This review focused on three main components of state policies: fee schedules, rules related to the implementation of fee schedules, and fraud prevention. In addition, the policies implemented in states that had judicially adopted rules related to home care services were briefly considered. The results of this review are presented below.

Calculation of Fee Schedules

WC fee schedules for home health care skilled services, home health aide services, and attendant care services vary from state-to-state. However, it is possible to group state fee schedules based on the general approach they have taken.

Some states have adopted a variable flat rate for home care services provided to WC recipients within the state, generally based on who is providing the service and what service they are providing. Although these states may look to other jurisdictions or other fee schedules for guidance, they ultimately calculate their fee schedule independently. For example, Ohio has set its fee for services provided by a home health agency at $18.75 per 15 minutes for services provided by a registered nurse, $15.00 per 15 minutes for those provided by an LPN, and $28.20 per hour for those provided by a nurse's aide.[1]

Other states have adopted fee schedules for home care services based on existing fee schedules, either from other agencies within that state or from other jurisdictions. Because of the similarities between services provided under WC programs and services provided by social service agencies, these states have been particularly interested in adopting fee schedules from public assistance programs. For example, in Massachusetts the payment rates of home health services provided to WC recipients are the same as the rates for services provided to recipients of public aid (Medicaid).[2] However, even though a state's WC authority bases its rate on the rates promulgated by a different agency, it may choose to set its own rate proportionally higher or

[1] Ohio Bureau of Workers' Compensation, *Fee Schedule Look-Up*, website, undated.

[2] Code of Massachusetts Regulations, 114.3 CMR, Section 50.01(1), Home Health Services. General Provisions, December 2008.

lower. For example, Texas has its rate for services provided through a licensed home health agency at 125 percent of the Texas Medicaid fee schedule.[3]

A few states have taken other approaches. For example, Pennsylvania bases its payments to home health care providers on its rates in effect in 1994 adjusted annually (increases or decreases) for the percent change in Pennsylvania's average weekly wage.[4]

Rules Related to Home Care of Injured Workers

The home care services covered by WC programs vary from state to state. Table 6.3 demonstrates the scope of this variation by summarizing which types of services are covered by a sample of WC programs in other states and the OWCP program.

Table 6.3. Types of Home Care Services Covered by Selected Workers' Compensation Programs

Jurisdiction	Medical Care Services	Personal Care Services	Chore Services
Massachusetts	Covers medical care services, including skilled nursing, physical therapy, and occupational therapy	Covers personal care services, including assistance with medication and self-help skills	Covers chore services, including assistance with the activities of daily life
Michigan	Covers medical care services	Covers personal care services, such as assistance with bathing and feeding	Does not cover chore services, such as routine household tasks
Ohio	Covers skilled nursing services provided by a registered nurse or licensed practical nurse	Covers home health aide services, including assistance with feeding, bathing, and hygiene	Does not cover chore services, including laundry, cooking, and cleaning
Washington	Covers medical care services	Covers attendant care services, including assistance with ambulation, bathing, and supervision of mentally impaired persons	Does not cover chore services, including assistance with laundry and child care
Federal OWCP	Covers services provided by a home health agency, licensed RN or LPN	Covers up to $1,500 in attendant care services provided by a home health aide, LPN, or similarly trained individual	Expressly not covered only if attendant care services are provided by a trained family member

In addition to restricting the types of services covered under workers' compensation, some jurisdictions have placed restrictions on either the amount of home care services the worker can receive or the amount of money that may be spent upon these series. Several states have implemented these restrictions by narrowing the type of service that may be provided: for

[3] State of Texas Administrative Code, Title 28, Part 2, Chapter 134, Subchapter C, Rule 134.204: Medical Fee Guideline for Workers' Compensation Specific Services, Section (f), 2008.

[4] Commonwealth of Pennsylvania, 34 Pennsylvania Code, Chapter 127, Section 127.157: Medical Fee Updates on and After January 1, 1995—Home Health Care Providers, 1994.

example, by covering only "intermittent nursing services" rather than just "nursing services." This is the approach taken by Medicare (see Chapter Three for Medicare's definition of intermittent or part-time skilled nursing care). Similarly, Ohio covers only part-time or intermittent care, defined as situations where "services are generally rendered for no more than eight hours per day."[5] Other states limit the amount that can be spent on home care services. For example, Hawaii mandates that individuals cannot receive more than four times the maximum weekly benefit rate per month for home health care services.[6]

States that allow for coverage of home health care services generally require that the worker receive some sort of prior authorization before the commencement of services. For example, many states require that the worker obtain written permission from a doctor before receiving covered home health care services. The doctor must certify that these services are "medically necessary,"[7] generally in writing. Some states additionally require the approval of the appropriate state authority overseeing WC programs.[8]

Provision of Services by Family Members

One major issue identified by stakeholders within the California WC system is coverage of services provided by the injured worker's family. Payer concerns included whether family members were appropriate caregivers, how payment for these services should be calculated, and whether there should be limitations on the types of services family members can provide, while representatives of injured workers were concerned that the injured worker retain control over the choice of caregivers and that family members receive appropriate compensation for the care they provide. A summary of other WC program policies on these issues follows.

Coverage of Services Provided by Family Members

States vary on whether home care services, particularly attendant care services, may be provided by family members. Table 6.4 describes which jurisdictions have allowed, disallowed, or not addressed provision of home care services by family members.

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[5] State of Ohio, Administrative Code—Workers' Compensation Rules, Chapter 6, Section 4123-6-38: Payment for Home Health Nursing Services, Part (D), July 2013.

[6] State of Hawaii, 2012 Revised Statutes, Title 21, Section 386-23, Services of Attendant, 2012.

[7] See, e.g., Michigan Department of Licensing and Regulatory Affairs, Workers' Compensation Agency, Michigan Administrative Code, R 418.10909, "Billing for Home Health Services," 2008.

[8] State of Hawaii, 2012.

Table 6.4. Coverage of Home Care Services Provided by Family Members

Services Provided by Family Members Covered	Services Provided by Family Members Not Covered	Coverage of Family-Provided Care Services Not Specified
Florida	Massachusetts	Hawaii
Michigan	Ohio	Montana
North Carolina	Washington	Pennsylvania
	Texas	Tennessee

Some jurisdictions do not explicitly prevent family members from providing home care services but instead place requirements on who may provide services that essentially exclude virtually all family members. For example, the OWCP policy allows family members to provide attendant services only when they meet the training requirements established for attendant services, which requires them to be certified home health aides or certified nursing assistants. While it is possible that an injured worker's spouse or close family member might have the certifications and institutional affiliations necessary to be qualified to provide home care services, it is unlikely that this occurs frequently, so that the requirement acts as a barrier to coverage of home care services provided by spouses.

Calculation of Payment for Services Provided by Family Members

The states that allow coverage of home care services provided by family members vary in the calculation of payment for these services. Some states, possibly considering the broad range of services that family members may provide, determine payment on the basis of the individual claim. For example, in North Carolina the fee is established by the Industrial Commission on a case-by-case basis depending on the services rendered.[9] At the other extreme, some states set a flat rate for reimbursement of spousal care providers. For example, Washington has assigned a flat rate of $12.88/hour on the services of spouse attendants authorized to provide services.[10]

In contrast, Florida has taken a novel approach to this issue. Florida calculates payment for nonprofessional attendant care by family members based on the employment status of the family member. Therefore, a family member who is not employed, or is employed and providing care during off hours, receives the federal minimum wage on an hourly basis. A family member who forgoes employment in order to provide care is paid the lesser of the hourly rate at his or her prior employment or the hourly rate generally paid for such care in the worker's community. Similarly, if the family member maintains employment while providing care, he or she receives

[9] North Carolina Industrial Commission, *Medical Fee Schedule*, 2013.

[10] Washington State Department of Labor and Industries, Workers' Compensation Services, "Payment Policies for Healthcare Services Provided to Injured Workers and Crime Victims," *Medical Aid Rules and Fee Schedules (MARFS)*, July 2013.

the lesser of the hourly rate received through the family member's employment and the hourly rate generally paid for such care in the worker's community.[11]

Florida's approach to calculating payment for home care services provided by family members is particularly interesting because it attempts to balance the worker's interest in being cared for by a family member, should he or she prefer that arrangement, the caregiver's interest in being highly paid for his or her services, and the insurer's interest in controlling costs. By paying a family caregiver based on employment status, this approach can ensure that caregivers who must forgo employment in order to care for a family member are paid commensurately with what they would have received in the job market. By capping the costs according to value of the care provided in the community, this approach can control the costs to the insurer. However, this policy may be difficult to implement and prone to abuse, as it requires additional information about the family member's work history.

Limitations on Services Provided by Family Members

Some states that allow for provision of home care services by family members have placed limitations on either the amount of care or the type of care that these family members can provide. For example, Florida restricts the type of care that family members can provide: They must provide "nonprofessional attendant care" that does not include the type of household tasks normally provided by members of a family.[12] Michigan restricts how much home care service family members provide, mandating that an employee's spouse or family cannot provide more than 56 hours per week of care.[13] The OWCP limits personal care services provided by a trained family member to 12 hours per day but does not cover chore services provided by the family member.

Additionally, some states require that the worker provide notice before the commencement of home health care services provided by family members. For example, Florida does not hold the employer or carrier liable for reimbursement of home care services provided by family members until the employer and insurance carrier receive the doctor's order for these services, which must establish the duration and type of care to be provided.[14] Because this order cannot be applied retroactively, the insurer is guaranteed notice before the commencement of services.

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[11] State of Florida, 2011 Florida Statutes, Title XXXI, Chapter 440, Section 13, paragraph (2)(b).

[12] State of Florida, 2011 Florida Statutes, Title XXXI, Chapter 440, Section 13 paragraph (1)(b), Medical Services and Supplies; Penalty for Violations; Limitations, 2011.

[13] Michigan Compiled Laws, Public Act 317, Worker's Disability Compensation Act of 1969, Section 418.315, 1969.

[14] State of Florida, 2011, paragraph (2)(b).

Review of Judicially Implemented Policies

Many states currently find themselves in a similar position to California before the passage of SB 863. Although their WC statutes do not explicitly allow for the provision of home care services, these statutes have been judicially interpreted to require coverage for home health care under certain circumstances. For example, Nebraska's WC statute holds the employer liable "for all reasonable medical, surgical, and hospital services . . . which are required by the nature of the injury and which will relieve pain or promote and hasten the employee's restoration to health and employment."[15] This liability has been judicially interpreted to include compensation for home health care services when the employee can prove that the employer has knowledge of both the disability and the need for assistance, the care provided is outside the scope of normal household tasks, and there is a way to calculate the value of the services provided.[16]

Although interesting, these policies do not inform the decisions currently before DWC. Judicially crafted policies provide insight into specific situations but can be difficult to extrapolate to the population as a whole. Furthermore, DWC has the opportunity to respond to the concerns of many stakeholder groups, rather than just settle a dispute between two parties. This is a much broader inquiry and requires the weighing of various concerns.

Results of Interviews

After completing the review of state policies, we contacted administrators from the states identified as having relevant home care services in order to ascertain the rationale for their policy choices and their experiences in implementing these policy choices. These interviews focused on several policy areas: the calculation of the fee schedule, the rules related to coverage of home care services, the provision of home care services by family members, and the cost and volume of services associated with home care services provided to injured workers.

The results of these interviews are reported below.

Rules Related to Home Care of Injured Workers

Most state administrators discussed the requirements that an injured worker must meet before receiving home health care services. Generally, the injured worker must have a doctor's order or prescription, and the home health services must be medically necessary. While representatives of some states indicated that they looked carefully at each individual request for home health care, they reported that they do not often turn down the request for home health services if it has been accompanied by a physician's order.

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[15] State of Nebraska, Revised Statutes, Chapter 48, Section 120, paragraph (1)(a), 2011

[16] Nebraska Court of Appeals, Memorandum Opinion and Judgment on Appeal, Traffansetdt v. Seal-Rite Insulation, No. A-12-183, 2012.

Several state administrators discussed the importance of preauthorization as a mechanism for ensuring that the home health care provided to the worker is appropriate. Preauthorization helps to avoid unforeseen and unpredictable costs. One administrator noted a desire for increased documentation of home care services provided to injured workers. Despite not experiencing many difficulties implementing the state's policies, the administrator described the current state of documentation as "incredibly poor" and the focus of improvement efforts.

Calculation of Fee Schedules

Some states calculate their fee schedule by comparison to the fee schedule in other states. This comparison may be more qualitative than quantitative: Some states merely contrast their rates against the rates in other jurisdictions to ensure that they are in the same ballpark. This approach allows them to ensure they are providing a reasonable level of payment while still allowing them the flexibility to make adjustments as appropriate to fit the needs of their particular state.

However, other states calculate their fee schedule by making a quantitative comparison to other jurisdictions, setting their hourly rate at a given percentage of a different program's fee schedule (for example, Medicare). Administrators from these jurisdictions describe this approach as "robust," as it is automatically updated as the other jurisdiction updates its fee schedule. The multiplier used to adopt the reference fee schedule was chosen based on the state's experiences and was consistent with the multiplier used for the state's other WC fee schedules.

In some states, there are no preset fee schedules regarding home health care services. In one of these jurisdictions, home care services must be preauthorized and are reimbursed "by report" based on the explanation for needed services. The worker's physician must therefore provide justification for the necessity of home health care services. If the physician asserts that these services are medically necessary and related to the worker's injury, there is a presumption that these services should be provided, although that presumption may be challenged by the employer or insurer.

Provision of Services by Family Members

Coverage of Services Provided by Family Members

Administrators from some states that allow family caregivers spoke extremely negatively about their experiences. One administrator described payment for family caregivers as "unfortunate." In her opinion, these situations are extremely hard to monitor and can often lead to abuse. As a result of this abuse, this state has been cracking down on the provision of home health care by family members.

