

# Defining the Value of Home Health

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Walter Borginis III, Editor  
Donna DeBlois | Pat Laff | Bill Musick | Cory Rutledge | Laura Wilson

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## Environmental Overview

Home health is facing one of its most difficult challenges. The Centers for Medicare and Medicaid Services (CMS) continues to reduce Medicare payment levels for home health and has developed a value-based purchasing model operating as a demonstration project in several states that puts a part of that payment at risk. In addition, CMS is working on a new payment system effective January 1, 2020 that will use a Patient Driven Grouping Model (PDGM) to reduce potentially Medicare reimbursement and move to a 30-day episode of care. Each 30-day episode will have its own separate price and will require skilled services in excess of the LUPA level.

At the same time, Medicare Advantage plans continue to grow in enrollment nationwide and many states have turned to insurance companies to run managed care programs as alternatives to their Medicaid coverage. For these plans, home health is a very minor segment of their patient related costs and is viewed as a mere commodity warranting only minimal payment rates.

On November 29, 2018, Larry Merlo, the President and CEO of CVS Health, appeared on CNBC and commented on his completed acquisition of Aetna by stating that he will redesign the CVS stores to include more clinical functions. He did not mention home health as part of his overall wellness plan. Under current Medicare regulations, CVS's nurse practitioners and physician assistants that staff their Minute Clinics are not able to order home health under Medicare. Would that lead to further avoidance of home health services? How do we make our case for services? Medicare is looking at removing this restriction.

Finally, innovations on the payment front by CMS created Accountable Care Organizations (ACO) and bundled payments that pose additional challenges to home health. Both payment systems are eligible for gain share payments that are calculated based upon how much they save in providing care as compared to traditional Medicare costs. For many of the ACO's, home health is a service they choose to completely avoid or dramatically reduce its use. Bundled payments roll reimbursement for both acute and post-acute services into a single payment to a hospital or physician group with the opportunity for a gain share if payment for all services were rationed below the overall payment bundle's historical cost.

Faced with these challenges, home health must develop a compelling value proposition to demonstrate why home health services are an important and necessary part of the healthcare continuum. We must clearly define our value in order to remain a relevant component of healthcare and to maintain our seat at the ever-changing healthcare delivery table. Effective care management is the key to creating value. Quality care produces great outcomes that we can quantify.

To help prove this point, we can look at two recent examples that give us insight to how some insurance companies view home health:

1. On November 16, 2018, *The Philadelphia Inquirer* carried an article reporting that the University of Pennsylvania Health System was able to reduce its hospital readmissions for Independence Blue Cross patients by 25% over the past year. Blue Cross claimed a savings of \$19 to \$20 million annually. These results were attributed to the use of remote monitoring, intensive case management and coordination with home care. They also claim scheduled follow-up doctor visits at 7 and 14 days after discharge and providing prescription drugs to patients upon hospital discharge contributed to the reduction.
2. On August 12, 2018, *Home Health Care News* reported that Humana was touting the value of its home health business, Humana at Home, in reducing hospital readmissions and streamlining transitions of care. They reported a 32% reduction in 30-day readmissions over a six-month period as well as patients experiencing less pain, fewer falls, better medication adherence and less depression with home health services.

This value proposition for home health will have two components. The first component is defining what we provide in a patient's home and why home health agencies are the best providers to deliver this care. The second component is outlining a concrete cost justification for home health services. Showing why money spent on home health has a significant return on payments made by insurance companies. We must prove that there is a positive return on investment for money spent on home health in order to protect our existing revenues and garner additional revenue at favorable prices.

This paper focuses on defining the value of home health and using that value proposition to work with Medicare Advantage plans and Medicaid managed care plans in order to obtain rational contracts and become providers of choice for those plans. These values are also important when dealing with health systems and accountable care organizations.



## Defining What Home Health Does

In terms of services exclusive to home health, we can cite the value of observing and understanding how the patient functions in their home. In most cases, physicians and hospital facilities really have little knowledge of the socio-economic factors that affect the patient's home and other factors present there that may help or hurt the patient's overall health and ability to recover from the condition that warranted hospitalization. By addressing the issues presented by directly observing the patient's environment, home health has proven successful in avoiding hospital readmissions and improving the patient's overall quality of life. After all, who really would choose to be in a hospital or nursing home over the comforts and familiarity of receiving care in their home?

