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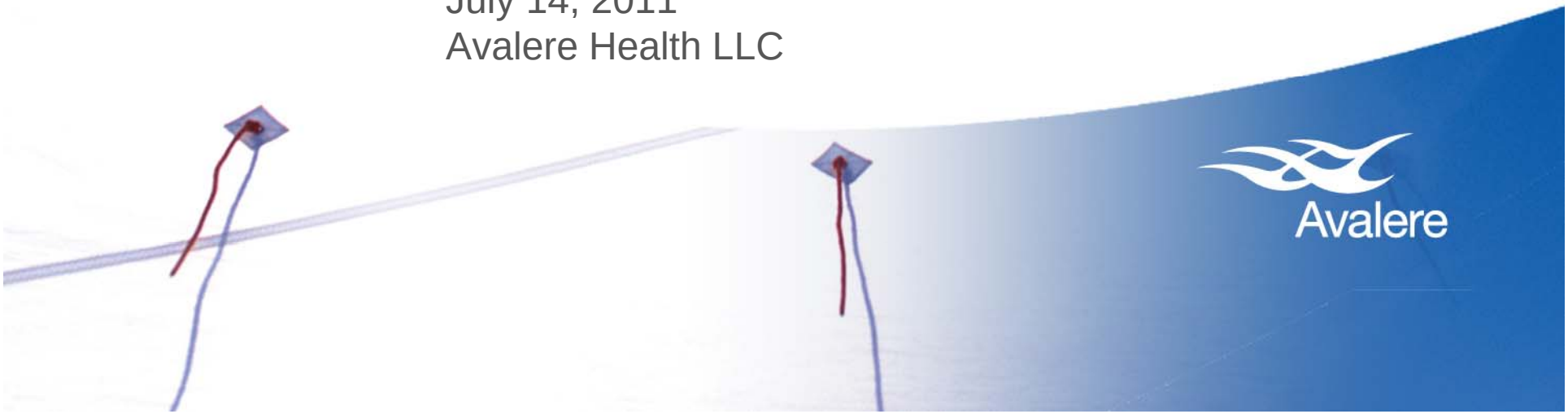
A Strategic Look at the Issues Facing Home Health Care

July 14, 2011
Avalere Health LLC



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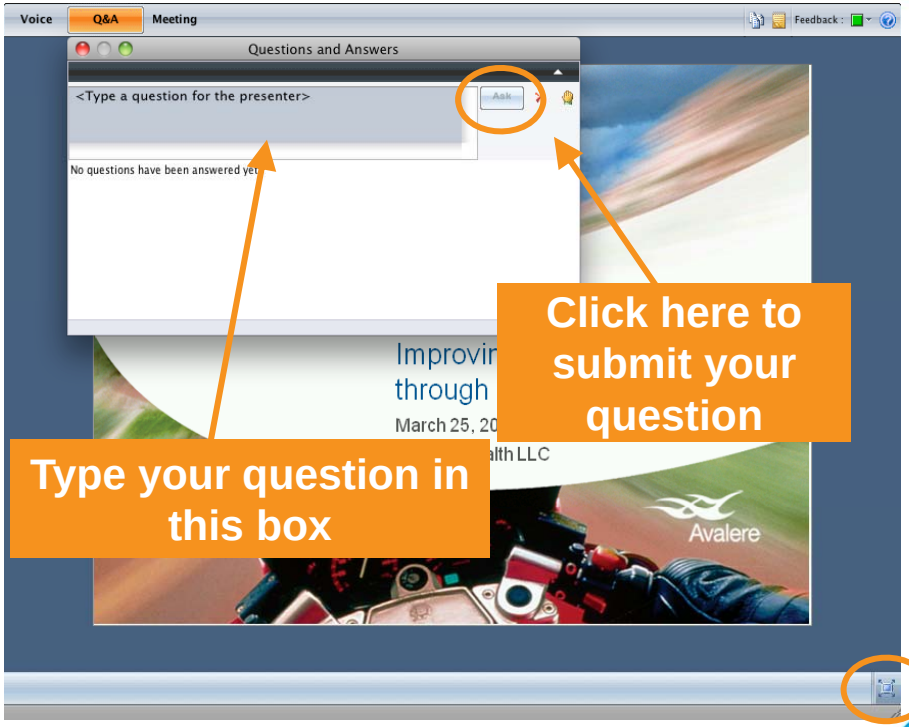

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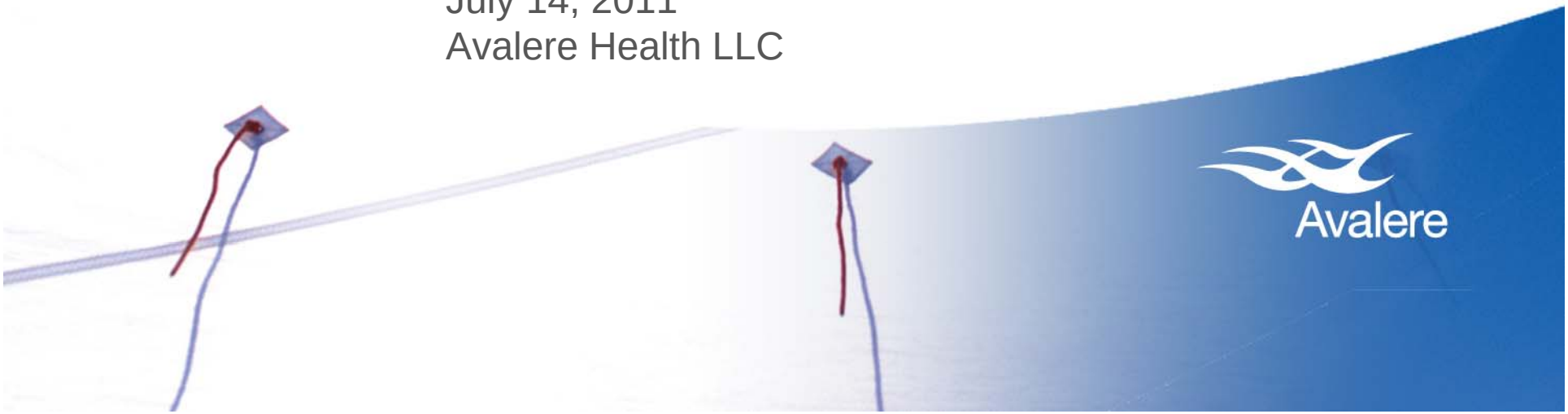


Sally Prendergast /

> Sally Prendergast, Manager, provides research and analytic support to clients on Medicaid and long-term care policy issues, focusing on long-term care reform.

Prior to joining Avalere, Sally worked as an Analyst for the Government Accountability Office (GAO), producing Congressionally-requested reports that analyzed domestic health policies and programs. Prior to GAO, Sally conducted survey research for the Center for the Study of Services and worked for a Washington, DC-based policy consultant.

Sally holds a B.S. in Health Promotion Disease Prevention Studies from the University of Southern California and received her M.P.H. with a concentration in policy from the George Washington University.

Emil Parker /

> Emil Parker, Director, provides deep experience in health care financing and public health policy, including design of health care reform initiatives. At Avalere Emil focuses on post-acute care payment policy, payment reform demonstrations and pharmaceutical treatment issues, among other areas.

Prior to joining Avalere, Emil worked for the DC Department of Health where he oversaw all capital projects, including investment in new community health centers, hospital emergency departments and health information technology. In addition, Emil spent two years in Ethiopia, helping to develop a national health insurance initiative to be implemented by the Ethiopian government. He also served as a policy advisor to the National Economic Council under President Clinton.

Emil holds a B.A. magna cum laude from Harvard University and received his M.P.A. from Princeton University.

Michael P Johnson /

> Michael P Johnson, PT, PhD, OCS, is the Chief Clinical Officer for the Medicare Skilled Home Health Practice at Bayada Nurses in Moorestown, NJ. He is a member of the senior leadership team and is involved in strategic planning, business development, and overall quality improvement for the practice. Dr. Johnson is responsible for leading a multidisciplinary team of professionals in supporting all aspects of interdisciplinary home health clinical practice across 50 offices in 17 states. He is accountable for the development and implementation of evidence-based best practice clinical guidelines and oversight of clinical research activities, continuous quality improvement (CQI) initiatives, regulatory compliance (federal and state), and best practices for recruitment, orientation, and development of nursing, social work, and physical, occupational, and speech therapy professionals.

Charlene MacDonald /

> Charlene MacDonald serves as Senior Health Care Policy Advisor to U.S. Representative Allyson Y. Schwartz (D-PA), a senior member of the House Budget Committee and prominent leader on health care issues in Congress. In this capacity, Charlene advises Representative Schwartz on legislative and regulatory issues in health policy, including implementation of health care reform, which the Congresswoman was instrumental in enacting. Charlene also oversees activities of the recently launched Congressional Health Care Innovation Task Force, co-chaired by Representative Schwartz, which focuses on the development of innovative health care payment and delivery models.

Prior to joining Representative Schwartz's staff, Ms. MacDonald served as Vice President of Government Relations for the American Clinical Laboratory Association (ACLA), lobbying Democratic leadership, as well as the Senate Finance and House Ways & Means Committees, and managing the association's political action committee. In her prior position with the American Osteopathic Association (AOA), she worked extensively on delivery system reform, physician payment, and workforce issues.

Charlene MacDonald holds a Master of Public Policy from the Harvard Kennedy School and undergraduate degrees in political science and sociology from Lake Forest College.

A Strategic Look at the Issues Facing Home Health Care

Presentation Overview

- What is home health care?
- Who uses home health care?
- The potential effect of a co-payment for home health care
- Shifting the focus from cost-sharing to cost-saving
- Innovative readmission reduction initiatives
- A perspective on legislative activities related to home health

Medicare-certified Home Health Care

BAYADA NURSES Home Care Specialists

- Eligibility:
  - *need for part-time (less than 8 hrs /day), intermittent skilled care*
  - *be unable to leave their homes without considerable effort.*
  - *NO hospital stay required*
- Services include:
  - *skilled nursing, physical therapy, occupational therapy, speech therapy, medical social work, and aide services.*
- Physician certification / involvement
- Utilization and costs (2009):
  - *3.3 million Medicare beneficiaries*
  - *$19 billion spent on home health care*

Who is a Potential Home Health Care Patient?

