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The Long-Term and Post-Acute Care Continuum

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As a geriatrician, a physician specializing in the care of the elderly, I have found that one of the most interesting as well as challenging aspects of providing geriatric care is understanding all the different types of care available for seniors, and appropriately advising patients and colleagues. I have repeatedly noticed that not only the general public but even many physicians don't fully appreciate the variety of care settings for seniors. Families need to understand what options are available for their loved ones, and health care providers need to understand what options are available for their patients. Too often I have seen, for example, patients discharged from the hospital on the assumption they can get certain types of tests or followup care in their "nursing home" when in fact the patient lives in an independent or assisted living facility where no such services are available. Therefore it will be helpful to summarize what the aging network calls "the continuum of care," following the trajectory of a hypothetical senior patient (*Mrs. "S.P."*) from independence down to the end of life.

As background, it is necessary to be familiar with Medicare and Medicaid and what they cover. Since their establishment in 1965 as Titles 18 and 19 to the Social Security Act (http://www.ssa.gov/OP_Home/ssact/ssact-toc.htm), both Medicare (Health Insurance for the Aged and Disabled) and Medicaid (Medical Assistance for the Poor) cover aspects of long term care (LTC) but in different ways. Medicaid covers long term nursing home care for those who qualify financially and medically, but generally does not cover residential care/assisted living. Medicare is more complicated due to its four different parts. Medicare Part B covers physician services and therapies, generally regardless of location (i.e. physicians bill Medicare Part B for patients seen in hospitals, outpatient or LTC settings, but using different billing codes based on setting). Medicare Part A covers hospitalizations, hospice, home care, and skilled nursing home care, but only temporarily after a 3 day hospital stay (about which, see more below). Medicare Part D covers drugs and vaccines regardless of settings, and Medicare Part C consists of various managed care plans, which vary in benefits but always cover at least whatever traditional Medicare covers. Most, if not all, seniors in America have Medicare. Medicaid has strict financial qualifications which differ by state. Those who qualify for both Medicare and Medicaid are termed "dual eligibles." In addition to U.S. government web sites such as www.medicare.gov, a good source of facts on Medicaid and Medicare may be found at the AARP Public Policy Institute web site, http://www.aarp.org/research/ppi/.

Simultaneously with the passage of Medicare and Medicaid in 1965, the federal government passed the "Older Americans Act" which funds social programs for seniors via the U.S. Administration on Aging ("AoA") and state/local Area Agencies on Aging ("AAA's") (http://www.eldercare.gov/Eldercare.NET/Public/About/Aging_Network/lndex.aspx).

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AAA's offer many services including senior centers in most communities, where the elderly can go for activities and meals during the day for a small fee.

The case

Mrs. S.P. is an 80 year old widow with osteoporosis and mild cognitive impairment due to early stage Alzheimer's disease, who still lives alone in her own home in a "55-plus" community. Her daughter a close friend/neighbor help her with shopping, paying bills, and traveling to appointments, but she is safe to be home alone most of the time. She sometimes goes to a Senior Center for lunch and companionship, visits her primary care physician's office every few months, and still manages her own prescriptions with occasional help and reminders from the daughter and the neighbor.

Independent Living

Like Mrs. S.P., a majority of seniors live independently in their own private homes or apartments, alone or with friends or loved ones, and are able to function sufficiently, schedule and travel to medical and other appointments, obtain food and medicine, and generally manage their own basic needs. "Independent Living" includes private homes or apartments, subsidized or other congregate apartments for seniors, sometimes attached to other levels of care in a residential care community. Most independent seniors' outpatient medical needs are covered by Medicare Part B and Medicare Supplement policies, including Medicaid. When function starts to deteriorate but the need for personal assistance is modest, seniors are often helped by their families, friends, or other informal nonpaid caregivers and are able to stay at home until something changes.

Home Care

Mrs. S.P. is hospitalized for a urinary tract infection with delirium. She recovers but remains deconditioned and cannot ambulate as well as before or get out to her doctor's office. She is not yet judged to require 24 hour care. Thus the hospital social worker sets her up for home nursing care and therapy upon discharge, and her doctor offers to follow her at home as well.

