Why Hospitals and Payers are Recommending Home Care Upon Discharge Instead of SNF or Traditional Home Health Services *- Alternative Payment Model Hospital Incentives Aligning with Patient Choice -*

JOSH LUKE, PH.D., FACHE
HEALTHCARE FUTURIST AND VETERAN HOSPITAL CEO
UNIVERSITY OF SOUTHERN CALIFORNIA,
SOL PRICE SCHOOL OF PUBLIC POLICY
FOUNDER, NATIONAL BUNDLED PAYMENT
COLLABORATIVE AUTHOR, READMISSION
PREVENTION: SOLUTIONS ACROSS
THE PROVIDER CONTINUUM

ABSTRACT: Seniors and other hospital patients in the United States have traditionally had the option of being discharged to a skilled nursing facility (convalescent home) for post-acute services, or home with nursing and therapy services provided in the home setting. Traditionally, these home based services have been referred to as "home health." As more Americans have retired, home health services have expanded and are readily accessible. This growth put tremendous stress on the Medicare fund which pays for senior care services. However, "Home Care," which traditionally has been viewed as non-medical home based services, has also become a booming industry for the cost conscious in recent years as more Americans reach retirement age. With the passing of the Affordable Care Act in 2010, providers and payers are now finding themselves responsible for post-acute care and continuous patient health, so cost efficient solutions for post-acute care are thriving. For the first time in history, American hospitals and Insurers are recognizing Home Care as an effective model that achieves the Triple Aim of Health Care reform. Home Care, which is no longer completely non-medical services, has proven to be an integral part of the care continuum for seniors in recent years and is now becoming a viable solution for keeping patients well, while still honoring their desire to age and heal at home. This paper analyzes the benefits and risks of home care and provides a clear understanding as to why American hospitals are emphasizing SNF Avoidance and skipping home health, opting instead to refer patients directly to home care as the preferred discharge solution in a value based model.

INTRODUCTION: AFFORDABLE CARE ACT INCENTIVES FOR HOSPITALS & PAYERS TO DISCHARGE HOME

Healthcare spending for seniors continues to balloon at alarming rates as ninety percent of seniors prefer to age and heal at home, as opposed to in a healthcare facility, With approximately 8,000 baby boomers a day turning 65 years old, the nation's senior population is estimated to increase by more than thirty percent by 2025. As a result, Medicare expenditures are projected to double to greater than $800 billion by 2018.[1] These expenditures will have a significant impact on hospitals, health systems and payers as Alternative Payment Models (APMs) become law.

The Patient Protection and Affordable Care Act (PPACA) of 2010 marked the beginning of a transformation in how acute care hospitals are reimbursed by the Federal government for care delivered.[2] While the triple aim of (PPACA) is improved care, improved patient satisfaction and lower delivery costs, recent recommendations from the Center for Medicare and Medicaid Services (CMS) also emphasize the importance of involving the patient in decisions related to their care. The pa-

tient's perception of his or her health care delivery correlates with outcomes and ultimately, satisfaction.[3]

In October 2015, CMS reinforced its desire for including patient preferences in the hospital discharge process in a press release. "CMS is proposing a simple but key change that will make it easier for people to take charge of their own healthcare. If this policy is adopted, individuals will be asked what is most important to them as they choose the next step in care -- whether it's a nursing home or home care," said CMS Acting Administrator Andy Slavitt.[3]

It is the final part of that quote, "whether it's a nursing home or home care," that will prove to be the driving factor in hospitals sending fewer patients to skilled nursing and home health in 2016 and beyond. Put simply, when given a choice, patients will opt not to go to a skilled nursing facility (SNF) unless it is viewed as a last resort.

As further evidence of the Federal Government's drive to reduce inpatient post-acute care utilization, the Affordable Care Act mandated the creation of the Community Living Assistance Services and Supports" Act (CLASS), a national long-term care insurance program with a daily financial benefit that covers up to (the industry standard) of three hours of home-based care per day per enrollee.[4]

Fee for Service Drove Inefficient Hospital Discharge Habits & Excessive Spending

Case managers and discharge planners have historically been charged with developing a comprehensive discharge plan for each patient in an acute hospital. However, through the years the time constraints and information-overload facing doctors, nurses and discharge planners led to discharge plans that were brief, free of detail and oftentimes non-existent beyond an order for "discharge to SNF."

Hospital discharge planners are some of the most overworked professionals in all of the healthcare industry, being asked to manage the constant flow of multiple patients a day. With new patients being admitted daily, coupled with a new case load that completely turns over every four to five days, case managers in the 1990s and 2000s expressed a mounting pressure to facilitate timely discharges of the patients to keep hospital costs low. The requirement of additional time to arrange discharge accommodations for acute patients led to less time and less reserved resiliency to adequately document the patient's needs in the discharge plan and summary.