We need to make the case on why home health services are necessary. Here are some of the services best provided by home health agencies to reduce unplanned re-hospitalizations and emergency department incidents that we need to have insurance companies focus on:

1. **Medication reconciliation**—by observation in the home, home health nurses provide accurate details on which prescriptions the patient has on hand and is used according to instructions. They can identify prescriptions that remain unfilled, especially after a hospital stay. They can also identify old prescriptions that should not be used. *Unfilled and ignored prescriptions are a leading cause of hospital readmissions.* Medication reconciliation is the valuable tool in helping the patient get better and stay healthy at home. In some cases, agencies have supplied community health workers to managed care companies in order to make home visits to patients that the insurance company has identified have not refilled prescriptions after a hospital stay. These CHW's set up ways to facilitate the delivery of prescriptions to the patient's home and educate the patients on the value of taking all the prescriptions ordered by their doctor. These insurance companies recognize the value of the home health agency in observing how the patient behaves at home. *Given the opioid epidemic, home health staff can also identify the possible diversion of controlled substances that may have occurred putting the patient at risk.*

2. **Falls assessments in patient's home**—by observation of the general condition of the home by an Occupational Therapist and the patient ambulating in their home, home health staff can suggest valuable improvements and necessary changes that would greatly reduce the risk of future falls. Some of these suggestions may include the removal of throw rugs and dangerously placed extension cords and the installation of assistive devices in the kitchen and bathroom. Falls represent a significant risk for elderly patients and only an in-home observation can address these problems. When indicated, a few physical and occupational therapy visits could greatly improve a patient's ability to navigate their homes.
3. **Remote monitoring for chronic disease**—technological advances in monitoring devices in the home have increased their acceptance by patients and improved the effectiveness of managing chronic diseases in the home. Typical diagnoses include cardiac, respiratory, diabetes and hypertension. These patients are frequently admitted or use emergency rooms. Agencies should keep outcome, emergency department incidents and hospital readmission data on patients that use monitors as compared to those that don't in order to confirm for insurance companies of the value of monitoring. Developing specific clinical pathways for each chronic disease, especially those that match the hospital Medicare readmission penalties and monitoring patient outcomes will be the best way to provide ROI data to insurance companies to justify payment for these services. They are focused on reducing the costs for their frequent flyers, but they will only pay for those services if you can show appropriate returns on their payments.
4. **Palliative care**—home health agencies, especially those with hospice programs, are uniquely equipped to provide palliative care home visits by nurse practitioners. These visits can determine if the patient's pain and symptoms are being properly managed at home. These visits also help to identify patients that may be better served by the hospice program. These patients frequently contact primary care providers and create a drain on practice resources. Some providers dread discussing a grim outlook with their patients. As a result, these palliative consults may be welcome relief for the primary care doctors. Under current regulations, Medicare Advantage patients that elect hospice care will have the costs of care related to their terminal illness shifted to the traditional Medicare program. That shift may convince the insurance company to pay for and even request these visits if the providers are properly credentialed with the insurance company. This is an ideal use for nurse practitioners with palliative care and hospice competency. Since not all patients are ready to elect hospice, palliative care could increase home health requests.
5. **Identification of food and nutritional deficiencies**—by visiting patients in their homes, home health can determine first hand if the patient has adequate food in their home. Food and nutritional deficiencies are a leading factor in poor health and a key driver of frequent hospitalizations. As the original practitioners of public health nursing, home health agencies are well equipped to identify issues in the plans of care and line up

potential solutions with their social workers, like meals on wheels. The ability to coordinate these services in the home is part of our uniqueness. The new focus on population health is driving many health systems and insurance companies have begun to address this issue in order to control overall costs.

