Unlocking the Power of Home Care

Thriving in the Value-Based Era
for Non-Medical Agencies

HomeCareCon 2026

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By the End of The Presentation:

- Recognize the pivotal role of home care in achieving Value-Based Care (VBC) outcomes
- Understand how ADLs impact hospital readmissions, recovery, and client satisfaction
- Identify key metrics that demonstrate value to hospitals, payers, home health, ACOs
- Apply strategies for building partnerships with hospitals, home health agencies, and other stakeholders
- Shift from a “service provider” mindset to a “strategic partner” mindset for long-term growth

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Today It's Not...

How *MUCH* a Provider Does (a.k.a. Fee-For-Service)

How *WELL* the Client Does (a.k.a. Value-Based Care)

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Home Care viewed as a

Supportive Provider

STRATEGIC Partner

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"Now is the time to abandon the status quo."

CMS Innovation Center Director, Abe Sutton

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CMS Innovation Center will begin to introduce new care models:

- Informational (Interoperability)
- Care Management
- Clinical
- ***Non-Clinical***

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Critical Mind Shift

Old Mind Set

- Task-based support
- Transactional
- Volume focused

New Mind Set

- Outcome-driven partnerships
- Integrated care coordination
- Long-term value creation

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TEAM- Bundled Payment Model

(Transforming Episode Accountability Model)

(Effective January 2026 - December 31, 2030)

When patients are discharged:

- The managing of the client and the cost of care extends out

30 days after discharge.

- Opportunity for partnership: "You" are the eyes and ears in the home

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"Home-based services expected to drive surge in Post-Acute Care (PAC) demand over the next decade."

Report by performance improvement company Vizient and its consulting firm Kaufman Hall – McKnight's Home Care, ***April 21, 2026***

Data Source: CMS' Medicare fee-for-service claims data

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Home Care as a Strategic Asset that can:

- Drive Innovation
- Improve Client Outcomes
- Reduces Readmission Risk
- Contain Cost
- Differentiates your agency in the market

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The Mindset of the Future is *Collaboration*

- Strategic Partnerships (New service lines, referral opportunities, access to funding, competitive advantage)
- Engage in Care Coordination –Interdisciplinary teams
- Closing care gaps from discharge to recovery
- Data Driven – Measurable Outcomes
- Data Reporting and Interoperability (Sharing of Client Information)
- Risk Related Contracts

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"Agencies not only will enhance the Value being delivered but will be positioned for **sustainable growth** in a rapidly changing healthcare environment."

Lisa Reminton
The Remington Report, August 2025

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By 2030 CMS expects 100% of Medicare beneficiaries to be treated by a provider in a value-based model.

Centers for Medicare and Medicaid Services (CMS)

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Projected that **$265 Billion** worth of care services will shift to the home by **2027,** representing up to 25% of the total cost of care.

Office of Budget Management (OBM)

($265B @80% = $212B)

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Whole Person Care

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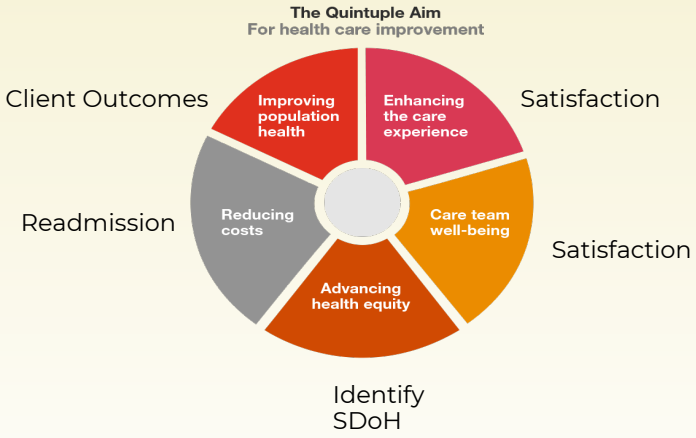
Value Based Care



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Value-Based Care Is the Future – *Outcome Driven*

Success is Measured By:

