The Alliance for Home Health Quality & Innovation

The Future of Home Health Care Project

MAY 2014

Alliance for Home Health Quality and Innovation

About the Alliance

The Alliance for Home Health Quality & Innovation is a 501(c)(3) foundation with a mission to lead and support research and education about the value of home health care to patients and the U.S. health care system. Working with researchers, key experts, thought leaders, and stakeholders across the spectrum of care, we strive to foster solutions that will improve health care at home through quality and innovation.

The Alliance is a membership organization that is comprised of home health care providers and organizations committed to advancing research and initiatives on the value of home health care.

Future of Home Health Care Project

The Alliance for Home Health Quality and Innovation is supporting a research-based strategic planning project on the future of home health care in America. In three phases, the Alliance will release this White Paper, sponsor a public workshop and hold a symposium on the topic. The final deliverable will be a research-based strategic framework for the future of home health.

In keeping with the mission of the Alliance, the goal of the project is to improve understanding of how home health care is currently used, and how it will be used in the future for older and disabled Americans.

The Alliance will commission research that will elucidate the role and value of home healthcare, and develop a strategic framework and plan capturing the critical role and impact of home health care with steps needed to achieve the vision of home health's role in the future of the health care system.

Authors

This white paper was produced by Alliance staff, in close collaboration with members of the Alliance's work groups on Quality/Innovation and Research. The Alliance would like to acknowledge Jennifer Schiller, Teresa Lee, Susan Smith and Steven Landers for their role in researching and drafting the final paper.

Table of Contents

Executive Summary

This white paper examines the role of home health care in the United States, both currently and in the future, as perspective and background for a project on the future of home health care.

There is high value in providing care in the home because it can improve patient outcomes in the least costly, and generally patient-preferred, setting.

- *Improving patient outcomes*. Medicare patients who receive home health care immediately after hospital discharge are more likely to improve self-care. More often than not, after receiving home health care Medicare patient outcomes improve in terms of wound improvement and healing, breathing, bathing, and less pain when moving around.
- *Efficient and least costly*. Among the formal post-acute care settings, Medicare home health care is generally the least costly alternative. Medicare expenditures for a patient treated in home health as the first setting after hospital discharge averages $20,345, compared to an average of $28,294 for patients across all settings.
- *Patient-preferred*. According to the AARP, persons 50 and older with disabilities, particularly those age 50 to 64, strongly prefer independent living in their own homes to other alternatives.[1] Preferences for services at home rather than in nursing homes are widespread among persons with disabilities. Even in the event they needed 24-hour care, 73 percent of persons with disabilities prefer services at home. Among the general population of persons 50 and older, 58 percent prefer services at home.

To date, the role of home health care has been influenced significantly by Federal policies, particularly Medicare. Home health agencies provide skilled, intermittent nursing and therapy services to beneficiaries who are "homebound," subject to a plan of care certified by a physician. In particular, home health agencies are specialists in serving patients who need post-acute care and/or need community-based care management to address chronic conditions.

This framework, however, was not designed to support the rapidly growing demographic of older Americans. As the U.S. health care system prepares for the future, seeking to leverage finite resources to pay for patient outcomes, home health holds significant potential to be a key player in health care delivery for older Americans and people with disabilities. A number of demonstration projects and programs are currently using or testing approaches to leveraging home health and home-based care, many with positive results. These projects and programs include the Veterans Affairs Home Based Primary Care (HBPC) and Medicare's Program of All-Inclusive Care for the Elderly (PACE), as well accountable care organizations (ACOs), bundled payment arrangements and the Independence at Home (IAH) demonstration.

The following are among the key challenges to address in order to best utilize home health care in the future as a sustainable, cost-effective, and patient-preferred mode of care.

- The payment system silos inherent in traditional Medicare promote volume over value, and fragmentation over coordinated care.
- Certain aspects of the Medicare home health benefit hinder the ability to delivery optimal care for patients (e.g., the homebound requirement, the face-to-face requirement, etc.).

- There is inadequate infrastructure and support to enable patients to age in place and receive care at home (e.g., for caregiving, transportation, housing and meals).

More in-depth analysis is needed to improve understanding of the role of home health care in the future of health care delivery in America. The Alliance intends this white paper to be a starting point for the Future of Home Health project, which will focus research, analysis and discussion on the role of home health care in the future of the U.S. health care system for the elderly and individuals with disabilities.

Introduction

Home health in the United States is at a crossroads. Although home health care is rooted in a rich history of providing high quality care to patients in their homes, and involving the patient in his or her own planning and execution of care,[2] it is unclear how home health care will be used in the future to serve older Americans and people with disabilities. As a result of the growth in the population of older Americans, home health care today is growing in relevance, as many strive to age in place and remain independent. These demographic trends are occurring at the same time that health care delivery systems, payers, and patients look to combat soaring health care costs. Given that home health care is often a cost-effective means of delivering care,[4] there is growing interest in how home health care should be used by older Americans and people with disabilities in the future.

At the same time, there are serious concerns in the Federal health policy community regarding the current Medicare home health benefit. The benefit supports home health services for over 3 million Medicare beneficiaries each year and accounts for nearly $20 billion per year in Medicare expenditures. While across the country 84 percent of Medicare home health agency patients rate their overall care a “9” or a “10” on a ten point scale, policymakers and public health officials in Washington, D.C. are concerned about rising costs, regional variation in home health service use, and the potential for home health fraud and profiteering. These concerns have led to payment cuts and new regulatory hurdles, and there are calls for further cuts and barriers. Beyond these concerns, there are a variety of health reform initiatives underway at the Federal and state levels that are changing the organization, financing, and delivery of health care. There are many questions about how home health fits in, or how home health agencies must change to contribute to improved health outcomes and value in these new paradigms. Many in the home health community are concerned or confused about their future role in the face of these challenges. It is in this context that we are bringing together the home health community in a collaborative project on the future of home health.

The purpose of this white paper is to provide the background for this project, which is intended to improve our understanding of the role of home health care in the future of the U.S. health care system. This white paper will describe the current role of home health care for older Americans and individuals with disabilities, its evolving future role, and the key challenges in meeting future needs. We will discuss the following: (I) the value of providing care at home; (II) federal policy and trends involving home health care; (III) the role of home health care today and challenges for meeting future needs; (IV) delivery system reforms and the evolution of home health care; (V) the value proposition for the future; and (VI) conclusion and pursuit of further understanding the future of home health care.