These added pressures led discharge planners to the path of least resistance to discharge patients in a timely manner. In short, for patients with a Medicare benefit, the quickest and easiest way to get the patient out the door quickly was to discharge them to a SNF or home health agency (in the event that the patient refused SNF) and open up the hospital bed. Additionally, doctors were hesitant to avoid skilled nursing and home health services even when a patient refused due to concerns should the patient experience an adverse outcome or deterioration in health status after discharge.

Lost in this ever-eroding discharge process during the fee for service era was the notion that patients would prefer to not be admitted to a SNF. Essentially, patient preference in level of care was not proven to be a factor. The topic of patient preference was simply a means of allowing the patient or family member to choose their preferred SNF, and not whether or not they truly needed SNF level care that could not have been given in a home setting.

Subsequently, SNF and home health volumes increased dramatically. Patient involvement and preference to avoid skilled nursing was no longer a factor in the conversation.

US Supreme Court Rules Patients Should be Discharged Directly Home

For years, the Federal Government has had legal muscle to encourage doctors and hospitals to send patients home and avoid the SNF unnecessarily, but has had little success doing so. However, the reimbursement model for physicians and providers in the fee for service era was prohibitive and inconsistent with that objective. The landmark United States Supreme Court ruling in 1999, Tommy Olmstead v. Lois Curtis stated that "Patients in an acute hospital have the right to be discharged to the least restrictive environment when the care team determines that community placement is appropriate and the patient does not oppose the transfer."[5]

Furthermore, the ruling stated, "Continued institutionalization of patients who may be placed in less restrictive environments often constitutes discrimination based on disability." Thus, operationally, both physicians and hospital case managers must first rule out the least restrictive environment as a safe discharge before considering institutionalizing a patient for post-acute services."[5]

The Care Plan Act: Episode Based Care Gives Way to the Permanent Care Taker

One of the benefits of home care as an alternative to traditional home health services, is that the care taker becomes the long term care taker, and not a short-term episode based care taker as is the case in SNF, home health and other levels of post-acute care. CMS clearly stated their preference to reduce the noise or the episodes of care and the volume of caretakers that come along with the episode. This leads to enhanced continuity, efficiency, and improved outcomes. While SNF length of stay varies it is often 20 days or less, and home health is normally a 2-3 month episode, neither range allows for a long term care taker who assumes responsibility and knowledge of the patient's needs as is the case in home care or assisted living.[3]

"The proposed rule emphasizes the importance of the patient's goals and preferences during the discharge planning process. These improvements should better prepare patients and their caregivers to be active partners for their anticipated health and community support needs...This rule puts the patient and their caregivers at the center of care delivery," said CMS Deputy Administrator and Chief Medical Officer Patrick Conway, M.D., MSc. "This leads to better care, smarter spending and healthier people."[3]

Incentives for Hospitals and Payers to Consider a Home-First Discharge Option

Hospital Incentives to Utilize Home Care as an alternative to SNF or Home Health

- Increased revenue as demonstrated through improved Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores
- Reduced Merit Systems Protection Board (MSPB) financial penalty exposure
- Reduced readmission financial penalty exposure
- Accountable Care Organizations (ACO) risk pool savings
- Bundle risk pool savings

Stating the Case for Home Care as a First Option

According to the Center for Medicare and Medical Services (CMS), the national readmission average for home bound individuals in 2012 was approximately twenty percent.[3] At least one study conducted in 2012 indicated a hospital readmission rate of 6.3% for patients receiving non-medical home care services (The Hospital to Your Home™ Study, https://www.24hrcares.com/24hr-homecare-conducts-study-on-preventing-hospital-readmissions-with-healthcare-partners/). However, preventing unnecessary readmissions is just one of many incentives to implement more affordable and efficient home based care practices.

Home care has proven to be an integral part of the care continuum for seniors receiving other levels of health care and support. For example, research indicates that not only do home care services increase the hours of care and supervision available to a senior, but reduced doctor's visits by as much as 25 percent.[1] In fact, that same study provided evidence that patients suffering from Alzheimer's disease or dementia experienced a reduction in annual doctor's visits of almost fifty percent. It further indicated that home care can delay or prevent the need for additional formal medical care.[1]

Is it Safe to Skip a SNF Episode and A Home Health Episode?

A recent CMS public comment document stated that "Patients discharged to community settings (home and assisted living) may incur lower costs over the recovery episode as compared with patients discharged to institutional settings.[2]

A recent article in the Annals of Long Term Care, Ostrovsky (2015) stated "The low cost and community connectedness of long term support service providers in the home may give them an advantage over traditional providers of care transition services, especially when their services are augmented by emerging mobile technology."[6]

The article further stated "the historical progression of bundled payments from acute to post-acute care, combined with a growing recognition of the value of home and community-based services, creates an interesting opportunity for sustainability integrating medical services and long term support services into bundles to more effectively achieve triple aim."

