

Exploration of the Value and Role of Home Health Care in Medicare Advantage

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EXECUTIVE SUMMARY

More than one-third of Medicare beneficiaries (36 percent) receive their benefits through private health plans in the Medicare Advantage (MA) program.^a Enrollment in MA has doubled over the last decade and is projected to cover about 51 percent of Medicare beneficiaries by 2030.^b Home health care (HH) is an important part of the care continuum for the Medicare population. Prior research has found HH after a hospital or an institutional post-acute care stay to be associated with lower readmissions and mortality, underscoring its crucial role in care transitions. By allowing beneficiaries to receive skilled care in their home instead of an institutional setting, HH can satisfy beneficiaries' general preference to remain in their residence for as long as possible,^c and potentially reduce overall health care spending by replacing costlier care provided in institutional settings. The key role HH plays in treating Medicare beneficiaries was further emphasized during the COVID-19 pandemic. As both ambulatory care and institutional care were reduced due to risk of COVID-19 spread during the early waves of the pandemic, HH offered an alternative care setting for patients who needed skilled health care or therapy.^{d,e} Additionally, HH served as an important post-acute care setting for COVID-19 patients after hospitalization. A recent study of COVID-19 patients who received HH after hospitalization suggests that HH can improve recovery of COVID-19 patients.^f

KNG Health Consulting (KNG Health) was contracted by the Alliance for Home and Health Quality and Innovation (AHHQI) to explore the role of HH in MA and investigate methods to demonstrate the value of HH to MA beneficiaries and the plans themselves. The purpose of this report is twofold. First, based on findings from literature review and key informant interviews, it presents existing evidence and knowledge gaps regarding the value of HH in MA. Second, it discusses the new supplemental benefits in MA and priority areas of research to help fully realize the potential of HH in serving MA beneficiaries.

^a Neuman, P., & Jacobson, G. A. (2018). Medicare Advantage Checkup. *New England Journal of Medicine*, 379(22), 2163–2172. <https://doi.org/10.1056/NEJMhpr1804089>

^b CBO. (2020). Medicare – CBO's March 2020 Baseline as of March 6, 2020. Retrieved October 1, 2020, from the Congressional Budget Office website: <https://www.cbo.gov/system/files/2020-03/51302-2020-03-medicare.pdf>

^c Home and Community Preferences of the 45+ Population. (n.d.). Retrieved September 16, 2019, from <https://www.aarp.org/research/topics/community/info-2014/home-community-services-10.html>

^d Mehrotra, A., Chernew, M., Linetsky, D., Hatch, H., Cutler, D., & Schneider, E. C. (2020). The Impact of the COVID-19 Pandemic on Outpatient Care: Visits Return to Prepandemic Levels, but Not for All Providers and Patients. *Commonwealth Fund*, Oct, 10.

^e Heist T., Schwartz, K, & Butler, S. (2020). Trends in Overall and Non-COVID-19 Hospital Admissions. Retrieved February 12, 2021, from the KFF website: <https://www.kff.org/health-costs/issue-brief/trends-in-overall-and-non-covid-19-hospital-admissions/>

^f Bowles, K. H., McDonald, M., Barrón, Y., Kennedy, E., O'Connor, M., & Mikkelsen, M. (2020). Surviving COVID-19 After Hospital Discharge: Symptom, Functional, and Adverse Outcomes of Home Health Recipients. *Annals of internal medicine*.

Existing Evidence and Knowledge Gaps on the Value of Home Health Care in Medicare Advantage

Literature Review

We conducted a scoping literature review to assess existing empirical evidence on HH use in MA and the value of HH to MA plans and beneficiaries. In total, we included 27 peer-reviewed studies, gray literature, and poster presentations in our assessment.

Utilization of Home Health Care. Prior literature suggests that utilization of HH is lower in MA relative to Traditional Medicare (TM). These findings are consistent with the view that MA plans, motivated by financial incentives to lower cost and armed with flexible benefit options and utilization management tools, can more successfully limit health care use. However, additional research is needed to understand the sources and consequences of this difference in the use of HH between MA and TM. Future research should focus on the extent to which there is a shift towards skilled HH from more expensive settings, and if so, for whom. We also need a better understanding of differences in the types of patients receiving HH in MA and TM, whether the relative use of HH in MA varies across conditions and patient types, the percentage of HH that follows an inpatient stay in MA and TM, and the types of services provided within HH in MA and TM.

Access and Regional Variation in Home Health Care. Several studies that investigated the access to home health agencies (HHAs) among MA enrollees found that MA enrollees may be more limited in accessing HH, in general, and high-quality HHAs, in particular. Both quantitative and qualitative studies have found that benefit design elements, such as cost-sharing, pre-authorization, and referral requirements, are associated with lower use of HH among MA enrollees. There are still unanswered questions about the extent to which MA enrollees can access skilled HH care, and studies with strong research designs are needed to assess the causal linkage between MA plan features and HH utilization. Studies that analyzed regional variation in HH use among MA beneficiaries found varying results, with some revealing greater regional variation in HH use in MA and others revealing smaller regional variation in MA relative to TM.

Patient Outcomes Associated with Home Health Care. We found only one study that examined the effects of MA on the outcomes of beneficiaries who received HH. The study concluded that outcome differences between MA and TM were small and inconsistent after adjusting for patient demographic and clinical characteristics. Broader literature on patient outcomes in MA yielded that the difference in patient outcomes between MA and TM can vary by condition- and patient type. The variation in findings related to outcomes associated with MA in prior literature has not been fully reconciled and requires future research.

Opportunities for Home Health Care Innovations. MA may provide an opportunity to HH providers to implement innovative care delivery models that are not included in TM. Our review focused on two examples of home-based care covered by certain MA plans: hospital-at-home and HouseCalls. Overall,

researchers found that these innovative programs implemented in MA plans can lead to cost savings and improved outcomes.

Interviews

We conducted interviews with HH providers and researchers to gather information on the use and value of HH in MA. Despite our attempts, we could not secure interviews with MA plan representatives.