Some administrators discussed situations where family members were hired by home health care agencies to provide services to the injured worker. At first glance, this would seem to eliminate many of the concerns associated with family caregivers. The home health agency could

act as an intermediary, ensuring that the family caregiver is properly trained and supervised. Payment to the family member would be the same as payment to any home caregiver. However, some administrators did not consider this a satisfactory solution, and were still uncomfortable with family members providing home care services even when these services were provided through a home health care services agency.

Administrators were also contacted in states whose guidelines do not address whether care provided by family members may be covered by WC insurance. After these interviews, it became clear that at least some of these states do allow coverage on a case-by-case basis. For example, one administrator said that while attendant care provided by a family member would not be considered a medical service, it might be covered under a broad interpretation of state policies. Whether or not this broad interpretation was actually applied would depend on the insurance carrier. Unsurprisingly, it did not appear that family members often provided home health care in this state, as the administrator could not recall more than two instances of being approached with questions regarding family caregivers.

Discontinuing Coverage of Services Provided by Family Members

Some states had allowed coverage for services provided by family members, either explicitly or implicitly, and subsequently disallowed this coverage. Interviews with administrators for these states suggest difficulties associated with monitoring these services were the main reason for discontinuing coverage. These examples strongly suggest that the DWC should carefully design monitoring and antifraud mechanisms if the fee schedule is to cover family members for providing home health care.

In this regard, we note that most payments for care provided by family caregivers under the California WC program are currently made to the injured worker. The OWCP has discontinued direct payments to injured workers. The OWCP maintains that requiring that the program be billed directly for attendant care services provides more assurance that the services are medically necessary and establishes more financial accountability for the services.

Volume and Cost of Service

In contrast to the California experience with home health, most administrators that we interviewed described the costs of home health services as inconsequential when compared with the overall costs of caring for individuals after work-related injuries. One administrator described it as “barely a blip on the radar.” Although most states could not provide precise statistics on home health care expenditures or the number of workers utilizing these services, they spoke about it as a rare event that did not constitute a significant drain on resources.

Summary and Discussion

Our review found that only a few states have policies specific to the provision of home health attendant services.

- Florida allows family caregivers to provide "nonprofessional attendant care" that does not include the type of household tasks normally provided by members of a family. Unlike most programs, the rate is based on the employment status of the caregiver. A family member who maintains the employment while providing care or forgoes employment in order to provide care is paid the lesser of his or her hourly rate at the prior employment or the hourly rate generally paid for such care in the worker's community.
- Michigan allows up to 56 hours of personal care services payable at the same hourly rate as other personal care services.
- North Carolina does not have a fee schedule for attendant care and determines payment on a case-by-case basis.

Washington previously covered family caregivers but ceased cover new arrangements in 2002.

Chapter Eight. Creating a Fee Schedule for California

Framework for a Home Health Care Fee Schedule

Based on discussions with DWC, our stakeholder interviews, and our review of home health fee schedules used by other programs, we developed the following framework to guide our analysis of potential options for a home health care fee schedule:

- To cover the home health care needs of the WC patient population, the fee schedule should address the range of home health services, including (1) temporary skilled and/or nonskilled supportive care services typically needed on a part-time or intermittent basis for a finite period of time following an acute care medical event, (2) more extensive (e.g., full-time or longer-term) skilled care, and (3) long-term supportive care services for a seriously injured worker needed to enable the individual to remain safely at home.
- To reduce administrative burden for providers and for DWC, the fee schedule should build on existing fee schedules' policies, coding systems, and payment amounts. Given the SB 863 requirements, priority should be given to adapting the IHSS fee schedules as needed for the WC patient population.
- To establish payment rates that provide access to different types of home care providers and to facilitate monitoring and deter fraud and abuse, there should be standardized codes describing the type and volume of services provided to the injured worker. To the extent feasible, the codes should draw on existing code sets.
- To ensure workers receive high quality medically appropriate care efficiently, the payment rates should be adequate to cover the estimated costs (including a fair return on investment) of providing the services efficiently, and the payment incentives should be structured to safeguard against the under- or overprovision of care.
- To ensure that workers receive needed services required by their work-related conditions and to reduce contention between payers and injured workers over what services are needed, there should be an independent patient needs assessment that considers the services required by the individual's functional status and home environment.
- To balance worker choice with safety and cost considerations, family members should be allowed to provide attendant care services when they have the training to do so and there is appropriate financial accountability and oversight.

Units of Service Used to Pay for Home Health Services

The fee schedules used by other jurisdictions use different units to pay for services ranging from 15-minute increments and hourly rates to per visit and per diem rates. Medicare is the only program we reviewed that uses 60-day episodes. In deciding which unit of payment to use, several trade-offs should be considered, and the choice may vary across services. The primary benefit of using time units is to improve payment accuracy by relating the payment to the length of the visit. However, the increased payment accuracy comes at a price: It increases the

incentives for overutilization of services (by encouraging longer visits) and increases the bill processing administrative burden. For intermittent or part-time care, variation in the length of a home health visit is most likely to occur where there are systematic differences in patient needs and for the first visit with a patient. The initial visit typically involves additional time for patient assessment and paperwork. For example, Medicare data show that the length of an initial skilled nursing visit was 83.07 minutes compared to 44.10 minutes for subsequent skilled nursing visits within the 60-day episode.[1]

A time-based rate creates an incentive to unnecessarily prolong visits. It overpays for prolonged visits and underpays for short visits because some costs are fixed (such as travel time) and are reflected in the rate for the average visit. A per visit rate creates incentives to reduce per visit costs (through reducing the visit length) and to increase the number of visits. However, a Medicare demonstration that used per visit rates found that despite the incentives, agencies did not increase their number of visits, decrease quality of care, or become more selective about patients they served. The most significant difference was in the length of home health aide visits. The visits for home health agencies paid per visit rates were much shorter than those provided by agencies paid based on costs.[2] It is unclear whether this reflected agency attempts to reduce costs by eliminating unnecessary aide services or by skimping on needed services. An analysis of 2010 data found that the average Medicare home health aide visit was slightly more than one hour: 64 minutes based on the 15-minute increments reported on the billing forms.[3]

When the patient needs more continuous nursing or home aide/homemaker care than the "intermittent part-time" care covered by Medicare (typically 35 hours or less of care per week) the per visit payment rates are not appropriate, and some type of time-based unit of payment is. Generally, hourly rates for full-time nursing and aide services are less than for part-time services. As discussed in more detail in the next section, the HCPCS T-code set allows for an adjustment for this by having separate codes to report services either in 15-minute increments or on a per diem basis. The federal OWCP rates use both codes and incorporate a lower hourly rate into the per diem services. The hourly rate for RN services reported in 15-minute increments is $110.62, compared to $82.67 per hour for RN services reported on a per diem basis (defined as eight hours by OWCP. When more than eight hours are provided, the per diem code is used for the first eight hours, and the remaining hours are reported using the 15-minute increment codes).

The per episode payments used by the Medicare program are designed to provide incentives for the efficient delivery of the full package of home health care likely to be needed by

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[1] ABT Associates, *Analyses in Support of Rebasing and Updating the Medicare Home Health Payment Rates—CY 2014 Home Health Prospective Payment System Final Rule*, Cambridge, Mass., November 27, 2013.

[2] C. E. Bishop, R. S. Brown, B. Phillips, G. Ritter, and K. C. Skwara, "The Home Health Visit: An Appropriate Unit for Medicare Payment?", *Health Affairs*, Vol. 15, No.4, 1996, pp. 145–155.

[3] Healthcare Market Resources, "Is Cutting Home Health Aide Visit Time a Viable Cost-Saving Step for Your Agency?", *Market Research Letter*, July/August 2012.

homebound beneficiaries over a 60-day period. As discussed next, there are sufficient differences in the two programs to suggest that basing the OMFS on Medicare's per episode payments would result in inaccurate payments and, for the more severely disabled workers, create problems with access to long-term nursing and supportive services provided in a home setting.

Coding Systems Used to Describe Home Health Services

A fee schedule for home health services requires that a standard set of codes be used to describe the full range of home health care services that might be provided to injured workers. The codes that DWC adopts should capture the information needed to bill and pay for services in accordance with the OMFS for home health services and to monitor the type and duration of services actually provided.

In total, five different code sets are used to describe home health services under the Healthcare Common Procedure Coding System (HCPCS). No single code set covers the full array of home health care services that might be furnished to injured workers, and DWC will need to decide which codes should be used to describe services covered under the OMFS. Following is a description of the available code sets.

1. Level 1 HCPCS codes are the Common Procedure Terminology (CPT) codes maintained and copyrighted by the American Medical Association. CPT codes are used to describe the professional services provided by physicians and other practitioners. They are also used to describe outpatient facility services. There are CPT codes for evaluation and management services provided during home visits and for home infusion therapy. When DWC implemented a Medicare-based fee schedule for physician and other practitioner services effective January 1, 2014, these codes were incorporated into the fee schedule. In addition, there is a set of codes for home health procedures/services (CPT 99500–99600) for services provided by nonphysician health care professionals. However, they are not used for home health services under either the Medicare or Medi-Cal programs. As a result, these codes are not suitable to the extent the OMFS builds on existing fee schedules.
2. Level 2 HCPCS codes are alphanumeric codes maintained by CMS. The Medicare program uses alphanumeric G-codes to describe home health services under a Medicare plan of care. Although Medicare pays for these services on a per episode basis, or on a per visit basis in the case of LUPA-adjusted services, the codes capture information on service utilization in 15-minute increments for six disciplines: skilled nursing, physical therapy, occupational therapy, speech-language pathology, medical social services, and home health aides. Under Medicare rules, the reported time is for time spent treating the beneficiary (i.e., travel time is not included) and may include time for any paperwork completed while in the home. There is no distinction between RNs and LPNs in the rates. The OWCP values these codes in 15-minute increments. The Medi-Cal program does not use them.
3. Alphanumeric S-codes are national codes reserved for private payer use. They are not recognized by the Medicare or Medi-Cal programs and are not to be used when the CPT 99500–99602 codes describe the services. The nursing rates for in-home services

distinguish between RNs and LPNs. Both the nursing and aide services are reported per hour. Physical therapy, speech therapy, and occupational therapy codes for in-home services are reported as "per diem." Presumably, payers would price these services to reflect a per visit payment. In addition, there are codes for chore services, attendant services, and companion and homemaker services in 15-minute and per diem increments.

4. Alphanumeric T-codes are national codes reserved for Medicaid state agencies to request any changes in the code series. The full range of nursing and home health aide/personal care services that might be covered under the home- and community-based waiver program are in the code set in 15-minute and per diem increments. Medi-Cal uses some but not all of the codes in its fee schedule.
5. Alphanumeric Z-codes are Medi-Cal–specific codes used to describe the same home health services covered by the G-codes but in per visit increments rather than 15-minute increments.

To some extent, the code sets are complementary. That is, the alphanumeric S- and T-codes do not duplicate the codes found in the G-code series but rather supplement those codes by providing additional codes for nursing and home health aide/homemaker services. However, there is some overlap between the S- and T-codes. An issue is how these code sets should be combined to cover the full range of home health services provided to injured workers. Options include: (1) select either the S- or T- code sets to supplement the G-codes, (2) "pick and choose" the individual codes from among the two sets that best describe the types and units of service recognized under the fee schedule, and (3) allow home health providers to use the codes that they use to bill other payers. Arguably, the most straightforward approach would be to select a single code set to supplement the G-codes. However, this might limit the information needed to align payments with the type and duration of home health encounters and to monitor the services provided. The federal OWCP has taken a different approach and established prices for selected S- and T-codes in addition to selected G-codes with some duplication. When the services are comparable (e.g., attendant care services (S5125 and S5126) and personal care services (T1019 and T1020), the prices are generally but not always the same. If different codes are used to describe comparable services, the payment rates should be the same in order to avoid payment disputes.

The choice of code sets is closely related to the choice of the units of service used to bill and pay for home health services. The code reported on the billing form should provide information on the units of service needed to price the encounter; however, the reported units need not be the same as fee schedule units of payment. For example, Medicare requires that the G-codes be used to report services by discipline in 15-minute increments, while the fee schedule payment is on a per episode or per visit basis. The more precise reporting (e.g., time-based units of service) facilitates monitoring of the actual services provided to the individual and helps guard against underprovision of services when payment is on a per visit basis. The Z –codes used by the Medicaid program would not provide information on the duration of visits.

Comparison of Different Fee Schedules for Home Health Services

As amended by SB 863, the Labor Code requires that DWC adopt a fee schedule for home health services. The fee schedule should be based on Medicare fee schedules and, to the extent the home health services are not covered by Medicare, the fee schedule must establish fees and service provider requirements based on the rules used by the IHSS program.[4]

In prior chapters, we reviewed the fee schedules used by different programs to pay for home health care services. Table 8.1 summarizes our findings regarding the types of home health services that injured workers require and how the services are treated under the Medicare and IHSS fee schedules relative to other fee schedules. We found that the Medicare fee schedule does not cover the range of home health services covered under California's WC program. Medicare's fee schedule is a reasonable starting point for the intermittent part-time home health care services that have a skilled care component. The per visit rates for physical therapy, speech-language and occupational therapy are better suited for this purpose than the skilled nursing and home health aide per visit rates. An injured worker may require more extensive skilled nursing or home health aide services than those incorporated into the Medicare rate. For these services, a time-based unit of payment is needed instead of a per visit payment. The IHSS fee schedule addresses longer-term attendant services but does not address the need for temporary but more extensive nursing and aide services and long-term nursing services for injured workers who would otherwise require institutionalization Therefore, additional fee schedules need to be considered. Both the Medi-Cal fee schedule and the federal OWCP fee schedule cover the full range of home health care services and are already in use in California. Assuming DWC wants to use existing fee schedules to cover the full range of home health services, we consider how the Medi-Cal and federal OWCP fee schedules could be used to (1) fill the gap between the Medicare and IHSS fee schedules, or (2) replace those fee schedules. The first approach is most consistent with the Labor Code requirements for the OMFS for home health services. The second approach would reduce administrative burden and provide an integrated approach to covering the full range of home health services provided to injured workers.