In this paper, the term "home health care" is defined as services provided by Medicare-certified home health agencies. Today, home health care is most commonly understood as those services that are covered under the Medicare home health benefit. However, it is critical to note that there are many types of "home care" services available, needed, and used by older Americans and people with disabilities.[4] The scope of home care services includes the skilled home health care provided by Medicare-certified home health agencies, and long-term services and supports, personal care services (which may be covered by Medicaid and other state programs as home and community-based services, but is often paid by individuals out of pocket), and end-of-life and hospice care (which may be covered under the Medicare hospice benefit). As we seek to understand the future of home health care, it is important to consider the full scope of home care services so that we can develop a comprehensive understanding of what is needed in the future to improve health care in the United States.

I. The Value of Providing Care at Home

Almost every person in the United States has either personally received, or has a loved one who has received, fragmented care that led to poor outcomes and poor patient experience, despite considerable expense. The policy focus today on achieving the Triple Aim of better population health, better patient experience, and lower per capita cost is being driven to address these issues.[5] The Triple Aim is becoming a focus at the same time that the baby boomer population is becoming eligible for Medicare and expressing their preference to age in place. Surveys of older Americans have found that most prefer to stay in their own homes.[6] More of these baby boomers are expected to live longer,[7] requiring more caregiving support whether from their families or from paid caregivers.[8] Individuals with disabilities, too, are in need of solutions to enable their independence in communities.

What is the Triple Aim?

The Triple Aim is a framework developed by the Institute for Healthcare Improvement that describes an approach to optimizing health system performance. It is IHI's belief that new designs must be developed to simultaneously pursue three dimensions, which we call the "Triple Aim":

- **Improving the patient experience of care (including quality and satisfaction);**
- **Improving the health of populations; and**
- **Reducing the per capita cost of health care.**

As a means of achieving the *Triple Aim* and respecting the preference of older Americans and individuals with disabilities to age in place, home health care's value proposition is that it offers the ability to deliver care cost effectively at home, with improved outcomes through patient-centered care.

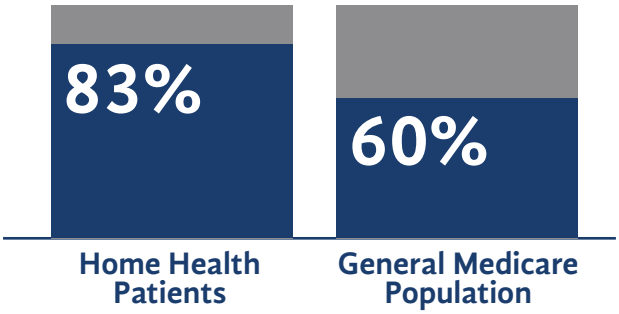
Home health care supports improved patient outcomes. The Medicare post-acute care payment reform demonstration found that after risk adjustment, patients receiving home health care after hospital discharge were more likely to improve self-care, although rehospitalization rates were similar to those who received facility-based post-acute care.[9] Similarly, the publicly available data from "Home Health Compare" reflect that more often than not, patient outcomes improve after receiving home health care. After receiving home health care, 89% of wounds improved or healed after an operation,

67% had less pain when moving around, 66% got better at bathing, and 64% had improved breathing.[10]

Patient Outcomes After Receiving Home Health Care:

These outcomes are significant improvements given that home health patients have a high prevalence of chronic disease, with 83% of Medicare home health patients suffering from 3 or more chronic conditions, compared to 60% of the general Medicare population who suffer from 3 or more chronic conditions.[11]

Percentage of patients suffering from 3 or more chronic conditions



In terms of post-acute care Medicare expenditures, home health care is generally the most cost-effective formal post-acute care setting. Home health care is the least costly alternative, representing 38.7 percent of all Medicare episodes using formal post-acute care first settings, but comprising only 27.8 percent of payments.[12] Moreover, data shows Medicare beneficiaries with the same diagnosis in the acute care hospital are receiving care in various post-acute care settings including: home health, skilled nursing facilities (SNFs), and to a more limited extent, inpatient rehabilitation facilities (IRFs), and long-term acute care hospitals (LTCHs). Across all Medicare diagnosis groups, the average 60-day episode expenditures (including the preceding acute care hospital admission) vary widely by formal post-acute care first setting. For example, Medicare expenditures for a patient treated in home health after hospital discharge average $20,345, compared to an average of $28,294 across all settings.[13]

Furthermore, older Americans and Americans with disabilities prefer to age in place and receive care at home. According to the AARP, persons 50 and older with disabilities, particularly those age 50 to 64, strongly prefer independent living in their own homes to other alternatives. Preferences for services at home rather than in nursing homes are widespread among persons with disabilities. Even in the event they needed 24-hour care, 73 percent of persons with disabilities prefer services at home. Among the general population of persons 50 and older, 58 percent prefer services at home.[14]

When care is delivered at home, patients are able to obtain truly patient-centered care. The Institute of Medicine (IOM) defines care that is "patient-centered" as "providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all decisions."[15] Because the home is the patient's daily environment,

it is the site of care that is most conducive to enabling respect for patient preferences, needs, and values. At home, patients are able to receive one-on-one coaching and education from home health providers that is individualized to their home settings, daily behaviors, and other specialized needs.

The bias toward institutional and office-based care exists even though much of what determines our health status is whether one adheres to behavioral and medication regimens that are carried out as daily decisions at home.[16] Better chronic condition management in home settings can help to reduce avoidable hospital admissions, nursing home care, emergency department visits, and outpatient clinic visits. As the population of older Americans grows, concerns are rising about insufficient space in facilities to meet growing needs, making the home an even more important locus of care.

Consequently, it is in the patient's best interest, both in terms of quality of care and preference to age in place, to receive health care at home. It is also in society's best interest to have patients receive health care at home when clinically appropriate for the patient because it is the least costly means of receiving care. The United States has not yet realized the full potential of home health care as a means to deliver high quality care at lower overall cost.