Agency Home Care

Medicare Part A pays for skilled home care by a visiting nurse agency, if the patient is predominantly homebound and requires intermittent skilled nursing care and therapies (http://www.medicare.gov/coverage/home-health-services.html). Care is not provided every day or indefinitely, and generally the patient will have had a recent change in condition such as acute illness or hospitalization. With the exception of special state "waiver programs" (discussed below), custodial or non-skilled long-term care at home is generally not covered by any health insurance, but there are many non-medical agencies and companion services available for a fee.

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Physician Home Care

Medicare Part B covers all medically necessary physician home visits, using home visit codes 99341-50 (Giovino, 2000). For physician home visits under Medicare Part B, the patient does not have to be completely home bound, though the reason for the medical necessity of the visit must be documented. Conversely, under the latest regulations, in order to be eligible for skilled agency home care under Medicare Part A, the patient must be certified home bound, and effective 2011 must be seen "Face to Face" by the physician or NPP (non-physician provider; nurse practitioner or PA) within 90 days before or 30 days after the start of home care services (http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1038.pdf). A form documenting the "Face to Face" visit, including the reason for the visit and for the patient's homebound status, must be provided to the home health agency in order for the agency to get paid and the patient to get services. The physician/NPP may bill Medicare Part B for both the face to face visit (office, hospital, nursing home or home visit), and additionally for filling out the home health certification forms (home care certification/recertification codes G0179-GO181) (Nicoletti, 2005).

Waiver Programs

For patients who qualify for both Medicare and Medicaid (dual eligibles) and who otherwise would qualify to be in a nursing home, state "Medicaid Waiver Programs" may provide extra home and community based care. Depending on state funds and regulations, extra social and nursing support may be available to help such individuals remain at home rather than being in a nursing home, which most people would prefer. The State of West Virginia does offer this "Waiver" program to a limited number of aged/disabled individuals subject to the availability of state funds (http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html).

Mrs. S.P's primary care physician visits her at home, bills Medicare Part B for a home visit code, 99349, and returns the Face to Face certification form sent by the home care agency by fax. Several days later he receives in the mail a home care plan of care certification form (Form "485") from the agency, and bills Medicare code G0180 for signing this form and returning it to the agency. The home care agency then bills Medicare Part A for their services which continue for several weeks. After the home care episode is over, in consultation with the visiting nurse and family, the doctor decides that Mrs. S.P. is no longer safe to live at home alone due to increasing frailty and dementia and requires care most of the day and assistance with medications and ADL's. After a period of trying Adult Day Care, she is admitted to an Assisted Living Facility.

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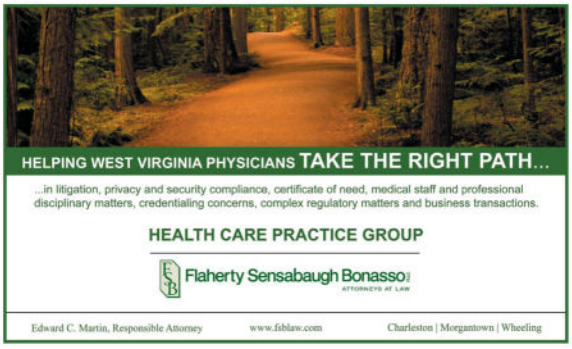

The necessity of, and insurance coverage for, long term care is often defined based on functional impairment and the need for assistance in activities of daily living. To qualify for nursing home care, the patient must usually be impaired in 4 activities of daily living (ADL's; 5 in West Virginia). The five classic basic/self-maintaining activities of daily living (ADL's) are bathing, dressing, toileting, transferring in and out of bed, and eating. More advanced functions such as going out and traveling, keeping track of money and medicine, and using the telephone are termed "Instrumental" or "Intermediate" activities of daily living (IADL's) (Lawton & Brody, 1969). To qualify for assisted living, less assistance is needed than for a nursing home (i.e. dependent in less than 4–5 ADL's), but there still must be some functional need such as provision of medications and meals. To qualify for payment under private long-term care insurance policies for any type of LTC, again some documented ADL impairment with corroborating medical justification is generally required, usually with a 100 day elimination period depending on the policy.