Value of Skilled Home Health Care. All interviewees indicated that skilled HH is an important part of the care continuum and provides important benefits to beneficiaries, such as medication management, and functional ability improvements. However, multiple interviewees noted that the true value of HH is not generally apparent to patients or providers outside of the HH industry.

Medicare Advantage Plans' Understanding of Home Health Care. Interviewees indicated that in general, MA plans do not have a good understanding of where HH fits in the care continuum and what value it delivers. Interviewees also noted that, in situations where financial incentives align with cost control and quality of care, such as integrated delivery systems, MA plans have started to recognize the value of HH.

Access to Home Health Care in Medicare Advantage. The provider representatives that we interviewed voiced concern that the authorization process employed by MA plans was onerous, placed added burden on the provider, and may be limiting access to skilled HH services. However, sharing analytics on patient outcomes with MA plans is helpful in broadening the plans' understanding of the value of HH.

Opportunities for Home Health Care Innovations. Recent regulatory and legislative changes have allowed MA plans to offer new supplemental benefits like in-home health care to beneficiaries meeting specific clinical criteria. Interviewees indicated that through these policies, MA plans can help address the needs of an aging population, and potentially realize a return on investment. Although, the interviewees were excited about the impact and opportunities these new benefits could have on the HH industry, they noted that the implementation of this policy will take time.

New Supplemental Benefits in Medicare Advantage

The Bipartisan Budget Act of 2018 coupled with 2019 and 2020 Medicare payment rules from CMS expanded the scope of supplemental benefits in MA, starting in 2019 with full implementation of changes in 2020. As a result, MA plans can offer access to home-based services, such as in-home support services and in-home palliative care, which were previously unavailable to Medicare beneficiaries. Initial reports on the new supplemental benefits in MA suggest that MA plans have largely viewed this new flexibility as a positive development that has allowed them to provide services that better address the health of their beneficiaries. However, MA industry experts expressed concerns regarding the upfront costs, tradeoffs, and potential return on investment associated with new benefits as well as the scalability of these benefits and the availability of community-based organizations that can provide these supplemental benefit services. Researchers have emphasized that supplemental benefits

are currently a relatively low priority for MA plans. Adding new supplemental benefits would require insurers, particularly larger insurers, to consider the cost, benefit, and feasibility of adding new benefits. However, home health care providers could expect to see smaller MA plans experimenting with these supplemental benefits sooner.

Research Priority: Demonstrating the Value of Home Health Care in Medicare Advantage

Our review of the existing literature and interviews with key informants revealed an important need to understand the value and utilization of skilled HH in MA and demonstrate it to MA plans and other stakeholders. Demonstrating the value of HH in MA involves addressing questions related to both quality and costs associated with HH. On the quality side, it involves understanding the effect of skilled HH on patient outcomes, such as mortality and readmissions after hospitalization. On the cost side, it involves estimating the cost savings that may result from reduced readmissions or other healthcare utilization associated with skilled HH use. This comprehensive approach to assessing the value of HH would show the extent to which HH is associated with improved patient outcomes and quality of care and the extent to which its costs are offset by any healthcare savings that it provides.

Conclusion

Home health care is an important care setting for Medicare beneficiaries. Prior studies on the TM population has found HH to be associated with lower readmissions and mortality following hospitalization or inpatient post-acute care stay. Studies on alternative payment models in TM further suggest that HH is a lower-cost alternative to institutional care and has the potential to reduce health care spending. Although MA currently covers about a third of Medicare beneficiaries and is expected to cover about half of the Medicare population in a decade, most of what we know about the role of HH in treating Medicare beneficiaries focuses on TM. Our review of the prior literature and interviews with key informants revealed a need for a better understanding of the value of HH in MA.

Demonstrating the value of HH in MA from both patient and payer perspectives is a principal research priority for AHHQI. Research to date has found that the use of HH is lower in MA relative to TM. Future research examining patient outcomes associated with HH in MA and TM is needed to understand whether this lower HH utilization in MA represents an efficient use of health care resources or barriers to access HH for MA beneficiaries who need HH.

Such research would also lead to a better understanding of HH's role in the broader care continuum, which would allow MA plans and other payers to use HH effectively in designing care delivery and payment models. Recent regulatory and legislative policy changes to MA supplemental coverage rules expand the scope of care that can be covered by MA beyond skilled HH. As MA plans implement and consider broadening the provision of HH services, it is crucial to have a clear understanding of what works and to disseminate these effective practices. Evidence on the value of HH can help MA plans identify the patient populations most likely to benefit from HH care and ensure their access to HH.

Introduction

More than a third of Medicare beneficiaries (36 percent) receive their benefits through private health plans in the Medicare Advantage (MA) program.¹ Although private health plans for Medicare beneficiaries have been around since the 1970s, enrollment in MA plans has gained momentum over the last 15 years. Enrollment in MA has increased from 5.6 million in 2005 to 24.1 million in 2020 while the share of Medicare beneficiaries enrolled in MA has increased from 13 percent to 34 percent during this period.^{1,2} Enrollment is projected to cover about 51 percent of Medicare beneficiaries by 2030.³ Despite the growing prevalence of MA, our knowledge of healthcare utilization and outcomes in MA is limited. Even less is known about the extent to which post-acute care, specifically home health care (HH), is used in the treatment of MA beneficiaries.

HH is an important part of the care continuum for the Medicare population. Medicare covers skilled HH services, which include physical therapy, occupational therapy, speech therapy, and skilled nursing. By allowing beneficiaries to receive skilled HH in their home instead of an institutional setting, HH can satisfy beneficiaries' general preference to remain in their residence for as long as possible.⁴ It also has the potential to reduce overall health care spending by replacing costlier care provided in institutional settings. In addition, recent regulatory changes will allow MA beneficiaries who meet specific criteria to access home care services, such as in-home custodial support and non-medical transportation. To fully realize the potential of HH in serving MA beneficiaries, stakeholders need information on the value of skilled HH in MA, and the opportunities that the recent regulatory changes regarding home care present to MA beneficiaries.