II. Federal Policy and Trends Involving Medicare Skilled Home Health Care

Over time, the role of home health care has been influenced greatly by Federal policy, specifically the creation and evolution of the Medicare program.[17] The legislation that created the Medicare program in 1965 included a home health benefit, which strengthened the credibility, significance, and public awareness of home health care.[18]

The traditional Medicare program pays in separate payment systems for different health care provider and professional services.[19] Thus, Medicare pays short-term acute care hospitals under the hospital inpatient prospective payment system; Medicare pays physicians under the physician fee schedule; and Medicare pays home health agencies under the home health prospective payment system. Each payment system is separate and unrelated to the other payment systems.

Under the home health prospective payment system, Medicare beneficiaries are eligible to receive home health care services delivered by a certified home health agency if the beneficiary meets the requirements below.

Home Health Prospective Payment System Patient Requirements:

- Is homebound;
- Needs intermittent skilled nursing and/or therapy services; and
- Is under the care of a physician and needs reasonable and necessary home health services that have been certified by a physician and established in a 60-day plan of care.[20]

Medicare pays for home health care services with both Medicare Parts A and B funds in 60-day episodes of care, and pays agencies by home health resource groups (HHRGs) that are based on clinical and functional status (drawn from the Outcome and Assessment Information Set (OASIS) instrument), and service use.[21] In general, Medicare pays with Part A funds if the home health care services follow discharge from

an acute care hospital; or Medicare pays with Part B funds if a physician refers the beneficiary for home health care services as part of community-based care.[22]

Driven by changes in Medicare hospital payment methodology in the 1980s, home health agencies were referred greater numbers of patients with prior hospitalizations and with higher levels of acuity. As the approach to Medicare payment for hospitals changed with the creation of the hospital inpatient prospective payment system (i.e., payment by diagnosis-related group (DRG) hospital payment bundles), hospital lengths of stay shortened, and more Medicare beneficiaries needed post-acute care services, including home health care. This led to increasing numbers of patients with higher levels of acuity seeking care in formal post-acute care settings like home health.

More recent changes in hospital payment policy have made hospitals more conscious of post-acute care and the need to reduce 30-day hospital readmissions. As of October 1, 2012, hospitals are subject to readmission payment penalties for patients readmitted within 30 days of discharge for select diagnoses. These payment penalties have begun to influence hospital practices related to both timing of discharge and interest in coordinating care with post-acute care providers, including home health care, and physicians caring for patients post-discharge.

Home health care has not only played a strong role as a provider of Part A post-acute care, it also plays a strong role as a provider of Part B community-based care. In 2000, beneficiaries with a prior hospitalization represented 47 percent of all home health episodes; by 2011, only 36 percent of home health episodes were for beneficiaries who had a prior hospitalization. The increase in proportion of Part B episodes suggests that Medicare may be paying more frequently for home health services for beneficiaries receiving care for chronic illnesses, who may need longitudinal treatment plans.[21]

III. The Role of Medicare Skilled Home Health Care Today and Challenges for Meeting Future Needs

a. Medicare Skilled Home Health Care's Role Today

Today, Medicare-certified home health agencies are specialists in providing in-home skilled nursing and therapy services to homebound patients who: (1) have had a prior hospitalization and are recovering from acute illnesses or conditions; and/or (2) need community-based care management to address their chronic conditions.

Home health agencies are unique as the only Medicare-certified providers who are specifically certified to provide skilled care to beneficiaries at home for acute, chronic, or rehabilitative conditions. Using interdisciplinary clinical teams of health professionals (including nurses, physical therapists, occupational therapists, speech language pathologists, medical social workers, and home health aides), they deliver the following aspects of skilled care to patients—

In delivering this care, home health providers often leverage technology to enable the provision of care at home. In varying degrees, home health providers use a diverse array of technologies from remote monitoring, to phone calls (including the growing array of mobile technologies and applications), to health information technology, to in-home therapeutic and diagnostic technologies. Such technologies are often key tools that enable home health providers to improve quality and reduce the cost of care delivered to patients.

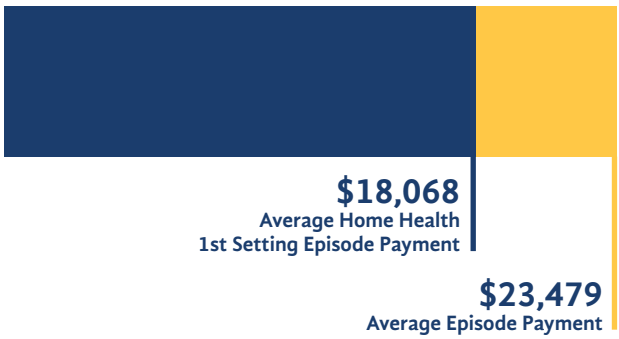
Care Provided by Home Health Agencies

- Medical treatment in the home, including chronic disease management;
- Care to improve or stabilize the patient's functional status;
- Care coordination services and management of care transitions (especially from hospital to home);
- Management of behavioral health conditions;
- Care that enables avoidance of unnecessary hospitalizations and rehospitalizations; and
- Support to patients and their family members to connect to community resources to enable and support independence.

Moreover, home health agencies are well positioned to facilitate population health management in the community because they deliver care pursuant to the orders of the patient's own physician. Having a plan for patient care that is reviewed by the patient's own primary care physician is key to providing coordinated, accountable care for the patient in the community.[24]

In addition, from a health care system and payer perspective, home health care is a cost-effective means of delivering care when it is clinically appropriate for the patient to receive care at home, particularly in the context of post-acute care. If a patient is discharged to home health care immediately following hospitalization, in general this is the least costly setting as compared with discharging patients to a SNF, IRF, or LTHC as the first setting post-discharge. In the context of a post-acute care episode (for inpatient hospital care plus 60 days post-acute care), the average Medicare payments for providing care to patients discharged after a major joint replacement under Diagnosis Related Group (MS-DRG) 470 vary considerably by which formal post-acute care setting the patient is admitted post-discharge. For all MS-DRG 470 episodes, the overall average episode payment is $23,479 per patient. Where home health care is the first setting post-discharge, Medicare episode payments are $5411 less than the overall average. By contrast, where the patient is discharged to SNFs, IRFs and LTCHs, Medicare episode payments are more than the overall average. LTCH first setting episodes are $34,417 more than the overall average.[25]

Average Medicare payments for providing care to patients discharged after a major joint replacement under Diagnosis Related Group



