

Home health care: New opportunities and challenges for care provided inside the home

Executive summary

As health care organizations map out their value-based care strategies, they are identifying ways to both reduce costs and meet the demands of the health care consumer of the future. To achieve these goals, traditional home health care providers are partnering with other organizations to decrease acute and post-acute care use (e.g., lowering readmission rates, identifying skilled nursing substitutes) as well as facility-based long-term care services and supports (LTSS). States, through their Medicaid programs, are entering into new payment arrangements with health plans and providers; many have a goal of redirecting resources away from facility-based long-term care.

Thinking of home care more broadly to include leveraging technology that allows care to be provided in people's homes, there is even greater potential for new models of care that — in the face of evolving payment incentives — should be valuable in engaging patients, improving health, and reducing costs.

Despite these opportunities, stakeholders should note that the payment and regulatory environment for home health care under traditional fee-for-service (FFS) Medicare may be very challenging. It requires that organizations focus on specific payment incentives, reduce costs where possible, and remain up-to-date about fraud and abuse enforcement activities.

Home health care sector size and organization

The traditional U.S. home health care market, valued at \$77.8 billion in 2012, is projected to grow to \$157 billion by 2022.¹ The proportion of the population age 65 years and older, expected to increase from 12.4 percent in 2000 to 19.6 percent in 2030, is a key driver of this growth.² Baby boomers — the customers of the future — are even less inclined than previous generations to relinquish their freedom when they need chronic or long-term care, and have a strong desire and commitment to remain at home.³



Other drivers of traditional home health care include increased chronic disease prevalence; general patient preferences to receive care at home, regardless of age; and payment arrangements that are expected to encourage a shift to lower-cost care settings. Among drivers for new types of home-based services are evolving payment and delivery models, which this paper will discuss in detail.

The home health care industry is diverse and fragmented. In 2013, the largest four firms accounted for only about 10 percent of industry revenue from more than 300,000 agencies.⁴ The landscape includes independent companies of all sizes; for-profit, nonprofit, and publically traded companies; those affiliated with hospitals; and others that are freestanding. In addition, some home health care providers are owned by non-traditional health care organizations, including technology companies. Some traditional home health providers also furnish services such as hospice and home therapy (Table 1).

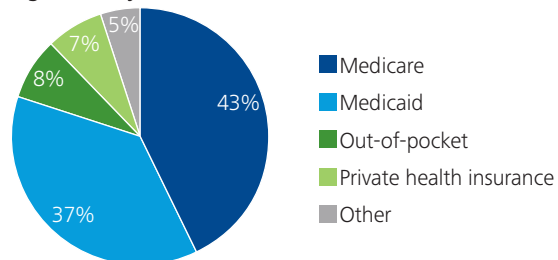
Spending growth for freestanding home health care agencies accelerated in 2012, increasing 5.1 percent to \$77.8 billion following growth of 4.1 percent in 2011. In 2012, at least 80 percent of home health care spending was paid by Medicare (43 percent) and Medicaid (37 percent) (Figure 1).

Table 1. Distribution of services in home health care market (2014)

| | |
|---|-----|
| Traditional home health and home nursing care | 66% |
| Home hospice | 15% |
| Home therapy services | 6% |
| Home-maker services | 7% |
| Other | 6% |

Source: IBIS Home Care Providers in the U.S., Feb 2014

Figure 1. Payers of Home Health Care in the U.S.



Source: National Health Expenditure Accounts, 2012

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Opportunities for the home health care sector

New value-based payment and care models

In the health care industry's quest for lower costs and higher quality, regulators, providers, and payers are piloting new value- and outcomes-based payment and care delivery models. Among these models are:

- Accountable Care Organizations (ACOs) and other forms of shared savings programs: The total number of public (Medicare) and private ACOs is estimated at more than 600 nationally, covering more than 18 million insured individuals.⁵
- Payment bundling: Under these arrangements, providers receive a single payment for an episode of care and will share savings from more efficient ways of delivering services.
- Patient-centered medical homes and health homes: These models often reward providers for better care of chronic conditions and better patient experiences.