KNG Health Consulting (KNG Health) was contracted by the Alliance for Home and Health Quality and Innovation (AHHQI) to explore the role of HH in MA and identify methods to demonstrate the value of HH to MA beneficiaries and the plans themselves. The purpose of this report is twofold. First, based on findings from our literature review and key informant interviews, it presents existing evidence and knowledge gaps regarding the use and the value of HH in MA. Second, it discusses the new supplemental benefits in MA and priority areas of research for AHHQI. The following sections provide background on HH in MA, present findings from our literature review and interviews with stakeholders, and provide a discussion of our findings within the context of demonstrating the value of HH in MA.

Background

Medicare Advantage

MA is the private health plan alternative to traditional Medicare (TM). MA plans have to offer at least the same benefits to Medicare beneficiaries as TM; however, they differ from TM in several aspects. The key difference between MA and TM is their payment structure. MA plans receive a capitated payment from CMS for each of their Medicare enrollees to cover the cost of care. They reimburse providers based

on individually negotiated contracts between MA plans and providers. By comparison, healthcare providers in TM are directly reimbursed by CMS, usually on an episodic basis.

MA plans tend to use a limited set of in-network providers or require beneficiaries to pay more for out-of-network providers. In contrast, TM beneficiaries can access all providers nationwide. In addition, MA plans have flexibility in designing their benefit package and cost-sharing requirements as long as they provide all Medicare-covered services and the resulting costs are actuarially equivalent to TM. They are more likely to use utilization management approaches, such as prior authorization, than TM. Finally, MA plans can provide additional benefits that are not available in TM. In the past, these supplemental benefits have generally included vision care, dental care, and hearing exams. Recently, CMS has issued regulations that allow a broader set of supplemental benefits, including additional HH benefits, as explained in the next subsection.

The Role of Home Health Care in Caring for the Medicare Population

Medicare covers HH services consisting of skilled nursing, physical therapy, occupational therapy, speech therapy, aide services, and medical social work provided to beneficiaries in their homes. To be eligible for HH under Medicare, beneficiaries must be homebound and in need of part-time or intermittent skilled nursing or therapy services. Furthermore, beneficiaries must be under the care of a physician, who must certify the beneficiary's eligibility for HH, and receive HH from a Medicare-certified home health agency (HHA).

Home health care is an important care setting for Medicare beneficiaries. Three-quarters of adults aged 45 and older in the US have a strong preference to stay in their residence to receive care, if possible.⁴ HH allows beneficiaries who need skilled care and therapy to remain in their residence instead of receiving care in institutional settings, such as skilled nursing facilities. Prior research has found HH after a hospital or an institutional post-acute care stay to be associated with lower readmissions and mortality.⁵⁻⁷ Therefore, HH plays an important role in care transitions by ensuring continuity of care and improving patient outcomes after hospitalization.

The COVID-19 pandemic further underscored the importance of HH as an essential care setting. As both ambulatory care and institutional care were reduced due to risk of COVID-19 spread during the early waves of the pandemic, HH offered an alternative care setting for patients who needed skilled health care or therapy.^{8,9} Additionally, HH served as an important post-acute care setting for COVID-19 patients after hospitalization. In a recent study, Bowles and her co-authors examined the outcomes of 1,409 COVID-19 patients who received HH in the New York City area in Q2 2020 and found that COVID-19 patients who were admitted to a HHA after hospitalization experienced statistically significant improvements in functional status and a decrease in symptom severity during their HH episode.¹⁰

Home health care is also important from a payer perspective as it can serve as a low-cost alternative to costlier institutional care settings, potentially reducing aggregate healthcare spending. In fact, recent payment reforms aimed at reducing health care spending have been associated with an increase in HH use.¹¹⁻¹³ Among Medicare beneficiaries discharged from an acute care hospital, receiving HH is

associated with lower Medicare payments over 60-day care episodes than receiving care in a skilled nursing facility.¹⁴

New Opportunities for Home-Based Care in Medicare Advantage

A key aspect of the HH benefit in TM is that it covers skilled HH services like skilled nursing or therapy services. Other home care services, such as in-home custodial care and long-term services and supports, are excluded from the HH coverage in TM. MA plans are required to offer at a minimum the same level of home-based care benefits as TM. Recent policy changes allow MA plans to offer additional home-based care services as supplemental benefits. The Bipartisan Budget Act of 2018 coupled with 2019 and 2020 Medicare payment rules from CMS expand the scope of supplemental benefits in MA, starting in 2019 with full implementation of changes in 2020. As a result, MA plans can offer access to home-based services that were previously unavailable to Medicare beneficiaries.

The recent regulatory and legislative changes to supplemental benefits that can be offered by MA plans fall under three categories.¹⁵ First, they allow MA plans to offer a wider set of health-related services under the supplemental benefits umbrella to beneficiaries. Previously supplemental benefits had to “prevent, cure, or diminish an illness or injury;” now they can “diagnose, prevent, or treat an illness or injury; compensate for physical impairments; act to ameliorate the functional/psychological impact of injuries or health conditions; or reduce avoidable emergency and healthcare utilization.”¹⁵ As a result, MA plans can now offer home-based services, such as help with activities of daily living and home-based palliative care, which are not currently covered by TM. Second, starting in 2020, MA plans are authorized to offer chronically ill MA enrollees non-medical supplemental benefits as long as they address social determinants of health or are reasonably expected to improve beneficiary’s health. As a result, interventions that address social determinants of health and long-term services and supports can be included in MA supplemental benefits. Third, MA plans can offer different supplemental benefits and cost-sharing requirements to beneficiaries with different medical conditions.

According to analysis by the AARP Public Policy Institute, the new home care benefits allowed under MA supplemental plans were offered by a small portion of MA plans in 2019.¹⁵ About 3.4 percent of MA plans offered in-home support services, and less than 1 percent offered in-home palliative care in 2019. The number of MA plans offering expanded supplemental home-based care benefits is expected to increase in the coming years as MA insurers have more guidance from CMS and more time to adjust their benefit design in response to the regulatory changes.

The expansion of home-based services allowed under MA supplemental benefits provides HHAs with an opportunity to serve MA beneficiaries in new ways. As a healthcare provider caring for patients in the community, HHAs are well-positioned to implement interventions that address social determinants of health, provide home-based palliative care, and provide transitional and personal care services to prevent readmissions and emergency care and improve patient outcomes.