[4] State of California, 2011, Section 76.

Table 8.1. Summary of Payment Methods for Different Types of Care Used by Medicare. IHSS, Medicaid, and OWCP

Type of Care	Medicare	IHSS	Medicaid	OWCP
Intermittent part-time skilled nursing/therapy services	Per visit rate by discipline	Not covered	Per visit rate by discipline	Rate in 15-minute increments by discipline; lower rates for therapy assistants than qualified therapists
More extensive nursing services	Not covered	Not covered	Hourly rates that differ by training level (RN, LPN/LVN, certified home health aide)	Both hourly and per diem rates that differ by training level
Paramedical services	Per visit rates by discipline	Hourly rates for attendant services regardless of skill level	Per visit rates if receiving temporary care from a home health agency; otherwise, hourly rate that differs by training level	Time-based rates that depend on level of training and whether services are on intermittent or more extensive basis
Personal care services	Per visit rate if furnished by home health aide incidental to skilled care	Hourly rates for attendant services	Rates in 15-minute increments for unskilled providers only	Rates in 15-minute increments or per diem for unskilled providers; higher than for chore services
Chore services	Per visit rates if furnished by home health aide incidental to skilled care	Hourly rates for attendant services	15-minute increment rates for unskilled providers only	Rates in 15-minute increments or per diems for unskilled providers; lower than for chore services

Below, we summarize considerations that should be weighed in adapting one or more of the following fee schedules to pay for the full range of health care services: Medicare, IHSS, Medi-Cal, and the OWCP.

Medicare

- Provides per visit rates for six disciplines, used only as the low utilization payment adjustment. The per episode fee schedule is not suitable for workers' compensation.
- Rates are updated on an annual basis. Separate rates apply to urban and rural areas with further adjustment for geographic location.
- Per visit rates for nursing and home health aide services would need to be supplemented with time-based codes to address situations where more prolonged services are needed. In addition, rates would be needed for attendant services.
- Rates are below the estimated average per visit costs for each discipline.
- Rates do not vary based on the level of the professional providing the service.
- Coverage policies are more restrictive than is appropriate for WC patient population (e.g., prerequisite for home health aide care is need for qualifying skilled services).
- Adoption of a Medicare-based fee schedule is consistent with the intent of the Labor Code.

IHSS

- Contains rates for hourly attendant care services only.

- Rates are determined at the county level, generally based on the hourly minimum wage level. Some but not all counties include fringe benefits.
- Adoption of the IHSS fee schedule for supportive services is consistent with the intent of the Labor Code.

Medi-Cal

- Provides rates for the full range of home health care services that might be needed by an injured worker.
- Updates occur intermittently and are budget-driven.
- Per visit rates for intermittent part-time services are patterned after Medicare but use Medi-Cal–specific codes rather than codes used by other payers. Rates are significantly lower than the Medicare rates.
- Rates for more extensive nursing and aide services under the HCBS waiver are based on hourly rates that vary according to the level of the professional providing the service and the employment arrangement. Services are designed to integrate with the supportive services provided under IHSS.

Federal OWCP

- Provides rates for the full range of home health care services that might be needed by an injured worker.
- Updates occur annually, and rates are readily available for download.
- Multiple codes describe similar services. This is confusing but could be overcome by adopting the fee schedule for a limited set of codes.
- The fee schedule does not incorporate the Medicare per visit rates for home health agency services. Instead, prices for the G-codes are set in 15-minute increments.
- Pricing is based on a relative value scale and conversion factor.

Using the OWCP Fee Schedule to Fill Medicare/IHSS Gaps

In this section, we examine how the Medicare, IHSS, and OWCP fee schedules might be integrated into a single fee schedule to cover the full range of home care services required by injured workers. As discussed in Chapter Three, Medicare's per episode rates are not an appropriate unit of payment for the WC population. However, the LUPA per visit rates could be used to pay for home health care needed on an intermittent and part-time basis, including personal care and chore services furnished by home health aides, incidental to the skilled care. When more extensive unskilled supportive services are needed to allow the injured worker to remain at home, the IHSS rules and hourly rates for attendant services would apply. The use of the OWCP fee schedule would be limited to those situations where the injured worker needs more extensive nursing services. These services could be furnished either through an agency or an individual with the appropriate training (RN, LVN, or certified nursing assistant/home aide). To implement this fee schedule approach, a uniform process would be needed to determine what services are required by the injured worker and which portion of the fee schedule should be used

to pay for specific services. In particular, clear rules would be needed to distinguish between "intermittent or part-time care" and more extensive nursing services, and between supportive services payable under the Medicare fee schedule and those payable under the IHSS fee schedule.

Assessing the Types and Extent of Needed Services

A physician order for home health care services should indicate whether the patient needs skilled services or only unskilled personal care and chore services. It should trigger an assessment by a qualified entity of the type, frequency, and duration of services needed by the injured worker. If the physician indicates that skilled services are needed (which would include paramedic services), the organization performing the assessment could use either its own tool or the OASIS instrument to determine the level of required services. A uniform assessment tool that covers the full range of services, such as OASIS, should provide a standardized assessment of a patient's functional status and living environment and reduce the need for multiple or "dueling" assessments. However, to be consistent with the Labor Code requirement for in-home supportive services, the IHSS assessment tool or a comparable instrument may be necessary to assess the need for these services. Further analysis would be needed to determine how best to meet the Labor Code requirement. If further analysis shows that the OASIS functional status findings regarding ADLs and IADLs can be used to estimate service needs consistent with the IHSS instrument, there would be no need to use the IHSS assessment tool. A single assessment would be less burdensome for payers and for injured workers. If not, DWC could (1) adapt the OASIS instrument as necessary to conform to any significant differences in the functional status scores generated by the IHSS assessment tool, or (2) replace the portions of OASIS relating to ADLs and IADLs with the IHSS assessment tool. If the physician order indicates only unskilled personal care and chore services are needed, there would be no need for an OASIS assessment, and the IHSS assessment tool could be used from the outset to determine the need for unskilled attendant services. [5] The IHSS assessment form is further discussed in the next section.

The assessment supports the plan of care developed for home health care services and prescribed by the physician. The CMS–Form 485 "Home Health Certification and Plan of Care" could be adapted for use in the WC program to cover the full range of anticipated home health care services. The form includes summary information from the assessment and the physician's orders for the frequency and expected duration of visits for each discipline covered under the

[5] Another consideration is the current qualifications of the individuals completing the assessments. The conditions of participation for home health agencies require that a registered nurse or licensed therapist complete the initial OASIS assessment; an LPN/LVN or medical social worker cannot complete the assessment. In contrast, the IHSS assessments are completed by county clinical social workers. Because the OASIS includes the IHSS domains (and not vice versa), it is likely that an RN trained to complete the OASIS could also complete the IHSS assessment.

Medicare home health benefit. It would need to be revised to establish separate categories for paramedical, personal care, and chore care services, or a separate certification form could be used for unskilled services that would be paid under the IHSS-based fee schedule. Presumably, the form(s) would be submitted by the physician for prior authorization of home health care services by the payer.

Two WC-specific issues are (1) whether prior authorization would also be needed for the assessment, and (2) what qualifying criteria should be established for performing the assessment. We do not see a benefit to requiring prior authorization for an assessment but note that OWCP requires prior authorization for both the initial assessment (which does not use a standard form) and the plan of care. However, prior agreement on the entity performing the assessment could lessen controversies over the plan of care.

For Medicare and Medicaid patients, assessments are performed by the home health agency that will be providing the services. The advantage of this approach is that the agency implements a treatment plan consistent with its service delivery preferences and is already knowledgeable about the patient when actual care is initiated, which could be during the same encounter as the assessment. If the assessment and plan of care are developed independent of the service delivery organization, the treatment plan could be inconsistent with the organization's service delivery preferences and lead to disagreements over an appropriate plan of care. However, an independent assessment has the advantage of providing a platform for agreement between the payer and injured worker on what services are needed for the injured worker to remain safely in a home environment and reduces the incentive to over/underestimate needed services. A compromise approach would be to require an independent assessment only with regard to services that would be paid under the IHSS-based fee schedule. As discussed in Chapter Two, we found from our stakeholder interviews that the need for in-home supportive services is an area of contention that often has led to "dueling" assessments and delays in obtaining needed care while the dispute is resolved through the administrative dispute resolution process. Given the level of distrust between the employer and the worker and his or her representatives, an assessment by an independent party not directly involved in the provision of the services such as a care management organization or home health agency staff with experience assessing individual needs for supportive services, mental status, physical environment, and family situation should be a desirable change in the current process. The services should be prescribed by the primary treating physician as medically necessary to allow the patient to remain in the home, and the plan of care should reflect agreement among the injured worker, primary treating physician, and the assessor in the decision to provide services at home and rules for resolving disagreement among the parties.

Using a Medicare-Based Fee Schedule for Intermittent or Part-Time Care

The plan of care prescribed by the physician and approved by the payer would be used to determine if the injured worker needs "intermittent" or "part-time" services. For consistency, the

Medicare definition should be used to define the level of care. Specifically, under Medicare the intermittent care criteria are met if the beneficiary needs therapy services or a skilled nursing visit at least once every 69 to 90 days and less than seven days per week. The part-time definition applies to skilled nursing and home health aide services worked each week and day and includes up to 28 hours per week. There are exceptions under Medicare that allow on a case-by-case basis 35 or fewer hours each week or up to eight hours daily for a finite and predictable time (21 days) that expand a beneficiary's eligibility to receive home health benefits. Under WC, a case that requires more than intermittent or part-time services does not need an exception in order to receive home health benefits. The more extensive services would nevertheless be covered, but the allowances would be based on the OWCP-based portion of the fee schedule instead of the Medicare-based fee schedule.

The DWC will need to address how services that could be provided by either a home health aide or unskilled individuals, such as assistance with chore and domestic services, should be counted in determining if the injured worker needs intermittent or part-time care. A straightforward approach would be to count any service furnished by a home health aide in making the determination. For consistency, this would imply that the services should also be covered by the Medicare-based fee schedule at a per visit rate. Another approach would be to include only personal care and paramedical services provided by a licensed nurse or certified home health aide, but to exclude any estimated hours for chore services. The assumption for doing so is that someone other than a certified home health aide could furnish these services, which are most appropriately paid under the IHSS-based portion of the fee schedule.

The services covered by the Medicare-based portion of the fee schedule should be reported using the G-codes that Medicare uses for home health agency services regardless of whether the services are provided by a home health agency or an independent home care provider.

Integrating IHSS into the OMFS

Section 5307.8 of the Labor Code requires that the OMFS establish allowances for non-Medicare–covered home care services based on the fees and requirements for service providers under the IHSS program. There are four potential policy areas where the IHSS program might be incorporated into the OMFS: assessing the need for in-home supportive services, limiting the amount of services provided, determining who can provide the supportive services, and setting the payment rate for individual covered services. Next, we explore potential policies with respect to each of these issue areas.

Assessing the Need for In-Home Supportive Services

The IHSS assessment instrument provides a standardized way to assess the needs of a patient requiring long-term supportive services to stay at home.[6] This instrument is designed to assess an individual's level of ability and dependence on assistance from others to perform personal care services and chore services. It is does not assess the need for nursing or other skilled services and, therefore, cannot be used as the sole assessment instrument when these services are required in addition to in-home supportive services. As discussed earlier, OASIS assesses need for the full range of home health care services and could be used as a single assessment instrument when the patient requires more than unskilled supportive services. The IHSS instrument is most suitable for assessing need for more extensive unskilled personal care and chore services and paramedical services over a prolonged period of time. The determination of the amount of supportive services needed is based on the individual's functional status, a standardized set of time guidelines, and living arrangements. The IHSS assessment guidelines could be used to determine the supportive services needed to allow a WC patient to remain at home, but some modifications should be considered.

- As will be discussed later, the tool should be used to determine the needed services without regard to the IHSS monthly caps on the number of service hours.
- The supportive services available when the worker has a spouse capable of performing chores should be reviewed. In particular, the IHSS restrictions that allow certain services only if they are needed in the spouse's absence, such as meal preparation, transportation, and protective services, may not be appropriate, particularly if the spouse is taking off from work to care for the injured worker.
- The IHSS tool includes paramedical services that can be provided by an attendant when ordered by a licensed health professional and provided under the direction of a licensed health professional Funding for these services is authorized for IHSS, but registered home care aides who are not under the IHSS program cannot provide services ordinarily performed by a licensed health care professional. IHSS providers may administer medication, but registered home care aides are limited to assisting the individual in self-administering medication. When the patient requires paramedical services, OASIS may be the more appropriate assessment tool, since it can address not only the need for paramedical services but who can provide them.
- The needs assessment should be tied to the services required by the individual's work-related injuries. Because these are long-term services, IHSS reassesses service need annually. For an injured worker, a reassessment every six months might be more appropriate, particularly if the limits on the number of service hours are not adopted. This is the time frame used by the Medicaid home- and community-based waiver program.

[6] California Department of Social Services, 2006.

Determining Arrangements for Provision of Supportive Services

There are three potential types of arrangements that should be considered for providers of in-home supportive services. First, the individuals could be employed by a home health agency or other home care organization. Second, the individual might be an independent home care aide providing services through a direct agreement with the injured worker. Third, the individual might be a family caregiver. Each of these arrangements has implications for the minimum qualifications of the caregiver and the care he or she can provide.