Assisted Living

When an older person, such as Mrs. S.P., needs enough assistance in ADL's that they are unsafe to live alone and don't have enough informal/family supports to survive safely at home, the next level of care is usually assisted living, also known as personal care, residential care, boarding homes or rest homes. These facilities range from small adult foster homes to large institutional settings and are generally privately owned and operated on a fee for service basis. Assisted living, like non-medical home care, is not usually covered by insurance unless the individual has purchased a private long term care insurance policy for such a contingency. Assisted living facilities (ALF's) are licensed and regulated by the

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individual states, but not as rigorously as with nursing homes; they vary in their capabilities and requirements under state law. Consumers must clearly understand what services they are paying for. Usually ALF's provide light duty nursing (including medication administration, insulin injections, and checking vital signs and labs) 24 hours a day, as well as outpatient therapy and activities. ALF's usually dispense medicine and provide three meals a day. Most ALF patients have at least one ADL deficit and often more, but are not completely dependent in all ADL's. ALF's do NOT usually have medical care available onsite and cannot care for anyone with heavy nursing needs (e.g. skilled wound care, feeding tubes, I's & O's (fluid intake/output), catheterization, IV's or other injectable medications other than insulin). Importantly, in most states including WV, ALF's cannot be responsible for individuals who are not ambulatory enough to vacate the building fairly independently in case of an emergency.

Physicians and NPP's may see ALF patients either in their office or at the facility, in which case "Domiciliary Care" codes 99324-99337 are used to bill Medicare Part B. The different billing codes used by Medicare since 2006 for visits to private homes vs assisted living homes and nursing homes are explained in the following Medicare document: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/mm4212.pdf.

Definitions, terminology, and regulation of assisted living also vary greatly from state to state. A very general definition for assisted living is a "facility where persons not related to the owners are provided assistance with ADL's, meals and medications in a residential setting." In West Virginia, Assisted Living Regulations may be found at 64CSR 14, http://www.wvdhhr.org/ohflac. These regulations in WV differentiate between assisted living facilities (4 or more beds), residential care facilities (17 or more units part of a larger independent living community), small boarding/rest homes, and small unlicensed homes. Assisted Living and Residential Care are defined in WV as "places providing personal assistance and/or supervision to persons who are dependent upon the services of others by reason of mental or physical impairment, and who may require limited/intermittent nursing care." The consumer, and health professionals recommending these facilities, should have a full understanding of the type of facility being looked at and exactly what is provided, since they vary greatly (AGS, 2005). Alzheimer's Care or Memory Care units are another variant of Assisted Living which provides secure care and extra supervision for dementia patients. There are approximately 100 ALF's in West Virginia with about 3000 beds, and about 50,000 ALF's nationally, serving over 1 million individuals.

Adult Day Care

For some older persons who have family members who can care for them at night at home, but who need activities and care during the day (e.g. Mrs. S.P., whose daughter works), Adult Day Care may be an option (http://www.eldercare.gov/Eldercare.NET/Public/Resources/Factsheets/Adult_Day_Care.aspx). These programs, available in most localities, offer several hours of care and supervision during the day, including meals and activities, and sometimes medication and therapies while the patient is there, several days per week. Most Adult Day Care programs are self-pay and not covered by insurance, but some

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programs have state funding or subsidies. An important variant of the Adult Day Care program, where available, is the "PACE" program – The Program of All Inclusive Care for the Elderly. PACE is generally a day-care center based intensive care management program, aimed at keeping nursing home-qualified patients on both Medicare and Medicaid ("dual eligibles") at home, which both saves money and improves quality of life. Modeled on the pioneering "On Lok" day care program in Chinatown in San Francisco, this excellent program has been replicated in many other areas of the country, but is unfortunately not available in West Virginia at this time due to a lack of state funding. A good summary of the history and nature of PACE programs may be found at http://www.npaonline.org/website/article.asp?id=12&title=Who,_What_and_Where_is_PACE?

