THE FUTURE OF HOME HEALTH: A NEW APPROACH TO SUCCESS
OVERVIEW

Corresponding to an aging population and an increase in the incidence of chronic health conditions, more than 3.4 million people currently receive Medicare skilled home health care services. With home health care service utilization on the rise, Medicare home health care spending has nearly doubled from 9.7 billion in 2001 to 18.3 billion in 2012. Additionally, home health agency growth has soared while profit margins have declined. Currently, both payment reductions from the Patient Protection and Affordable Care Act of 2010 (ACA) and greater recent efforts to address fraud currently threaten the viability of the industry. With home health care under regulatory scrutiny, a recent projection is that approximately 40% of providers are expected to be in debt within the next few years.
SUSTAINING A VIABLE HOME HEALTH AGENCY

The management of an agency is complex, highly affected by legislation and changes within the health care system. Agencies must balance the ability to generate profit, meet compliance regulations, and provide high quality care.

To sustain and grow a healthy organization, owners need to analyze how well their agencies are doing as a whole and proactively adjust their business models. While monitoring cost effectiveness and utilization is imperative, so is establishing and tracking productivity, operational, and quality goals.

LEAVING MONEY BEHIND

Too often money is left on the table and inaccurate documentation practices affect payments. Agency owners need to get the money they deserve. Fear of audits, increased reporting requirements, and the burden of proving that high quality care is being provided becomes the focus of survival. Home health care reimbursements traditionally have not been maximized appropriately, leading to a decrease in net profit and unneeded waste of valuable resources. A Medicare Home Health Study found that 17.2% of agencies reported insufficient reimbursement as an important contributing factor in the inability to admit or serve patients.6
Particular patient characteristics such as demographics and diagnoses can often result in lower payments, which may suggest a disincentive in the prospective payment system (PPS) to provide home health care for certain types of patients over others or may result in the difference between healthy and weak profit margins.

Medicare margins for freestanding agencies averaged 19.4% in 2010 and decreased to an average of 12.4% in 2013. Not surprisingly, tax status also plays a role in profit margins. In 2013, while aggregate margins declined by approximately 2 percentage points, nonprofit margins declined by 4.5 percentage points. In 2013, the average margin for a nonprofit home health agency was 10% as compared to 13.7% for for-profit agencies. MedPAC projected that average Medicare margins for home health agencies was estimated to decline from approximately 12.6% in 2014 to 10.3% in 2015.*

*2015 estimated.
REASONS FOR IMPROPER PAYMENTS

With declining profit margins, agencies are often forced to operate with limited staff and antiquated technology. As a result, clinicians struggle to balance the multiple aspects of delivering quality patient care with the administrative burden of producing accurate and complete clinical documentation, creating an arena for erroneous billing practices. According to the Department of Health and Human Services' (DHHS) FY 2015 Agency Financial Report, the improper payment rate for home health claims increased almost 8% in one year (from 51.38% in FY 2014 to 58.95% in FY 2015), equating to an estimate of over 40 billion dollars.7

The report notes that the majority of improper payments for Medicare FFS CAP are due to a lack of documentation to support the services or supplies billed to Medicare (68.6%), medical necessity errors (17.3%), and administrative/ process errors or coding errors (14.1%).8
Due to the volume of claims processed by Medicare and the cost of conducting individual medical reviews, DHHS has implemented numerous policies to prevent and reduce improper payments. To detect administrative and process errors during claim submission, automated edit systems are used to identify inappropriate claims, detect anomalies, or stop claims that never should be paid. DHHS has required Medicare review contractors to focus on identifying and preventing improper payments due to documentation errors in home health claims.

Under policy changes in the 2014 Final Rule (CMS-1611-f), DHHS noted multiple corrective actions to prevent and reduce improper payments, including the establishment of a Healthcare Fraud Prevention Partnership. This partnership is charged with improving the detection and prevention of health care fraud, waste, and abuse. DHHS also announced the use of pre-payment reviews of home health claims for episodes beginning on or after August 1, 2015. These reviews include a “Probe and Educate” strategy that is designed to help agencies understand the new patient certification requirements. The consequence of known fraudulent practices will lead to the suspension of payments and the enrollment of new providers.

**VALUE-BASED PURCHASING**

Collecting quality measures is not new to home health, which has been publicly reporting patient experience measures since 2012. MedPAC has reported that quality of care has remained steady or showed a small improvement.

With the proposal of Value-Based Purchasing, a new system for tying Medicare payments to quality measures, payments would annually adjust upward or downward starting at 3% in 2016 and increasing to 8% by 2022 based on 20 quality measures. However, concern has been generated by many that the proposed model includes too many quality measures, increasing the operational burden on agencies.

MedPAC suggests that the quality measures should focus on what is important to beneficiaries, with preference for clinical outcome measures over process measures. They recommend that agencies only receive credit for performance on any given measure, rather than earning incentive payment simply for reporting data.
Additionally with about 29% of post-hospital home health stays resulting in readmission, there is an additional push for Medicare to establish a program to incentivize agencies to reduce avoidable hospital readmissions. This measure would apply to stays preceded by a hospitalization. Ultimately, payments would be reduced to agencies with relatively high risk-adjusted rates of hospital readmission.