BAYADA NURSES
Home Care Specialists

- Age / Gender — *- 77 year old, female (64%)*
- Income level — *- over half are below $21,780 / year*
- Health status
  - *- greater than four (4) diagnoses*
  - *- 90% had medication changes*
  - *- 61% are physically de-conditioned*
  - *- 42% have urinary incontinence*
  - *- 39% have skin integrity problems (wounds)*
- Support — - 50% have no primary care giver
- Referral — - 75% come from inpatient facilities

A Home Health Co-Payment: Affected Beneficiaries and Potential Impacts

July 13, 2011

Avalere Health LLC

Executive Summary

78 percent of home health users who are not dual eligibles do not have Medigap coverage and could have to pay the full co-payment out of pocket*

- Nearly 52 percent of these home health users have *incomes below 200% of the poverty line*
- The co-payment for three episodes would consume almost *6 percent of annual income* for a beneficiary at 150 percent of the federal poverty line, living alone

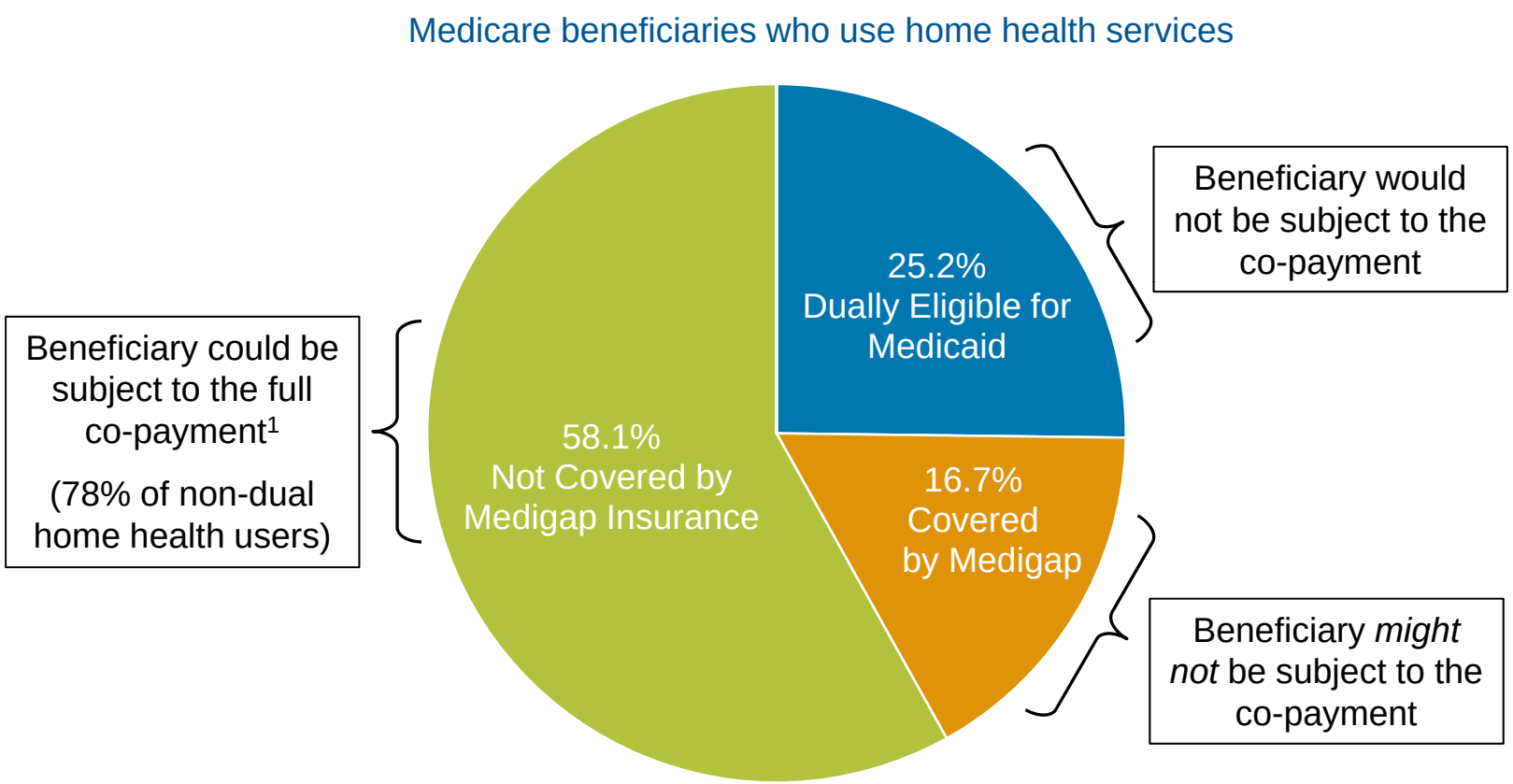
Home health users without Medigap coverage are sicker, more likely to have severe disabilities, and more likely to live alone than other Medicare beneficiaries

- 86 percent of home health users who would pay the co-payment out of pocket have *3 or more chronic conditions*; 36 percent live alone
- 19 percent have disabilities severe enough to quality for a nursing home level of care

Studies show that co-payment policies that reduce utilization of services (such as outpatient visits) can lead to higher inpatient costs.[1]

*Some of these beneficiaries may have other private health insurance that could cover a home health co-payment.
[1]Trivedi, Amal N., Husein Moloo and Vincent Mor. "Increased Ambulatory Care Copayments and Increased Hospitalization among the Elderly." *New England Journal of Medicine* 362 (2010): 320-328.

Home Health Users in 2008



Source: Avalere Health analysis of 2008 Medicare Current Beneficiary Survey, Access to Care file.
[1]Some of these beneficiaries may have other private insurance coverage that could cover a home health co-payment.

Potential Impact of Proposed Home Health Co-Payment

The co-payment could constitute a significant financial burden

- For purposes of this analysis, we assume a co-payment of $300 per episode
- In this scenario, the co-payment for three episodes would represent 6 percent of annual income for a beneficiary at 150 percent of the poverty line, living alone
- Almost 52 percent of (non-dual eligible) home health users without Medigap coverage have incomes under 200 percent of the Federal Poverty Level

The co-payment proposal will affect a vulnerable population

- Home health users are sicker, more likely to have a disability, and more likely to live alone than other Medicare beneficiaries.
- Studies suggest that the negative effects of cost-sharing disproportionately affect poorer, sicker beneficiaries

A home health co-payment could lead to unintended effects

- In some states, the proposed co-payment could shift costs from Medicare to Medicaid
- Imposing cost-sharing for this population could lead to higher utilization of inpatient services, meaning increased costs for Medicare[1]

[1]Trivedi, Amal N., Husein Moloo and Vincent Mor. "Increased Ambulatory Care Copayments and Increased Hospitalization among the Elderly." *New England Journal of Medicine* 362 (2010): 320-328.

Potential Financial Impacts of a Home Health Co-Payment

Co-Payments Could Constitute a Financial Burden for Low-Income Beneficiaries

- 78 percent of home health users who are not dual eligibles do not have Medigap coverage, and could have to pay the full co-payment out of pocket*
- This group of home health users is predominantly lower-income – 52 percent are below 200 percent of the Federal Poverty Line (FPL), compared to 41 percent of all Medicare beneficiaries[1]
- The co-payment for three episodes would consume almost 6 percent of annual income for a beneficiary at 150 percent of the FPL, living alone
- Studies suggest that low-income beneficiaries often perceive co-payments to be a significant financial burden[2]

*Some of these beneficiaries may have other private insurance that could cover a home health co-payment.
[1]Dual eligibles are excluded from both groups.
[2]Ku, Leighton, Elaine Deschamps and Judi Hilman. "The Effects of Copayments on the Use of Medical Services and Prescription Drugs in Utah's Medicaid Program." Center on Budget and Policy Priorities, November 2004.

Three or More Episodes Would Represent 3-14 Percent of Annual Income for Low-Income Beneficiaries – Comparable to Spending on Transportation or Food[1]

Number of Home Health Episodes	Living Arrange-ment	Co-Pay as Percent of Household Income at 100 Percent FPL	Co-Pay as Percent of Household Income at 150 Percent FPL	Co-Pay as Percent of Household Income at 200 Percent FPL
One Episode	Alone	2.8%	1.8%	1.4%
	2-person	2.0%	1.4%	1.0%
Two Episodes	Alone	5.5%	3.7%	2.8%
	2-person	4.1%	2.7%	2.0%
Three Episodes	Alone	8.3%	5.5%	4.1%
	2-person	6.1%	4.1%	3.1%
Five Episodes	Alone	13.8%	9.2%	6.9%
	2-person	10.2%	6.8%	5.1%

Note: These data were calculated as a percentage of the 2011 Federal Poverty Level for a household of one or two ($10,890 and $14,710, respectively), assuming a $300 per episode co-payment.
[1]Individuals under 65 years old devoted 4.1 percent of annual expenditures to car payments and 12.8 percent to food. Consumer Expenditures in 2008. Bureau of Labor Statistics. U.S. Department of Labor. March 2010.

Home Health Co-Payments Likely to Affect Low-Income, Sicker Medicare Home Health Beneficiaries

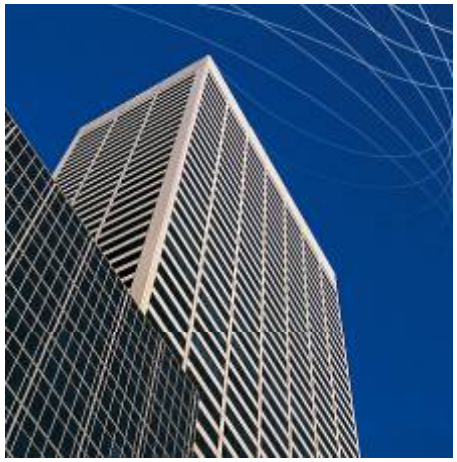
Many low-income beneficiaries are not enrolled in programs that may cover the co-payment, and even those with Medigap may not be protected

Medicaid	Medicare Savings Programs	Medigap
More than half of eligible, community-dwelling beneficiaries are not enrolled.[1] These beneficiaries are the poorest and least likely to be able to afford a co-payment	One-third of eligible Medicare beneficiaries are not enrolled in the Qualified Medicare Beneficiary (QMB) program, which covers Medicare cost-sharing requirements[2]	Only 22 percent of home health users have coverage. Some existing Medigap plans do not cover co-payments; the extent to which these co-payments would be covered is unclear

The remaining 78 percent of these non-dual eligible home health users could be subject to the full co-payment; these beneficiaries are disproportionately low-income, in poor health, and living alone, putting them at risk of health decline

If beneficiaries with low income and/or in poor health forgo needed care, *both adverse health events and inpatient costs could increase*

[1] Pezzin, Lilianna E. and Judith D. Kapser. "Medicaid Enrollment among Elderly Medicare Beneficiaries: Individual Determinants, Effects of State Policy, and Impact on Service Use." *Health Services Research* 37(4) (2002).
[2] Haber, Susan G., Walter Adamache, Edith G. Walsh, Sonja Hoover and Anupa Bir. "Evaluation of Qualified Medicare Beneficiary (QMB) and Specified Low-Income Medicare Beneficiary (SLMB) Programs." RTI, 2003.



