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Home Health Agencies

Home health agencies bring skilled care to homebound patients to help them recover from illness or injury, or to support independence and self-sufficiency, or to slow functional decline due to aging or chronic conditions.

Introduction

Home health agencies provide medically necessary skilled nursing and therapy services to patients who do not need full-time care in an institutional setting, but who would be unable to leave home for outpatient services without great difficulty.

Home Health Agencies offer a safe, convenient and potentially cost-effective mode of care within in the continuum of healthcare in the United States.

History

The concept of home health care has its origins in the early 19th century in the United States. Hospitals were considered extreme and mostly served patients without families or caregivers. Wealthy families hired doctors, nurses and midwives to provide care in their homes. Volunteer "visiting nurse" groups formed across the country to provide home care to those families who were unable to hire their own medical care.

In 1909, the Metropolitan Life Insurance Company included home nursing care in their insurance packages for policyholders. In the 1930s and 40s hospitals began to reach capacity and home care was viewed as a solution to reduce hospital census.[1]

With the establishment of Medicare and Medicaid in 1965, home care was included as a covered benefit primarily to offer an alternative to hospital care.

The term "home health" is often used to represent a broad array of nursing or caregiving services provided in a patient's residence. This primer pertains to medically-necessary skilled care provided at home, and eligible for coverage under public or private health insurance.

Current Role in the US Health System

Home health agencies help patients recover from a wide variety of needs. Home health care can be prescribed as follow-up care after a hospitalization or as care unassociated with a hospital stay.

Visiting Nurse Society of Philadelphia—1909

While in the home, patients will primarily receive care because they are in need of skilled nursing services and therapy. In addition, some patients will receive visits from an aide to support activities of daily living and for certain social services. Today there are over 11,500 Medicare-recognized home health agencies across the country.[2]

Did You Know?

Home health agencies bring medically necessary services to patients at home.

- **11,500** Number of Agencies
- **$102B** Total Spending
- **34%** Proportion of Patients referred post-hospital stay
- **34** Average Number of visits per patient
- **5.13M** Medicare Beneficiaries

Source: Cms.gov; Medpac 2020 report to Congress; ICC Analysis

Medicare Coverage Requirements

To be recognized as a home health agency **("HHA)** for reimbursement purposes, the provider must meet several requirements:

- The provider must be licensed as a home health agency in the state where they provide services
- The provider must periodically measure and report data on their patients progress across a range of functional goals **("patient assessment data")**[3]

Homebound Requirement

For some patients in need of intermittent skilled nursing or therapy, a doctor may determine that it is safer, more convenient, and potentially less expensive to receive services at home, rather than in a care facility. Eligible home health services are provided to Medicare FFS enrollees with no-cost-sharing obligation. However, the Medicare program limits its coverage of home health services to beneficiaries who are unable to leave home for medical services. Referred to as the "homebound" requirement, a home health provider must be able to prove that leaving the home is to "taxing" on a beneficiary. The Social Security Act defines home confinement as either: 1) illness or injury requiring the aid of supportive devices such as crutches, canes, wheelchairs and walkers, the use of special transportation, or the assistance of another person in order to leave a place of his/her residence; or 2) a condition such that leaving the home is medically contraindicated.[4] If this requirement is unable to be met and services are still delivered, the home health provider may face a payment denial. Until March 2020, only a physician could certify that a beneficiary was homebound. This requirement was been permanently rescinded as part of the emergency waivers in response to the COVID-19 pandemic emergency. From March 2020, other professionals such as nurse practitioners and physician assistants can certify the need for home health services.[5]

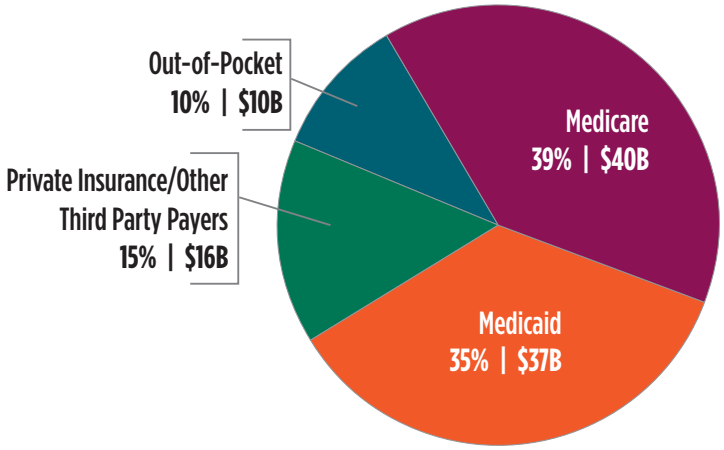
In 2018, $102 billion was spent on Home Health in the U.S.[6] Medicare was the single largest payer, at $40 billion in services to 5.13 million beneficiaries,[7] including 3.4 million Medicare FFS beneficiaries.[8] Medicaid and CHIP paid $37 billion, private