Success measures include fewer hospital admissions and readmissions, less emergency room care, better chronic care management, and lower total cost of care. Organizations which are able to reduce the use of expensive, high-cost settings like hospitals in favor of outpatient and home-based care might succeed under these models. For models that include post-acute care, home-based and other non-facility care settings are preferable to other options — if the providers can deliver the same or better outcomes as facility-based care — because home health care is the least expensive post-acute care setting. However, being able to deliver better outcomes likely will require that home health providers, which have primarily focused on providing unskilled aide services, now invest in new staff and capabilities to deliver more skilled care. In addition, organizations that demonstrate proficiency in drug reconciliation, care coordination, and symptom monitoring are likely to become preferred partners.

In addition to new value-based models, traditional managed care arrangements are expanding within both Medicare and Medicaid to cover new populations, including dual eligibles, and new benefits such as managed LTSS.

Finally, the Affordable Care Act (ACA) called for the Independence at Home demonstration (one of a number of ACA demonstrations), which replaces acute care with physician home visits. The ACA also funded pilots to support the reduction of hospital readmissions via transitional care.

Providers and health plans may be more likely to incorporate home health care services (onsite or virtual) into a patient’s coordinated care plan if these services improve health status at a lower cost or if a particular home health care provider can demonstrate capabilities and outcomes that make it an attractive partner. Such providers vary in quality and capabilities, and those focused on providing a greater mix of skilled services may be best-positioned for the new payment models.⁶ As health care organizations try to reduce preventable admissions, readmissions, and complications, many are identifying “preferred referral” lists of home health care providers which are willing to partner on such efforts.⁷ In addition, some hospitals and physicians may seek stronger alignment through partnerships or acquisitions, as they seek to “own” the entire care continuum.

Home health care providers can play an important role in addressing transitional care needs, particularly preventing readmissions. The Visiting Nurse Associations of America has a demonstration project, the Blueprint for Excellence, which offers tools to hospitals and primary care physicians to assess the value of home health. The effort also includes educating home health care professionals to identify and prevent common readmissions causes. Multiple studies suggest that home visits by advance practice nurses to recently discharged patients prevented readmissions for chronically ill older adults.⁸

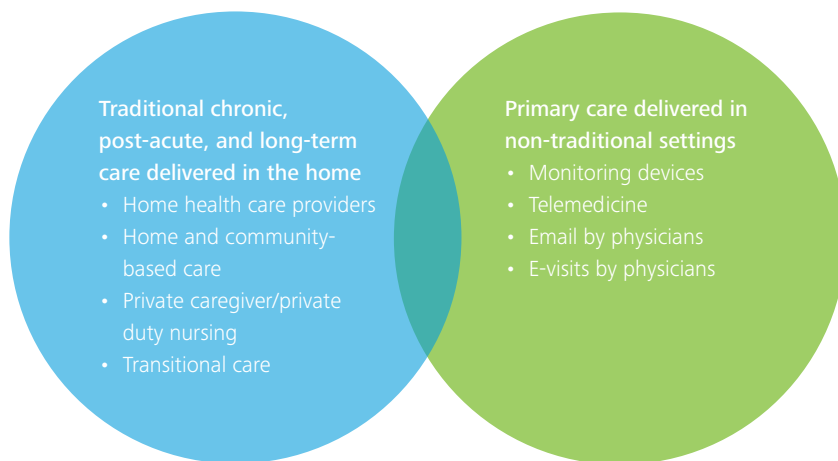
Evolving technology

Traditional in-home health care devices have included those that assist with activities of daily living (ADL) or support respiratory and infusion therapies. The desire to better track and monitor patients who are being cared for at home is driving an entirely new technology market for wearable devices. Technology companies likely view health care as an opportunity as they are bringing advanced technologies to the industry. The value-based care focus on lower-cost settings is also expanding traditional home health services into the practice of in-home, technology-enabled primary care (Figure 2).

Hospitals and physicians seeking to clinically integrate and align with home health care providers may leverage new technologies for care coordination and data-sharing efforts. Home health care providers, in turn, may develop service delivery capabilities based upon these technologies that go some way towards improving costs, outcomes, and overall population health. The value of new technologies will likely be in their integration into value-based care. Successful value-based care organizations are expected to combine technology with the right business model and employee talent for high-quality, cost-efficient care coordination.

Home health care-related mobile applications are a growing trend.⁹ While not every traditional home health care service can be replaced by an app, such as assistance with bathing, these apps may increase the connection between consumer and provider and improve subsequent use of services. New technologies may also reduce costs if the payment incentives are appropriate. A case study of a health system whose caregivers used tablets for home health care services found that using the tablets in combination with using a formulary helped to cut medical supply costs by 20 percent per home health visit.¹⁰

Figure 2. The changing home health care landscape



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The result of technology's evolution may be a fundamental change in the delivery and operating model for traditional home health care. Instead of a nurse or clinician physically visiting patients, providers may be able to leverage technology to monitor and treat them.

