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Editorial

Emerging Challenges and Opportunities for Home Health Care in the Time of COVID-19

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As the coronavirus disease 2019 (COVID-19) pandemic has overwhelmed hospital systems and nursing homes, skilled home health care (HHC) has emerged as an increasingly attractive alternative for patients able to receive care at home. It might be easy to imagine that HHC might emerge as a health care growth sector during the COVID-19 pandemic. Indeed, HHC has great potential to expand and innovate during this time with telehealth visits and use of remote telemonitoring to provide individualized, data-driven care at home.[1] However, widespread growth and innovation may not be the current reality for home health agencies (HHAs) throughout the United States, many of which are struggling with financial viability.

The reasons that HHAs may not be thriving during the COVID-19 pandemic are multifold: (1) recent implementation of a new Medicare payment system for HHC services, (2) decreased volume of HHC referrals during COVID-19 surges, (3) shortages and costs of personal protective equipment (PPE) and testing, and (4) lack of reimbursement to provide telehealth. As with other health care sectors, COVID-19 has highlighted multiple challenges and opportunities for HHC.

In January 2020, Medicare implemented a new payment system, termed the Patient-Driven Groupings Model (PDGM).[2] The purpose of PDGM is to better align HHC payment with patient acuity and need for services through a relative increase in payments for nursing visits and a relative decrease in payments for therapy (eg, physical, occupational, and speech therapy) visits compared to the prior payment system. Overall, PDGM implementation has represented a major change in service delivery and payment structure for HHC.

The combination of PDGM implementation and arrival of the COVID-19 pandemic in the United States could be described as a "perfect storm" for many HHAs. Leading up to January 2020, most HHAs were preparing for the major shift in service delivery and payment that would come with PDGM implementation. When the COVID-19 pandemic hit in March 2020, many HHAs were in the process of shifting their service delivery with PDGM, yet were still reliant on patient referrals following elective surgeries for revenue. Between widespread cancellation of elective surgeries and an overall decrease in non-COVID-19 hospitalizations, HHAs in areas hard hit by COVID-19 noted a dramatic drop in hospital referrals and a related loss in revenue.[3] In addition, many patients who were referred for HHC then canceled HHC services because of virus fears, as described by respondents to a national survey of HHAs conducted by Shang and colleagues.[3] At the Visiting Nurse Service of New York (VNSNY), an HHA that serves more than 82,000 people in and around New York City annually, overall referrals were noted to steeply decline by more than half during April 2020, even while VNSNY provided care for more than 2000 patients with COVID-19.[4]

In addition to decreased referrals after elective surgeries and other hospitalizations, HHC services were likely underutilized for patients with COVID-19. Early estimates from 109,607 Medicare beneficiaries show that HHC services were used for only 11% of patients with COVID-19, whereas 21% were referred to skilled nursing facilities even in the midst of widespread COVID-19 outbreaks in these facilities.[5] Although some HHC claims may be lagging, and not yet included in this preliminary Medicare data snapshot, an 11% rate for HHC referrals after hospitalization is lower than the usual HHC referral rates for Medicare beneficiaries. This underutilization of HHC could also reflect that hospital-based clinicians may have a limited understanding of HHC services and how they could provide additional support for their patients after discharge.[6,7]

Like many other health care organizations, HHAs needed to purchase additional PPE kits, COVID-19 tests, and other supplies for their nurses and therapists to safely care for patients with COVID-19. Yet, because of shortages, these supplies were either not available for purchase or were exorbitantly expensive. For VNSNY, the steep decline in referrals combined with costs of PPE to care for patients with COVID-19 resulted in an estimated loss of tens of millions of dollars through July 2020.[4] As COVID-19 continues to spread and surge across different communities in the United States, financial strains have already led to furloughs and layoffs for HHC nurses and therapists.[3]

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Although the COVID-19 pandemic has brought several challenges for HHAs, opportunities exist to innovate during this time if payment policies change to become supportive. One such innovation includes expanding telehealth delivery in HHC through remote patient monitoring and remote patient encounters facilitated by audio and/or video. In a recent national survey of HHAs, more than half of the respondents indicated that their agency had increased telehealth usage during this time.[3] This expansion of telehealth in HHC was recently approved by a Medicare rule that allows HHAs to provide more services using telehealth technology. However, this Medicare rule also states that telehealth visits cannot be used in place of in-person visits and that for payments, "only in-person visits can be reported on the home health claim."[8] Therefore, although telehealth encounters are allowed in HHC, they are not currently reimbursed by Medicare, which leaves HHAs dependent on in-person patient encounters for revenue.

Rigid reimbursement requirements for in-person visits are problematic for multiple reasons, including patient-initiated HHC cancellations due to COVID-19 concerns and PPE shortages for staff. As a result of patients canceling in-person HHC visits and telehealth not qualifying as a reimbursable HHC encounter, HHAs are noting further reimbursement reductions for episodes as a result of low-utilization payment adjustments (LUPAs). LUPAs occur when the number of in-person visits falls below a certain threshold during a 30-day period of care. HHAs are then paid per visit rather than for the period of care, which has the effect of reducing payments to HHAs substantially. The LUPA threshold used to be 4 or fewer HHC visits during a 60-day "episode of care" under the prior payment model but now ranges from 2 to 6 in-person visits for a 30-day period of care under PDGM.[2]

Overall, the combination of reduced HHC referrals, PPE shortages and costs, no reimbursement for telehealth, and LUPA payment adjustments has been devastating for HHAs. Yet, a combination of policy changes could help HHAs to survive by addressing financial losses related to COVID-19 while supporting telehealth innovation during this time. These policy changes could include (1) Medicare reimbursement increases and/or targeted financial support for HHAs suffering revenue losses related to COVID-19 through congressional stimulus or relief packages, (2) HHA inclusion in coordinated federal and/or state efforts to purchase and distribute PPE, (3) HHA reimbursement for virtual visits as if they were in-person visits, and (4) elimination of LUPAs during the COVID-19 pandemic or count telehealth encounters to help HHAs avoid LUPAs for episodes with fewer in-person visits. Of note, in a recent letter to the United States Department of Health and Human Services and the Centers for Medicare & Medicaid Services, a number of senators have advocated for these policy changes.[9]

In addition to urgent payment policy changes for HHC services, the underutilization of HHC due to limited hospital clinician knowledge could be addressed through use of decision support tools that identify and alert hospital-based clinicians to consider post-acute HHC for patients who are most likely to benefit from these services.[10] Finally, enhanced partnerships between hospitals and HHAs are needed to better utilize HHC services to provide post-acute care for patients with COVID-19. Overall, for HHAs to thrive during this time, many first need to survive, which will be dependent on congressional support for HHAs and advancement of Medicare payment policies to reimburse telehealth throughout the ongoing COVID-19 pandemic.

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