The California Health and Safety code requires that all home health agencies that provide skilled nursing services be licensed and that home health aides employed by the agencies meet training requirements and background checks. Except for IHSS caregivers, there have not been similar requirements for other home care organizations. The Home Care Services Consumer Protective Act (AB 1217, enacted October 13, 2013) added Chapter 13 to Division 2 of the Health and Safety Code. Effective January 1, 2015, under the provisions added by AB 1217, home care organizations must be licensed by the California Department of Social Services (DSS). Licensed home care organizations will be required to maintain an employee dishonesty bond with a minimum limit of $10,000 and provide caregiver training to their affiliated home health aides. AB 1217 also requires that home care aides employed by a home care organization undergo a background check, demonstrate that they are free of active tuberculosis, and register with DSS. In addition, independent home health aides may undergo a background check and register with DSS. DSS will maintain a web-based registry of home health aides that will enable consumers to look up the registration status (similar to the registries maintained by IHSS public authorities in some counties). Except with regard to family caregivers, a WC requirement that only registered home health aides provide personal care services should address several of the concerns expressed by applicants' attorneys regarding payer-placed caregivers as well as payer concerns with caregivers selected by the injured worker.

The Health and Safety Code has an explicit exception for family members providing services to children but not to adults.[7] However, registration by independent home health aides is not mandatory, and Section 1796.15 explicitly states that an individual is not prohibited from employing someone not listed on the home care registry to provide home care services. When the need assessment is provided, it would be important for the assessor to evaluate the ability of the family caregiver or any other nonregistered home care provider to furnish the needed services, whether training might be needed, and the level of supervision by a health care professional required.

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[7] Section 1796.12(f) defines family member as "any spouse, by marriage or otherwise, child or stepchild, by natural birth or by adoption, parent, brother, sister, half-brother, half-sister, parent-in-law, brother-in-law, sister-in-law, nephew, niece, aunt, uncle, first cousin, or any person denoted by the prefix 'grand' or 'great,' or the spouse of any of these persons, even if the marriage has been terminated by death or dissolution."

Arguably, the potentially most divisive issue concerning home care attendant services is the choice of the home care provider. Using the IHSS model, the injured worker should be able to choose the home care provider. If that choice involves a home caregiver who is not registered, the payer has an interest in assuring that the individual has the background and training to provide services that will allow the worker to remain safely at home. The options may be more limited if paramedical services are needed than if only unskilled attendant services are needed.

Limiting the Amount of Services Provided

As discussed in Chapter Four, there are monthly maximums on the amount of services provided to an individual under the IHSS program: 195 hours per month for non–severely impaired and 283 hours for severely impaired cases. These particular limits are based on budget limitations for this public-benefit program; however, other public programs have also incorporated limitations on the extent of coverage for long-term care services provided in the home. For example, an individual does not qualify under the Medi-Cal HCBS waiver program unless estimated aggregate expenses for all home care services would be less than the amount that would otherwise be paid for providing the appropriate level of care to the individual in an institutional setting. The VA sets the limit for its expenditures at 65 percent of the cost of providing the services in the nearest VA nursing home. The veteran has the choice of deciding whether to pay for any excess costs to remain in the home. A limit on aggregate expenditures is a way to assure that the decision to remain at home is cost effective; however, in the absence of an OMFS for different levels of nursing home care, it may not be feasible except through benchmarking to non-WC data on average costs for different levels of institutional care.

Some programs establish limits on the hours of service provided by family caregivers. The VA limits the services of family caregivers of post-9/11 veterans to 10 to 40 hours of care per week depending on the number of required hours of personal care services. The OWCP limits personal care services to 12 hours per day, while Michigan WC limits services provided by a spouse to no more than 56 hours per week.

Setting the Payment Rate for Individual Covered Services

In Table 8.2, we report the mean, 25th, 50th, and 75th percentile of Bureau of Labor Statistics hourly wages for home health aides and personal care aides in California in May 2012. These rates are for earnings only and do not include fringe benefits. As expected, the hourly wage for personal care aides is lower than for home health aides. Aides employed by an agency in an "on call" arrangement often receive no fringe benefits, while those employed on a part-time or full-time basis may receive fringe benefits such as paid sick leave and vacation and health insurance. Under the Domestic Workers Bill of Rights Act, effective January 1, 2014, private health care aides qualify for overtime pay if they work more than nine hours a day or 45 hours a week. New federal rules that become effective January 15, 2015 will require work time pay for home care

workers who work more than 40 hours per week. These policies should be factored into the fee schedule.

Table 8.2. BLS Hourly Wages, in Dollars, for Home Health Aides and Personal Care Aides (May 2012)

Occupation (SOC code)	Hourly mean wage	Hourly 25th percentile wage	Hourly median wage	Hourly 75th percentile wage	Hourly 90th percentile wage
Home Health Aides (311011)	11.51	9.12	10.52	12.95	16.32
Personal Care Aides (399021)	10.64	9.16	10.31	11.51	13.72

The IHSS rates for attendant care services are set at the county level, most typically at the minimum wage but with adjustment in some counties for fringe benefits. The median hourly rate for the counties in the CAPA survey in May 2012 was $9.30 (Appendix A). This is below the BLS hourly median wage rate for May 2012. For comparison, the OWCP hourly rate for attendant services (after adjustment with a statewide geographic adjustment factor) is $18.12. The VA rate for attendant services is set at the 75th percentile of the home health aide hourly rate in Table 8.3, or $12.95. The decision as to the OMFS payment rate for attendant services is a policy choice. While the plain reading of SB 863 suggests that the rates are to be based on IHSS rates, both the variation in rates across counties and the relatively low payment levels suggest that alternatives be considered if permitted under current law. This could be a rate set by another program, such as those set by OWCP for attendant services or by Medicaid for personal care services, or it could be established by benchmarking to BLS data. For example, the VA uses the BLS 75th percentile as a cap on attendant services.

Establishing Codes to Describe Supportive and Paramedical Services

IHSS does not use any procedure codes to describe the supportive services provided under its program but rather uses a form to report the number of hours by type of service furnished by the caregiver. The form should provide the information needed by the payer to process the claim, but one or more procedure codes are needed to capture the services for monitoring purposes in the Workers Compensation Information System (WCIS). Without a standard code set for these services, DWC will continue to lack information on the type and duration of home care services provided under the WC program. The individual or entity billing for the services could be required to report the services by code, or the payer could add the codes when the bills for the services are processed and reported to the WCIS. Ideally, the codes would be based on an existing code set and would distinguish between personal care services, chore services, and, if covered under the WC program, any paramedical services furnished by the unskilled attendant. However, it is not clear that this is feasible even with WC-specific codes. The existing code sets include different types of supportive services (Table 8.3), but they do not describe paramedical services furnished by an unskilled individual. Further, it is likely that accurate reporting by type

of care may be difficult to document because the same individual is likely to furnish more than one type of supportive care. Perhaps most importantly, the uniform time sheets used by the IHSS program require documentation by the caregiver of only the number of hours worked and not the nature of the services provided. If DWC follows the IHSS requirements, this would make the code for attendant services (e.g., S5125 in Table 8.3) most feasible of existing codes for reporting services.[8] If DWC wants the information on the types of supportive services being provided, separate reporting based on the plan of care might be a way to obtain this information.

Filling the Gaps with the OWCP Fee Schedule

Several issues will need to be addressed if the OWCP fee schedule is used to fill gaps between the Medicare fee schedule for skilled home health care and the IHHS for unskilled personal care and chore services. These include distinguishing the "border" between the care covered by each fee schedule, minimizing opportunities for duplication of services and/or shifting services in response to payment incentives ("gaming"), and deciding which codes to use for the services covered by the OWCP fee schedule.

Integrating Medicare-Based and OWCP-Based Fee Schedules

The distinction between which services are covered under the Medicare-based portion of the OMFS and which services are covered under the OWCP should draw on the assessment of the patient's approved plan of care. If the worker needs intermittent or part-time skilled care as defined and operationalized by Medicare, the Medicare-based portion of the OMFS would apply, and no services would be payable under the OWCP fee schedule. Conversely, if the beneficiary needs more than part-time or intermittent care, the OWCP-based fee schedule would apply instead to the services not otherwise covered by the IHSS-based fee schedule.

The difference between the Medicare-based per visit rates and the time-based OWCP rates is likely to create incentives inconsistent with efficient delivery of needed services. The average Medicare skilled nursing visit is 44 minutes (after the initial visit) and home health aide visit is 64 minutes. If the average encounter is longer for an injured worker requiring intermittent or part-time care, the average allowance is unreasonable, and incentives are created to either overstate the total care needs in order to shift to the OWCP-based fee schedule, or to furnish services in multiple visits that could be furnished in a single visit. For example, if the home health aide tasks needed during an encounter require, on average, four hours, the 2013 allowance based on 120 percent of the Medicare per visit rate would be $63.44, compared to $100.92 under the OWCP fee schedule. If the total services remained intermittent or part time, the incentive

[8] If the OWCP fee schedule is used, S5125 would be problematic to use for unskilled attendant services. This is because the Division of Energy Employees Occupational Illness Compensation (DEEOIC)'s policy is that only certified home health aides and certified nursing assistants are qualified attendants. It uses S5126 for home health aide per diem services.

would be to divide the care into two or more visits during the same day. For two visits, the allowance on the Medicare-based rates would double to $127.88.

There are several ways to minimize these incentives. Having an independent assessment by a qualified home health care agency or care management organization not involved in actually delivering the care would help safeguard against over/underestimating the number of hours of needed care. The longer encounters are more likely to occur for home health aide services than for skilled nursing visits. The VA, which caps its payments for home health services provided to veterans based on the Medicare per visit rates, defines a home health aide visit as two hours of care and allows additional visits provided on the same day. Another approach would be to determine that the limited home health aide services provided under Medicare are not comparable to the home health aide services required by injured workers and to exempt these services from the Medicare-based fee schedule and instead use a combination of the OWCP and IHSS fee schedules to pay for any aide services. The OWCP fee schedule would apply for services provided by a certified home health aide, while the IHSS attendant rates would apply to unskilled personal care or chore services.

To clearly distinguish services paid under the Medicare-based fee schedule from those payable under the OWCP-based fee schedule, the services should be reported using different code sets. Medicare uses the G-codes; either the T- or the S-codes could be used for situations that require more extensive care than intermittent or part-time care. Licensed individuals, either employed by an agency or self-employed, would provide these services. To simplify the fee schedule, we recommend that the OMFS incorporate only a subset of codes. For nursing services (RN and LPN/LVN), the policy decision is whether codes are to be reported in hourly time periods (S9123, S9124) or in 15-minute increments (T1002, T1003), and whether there should be a per diem rate (T1030, T1031). The S-codes are consistent with the codes that Medi-Cal uses for long-term waiver services and are likely to be more familiar to home health agencies than the T-codes. The T-codes improve payment accuracy by capturing service time in 15-minute increments (which may be more discrete than necessary for prolonged nursing services) and setting a lower rate for per diem services. The OWCP (Division of Energy Employees Occupational Illness Compensation [DEEOIC]) uses a combination: the S9123 and S9123 for less than eight hours of care and the T030 and T1031 for an eight-hour shift.

The procedure code for any home health aide services should be different from the G-codes used by Medicare and the codes established to describe IHSS unskilled attendant services. The OWCP (DEEOIC) uses S9122 for hourly services and S5126 for per diem services. It has re-defined the latter code to “Attendant: Home Health Aide and Certified Nurse Assistant” since the agency’s policy is that only home health aides and certified nurse assistants are qualified attendants. If the S5126 code is used as it is used by OWCP, it should not also be used to describe other unskilled attendant services.

Replacing the Medicare-Based Fee Schedule with an OWCP-Based Fee Schedule

The preceding section examined how three fee schedules (Medicare, IHSS, and OWCP) could be combined into a single OMFS fee schedule for home health services. In this section, we examine how the OWCP and IHSS fee schedules might be combined. In our view, there are definite benefits to using the OWCP fee schedule instead of the Medicare fee schedule for the subset of services covered by the Medicare fee schedule. Using multiple fee schedules increases administrative burden for providers, payers, and the DWC. For home health services provided to injured workers, the distinction between intermittent and part-time care is artificial in determining whether home health services should be covered and creates an incentive to overestimate needed care. The OWCP time-based rates provide a better match of allowances with the care that is provided and are consistent with how services are defined by the G-codes. However, as discussed in the sections that follow, there are several issues that would need to be addressed. Three different federal workers' compensation programs use the OWCP fee schedule. Of particular relevance are guidelines issued by the DEEOIC for long-term home health care services.

Aggregate Payment Levels

The first issue is whether using the OWCP fee schedule would meet the Labor Code requirement that aggregate allowances under the OMFS not exceed 120 percent of the amounts payable under Medicare for comparable services. We do not have sufficient information on the distribution of WC home health services to estimate aggregate expenditures under the two fee schedules. As a result, our comparison is limited to the rates for individual services. Table 8.3 compares 1.20 times the 2014 Medicare LUPA per visit rates to the amounts payable under the 2013 federal OWCP rates (updated each July). The rates are not directly comparable for several reasons. First, the Medicare rates are on a per visit basis, while the OWCP rates are in 15-minute increments. If we use the average Medicare visit length for qualifying home health services (after the initial assessment) to estimate the average OWCP per visit payment, we find that the estimated OWCP per visit rate is slightly higher for skilled nursing and physical therapy visits but significantly lower for speech-language pathology visits. This estimate assumes an average per minute payment. If a full unit were billed for any fraction of a 15-minute increment, the OWCP estimated per visit rates would on average be based on four units, or much higher than 120 percent of the Medicare per visit rates. Second, the OWCP rates distinguish between visits by therapists and by therapy assistants, while the Medicare rates do not. We would expect the Medicare rates to be lower than the therapist rate and higher for the therapy assistant because they reflect the average cost for all visits provided in a therapy discipline. We do not know the WC mix of therapist/therapy assistant services by discipline provided in the home that would

allow us to ascertain whether the 120 percent limitation would be exceeded if the OMFS were tied to the OWCP fee schedule.