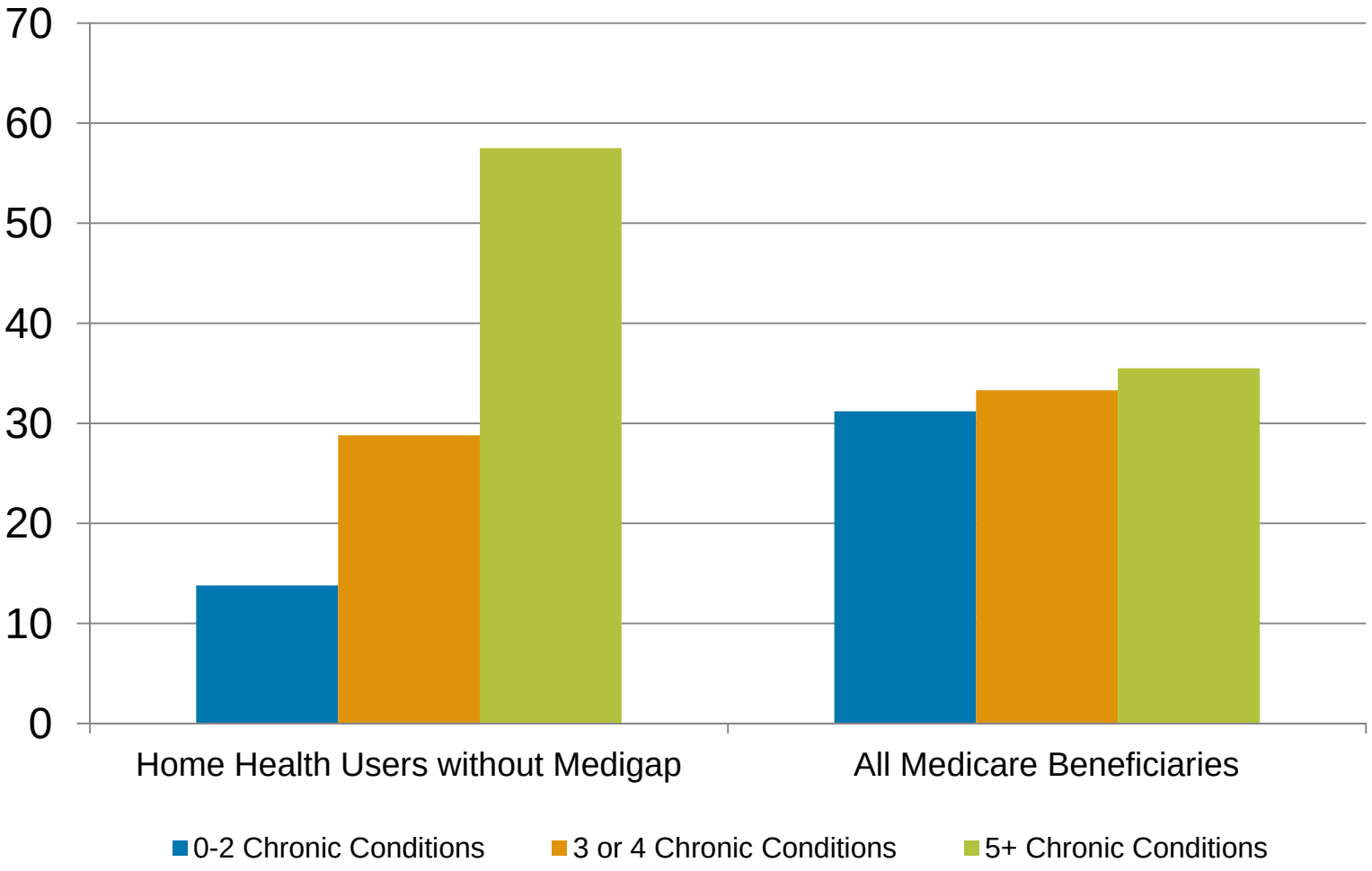
Profile of Home Health Users Who Would be Subject to the Co-Payment

Home Health Users without Medigap Are Older and in Poorer Health than Other Medicare Beneficiaries

	Home Health Users without Medigap	All Medicare Beneficiaries
Over age 85	28.1%	11.7%
Live alone	36.4%	31.8%
Have 3 or more chronic conditions	86.2%	68.6%
Have 2 or more Activities of Daily Living limitations[1]	18.8%	5.8%
Report fair or poor health	45.9%	26.7%
Are in somewhat or much worse health than last year	40.7%	23.1%

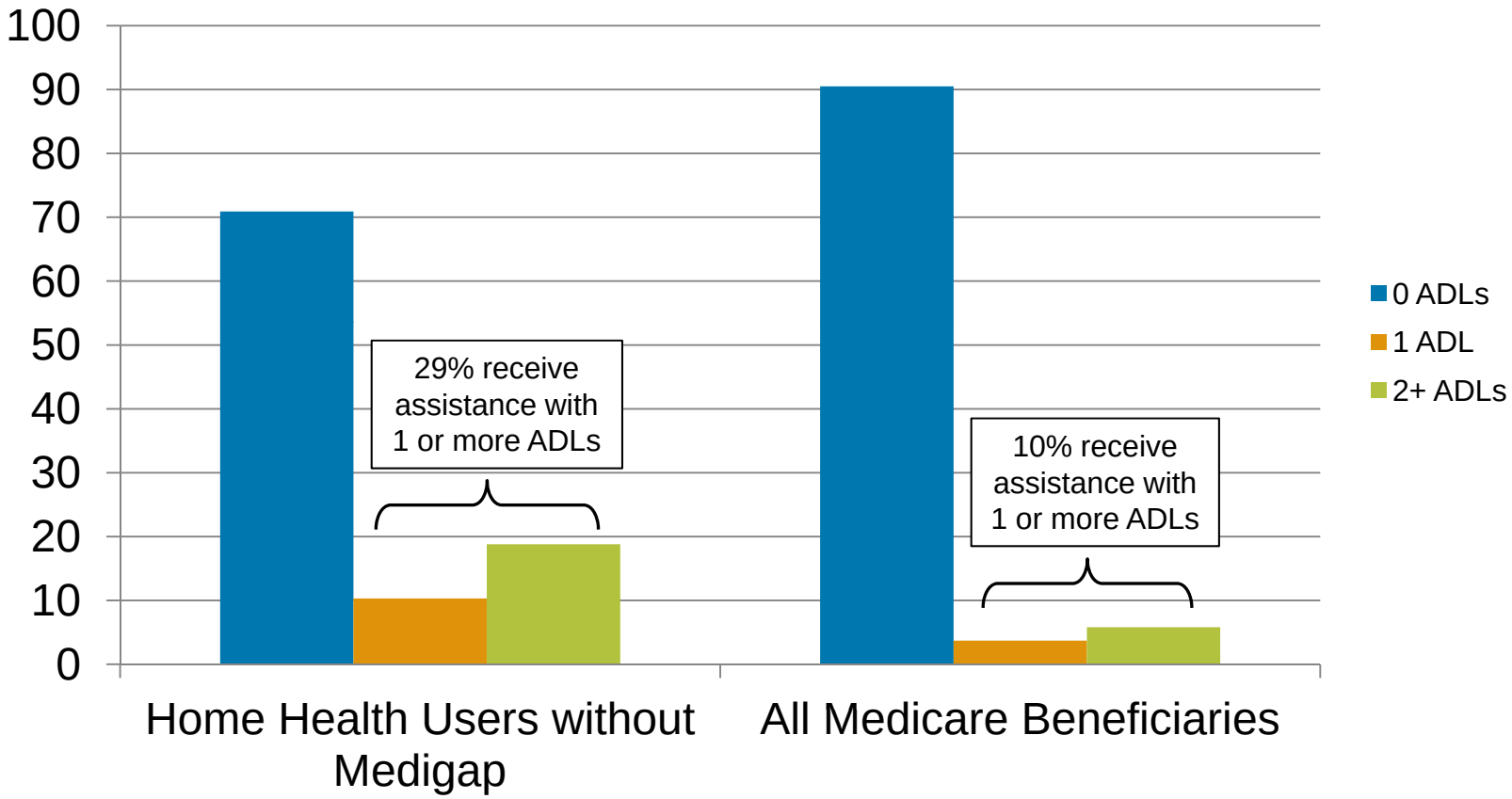
Source: Avalere Health analysis of 2008 Medicare Current Beneficiary Survey, Access to Care file.
[1]This is considered a measure of moderate to severe disability and is often the eligibility threshold for a nursing home level of care.

Home Health Users without Medigap Are More Likely to Have Five or More Chronic Conditions



Source: Avalere Health analysis of 2008 Medicare Current Beneficiary Survey, Access to Care file.

Home Health Users without Medigap Are More Likely to Have Moderate to Severe Disability



Note: In most states, people requiring assistance with 2 or more Activities of Daily Living (bathing, dressing, transferring, using the toilet, eating, and continence) are considered to have an "institutional level of need", meaning they are sufficiently disabled as to potentially need placement in a nursing home or to need other paid long-term care services.[1]

Source: Avalere Health analysis of 2008 Medicare Current Beneficiary Survey, Access to Care file.
[1]Kaye, Stephen, Charlene Harrington and Mitchell P. LaPlante. "Long-Term Care: Who Gets It, Who Provides It, Who Pays, And How Much?" Health Affairs 29(1) (2010): 11-21.

Home Health Users without Medigap Have High Utilization of Other Medicare Services, Despite Cost-Sharing Requirements

	Beneficiary Cost-Sharing Requirement[1]	Annual Average for Home Health Users without Medigap	Annual Average for All Medicare Beneficiaries
Physician claims	20 percent of the Medicare-approved amount	52.5 claims	21.9 claims
Office visits	Same as above	11.6 visits	6.5 visits
DME claims	Same as above	5.9 claims	1.9 claims
Inpatient days	$1,132 deductible for days 1–60	8.6 days	1.4 days
SNF days	$0 for first 20 days, $141.50 per day for days 21–100	7.3 days	0.7 days

Consistent with their poorer health, home health users without Medigap have higher utilization of all Medicare services, which suggests that their home health usage is not driven primarily by the absence of a co-payment; *imposing a home health co-payment may not reduce utilization to the extent expected*

Source: Avalere Health analysis of 2008 Medicare Current Beneficiary Survey, Access to Care file.
[1]All beneficiaries are subject to a deductible of $162 for Part B-covered services or items.

Research on the Effects of Co-Payments

Studies Suggest That Co-Payments for Some Services Can Lead to Increased Utilization of More Expensive Services

Trivedi *et al.,* in *The New England Journal of Medicine*, analyzed a nationally representative sample of elderly Medicare managed care enrollees[1] and found that:

Decreases

Medicare Advantage plans that raised co-payments for outpatient care had 19.8 *fewer annual outpatient visits* per 100 enrollees, however…

Increases

These plans saw 2.2 *more annual hospital admissions* and 13.4 *more inpatient days* per 100 enrollees

The authors estimate that the *cost of the additional hospitalizations exceeded the savings* from the decrease in outpatient visits

[1]Trivedi, Amal N., Husein Moloo and Vincent Mor. "Increased Ambulatory Care Copayments and Increased Hospitalization among the Elderly." *New England Journal of Medicine* 362 (2010): 320-328.

Adverse Effects of Co-Payments Are Greater for People with Chronic Disease and/or Low Incomes

A study on the impact of co-payments in Utah's Medicaid program found that *individuals in poor health* suffered adverse effects, especially if they were low income[1]

- Between 2001 and 2002, Utah instituted co-payments for most services. Co-pays were modest: $2 per physician/outpatient hospital visit or prescription
- Nevertheless, 39 percent of beneficiaries stated that the *co-payments caused serious financial difficulties*

Chandra *et al.,* found that when California's public retirement system raised drug and office co-payments:[1]

- For beneficiaries with the greatest chronic disease comorbidities (Charlson Index 4 or more), increased inpatient *costs exceeded savings* from decreased physician and drug use by 78 percent

If beneficiaries with low income and/or in poor health forgo needed care, *both adverse health events and inpatient costs could increase*

[1]Ku, Leighton, Elaine Deschamps and Judi Hilman. "The Effects of Copayments on the Use of Medical Services and Prescription Drugs in Utah's Medicaid Program." Center on Budget and Policy Priorities, November 2004.

Data Specifications

Avalere's Analysis of Home Health Beneficiaries

The data in this presentation were generated using the 2008 Medicare Current Beneficiary Survey (MCBS) Access to Care file, which includes the "always enrolled" Medicare population, or beneficiaries who were enrolled for the full calendar year[1]

To create a demographic profile of home health users who would be subject to a co-payment, we excluded:

- Dual-eligible beneficiaries
- Beneficiaries residing in a facility, such as a nursing home
- Beneficiaries reporting that they are enrolled in a Medigap plan

Some Medigap plans do not fully cover co-payments. On the other hand, some of the beneficiaries who are not enrolled in a Medigap plan may have other private health insurance (e.g., retiree health coverage) that could potentially cover a home health co-payment.

