Home Health Care:
A More Cost-Effective Approach to Medicaid in Illinois
Illinois HomeCare & Hospice Council
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As the Illinois Legislature prepares to act on the future of Medicaid, it is important to understand the role that home health care can play and the immense savings it could offer for the state’s Medicaid budget.

Home Health is essential to the state’s care continuum – it is preferred by most patients, costs far less than alternative care models and, in many cases, produces superior outcomes. Action is needed, however, to ensure continued access to home health services, and to adopt new delivery models that include home health care as an active component.

In this report, we address the current state of Home Health Medicaid in Illinois and provide sound recommendations for the state’s fiscal health and the health of Illinois citizens in need. With Illinois at its fiscal breaking point and Medicaid continuing to be an enormous driver of state spending, the state must adopt new approaches that will save money while delivering quality care.

Now is the time for Illinois to reform its Medicaid system by investing in Home Health to provide critical care in the most cost-effective setting. As a result of federal Health Care Reform, estimates show 700,000 new patients will be entering the Medicaid program in Illinois by 2014. With its ability to deliver both quality care and cost-effective care, Home Health Care is a critical part of the solution.

Ensure Access to Home Health for People in Need

While the cost to provide a skilled nursing visit in the home is $168.44, Illinois’ Medicaid system reimburses at a rate of just $61.34. That leaves provider agencies losing more than $100 per visit for Medicaid patients. Home Health agencies provide care because they believe in keeping patients in the home but it is a severe strain on their own budgets. Agencies are able to provide access to Medicaid patients only because reimbursement rates from Medicare are more in line with actual costs of providing care.

Unfortunately, Medicare rates now are being cut under the federal Health Care Reform initiative of 2010. Drastic Medicare cuts will be implemented to pay for the many new facets of reform.

According to FR&R Healthcare Consulting, Inc., home health agencies in Illinois will see a 5.19% cut in Medicare reimbursement beginning next year. Already thin profit margins are going to be much thinner or non-existent -- this will force some agencies to close, further restricting access to care. The most likely scenario is that Home Health agencies will go into “survival mode” and look for areas to cut in order to stay open.

With the slow and low pay of reimbursement, Medicaid will be the most likely area agencies will cut leaving many patients with the only options of remaining in much more expensive hospitals or placement in a skilled nursing facility. Under either scenario, the State of Illinois – and its taxpayers -- will be forced to pay substantially more for care.

**Home Health is the Cost Effective Healthcare Option**

Home Health is recognized as the most cost-effective form of long-term healthcare (as compared to hospitals and nursing homes). Here are the numbers that bear this out:

- The average cost to provide home care (including skilled and non-skilled care) is $150 per day.
- The same care provided in nursing homes costs $209 a day.
- The same care in a hospital costs $1,500 a day.

The significant cost savings of Home Health provides an enormous fiscal benefit to the State as it reduces the total Medicaid dollars spent in Illinois. Yet, despite these benefits, the low state Medicaid reimbursement rate threatens access to home care in Illinois.

The more a state spends on home-based care, the less it spends on total long-term care, as demonstrated in a recent study of state Medicaid spending on long-term care from 1995-2005. The study compared home care (skilled and non-skilled care) spending to institutional care (nursing homes) spending.

States that have significantly invested in home care services actually showed a savings of **7.9% in total long-term care spending.**

These states decreased spending on institutional care by 16.3% while increasing the state’s investment in home care spending by 21.2%. Meanwhile, states that did not make significant investment in home care services saw the total cost of long-term care actually rise by 8.8%. The conclusion is clear: states that invest more to care for Medicaid patients in the home save significant money.

The most costly form of healthcare is hospitalization. Hospitalization care costs an average of $1,350 a day more for patients than if the patient were in the home. Re-hospitalization is one of the major costs in the post-acute stage of care. Home care has been shown to reduce emergency room visits and hospital readmissions.

**Ensuring Continued Access to Home Health Services**

As we have noted, current Illinois Medicaid reimbursement rates for home health are unsustainable. Many Home Health agencies will not be able to provide care to Medicaid patients, leading to more expensive forms of care for the state to fund. A solution to address this structural crisis is to increase the Medicaid reimbursement rate for Home

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3 Annual Cost of Care Survey for Long Term Care, 2008; AARP and Genworth Financial;


5 Avalere Health Report: Medicare Spending and Rehospitalization for Chronically Ill Medicare Beneficiaries: Home Health Use Compared to Other Post-Acute Care Settings, May 2009
Health providers. The cost to increase reimbursement rates for Home Health care would be more than offset by tremendous long-term savings from the high cost of treatment in hospitals or nursing homes.