Top Home Health Providers

- Kindred at Home (AL)
- Amedisys (LA)
- LHC Group (LA)
- Encompass Health (AL)
- AccentCare (TX)
- Brookdale Senior Living Solutions (TN)
- Bayada Home Health Care (NJ)

Source: Home Health News[9]

Home Health Payers (2018)



Top Primary Diagnoses of Home Health Patients Referred from Hospital

Diabetes	**7.14%**
Orthopedic aftercare	**6.17%**
Other chronic obstructive pulmonary disease	**4.89%**
Encounter for other postprocedural aftercare	**4.42%**
Essential (primary) hypertension	**3.61%**
Hypertensive heart disease	**3.53%**
Pressure ulcer	**3.51%**
Other disorders of muscle	**3.21%**
Sequelae of cerebrovascular disease	**3.21%**
Hypertensive heart and chronic kidney disease	**2.30%**
Abnormalities of gait and mobility	**2.25%**
Heart failure	**1.90%**
Fracture of femur	**1.76%**
Atrial fibrillation and flutter	**1.75%**
Other disorders of urinary system	**1.45%**
Dorsalgia	**1.43%**
Parkinson's disease	**1.42%**
Other disorders of veins	**1.38%**
Osteoarthritis of knee	**1.19%**
Encounter for fitting and adjustment of other devices	**1.15%**
Total for Top 20 Primary ICD-10 Diagnoses	**57.67%**

Source: MedPAC Report to Congress, March 2020

Key Medicare Policy Changes

- **1997—**Congress requires development of HHA PPS; facilities previously paid on a modified cost-basis
- **2000—**Full implementation of PPS
- **2007—**Establishment of the HHA Quality Reporting Program
- **2014—**Passage of IMPACT Act seeks to align all post-acute care patient assessment efforts and establishes a HHA quality reporting program
- **2016—**CMS initiates the Home Health Value-Based Purchasing Model
- **2020—**CMS implements the Patient Driven Groupings Model for case-mix adjustments

insurance and other third party payers paid for almost $16B, and patients spent just over $10 billion out-of-pocket.[10]

Medicare Reimbursement

Medicare pays home health agencies using a unique prospective payment system **("HHA-PPS")**. Each agency is paid a fixed amount for a 30-day period **("episode")** of care provided.

In the HHA-PPS, the episode rates are defined by the Centers for Medicare and Medicaid Services **("CMS")**. There are 432 different types of episodes which are adjusted by weights or relative values based upon a variety of factors, including the patient's primary diagnosis, their score on functional or cognitive assessments, and their age. The episodes are assigned by a hierarchy of four different criteria: 1) timing and referral source; 2) clinical category; 3) functional and cognitive level; and 4) presence of co-morbidities.[12]

The timing and referral criteria further delineate into early/late and institutional/community categories, as noted in the figure above. The clinical category breaks down into 12 subcategories: musculoskeletal rehab, neurological/stroke rehab, wound care, behavioral health care, complex care, medication management, teaching and assessment for surgical aftercare, cardiac and circulatory conditions, endocrine conditions, infectious diseases, respiratory conditions, gastrointestinal conditions, genitourinary conditions and other conditions.

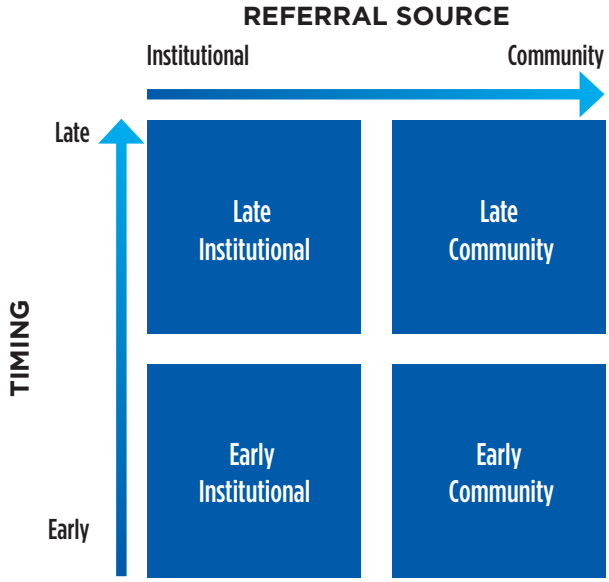
Initial criteria for home health episode assignment

The functional and cognitive criteria are derived from patient assessment data and fall into three categories of low, medium and high. Finally, the comorbitity adjustment is determined from secondary diagnosis codes and is further classified into none, low and high.

Therapists help homebound patients gain independence to perform daily tasks safely.[11]

Each year, in a rule providing updates for the HHA-PPS, CMS stipulates a base episode rate. To calculate a payment for a specific case, a HHA takes the base episode rate as the starting point. A majority portion of this base rate is then adjusted based on the HHA's geographic location (to account for varying labor costs), then multiplied by the episode weight applicable to a particular patient.