Table 8.3 Estimated OWCP per Visit Times Based on Medicare Mean Length of Follow-Up Visits Compared to 1.2 x Medicare per Visit Rate

Discipline	Mean length of follow-up visits within an episode (minutes)[a]	OWCP Allowance per 15-minute increment[b] $	Estimated OWCP per visit allowance assuming fractional time units $	1.2 x Medicare Rate Per Visit $
	A	B	C = A/60 x B	
Skilled nursing	44.1	50.46	149.78	145.32
Physical therapy	47.3	50.95	162.18	158.88
Speech-language pathology	50.37	51.43	148.27	172.66

[a] ABT Associates, 2013.

[b] U.S. Department of Labor, 2013.

In Table 8.4, we show the OWCP home health care fee schedule amounts. As noted earlier, the fee schedule is tied to a Medicare-based Resource-Based Relative Value Scale (RBRVS) for physician and other practitioner services. Columns D through F show the relative value units assigned to each component of the fee schedule: work, practice expense, and malpractice expense. The July 2013 conversion factor is shown in Column G. Some services are paid in 15-minute increments (e.g., G0151) while others are paid hourly (e.g., S9124) or per diem rates (S5121). In Column A, we show the OWCP rate for each unit of service prior to adjustment for price differences across geographic areas. The rate is the sum of the RVUs for the three components times the OWCP conversion factor. For comparison purposes, we show the equivalent hourly rate in Column B. To derive these amounts, we multiplied the rate in 15-minute increments by four, and we divided the per diem rates by eight. This allows, for example, a comparison of the equivalent hourly rates for a skilled nursing visit provided by a home health agency (G0154, $176.61) to those for general nursing care provided by an RN (S9123, T1000, and T1002, $110.14–$110.63) or LPN (S9124, $88.31; T1003, $87.34).

The rates shown in Columns A and B are based on the OWCP 2013 conversion factor of $48.52. The OWCP conversion factor is about 133 percent of the Medicare 2012 conversion factor updated to 2013. Thus, OWCP RBRVS fee schedule payment levels are generally higher than 120 percent of what would be payable under Medicare for comparable services. The home health services that would be payable under Medicare represent only a subset of the services for which the OWCP has established fee schedule amounts. For this subset of services or for the full range of home health services, an alternative would be to adopt the OWCP fee schedule relative value units but use the OMFS conversion factor under the RBRVS for physician and practitioner

services rather than the OWCP conversion factor. This fee schedule was implemented January 1, 2014, and uses a conversion factor set at the Medicare 2012 conversion factor times a 1.2 multiplier ($40.8451). Allowances for home health services would generally be in line with other OMFS allowances if this conversion factor, updated for inflation to 2014 ($43.45), were used in lieu of the OWCP conversion factor. The fee schedule rates using this conversion factor and the OWCP relative weights are shown in the Column C of Table 8.4.[9] However, unless DWC determines that such an adjustment is needed to conform to the Labor Code requirement that aggregate allowances not exceed 120 percent of what would be payable for comparable services under the Medicare fee schedule, the lower conversion factor may not be appropriate. As discussed in Chapter Three, a payment rate set at 1.20 times the Medicare fee schedule rate is unlikely to cover the estimated cost of providing the service.

[9] There are a few services (shown in italics in the last column) that use a conversion factor other than $43.45 (i.e., 1.0 or 1.25). The adjusted fee for these services is based on the total allowance multiplied by the ratio of the OMFS conversion factor to the OWCP conversion factor.

Table 8.4. 2013 OWCP Fee Schedule for Home Health Services

Code	Description	OWCP rate per unit using OWCP CF A	OWCP rate per hour using OWCP CF B	Adjusted OWCP rate (OMFS 1.20 CF) C	Work RVUs D	Practice Expense RVUs E	Malprac-tice Expense RVUs F	OWCP CF G
G0151	Services performed by a qualified physical therapist in the home health or hospice setting, each 15 minutes	50.46	201.84	45.19	0.91	0.11	0.02	48.52
G0152	Services performed by a qualified occupational therapist in the home health or hospice setting, each 15 minutes	50.95	203.78	45.62	0.92	0.11	0.02	48.52
G0153	Services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes	51.43	205.72	46.06	0.93	0.11	0.02	48.52
G0154	Direct skilled nursing services of a licensed nurse (LPN or RN) in the home health or hospice setting, each 15 minutes	44.15	176.61	39.54	0.80	0.09	0.02	48.52
G0155	Services of clinical social worker in home health or hospice settings, each 15 minutes	61.62	246.48	55.18	1.14	0.11	0.02	48.52
G0156	Services of home health/hospice aide in home health or hospice settings, each 15 minutes	6.79	27.17	6.08	0.12	0.01	0.01	48.52
G0157	Services performed by a qualified physical therapist assistant in the home health or hospice setting, each 15 minutes	24.75	98.98	22.16	0.45	0.05	0.01	48.52
G0158	Services performed by a qualified occupational therapist assistant in the home health or hospice setting, each 15 minutes	25.72	102.86	23.03	0.46	0.06	0.01	48.52
G0159	Services performed by a qualified physical therapist, in the home health setting, in the establishment or delivery of a safe and effective physical therapy maintenance program, each 15 minutes	44.64	178.55	39.97	0.45	0.46	0.01	48.52
G0160	Services performed by a qualified occupational therapist, in the home health setting, in the establishment or delivery of a safe and effective occupational therapy maintenance program, each 15 minutes	49.98	199.90	44.75	0.45	0.57	0.01	48.52
G0161	Services performed by a qualified speech-language pathologist, in the home health setting, in the establishment or delivery of a safe and effective speech-language pathology maintenance program, each 15 minutes	106.74	426.98	95.59	1.30	0.83	0.07	48.52
G0162	Skilled services by a registered nurse (RN) for management and evaluation of the plan of care; each 15 minutes (the patient's underlying condition or complication requires an RN to ensure that essential nonskilled care achieves its purpose in the home health or hospice setting)	38.69	154.76	*34.65*	38.69	0.00	0.00	1.00
G0163	Skilled services of a licensed nurse (LPN or RN) for the observation and assessment of the patient's condition, each 15 minutes (the change in the patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment in the home health or hospice setting)	38.69	154.75	*34.64*	30.95	0.00	0.00	1.25

Code	Description	OWCP rate per unit using OWCP CF A	OWCP rate per hour using OWCP CF B	Adjusted OWCP rate (OMFS 1.20 CF) C	Work RVUs D	Practice Expense RVUs E	Malprac-tice Expense RVUs F	OWCP CF G
G0164	Skilled services of a licensed nurse (LPN or RN), in the training and/or education of a patient or family member, in the home health or hospice setting, each 15 minutes	25.23	100.92	22.59	0.00	0.51	0.01	48.52
S5120	Chore services; per 15 minutes	3.40	13.59	3.04	0.07	0	0	48.52
S5121	Chore services; per diem	81.51	10.19	73.00	1.68	0	0	48.52
S5125	Attendant care services; per 15 minutes	4.37	17.47	3.91	0.09	0	0	48.52
S5126	Attendant care services; per diem	140.22	17.53	125.57	2.89	0	0	48.52
S5130	Homemaker service, NOS; per 15 minutes	3.40	13.59	3.04	0.07	0	0	48.52
S5131	Homemaker service, NOS; per diem	81.51	10.19	73.00	1.68	0	0	48.52
S9122	Home health aide or certified nurse assistant, providing care in the home; per hour	25.23	25.23	22.59	0.5	0	0.01	48.52
S9123	Nursing care, in the home; by registered nurse, per hour (use for general nursing care only, not to be used when CPT codes 99500-99602 can be used)	110.14	110.14	98.63	2.27	0	0	48.52
S9124	Nursing care, in the home; by licensed practical nurse, per hour	88.31	88.31	79.08	1.82	0	0	48.52
S9125	Respite care, in the home, per diem	34.13	0.00	*30.56*	27.3	0	0	1.25
S9126	Hospice care, in the home, per diem	152.48	0.00	*136.54*	121.98	0	0	1.25
S9127	Social work visit, in the home, per diem	742.36	92.79	664.79	15.3	0	0	48.52
S9128	Speech therapy, in the home, per diem	614.75	76.84	550.51	12.67	0	0	48.52
S9129	Occupational therapy, in the home, per diem	608.93	76.12	545.30	12.55	0	0	48.52
S9131	Physical therapy; in the home, per diem	606.50	75.81	543.13	12.5	0	0	48.52
T1000	Private duty/independent nursing service(s)—licensed, up to 15 minutes	27.66	110.63	24.77	0.57	0.00	0.00	48.52
T1001	Nursing assessment/evaluation	162.54	NA	145.56	1.72	1.56	0.07	48.52
T1002	RN services, up to 15 minutes	27.66	110.63	24.77	0.57	0.00	0.00	48.52
T1003	LPN/LVN services, up to 15 minutes	21.83	87.34	19.55	0.45	0.00	0.00	48.52
T1004	Services of a qualified nursing aide, up to 15 minutes	4.37	17.47	3.91	0.09	0.00	0.00	48.52
T1005	Respite care services, up to 15 minutes	0.00	0.00	0.00				
T1019	Personal care services, per 15 minutes, not for an inpatient or resident of a hospital, nursing facility, ICF/MR or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant)	4.85	19.41	4.35	0.10	0.00	0.00	48.52

Code	Description	OWCP rate per unit using OWCP CF A	OWCP rate per hour using OWCP CF B	Adjusted OWCP rate (OMFS 1.20 CF) C	Work RVUs D	Practice Expense RVUs E	Malprac-tice Expense RVUs F	OWCP CF G
T1020	Personal care services, per diem, not for an inpatient or resident of a hospital, nursing facility, ICF/MR or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant)	140.22	17.53	125.57	2.89	0.00	0.00	48.52
T1021	Home health aide or certified nurse assistant, per visit	16.98	0.00	15.21	0.35	0.00	0.00	48.52
T1030	Nursing care, in the home, by registered nurse, per diem	661.33	82.67	592.22	13.63	0.00	0.00	48.52
T1031	Nursing care, in the home, by licensed practical nurse, per diem	529.35	66.17	474.04	10.91	0.00	0.00	48.52

Codes Included in the Fee Schedule

A second set of issues concerns which OWCP codes should be included in the OMFS fee schedule. As discussed earlier, the OWCP fee schedule establishes prices for codes that appear to be duplicative of other codes for home health services (Table 8.4). The values for these codes are usually but not always the same. For administrative simplicity and to avoid potential billing disputes when seemingly similar codes have different fee schedule amounts, the DWC should consider a single set of nonduplicative codes. We have highlighted in bold recommended codes to be used when an injured worker requires home health care services (G0151–G0158) furnished by a home health agency. We have also shaded out selected codes that we believe should not be included in the OMFS (e.g., S9125–S9131). The respite and hospice services are not within the definition of home health services, and per diem rates for other than nursing or aide services are unnecessary and inappropriate. The remaining codes involve policy choices.

HCPCS codes G0159 through G0163 are used to describe the initial development of the plan of treatment for each discipline and any needed reevaluations.[160] G0164 describes patient/family training by a skilled nurse. These codes are potentially problematic for two reasons. First, the OWCP rates for these services are lower than for other home health services furnished by a licensed professional in the same discipline. For example, the 15-minute rate for a physical therapist to develop a therapy program is $44.64 per 15-minute increment compared to $50.46 for other services in the home furnished by a qualified physical therapist. It is not clear why an evaluation and management services should have less value than the other nursing services. The lower rate is also inconsistent with the rates set in other parts of the OWCP for home health visits. For example, the OWCP sets the same rates for a nursing assessment/evaluation visit under T1001 and other nursing visits under CPT 99503-99512. Second, a visit may often involve more than one of the services identified by separate codes. For example, the initial visit may involve both an assessment and services and some patient or family teaching. If each service is reported separately in 15-minute increments, it is possible that the sum of the units for each service will exceed the number of time units that would be reported using total time for the encounter. Potential options are:

- Require that only the code that reflects the primary purpose of the visit be reported along with the total time for the encounter. Most often, this will be the service that took the most time. This approach is consistent with Medicare billing rules (and presumably

[160] Medicare uses the assessment codes for reporting purposes only and does not make a separate per visit payment for the initial assessment that establishes a plan of treatment. Instead, the costs for the initial assessments are treated as an overhead cost and allocated to the service cost per visit. When a low-volume payment adjustment is made, the payment for the initial visit is multiplied by an adjustment factor to recognize that the overhead cost of the assessment visit is spread over fewer visits. The OWCP policy of separately paying for initial assessments is consistent with using time-based units of service. When time-based codes are used, the assessment time is captured in the units and an adjustment to the initial service visit is unnecessary.

OWCP). It addresses the potential overstatement of total time units. However, if the primary purpose is an assessment, the entire visit would be valued less than other nursing services. Because of the payment differential, it also raises the potential for billing disputes over the primary purpose of the visits.

- Exclude the G0159–G0164 codes from the fee schedule. This simplifies the fee schedule, since all home health agency services would be billed under G0151–G0158, including the initial assessment. It eliminates any provider/payer issues regarding the nature of the services provided during the visit. However, it changes the HCPCS coding rules and reduces the capability to monitor the frequency and duration of specific activities.
- Include the G0159–G0164 codes but price them the same as the G0151–G0158 codes. This addresses the payment differential issues. If the codes are to be reported only when reflecting the primary purpose of the visit, it would also address the potential over-statement of total time units. This approach would avoid provider/payer disputes over the primary purpose of the visit and maintain some capability to monitor specific activities. However, it increases the complexity of the fee schedule, since the payment for these codes would deviate from the OWCP policies.

Another issue involves the use of the T- and S-codes. To avoid duplication with the G-codes, these should be limited to situations that require more extensive care than intermittent part-time care over a finite period of time (e.g., 60 days). Licensed individuals either employed by an agency or self-employed would provide these services. To simplify the fee schedule, we recommend that the OMFS incorporate only a subset of codes.

