Hospital-Based Home Health: Weighing Finances and Philosophy of Care

By Lisa Yarkony

As we begin a new decade, hospital-based home health agencies have been waning over the last one, and for a number of reasons. An examination of hospital-based home health since its beginnings in this country yields some answers, but also reveals the importance of many of these home health programs in the communities they serve. There are often more components to consider when weighing the value of these programs than financial statements alone can illuminate.
In 1948, Montefiore Hospital started home care for low-income seniors in the surrounding New York borough of the Bronx. The new program enriched doctors’ “understanding of sick human beings as social beings,” Martin Cherkasky, Montefiore’s president for 30 years, said then as he addressed the American Public Health Association in Boston. “It is no more fair and useful,” he asserted, “to separate a man from his environment than it is to divide him into separate and independent parts.” Cherkasky contended that the most accurate diagnosis and understanding of the patient requires knowledge of a patient’s family, home, job, and way of life, not just a test in a lab or a visit in a health care facility. When applied properly and because of its unique characteristics, he added, “home care for patients who are suitable is not only as good as hospital care — it is infinitely better.”

So was this vision worth making the financial investment to embrace the humane philosophy of home health? Hospitals weren’t convinced that, as Cherkasky claimed, “the rigidity and chilliness of a hospital” could be “profitably exchanged for the flexibility and warmth of the home.” As a result, hospital-based home care grew slowly in the first decades after Montefiore began its landmark program. Many key players had doubts about its medical value and financial viability. Doctors found the hospital more convenient and conducive to oversight of patients. Hospital directors hesitated to divert business away from their existing services, and fiscal intermediaries weren’t sure how to audit home care programs.

These reservations dissipated in time due to developments that continue to this day and have fueled the growth of home health, including an increase in the number of seniors, innovations in technology, the movement toward coordination of care, and political activity to expand health insurance coverage. Yet many hospital-based home health agencies have been sold or closed, with little apparent regard to size, reputation, or integration within a hospital’s continuum of care. Some executives at both large urban hospitals and small rural facilities no longer consider their home health programs a viable core service, though they reduce inpatient lengths of stay, save on care costs, and cut down on rehospitalizations.

Those benefits were documented after Massachusetts General Hospital launched its “Coordinated Home Care” program in 1968. The program showed its value by allowing the hospital to make better use of health care resources, freeing beds for patients who required acute care hospitalization and providing a more appropriate option for patients who only needed optimal post-hospital care. It reduced the total cost of caring for patients by as much as two-thirds over equivalent care in a long-term care facility. And it made it possible for patients who otherwise would have been placed in long-term care facilities to remain at home with their families for extended lengths of time.

One Massachusetts patient summed up how much that program mattered shortly before his death from metastatic carcinoma: “I knew when I left the hospital that I was going to die, but you can’t know what it has meant to me to be with my family and watch my grandchildren grow a bit.
more, to see my wife is taken care of. . . I’m ready to go now, and I am not afraid.”

Those were sentiments other patients echoed in the 1960s and 1970s when a number of U.S. hospitals began launching pilot programs in home health. For example, hospital researchers documented a strong preference for home care when Milwaukee County General Hospital placed a random group of 175 patients in home health care and compared their treatment with a control group of 85 patients retained in the hospital. Follow-up study of the two groups revealed that on the surface, the end results of care in either venue were not significantly different. But applied appropriately, home care had clear benefits, as New York’s Saint Vincent’s Hospital confirmed when it launched its own pilot program for the homebound aged. Home care, researchers agreed, serves society by delivering substantial cost savings and fulfilling the wishes of older people as the care they’d prefer to have.

Hospitals responded to the demand by rushing to share in what had become a multi-billion dollar industry. By 1990, 35.6 percent of hospitals operated a home care program, up from 11.5 percent in 1980. In U.S. Census Region 6 — Iowa, Kansas, Missouri, Minnesota, Nebraska, and North and South Dakota — 43 percent of hospitals had a home health program. Growth was especially dramatic among rural hospitals with 300 or more beds, about half of which had their own home health agency.

Hospitals had come to see that home care had advantages for both them and their patients. Advances in medical equipment technology began permitting safe, and sometimes superior, treatment at home. Increasing acceptance by physicians and the public resulted in more referrals to home care. And operating their own home health programs allowed hospitals to manage their patients’ care more comprehensively across the service continuum while freeing acute care beds for those who actually needed them.