An abundance of evidence suggests high utilization of skilled nursing upon hospital discharge is more likely a result of an episode based reimbursement model for providers and doctors, than a clinically justified necessity. Further, when a patient declines skilled nursing care the default option has been traditional home health services. Again, a short-sighted approach as home health services are often capped and limited to benefit allowances despite if a patient is in need of additional care or therapy.

Home care, for the most part, has not been offered as an option for patients being discharged from the hospital. There are two main drivers of home care not often being offered upon hospital discharge. First, hospital discharge planners make an assumption that the patient (and family) do not have the financial means to pay for home care, or simply opt not to pay as traditional home health is a covered Medicare benefit. Second, financially vetting each patient and family upon discharge can be a time consuming process and may delay discharge. Thus, as a result of these two factors, patients are often denied the opportunity to be informed that home care is an option upon discharge from the hospital.

Home Care is Often a Higher Level of Care than Traditional Home Health

Home Care services include providing services to those requiring daily living assistance due to physical, cognitive, or chronic health conditions.[5] This workforce includes personal care attendants and other essential care providers who serve non-medical functions. Non-medical workers are involved in 8 to 10 hours of paid services to older patients and to individuals with disabilities and there is growing evidence that these workers can improve patient experience and outcomes.[6]

As mentioned earlier, traditional home health services are often capped and limited to what the benefit allows – even if a patient is in need of additional care or therapy. With CMS approving reimbursement for home visits, chronic care management and transitional care management, home care providers who partner with physician house call groups are able to offer a higher level of care and less spending than home health, as a physician or nurse practitioner visit is not a covered home health benefit and therefore, not offered as part of the home health episode. Thus, home care often includes a physician, physician assistant or nurse practitioner visiting the patient in the home, whereas in traditional home health the visit occurs primarily with a nurse.

The Argument for Cost Savings for Payers and Conveners

Payer Incentives to Utilize Home Care as an alternative to SNF or Home Health

- Improved patient satisfaction
- Extended home based services times
- Diverse patient-specific needs not limited by home health benefit
- Risk pool saving

Although home care was traditionally viewed as non-medical care and therefore a non-covered benefit, organizations nationwide have started bucking this trend by employing non-medical home care services as a covered benefit that comes with a cost much less than that of traditional home

health services. For example, "the average non-medical worker is paid an hourly salary that is approximately seventy percent and ninety percent less than the salary of a nurse or physician, respectively."[6]

Conclusion

Alternative Payment Models have driven payers and providers to consider non-traditional methods of caring for patients to improve outcomes and control costs. While traditionally non-medical services (assisted living was viewed as "rent," and non-medical home care was viewed as "babysitting" by many) were not covered benefits, insurers and conveners are finding that utilizing these non-traditional levels of care can ensure patient satisfaction and lead to significant cost savings. Assisted living placement often causes delays in discharge. However, home care referral and same day start of care is often the best approach from a quality and financial standpoint as the patient's desire to return to home is honored.

Although on the surface it may seem brash, payers are focusing on how the patient can best be cared for in the home, and when done correctly patients can avoid admission to a SNF as well as Medicare or Insurer based home health services which are often limited and capped at specific amounts. The IMPACT Act (Improving Medicare Post-Acute Care Transformation Act) requires greater patient involvement in discharge planning. This patient involvement will lead to more specific discharge plans, with the primary goal of allowing a patient to age, recover, and heal in a home based setting.

Ultimately, the patient/s specific needs may be less expensive and less acute, than a $200-$800 per day SNF stay, or $3,600 home health episode. As a result, hospital discharge planners and payers are moving quickly to consider home-based care, with non-medical home health as a first-option before considering a SNF stay or home health order.

Hospitals and payers should not only be revising discharge protocols to consider a home-based discharge first, those who are doing so are experiencing enhanced patient engagement and improved patient satisfaction scores. Home care and a "home-first" mentality upon discharge not only reduce the risk of infection that comes along with a SNF stay, but improves patient satisfaction, reduces spending for care, minimizes exposure to readmission penalties and over-utilization of Medicare funds, and enhances an organization's ability to maximize risk pool residuals in Alternative Payment Models. Hospitals who do not adopt a home-first mentality will incur significant losses in alternative payment models and will continue to feel the financial sting of allowing fee-for-service motivated physicians to dictate oftentimes inappropriate post-acute plans, without offering the patient the option of going home.

For insurers, medical groups and other payers, spending a dime to save a dollar often comes with great risk. Home care, however, is not a new service and has proven to enhance the care continuum for years. Thus, payers are increasingly more willing to suggest discharge home with home care as an option before considering skilled nursing or traditional home health services.

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