[1]Beneficiaries who died after the fall survey are included in this file.
[2]MCBS also includes two income categories for beneficiaries who are unsure of their income: "less than $25,000" and "more than $25,000." We included these beneficiaries to the extent that they fell into one of our income categories.

Medicare Savings and Reductions in Rehospitalizations Associated with Home Health Use

June 23, 2011

Avalere Health LLC

Table of Contents

Introduction

- The Partnership for Quality Home Healthcare commissioned Avalere Health in February 2011 to evaluate the impact of post-hospital home health use on Medicare spending and hospital readmissions.

- The purpose of the study is to quantify the impact of post-acute care home health use, by comparing Medicare spending and readmissions for chronically ill beneficiaries who receive home health care* after a hospitalization with Medicare spending and readmissions for comparable beneficiaries who use other post-acute care services** after a hospitalization.

* Home health care after a hospital visit is covered under the Part A Medicare benefit. It consists of part-time, medically necessary skilled care (nursing, physical therapy, occupational therapy, and speech-language pathology) that is ordered by a physician. Source: CMS, Home Health Quality Initiative: http://www.cms.gov/HomeHealthQualityInits/
** Services from long-term acute care hospitals (LTACHs), inpatient rehabilitation or skilled nursing facilities (IRFs or SNFs), or hospices

Overall Findings

Home Health Users Had Lower Medicare Part A Costs and Fewer Rehospitalizations

- We compared beneficiaries with post-hospital home health use to beneficiaries who received other post-hospital/post-acute care (PAC) services for the following conditions – diabetes, chronic obstructive pulmonary disease (COPD), and CHF (congestive heart failure).
- The study examined total Medicare Part A spending* after the initial hospital visit, including costs associated with readmissions, over the course of twelve calendar quarters, from October 2006 – September 2009.
  - » We divided the twelve quarters into two separate periods of six quarters each, to observe the trend (if any) over time.
- **Medicare Part A spending after the initial hospitalization for patients** with diabetes, COPD, or CHF **who received home health services** in the same quarter as the initial hospitalization **was lower than Part A spending for similar patients who received other post-acute care services** in that initial quarter, and the difference increased over time. This result is statistically significant across all severity of illness categories (that is, for a wide range of patients with these diagnoses).
  - » The differences in post-hospital Medicare Part A spending are generally largest for the most severely ill -- i.e., those with a severity of illness (SOI) score of 4.
- Diabetes, COPD and CHF **patients who received home health services were less likely to be rehospitalized than similar patients who received other PAC services****

* Includes Part B home health payments but no other Part B payments

** The rehospitalization results were not statistically significant for all categories

Home Health Users Had Lower Medicare Part A Costs

Home health use was associated with a $2.81 billion reduction in post-hospitalization Medicare Part A spending over the 2006-2009 period. That is, Medicare Part A spending on these home health users was $2.81 billion less than it would have been if they had received other PAC services. This estimate controls for differences in beneficiaries' age, sex, race, urban/rural location, condition, severity of illness, dual-eligible status, and hospice utilization.*

Savings Per Beneficiary**

Time Period 1: October 2006 – March 2008		Time Period 2: April 2008 – September 2009	
Diabetes	$6,281 – $12,267	Diabetes	$7,383 – $9,225
COPD	$6,098 - $11,928	COPD	$7,106 - $11,441
CHF	$5,020 - $7,879	CHF	$5,514 - $8,883

* The extent of risk adjustment is still limited

** Savings vary by severity of illness level

Detailed Impact Analysis

- Use of home health care after the initial hospital visit was associated with a $2.81 billion reduction in Medicare Part A spending over the 2006-2009 period. If the beneficiaries who received other PAC services after the initial hospitalization had used home health instead, Medicare Part A spending over the 2006-2009 period could have been further reduced by $2.07 billion. We arrived at this estimate by applying the per-beneficiary savings associated with home health use to the cases with other PAC services.

- Home health use after the initial hospital visit is associated with an estimated 20,426 fewer hospital readmissions – avoiding these readmissions saved Medicare an estimated $670 million over the 2006-2009 period.*

- In addition, if the beneficiaries who received other PAC services after the initial hospitalization had used home health instead, an estimated 14,239 readmissions could have been avoided.

Category of Analysis	Result
Reduction in post-hospital Medicare Part A spending from 2006 to 2009 associated with use of home health	$2.81 billion
Potential reduction in post-hospital Medicare Part A spending from 2006 to 2009 if beneficiaries who received other PAC services had used home health care instead	$2.07 billion
Decline in hospital readmissions over 2006-2009 period associated with use of home health care	20,426
Reduction in Medicare spending over 2006-2009 period from 20,426 fewer readmissions	$670 million
Potential reduction in readmissions over 2006-2009 period, if beneficiaries who received other PAC services had used home health care instead	14,239
Potential further reduction in Medicare spending over 2006-2009 period from fewer readmissions, if beneficiaries who received other PAC services had used home health care instead	$485 million

* The $670 million reduction is a component of the $2.81 billion in total savings

Methodology*

Study Design

- Avalere compared users of post-acute care home health to users of other PAC services on three outcome measures: total post-hospital Medicare Part A** payments, readmission rates, and Medicare Part A payments associated with readmissions.
- Study was conducted using Medicare Standard Analytic Files (SAFs) for 2006-2009.

Population

- Restricted to Medicare fee-for-service beneficiaries with a hospital primary or secondary diagnosis of diabetes, COPD, or CHF
- The post-hospital home health users are defined as beneficiaries with home health utilization in the same quarter as the initial hospital stay during the study period.
- The comparison group consists of beneficiaries who received PAC services other than home health (i.e., services from a skilled nursing facility, long-term care hospital, inpatient rehabilitation facility, or hospice) during the same quarter as the initial hospitalization.

* Please see Appendix for a more detailed description of the methodology
** Includes Part B home health payments but no other Part B payments

Methodology (continued)

Propensity Score Matching

- Avalere conducted a propensity score matching analysis that controlled for certain factors including:
  - » Condition and SOI*, age, sex, race, dual-eligible status, urban or rural location, and hospice utilization**
- For the propensity score analysis, we matched post-acute care home health users with users of other PAC services who were comparable with regard to these variables, and limited the analysis to that population. By excluding users of other PAC services who were not comparable to home health users on these variables, we attempted to isolate the effect that home health use alone has on the outcomes of interest (total post-hospital Medicare Part A spending, readmission rates, and readmissions-related spending) separate from the effects of other factors that directly affect both home health use and those outcomes.

*The SOI metric rates a patient's level of severity on a scale of 1-4 (the higher the score, the more severely ill the patient). SOI is based on the patient's hospital procedures and diagnosis codes and is produced by running these data through the APR-DRG grouper. Results are presented by SOI because patients with higher SOI scores are more clinically complex than patients with the same conditions but lower SOI scores.
** The degree of risk adjustment is still limited

Appendix:
Detailed Study Methodology, Specific Findings, and Study Limitations

Study Methodology

- Study Sample
  - » Sample consisted of Medicare beneficiaries with a primary or secondary diagnosis of diabetes, COPD, or CHF who utilized PAC services
  - » ICD-9-CM codes were identified by a technical advisory panel and supplemented by codes used in the CMS Chronic Condition Warehouse and other codes identified by an Avalere internal coding team.
- Definition of Post-Acute Care Home Health Users
  - » Beneficiaries with a home health claim in the same quarter as the initial hospitalization – these beneficiaries may have subsequently received services in another PAC setting
  - » The Medicare claims data sets we used (the SAFs) include quarters of service but not dates of service. For purposes of this analysis, we assumed that the initial hospital stay preceded the home health or other PAC utilization in that quarter
- Definition of other PAC Users
  - » Beneficiaries with other PAC (SNF, IRF, LTACH, or hospice) but no home health utilization during the same quarter as the initial hospitalization

Study Methodology (continued)

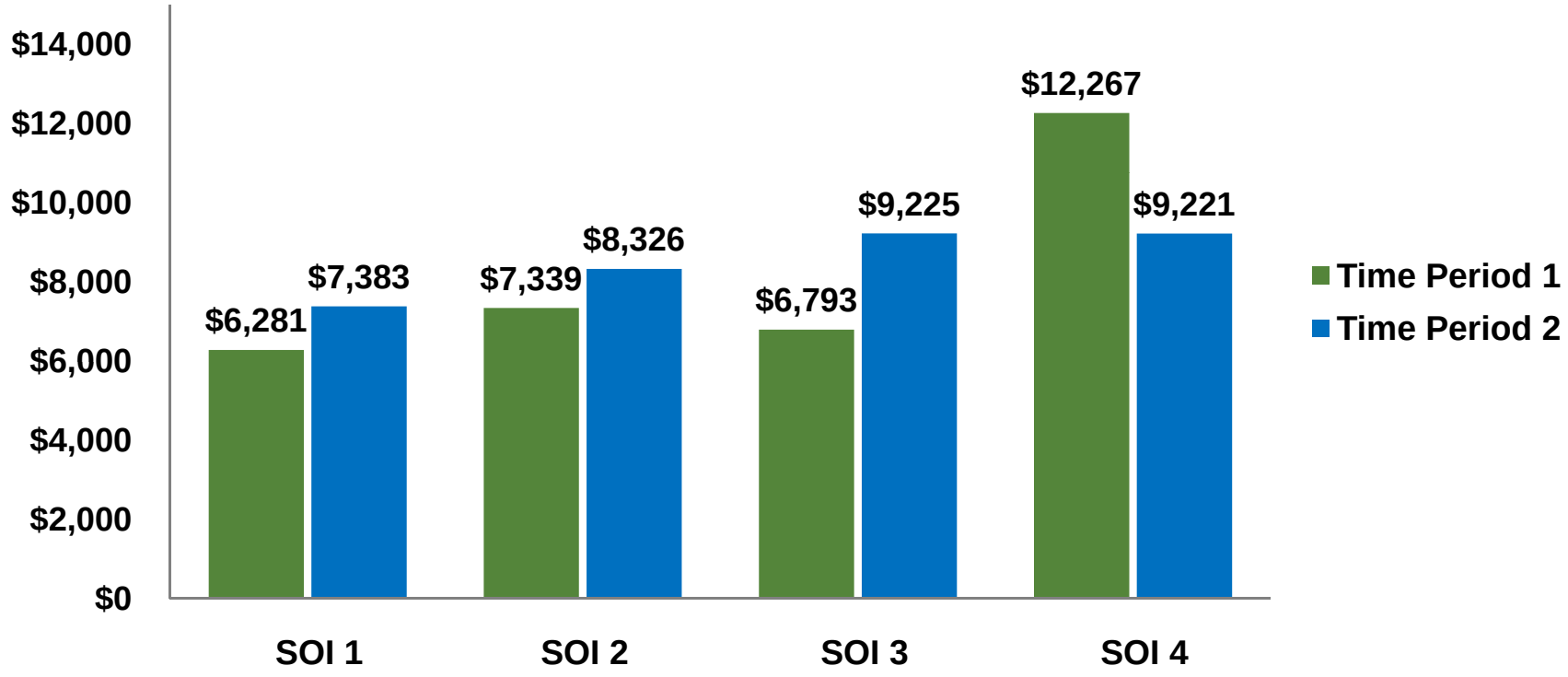
- Definition of Post-Hospital Period
  - » The post-hospital period begins with the quarter in which the initial hospitalization occurred and ends with the first subsequent quarter with no hospital or PAC utilization.
- Definition of Post-Hospital Costs
  - » All Medicare Part A costs* incurred ***after*** the initial hospitalization — the cost of the initial hospital stay was excluded
- Statistical Analysis
  - » Estimated post-hospital Part A costs, including readmissions costs, through a propensity score matching analysis, one for each condition and SOI.
  - » Employed a propensity score matching model to limit the potential effects of factors that affect both the likelihood of home health use and the outcome variables (i.e., total Medicare spending, readmission rates, and readmissions-related spending).
  - » Model included the following risk-adjustment variables: age, sex, race, dual-eligibility status, urban/rural location, and hospice utilization.