Under the current siloed traditional Medicare program, patient needs are considered, but cost effectiveness generally is not a consideration in determining where a patient will be discharged for post-acute care.

b. Challenges for Meeting Future Needs

Traditional Medicare and the home health benefit were designed in the 1960s, and the policies in place today were not designed to meet the needs of the growing numbers and changing demographics of older Americans (both patients and caregivers).[26] By 2030, the U.S. Census Bureau predicts that the 65 and

older population will grow by 80 percent;[27] and the government predicts that the 85 and over population will grow by more than 300 percent over the next 40 years.[28] The prevalence of chronic illnesses among older Americans has also been growing, and patients with these conditions incur much greater health care costs.[29] Between 2000 and 2030, RAND predicts that the number of Americans with chronic conditions will increase by 37 percent, an increase of 46 million people. The conditions of older Americans are of great concern, but there is also concern about insufficient numbers of caregivers and health care professionals to meet the needs of both older Americans and people with disabilities.

Key Home Health Challenges:

- Silos in traditional Medicare payment policy, which promote volume over value and fragmentation over coordinated care
- Certain aspects of the Medicare home health benefit that hinder the ability to deliver optimal care for patients (e.g., the homebound requirement, the face-to-face requirement, practice level restrictions, etc.)
- Lack of adequate support and infrastructure for patients to age in place and receive care at home (e.g., caregiving, transportation, housing, and meal supports are needed)

Given these anticipated issues, we believe there are three key challenges that hinder the ability of Medicare skilled home health care to meet health care needs of older Americans and people with disabilities. The challenges are:

Silos. Home health care provides high quality, cost-effective, skilled care to patients at home and in their communities. However, the constraints of the current U.S. health care system, which is largely based on payment silos that pay for volume rather than value and lead to fragmentation, limits the ability to leverage home health care to achieve the Triple Aim. Incentives need to be aligned among multiple different health care providers and professionals delivering care—this will require changes in the way health care services are both delivered and paid. Payment and health care delivery system reforms are needed to enable coordinated care and focus on value instead of volume. Such health care reforms that seek to align incentives are being tested through the Medicare shared savings program (and other accountable care organization programs), the bundled payment for care improvement initiative, and the Independence at Home demonstration project. These programs and projects are testing arrangements in a limited number of sites, however, leaving traditional Medicare as the rule rather than the exception.

The Medicare Home Health Benefit. The Medicare home health benefit is not structured to enable optimal patient care, and contains limitations that hinder the ability to leverage the value of home-based care. The homebound requirement limits the ability to offer patients continuous, longitudinal care and support. Once a patient receives skilled care from home health professionals and their condition improves, sometimes the patient is no longer homebound and the home health agency is required by law to discharge the patient. Once the patient is discharged, and is no longer receiving home health care, the patient's condition often worsens, and may even result in hospital admission.

Another constraint of the home health benefit is the requirement to provide skilled care. There are many patients who need behavioral and social support that is critical to avoiding hospitalizations, but they may not meet the

requirements in the law to be eligible for the home health benefit (e.g., the criteria for homebound status or the definition of "skilled" services). For example, the patient may be forgetful about taking his or her medications, or have trouble affording medications. Providing patients care at home to support medication adherence and to help them to obtain needed items and services is key to achieving the Triple Aim, but the Medicare home health benefit may not currently cover such services as a stand-alone.

Furthermore, home health care is not currently geared toward providing intensive care over shorter periods of time, particularly immediately post-discharge.[30] Although there are some innovative programs that are emerging to handle such cases, the structure of the home health benefit is to provide skilled care over 60-day episodes. Patients typically need services over the entire 60-day episode, not for a shorter period that requires more intensive skilled care.

The face-to-face requirement also stymies the ability to provide coordinated care. While the intent of the requirement was to encourage physician engagement, the requirement has had the effect of delaying needed care and creating unnecessary administrative burden. In addition, home health providers sometimes need to make modifications to the home health plan of care to meet patient needs; such modifications, even minor ones, require the physician's review and signature, but present an administrative burden that hinders the delivery of timely, appropriate care. Addressing all of these issues would facilitate optimal patient care.

It is important to note that home health care is not appropriate for every patient. For example, some patients in need of therapy after hospital discharge may be able to obtain outpatient therapy in an office or clinic environment and adequately meet their needs. Other patients may need only a follow up with their primary care physician and are capable of adhering to their medication regimen without assistance through home visits. For some patients, home health care is not appropriate and would offer a low value to the health care system. However, for many patients with multiple chronic conditions, home health care services are needed and of a high value for both patients and the health care system.

Support and Infrastructure. Finally, older Americans and individuals with disabilities often lack the infrastructure and support to age in place. These needs are multidimensional in nature and include: personal care services and caregiving supports; appropriately designed housing; meals/nutrition; and transportation. These supports and infrastructure are critical to enabling patients to age in place, but there is no single comprehensive system in the United States to address these needs. Rather, Americans in need face a patchwork that may partially be funded by Medicaid, state, and local programs, but often the services and their costs are not covered at all. These services and supports may even be difficult to assemble when one is willing and able to pay out of pocket.

IV. Delivery System Reform: the Evolving Future of Home Health Care

The future of health care is in models that leverage finite resources to pay for the achievement of patient outcomes. In this context, a shift towards high-value home health care will grow in importance to older Americans and people with disabilities because of its ability to deliver uniquely patient-centered care at home that improves outcomes more cost-effectively.

There are glimpses of the future in both the public and private sectors, where payers have been seeking to drive reforms in health care delivery and payment in order to address issues with cost of care and patient outcomes. Demonstration projects, programs, and pilots are being conducted to test approaches to care delivery and payment that emphasize value, rather than volume of services.[31] Many of these project and program sites are recognizing the high value of home health and home-based care in efforts to achieve the Triple Aim. The more established programs have developed approaches to care delivery that address the challenges articulated above (i.e., silos, limitations of the Medicare home health benefit, and support/infrastructure limitations). Consequently, these programs elucidate potential key reforms to consider in the future.

1. Established Programs that Optimize High Value Home Care

Two well established programs have demonstrated evidence of significant improvements in patient outcomes, leveraging home care: (1) the Veterans Affairs Home Based Primary Care program; and (2) Medicare's Program of All-Inclusive Care for the Elderly (PACE).