- For nursing services, (RN and LPN/LVN), the policy decision is whether codes are to be reported in hourly time periods (S9123, S9124) or in 15-minute increments (T1002, T1003) and whether there should be a per diem rate (T030, T1031). The S-codes are consistent with the codes that Medi-Cal uses for long-term waiver services. The T-codes improve payment accuracy by capturing service time in 15-minute increments (which may be more discrete than necessary for prolonged nursing services) and setting a lower rate for per diem services. The DEEOIC uses a combination: the S9123 and S9123 for less than eight hours of care and the T030 and T1031 for an eight-hour shift.
- OWCP has prices for multiple codes for nonskilled services, including separate codes for certified home health aides or certified nursing assistants, personal care services, attendant services, personal care services, chore services, and homemaker services. There are several issues that must be addressed in deciding which codes to incorporate into the OMFS:
  - An important consideration is whether attendant services should be separated into personal care and chore services. The IHSS rates do not distinguish between types of unskilled services. OWCP rates are higher for personal care services than homemaker/chore services, but both types of services are unskilled and are often provided by the same individual. The hourly attendant rate falls between the rates for the other two types of services (but the per diem is the same as for personal care).
  - A second consideration is whether home health aides or certified nursing assistants should be paid at a higher rate than other individuals providing personal care services.

- A third consideration is what time units should be used to report services (15-minute, hourly, and per diem). There is no per diem code for services furnished by home health aides or certified nursing assistants.

Medi-Cal uses only two codes: S9122 for services provided by a home health aide and supervised by an RN (hourly rate of $18.90), and T1019 for other personal care services (15-minute increment rate of $3.62). Because Medi-Cal does not explicitly cover homemaker/chore services, it does not use any of the other codes. DEEOIC uses T1019 (15-minute rate of $4.85 which converts to an hourly rate of $19.41), and T1020 (per diem rate which converts to an hourly rate of $17.53) for personal care services. Under DEEOIC's policies, a home health aide, licensed practical nurse, or similarly trained individual must provide these services. DEEOIC uses S9122 for home health aides or certified nurse assistants (hourly rate of $25.23). A trained family member may also provide up to 12 hours of care. When a home health aide provides eight hours of care, he or she is instructed to bill under S5126 Attendant (per diem rate which converts to an hourly rate of $17.53). On an hourly basis, the $17.53 rate for this code is the same as the OWCP per diem rate for T1020. Thus, the hourly rate for home health aides is higher but the per diem rate is the same as for other individuals furnishing personal care services.

Summary and Discussion

In this chapter we examined various issues that DWC will need to address in implementing an OMFS for the full range of home health care services. The plain reading of the Labor Code suggests that the OMFS should be based on the Medicare and IHSS fee schedules for home health care services. The limited nature of both the Medicare-covered services and the IHSS-covered services poses several challenges. Most stem from Medicare's limitation on home health services to intermittent or part-time care. It creates an artificial distinction that, absent the Labor Code requirements for the home health care fee schedule, is irrelevant for services provided to injured workers but increases the complexity of the fee schedule. Moreover, Medicare's per visit rate does not provide as accurate payments as time-based units. Another set of issues pertains to the appropriateness of the IHSS guidelines for injured workers and the adequacy of the hourly rates for attendant services. There is also a gap between the Medicare-covered services and the IHSS-covered attendant care services. Filling the gap with another fee schedule such as the OWCP creates additional complexities by requiring rules to determine which services are subject to each portion of the fee schedule and creates incentives inconsistent with efficient delivery of needed home health services. These issues would intensify if the gap were left unfilled, and disputes over extensive services would remain unaddressed. However, they could be reduced significantly if the OWCP were used to cover all services, or services other than unskilled attendant services.

Chapter Nine: Summary of Findings and Recommendations for Creating an OMFS for Home Health Care Services

DWC asked RAND for technical assistance in developing fee schedule policies for home health care services. We first consulted with stakeholders in the California WC system to outline key concerns with home health care services provided to injured workers that the fee schedule should address. Once we identified the main issues, we reviewed home health fee schedule rates and policies used by other payers to determine how they had addressed similar problems and conducted interviews with WC administrators from other jurisdictions to elicit their experiences in implementing home health care policies in the WC context. We used this information to develop recommendations for the OMFS for home health care services. We now summarize our findings with respect to the specific questions DWC asked RAND to consider and follow with our recommendations.

Summary of Findings

What types of home care services are provided to individuals covered by the WC program, and what is the volume and cost of these services?

From our interviews with California stakeholders, we found that the home health care services being provided to injured workers range from short-term care following an acute episode to longer-term nursing care and supportive services for seriously disabled workers who would otherwise be institutionalized. Because there is no standardized way to report and pay for these services, we were unable to find reliable information on the total volume and cost of the services. Data provided by the WCIRB and One Call Care Management, Inc., indicate that a substantial portion of payments to home care providers is for home health aide and certified nursing assistant services (62 and 73 percent, respectively). Payments for skilled nursing care and physical therapy services are also significant (35 and 24 percent, respectively), but payments for occupational therapy and speech therapy in the home are minimal. We were unable to obtain information on payments to individual injured workers for attendant services either on an ongoing basis or as part of the case settlement.

What features of existing fee schedules for home care services, including Medicare, other WC, and California Welfare and Institutions Code §12300, might serve as a model for the OMFS, keeping in mind the statutory directives to base the schedules on Medicare and IHSS,?

In addition to Medicare and IHSS, we examined in depth the fee schedules used by the OWCP, Medi-Cal, and the VA to ascertain whether they might have features that DWC should consider. Each of these fee schedules is already in use in California for its respective population. In particular, the OWCP (DEEOIC) and Medi-Cal fee schedules cover the full range of home

health services provided to injured workers, and the OWCP policies have been developed for a WC population. Fee schedule features that DWC might want to consider include:

- Allowances that differ by the level of training/licensure of the care provider and whether he or she is (1) an employee of a certified home health agency or (2) an employee of a home care organization or an independent provider. For example, the Medi-Cal fee schedule has higher rates for services furnished by a certified home health agency. Medicare pays only for services furnished by a Medicare-participating agency but does not cover the full range of services, some of which could be provided by a home care organization or qualified independent caregiver.
- Time-based rates that include a lower rate for eight-hour shifts than for services provided over less than eight hours. OWCP uses this approach.
- An aggregate monthly cap on the estimated cost of in-home services. Both Medi-Cal and the VA impose an aggregate cap on all home health services, based on the type of institutional care that would be needed if a seriously disabled individual did not receive home health nursing and supportive services. The VA allows the individual to pay for the excess service costs. OWCP imposes a $1,500 monthly cap on attendant care services.

What options should be considered regarding the services, units of service, and payment amounts for the fee schedule? Could the OMFS be linked to one or more existing fee schedules?

In Chapter Eight, we discuss the various options regarding how the fee schedule might be structured. Overall, we found that the fee schedule maintained by the OWCP (DEEOIC) is the most comprehensive and has the advantage over other fee schedules of already being tailored to the WC population and being integrated with a fee schedule for other medical services (i.e., a Medicare-based RBRVS for physician services). It could be used to supplement Medicare-based and IHSS-based fee schedules or, if there is statutory authority to do so, replace one or both of these fee schedules.

Are there model rules concerning supportive services provided by relatives that might be adapted for the WC program?

Given the Labor Code requirements, we assume that IHSS rules pertaining to supportive services provided by relatives would be the starting point for any DWC policies. One legal issue that DWC will need to consider is whether the provision in the Welfare and Institutions code that explicitly allows certain categories of IHSS services to be provided by a spouse of the recipient (personal care services and paramedical services) would also pertain to the WC program through the Labor Code requirement that home health services not covered by Medicare should be based on the fees and service provider requirements used by IHSS. For assistance with IADLs, the services that may be provided under IHSS are limited if the recipient lives with a spouse who is capable of regular household activities. Neither the spouse nor any other IHSS provider will receive payment for chore and related services, yard work, teaching and demonstration, and

heavy cleaning.[1] Payment for meal preparation, transportation, and protective services is available only if these services are needed in the spouse's absence.[2] A spouse may also be paid for transportation or protective supervision if these activities have required the spouse to forgo full-time employment because another suitable caregiver cannot be found.[3]

Potential models from other programs are limited. The Medicare and Medi-Cal programs do not cover services furnished by family caregivers (except through Medi-Cal's IHSS waiver). Of the 11 states that we identified with legislatively created policies for home health care services, we found that only three states expressly covered the services, four states expressly did not cover the services, and four states did not have specific provisions pertaining to family caregivers (Table 6.4). OWCP allows a relative to provide attendant services for up to 12 hours per day *if* the relative has been properly trained (certified home health aide or certified nursing assistant). Payment may not be made for care that falls within the scope of household duties and other services normally provided by a relative. Duties such as maintaining a household, washing clothes, or running errands are not covered. The restriction of attendant care services to personal care services is typical of the other WC programs that pay for family caregivers.

The VA's family caregiver program for post-9/11 offers a different model. The program is available only to veterans who sustained a serious injury and need at least six months of personal care services or protective services. Compensation is a monthly stipend based on an assessment of the veteran's level of dependency. The stipend avoids the reporting and billing issues that arise regarding the type and duration of services actually provided in a given month and reduces administrative burden but does not account for month-to-month variation in level of services.

What has been the experience of other programs in administering fee schedules for supportive services? What program safeguards do they use to protect against fraud and abuse?

Most state WC programs that cover supportive services limit coverage to personal care services and rely on preauthorization and time-limited authorizations (e.g., OWCP authorizes services for no more than six months at a time) as a mechanism for assuring the care provided to an injured worker is appropriate. The issues and concerns raised in our interviews with California stakeholders did not seem prevalent in states that have established fee schedules and prior authorization requirements.

Fraud and abuse has been an ongoing concern for the IHSS program. The most common form of fraud concerns providers billing for services not performed or for the care of more beneficiaries than they can actually serve. Beneficiaries may fail to report all members of their household and changes in their living arrangements or level of disability that could affect the amount of available services. Safeguards against program abuse have included:

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[1] California Department of Social Services, 2006, 30-763.413.

[2] California Department of Social Services, 2006, 30-763.414.

[3] California Department of Social Services, 2006, 30-763.416.

- an initial and annual assessment of service needs by a clinical social worker
- background checks and fingerprinting of qualified providers
- daily timesheet filed monthly and countersigned by the beneficiary
- comparing caregiver billings against Medicaid claims for periods of time the beneficiary was institutionalized
- in-home visits by county welfare staff to verify authorized IHSS services are being provided and the quality of those services
- maintaining an IHSS hotline for suspected fraud.

Are there existing billing forms that should be adopted for use under each fee schedule? What billing rules should be considered for adoption?

It is likely that multiple billing forms will need to be adopted. Home health agencies use the institutional billing form (UB-04) to bill for services, whereas independent health care practitioners use the CMS-1500. IHSS does not use a billing form, but caregivers are required to submit a standard timesheet each month to the county for processing and payment. DWC may need to develop a billing form for unskilled attendant care tied to an IHSS-like timesheet (assuming that allowances will be based on an hourly rate).

In developing the fee schedule, the billing rules should provide for a standard mutually exclusive set of HCPCS codes that include the full range of home health services and provide guidance on the circumstances under which each code should be used and the items and services included in each unit of service. If DWC needs to draw on multiple fee schedules in developing the OMFS for home health services, the billing rules for a particular code should be consistent with the rules used to develop the allowance. For example, the Medicare per visit rates include both routine and nonroutine supplies furnished during a visit. Moreover, the home health agency is required to furnish all supplies that a beneficiary needs while under a home health plan of care.

What rules should be considered for adoption to clearly delineate the Medicare-based home health agency fee schedule from the IHSS-based home health care services fee schedule and from other workers' compensation fee schedules such as the fee schedule for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) or the physician fee schedule?[4]

Potential rules to delineate Medicare-based care from IHSS-based care are complex and discussed in considerable detail in Chapter Eight. The key factors involve the type of care (intermittent or part-time skilled nursing versus unskilled attendant services) and how the services are delivered (certified home health agency versus home care organization or individual caregiver). The more problematic task will be to differentiate between the services covered by Medicare and the more extensive nursing services that fall into the gap between Medicare-covered services and IHSS-covered services.

[4] California Department of Social Services, 2006.

The distinction between the OMFS for home health services and other OMFS fee schedules should not be problematic as long as the procedure codes and the rules for what items and services are bundled into the payment for the home health services are consistent with whichever fee schedules are adopted for home health services. For example, Medicare pays for all durable medical equipment under the DMEPOS fee schedule, which has already been adopted by the OMFS and requires that all medical supplies be provided by the home health agency.

Recommendations

The task that DWC faces in establishing a fee schedule for home health services that meets the requirements imposed by the Labor Code is difficult. Weaving multiple fee schedules into a single integrated fee schedule is challenging in itself and is further complicated by the absence of data on the volume and cost of different types of home services and caregivers providing services to injured workers. In this report, we have concentrated on identifying options that would result in a single fee schedule covering the full range of home health services furnished to injured workers and have identified a number of options that could be considered. We have developed three sets of recommendations.

The first set deals with policies and activities that should be undertaken regardless of the actions of the other sets of recommendations. The second set pertains to implementing a single integrated fee schedule that would draw on three existing fee schedules: Medicare, IHSS, and the OWCP. These recommendations are based on a straightforward reading of the Labor Code requirements for a home health fee schedule under current law and are being made at the request of DWC. Because we are concerned by the complexities raised by this type of fee schedule and the adequacies of both the Medicare per visit allowances and the IHSS allowances, we have also developed a third set of recommendations based on implementing an OWCP-based fee schedule, at least with respect to skilled home health services that would not otherwise be covered under IHSS. We believe that this fee schedule is more likely to accurately match the allowances with the services needed by injured workers, is less prone to payment disputes and potential abuse, and is administratively less complex. DWC has authority under Labor Code Section 5307.1(b) to establish different payment parameters from those used in the Medicare payment system to make sure that the OMFS allowances are adequate to ensure a reasonable standard of services and care for injured workers as long as the estimated aggregate fees do not exceed 120 percent of the amounts payable in the relevant Medicare payment system for comparable services in the relevant Medicare payment system. Arguably, the DWC might conclude that this provides sufficient authority to adopt the OWCP fee schedule with appropriate modifications to keep within the 120 percent limitation on aggregate fees with respect to intermittent or part-time services covered by Medicare.