There also were financial incentives fueling the growth in hospital-based home health. Hospitals received an exclusive per-visit add-on payment to Medicare’s cost-based reimbursement for home health services to cover their extra expenses, so a home health program — even if it wasn’t profitable on the surface, per se — could help a hospital spread overhead costs across a broader base. Hospitals with their own home health agencies could shorten patient stays, as many did after Medicare instituted a diagnosis-related group, or DRG, methodology for adjusting reimbursement. Under a DRG system, Medicare sets standard fees for certain medical treatment, so it will only pay a set amount even if patients need additional care, leading to skyrocketing costs vs. reimbursement for those costs. As a result, patients were coming home sooner and sicker. That’s where home health came in.

Home health showed promise to increase revenues, but industry experts cautioned against adding a home care program just to boost the bottom line. Then, as now, it was expensive to have a hospital-based home care agency. Heavy regulation and legislative mandates could eat away at profits, so hospitals were advised to consider the place of home care within their mission. Home care is a service, experts told hospital directors. They’d need to believe in the philosophy of home care, rather than simply trying to justify it on a dollar-for-dollar return. And then, in a dramatic turning point, it was suddenly far more difficult to do so after 1997, when changes in
Medicare reimbursement forced many hospitals to rethink the value of running a home health agency in-house.

The Balanced Budget Act of 1997, which mandated lower reimbursement levels — including both cost-per-visit limits and annual per-patient caps — cut the amount of reallocated hospital costs that hospital-based home health agencies could reasonably absorb and still remain financially viable. This placed most hospital-based agencies on potentially dangerous financial footing as both patient visits and revenue sharply declined. So pronounced were the effects of “BBA ’97” that Medicare spends less today in aggregate on home health than it did prior to the legislation’s enactment.

The majority of hospital-based home health agencies soon became financial burdens on their parent institutions, which began to feel the pressure even more with the approach of 2000, when the inception of the Medicare Home Health Prospective Payment System would end cost-based reimbursement. The cumulative result was that hospitals could no longer use their home health agencies to spread overhead costs. In the late 1990s and early 2000s, many hospitals decided to jump ship by closing their agencies or spinning them off as freestanding entities with their own operating structures.

There are now 1,626 agencies that are part of a hospital or skilled nursing facility, down from 2,594 in 1995. And most of these remaining agencies aren’t as efficient and don’t fare nearly as well as their freestanding counterparts, as some comparisons demonstrate:

- Freestanding agencies receive 18.3 percent more revenue per episode than hospital-based ones;
- Freestanding agencies have a higher full episode average case weight;
- Freestanding agencies are more likely to care for patients with primary chronic diseases or conditions that are rehabilitative intensive;
- The fully loaded cost to deliver care is less for freestanding agencies than for hospital-based ones;
- Despite higher revenue per episode, freestanding agencies perform 14.9 percent more visits per episode than hospital-based agencies do;
- Freestanding agencies provide more total home visits; and
- Freestanding agencies serve a more non-white population, which generally means a lower socioeconomic status and a less likely presence of family caregivers.

As a result, freestanding agencies must compensate by providing more nursing and home health aide visits.

These factors lead to much lower revenues for hospital-based agencies. According to the Medicare Payment Advisory Commission (MedPAC), hospital-based agencies have an average Medicare profit margin of negative 6.19 percent as opposed to freestanding agency margins, which range from 3.1 percent to 26.1 percent. Yet hospital-based home health agencies serve a crucial function in some rural states where hospital-based home care once experienced its greatest growth. Returning to Oregon, Montana, North Dakota, South Dakota, and Nebraska, more than 50 percent of home health agencies remain hospital-based.

A number of these hospitals are the sole health care providers serving communities for many miles, so essential services could be threatened in many such areas should Congress proceed with proposals to enact deep cuts to the Medicare Home Health Benefit. Until recent weeks, those proposals were folded into the broad health care reform effort, but Congress could proceed in piecemeal fashion with elements of health reform legislation. The implications of deep home health cuts — particularly if they were made in an across-the-board, indiscriminate manner — would be grim, because the home health care provided by these hospitals often substitutes for less available forms of care in the most rural of regions. But that’s not to say that hospital-based home health doesn’t also play an important role in cities.

Montefiore Home Care is still in business after all these years. Its daily census averages 1,200 people who will be in the system for six weeks or less, and 650 who are in for the longer term. The hospital has expanded its home health services to serve people at all stages of life. And the program has advanced with the times by offering specialty programs in areas like telehealth, pediatrics, depression intervention, HIV/AIDS, and home infusion therapy. But the program still has a strong social philosophy, hospital spokesman Michael Quane told CARING Magazine: “Montefiore Home Care serves a financially challenged area. We provide services that are necessary to our community,” he said. “They can’t be measured in dollars and cents.”

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