Veterans Affairs Home Based Primary Care. The U.S. Department of Veterans Affairs operates a Home Based Primary Care (HBPC) program that provides care to patients with "complex chronic disabling disease and uses an interdisciplinary team of ... geriatric-skilled practitioners to provide comprehensive longitudinal primary care in the homes of veterans for whom routine clinic-based care is not effective."[32] Begun in 1972, the program's intent is to deliver comprehensive primary care in the home, where the primary care provider is the HBPC medical director alone, or in collaboration with a nurse practitioner or physician assistant. An interdisciplinary team is used to manage the complex health problems of chronically and terminally ill patients. The core team is a physician, nurses, social worker, rehabilitation therapist, pharmacist, dietitian, and psychologist.[33] The HBPC program uses telehealth as needed to closely monitor its patients.

The HBPC program has yielded significant improvement in outcomes and cost savings. A 2002 analysis found that the 11,334 veterans in HBPC had a 62 percent reduction in hospital bed days of care, 88 percent reduction in nursing home bed days of care, and an increase in home care visits by 264 percent. The mean total VA cost of care dropped 24 percent from $38,000 to $29,000 per patient per year. Enrollment in HPBC in fiscal year 2007 was associated with a 59 percent reduction in hospital bed days of care, 89 percent reduction in nursing home bed days of care, and a combined reduction of 78 percent in total inpatient days of care. It was also associated with a 21 percent reduction in 30-day hospital readmissions rates.

Critical differences exist between the VA's HBPC program and Medicare home health care.

HBPC provides comprehensive primary care led by a HBPC medical director in coordination with an interdisciplinary team. By contrast, Medicare home health is guided by a plan of care reviewed and approved by the patient's community physician, but because the physician's Medicare payment is unrelated to Medicare home health, care is rarely fully coordinated.

Medicare home health care is provided only to patients who require skilled nursing or therapy care, and who are homebound. By contrast, HBPC patients need not require skilled care,

and the patient does not need to be homebound. HBPC program eligibility is possible for patients "for whom routine clinic-based care is not effective."[34]

HBPC targets patients with chronic disease. It is accepted that the patient's health status will decline, and HBPC meets needs even through the end of life. Medicare home health has largely focused on remediable conditions due to Medicare contractor interpretations that created an "improvement standard." This standard has been challenged and overturned by the federal courts and it remains to be seen how application of the Medicare benefit may change. Moreover, although many Medicare home health providers offer palliative care programs, there is a separate Medicare hospice benefit that is independent of the Medicare home health benefit.

HBPC provides longitudinal care. By contrast, Medicare home health is structured to provide care in short-term 60-day episodes.

HBPC provides support and education for caregivers, adapts the home as needed for a safe and therapeutic environment, and contracts as needed with adult day health care programs, home maker and home hospice programs. The Medicare home health benefit is limited in nature, and while home health aide services are provided (incident to the skilled needs), home maker supports, home adaptations, and adult day services are not covered by Medicare.The VA's HBPC program offers an example of how home-based care can be optimized to deliver improved outcomes for Americans who are older and have disabilities, simultaneously generating considerable cost savings to the health care system.

Critical differences between the VA's HBPC program & Medicare home health care

VA's HBPC	Medicare HH
Led by a HBPC medical director in coordination with an interdisciplinary team.	Guided by a plan of care reviewed and approved by the patient's community physician. Care is rarely fully coordinated.
Patients need not require skilled care, and the patient does not need to be homebound.	Provided only to patients who require skilled nursing or therapy care, & who are homebound.
Targets patients with chronic disease.	Largely focused on remediable conditions due to Medicare contractor interpretations that created an "improvement standard."
Provides longitudinal care.	Structured to provide care in short-term 60-day episodes.
Provides support and education for caregivers, adapts the home as needed for a safe and therapeutic environment, and contracts as needed with adult day health care programs, home maker and home hospice programs.	Benefit is limited in nature, and while home health aide services are provided (incident to the skilled needs), home maker supports, home adaptations, and adult day services are not covered by Medicare.

Medicare's Program of All-Inclusive Care for the Elderly. Another federal program that has leveraged home-based care to improve outcomes and lower cost of care is the Program of All-Inclusive Care for the Elderly (PACE).

PACE is a comprehensive capitated benefit package that integrates Medicare and Medicaid financing to provide acute and long-term care for the elderly. Eligible participants must be aged 55 or over, need nursing facility-level care, live in a PACE organization care area, and are able to live safely in the community. For most participants, the comprehensive benefit allows them to receive care at home, rather than in a nursing home.[35]

Today there are 98 PACE programs operating in 31 states. PACE programs deliver all needed medical and supportive services, providing the entire continuum of care and services to seniors with chronic care needs while maintaining their independence in their homes for as long as possible. The care and services provided include: adult day care that offers nursing, physical, occupational, and recreational therapies, meals, nutritional counseling, social work and personal care; medical care provided by a PACE physician; home health care and personal care; all necessary prescription drugs; social services; medical specialists such as audiology, dentistry, optometry, podiatry, and speech therapy; respite care; and hospital and nursing home care when necessary.[36] An interdisciplinary team provides services in PACE.

PACE program enrollment is associated with improved care quality, less mortality, preservation of function, fewer unmet assistance needs, greater patient and caregiver satisfaction, less hospital/nursing home utilization, and lower Medicare costs.[37] In one study at a PACE site in Seattle, Wash., those enrolled in PACE had a 13 percent mortality rate as compared to 19 percent for those enrolled in home and community based services alone.

PACE organizations take on full financial risk in addressing all aspects of care, including both medical and long-term care needs. In PACE, enabling care at home is a means to avoid unnecessary admissions to the nursing home and hospital. Although the PACE program's cost effectiveness is under ongoing evaluation, the favorable outcomes suggest the need for reforms that focus on home and community-based care that comprehensively meets the broad array of needs of older Americans.

Both the VA Home Based Primary Care program and the PACE program have been established as effective models of care that emphasize care delivered at home and in the community as a means of achieving the Triple Aim. These are limited programs, however, that are not available to every older American in need. The VA HBPC program is limited to veterans and by geography. The PACE organizations only offer services to those in PACE care areas and those who are Medicaid eligible.