6. **Mental health issues driven by isolation and loneliness**—these issues are more readily identified by home observation. Depression in post-acute patients is a significant factor in the patient’s willingness to get better and be compliant. Mental health issues are typically not identified during a hospital stay and may be only recognized by home staff assessments. This is another value for home health in reducing the costs of high care patients. Home health psychiatric nurses are the best solution here and this specialty is not always available. Managed care insurance companies require that only master’s prepared psych nurses with separate accreditation can make these visits. As a result, payments for these visits are much higher than a regular nursing home health visit.
7. **Assistance with transitions of care from hospital/rehab facility/skilled nursing facility to home**—by assessing the patient prior to discharge and having staff in the patient’s home, home health is uniquely positioned to help patients transition from a hospital, rehab facility or skilled nursing home to home. Home care staff can assess any problems the patient at home may be facing and develop appropriate and safe solutions to address them. This assistance relieves patient anxiety and reduces readmission risks.
8. **Private duty and personal care services**—Medicare Advantage plans are now authorized to use and pay for private duty services. Home health agencies that offer these services directly or through a contractual arrangement with a licensed provider are uniquely positioned to offer one stop comprehensive services at home to the insurance company. Assisting patients with their daily activities of living will make them healthier and happier at home.
9. **Education, teaching and connectivity**—home health provides patient with continued teaching and education in the least stressful and most effective environment, namely the patient’s home. Focus can be very specific to the patient’s needs in order to best improve their overall health. Home health agencies are ideally suited to keep patients connected to their physicians and health systems. Remember that most of the healthcare delivered occurs outside of hospitals in post-acute settings. Communication is the key to successful coordination of care.



## Defining Return on Investment (ROI)

In order to show the return on payments made for home health services, agencies must quantify the impact of recovered costs through reduced hospital admissions and emergency room use. Value includes the benefits of rapid initiation of home health services, including needed interventions and overall patient satisfaction with services in their homes. To some extent, CMS has tracked these quality outcome measures by agency as part of Home Care Compare. You can use this data to compare your performance with other competing agencies as part of your presentation to Medicare Advantage insurance companies and other referral sources on the benefits of using your agency for home health services.

Hospital readmissions and emergency department incidents represent the biggest cost for the insurance company. Many health systems have risk-based contracts with insurance companies which shift the cost of excess care back to the health system. As a result, your agency must maintain your reported quality scores, patient satisfaction and Home Health Compare Star Ratings at a level that exceeds the area's average score. In addition, you should track readmission rates by health insurance plan in order to determine if you are doing an even better job with an insurer. As you develop new programs, you must measure the impact of the program on readmission rates. This tool will help you sell those programs to insurance companies, who are always looking for ROI proof that payment for these services will save them money overall.

Agencies can negotiate annual bonuses in their contracts with insurance companies based upon keeping readmissions below the insurance company's regional experience or below the agency's own experience in the prior year. This pay for performance bonus could really be significant as the agency works to reduce readmissions. *As a rule of thumb, an insurance company will price each admission at an estimated value of \$10,000. As a result, good performance could really save the insurance company substantial value. This could be a new twist on pay for performance.*

Most insurance companies insist that home health services must occur within 24 hours after discharge from a hospital, including weekends and holidays. You must be able to demonstrate that you can consistently meet these requirements. Patients are most anxious when they



return home and rapid delivery of home health reassures the patient and their family and reduces hospital readmissions. Some agencies have negotiated bonus and penalty clauses in their contracts for timeliness of care implementation. The key to measurement is the ability to get good data, especially if there are delays in patient discharge, delays in signed physician orders or delays in the receipt of required authorizations from the insurance company. This is a very difficult aspect to properly and accurately monitor and it can only be done if excellent data is present from all sources.



## How to Apply to Your Agency - A Summary

The final step will be training your agency's key staff to effectively communicate and calculate the value your agency is providing to patients. This value proposition proves that your agency continues to serve all the patient needs in the most economic matter possible. These calculations will prove that home health is a relevant and necessary service that is an integral part of the insurance company's treatment plans.

It is necessary as part of the process for obtaining successful managed care contracts that the agency direct a lot of its efforts to reducing hospital readmissions and emergency room use, as they represent two of the costliest expenses for the insurer. Each agency should attempt to quantify the impact of these reductions for each insurance company. These results should be communicated to the insurance company at least annually in order to identify the value provided.

In addition, care must be provided as quickly as possible. Plans should be made by the agency to handle referrals requiring initiation of care within 24 hours of hospital discharge seven days a week. This nimbleness will further reinforce the benefits of home health and be well received by patients. It shows that you are truly concerned for their welfare and ready to meet their needs.

Finally, agencies should implement effective programs to improve patient satisfaction scores. Insurance companies value content patients as they have their own set of published patient satisfaction scores as well. Happy patients are the best proof that home health works and is a valuable component of the healthcare continuum.

Best wishes for your continued success.