Medicaid's emphasis on quality and personal choice

Medicaid offers a number of opportunities for states to cover home- and community-based services (HCBS), including standard services such as case management and adult day services and non-standard services that help to keep individuals out of institutional settings. (Medicaid coverage tends to be for people who need long-term services and supports.) Total Medicaid spending for home health care reached an all-time high of \$29 billion in 2012, with the federal government funding slightly more than half (54 percent) of services and the rest primarily funded by state and local governments.¹¹

States can offer HCBS through two traditional channels: home health services benefits (both mandatory and optional) via the state plan and 1915(c) HCBS waivers. The ACA also expanded HCBS offered through Medicaid by adding the 1915(i) HCBS state plan option, Money Follows the Person demonstration program, 1915(k) Community First Choice state plan option, and the Balancing Incentive Program (Figure 3).¹²

Several states are testing HCBS models by moving services under new waiver programs:

- Oregon Community First Choice Program: In 2013, Oregon was the first state to receive approval for a 1915(k) waiver to further expand HCBS. (To date, California is the only other state to receive approval for a 1915(k) waiver.) Eligible individuals work with a plan coordinator to determine their specific needs; benefits can encompass attendant services and supports to accomplish ADLs as well as instrumental activities such as light housekeeping, laundry, meal preparation, and shopping.¹³

- Tennessee CHOICES Program: In 2010, Tennessee shifted incentives for using long-term care options away from nursing facilities and toward home care services with its new CHOICES program. The state uses a managed care approach to pay up to \$15,000 per year for HCBS services to individuals whose incomes are below 300 percent of the federal poverty level. Included services for enrollees are attendant care, home-delivered meals, adult day care, minor home modifications, and pest control.¹⁴
- Arizona Long Term Care System: The Centers for Medicare and Medicaid Services (CMS) approved Arizona's 1115 waiver through the Arizona Health Care Cost Containment System. The program provides coverage for all Medicaid benefits through risk-based contracts with managed care organizations, with LTSS and behavioral health provided separately through specialized contracts.¹⁵

Through section 1915(b) waivers, states increasingly have been moving their Medicaid populations' care to managed care organizations via capitated payment arrangements. The Medicaid populations enrolled in managed care have grown to 74 percent, up more than 40 percent over the course of nearly a decade. States such as Arizona and Tennessee have enrolled all of their Medicaid populations into managed care, and many states offer home health care services to participants as part of the managed care package.^{16,17}

HCBS services offered through Medicaid are not immune to recent trends impacting the wider health care industry. As waste, fraud, and abuse practices come under greater scrutiny, CMS continues to require quality measure reporting and patient-centered planning for HCBS offered through Medicaid.¹⁸ As a result, HCBS performance and integrity issues are expected to garner increased attention. As an example, states are likely to see rising costs resulting from a new rule by the U.S. Department of Labor that requires home health care workers be paid at the federal minimum wage level beginning January 1, 2015. While this rule pleases many fair labor advocates and direct care workers, state Medicaid agencies are likely to see a spike in costs, as payments will go directly to home health care agencies that then set workers' wages.

