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Managing post-acute recovery at home to improve outcomes and reduce avoidable utilization

Why home health is central to an effective post-acute strategy

Historically, post-acute recovery was heavily dependent on facility-based care, such as skilled nursing facilities and inpatient rehabilitation facilities. As more recovery moves into the home, health plans face a level of clinical variability that traditional utilization-management workflows were not built to manage alone. Recovery no longer happens in controlled clinical environments. It happens in homes that can vary widely in safety, support, and stability.

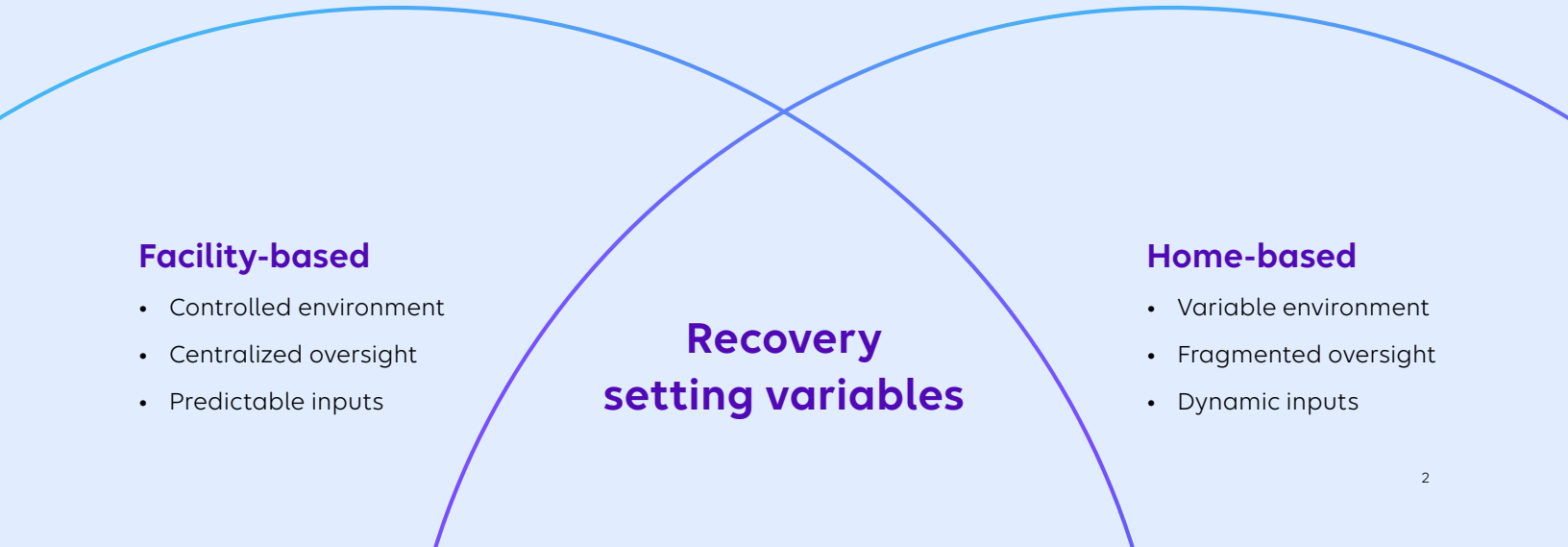
Leading health plans are responding by shifting toward clinically integrated post-acute recovery models that provide more robust support in the home. They are treating home health as an active recovery management function rather than a transactional benefit.

Carelon's clinically integrated approach can transform home-based services into a strategic platform for recovery management. By combining specialized clinical expertise, advanced analytics, curated care provider networks, and integrated care programs, Carelon enables health plans to improve outcomes while reducing avoidable utilization.

Home health is reshaping post-acute care

For many conditions, recovery at home can reduce complications, accelerate functional improvements, and enhance member satisfaction. Members often prefer recovering in familiar environments surrounded by caregivers and family support. From a health plan perspective, home-based recovery can reduce total costs of care by minimizing unnecessary facility utilization.

A common misconception among healthcare organizations is that home health utilization can be managed through straightforward approval rules. From a health plan perspective, home health represents an opportunity and a risk. When managed effectively, it can reduce total costs of care. When managed inconsistently, it can lead to avoidable utilization and downstream complications.



How our expertise guides interpretation

Evidence-based guidelines provide an important foundation for home health utilization management. However, the true value of a clinically integrated model emerges in how those guidelines are interpreted and applied to real member scenarios.

Carelon's model is guided by specialized post-acute clinical expertise, evidence-based criteria, and data-driven insights that help align home health services to each member's evolving recovery needs.

Expertise

300+ post-acute clinicians, including **166+** dedicated to home health

Alignment

with Centers for Medicare & Medicaid Services (CMS) Chapter 7 guidance and national clinical criteria

Experience

spanning the full care continuum

Home health clinical decision framework

Carelon combines rapid access to care with disciplined reassessment. Initial authorizations help members receive care quickly after discharge, while ongoing clinical review helps ensure visit frequency and duration remain aligned to the member's current condition, functional progress, safety risks, caregiver support, and recovery trajectory. As the member's needs evolve, Carelon reassesses their care plan and adjusts services to support recovery, avoid unnecessary utilization, and maintain continuity of care.

Once services begin, care providers complete the Outcome and Assessment Information Set (OASIS) evaluation in the home. This comprehensive assessment provides critical insight into the member's physical condition, functional limitations, safety risks, caregiver support, and social needs. Carelon uses these insights, along with post-acute clinical expertise and escalation pathways, to help ensure the member receives the right services at the right intensity over time.