Nursing Homes

After a few months at the ALF, Mrs. S.P falls and breaks her hip. She is now non-ambulatory and dependent in several ADL's and thus needs complete 24 hour care. For post-acute care, she is considered for an inpatient rehabilitation facility (IRF) but is felt to be too weak to qualify for an intensive rehabilitation program. The hospital social worker now refers her for nursing home placement. The hospital physician signs a "PAS" form (Pre Admission Screening) which certifies that the patient has at least 4–5 ADL deficiencies and needs to be in a skilled nursing facility for rehabilitation and possibly long-term care. The physician bills Medicare Part B for seeing her in the hospital and then in nursing home, and the skilled nursing facility bills Medicare Part A for up to 100 days of skilled care.

Nursing homes (NH's), also known as nursing facilities (NF's) or skilled nursing facilities (SNF's), care for the sickest, neediest people in our society. When someone is too impaired to live at home or in the relatively unsupervised ALF setting, the next stop is usually a nursing home. Patients may stay in a NH temporarily for rehabilitation and recuperation after a minimum 3 day hospitalization (in which case Medicare A pays for up to a few months), or long term for the rest of their lives (in which case Medicare does NOT pay for the nursing home but Medicaid does after personal assets have been spent down). Regardless of setting, Medicare (Part B) generally pays for doctor's bills and outpatient testing and therapies. Medicare Part A pays the SNF 100% of skilled care fees for days 1–20, partially for days 21–100 (with a patient co pay currently set about $143/day), and nothing thereafter. The full/cash prices of nursing homes are even more expensive, averaging $248/day nationally, or over $90,000 per year! (http://www.medicare.gov/coverage/nursing-home-care.html.) In order to qualify for SNF benefits under Medicare Part A, the individual must have been hospitalized for 3 days – the notorious "3 day rule." "Observation" days do not count towards the 3 day payment window, a very controversial and problematic requirement which many Medicare beneficiaries and their families may not appreciate. The patient staying in the hospital may not even be aware that he or she is under "observation status" and not actually considered to be officially hospitalized for Medicare purposes, which may lead to confusion and unexpected bills – see recent articles in the New York Times and Wall Street Journal, (http://newoldage.blogs.nytimes.com/2013/10/29/two-kinds-of-hospital-patients-admitted-and-not/?_r=0) and (http://online.wsj.com/news/articles/SB10001424052702303376904579135732284488114). CMS regulations regarding inpatient payment have become even stricter in the past year, with patients staying over in the hospital

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but less than “two midnights” paradoxically being considered “outpatients” subject to Medicare Part B rather than Part A.

Federal nursing home regulations are part of the Social Security/Medicare law, as cited above, and are the same for every NF/SNF in the US, administered by the Centers for Medicare and Medicaid Services (CMS, formerly HCFA). These extensive regulations stem from the 1987 “OBRA” law (Omnibus Budget Reconciliation Act) which contained numerous nursing home reforms in response to a 1986 Institute of Medicine study on improving the quality of care in nursing homes (IOM, 1986). The congressional law may be found at 42USC and the corresponding CMS regulations may be found at 42CFR Part 483 – “REQUIREMENTS FOR STATES AND LONG TERM CARE FACILITIES.” These are available online at http://www.law.cornell.edu/cfr/text/42/483. State nursing home regulations essentially mirror the federal requirements and differ only slightly from state to state. The WV State regulations for nursing homes (64CSR 13) are available on the OHFLAC website, http://www.wvdhhr.org/ohflac. Each year, state health surveyors on behalf of Medicare and Medicaid inspect each and every nursing home in the US and prepare a list of citations or violations of the state and federal NH regulations. Survey and quality information may be seen by any member of the public at www.nursinghomecompare.gov. The “State Operations Manuals” used by the surveyors, listing all nursing home regulations and interpretive guidelines in detail, are available at: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf. Nursing facilities are required to respond to and correct all citations or else face financial penalties or loss of their operating licenses.