Figure 3. State HCBS waivers and programs

| Waiver/program | Description |
|---|--|
| State plan reimbursement methodology, benefit requirements, and eligibility criteria | Medicaid state plans must include benefits that cover home health care services as part of a physician’s written plan of care. Mandatory benefits include registered nurse and home health aide visits and medical supplies and equipment, if deemed appropriate by a physician. Optional benefits for personal care services also may be included; 30 states and the District of Columbia include personal care services under their state plans. ¹⁹ |
| 1915(c) waivers | Section 1915(c) of the Social Security Act allows states to submit a waiver to their Medicaid program to help pay for all or part of the cost of HCBS (not including room and board) for specific populations. Individuals must be deemed “likely to require” care similar to that which would be administered in an institutional setting. States must limit this benefit to a maximum number of eligible enrollees. ²⁰ |
| 1915(i) HCBS state plan option | The ACA expands on the current HCBS offered by Medicaid, allowing states to target benefits to one or more specific populations and to establish a new eligibility group for individuals who are already receiving HCBS through state plan benefits. The benefit must be available to all eligible individuals in the state (i.e., states may not maintain a waiting list). ²¹ |
| 1915(k) Community First Choice state plan option | The Community First Choice 1915(k) option permits states to provide HCBS services to individuals with disabilities under their state plan. The benefit allows states to cover transition costs such as housing needs and supplies (e.g., rent, kitchen supplies). States receive an extra six percent in their federal medical assistance percentage (FMAP) for services and supports provided through this benefit. ²² |
| Balancing Incentive Program | Through the ACA, CMS in 2011 began offering states targeted increases in their FMAP for making structural reforms that increase access to non-institutional LTSS and divert individuals away from nursing facilities. States receive enhanced matching payments tied to the amount spent on LTSS. The program is funded for four years (until September 2015) and cannot exceed \$3 billion in payments. ²³ |
| Money Follows the Person (MFP) Rebalancing Demonstration | MFP aims to help states “rebalance” their long-term care systems through Medicaid. The program’s goals include increasing HCBS use and decreasing institutional care use; eliminating state-level barriers that restrict Medicaid dollars; and providing HCBS quality assurance and improvement. The ACA expanded the program by extending funding through 2016 and changing the definition of eligibility to include more individuals. ²⁴ |

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The post-acute continuum

Medicare coverage of home health care services is a part of post-acute care. It is primarily intended to support beneficiary recovery, but not necessarily to serve as long-term care. However, the types of services provided under home health overlap somewhat with those that someone needing long-term care services and supports would use. Home health care is the only post-acute care service that does not require a hospital stay to trigger coverage. Medicare’s payment system rewards providers that have maximized revenues by calibrating service delivery closely to the specific payment incentives in the FFS program, exercising careful control over the number of visits provided during an episode of care; focusing on therapy services over home health aide visits; reducing costs; and coding for severity and complexity of patients seen.

Challenges to the home health care sector

Among the market- and reform-related challenges that could impede growth in the home health care sector, Medicare, the main payer for home health services, has acted over the past four years to limit spending and eligibility. Significant margins and growth in service volume and the number of home health care agencies have made the industry a target for federal action to cut payment rates, often (when a legislative change occurs) to pay for other policies that increase spending. Both CMS and Congress have proposals to change home health and other post-acute care payment systems, including moving to a single-payment system with increased bundling and pay-for-quality elements.

Little research has been published on the use of home health care services under Medicare Advantage. Enrollment in the program has grown over time; the most recent estimate is that 30 percent of Medicare beneficiaries are enrolled in Medicare Advantage plans.²⁵ These plans must cover all Medicare services, but have some flexibility to structure preferred relationships with providers and use alternative payment methodologies that can reward providers who deliver better results in overall service use and outcomes.

Specific Medicare-related challenges include:

Payment cuts. In the last four years, legislative and regulatory actions have cut traditional FFS payments to home health care agencies for Medicare services. These actions have included reducing the base payment rate (called “rebasings”) to account for coding practices that have increased reimbursement, and reducing or eliminating the annual payment update. Despite these cuts, the Medicare Payment Advisory Commission (MedPAC) projects a 2014 margin of 12.6 percent (10.2 percent factoring in the scheduled two percentage point cut due to the sequester).²⁶ The Congressional Budget Office (CBO) forecasts that spending on home health care services in Medicare will grow from \$19 billion in 2013 to \$30 billion in 2024, even after these reductions.²⁷ Medicare’s cuts are putting pressure on existing HCBS models to become much more efficient in their targeting and deployment of costly resources.

Penalties for readmissions. In March 2014, MedPAC recommended that Congress adopt a hospital readmissions incentive program for home health care that would

create penalties for agencies with higher rates of hospital readmissions. This program would be in addition to the existing policy that penalizes hospitals for higher rates of readmissions. Note that MedPAC recommendations are not immediately adopted by Congress, but often appear when major Medicare legislation is enacted.