Recommended Steps Regardless of How the Fee Schedule Is Established

1. Convene an expert panel representing different perspectives on the home care provided to injured workers to consider issues related to an assessment of an injured worker's need for home health services. The issues that it might consider are:
    a. Whether a standard assessment form should be used for skilled services, and, if so, whether and how the IHSS assessment form might be integrated with an OASIS assessment for skilled services.
    b. Whether the assessment for skilled care and/or supportive services should be independent of the organization(s) that would provide the services, and, if so, the process for undertaking an independent assessment. Would the processes for medical-legal examinations provide a model for consideration?
    c. What other policies should be established regarding the assessments, such as the qualifications of the individual performing the assessment and how often the assessment is performed?
    d. What level of specificity should be required for a physician's prescription?
2. Evaluate whether the IHSS guidelines can be applied to functional status scores for ADLs and IADLs generated with the OASIS instrument and assess whether the resulting estimates of service needs are comparable using the two different instruments.
3. Partner with payer(s) and/or WC case management organizations for a sample of WC patients for whom skilled care is prescribed to obtain a better understanding of the volume and type of home health services currently being provided and the arrangements for providing them.
    a. In the short term, review the medical records to obtain information on the type and duration of visits and the types of arrangements being used. Simulate payments under an integrated fee schedule to identify the "border" issues between the Medicare, OWCP, and IHSS fee schedules.
    b. As a longer-term research effort, use the OASIS instrument prospectively to assess a worker's home health service needs and to compare the actual services to the average services assumed under Medicare's per episode payment. Simulate what would be payable under Medicare's per episode payment to identify the "border" and "bundling" issues and assess whether the per episode payment might be feasible for selected cases (e.g., postsurgical cases that do not require supportive services).
4. With regard to support services:
    a. Confirm the skill levels required to furnish paramedical services under the WC program, i.e., whether the WC program can adopt IHSS policies in this regard without specific statutory authorization.
    b. Require that any caregiver providing attendant services be either employed by a licensed home health agency or registered with the Department of Social Services unless the payer and worker agree to an unregistered home care aide (who may be a family member) who has the necessary skills to provide personal care services.
    c. Require that the physician, the health care professional conducting the assessment, and the injured worker (or representative) participate in the decision regarding whether needed long-term care services can be provided in a home environment safely and the type of arrangements for attendant care services.

d. Use the IHSS guidelines as a starting place to determine the number of hours needed for supportive services exclusive of the monthly cap. Consider what changes might be necessary in the IHSS policies and guidelines to ensure that workers have access to needed services.
e. Assume that the IHSS restriction on services provided by spouses or other family members would be a simple but effective way to address the requirement that family members do not receive payment for services customarily performed prior to the injury.
f. Consider whether to impose a cap on aggregate expenditures, e.g., 120 percent of Medicaid limitations for long-term home care under its waiver program. This would balance worker choice with the cost effectiveness of the arrangement.

5. Standardize the physician prescription forms and billing forms that should be used for home health services to facilitate fiscal responsibility and monitoring of home care services. The OWCP requires that the HCFA-1500 be used for home health services and does not make supplemental payments to injured workers. If injured workers are allowed to pay for services, IHSS requirements for documentation of the services provided during the month should be considered.

Recommendations for a Fee Schedule Developed from Medicare, IHSS, and OWCP

The recommendations that follow are based on using the Medicare per visit rates to pay for intermittent or part-time care, the IHSS hourly rates for unskilled attendant services, and the OWCP rates to fill the gaps between the two fee schedules. There are "border" issues under this approach that would need to be addressed; however, these border issues would still occur if no fee schedule covered extensive nursing services, and the potential for payment disputes would intensify.

1. Use procedure codes to delineate the services covered under the respective fee schedules. Use the G-codes to describe services covered under the Medicare-based portion of the fee schedule. Select a different set of time-based codes to describe the services payable under the OWCP-based portion of the fee schedule and establish a unique code for services that would be paid at the IHSS hourly rates.
2. Use the physician's prescription for home health services to determine whether the patient has need for part-time or intermittent care only or whether more extensive services are needed.
    a. If only intermittent or part-time skilled care (including personal care services) are prescribed, apply the Medicare-based per visit fee schedule to services furnished by a home health agency, licensed nurse, or certified home health aide or nursing assistant and the IHSS fee schedule to any unskilled attendant services.
    b. If the prescribed skilled services exceed the definition of intermittent or part-time, use the OWCP fee schedule to pay for all needed services other than attendant services, which would be paid under the IHSS-based fee schedule.
    c. If only attendant services are required, all services would be payable under the IHSS-based fee schedule.

3. Develop policies to address the fee schedule implications of situations where the actual level of care provided to the injured worker does not match the prescribed level.

Recommendations for a Fee Schedule Based Only on OWCP

The recommendations that follow are based on using OWCP (DEEOIC) rules and payment rates for home health services as the basic model for the OMFS fee schedule with appropriate adaptations for the California WC program. The OWCP fee schedule covers the full-range of home health services, is updated regularly, ties into the OWCP fee schedule for physician services (which uses the RBRVS) and is coordinated with other Medicare-based fee schedules. Unlike the Medicare or Medicaid fee schedules, it has policies tailored to a workers' compensation population, e.g., coverage limited to services required by the work-related condition.

1. Select a subset of HCPCS codes that cover the full range of home health services to be covered under the OMFS. These codes should be time-based (including a per diem code for eight-hour shifts) and should differentiate between training and licensure/certification levels (e.g., RN vs. LVN; certified home health aide vs. unskilled attendant), and how the services are provided (e.g., certified home health agency vs. home care organization or independent caregiver).
2. In setting the allowances,
    a. Adjust the conversion factor for skilled services as necessary to keep the payment for intermittent or part-time care within the 120 percent aggregate limit.
    b. Benchmark the rate for attendant services to the prevailing rate for personal care services in California (updated for inflation) rather than either the IHSS or OWCP rates.
3. Adopt billing rules consistent with how they are applied under the OWCP fee schedule.

Our recommendations are based on the Labor Code requirements, which may not provide DWC with the flexibility needed to implement an OMFS for home health services that provides for efficient delivery of appropriate home health care to injured workers. If statutory changes are needed, DWC may wish to concentrate in the short term on the IHSS-like services because these are the services that engender the most concern in the current system. However, we would be concerned about putting in place fee schedule features that may not be the most appropriate policies in the long run but may be difficult to change after they are implemented.

Appendix A. Data Collection Methodologies

This appendix provides an overview of the way we collected and analyzed data to inform the development of the California WC home care services fee schedule. We provide a description of how we conducted stakeholder interviews, performed a scan for similar policies in other jurisdictions, and interviewed administrators from other jurisdictions. We then briefly address how we analyzed the findings of our research so as to provide information to the DWC. Finally, we discuss the limitations to this research.

Goal of Data Collection

Our goal in conducting this research was to provide information relevant to the California DWC's adoption of a new fee schedule for home care services. To this end, we structured our data collection toward defining the problem before the DWC through a series of stakeholder interviews and exploring issues faced by other jurisdictions with similar policies through a series of interviews with representatives from WC programs in other jurisdictions. However, due to the limited time frame of the project and the complexity of issues in this policy area, we confined ourselves to gathering material that could directly inform the policy being implemented by the DWC. As will be discussed, our findings are of limited applicability outside this particular context.

Data Collection

All interviews were conducted by one of the coauthors, both of whom have prior experience in interviewing. The interviews were conducted on the phone. Although they were not recorded, extensive notes were taken during the interviews; these notes formed the basis for our subsequent analysis. We interviewed two groups of people: stakeholders in the California WC system and representatives from other states' WC systems. In addition, we performed a scan for similar policies in other jurisdictions.

Stakeholder Interviews

Given the sensitive nature of this issue and the DIR's interest in meeting the needs of all stakeholder groups, we identified groups of stakeholders with significant interest in the fee schedule and related issues: applicants' attorneys representing injured workers, payers and defense attorneys, home care providers, and care management organizations. We identified individuals in each key stakeholder group in the California WC system through our prior research and knowledge of California's WC system and conversations with the DIR at the outset of the project. We conducted nine interviews with a convenience sample of California

stakeholders, including at least two representatives from each group. Because our goal was to conduct an environmental scan of home care issues under WC, we elected to interview applicants' attorneys who have experience with the issues confronting multiple injured workers rather than a few individual workers receiving home care services whose experiences may not be representative of the broader WC population.

Once they had been identified, stakeholders were contacted and asked a series of open-ended questions designed to elicit their concerns regarding coverage of home health services and attendant care services as it existed before the passage of SB 863. A complete list of these questions can be found in Table A.1. Respondents were asked to identify what problems they had seen regarding both the calculation of payment for these services and the rules in place to regulate these forms of care. This information was then used to outline the issues facing the DIR, so that this analysis could address the concerns of the stakeholder groups.

Table A.1. Description of Interview Protocol

	Questions
1	Would you please describe how you are involved in the WC medical treatment system in California generally? With respect to the provision of home health services?
2	In your experience, what types of injured workers require home health services? What is the process for determining what services are needed? Who provides the services? The payments for the services?
3	Are there specific types of services that seem to be more problematic than others in reaching agreement between the payer and injured worker regarding what home health services are needed? Are there specific regulatory changes that you would like to see that would address these areas?
4	We are trying to get better data on the types of patients requiring home health care, the types and duration of services that are provided, and the characteristics of service providers. Do you have access to any data in this regard that you would be willing to share with us?
5	What issues prompted the enactment of the SB 863 provisions regarding home health? Are these issues widespread among workers receiving home care or are they limited to a subset of patients or types of services?
6	In your view, what issues are posed by the implementation of the SB 863 provisions? Do you have recommendations for specific policies that DWC might consider?

Scan of Policies from Other Jurisdictions

In order to present policy alternatives from other jurisdictions, we first engaged in a review of the theoretical literature to determine whether any states were identified as having particularly influential policies in the area of WC and home care services. After this was complete, we engaged in thorough LEXIS searches of state statutes and administrative codes to discover all

jurisdictions that had made policy in this area. It was soon apparent that, while some states had implemented statutes and regulations specifically to address the issue of WC and home care services, others had created policy only through judicial interpretation of WC statutes that did not explicitly address home care services. Because California has passed a statute to address WC payment for home care services, we focused on those states that had enacted similar policies.

Once the appropriate states had been identified, we then searched for appropriate documentation from each state. This search began with the state's statutes and regulatory codes, and then expanded to include other sources of information from the state agencies involved in implementing WC policies. While we were particularly interested in finding official medical fee schedules or related rules from each state, we also paid attention to other types of documentation provided to workers' compensation recipients and providers within each state, including publications describing the state's policies and responses to "frequently asked questions." The goal of this research was to be able to characterize how each state had or had not enacted policies that addressed the concerns of the DIR and California stakeholder groups.

State Administrator Interviews

After we had identified states with policies on WC and home care services that might inform the DIR during the upcoming rulemaking process, we contacted administrators from each state with relevant policies. We began by contacting a high-ranking leader within each agency by email, either directly where the appropriate contact information was available or indirectly though the general email directory where it was not. We asked to be directed to the most appropriate person to interview regarding the implementation of home care policies within the state. We made repeated efforts to contact informants from each state, generally through both email and phone calls. In total, we conducted seven interviews with administrators from six different states.

Once we had located an appropriate informant, we interviewed that person about the state's experiences in implementing policies related to WC and home care services. We utilized a standard interview protocol but allowed for flexibility where the subject identified additional issues or concerns. Specifically, we asked questions regarding composition of the fee schedule, limitations on coverage, provision of services by family members, and the volume and costs of services. Table A.2 describes the interview protocol used to elicit this information.

Table A.2. Description of Interview Protocol

	Questions
Fee schedule and related rules	• How does your state determine who is eligible to receive home health care services? • How is the fee schedule calculated?
Limitations on coverage	• Are there any other conditions that must be met before receiving home health care services? • Is there a cap on reimbursement?
Provision of services by family members	• Does your state allow for reimbursement of home health care services provided by a spouse or family member? – If so, are there any conditions that must be met? – What services can the spouse or family member provide? – Are there any additional limitations? – How is payment to the spouse or family member calculated? – What has been your experience in implementing these rules? Have you experienced any major problems, or had any significant push-back from key stakeholders? – Have there been systematic problems with fraud or abuse of this program? – What, if any, safeguards do you have in place against fraud and abuse? – What sort of notice must be given the employer?
Cost and volume of services	• What is the volume and cost of these services?

Data Analysis

After data collection had been completed, the interview notes were used as the basis for our analysis. We reviewed the notes carefully, making note of instances where the interview subjects mentioned something relevant to our research. Due to the short time frame of the project, we did not formally record, transcribe, and thematically analyze our interviews. As our goal was to assist a specific policy effort, we believe that our simple procedure to explore the information obtained through the interviews was appropriate. However, as discussed in the next section, it will limit our results.

The information gathered was then organized into a matrix, with the key issues identified by both the DIR and the key California stakeholders across the horizontal axis and the alternative policies identified through the research of other jurisdictions down the vertical axis. This matrix enables analysis of various policy options both within and across jurisdictions and makes it possible to understand how different state policies addressed different issues currently facing the DIR.

Limitations

Our selection of key stakeholders from the California WC system was based on conversations with the DWC and our prior knowledge of the California WC system. The stakeholders interviewed included representatives from both insurer groups and worker groups. We chose to interview applicants' attorneys representing injured workers rather than individual

injured workers. While applicants' attorneys have broader exposure to issues involving home care services, their perspectives may not be the same as injured workers'. In addition, we interviewed a small number (n = 9) of stakeholders. Interviewing other stakeholders might have added to the list of potential issues, and a more complete investigation of issues related to provision of home health services within the WC system could elicit interesting problems we have not uncovered. However, given the short time frame and narrow scope of the project, our goal was simply to discover and document the most pressing issues underlying the passage of SB 863.