**REPUTATION MANAGEMENT & REFERRALS**

Quality measures currently used in home health quality reporting program are derived from two sources: (1) data collected in the Outcome and Assessment Information Set (OASIS) and (2) data submitted in Medicare claims.

OASIS data elements are required to be collected and electronically submitted to CMS. The elements address socio-demographic, environmental, support system, health status, functional status, and health service utilization characteristics of the patient and represent core items of a comprehensive assessment for an adult home care patient. Compliance with OASIS data collection and reporting affects an agency’s payment determinations.

Since 2012, the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Home Health Care Survey, (HHCAHPS) has been linked to the quality reporting requirement, which also affects an agency’s payments. Both OASIS and HHCAHPS scores can be viewed publicly on the Home Health Compare website.¹⁰

With OASIS and HHCAHPS data publicly available, a strong focus on delivering quality patient care and a positive experience is imperative to an agency’s survival. Patients, family members, physicians, and hospitals are able to easily review an agency’s performance, so that they can be more proactive in the selection of a provider or partner. Agencies that can demonstrate quality patient care are inevitably going to receive more referrals than their competition.
Ensuring Your Agency’s Viability

In order to produce recurring revenue, agency owners need to be able to serve a sufficient number of patients and bill appropriately for the services they provide. At the same time, they need to reduce the occurrences of poor documentation which can lead to the appearance, albeit unintentional, of fraudulent practices. Compounded by numerous governmental regulations and publicly reported data requirements, a simple mistake can cause an agency’s reputation for providing quality care to vanish almost overnight.
ENSURING YOUR AGENCY’S VIABILITY

As the state of the home health industry continues to fluctuate, it is imperative that home health agencies are quickly able to adapt to changes in order to sustain a healthy organization. To protect viability, agencies need to utilize a systematic and streamlined approach to manage their businesses. Such an approach needs to maximize profits, minimize risk, and align value with strategy.

Traditionally, separate management systems have been utilized to address issues such as billing and coding, quality, and clinical information. Nowadays, with increased regulation and competition, these duplicative efforts are no longer efficient and are leading to wasteful and inefficient practices including producing data that are incompatible with other systems.

Luckily, new solutions are available. By employing a single, integrated management solution capable of achieving business objectives and ensuring consistency across all facets of operation, an agency can improve net revenue, minimize the risk of changing government regulations, improve its reputation, and receive more referrals than its competitors.
HOME HEALTH SOLUTION SUITE: THE KEY TO ENSURED SUCCESS

HEALTHCAREfirst’s Home Health Solution Suite revolutionizes the home health industry by uniting the best software, services, and analytics into one integrated suite. As a result, your home health business will achieve unparalleled success across your entire organization. Home Health Solution Suite includes:

**Agency Management Software**
Web-based software that includes a mobile point-of-care solution accessible from anywhere, at any time.

**Coding & OASIS Review Services**
Ensure the accuracy of each episode so you are paid the maximum amount for the services you provide.

**Billing Services**
Experience fewer billing errors and increased cash flow through outsourced Medicare and private insurance billing.

**Advanced Analytics**
Improve quality and efficiency with real-time insight into your OASIS, receivables, and revenue.

**DDE Payer Connectivity**
Enjoy real-time, high-speed DDE connection, simplifying the eligibility verification processes.

**HHCAHPS Survey Administration and Analysis**
Save administrative time while driving performance improvement with automated file processing, survey administration, and analysis.
THE KEY TO SUCCESS

GUARANTEE SUCCESS WITH HEALTHCAREFIRST

• Increase net revenue through minimized overhead costs and maximized reimbursement.
• Total regulatory compliance as a result of accurate and complete clinical documentation.
• Acquire more high-value referrals through the demonstration of positive outcomes and excellent patient care.
• Monitor trends, identify improvement opportunities, and celebrate success with advanced financial, clinical, quality, and operational analytics.
• Improve employee satisfaction through easy program implementation and ongoing support from a dedicated team of professionals specializing in implementation, training, and client service.
• Simplify vendor management by working with one expert business partner. One vendor, one invoice.

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About HEALTHCAREfirst

HEALTHCAREfirst provides cloud-based technologies and services to improve business and clinical operations for over 4,000 home health and hospice providers nationwide. Based in Springfield, MO and one of the fastest growing solutions providers of its kind, the company provides agency and clinical management software, advanced analytics and program management solutions, CAHPS survey administration, and revenue cycle management services. HEALTHCAREfirst’s breadth of solutions offer agencies a single source to improve patient care, create operational efficiencies, increase profitability, and simplify CMS compliance. With HEALTHCAREfirst, agencies can focus on patients instead of paperwork.

For more information, call 800.841.6095 or visit www.healthcarefirst.com.
REFERENCES

1 Forum on Aging, Disability, and Independence; Board on Health Sciences Policy; Division on Behavioral and Social Sciences and Education; Institute of Medicine; National Research Council. The Future of Home Health Care: Workshop Summary. Washington (DC): National Academies Press (US); 2015


8 See https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Home-Health-Prospective-Payment-System-Regulations-and-Notices-Items/CMS-1611-F.html

9 42 CFR Part 409, 424, and 484 Medicare and Medicaid Programs; CY 2016 Home Health Prospective Payment System Rate Update; Home Health Value-Based Purchasing Model; and Home Health Quality Reporting Requirements; Final Rule