Special policies reduce payments if patients are discharged with less than 6 (or fewer) visits within an episode of care. Referred to as a low utilization payment adjustment **("LUPA")**, these short-stay episodes are reimbursed on a per visit basis. In addition, increased payments are provided in rare cases where the number of visits within an episode far exceeds that which is expected for the episode **("high-cost outlier policy")**. High cost outlier payments are capped—no single home health agency can receive more the 10-percent of the its annual Medicare payments from the home health outlier pool.[13]



Recent News

- During the Covid-19 National Emergency CMS waived several regulatory requirements for HHAs, including the use of telehealth services. The telehealth waiver includes the ability for the home to serve as the originating site for a visit within an episode.[14]
- In the Medicare program, home health services must be ordered by a medical or doctor of osteopathic medicine—however, during the Covid-19 National Emergency, other non-physician practitioners such as nurse practitioners and physician assistants are able to order home health

In 2018, the average HHA reimbursement per stay was $3,089. The average length of stay was 1.9 episodes, with about 17 visits per 30-day episode.[15]

Patient Driven Groupings Model ("PDGM")

On January 1, 2020, CMS began using a new case-mix or risk-adjustment model for HHA reimbursement. PDGM focuses on classifying patients into payment groups based on data-driven patient characteristics, such as clinical condition and functional score. Prior to implementation of PDGM, much of HHA reimbursement relied on the number and intensity of therapy services provided.[16]

Future of Home Health Agencies

The demand for Home Healthcare is expected to continue to increase due to demographic trends and as payers face increased pressure to carefully manage cost growth in healthcare. Optimizing the use of home health may help reduce costs on both pre-acute and post-accute institutional care settings.[17]

Key Regulatory Leaders

- **Seema Verma**, *Administrator,* Centers for Medicare and Medicaid Services
- **Demetrious Kouzoukas**, *CMS Principal Deputy Administrator and Director,* Center for Medicare
- **Hiliary Loefler**, *Acting Director,* Chronic Care Policy Group
- **Brian Slater**, *Director,* Division of Home Health and Hospice

Home health patients are visited by nurses and therapists according to personalized plans of care.[18]

There are several ongoing trends and policy discussions that could impact how HHAs operate in the future.

The IMPACT Act of 2014 requires CMS to study and report back to Congress on the potential unification of the HHA-PPS with other post-acute payment systems, like those for nursing homes and rehab hospitals. This is expected sometime in 2023. Similarly, several CMS demonstration projects and private insurer initiatives have encouraged the bundling of hospital services and post-acute care services into new payment models – often with providers bearing financial risk.

Meanwhile, HHAs continue to provide an important role in the continuum of care- a trend which is expected for years to come. Another trend to watch in the future will be the difference in the scope of services beneficiaries have access to between the tradition FFS and MA benefits. MA has greater ability to provide benefits, such as personal care services. As the MA advantage program continues to grow, policy makers will need to consider the divergence in benefits for home health between FFS and MA.

References

1 U Penn Nursing https://www.nursng.upenn-edu/nhhc/home-care/

2 Home Health Care Services. Chapter 9. March 2020 Medicare Payment Advisory Commission Report to Congress.

3 Home Health Prospective Payment System. Centers for Medicare and Medicare Services. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Home-Health-PPS-Fact-Sheet-ICN006816.pdf

4 1814(2)(C)

5 §§ CFR 409.41 through 409.48; 424.22; 424.507(b)(1); § 440.70(a)(2) and (3), and (b)(1), (2) and (4); 42 CFR part 484 (April 30, 2020)

6 CMS.gov, Home Health Quality Reporting program. Includes traditional Medicare and Medicare Advantage enrollees. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInit

7 National Health Expenditures Fact Sheet, CMS.gov, Office of The Actuary

8 Home Health Care Services. Chapter 9. March 2020 Medicare Payment Advisory Commission Report to Congress.

9 https://homehealthcarenews.com/2019/11/the-top-10-largest-homehealth-providers-in-2019/

10 National Health Expenditures Fact Sheet, CMS.gov, Office of The Actuary

11 Home Health Care Services. Chapter 9. March 2020 Medicare Payment Advisory Commission Report to Congress.

12 Encompass Health Investor Report. January 2020.

13 Home Health Care Services. Chapter 9. March 2020 Medicare Payment Advisory Commission Report to Congress.

14 Home Health Agencies: CMS Flexibilities to Fight COVID-19. Centers for Medicare & Medicaid Services. https://www.cms.gov/files/document/covid-home-health-agencies.pdf

15 Ibid

16 Overview of the Patient-Driven Groupings Model. Centers for Medicare and Medicaid Services. https://www.cms.gov/files/document/se19027.pdf

17 "National HH Spending Hits Record" Home Health Care News, 12/5/2019

18 Photo courtesy of Encompass Health

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