- Reduced rehospitalizations
- Improved Functional Outcomes
- Client & Caregiver Satisfaction
- Addressing Social Determinants of Health (SDoH)
- Cost containment with quality improvement

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Stakeholders Challenges (A.K.A. Pain-Points)

- Avoidable Hospitalization
- Declining Functional Capabilities (ADLs)
- Falls and safety incidents
- Low Satisfaction Scores: Clients & Care Teams
- Gaps between discharge and recovery

Financial Implications

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From Service Provider to Strategic Partner

- Rehospitalization prevention partner
- Functional expert (speed and quality of recovery)
- Promoting safety and independence
- Frontline against social isolation
- Core member of VBC team – “Eyes and Ears”

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Non-Medical ≠ Non-Essential

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HOME HEALTH AGENCY (Medical)

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Patient-Driven Groupings Model (PDGM)

- Implemented in January 2020
- Determines reimbursement based on patient characteristics
- Aims to reduce overutilization and encourage Value-Based care in the home health settings
- Medicare reimbursement from a 60-day episode to two 30-day billing periods

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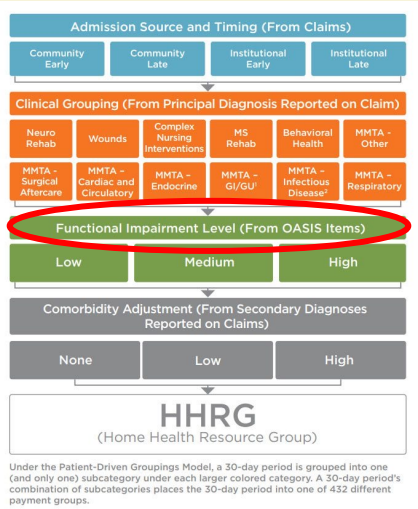
Patient-Driven Groupings Model (PDGM)



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Functional Impairment Level

The PDGM designates a functional impairment level for each 30-day

VARIABLE #	DESCRIPTION
M1800	Grooming
M1810	Current ability to dress upper body safely
M1820	Current ability to dress lower body safely
M1830	Bathing
M1840	Toilet transferring
M1850	Transferring
M1860	Ambulation and locomotion
M1033	Risk for hospitalization

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Home Health Value-Based Purchasing (HHVBP)

- Introduced in 2016 with 9 states as the pilot.
- Medicare-certified HHAs in all 50 states must follow the model

Objective:

- Decrease unnecessary emergency room visits,
- Improve patient mobility
- Reduce Medicare spending

Agencies will experience payment adjustments between ***a 5% increase or a 5% decrease*** based on their performance data (Medicare fee-for-service payments)

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Home Health Value-Based Program (HHVBP)

"The overall economic impact of the extended HHVBP Model of CY's 2023-2027 is an estimated ***$3.4 billion*** in total savings to FFS Medicare from a reduction in unnecessary hospitalizations and skilled nursing facility usage with greater quality improvements in the home health industry."

Congressional Budget Office

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OASIS Based Measures – 35%

Functional Items	**CY2026**
Eating	*Improvement in Bathing*
Oral Hygiene	*Improvement in Upper Body Dressing*
Toileting Hygiene	*Improvement in Lower Body Dressing*
Roll left and right	
Lying to sitting on side	
Sit to stand	
Chair/Bed to Chair transfer	
Toilet Transfer	
Walk 10 feet	
Walk 50 feet with 2 turns	
Wheel 50 feet with 2 turns	

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Patient Experience Measures (HHCAHPS)

(20% of total score)

(April 2026)

Patient and Professional Caregiver Centered Experience:

- Willingness to recommend the agency
- Communications between Staff and Patient
- Staff kept you informed of arrival times
- Staff listened carefully
- Staff treated you with courtesy and respect
- Staff provide your family or friends with information or instructions about your care as much as you wanted?

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Reducing in-stay ***Potentially Preventable Hospitalizations*** (PPH) shows the strongest relationship with

Willingness to Recommend Home Care Agency.