Existing Evidence and Knowledge Gaps on Value of Home Health Care in Medicare Advantage

Literature Review

Most of what we know about HH in the Medicare population is based on the analysis of data on TM beneficiaries. In TM, HH benefits offered to beneficiaries and the reimbursements to HH providers are uniform across beneficiaries and providers and are transparent to researchers. Medicare claims data for services provided to TM beneficiaries are also available, allowing for empirical research on the utilization of HH and outcomes associated with HH in TM. Unlike TM, little is known about the care patterns and outcomes of beneficiaries enrolled in MA plans due to research challenges and data limitations related to studying the MA population. First, there is limited data on health care utilization and outcomes of MA beneficiaries since MA plans were not required to report encounter data from providers in their networks to CMS until 2012. CMS has recently started making encounter data (currently for years 2015-2017) publicly available.^{16,§} Second, the large amount of heterogeneity across MA plans further complicates data collection and research efforts relative to TM. The benefit design aspects, such as provider networks and cost sharing, HH benefits covered, and the contractual arrangements between HH providers and MA insurers, can vary across MA plans, requiring further data collection on plan types and benefits to better interpret empirical findings.

Although previous literature on MA is limited, there has been a recent increase in the number of studies examining health care utilization and outcomes in MA. We conducted a review of recent literature to assess existing empirical evidence on HH use in MA and the value of HH to MA plans and beneficiaries. We conducted a scoping literature review of published peer-reviewed articles using the PubMed database (National Center for Biotechnology Information, National Institutes of Health, Bethesda, Maryland). The search terms used included the following: HH, post-acute care, MA, spending, and patient outcomes. Reviewers conducted a title screening, abstract screening, and full-text review of the articles identified. During title screening, reviewers evaluated the article's title and publication information. Only articles that were published in English and after January 2010 were included. Abstracts were screened for references to value or utilization of post-acute care by Medicare beneficiaries. Articles that met these inclusion criteria underwent a full-text review. Relevant data details were compiled in an Excel document to facilitate analysis and review. After the screening process, selected articles were reviewed and their references were assessed for inclusion in the literature review. To supplement the search on PubMed, we also performed a search of gray literature using the Google Scholar database for working papers and white papers focused on HH, post-acute care, MA, spending, and patient outcomes. In addition, we reviewed relevant conference presentations and posters discussing HH and MA to ensure a comprehensive review of the recent research on the topic. In total, we included 27 peer-reviewed studies, gray literature, and poster presentations in our

[§] The Final 2015 Medicare Advantage Encounter Data became available to researchers in July 2019. Preliminary encounter data were available in 2018.

assessment. We did not do a formal assessment of the methodological quality or risk of bias of studies included in the literature review.

Our literature review focused primarily on the utilization of HH, value of HH, and HH innovations in MA. However, we also reviewed articles related to broader health care utilization and outcomes associated with MA as well as HH use in alternative payment models to gain a deeper perspective on the potential role of HH in MA. After a review of existing literature, we categorized our findings related to MA under the following themes:

- Utilization of Home Health Care
- Access and Regional Variation in Home Health Care
- Patient Outcomes Associated with Home Health Care
- Opportunities for Home Health Care Innovations

Utilization of Home Health Care

Although one might expect MA plans to have lower *overall healthcare utilization* and lower costs due to the financial incentives introduced by its capitated payment structure, the effect of MA on the *utilization of HH* is not immediately clear. HH use in MA may be lower than TM if MA plans limit its use through, for example, prior authorization restrictions. In other instances, HH use in MA may be higher than TM if MA plans substitute skilled HH for more expensive institutional care, such as care provided in skilled nursing facilities (SNFs). Therefore, understanding the effect of MA on HH use requires an empirical investigation.

Empirical evidence to date suggests that utilization of HH is lower in MA relative to TM. Waxman et al. compared HH utilization among beneficiaries enrolled in TM and MA plans and found that the odds of receiving HH among TM beneficiaries was 1.8 times higher than in MA.¹⁷ They also found that the duration of HH episode among beneficiaries receiving HH was 34 percent longer in TM relative to MA. HH utilization was identified based on Outcome and Assessment Information Set (OASIS) data. The analyses controlled for patient case mix using Hierarchical Condition Category (HCC) scores of beneficiaries and zip-code level socio-economic indicators based on data from American Community Survey.

Analyzing data from OASIS, Healthcare Effectiveness Data and Information Set (HEDIS), and Medicare claims spanning 2007-2013, Li et al. also found lower use of HH among MA population as compared to TM population.¹⁸ Specifically, the authors estimated risk-adjusted HH use in MA and TM to be 4,712 days and 7,257 days, respectively, per 1,000 beneficiary-years. While the trend in HH use increased between 2007 and 2010 and decreased between 2010 and 2013 in both MA and TM, the difference in HH use between TM and MA decreased slightly between 2007 and 2013 from 3,262 days to 2,545 days per 1,000 beneficiary-years. Analyses adjusted for demographic characteristics, zip-code level income from census data, dual eligibility, and Hospital Referral Regions (HRRs).

Skopec et al. examined HH use among MA and TM beneficiaries between 2011 and 2016 using data from OASIS and Medicare Beneficiary Summary File (MBSF).¹⁹ After controlling for age, gender, race and ethnicity, dual-eligibility, original reason for Medicare entitlement, and eligibility for the Part D low-income subsidy, the authors found lower rates of HH use among MA enrollees compared to TM enrollees. Specifically, MA enrollees were 3.2 percentage points less likely to receive HH in 2011 relative to TM enrollees, although the difference in HH use between MA and TM decreased to 2.6 percentage points by 2016. The authors found lower HH use in MA relative to TM both in home health following acute care hospitalization and community-admitted home health.