2. Emerging Programs and Projects that Leverage Home Health and Home Based Care

Emerging models of care delivery and payment, such as accountable care organizations (ACOs), bundled payment arrangements, and the Independence at Home (IAH) demonstration project are being advanced (in both the public and private sectors). In these arrangements, the incentive is to lower overall health care costs through improved coordination of care among all providers—including hospitals, physicians, and home health providers—while achieving quality measures. The providers involved in these arrangements are able to share in savings against a baseline or set bundled payment amount.

Some of these emerging models are focusing on post-acute care (PAC) and leveraging high-value home health and home-based care to achieve quality metrics and overall cost savings. This focus is consistent with the findings of a consensus report issued by the Institute of Medicine in July 2013 on "Variation in Health Care Spending: Target Decision Making, Not Geography", which identified post-acute care variation as the main driver of variation in Medicare spending. The report found that "if there were no variation in PAC spending, variation in total Medicare spending would fall by 73 percent."[38]

ACOs, bundling, IAH, and other arrangements have heightened an emphasis on: (1) the patient's care after discharge to lower post-acute care costs and prevent avoidable hospital readmissions; and (2) promoting population health management. In this context, care is being delivered in the home in three ways:

- Medicare home health is being leveraged after hospital discharge to reduce 30-day readmissions and to keep the patient safe and independent at home.[39] Home health is particularly appealing as a lower cost alternative to facility-based care when it is clinically appropriate for the patient to receive home health care.
- Home-based care is sometimes being provided to patients outside of the four corners of the Medicare home health benefit to those who do not meet the definition of the homebound requirement as a means of providing key services (such as medication reconciliation and securing follow-up physician appointments) to improve care transitions and prevent 30-day hospital readmissions. One CMS demonstration program, the Community-based Care Transitions program, is explicitly offering additional payment to program sites to support care transitions management services as a means of reducing hospital readmissions and lowering overall health care costs.[40]
- Home health professionals are being used as navigators and care coordinators in close coordination with primary care physicians in patient-centered medical homes and with home care physicians (in IAH programs) to improve care management in the home, particularly for high cost, high need beneficiaries, often leveraging technology appropriately to monitor care.[41]

How Care is Being Delivered

- Medicare home health as a partner in reducing readmissions and as the least costly PAC alternative
- Home-based care outside the limits of the home health benefit to non-homebound to support care transitions
- Home health professionals working with PCMH & IAH to provide care coordination and management in the home

The quality and cost effectiveness of these programs have not yet been fully evaluated and the information to date has been reported in a serial fashion.

Notwithstanding, these models of care have been created to align incentives among multiple health care providers and professionals, and reward them for achievement of goals consistent with the Triple Aim. Home health care teams are natural partners in these arrangements because their expertise can be leveraged to support the needs of the rapidly aging U.S. population. The U.S. health care system is increasingly leveraging home health care as it shifts to focusing to value, rather than volume, and on providing person

and patient-centered care with an eye towards delivering clear outcomes.

V. Home Health Care's Value Proposition Now and in the Future

The value proposition that home health care offers today and in the future is that home health professionals have the critical expertise to deliver health care at home. As the health care system evolves and is reformed to meet the future needs of the rapidly aging U.S. population, the value of health care delivery at home will grow because it is a patient-preferred, cost-effective means of delivery high quality care. New models of health care delivery are already starting to recognize the value of home health care in this context.

In the future, home health care should be used to provide care to patients whose behaviors and care are best addressed in the home to improve overall health and lower health care costs. Home health providers can be high value partners offering:

- Population health management, in addition to disease management and health promotion skills;
- Services that optimize multiple types of technologies and approaches to leverage the health professionals workforce and enhance person-centered care;
- Coordinated care that is facilitated by seamless health information exchange; and
- Services that are what patients need, rather than only what Medicare traditionally pays for because of payment, coverage and benefit requirements.

Home health providers are capable of delivering these services, but key challenges must be addressed to realize the full potential of home health care in facilitating achievement of the Triple Aim. To attain high-value home health care it will be critical to overcome silos created by fee-for-service Medicare, address aspects of the current home health benefit, and enable supports and infrastructure to allow patients to age in place.

VI. Conclusion and Pursuit of Further Understanding the Future of Home Health Care

The health care delivery system of the future should be reformed to promote and deliver—

- Quality care provided in the most cost effective setting;
- Care that is guided by patient preferences;
- Care over the individual's lifetime based on need;
- Accountable care through payment approaches that align incentives; and
- Team-based care that is structured to support caregivers.

This paper offers the Alliance's perspective on home health care's role at present, and its role in a reformed delivery system in the future. Further rigorous, in-depth analysis is needed to clarify the nation's understanding of its home health care needs in the future. To achieve this more in-depth analysis, the Alliance is undertaking a project on the Future of Home Health Care as a means to expand understanding of home health's role in the future of the U.S. health care system. The goals of this project are to undertake a research-based approach to: (1) articulate the role and value of home health care for older Americans and people with disabilities today; (2) understand and clarify the relevance of home health care in the health care system of the future; (3) develop a construct that captures the vision for the future of home healthcare;

and (4) identify key strategies needed to achieve the future vision. The deliverables from this project will be articles on the future of home health care that are publishable in peer-reviewed publications. In addition, the Alliance will be sponsoring a public workshop and symposium on the future of home health care, which will inform the work conducted in the project and its deliverables. The Alliance welcomes input, collaboration and support for this project.

The value proposition of home health care now and in the future is strong, but that proposition alone is limited without research and analysis. The Alliance looks forward to pursuing research and analysis to explore the validity of that proposition.

Our Goals

- Articulate the role and value of home health care for older Americans and people with disabilities today
- Understand and clarify the relevance of home health care in the health care system of the future
- Develop a construct that captures the vision for the future of home healthcare; and
- Identify key strategies needed to achieve the future vision.