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HOSPITAL

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The Hospital Readmission Reduction Program
(30-day readmission)

- **2009:** CMS began public reporting of Hospital readmission rates
- **2012:** CMS started implementing penalties.
- Medicare Value-Based Purchasing program.
- Aimed at reducing **avoidable hospital readmissions** by encouraging hospitals to enhance ***communication and care coordination***.

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Causes for readmission:

- High-risk patients who don't qualify for home health care under the Medicare benefit
- Falls within the first 24/48 hours of discharge
- Medication errors /non-compliance
- Failure to see a primary care physician within 2 weeks of discharge
- Nutrition – shopping, meal prep, prescribed diet – i.e., low sodium

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Medicare Advantage

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Why it's Important

Loss of Membership – Enrollment is their lifeli

Star Ratings (Public Perception)

Population that on avera

Social Determi

The non-medi outcomes:

* Nutrit
* Transp
* Medication adherence
* In-home supportive care (a.k.a. Personal Care)
* Education
* Social Isolation

READMISSIONS
FALLS
FUNCTIONALITY LIMITATIONS (ADLs)
CLIENT & CAREGIVER SATISFACTION

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Value-Based Outcomes Dashboard

Re-hospitalization		
Hospitalization Statistics	Clients	%
At Start of Care, clients hosp in last 30 days		
At 30 day eval has client been rehosp since last eval?		
At 60 day eval has client been rehosp since last eval?		
At 90 day eval has client been rehosp since last eval?		
Clients re-hospitalized w/in 7 days of any d/c		
Heart Related Hospitalization Statistics	Clients	%
Clients hospitalized for heart related w/in 60 days **prior** SOC		
Clients re-hospitalized for heart w/in 30 days **post** Start of Care		
Clients re-hospitalized for heart w/in 60 days **post** Start of Care		
Clients re-hospitalized for heart w/in 90 days **post** Start of Care		
Clients re-hospitalized for heart related w/in 7 days of a d/c		
Client Satisfaction	Score 1 - 10	
Overall Satisfaction		
Recommend Provider		
Impact of Services on Daily Life		
Ability of Caregivers		
Communication from Provider		
Client/Caregiver Compatibility		

Quality - Functional Levels			
Improved or maintained functional status since SOC			
Functionality	30 Days	60 Days	90 Days
Overall			
Personal Care			
Mobility			
Client Falls	Admitted	ED Visit	Refused
Total Falls			
On Shift			
Off Shift			
Caregiver Satisfaction		Score 1 - 10	
Overall Satisfaction			
Recommend Employer			
Training Received			
Office Staff Support			
Caregiver Recognition			
Client/Caregiver Compatibility			

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Benefits for Home Care Agencies

- Stronger Partnerships
- Better Caregiver Retention
- Valued Strategic Partner
- Provider of Choice
- Employer of Choice
- Higher Level of Trust
- Competitive Advantage
- Sustainable Growth

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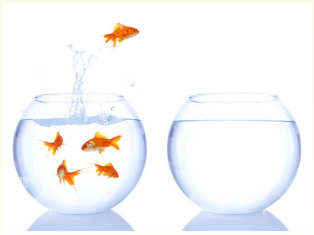
The Future Won't Wait — And Neither Should You!

- Step Into the Conversation – Reach out to Hospitals, MA, and home health leaders
- Measure What Matters – Track 3 key metrics starting tomorrow (readmissions, falls, ADLs)
- Pilot Something New – Launch a 30-day rehospitalization partnership with a hospital and show results
- Invest in Your Story – Link services to outcomes with case studies and testimonials
- Lead the Change, Don't Follow – Innovate your way into the value chain



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Summary

- The shift to Value-Based Care is happening *NOW*
- Agencies that *Evolve* will *THRIVE – Market position predicts sustainability*
- Strategic partnerships unlock *GROWTH*
- The future is *COLLABORATIVE*, *DATA-DRIVEN*, and *VALUE-FOCUSED.*

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Home care isn't just part of the system –
it's where the future of healthcare lives.

Hospital@Home
Leadership Summit
Boston, MA 2025

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Questions?

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