Due to this complex and strict regulatory system, nursing homes are standardized and similar everywhere in America, varying only in ownership, size and perhaps quality. Of about 15,000 nursing homes in the US, 82% of facilities have 26 or more beds, and approximately 65% are privately owned for profit; the rest are nonprofit (25%) or governmental ownership (10%). About 2/3 of nursing home patients are paid for by Medicaid (http://kff.org/medicaid/fact-sheet/overview-of-nursing-facility-capacity-financing-and-ownership-in-the-united-states-in-2011/). There are about 129 nursing homes in West Virginia – lists and quality ratings may be found at the OHFLAC website as well as Medicare’s “Nursing Home Compare” site (http://www.medicare.gov/nursinghomecompare/search.html). The distinction between NF and SNF refers chiefly to the payer source (Medicare Part A or other insurance for the period of SNF care, Medicaid or self-pay for long-term NF care); in reality most facilities contain both skilled/non-skilled patients who may even be intermingled on the same unit, the difference only being relevant for billing purposes. Physicians see both skilled and non-skilled nursing home patients similarly, as medically necessary and as required by regulations – once every 30 days for the first 90 days then once every 60 days thereafter. Medicare Part B may be billed by the physician or NPP for any medically necessary or legally required visits for as long as the patient remains in the facility, using nursing facility CPT codes 99304–99318.

Medically, the needs of nursing home patients encompass all of geriatric medicine. Several articles in the literature offer helpful overviews of the medical care of nursing home

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residents. (Ouslander & Osterweil 1994; Evans et al. 1995), as does the online reference "UpToDate" (Gillick, 2013).

Hospice Care

After 100 days in the nursing home, Mrs. S.P. exhausts her Medicare Part A benefits, but needs to remain for long-term care, which is covered by Medicaid due to her lack of financial assets. After several more months her dementia and frailty continue to progress, and she stops eating and getting out of bed. In consultation with the nursing home staff and family, the doctor refers her for hospice care.

When an individual gets to the final 6 months of life due to a terminal illness, they are entitled to Hospice Care under Medicare Part A and most other insurances. Hospice is a philosophy of care and a Medicare benefit program, not necessarily a place. It can be provided at home, in a hospital, in a nursing home, or in an inpatient hospice facility if such exists in a given area (in Charleston, WV we are fortunate to have the Hubbard Hospice House). In some states there are multiple competing hospices in every area, but in WV there are exclusive hospices licensed in each region across the state. The diagnosis to qualify for hospice is not only cancer but any terminal illness, including heart or lung disease or Alzheimer's. Once certified by a doctor and hospice agency to be appropriate, extra nursing and supportive care is provided until death, and even post-death grief counseling is provided to the family, a truly wonderful benefit. Both healthcare providers and the general public should be more aware of and accepting of hospice as they face death, as it is a valuable service which people often don't accept and utilize until the very end, for too short a time. The patient's end of life care preferences in West Virginia should be documented on the state-approved "POST" form, Physicians Orders for Scope of Treatment, available from the WV Center for End of Life Care, www.wvendoflife.org. Many other states utilize similar forms under different names such as POLST and MOST. A summary of hospice eligibility guidelines for different diseases is available at http://www.hov.org/hospice-eligibility-guidelines.

In summary, patients needing long term/chronic care have four basic options: 1) care at home, including waiver programs; 2) assisted living; 3) nursing homes; or 4) adult day care/PACE. Patients needing only short term rehabilitative or "post-acute care" have essentially six different options for rehabilitation and therapies depending on their needs and preferences and location: 1) home physical therapy via agency home care, 2) outpatient therapy (available for patients independent at home or in assisted living), 3) acute inpatient rehabilitation facilities (IRF's)/rehab hospitals (e.g. in West Virginia, Peterson Rehab Hospital in Wheeling; CAMC General's Medical Rehab Unit, and four Health South Rehabilitation Hospitals across the state), 4) long-term acute care hospitals (LTAC), 5) skilled nursing facilities, and, 6) for terminally ill patients, hospice is the final option (Kane, 2011). Each has their own criteria and systems for eligibility and reimbursement, as summarized in Table 1. Note that for long-term/chronic ventilator patients, LTAC is the only option in this state, as West Virginia nursing homes do not take ventilator patients. Other states may not have similar restrictions. Note also that acute and long-term care systems for mental illness and for mental retardation have completely different systems of

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facilities and regulations, and are not discussed in this article, nor are programs for children/non-elderly persons.

