Seizing Opportunities in Continuing Home Health Care under Medicare Part B: A Path for Connecticut Agencies

By: Ana Handshuh & Julie Kennedy, RubyWell

The demand for home health services in Connecticut continues to grow as its population ages. According to Connecticut's State Plan on Aging, adults 65 and older make up over 17 percent of the overall population. And their numbers are expected to increase 57% by 2040. This demographic shift will continue to drive the increasing need for home health services, particularly for patients requiring ongoing care beyond post-discharge recovery.

Despite the growing need, the current system presents challenges for home health agencies seeking to serve these patients. Confusion persists around documenting and demonstrating medical eligibility for ongoing home health services covered by Medicare Part B. Agencies often struggle with the nuanced requirements for skilled supervision of care plans and face potential audits or payment claw backs when patients require long-term services without discharge.

The payment structure of the HH PPS, including the PDGM model, quality reporting, and value-based care, all prioritize outcomes like patient improvement and cost efficiency. These mechanisms create financial disincentives for agencies to continue serving stable patients, even when ongoing care is medically necessary under the clarified standards of Jimmo v. Sebelius. These dynamics create a financial strain for agencies focused on long-term care, as the payment model rewards short-term, improvement-driven outcomes rather than the maintenance and stabilization goals central to chronic care management.

To mitigate these regulatory and financial risks, home health agencies should:

- adopt technological solutions to drive compliance
- enhance accuracy of clinical recordkeeping
- improve the efficiency and billing processes.

Implementing systems with built-in compliance checks can ensure accurate and complete supportive documentation aligned with Medicare guidelines. Data analytics tools can help agencies identify potential compliance gaps and proactively address issues before they arise. And automation of key processes, such as eligibility verification and care plan updates, can reduce the likelihood of errors that may trigger payment claw backs.

Though payment and compliance hurdles may seem daunting, they can be effectively managed. By enhancing documentation practices and refining care models, agencies can reduce financial

and regulatory risks. Simultaneously, they can capitalize on Medicare's clarified coverage policies to sustainably expand services for patients with chronic and stable conditions.

Agencies that lead the way as early adopters of this approach will position themselves as foundational pillars of a more resilient and adaptive home health care ecosystem in Connecticut. And they'll likely gain a competitive edge in addressing the long-term needs of patients and families.

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