More recently, Skopec and her co-authors examined the use of HH among Medicare beneficiaries following hospitalization for lower extremity joint replacement, stroke, or heart failure.²⁰ The authors used 2015 and 2016 data from Medicare Provider Analysis and Review File, Minimum Data Set, Inpatient Rehabilitation Facility Patient Assessment Instrument, OASIS, and MBSF and calculated risk-adjusted differences in post-acute care use between MA and TM enrollees. They found that MA enrollees with joint replacement were 3.0 percentage points less likely to use a combination of institutional (SNF and inpatient rehabilitation facility) and home health post-acute care and 4.0 percentage points less likely to use HH alone relative to TM. Among stroke patients, MA enrollees were 3.4 percentage points less likely to use a combination of institutional and home health post-acute care and equally likely to receive only HH after hospitalization compared to TM. Following hospitalizations for heart failure, MA enrollees were 2.7 percentage points less likely to use HH in combination with institutional post-acute care and 4.2 percentage points less likely to use HH alone.

Kosar and his co-authors investigated the prevalence of HH among Medicare beneficiaries who were discharged from hospital to HH.²¹ Authors found that 44 percent of MA beneficiaries prescribed to receive HH after hospitalization did not receive HH as compared to 14 percent of TM beneficiaries. In a more recent study, Loomer et al. found that 38 percent of MA beneficiaries who were prescribed to receive HH following hospital stay did not receive HH as compared to 25 percent of TM beneficiaries. After risk adjustment, authors found that MA beneficiaries were about 12 percentage points less likely to receive prescribed HH after hospitalization than TM beneficiaries.²²

Collectively, these findings are consistent with the view that MA plans, motivated by financial incentives to lower cost and armed with flexible benefit options and utilization management tools, can more successfully limit health care use. Other studies have found lower use of other types of health care services in MA as compared to TM. For example, Landon et al. found lower use of emergency department (ED) and ambulatory surgery and procedures in MA relative to TM.²³ They also found lower rates of hip and knee replacement but higher rates of coronary bypass surgery among MA beneficiaries as compared to TM. Curto et al. examined health care utilization and spending in MA and TM and found that the use of hospitalizations, outpatient office visits, SNF stays, physician visits, and ED visits was lower in MA as compared to TM.²⁴ Among Medicare beneficiaries with hip fractures, Kumar et al. found lower SNF use among MA beneficiaries with hip fracture as compared to TM, both in terms of the percentage of the study population with SNF use as well as the duration of the SNF stay and physical

therapy during the stay.²⁵ Furthermore, Meyers et al. found lower use of long-term care hospitals in MA relative to TM.²⁶

Despite the recent surge in studies related to the utilization HH in MA, there is still a lot that we do not know about HH use in MA. One important gap in our knowledge is regarding substitution of care between HH and other settings. Prior studies, such as Curto et al., have found empirical evidence consistent with substitution towards less expensive care settings, such as the use of outpatient instead of inpatient surgery.²⁴ Evaluation of bundled payment programs in TM have also found bundled payments to be associated with lower rates of institutional post-acute care, such as SNFs.²⁷⁻²⁸ Based on their recent study, Skopec and her co-authors concluded that “MA plans are not substituting HH for institutional post-acute care but are providing less care than traditional Medicare does overall.”²⁰ Additional research is needed to understand the extent to which there is a shift towards skilled HH from more expensive settings, and, if so, for whom. We also need a better understanding of differences in the types of patients receiving HH in MA and TM, whether the relative use of HH in MA varies across conditions and patient characteristics, the percentage of HH that follows an inpatient stay in MA and TM, and the types of services provided during HH in MA and TM. Finally, studies comparing health care utilization in MA and TM may suffer from unobservable selection bias, which occurs when the differences in health care utilization between MA and TM are due to differences in patient characteristics unobservable in the data. Robust study designs that control for unobservable selection bias are needed to ensure that the differences in HH utilization between MA and TM are attributable to enrollment in MA rather than differences in patient characteristics.

Access and Regional Variation in Home Health Care

Although prior research has found some evidence for lower HH utilization in MA as compared to TM, it is not clear whether the level of HH use in MA is appropriate. Stronger financial incentives and the flexibility to use case management tools could lead MA plans to reduce wasteful or inappropriate health care utilization. However, the same factors can result in MA plans restricting beneficiaries’ access to needed and appropriate care. To better understand whether utilization of health care under MA is too high or too low, researchers have used three strategies. Some have investigated issues related to the access to HH among MA beneficiaries, and others have compared regional variation in HH use between MA and TM. A third avenue of research that has accompanied healthcare utilization under MA has been to investigate the association between MA and patient outcomes. In this section, we discuss the first two research paths (access and regional variation), and we discuss the third path (MA and patient outcomes) in the next section.

Access to Home Health Care in Medicare Advantage

An important question regarding access to HH care among MA beneficiaries is whether the narrow provider networks, cost-sharing and other benefit elements in MA limit beneficiaries’ access to HHAs. In a recent study, Schwartz et al. examined whether MA enrollment is associated with being treated by a low-quality HHA.²⁹ The authors used CMS’ publicly reported quality of care star ratings to identify HHA

quality and data from OASIS to identify HH use. After adjusting for patient demographic and clinical characteristics as well as market characteristics at the zip-code level, they found that MA beneficiaries are more likely to receive care from a low-quality HHA than TM beneficiaries. This result held irrespective of the quality of the MA plan, with beneficiaries in low-quality MA plans being 4.9 percentage points less likely to be treated by a high-quality HHA and beneficiaries in high-quality MA plans being 2.8 percentage points less likely to be treated by a high-quality HHA compared to TM beneficiaries.

Schwartz et al.'s findings are consistent with those from an earlier study by Meyers et al., which revealed that MA enrollees are substantially more likely to receive care from a lower-quality SNF as compared to TM.³⁰ Collectively, these results are consistent with the hypothesis that MA plans provide limited access to high-quality HHAs for their enrollees. Additional research is needed to ensure that the relationship between MA enrollment and HHA quality is not driven by unobservable factors, such as patient health literacy, differential discharge planning, and patient and hospital preferences.