* Includes Part B home health payments but no other Part B payments

Study Methodology (continued)

- Calculation of Reduction in Medicare Part A Spending
  - » Multiplied the estimated difference in post-hospital spending for home health as opposed to other PAC users, for each chronic condition/SOI combination (e.g., beneficiaries with a diagnosis of diabetes and an SOI of 2), by the number of cases in that category for home health users and other PAC users.
- Calculation of Reductions in Readmissions and Readmissions-related Spending
  - » Calculated the average readmission rate for each chronic condition/SOI combination, for home health users and other PAC users. To calculate reduced readmissions associated with home health, multiplied the difference in the readmission rates by the number of home health users in each chronic condition/SOI category. To calculate the potential reduction in readmissions for other PAC users, multiplied the difference in rates by the number of other PAC users in each chronic condition/SOI category.
  - » To determine the total reduction in Medicare spending associated with readmissions, multiplied the estimated difference in readmissions-related spending for each chronic condition/SOI score combination by the number of cases in that category for home health and other PAC users.

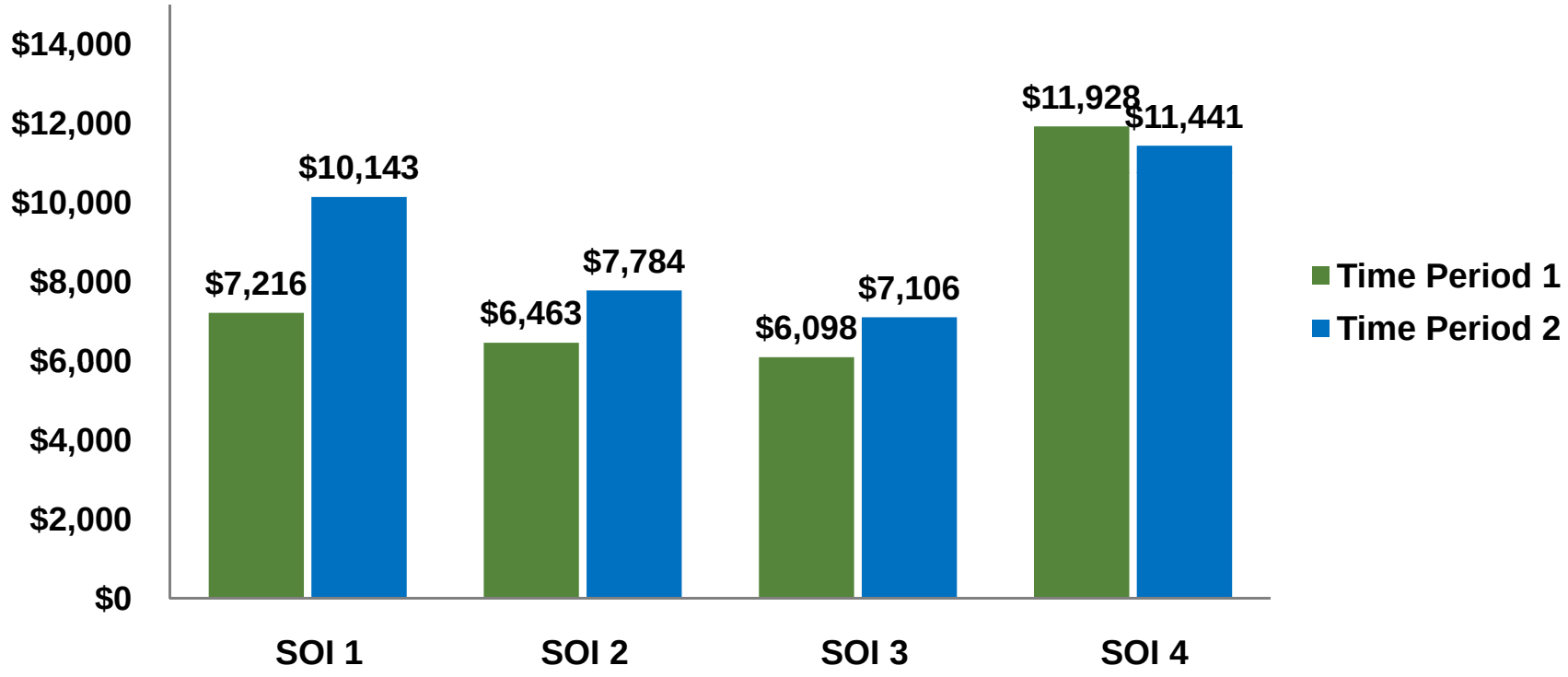
Medicare Part A Savings from Home Health Use, per Beneficiary with Diabetes



An SOI score of 1 is least clinically severe and an SOI score of 4 is most clinically severe

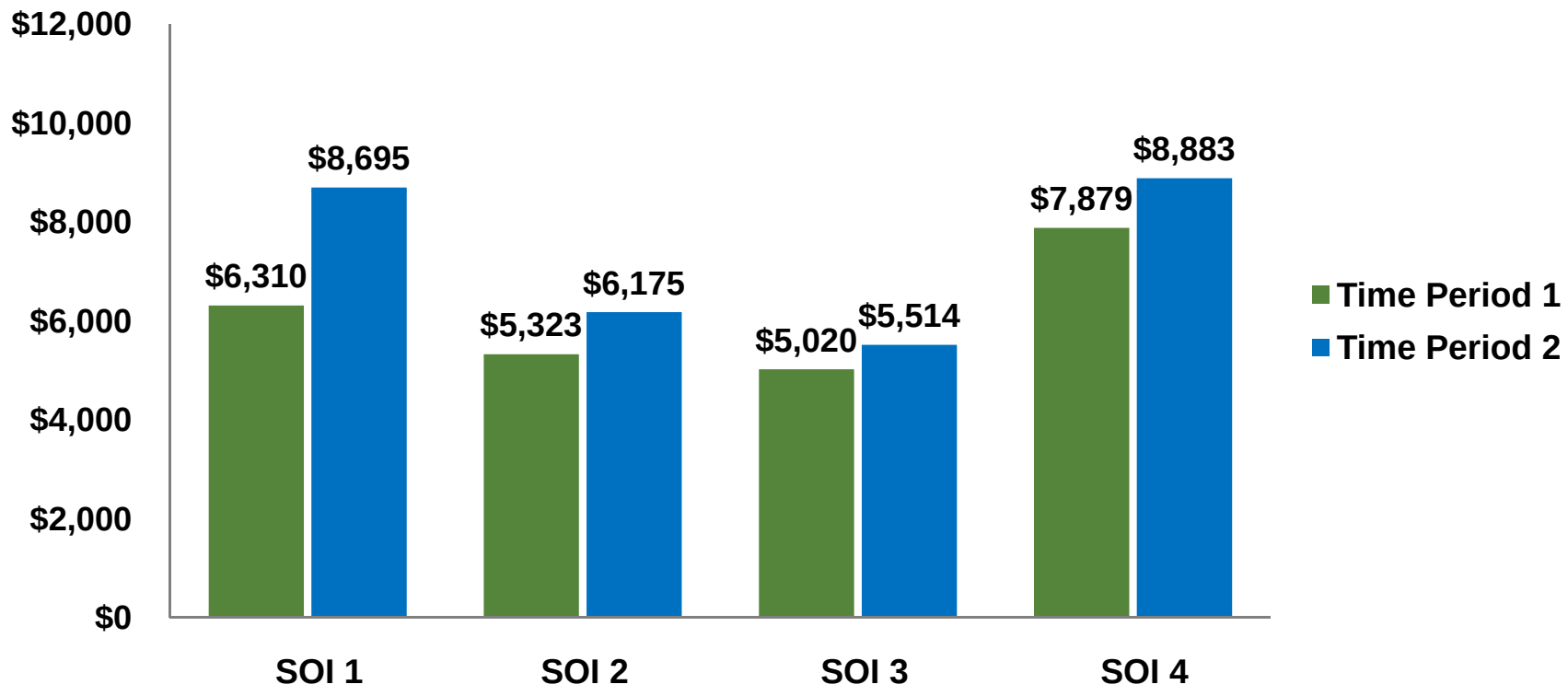
Time Period 1 is October 2006 – March 2008; Time Period 2 is April 2008 – September 2009

Medicare Part A Savings from Home Health Use, per Beneficiary with COPD



Time Period 1 is October 2006 – March 2008; Time Period 2 is April 2008 – September 2009

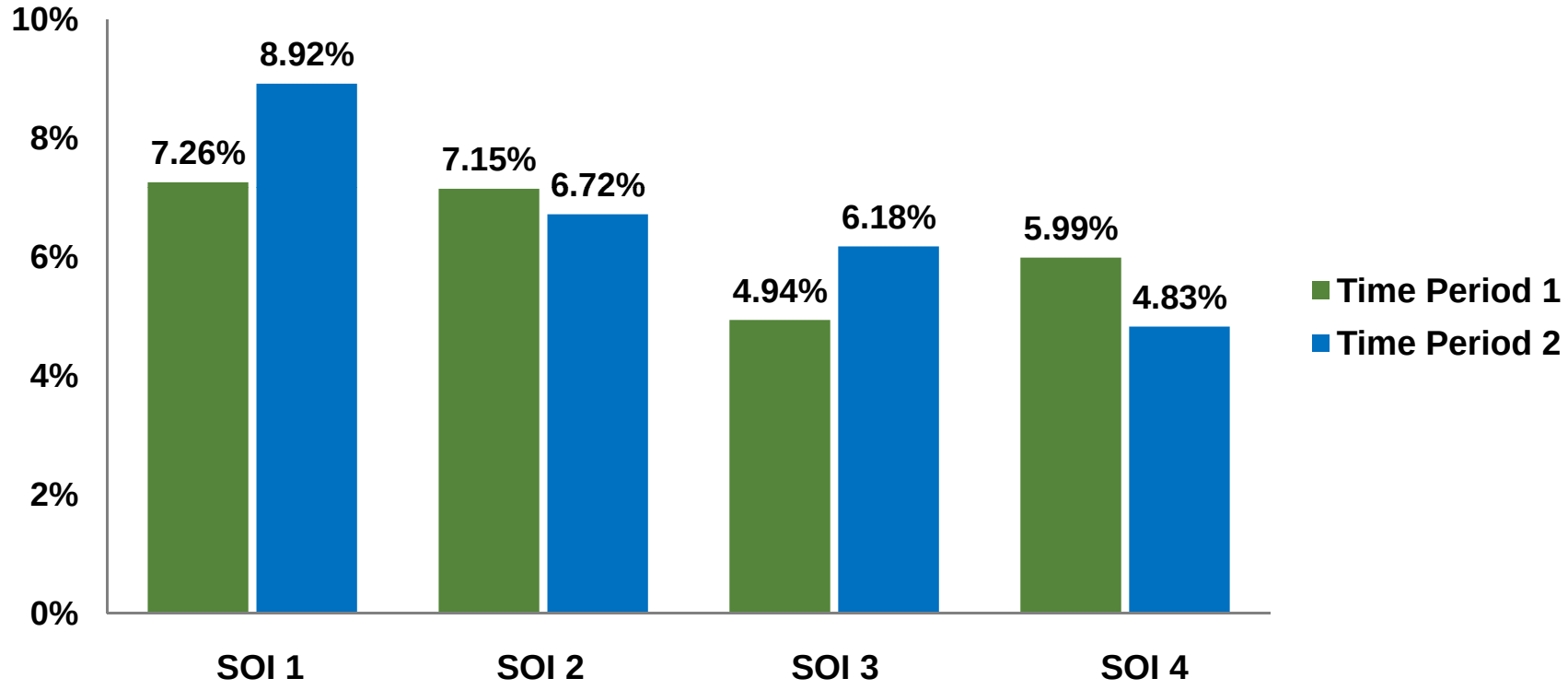
Medicare Part A Savings from Home Health Use, per Beneficiary with CHF