ENDNOTES

1 http://assets.aarp.org/rgcenter/il/beyond_50_il.pdf

2 Beginning in the early part of the 19th century, the Ladies Benevolent Society in Charleston, South Carolina provided volunteer health care services to the sick and poor. According to the South Carolina Department of Health and Environmental Control, this was the start of public health care in the state. "Public Health History." South Carolina Department of Health and Environmental Control. DHEC. Web. 18 Dec 2013. <http://www.scdhec.gov/administration/history/timeline.htm>. Over time, visiting nursing positions were created to meet the to meet the needs of public health care. Lillian Wald, a social reformer and nurse, is credited with pioneering the idea that led to the New York Board of Health organizing the world's first public nursing system. "Lillian D. Wald (1867-1940)." National Women's History Museum. National Women's History Museum. Web. 18 Dec 2013. <http://www.nwhm.org/education-resources/biography/biographies/lillian-wald/>. Home health would continue to help avoid overcrowding in hospitals during war times and to address public health issues throughout the 20th century.

3 See Mechanic, R. (2014), "Post-Acute Care—The Next Frontier for Controlling Medicare Costs", The New England Journal of Medicine, 370(8), 692; see also Allen Dobson, et al., Improving Health Care Quality and Efficiency ("Final Report"), Clinically Appropriate and Cost-Effective Placement (CACEP) Project, Dobson | DaVanzo (Nov. 9, 2012), http://ahhqi.org/images/pdf/cacep-report.pdf.

4 The National Association for Home Care and Hospice defines "home care" as follows: "Home care encompasses a wide range of health and social services. These services are delivered at home to recovering, disabled, chronically or terminally ill persons in need of medical, nursing, social, or therapeutic treatment and/or assistance with the essential activities of daily living. Home care is appropriate whenever a person prefers to stay at home but needs ongoing care that cannot easily or effectively be provided solely by family and friends." (http://www.nahc.org/faq/#110).

5 http://www.ihi.org/offerings/initiatives/tripleaim/pages/default.aspx

6 AARP Beyond 50.05 Survey, April 2005 at 9; available at: http://assets.aarp.org/rgcenter/il/beyond_50_05_survey.pdf

7 RWJF and Hopkins Chronic Care Chartbook at 9 (citing U.S. Bureau of the Census statistics released August 2008).

8 As the baby boomers age, their middle aged children bear increasing responsibilities for caregiving, or providing financial assistance to pay for caregiving services. According to the MetLife Mature Market Institute, nearly 10 million adult children are caring for aging parents, and still other adult children are contributing to the cost of a parent's care. The percentage of adult children providing personal care and/or financial assistance to a parent has more than tripled over the past 15 years.

9 Gage et al., "Post-Acute Care Payment Reform Demonstration: Final Report, Volume 1 of 4", at 18-20 (March 2012). The authors note that one should be cautious, however, in drawing conclusions about causality based on their findings.

10 Home Health Chartbook, p. 55 (Chart 7.3) (Source: Medicare Home Health Compare. April 18, 2013), http://ahhqi.org/images/uploads/20130906_Home_Health_Chartbook_FINAL.pdf

11 Id. at p. 14 (Chart 2.6).

12 Clinically Appropriate and Cost Effective Placement Project, Study Highlights for Working Papers #1 and 2, http://www.ahhqi.org/images/pdf/cacep-wp1-highlights.pdf

13 Allen Dobson, et al., Improving Health Care Quality and Efficiency ("Final Report"), Clinically Appropriate and Cost-Effective Placement (CACEP) Project, Dobson | DaVanzo (Nov. 9, 2012), http://ahhqi.org/images/pdf/cacep-report.pdf.

14 AARP, "Beyond 50.03: A Report to the Nation on Independent Living and Disability," pp. 177-178 (2003), http://assets.aarp.org/rgcenter/il/beyond_50_il.pdf

15 "Crossing the Quality Chasm: A New Health System for the 21st Century," Institute of Medicine, Executive Summary, p. 3 (March 2001).

16 Moreover, there are risks associated with institutional care. Not only are institutionalized patients at risk of iatrogenic infections and healthcare acquired conditions, patients often emerge from facilities weakened because of stressors that are independent of their underlying illnesses. Institutional care often causes patients who are already in need of recovery and rehabilitation to become still more vulnerable. Dr. Harlan Krumholz wrote in the New England Journal of Medicine on "Post-Hospital Syndrome — An Acquired, Transient Condition of Generalized Risk" (N Engl J Med 2013; 368:100-102), explaining that hospitalized patients experience an "acquired, transient period of

vulnerability. . . . [that] might derive as much from the allostatic and physiological stress that patients experience in the hospital as they do from the lingering effects of the original acute illness." Dr. Krumholz uses this "post-hospital syndrome" as a rallying cry to hospitals to focus more on rehabilitative care and targeting stressors that lead to vulnerability, but it also highlights the hazards of institutional care as a general matter.

17 The Medicaid program also covers home health care, subject to highly variable requirements set state-by-state. Older Americans eligible for Medicaid would typically be dual eligible (for both Medicare and Medicaid). Medicaid is most often relevant for dual eligible patients because of Medicaid payment for long term supports and services.

18 http://www.ssa.gov/policy/docs/statcomps/supplement/2011/medicare.html

19 Health care items may be bundled or paid separately. For example, payment for an implantable medical device may be bundled into a short term acute care hospital's DRG, but a piece of durable medical equipment would be paid separately.

20 Section 1835(a)(2)(A) of the Social Security Act.

21 In cases where a beneficiary receives fewer than 5 visits, there is a low utilization payment adjustment.

22 This paper's description of federal Medicare policy focuses on traditional fee-for-service Medicare. It is important to note that some Medicare beneficiaries enroll in Medicare Advantage plans that also cover home health services. Payment for home health care in such plans may differ dramatically from the description herein. http://www.medicare.gov/sign-up-change-plans/medicare-health-plans/medicare-advantage-plans/how-medicare-advantage-plans-work.html

23 S. Talaga, CRS Report for Congress on "Medicare Home Health Benefit Primer: Benefit Basics and Issues" at p. 25 (March 14, 2013).

24 By contrast, SNFs, IRFs and LTCHs each develop care plans for their patients, but it is the SNF, IRF or LTCH physician that develops the plan of care with the facility staff, not the patient's primary care physician.

25 A. Dobson et al., "Clinically Appropriate and Cost-Effective Placement (CACEP) Project Working Paper Series, Working Paper #2: Baseline Statistics of Medicare Payments by Episode Type for Select MS-DRGs and Chronic Conditions," at p. 30, http://ahhqi.org/images/pdf/cacep-wp2-baselines.pdf, October 2012.

