Home Health Care News

Morgan Gonzales, Dec 02, 2025

Industry-wide pressures are necessitating that home-based care providers step away from traditional fee-for-service models – but payer trends and other factors can complicate the process of establishing innovative reimbursement arrangements.

Some of the momentum toward value-based care in managed care has slowed due to pressure on payers, experts said during a recent Home Health Care News webinar. Despite some sluggishness in the trend toward value-based care, providers are seeing opportunities to innovate and have crafted strategies to aid in the development of alternative payment models.

"The pressures the payers are facing, that's going to flow downward to our providers as well," Hillary Loeffler, vice president of policy and regulatory affairs for the National Alliance for Care at Home (the Alliance), said during the webinar. "I think our members would love to show their value and engage in more value-based contracts with [Medicare Advantage] plans, it just seems hard to get some of them to move away from paying per visit."

To establish value-based or alternative payment plans requires that providers understand what payers want – and payers want evidence that a provider is doing something different before it will offer an upside contract, according to Devin Woodley, vice president of managed care contracting at VNS Health.

"Payers really want to see … what additional value are you bringing to get a piece of that pie?" Woodley said on the webinar. "It's the same with alternative reimbursement models. What are you doing that's alternative? What are you doing that's different from today to deserve this different payment methodology?"

New York-based VNS Health is a nonprofit home-based care organization offering home health, hospice and behavioral health services. The company has over 73,000 patients, members and clients daily. Two-thirds of the organization's revenue comes from its health plan arm.

Alternative payment model trends

Significant shifts in payers' interests have required new and innovative payment models. Payers are less interested in "sharing in the pie" than they were even a few years ago, Woodley said.

"When we're coming with new models or an opportunity for value-based, that payers are looking for significantly higher return on investment calculations than they were a few years back," he said. "A few years ago, they may have been looking for a 1.5 to 2.5x on ROI, and now they're looking more like a three-plus, and preferably more in the four range. So they want to see a program that has incredible outcomes, like mind-blowing outcomes, before they're willing to invest in it and take a chance on it."

Episodic or 30-day period payments are still relatively uncommon, according to Loeffler, with payers predominantly paying per visit. She suggested that there had been some movement toward bundled and value-based payment models, but headwinds in Medicare Advantage added pressure to payers – which is then passed down to providers.

The Alliance's members currently cope with lengthy approvals processes due to Medicare Advantage plans' stringent utilization management practices, Loeffler said.

One major hurdle in the transition to more value-based care models, according to Loeffler, is that payers are often focused solely on lowering the total cost of care – sometimes to the detriment of improving outcomes.

Without ensuring a focus on quality, value-based models may carry certain risks, she said. Mitigating these risks requires a delicate balance between lowering the total cost of care while ensuring patients receive necessary care.

"I worry that maybe some home health agencies get caught in lowering the cost of care and lose sight of improving the quality aspect of value-based care," Loeffler said. "I do worry a little bit about under-investment in services and the incentives that maybe some of these models create."

Branching away from fee-for-service

Achieving beneficial alternative payment arrangements requires evidence of value, efficiency and innovation, and sometimes adjusting clinical models.

VNS Health has successfully renegotiated managed care payer contracts by leveraging its value-based programs to achieve other alternative reimbursement models.

"An example is, for certified home health, we would add a value-based upside only [component], prove our value, prove that we're doing really well, and that can be a path to get us into episodic," Woodley said. Now, almost all of our home health, Medicare, Medicare Advantage book of business, are in episodic arrangements, where we do still have a value-based [element] to keep us true and to prove our value ongoing."

With new pressure for higher returns from health plans, VNS is now refining the programs it offers payers, focusing more on operational efficiencies and performance.

The transition to mostly episodic contracts required VNS Health to change its care delivery model, Woodley said.

"We had to layer in other things, like CMS doesn't recognize virtual visits at this time," he said. "But now, where you're getting an episodic bundle from a payer, you can layer in a virtual visit, remote patient monitoring and NP escalation. You can layer in community paramedicine. You can create this bundle that you know is going to deliver a lot of value and decrease those rehospitalizations."

For providers, the pains of creating value-based or alternative models can pay off in dividends.

"I had one of my finance guys in here today who was talking about $1.9 million bonus that we have coming from one of our payers based on the payer's analysis of our performance last year," Woodley said. "That's just on one payer. So there is a significant opportunity, if you structure the contract correctly, and then you perform on the contract."