Time Period 1 is October 2006 – March 2008; Time Period 2 is April 2008 – September 2009

Reduction in Readmission Rates Associated with Home Health Use, for Beneficiaries with Diabetes

Difference in Readmission Rates for Post-acute Care Home Health and other PAC Users, by SOI



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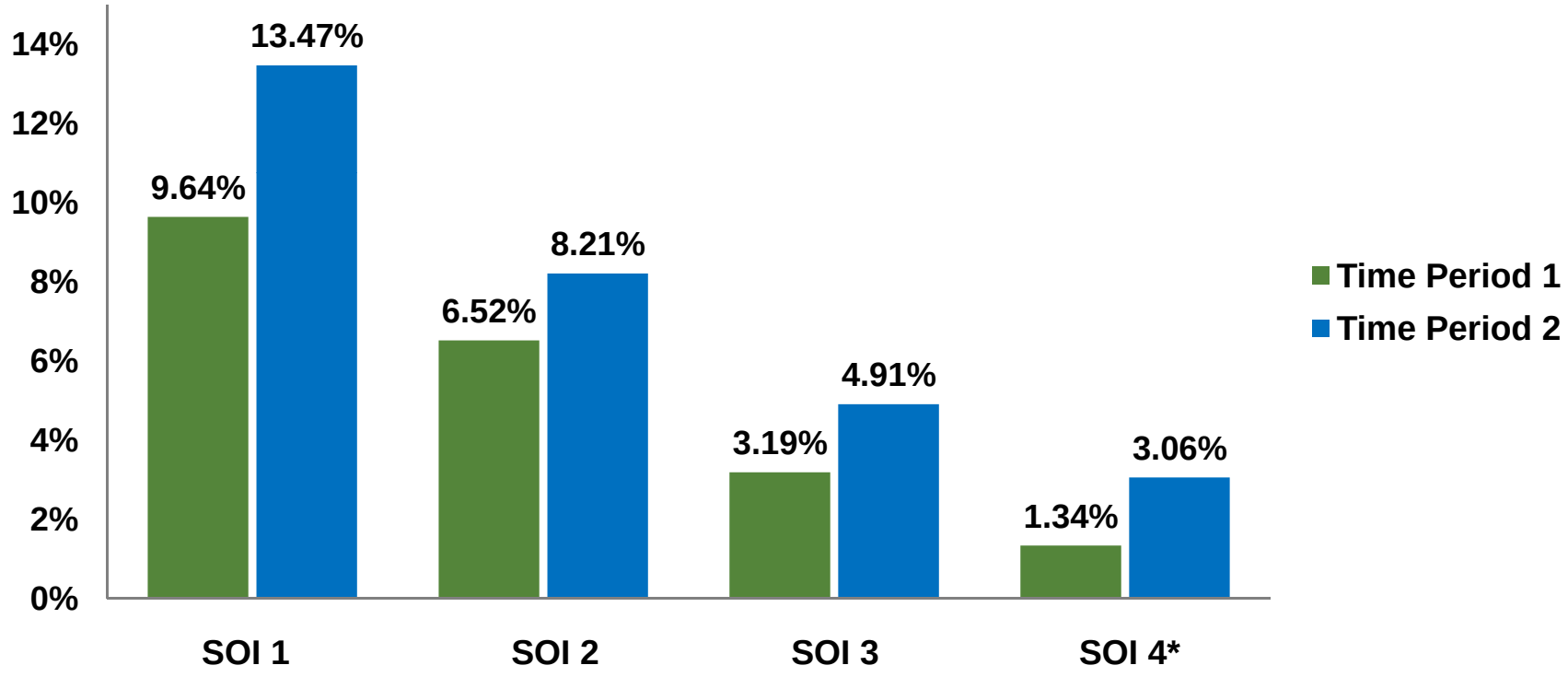
Reduction in Readmission Rates Associated with Home Health Use, for Beneficiaries with COPD

Difference in Readmission Rates for Post-acute Care Home Health and other PAC Users, by SOI

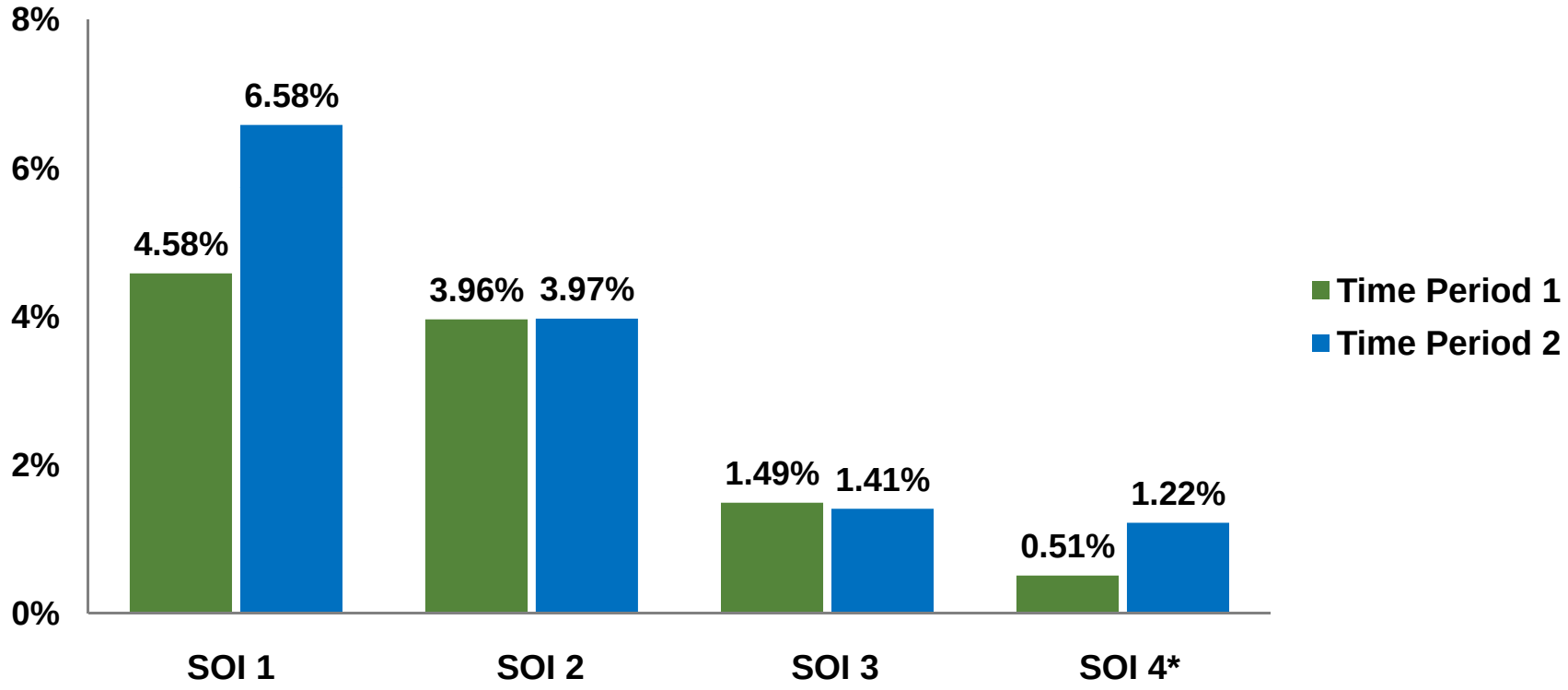


Time Period 1 is October 2006 – March 2008; Time Period 2 is April 2008 – September 2009

* Not statistically significant for time period 1

Reduction in Readmission Rates Associated with Home Health Use, for Beneficiaries with CHF

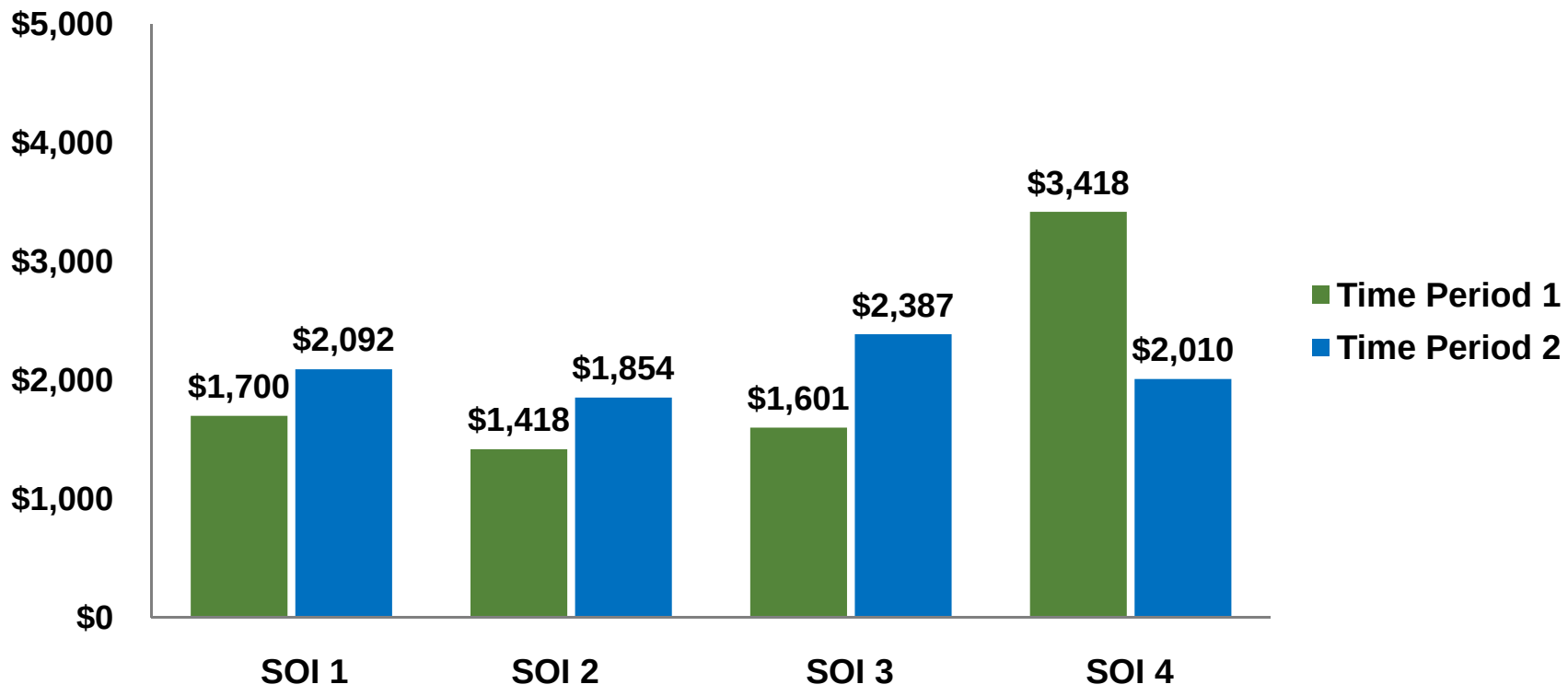
Difference in Readmission Rates for Post-acute Care Home Health and other PAC Users, by SOI