As stated earlier, the current reimbursement rate in Illinois for Registered Nurses (RN), Physical Therapists (PT), Occupational Therapists (OT) and Speech Therapists (ST) is $61.34 per visit.

The chart below illustrates how Illinois compares to other Midwestern and larger states:

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<th>OT</th>
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| Difference | $15.51 | $20.42 | $20.43 | $25.34 |

**Establish Integrated Care for Medicaid With A Home Health Focus**

While the state of Illinois is already piloting an integrated care pilot project that will be established by mid-2011, additional consideration should be given for other models that better integrate home health care, and may offer the opportunity for better outcomes at reduced cost.

Outlined below is a potential pilot program that could be tailored for Medicaid enrollees with chronic conditions. The interdisciplinary team-based approach includes home health care as the Coordinating Provider with other team members to include the Primary Care Physician, Case Coordination Units, Hospital Case Managers/Discharge planners, Outpatient (Post Acute care) providers, Pharmacies and other ad hoc providers as is deemed necessary to achieve goals.

Goals of this pilot project would be to:
- Reduce health care expenditures
- Reduce hospital admissions
- Improve customer satisfaction
**Strategy:**
Patients with chronic conditions will be referred to the home health coordination unit for entry into the system. **The Coordinator will:**

1. **Assess eligibility for admission into the pilot program.** This will include a home visit (or hospital visit). A full social, health history, physical and environmental assessment will be conducted by the RN Coordinator.

   **Method:** Tools may include (but are not limited to) the OASIS assessment tool, DON social assessment tool, and a depression assessment tool.

2. **Use the assessment to design a plan of care with the patient, the family and the physician most suited to the patient’s needs and ability.**

   **Method:** An RN Coordinator must be trained in chronic disease management and skilled in case management. A nurse certified in chronic care management or with graduate level training is preferred in order to ensure the utilization of evidence based practice.

   The Plan may include:
   - Home health services such as nursing, physical, occupational or speech therapy, personal care services or the services of a medical social worker.
   - Home visits by the physician.
   - Referrals to outpatient services such as a heart failure clinic, a diabetes center, outpatient physical therapy, outpatient mental health services, or other outpatient services within the community.
   - Social networking support through in-home case coordination services, or services at a local senior wellness center.
   - Health promotion and wellness services through community outreach programs within the community (hospitals, county health department, churches).

3. **Assume responsibility for health care coordination and management across all service lines,** working closely with the primary care physician to ensure equipment, pharmaceutical, environmental, and treatment needs are met in accordance with evidence based standards of care.

   **Method:** Tracking of utilization and routinely scheduled contact with service providers as well as the patient and family (home visits or telephonic visits) will be necessary. The employment or utilization of a registry or similar application will be necessary.

4. **Utilize home telemonitoring for individuals at highest risk** for exacerbation, highest risk for hospital readmission, or individuals with limited mobility and accessibility.

   **Method:** Coordinator will use baseline assessment data and past medical history (rehospitalization data) to determine patient needs in this regard. There are many options for telemonitoring in the home environment. Selection criteria will be based upon those systems best designed to achieve goals.
5. **Work closely with the Case Coordination Unit** to ensure social and mental health needs are met.

**Method:** Patients with chronic illness are particularly isolated and vulnerable to depression, impacting the course of their illness and their ability to engage in self-management behavior. Socialization and integration with the CCU in the approach to management of this population will be essential. Existing services currently operate in silos; this will be eliminated. The CCU will be an integral part of this pilot model.

6. **Establish and maintain a system to measure efficacy** of the program in achieving goals of care.

**Method:**
- Obtain baseline measures for annual cost of care per patient and aggregate, then reevaluate annually
- Monitor hospital admissions on an ongoing basis. Track individual admissions, and compare with previous data. Track by illness, by age, by ethnicity and by co-morbidity.
- Develop a tool to measure customer satisfaction. Measure satisfaction with program ongoing (monthly) and annually.

**Design:**
The design of the home health care based pilot program for chronic care management is multifaceted, incorporating issues of wellness and prevention with comprehensive planning and follow-up for those seeking medical care for a chronic illness. Key to the design is providing oversight for all facets of the program—a coordination center—where the Coordinator serves as the central point for planning, coordination and follow-up across service lines and within the community. The Coordinator (The position could be titled “Health Home Coordinator”) works with patients in the continuum and in the community as a coach and planner in their quest for wellness, collaborating with the physician and other health care providers.