Ideally, as a person's needs change, they would move smoothly from one care setting to another as determined by their physicians, nurses, families, therapists, social workers, and other relevant/knowledgeable professionals. However, often both the public and professionals don't really know of or understand what is available. So, unfortunately people often tend to bounce back and forth from home to hospitals to nursing homes in a haphazard manner based on emergencies and other circumstances. In some areas either state or local departments of aging or private geriatric care managers can help better monitor, plan and supervise safe and appropriate "transitions of care" – an emerging concept which is critically important in avoiding problems such as excessive hospital readmissions.

So while in theory there is a "continuum of care" ranging from outpatient to inpatient to home care to nursing home care to hospice, in reality all these components of the healthcare system tend to operate in their own independent spheres with different regulations and funding streams and too little coordination and communication. In the future it is hoped that electronic health records will follow the patient and communicate from setting to setting, and that different components of the healthcare system will learn to work together more effectively. It all starts with both lay people and professionals understanding the system, communicating and knowing what is actually available in your particular area and for your particular needs.

For more information on available facilities and services for older adults, some sources to consult include the AARP, Alzheimer's Association, federal, state and local government agencies including Medicare.Gov; state and county Aging departments, social workers in the hospital or other facilities, and the WVU Geriatric Education Center website, which posts a list of Caregiver Resources for Elder Care at http://www.wvgec.org/pages/Publications.

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Table 1

Coverage for different levels of post acute care and therapy

Level of Care	Medicare Payment to Physician/ NPP	Medicare Payment to Institution/ Therapy Provider	Medicaid Payment to Institution	Private/Other Medical Insurance	Self Pay	Comments/References/for additional information:
Outpatient Therapy	Medicare Part B pays NPP/ physician for out-patient services	Medicare Part B pays therapy provider	Medicaid pays provider for service (primary/ secondary)	Yes	Yes (co pays/deductibles)	Patient travels from home to outpatient therapy provider. Therapy providers may also have sites within independent living or assisted living facilities.
Home Care	Medicare Part B pays physician/NPP for home visits and care certification/ oversight.	Medicare Part A pays agency for nursing care and therapies	Medicaid may pay for home/waiver care for those eligible (see text)	Yes: Private medical insurance may pay for limited home care; private LTC insurance may cover LTC at home	Yes (co-pays/deductibles for skilled care; private pay for non-skilled personal care).	Patients must be homebound and certified as such Face to Face by Physician. Refs. Giovino 2000, Nicoletti 2005, http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1038.pdf. American Academy of Home Care Medicine, www.aahcm.org.
Inpatient Rehab Facility (IRF)	Medicare Part B (for physician/NPP visits)	Medicare Part A	Yes in most states, No in WV.	Yes	No – insurance usually pays. May be co-pays/ deductibles.	Refs: American Academy of Physical Medicine and Rehabilitation, www.aapmr.org; http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Inpatient_Rehab_Fact_Sheet_ICN905643.pdf.
Assisted Living/ Personal Care Facility	Medicare B pays MD/NPP for office/ home visits.	None	None	No (Unless patient covered by private LTC insurance).	Yes (most Assisted Living is private self-pay).	AGS 2005, Assisted Living Federation of America, www.alfa.org; http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/mm4212.pdf.
Nursing Home Care	Medicare Part B pays physician/NPP for NF/SNF visits.	Medicare Part A (only up to 100 days)	Medicaid pays for LTC after Medicare and private pay exhausted	Private insurance may pay for SNF care similar to Medicare	Yes (for expenses not covered by Medicare/ Medicaid).	Ouslander 1994; Evans 1995; American Medical Directors Association for Long-Term Care, www.amda.com; American Health Care Association, http://www.ahcancal.org/.
Hospice	Medicare Part B continues to pay for physician visits separate from hospice	Medicare Part A	Medicaid pays provider	Private insurances may cover hospice care if terminal illness	No – insurance usually pays.	American Academy of Hospice & Palliative Care Medicine http://www.aahpm.org/.