Time Period 1 is October 2006 – March 2008; Time Period 2 is April 2008 – September 2009

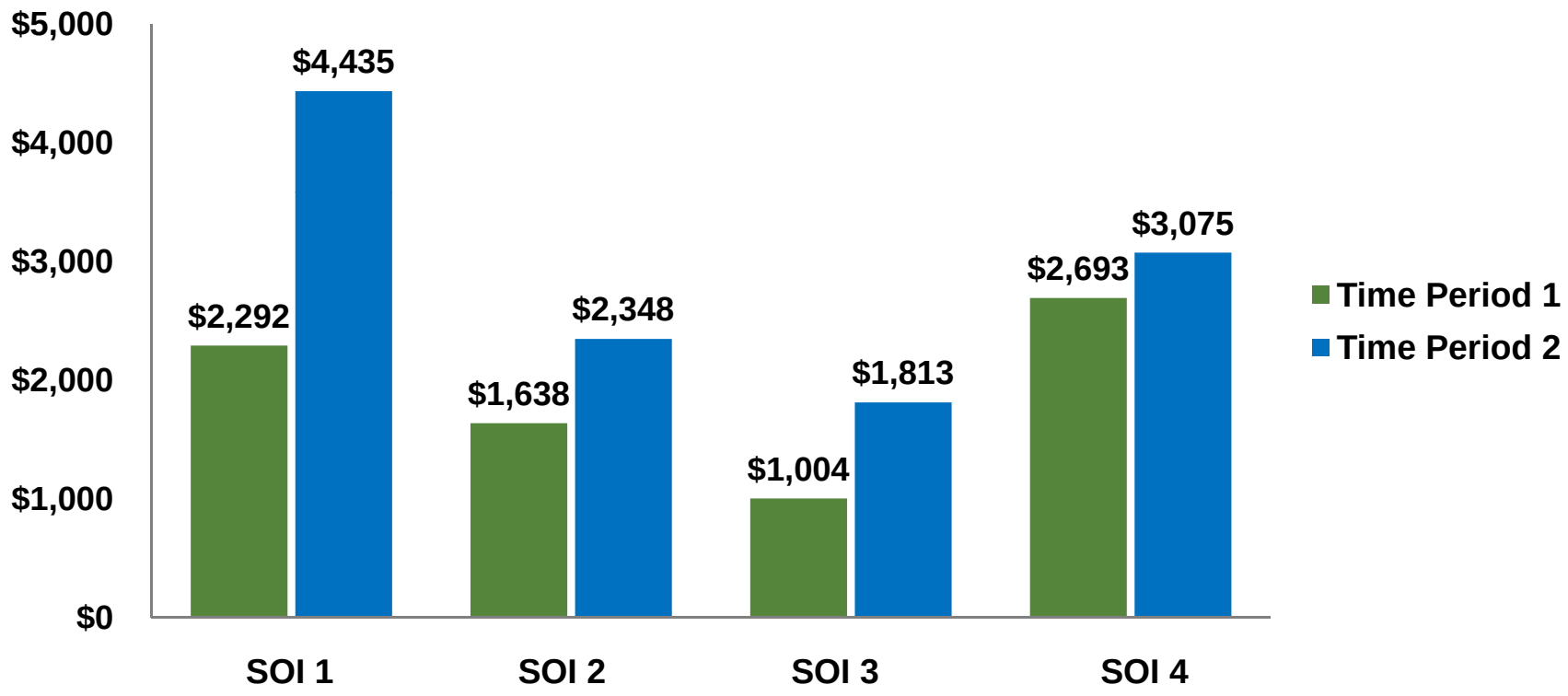
* Not statistically significant for time period 1 or 2

Savings from Reduction in Medicare Readmissions-Related Spending, per Beneficiary with Diabetes Who Used Home Health



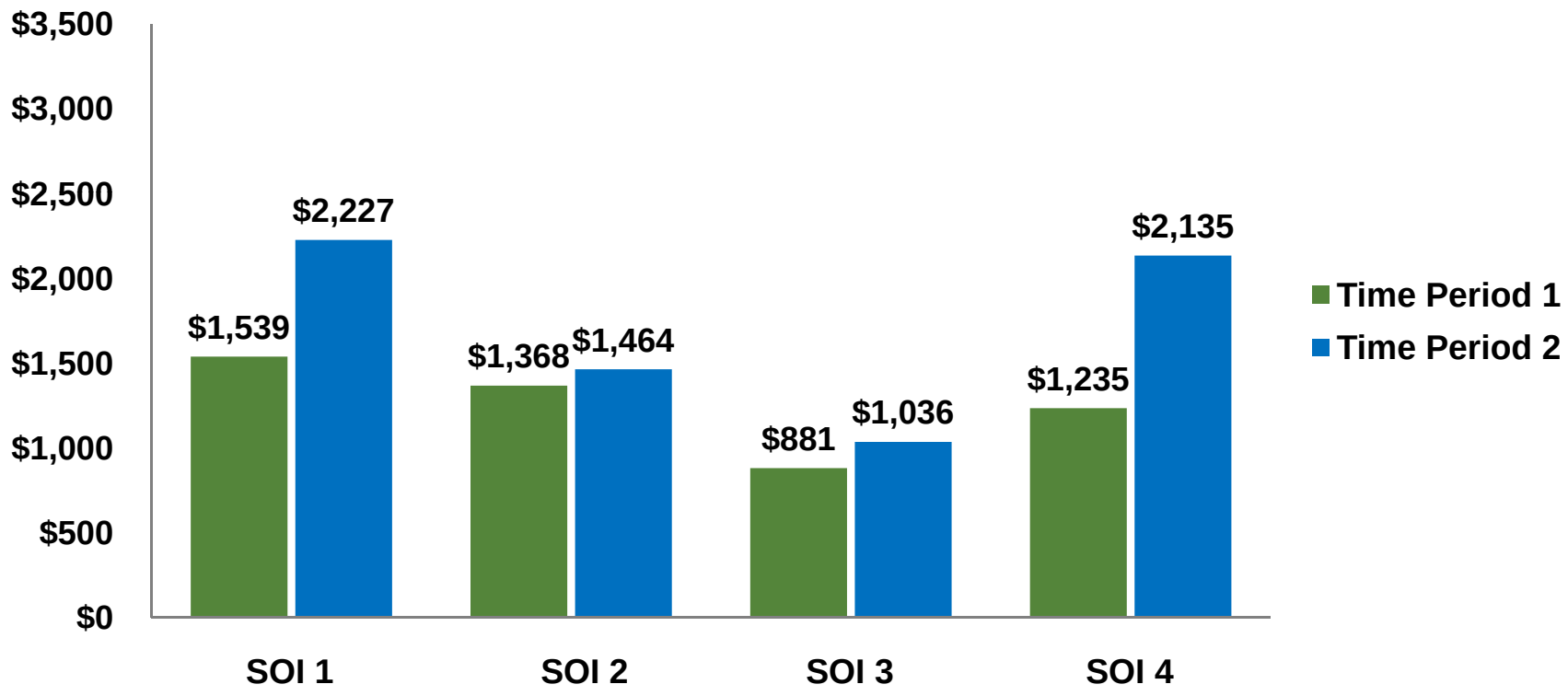
Time Period 1 is October 2006 – March 2008; Time Period 2 is April 2008 – September 2009

Savings from Reduction in Medicare Readmissions-Related Spending, per Beneficiary with COPD Who Used Home Health



Time Period 1 is October 2006 – March 2008; Time Period 2 is April 2008 – September 2009

Savings from Reduction in Medicare Readmissions-Related Spending, per Beneficiary with CHF Who Used Home Health



Time Period 1 is October 2006 – March 2008; Time Period 2 is April 2008 – September 2009

Study Limitations

- While we controlled for a number of factors to account for patient characteristics and non-random assignment to home health, we could not control for variables that were not observed in our data sets, such as functional status and caregiver status.
- Another limitation is that our data sets do not include dates of service; we assumed that in the quarter of the initial hospitalization, the hospital stay preceded home health or other PAC use. It is possible that some of the beneficiaries in our sample received PAC services, including home health, before the initial hospital stay.
- The study findings are applicable to a specific group – beneficiaries with a primary or secondary diagnosis of diabetes, COPD, or CHF who used home health or other PAC services during the 2006-2009 period. These findings cannot be extrapolated to the entire home health population, PAC population, chronically ill population, or Medicare population.
- Due to the transition from (inpatient hospital) DRGs to MS-DRGs and changes in coding practices and payment incentives, the coding of these select chronic conditions has changed over time, making it appear that case counts have declined. We chose not to expand the study population to include beneficiaries with a diagnosis of diabetes, COPD or CHT that was not the primary or secondary diagnosis, in order to avoid including Medicare payments that were driven by other conditions.

Impact of a Co-payment on Medicare Beneficiaries

- **Financial burden**
  - *4 out of 5 non-dual eligible's do not have Medigap*
  - *>50% have incomes less than $22,000 / year*
- **Shift to higher cost settings**
  - *may use higher cost post---acute care settings (SNF, Hospitals, etc)*
  - *may increase Medicare costs by as much as $16.7 billion over the next 10 years*
- **Previous co-payment repealed (1972)**
  - *evidence of burden on seniors AND shift of care to higher cost settings*
- **Currently, 81% of seniors oppose a home health copayment**