The Coordinator position is a crucial one, and the qualifications of a home care nurse uniquely match those required for this position. The Coordinator will incorporate the concepts of coaching and patient engagement to promote self-care behaviors. The Coordinator will be cognizant of the impact of depression on healthy behaviors, and will understand the rationale and methods for treatment. The Coordinator will be skilled in motivational interviewing (widely used by diabetes educators), principles of adult learning, and health care literacy. The Coordinator will also be culturally competent, with skills and tools to address both cultural issues and language barriers.

**Discussion:**
The organization based its approach on the premise that the current acute care system in our country is not designed to meet the needs of the chronically ill. The plan is based on a new approach to chronic illness which incorporates relationship building, along with guided, non-judgmental communication, theory based management support (Albert Bandura’s principles of self-efficacy, motivational interviewing, health care literacy, and principles of adult education), specialist oversight (ensuring evidence based clinical
practice), and the use of technology (remote monitoring for early detection of exacerbations).

**Proposed Reimbursement:**
There are multiple demonstration projects and programs currently being tested in other parts of the country. These need to be examined as the scope of the pilot project is considered. There is currently a simple mechanism already in place for home care reimbursement in the Medicare Prospective Pay environment for home care agencies. Although this model is not perfect, it affords opportunity to quickly implement a proven system. Simple alterations to the payment categories could be made in accordance with the pilot project. The payment categories are currently based on diagnosis, as well as clinical, functional and therapy needs. Although the chronically ill recipient could be quite acute with multiple home needs (placing them in a higher payment category), most of these patients would likely fall into the lower category, simply requiring ongoing support and care to ensure needs are met in the home and costly exacerbations are avoided.

**Establish Medicaid Reimbursement for Home Telehealth**

Advances in technology have made “telehealth” another viable and cost efficient method to manage chronic care. Telehealth is the use of telemonitoring devices for prevention, diagnostic and curative purposes.

Studies of the cost effectiveness of telehealth demonstrate its cost effectiveness. In New York, a recent study\(^6\) showed a 55% decrease in hospitalizations and a 29% drop in emergency room visits through the use of home care and telehealth care. The study examined a telehealth demonstration project that monitored patients who had been identified as having two or more hospitalizations or emergency room visits in the prior 12 months. For one year, home care nurses monitored the patients’ blood pressure, oxygen saturation, weight changes, heart rate, blood glucose levels, and responses to disease-specific questions. As a result, there were 93 physician interventions that included medication changes, office visit orders and referring patients to a specialist. The bottom line: The cost of care for these same patients dropped from nearly $3 million to $1.7 million over the previous year.

Currently, the Medicaid program in Illinois does not reimburse for telehealth but the process to begin doing so could easily fit into a new piece of legislation that would set rates and criteria. The State of New York passed legislation in 2007 that established Medicaid reimbursement for home telehealth. It could be used as a model for Illinois.

Some of the key points of the New York program are:

- Home telehealth reimbursement is only available for patients receiving home care services under Medicaid.

Providers must be preapproved by the State (equivalent of the Illinois Department of Public Aid).

Reimbursement is on a daily basis for high risk patients only.

The rates are prorated to a monthly basis. The rates are $270 per month if the equipment can operate properly with all the components or $310 per month if the equipment is integrated with the agency’s electronic health equipment. There is also a $50 one-time installation fee.

Summary

In summary, home health demonstrates the goals set forth in the 2010 Health Care Reform law: Cost reductions, care coordination and quality patient outcomes. Home health provides patients with more than just direct care. It provides patients and families with the education they will need to heal and care for themselves in cases of chronic care and post-acute care. A healthcare professional in the home also increases the chances of being able to catch and treat a condition that would otherwise go unnoticed and lead to a trip to the doctor’s office or emergency room.

Some of the most common conditions that require rehospitalization are heart failure, pneumonia, COPD, cardiac stent placement, hip or knee surgery and vascular surgery. Without home health, patients are sent home with medicine and written instructions but no guidance on how to manage themselves in daily living. This often leads to exacerbation of the chronic illness or post-surgical complications that sends people back into the hospital. Self management is a vital component to keeping Medicaid costs down.

A solution to containing Medicaid costs will not be found under the current health care methodology. Solutions will be found through new and innovative ways to deliver care with an emphasis on coordinative and preventive practices. Home care must be part of the solution.