Researchers have also been concerned about other potential negative effects of MA's coverage flexibility on MA enrollees' access to needed health care. In their study examining HH use in MA, Skopec and her co-authors conducted interviews with MA plans and HHAs to understand the role of MA benefit design features in explaining lower HH use in MA.¹⁹ Information gathered during these interviews suggested that "MA plans control HH use more tightly, limiting the number of visits, paying on a per-visit rather than a per-episode basis, and managing networks through certification processes." Skopec et al.'s finding is consistent with those found by Jacobson and Neuman, who examined CMS MA Plan Benefits Package Files for 2018.³¹ The authors found that about 62 percent of MA beneficiaries are enrolled in plans that require prior authorization for HH.

Loomer et al.'s study on the use of prescribed HH after hospitalization provides further insight on MA design elements and their impact on HH use among MA enrollees.²² The authors found that among MA enrollees who are prescribed HH following hospital stay, those enrolled in HMO plans with cost-sharing, referral requirements, or pre-authorization were less likely to receive the prescribed HH. The study findings suggest that design elements, such as cost-sharing, referral requirements, and pre-authorization, serve as effective tools for restricting HH use for MA beneficiaries enrolled in HMO plans.

Li et al. examined the relationship between HH copayments in MA and utilization of HH.³² Using a difference-in-difference case-control study design and data from HEDIS and OASIS, authors examined changes in HH use in MA plans that introduced home health copayments between 2007 and 2011. Their analysis revealed no statistically significant relationship between the increase in HH copayment and HH use.

The question of whether the lower health care utilization under MA is a reflection of a reduction in inappropriate care or reduction in access to needed care is an important one. It is particularly important for HH since HHAs are excluded from MA network adequacy criteria.³³ While existing research provides some initial answers, there are still unanswered questions. For example: how many HHAs are there in

MA plan networks? What are the characteristics of HHA in MA networks? What are the payment structures between MA plans and HH providers and what is the effect of these payment structures on beneficiaries' access to HH? Is there evidence of MA beneficiaries switching to FFS due to limitations in HH coverage or access to HH providers?

Furthermore, studies with stronger research design are needed to assess the causal linkage between MA plan features and HH utilization. Studies by Skopec et al. and Schwartz et al. suggest that there may be an association between MA plan benefit design features (limited provider network, prior authorization, etc.) and HH use, but they may be limited by unobserved selection bias. Li et al.'s study is an example of a more robust research design, but finding more such opportunities for quasi-experimental study design may be difficult. Nevertheless, researchers should look for opportunities in data to strengthen their methodology and hence their conclusions on the access to HH in MA.

Regional Variation in Home Health Care under Medicare Advantage

Regional variation in health care utilization has been an important indicator for potential opportunities for cost savings. Unexplained regional variation in health care use (unexplained by patient differences) indicates that the use of health care resources in at least some of the regions is either too high or too low. A widely cited Institute of Medicine report has highlighted the role of post-acute care services in explaining regional variation in healthcare spending in TM.³⁴ Specifically, the report stated that a substantial amount of regional variation in health care spending remained after controlling for factors that are measurable in the data. It identified post-acute care services as the primary driver of regional variation in healthcare spending, based on the finding that post-acute care services explained 73 percent of the regional variation in adjusted total Medicare spending.

Waxman et al. compared regional variation in HH use between MA and TM using two measures of regional variation: 1) ratio of the share of beneficiaries using HH in high-utilization and low-utilization HRRs, 2) ratio of mean HH episode duration in high-utilization and low-utilization HRRs.¹⁷ Authors found greater regional variation in HH use in MA according to the first measure and slightly lower regional variation in HH use in MA according to the second measure. Based on their findings, Waxman and his co-authors concluded that MA plans may be limited in their ability to manage health care utilization and face other determinants of health care use such as local health care practices and market forces.

Li et al. also examined regional variation in HH, SNF, and hospital care using relative differences between HRRs based on data from OASIS, HEDIS, and Medicare claims.¹⁸ Their study revealed that regional variation in HH was higher than the regional variation observed in SNF and hospital care. In contrast to Waxman et al.'s findings, Li et al. found that MA exhibited smaller regional variation in HH use but larger regional variation in SNF use as compared to TM. Larger regional variation in SNF use in MA remained after controlling for sociodemographic factors, functional status, and cognition. Finding of smaller regional variation in HH use in MA compared to TM is consistent with the view that MA plans may be more successful in curbing inappropriate HH use. However, existence of regional variation in MA also suggests that there may be limits to MA plans' ability to manage HH utilization.

Patient Outcomes Associated with Home Health Care

Effect of Medicare Advantage on Beneficiaries Receiving Home Health Care

We found only one study that examined the effects of MA on the outcomes of beneficiaries who received HH. Waxman et al. compared MA and TM beneficiaries who received HH in terms of seven clinical outcomes: improvement in three measures of activities of daily living; acute care hospitalizations; and improvements in pain, dyspnea, and management of oral medications.⁷ Analyses involving risk adjustment for patient demographic and clinical characteristics revealed that outcome differences between MA and TM were small and inconsistent. MA outperformed TM in three measures, TM had higher performance than MA in three measures, and there was no statistical difference between TM and MA in one measure.

Effect of Medicare Advantage on Patient Outcomes

The existing literature that investigates patient outcomes in MA is primarily aimed at understanding the extent to which patient outcomes differ between MA and TM. Although most of these studies do not focus on HH in MA, we present a summary of their analyses to illustrate the current questions surrounding patient outcomes in MA.

Previous literature investigating the effects of MA on patient outcomes has yielded contradictory findings. Huckfeldt et al. examined post-acute care utilization and patient outcomes between MA and TM beneficiaries with lower extremity joint replacement, stroke, and heart failure.³⁵ They found lower readmission rates and higher discharge to community rates for MA beneficiaries relative to TM beneficiaries. Similarly, Kumar et al. found lower rates of readmission and higher rates of discharge to community among MA beneficiaries with hip fracture as compared to similar beneficiaries in TM.¹⁵ Kumar et al.'s study also revealed, however, lower improvement in functional status among SNF patients enrolled in MA relative to TM patients, although the authors note that the difference in improvement is not generally considered clinically meaningful. Timbie et al. compared MA and TM beneficiaries in California, Florida and New York in terms of 22 performance measures that are reported by MA insurers to CMS and used in generating star ratings.³⁶ Of the 22 measures, 16 were clinical quality measures, and six measured beneficiary experience. Authors found higher performance among MA beneficiaries in all 16 clinical quality measures.