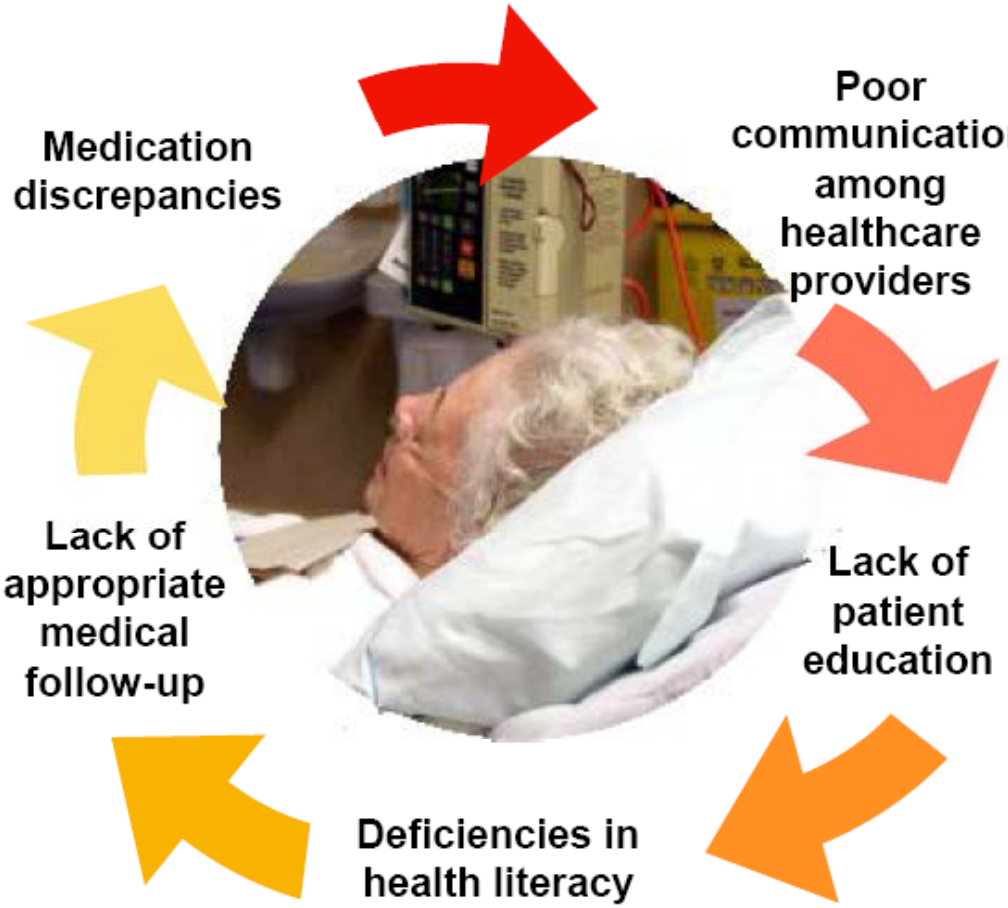
Hospital Readmission of Medicare Beneficiaries

- Rate
  - *1 in 5 - within 30 days*
  - *1 in 3 - within 90 days*

- Costs
  - $17.4 billion - readmissions within 30 days of discharge

Jencks S, Williams MV, Coleman EA, et al. *Rehospitalizations among patients in the Medicare Fee-for-Service Program.* New England Journal of Medicine. 2009; 360: 1418-1428.
Medicare Payment Advisory Committee (MedPAC). *Report to the Congress: Promoting Greater Efficiency in Medicare.* Washington, DC: June 2007:103-120.

Factors leading to Hospital Readmission



Bisognano M & A Boutwell. *Improving Transitions to Reduce Readmissions.* Frontiers of Health Service Management. 2009. 25(3): 6

Components of a Readmission Program

1. Timely admission (24 hour start of care)
2. Identification of Clients at High Risk
3. Front Loading visits
4. Teletriage calls between visits
5. Client/Caregiver Education to include:
   - Disease Management
   - Early identification of exacerbation symptoms
   - Knowing who to call when

Home Health Quality Improvement. Best Practice Intervention Package .*Fundamentals of Reducing Acute Care Hospitalization.* 9SOW -WV-HH-BBK-11710

Client's Name: _____

Date: _____

EMERGENCY/EDUCATION PLAN FOR HEART FAILURE

BAYADA NURSES
Home Care Specialists

GREEN ZONE = "All Clear"

My Goal Weight:

- My weight has not changed
- I have no trouble breathing at any time
- I have no increased swelling anywhere
- I can do my normal activities
- I have no changes in my cough
- _____

GREEN ZONE MEANS:

- My symptoms are under control
- Continue taking your medications as ordered
- Continue daily weights
- Follow low salt diet

Keep home care nurse appointments

Keep physician appointments

YELLOW ZONE = "CAUTION"

Ask yourself the following questions each day:

- Have I gained weight since the last time I was weighed?
- Have I experienced an increase in shortness of breath at rest, with activity or when sleeping?
- Have I had any new or increased swelling (anywhere)?
- Have I been more tired than usual?
- Do I have a new or increased cough?
- _____

Call your nurse if the answer to any of the above is **YES.**

** **Call Bayada Nurses** EARLY in the day if you are in the YELLOW ZONE.

YELLOW ZONE MEANS:

- My symptoms may indicate that I may need an adjustment in my medications
- **Call Bayada Nurses**

Bayada Nurses

Contact: _____

Phone Number: _____

(Please notify **Bayada Nurses** if you contacted or went to see your physician)

RED ZONE = "MEDICAL Alert"

- **Call 911** for severe shortness of breath, chest pain that does not go away or sever confusion.
- Call your **physician** for the following **RED ZONE** Symptoms
  - Wheezing or chest tightness at rest
  - Need to sit in chair to sleep
  - Weight gain of more than 5 pounds in 2 days
  - Changes in your ability to think clearly

Call your physician and/or go to the Emergency Room or call 911 if you are in the RED ZONE

RED ZONE MEANS:

Your symptoms indicate that you need to be evaluated by a physician right away.

Primary MD: _____

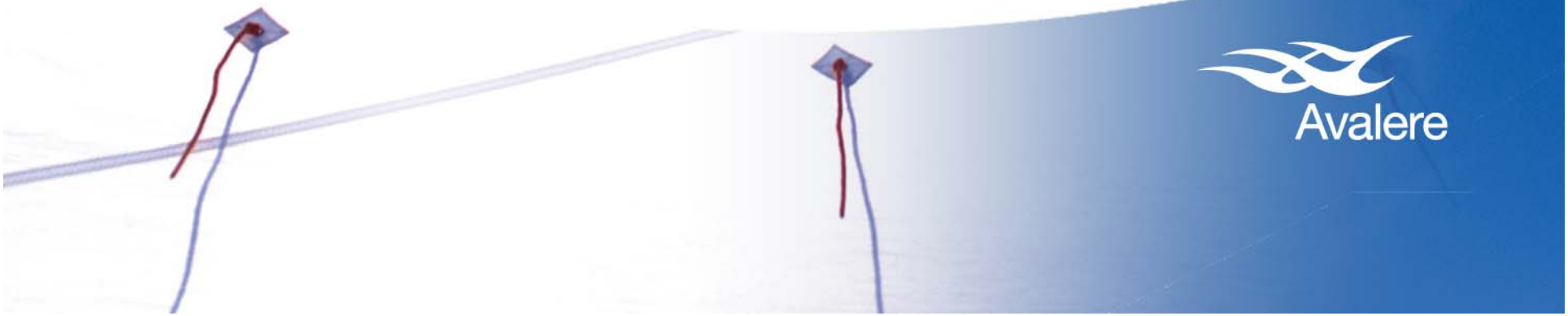
Phone Number: _____

(Please have your family notify **Bayada Nurses** if you go to the Emergency Room or are hospitalized)

Position Yourself /
A Strategic Look at the Issues Facing Home Health Care

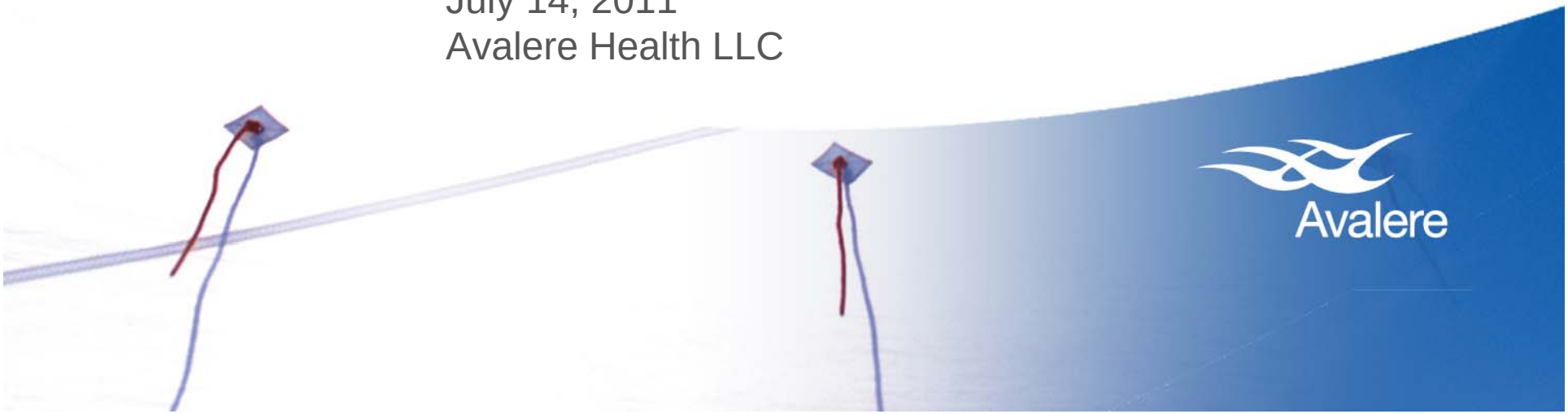
Now Speaking

Charlene MacDonald, Senior Health Care Policy Advisor
Rep. Allyson Schwartz (PA-13)



Position Yourself /
A Strategic Look at the Issues Facing Home Health Care

July 14, 2011
Avalere Health LLC



Web-Based Interface / Question and Answers

Submit Questions Via Phone

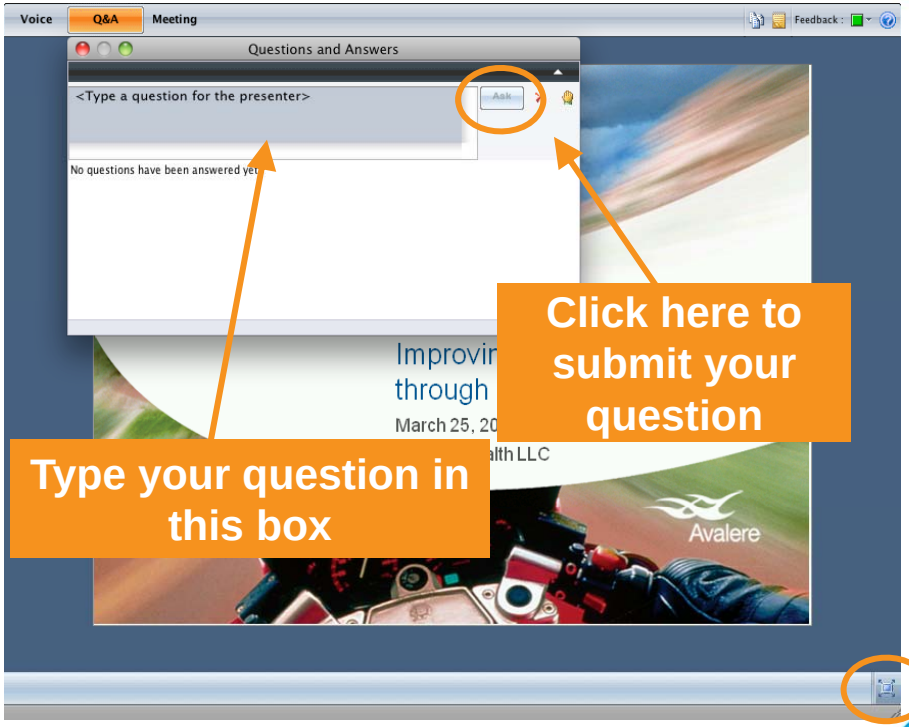
- Press *1 on your telephone key pad

Submit Questions Via the Question and Answer Feature

- Type your question in the text box in the drop down Q&A menu
- Click as shown to submit your question
- Please hold questions until the question and answer session at the end of the formal presentation
- Clarification questions can be asked at any time

Technical Support

- Press *0 on your telephone key pad to be transferred to Live Meeting Technical Support



Position Yourself /
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July 14, 2011
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