Initial request and rapid start of home care

Clinical interpretation of function, risk, and need

Escalation to connected programs when indicated

OASIS assessment completed in the home

Visit planning aligned to current clinical need

Ongoing reassessment and 60-day navigation support

How historical insights lead to more strategic decisions

When combined with clinical expertise, data helps guide more precise and proactive care decisions. Carelon leverages more than a decade of history (representing 10 million+ post-acute claims) to inform utilization insights, care provider performance benchmarking, and recovery pathway optimization.

65%

of claims volume with 4+ Star care providers[1]

Such data helps:

- Determine appropriate visit allocation
- Identify high-performing care providers
- Detect early indicators of member decline

Carelon uses analytics to monitor care provider quality across its delegated network, which spans 22 states, with home health utilization management delegation in three additional states.

How we deliver high-quality home health at scale

Carelon's strong network includes the nation's largest home health organizations. Care provider performance is assessed using quality scorecards, clinical outcome metrics, and CMS Star Ratings performance. This network enables health plans to rapidly deploy programs across multiple markets without building care provider relationships from scratch.

How home health connects to whole-person care

Home visits create visibility that is difficult to achieve in other settings. Care providers can identify unmet needs that were not apparent during hospitalization.

Carelon connects these insights to supporting resources and programs, including:

- Social Drivers of Health program
- Wound Care Connect program
- Carelon's Palliative Care program
- Care navigation

Why health plans choose to partner with Carelon

Health plans increasingly recognize the strategic importance of a home health management model. However, building one internally could take multiple years of investment in technology, staffing, and care provider contracting.

Highly specialized clinical expertise
Decision-making spans skilled nursing, physical therapy, occupational therapy, speech therapy, home health aides, and medical social work. Our experts have deep familiarity with functional assessments, caregiver dynamics, and evolving member conditions.

Mature data infrastructure
Accurate visit allocation, care provider performance monitoring, and outcome tracking depend on years of claims history and advanced analytics capabilities.

Capacity to scale
Establishing a high-quality national network involves negotiating relationships, monitoring performance, and directing volume toward high-performing agencies.

Integration
Operational integration across authorization, claims processing, and care provider engagement is critical for efficiency.

Escalation resources that extend the value of home-based visibility

Social Drivers of Health program

18:1
return on investment[1]

~$9,300
savings per completed referral[1]

Wound Care Connect program

$8K–$10K
savings per engaged member[1]

Carelon's Palliative Care program

25%
of Medicare Advantage referrals to palliative care[1]

25%
higher engagement from Carelon Post-Acute Solutions[1]

Care navigation

60-day
post-discharge monitoring and escalation

Partnering with Carelon helps address gaps in expertise, infrastructure, scale, and connectivity while enabling health plans to accelerate post-acute strategies, maintain strategic oversight of their populations, and access a robust home health management platform.

Home health case summaries

79-year-old member

- Recovering from hip fracture surgery
- Required post-acute therapy

Therapy management after hip fracture

Initial visits were approved to establish care and assess function. As the member progressed, Carelon aligned subsequent visits to current clinical need. In one reassessment, 12 visits were requested and four were approved based on functional improvement, including the member walking 75 feet with contact guard assist and residing in an assisted living facility with around-the-clock caregiver support for activities of daily living and mobility. When a possible deep vein thrombosis concern emerged, additional visits were approved while the member awaited Doppler evaluation.

Adjusted therapy based on recovery progress:

- Care plans evolved with member progress.
- Utilization aligned to function, not assumptions.
- Clinical oversight prevented both overuse and gaps in care.

72-year-old member

- Discharged on anticoagulation therapy
- Required ongoing monitoring

Nursing management following sepsis and DVT

The member was discharged after sepsis and deep vein thrombosis (DVT). Initial skilled nursing visits were approved for medication education, DVT management, and chronic condition support. During a later review, Carelon identified a supratherapeutic international normalized ratio (INR) of 3.6 against a goal range of 2–3, prompting outreach to the prescribing care provider and a Coumadin dose adjustment. Six skilled nursing visits were approved to monitor for adverse events and support repeat INR checks.

Adjusted skilled nursing visits based on medication-safety risk:

- Real-time clinical signals drive decision-making.
- Coordination improves medication safety.
- Targeted utilization reduces unnecessary services.

In both cases, Carelon:

Aligned visits to recovery progress | Avoided unnecessary utilization
Maintained care continuity

Prioritize home health as a strategic advantage in post-acute care

Home health has moved to the center of post-acute care strategies. It's now a key driver of both outcomes and cost performance. Realizing its full value requires a shift in approach, as static utilization models are not sufficient for managing dynamic recovery needs.

Health plans that adopt clinically integrated, data-informed models are better positioned to:

- Improve member outcomes
- Reduce avoidable utilization
- Strengthen performance in value-based environments

Carelon's framework illustrates how this transformation can be achieved in practice.

Connect with Carelon to explore how a more robust approach to home health can support your post-acute strategy.

Achieve clinical, operational, and care provider impact

Health plans working with Carelon report measurable operational and clinical improvements. These results reflect the combined effect of clinical expertise, data-driven insights, and integrated care delivery.

Clinical and financial

- Supports reduced readmissions
- Improves care coordination
- Helps lower total cost of care

Operational

- **96%** of home health requests submitted through the care provider portal[1]
- **80%** automated approval rate for initial home health authorization requests[1]
- **<1** calendar-day average authorization turnaround[1]

Care provider experience

- **88%** overall provider satisfaction[2]
- **90%** overall satisfaction with clinical reviewers[2]
- **91%** overall satisfaction with the Provider Relations team[2]

1 Carelon internal data, 2024.
2 Carelon internal data, 2025.

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