26 Various demonstration projects, pilots and programs are intended to reform health care in America, but traditional Medicare continues to be the dominant payer.

27 According to the U.S. Census Bureau, the population age 65 and older in the United States was 40,267,984 in 2010. Carrie A. Werner, U.S. Census Bureau, U.S. Department of Commerce, "The Older Population: 2010, 2010 Census Briefs" (November 2011) (hereinafter "Census Brief: The Older Population"). The Census Bureau predicts that the 65 and older population will grow to 55,969,000 in 2020, and 72,774,000 in 2030. U.S. Census Bureau, Population Division, Projections of the Population by Selected Age Groups and Sex for the United States: 2015 to 2060 (NP2012-T2) (Release date: December 2012) (hereinafter "Census Population Statistics by Age").

28 RWJF and Hopkins Chronic Care Chartbook at 9 (citing U.S. Bureau of the Census statistics released August 2008). By 2045, the Census Bureau predicts that 20% of the 65 and older population will be 85 or older. Census Population Statistics by Age. By way of contrast, in 2010, only 13.6% of the 65 and older population was 85 or older. Census Brief: The Older Population at 2.

29 According to RAND, the number of people with chronic conditions is anticipated to increase rapidly over time, with 1% increases each year projected through 2030. Between 2000 and 2030, RAND predicts that the number of Americans with chronic conditions will increase by 37 percent, an increase of 46 million people. Wu, Shin-Yi and Green, Anthony, Projection of Chronic Illness Prevalence and Cost Inflation, RAND Corporation (October 2000).

30 Ackerly, D. C., & Grabowski, D. C. (2014). Post-Acute Care Reform - Beyond the ACA. The New England Journal of Medicine, 370(8), 689-91.

31 The Centers for Medicare and Medicaid Services (CMS) has selected multiple sites across the United States that are part of the following types of innovative programs and demonstration projects: accountable care organizations (ACOs) (including the Pioneer ACOs and the Medicare shared savings program); patient-centered medical homes (PCMH); the independence at home (IAH) demonstration project; the community-based care transitions demonstration project; the bundled payment for care improvement (BPCI) initiative; managed long term care; and state demonstrations to integrate care for Medicare-Medicaid dual eligible individuals (many through managed care approaches that integrate and coordinate medical, behavioral and long-term supports and services). Other federal government programs and demonstrations, such as the Veterans Administration's home-based

primary care (HBPC) program and the Medicare's Program for All-Inclusive Care for the Elderly (PACE) are also in operation and conducted in many sites across the country. Each of these programs or projects seeks to emphasize value, rather than volume, of services. They seek to improve efficiency of care delivery by improving or maintaining quality of care, while reducing per capita cost of care; or by improving quality of care while maintaining per capita cost of care. Consistent with the Triple Aim, these reforms are aimed at shifting the health care system toward population health management, enhancing patient experience and lowering per capita cost of care.

32 J. Beales & T. Edes, "Veteran's Affairs Home Based Primary Care", Clin Geriatr Med 25 (2009) 149, 150.

33 Id. at 150-51.

34 Id.

35 http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Integrating-Care/Program-of-All-Inclusive-Care-for-the-Elderly-PACE/Program-of-All-Inclusive-Care-for-the-Elderly-PACE.html

36 Centers for Medicare and Medicaid Services, "Quick Facts about Programs of All-inclusiveCare for the Elderly (PACE)," CMS Publication No. 11341 (January 2008)

37 Boult C, Wieland D. (2010). Comprehensive primary care for older patients with multiple chronic conditions: "Nobody rushes you through." JAMA 304(17):1936–1943. White AJ, Abel Y, Kidder D. Final Report: A Comparison of the PACE Capitation Rates to Projected Costs in the First Year of Enrollment.
Cambridge, MA: Abt Associates, Inc.; 2000. Contract No. 500-01-0027. Mancuso D, Yamashiro G, Felver B. (2006). PACE: An Evaluation. Olympia, WA: Research and Data Analysis Division, Department of Social and Health Services; (online) Report No. 8.26. Accessed online at: http://www1.dshs.wa.gov/pdf/ms/rda/research/8/26.pdf. Beauchamp J, Cheh V, Schmitz R, Kemper P, Hall J. (2008). The Effect of the Program of All-Inclusive Care for the Elderly (PACE) on Quality: Final Report. Princeton, NJ: Mathematica Policy Research. CMS Contract No.: 500-00-0033. Meret-Hanke, LA. (2011). Effects of the Program of All-Inclusive Care for the Elderly on Hospital Use. The Gerontologist 51(6): 774-785.

38 IOM Consensus Report, Report Brief at p. 2-3, "Variation in Health Care Spending: Target Decision Making, Not Geography" (Released July 24, 2013).

39 Community based care transitions programs are recognizing how home health providers are able to contribute to achieving reductions in 30-day readmission rates. One example is the program at Wake Forest Baptist Medical Center. (http://ahhqi.org/images/uploads/Revolutionizing_Healthcare_Pam_Duncan_Article_05-08-13.pdf). These efforts are not limited to such programs, however. Home health agencies today are better managing care transitions from hospital to home using techniques such as the ones advanced by Sutter Care at Home. (see http://www.ahhqi.org/images/pdf/innovation-paula-suter.pdf).

40 Eastern Maine Health System is part of a Beacon telehealth program that collaborates closely with patient-centered medical homes to care for both homebound and non-homebound patients. The program provides telehealth services and home care nurses in partnership with nursing care managers in the PCMH to manage chronic diseases. The outcomes have been decreases in emergency department visits and readmissions, improved self-management of medications and increased use of home care and home telehealth. (http://ahhqi.org/images/uploads/AHHQI_PCPCC_Conference_Slides_101413_PDF.pdf).

41 Trinity Pioneer ACO is employing this approach (http://ahhqi.org/images/uploads/innovation-perspectives-20130918-reese.pdf) as is Eastern Maine Health System through both its "community care teams" and its pioneer ACO (http://ahhqi.org/images/uploads/AHHQI_PCPCC_Conference_Slides_101413_PDF.pdf). Centura Health at Home has also developed a telehealth and hospital-at-home program for high need, high cost patients integrated closely with primary care physician practices.

WWW.AHHQI.ORG