A recent study by Panagiotou and co-authors yielded results that are different from these earlier findings.³⁷ Panagiotou et al. examined 30-day readmission rates between MA and TM enrollees after hospitalization for acute myocardial infarction (AMI), congestive heart failure (HF) and pneumonia between 2011 and 2014. The authors found that 30-day risk adjusted readmission rates after discharge for the three conditions were higher in MA compared to TM beneficiaries. The gap in readmission rates between MA and TM for all three conditions consistently increased during the study period. The variation in findings across studies related to outcomes associated with MA has not been fully reconciled and requires future research.

Skopec et al. found that among patients hospitalized with joint replacement, stroke, and heart failure, MA enrollees had lower readmission rates than TM enrollees within 30 and 90 days of hospital discharge.²⁰ Among joint replacement and stroke patients, MA enrollees had slightly higher mortality within 90 days of hospital discharge compared to TM enrollees. Difference in 90-day mortality between MA and TM among heart failure patients was statistically insignificant.

Opportunities for Home Health Care Innovations

MA's financial incentives, benefit design flexibility, and ability to enter into contracts with providers presents an opportunity for innovations in HH. These innovations can involve both new health care delivery and payment models. Prior literature has highlighted several examples of innovative partnerships between home-based care providers and MA plans. Examinations of these partnerships can provide insight into potential new opportunities for HH providers and MA plans. Below we discuss two examples of home-based care covered by certain MA plans: hospital-at-home and HouseCalls.

Hospital-at-home, a care delivery model, developed by researchers at the Johns Hopkins Schools of Medicine and Public Health, provides hospital level of care in a patient's home. It is tested in several health care systems and MA plans. In their assessment of the model in three MA plans, Leff and his co-authors found hospital-at-home to be not only feasible but also effective in delivering hospital-level of care at home to patients who required admission to a hospital for pneumonia, exacerbation of chronic heart failure, exacerbation of chronic obstructive pulmonary disease, and cellulitis.³⁸ The authors found some evidence of fewer complications for the hospital-at-home patients, and the mean cost of the model was lower than for acute hospital care.

More recent evaluations of the hospital-at-home model implemented in MA plans have found cost savings and improved outcomes associated with the model. In their evaluation of the hospital-at-home model offered by Presbyterian Healthcare Services to its MA and Medicaid patients, Cryer and his co-authors found that the model was associated with similar or better clinical outcomes, higher patient satisfaction, and lower costs.³⁹ The cost savings were due to lower average length-of-stay and use of fewer laboratory and diagnostic tests compared with similar patients treated in acute care hospitals. Federman et al. reported on outcomes associated with a hospital-at-home bundled with a 30-day episode of post-acute transitional care.⁴⁰ They found that patients treated in the hospital-at-home model had lower readmission rates, lower ED visits, and lower SNF admissions than similar patients treated in acute care hospitals. Hospital-at-home patients also indicated higher patient satisfaction similar to previous studies.

UnitedHealth Group's home visit program, HouseCalls, provides annual in-home physician or nurse visits and care coordination with eligible MA members' primary care providers. Whenever the beneficiary has urgent health issues, practitioners contact the member's primary care to facilitate the member's transfer to the ED or hospital. HouseCalls practitioners can refer members to health plan resources, including disease and care management, mental health services, social services, medication

management, and palliative care. Mattke et al. assessed the HouseCalls program's impact on the level of healthcare utilization.⁴¹ The authors used a difference-in-difference approach, comparing changes in inpatient and outpatient health care utilization experienced by HouseCalls participants to those experienced by non-HouseCalls MA plan members and TM beneficiaries. They found the HouseCalls program to be associated with reductions in acute care hospital and nursing home admissions and a shift from institutional care toward outpatient care.

The Home Health Value-Based Purchasing (HHVBP) Model, which is tested on a select TM population, can also provide insights for similar efforts in MA.⁴² This model, currently implemented in nine states, ties CMS payments for Medicare-certified HHAs to quality of care. Under this model, HHA payments are adjusted upward or downward based on HHAs' Total Performance Score (TPS), which reflects performance on 20 measures. The evaluators for the HHVBP assessed the change in patient outcomes in HHVBP states relative to outcomes observed in a comparison group, consisting of beneficiaries and HHAs in non-HHVBP states.⁴³ They found an increase TPS of HHAs in both HHVBP and comparison groups after the first year of the model, but HHAs in HHVBP states experienced larger improvements in TPS. Of the 17 performance measures included in the TPS, the largest improvements were observed in the four OASIS functional improvement outcome measures. Preliminary findings on healthcare utilization, outcomes, and Medicare spending revealed no statistically significant effect of HHVBP on utilization, outcomes, and spending measures during the first year of implementation. The effect of HHVBP on outcomes may increase over time as the financial incentives under the model become stronger over the next five years.

MA provides an opportunity for HH providers to implement innovative care delivery models that are not included in TM. Recent regulatory and legislative policy changes to MA supplemental coverage rules expand the scope of care that can be covered by MA. They further expand the potential opportunities for MA plans to partner with home-based care providers and offer innovative home-based care to MA beneficiaries. New models and innovations should be based on a deep understanding of MA plans and population and should leverage lessons learned from prior models that were tested in both TM and MA.

Interviews

We conducted interviews with stakeholders to gather information on the use and value of HH in MA. These interviews focused primarily on skilled HH, including physical therapy, occupational therapy, speech therapy, and skilled nursing. The interviews were conducted with HH providers and researchers. We worked with AHHQI's Subcommittee to identify potential interviewees and develop a semi-structured interview protocol for each type of interviewee. Although we reached out to MA plans, both directly and indirectly through AHHQI Subcommittee members, we were unable to identify MA plan representatives willing to participate in our interviews.