Similarly, we purposely targeted informants from agencies in states with similar workers' compensation home health care policies. As our goal was to shed light on problems that might be faced by the California WC system, we prioritized gathering information from agencies that had implemented similar policies. However, this limits the generalizability of our results. Our description does not represent all or typical concerns related to WC payment for home health services. Rather, it was intended to be an exploration of potential issues that might be faced by a specific agency implementing a specific policy. These issues might be different in the context of a different WC system with different policy priorities.

Finally, due to the short time frame of this project and the legislatively imposed deadline for policymaking, we were not able to record, transcribe, and formally derive themes from our interviews. A more extensive analysis might have yielded more detailed information about the experiences of stakeholders and informants from other jurisdictions. In addition, we have not verified our analysis by asking interview subjects to review and remark upon our results. In line with the goals of the project, our discussion of the findings from our interviews should be viewed as only an exploration of potential experiences and complications that the DIR may face when implementing a home health services fee schedule, rather than a comprehensive description of all issues regarding payment for home health services by WC.

Appendix B. California Academy of Physician Assistants Survey on IHSS Wages as of May 28, 2012

Table B.1. California Physician Assistant Hourly Wages, by County

County		Hourly Wage ($)	County		Hourly Wage ($)
Alameda		11.50	Orange		9.30
Alpine	(not a Public Authority county)	8.00	Placer		10.00
Amador		8.50	Plumas		8.56
Butte		8.15	Riverside		11.50
Calaveras		10.00	Sacramento		10.40
Colusa		8.00	San Benito		10.50
Contra Costa		11.50	San Bernardino		9.25
Del Norte		9.00	San Diego		9.50
El Dorado		9.00	San Francisco		11.54
Fresno		10.25	San Joaquin		9.45
Glenn		8.15	San Luis Obispo		10.00
Humboldt		8.00	San Mateo		11.50
Imperial		9.00	Santa Barbara		10.00
Inyo		8.75	Santa Clara		12.20
Kern		9.50	Santa Cruz		11.50
Kings		9.00	Shasta		9.30
Lake		8.75	Sierra		8.56
Lassen		8.00	Siskiyou		8.00
Los Angeles		9.00	Solano		11.50
Madera		9.75	Sonoma		11.50
Marin		11.55	Stanislaus		9.38
Mariposa		9.30	Sutter		9.25
Mendocino		9.90	Tehama		8.40
Merced		9.00	Trinity		8.00
Modoc		8.00	Tulare		9.00
Mono		8.00	Tuolumne	(not a Public Authority)	8.00
Monterey		11.50	Ventura		9.50
Napa		11.50	Yolo		10.50
Nevada		8.56	Yuba		10.00

NOTE: The information is as up to date as individual county Public Authorities provided.

Appendix C. Overview of Policies on Attendant Care Services

Table C.1. Comparison of Various Payers' Policies on Attendant Care Services

Jurisdiction /Payer	Attendant Care Services Covered	Activities Included Within Attendant Care Services	Limitations on Availability of Attendant Care Services
IHSS	Yes	Covers both personal care services and chore services	
Medicare	No, unless skilled nursing care is also needed	Personal care services and limited chore services that do not substantially add to time	May only be provided when skilled nursing care is needed
VA	Yes	Covers both the activities of daily living (personal care services) and the instrumental activities of daily living (chore services)	
Florida	Yes	Must be provided by a trained professional and does not include normal household duties	
Hawaii	Yes	Not explicitly defined	Total monthly award for attendant care services may not be more than four times the maximum allowable weekly award.
Massachusetts	Yes	Covers both personal care services and chore services	
Michigan	Yes	Covers personal care services, such as assistance with dressing and medications; does not cover chore services	
North Carolina	Yes	Not defined; included as part of the definition of medical compensation	
Ohio	Yes	Personal care services such as assistance with feeding, bathing, and hygiene; but not chore services such as cooking and cleaning	
Pennsylvania	No		Coverage of attendant care services is at discretion of insurance provider.
Tennessee	No		Coverage of attendant care services is at discretion of insurance adjuster.
Texas	No		Attendant care services are not a medical service; would be between employee and insurance carrier.
Washington	Yes	Personal care services such as assistance with ambulation, bathing, supervision of mentally impaired persons; but not chore services such as assistance with laundry	Maximum allowable number of hours is based on the nursing assessment of the injured worker.

Appendix D. Overview of Policies on Services Provided by Family Members

Table D.1. Comparison of Various Payers' Policies on Services Provided by Family Members

Jurisdiction/Payer	Family Caregivers Allowed	Limitations on Services Family May Provide	Other Limitations
IHSS	Yes	May provide only certain types of care, e.g., will not be reimbursed for providing chore services	Cap on maximum number of hours of care covered per month
Medicare	No		
VA	No, except for seriously injured 9/11 victims		10–40 hours per week based on level of needed personal care services
Florida	Yes	Can provide only "nonprofessional attendant care," cannot be reimbursed for normal family chores	
Hawaii	Not specified		
Massachusetts	No		
Michigan	Yes		Spouse cannot provide more than 56 hours/week of care.
North Carolina	Yes		Must first obtain written permission from the N.C. Industrial Commission for family members to perform services
Ohio	No		As allowance of family caregivers is being phased out, this may be allowed for injuries sustained before a certain date.
Pennsylvania	Not specified		
Tennessee	Not specified		
Texas	No		
Washington	Only if approved prior to 2001	Grandfathered spousal services limited to 70 hours per week	Must allow periodic nursing evaluations in the worker's residence
Federal OWCP	Only if trained as a home health aide, licensed practice nurse or similar training	No more than 12 hours per day	

References

ABT Associates, *Analyses in Support of Rebasing and Updating the Medicare Home Health Payment Rates—CY 2014 Home Health Prospective Payment System Final Rule*, Cambridge, Mass., November 27, 2013. As of December 4, 2014: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Downloads/CY2014-HH-PPS-Final-Rule-Technical-Report.pdf

Bishop, C. E., R. S. Brown, B. Phillips, G. Ritter, and K. C. Skwara, "The Home Health Visit: An Appropriate Unit for Medicare Payment?", *Health Affairs*, Vol. 15, No.4, 1996, pp. 145–155. As of December 4, 2014: http://content.healthaffairs.org/content/15/4/145.full.pdf

California Advocates for Nursing Home Reform, *IHSS—In Home Support Services,* website, September 2014. As of December 3, 2014: http://www.canhr.org/factsheets/misc_fs/html/fs_ihss.htm

California Department of Health Care Services, *Manual of Criteria*, "Chapter 9.1, Criteria for Home Health Agency Services," 2014. As of December 3, 2014: http://www.dhcs.ca.gov/services/medi-cal/Pages/ManualofCriteria_ada.aspx

———, Medi-Cal, *Medical Manual Part 2: Outpatient Services for HHA and HCBS*, January 2012.

———, Medi-Cal, *Provider Manuals*, website, 2007. As of December 3, 2014: http://files.medi-cal.ca.gov/pubsdoco/manuals_menu.asp

California Department of Industrial Relations, Request for Proposal, DIR/DWC RFP No. 12-008, January 10, 2013.

California Department of Social Services, *Social Services Standards*, Service Program No. 7: In-Home Supportive Services, Chapter 30-700, October 12, 2006.

CMS—*See* U.S. Department of Health and Human Services, Centers for Medicare & Medicaid.

Code of Massachusetts Regulations, 130 CMR, Section 422.111, Independent Living Services for the Personal Care Attendant Program, March 2008.

Code of Massachusetts Regulations, 114.3 CMR, Section 50.01(1), Home Health Services. General Provisions, December 2008.

Code of Massachusetts Regulations, 114.3 CMR, Section 50.02, Home Health Services, General Definitions, December 2008.

Commonwealth of Pennsylvania, 34 Pennsylvania Code, Chapter 127, Section 127.157: Medical Fee Updates on and After January 1, 1995—Home Health Care Providers, 1994.

Disability Rights California, *In Home Supportive Services: Nuts and Bolts*, May 2008.

———, *In Home Supportive Services Protective Supervision*, Publication 5493.01, December 2010.

Federal Register, Code of Federal Regulations, Title 20, Volume 1, Section 10.314—Will OWCP Pay for the Services of an Attendant?, 2010.

———, Title 38, Chapter 1, Part 17, Section 17.37—Enrollment Not Required, 2013.

Florida Division of Workers' Compensation, *Health Care Provider Reimbursement Manual, 2008 Edition*, 2008. As of December 12, 2014: http://www.myfloridacfo.com/WCAPPS/CPT/ProviderManMenu9.asp

Healthcare Market Resources, "Is Cutting Home Health Aide Visit Time a Viable Cost-Saving Step for Your Agency?", *Market Research Letter*, July/August 2012. As of December 4, 2014: http://www.healthmr.com/1208-metrics-matter/

Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, 2014a.

———, *A Data Book: Health Care Spending and the Medicare Program*, 2014b.

MedPAC—*See* Medicare Payment Advisory Commission.

Michigan Compiled Laws, Public Act 317, Worker's Disability Compensation Act of 1969, Section 418.315, 1969.

Michigan Department of Licensing and Regulatory Affairs, Workers' Compensation Agency, Michigan Administrative Code, R 418.10909, "Billing for Home Health Services," 2008.

Montana Department of Labor and Industry, Montana Professional Fee Schedule, 2013. As of December 16, 2014: http://mtwcfeeschedule.ingenix.com/feeSchedule.aspx

Nebraska Court of Appeals, Memorandum Opinion and Judgment on Appeal, Traffansetdt v. Seal-Rite Insulation, No. A-12-183, 2012.

North Carolina Industrial Commission, *Medical Fee Schedule*, 2013.

Ohio Bureau of Workers' Compensation, *Fee Schedule Look-Up*, website, undated. As of December 4, 2014: https://www.ohiobwc.com/provider/services/feelookup/

State of California, Senate Bill No. 863, 2011–2012 Regular Session (California 2012). September 19, 2012.

State of California, Welfare and Institutions Code, Section 12300-12330, 2013.

State of Florida, 2011 Florida Statutes, Title XXXI, Chapter 440, Section 13, Medical Services and Supplies; Penalty for Violations; Limitations, 2011.

State of Hawaii, 2012 Revised Statutes, Title 21, Section 386-23, Services of Attendant, 2012.

State of Nebraska, Revised Statutes, Chapter 48, Section 120, 2011.

State of Ohio, Administrative Code—Workers' Compensation Rules, Chapter 6, Section 4123-6-38: Payment for Home Health Nursing Services, Part (D), July 2013.

State of Texas Administrative Code, Title 28, Part 2, Chapter 134, Subchapter C, Rule 134.204: Medical Fee Guideline for Workers' Compensation Specific Services, Section (f), 2008.

United States Code, Title 38, Part II, Chapter 17, Subchapter II, Section 1720C—Noninstitutional Alternatives to Nursing Home Care, 2011.

———, Title 42, Section 1397, Subchapter XX—Block Grants to States for Social Services, Section 1397—Purposes: Authorization of Appropriations, 2013.

U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, *Medicare and Home Health Care*, Baltimore, Md., 2010.

———, Centers For Medicare & Medicaid Services, "Home Health Prospective Payment System Rate Update for CY 2014, Home Health Quality Reporting Requirements, and Cost Allocation of Home Health Survey Expenses; Final Rule," *Federal Register,* Vol. 78, No. 231, 2013. As of December 2, 2014: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Home-Health-Prospective-Payment-System-Regulations-and-Notices-Items/CMS-1450-F.html?DLPage=1&DLSort=2&DLSortDir=descending

———, Centers for Medicare & Medicaid Services, *Home Health Providers*, website, April 2013. As of December 2, 2014: http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/HHAs.html

———, Centers. for Medicare & Medicaid Services, *Home Health Care: What It Is and What to Expect*, website, undated. As of December 2, 2014: http://www.medicare.gov/what-medicare-covers/home-health-care/home-health-care-what-is-it-what-to-expect.html

———, Centers for Medicare & Medicaid Services, *What is Medicare?*, website, undated. As of December 2, 2014:

http://www.medicare.gov/sign-up-change-plans/decide-how-to-get-medicare/whats-medicare/what-is-medicare.html

U.S. Department of Health and Human Services and U.S. Department of Justice, *Health Care Fraud and Abuse Control Program, Annual Report for Fiscal Year 2011*, February 2012.

U.S. Department of Labor, Bureau of Labor Statistics, Occupational Employment Statistics, *Occupational Employment and Wages*, website, April 2014. As of December 3, 2014: http://www.bls.gov/oes/current/oes311011.htm

———, Office of Workers' Compensation Programs, *OWCP Medical Fee Schedule*, 2013.

U.S. Department of Veterans Affairs, *Purchased Skilled Home Health Care Services*—FAQs, VA Palo Alto Health Care System, January 2014. As of December 3, 2014: http://www.paloalto.va.gov/pshhfaq.asp

———, *Geriatrics and Extended Care: Skilled Home Health Care*, September 2014. As of December 3, 2014: http://www.va.gov/geriatrics/guide/longtermcare/Skilled_Home_Health_Care.asp

———, Veterans Health Administration, *VHA Handbook 1140.3*, *Home Health and Hospice Care Reimbursement Handbook*, Washington, D.C., August 2004. As of December 3, 2014: http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=1139

———, Veterans Health Administration, *VHA Handbook*,*1140.02, Respite Care*, Washington, D.C., 2008.

Washington State Department of Labor and Industries, Workers' Compensation Services, "Payment Policies for Healthcare Services Provided to Injured Workers and Crime Victims," *Medical Aid Rules and Fee Schedules (MARFS)*, July 2013.