Single payment and assessment tool across post-acute care. MedPAC also recommended that Congress take steps towards a single approach to paying across post-acute care settings. In March 2014, the Senate Finance Committee released a discussion draft for a legislative proposal (Improving Medicare Post-Acute Care Transformation Act of 2014) for a single assessment tool for post-acute care. The tool would “create a standard post-acute care assessment tool that would require collection and analyses of data that will enable Medicare to compare quality across post-acute care settings; improve hospital and post-acute care discharge planning; and use this information to reform post-acute care payments (via site neutral or bundled payments or some other reform).”²⁸

Although the timeline for implementing the new payment models is long and passage of the recommended legislation is uncertain, ongoing activity does signal Congressional interest in a system that could potentially produce major changes for home health and other post-acute care providers. A demonstration of a uniform tool to collect and predict costs across post-acute care settings was generally successful, although home health had to be separated from other settings for best model performance.²⁹

Fraud and abuse focus. Home health care agencies have been one of the main targets of federal fraud and abuse activity. The 2013 report from the Office of Inspector General (OIG) of the Health and Human Services (HHS) agency detailed numerous actions against home health care organizations in several U.S. markets, with significant lawsuits and recoveries, leading to flat-line utilization in areas where enforcement activity has been focused.³⁰

Under the ACA, Medicare implemented a policy that places some limits on using the home health care benefit by requiring a face-to-face visit between the patient and physician before the care can begin. In April 2014, the OIG reviewed implementation of the face-to-face visit requirements and found that “for 32 percent of home health claims that required face-to-face encounters, the

documentation did not meet Medicare requirements, resulting in \$2 billion in payments that should not have been made.”³¹

Medicare contractors in some regions had been disallowing payments for post-acute care where the patient was not showing evidence of improvement. The case *Jimmo vs. Sebelius* established that the law does not support the requirement for patients to improve; CMS is taking steps to make sure that stakeholders are aware of this clarification.³²

Pay for performance in home health. CMS posts home health care agencies’ quality performance data on its Medicare.gov website. The performance measures are based upon information reported by home health care agencies in the Outcome and Assessment Information Set (OASIS) dataset.³³ The ACA required CMS to develop a plan for a value-based purchasing program (where agencies would receive higher payments for higher-quality care) for home health. CMS completed a report to Congress indicating its strong interest in moving to a value-based payment system for home health (that would pay incentives based on quality results) but the program has not yet been implemented.³⁴

Implications for health care systems

Changing payment models, the shift toward value-based care, and new enabling technologies may prompt other health care providers — hospitals, physicians, and integrated delivery networks (IDNs) — to seek alignment with the home health care sector. In particular, providers taking on new or additional financial and performance risk should consider how providing care outside of traditional settings can support the following competencies:

- Reducing hospital readmissions by providing transitional care
- Shortening length of rehabilitation needed and improving rehabilitation results in anticipation of pay for outcome measures
- Avoiding use of higher-cost settings, including skilled nursing facilities and traditional nursing homes
- Reducing emergency room use, particularly for “frequent fliers”
- Managing chronic conditions by monitoring symptoms over time and improving medication adherence
- Using technology to track and monitor patients and report to primary care providers and specialists when they need to be proactive

- Training and ongoing support of family caregivers
- Focusing on meeting/resolving ADL needs
- Enhancing the organization’s ability to manage financial risk.

As health care providers consider their home health care strategies, possible scenarios for the sector’s future, while differing by market, could include the following:

- Regional home health care providers may seek to consolidate to gain scale and capital that will likely help them participate in new payment models, share data to coordinate care, have electronic medical records, and operate more efficiently.
- Integrated delivery systems may enter the home health care market in an attempt to control the full continuum of care for patients for whom they hold financial risk or as a response to readmission prevention incentives.
- Primary care physicians, who may begin increasing their use of telehealth and e-visits to treat more patients more efficiently, could view home care services as a way to support better outcomes.
- National inpatient, post-acute providers may enter the home health care market using their scale and efficiencies to offer the full range of post-acute services lines to better navigate a potential single, post-acute payment structure from CMS.
- Retail clinics or other new provider delivery models may use home care services to support their efforts to offer more convenient care.

Conclusion

The demand for efficient home health care — both traditional and more broadly defined — is projected to grow, particularly amid the adoption of new and expanded payment and delivery models. Industry stakeholders who seek to partner with, contract with, refer to, or sell to HCBS providers will need to carefully navigate this new landscape — the most strategic providers and partnerships should consider demonstrating the ability to reduce costs and improve patient outcomes. States, meanwhile, are expected to take advantage of new funding and flexibility to expand their alternatives to facility-based, long-term care under Medicaid. Finally, Medicare is anticipated to continue applying considerable payment and oversight pressure to home health care and is considering strategies to create stronger incentives for better outcomes and cost control.



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