We interviewed two executives of HHAs and two physician-researchers who are active in HH research. One of the HHA executives interviewed represented a non-profit provider within a large, academic, integrated health system while the other executive represented a large for-profit provider. Both

researchers interviewed were physicians at a large hospital and engaged in research on HH. Telephone interviews were conducted in December 2019. All interviews were recorded and summarized. The authors then synthesized the findings.

Two limitations of the interviews should be considered when reviewing our findings from the interviews. First, due to the limited project scope, we interviewed a small number of providers and researchers. Therefore, the information collected during the interviews may not be generalizable. Second, we were unable to interview MA plan representatives – a core group given our topic. As a result, our interviews capture provider and researcher perspectives on this topic but do not include MA plans' perspective. We also reviewed prior studies that interviewed MA plans regarding the recent regulatory changes to supplemental benefits and presented this MA perspective in the next section.

After a review of the interview responses, we categorized our findings related to HH in MA under the following themes:

- Value of Skilled Home Health Care
- Medicare Advantage Plans' Understanding of Home Health Care
- Access to Home Health Care in Medicare Advantage
- Opportunities for Home Health Care Innovations

Value of Skilled Home Health Care

All interviewees indicated that skilled HH is an important part of the care continuum and provides important benefits to beneficiaries. They stated that skilled HH provides services that allow successful patient recovery, medication management, and functional ability improvements. Especially for individuals who have experienced significant changes in health status, these services offer patients the opportunity to receive physical therapy, occupational therapy, speech therapy, and skilled nursing in their home. As one interviewee remarked, skilled HH is specifically beneficial for geriatric patients and allows these frail individuals to be treated in their homes instead of forcing them into hospitals. Overall, interviewees stated that skilled HH allows patients to return to their routine faster and allows them to age at home.

In addition, interviewees stated that skilled HH is valuable not only from the patients' perspective but also from the perspective of the broader health care system. They expressed that the health systems viewed skilled HH as a key part of achieving value-based purchasing goals. The unique benefits of skilled HH for patients after hospital discharge and specialized patient care that it provides can help prevent hospital readmissions and has the potential to reduce health care costs.

Multiple interviewees noted that the true value of HH is not generally apparent to patients or providers outside of the HH industry. One interviewee observed that patients and families confuse out-of-home placement with greater treatment intensity even though patients may have more intense and more frequent therapeutic contact through skilled HH with better functional outcomes. The interviewee argued that many SNF patients spend most of their time in a small room, removed from their typical routine, with limited access to intense and/or frequent therapy and they would not receive the same

level of therapy services at a SNF that they would receive with skilled HH. Skilled HH allows these patients to return to their normal routine while still being rehabilitated. As a result, patients treated in their homes generally return to their normal state of being at a faster rate.

Medicare Advantage Plans' Understanding of Home Health Care

One of the purposes of the interviews was to gather information on MA plans' perception of HH within the broader continuum of care. Although we could not secure interviews with MA plan representatives, we posed this question to our interviewees from the research and provider sides. Specifically, the interviewees were asked to share their thoughts on MA plans' understanding of HH based on their interactions with MA plans, prior experience in the area, or research.

Interviewees' responses revealed that there may be significant gaps in MA plans' understanding of what HH entails and its value. One of the interviewees indicated that MA plans are not aware of the full spectrum of services offered by HHAs. According to the interviewee, MA plans consider HH to consist of community-based care or non-skilled care, such as an aide providing assistance with Activities of Daily Living (ADLs). They are less aware of the skilled nursing care, such as wound care and therapy provided by HHAs. The interviewee suggested that MA plans' lack of understanding of what constitutes HH is reflected in MA beneficiaries as MA beneficiaries seem to be less aware of HH services available to them compared to TM beneficiaries.

Other interviewees agreed that in general, MA plans do not have a good understanding of where HH fits in the care continuum and what value it delivers. For example, one interviewee suggested that MA plans do not understand the health benefits associated with HH services. Others indicated that MA plans do not view HH as a way to reduce hospital admissions and readmissions. They also do not view HH as a lower-cost alternative to more costly settings but rather as an added cost they must incur. One of the interviewees suggested that the gap in MA plans' understanding of the value of HH is partially due to a lack of shared understanding of HH among stakeholders. The researcher interviewees agreed that there were a lot of questions about HH that are yet to be answered. Some of these questions are about the benefits of HH (e.g., what is the effect of HH on readmission rates?), and others are about the effective ways to administer HH (e.g. what is the most effective timing, duration, and frequency of services? Does it vary based on clinical conditions and home supports, ability?).

Interviewees noted that where financial incentives align with cost control and quality of care, such as integrated delivery systems, HH plays a bigger role. The provider interviewees both indicated that some MA plans have started to recognize the value of HH and consider skilled HH as a lower-cost alternative to more expensive care settings. The recent focus on readmissions has also increased recognition of HH as a valuable care setting. The interviewees indicated that providing evidence to MA plans on the outcomes associated with skilled HH would inform MA plans' perspective on HH and help them view HH as a valuable part of the care continuum.

Access to Home Health Care in Medicare Advantage

The provider representatives that we interviewed both voiced concern that the authorization process employed by MA plans was onerous, placed added burden on the provider, and may be limiting access to skilled HH services. One of the interviewees explained that the authorization process and the documentation required from the physician were too burdensome and expressed that the authorization process seemed to be designed to limit the amount of skilled HH provided to patients. The second provider interviewee agreed that MA plans seem to restrict the number of HH visits. She also pointed out that the authorization process requires the clinician rather than the case manager to make the case for the number of visits and communicate the need for visits to the MA plan. This forces the beneficiary to rely on the clinician to be their advocate, which is frustrating for both the clinician and the patients. Furthermore, one of the provider representatives interviewed indicated that the current eligibility criteria based on functionality and being homebound is restrictive in that it limits access to skilled HH to chronically ill patients.

Interviewees indicated that MA plans' restrictions on the amount of skilled HH provided stem from a lack of understanding among MA plans about the value that HH offers to the beneficiary and the overall health system. One of the researchers interviewed pointed out that MA plans that are integrated with a health care delivery system tend to have a better understanding of the value of HH and better control over skilled HH resources, and, thus are less restrictive. Non-integrated MA plans, on the other hand, tend to have less control over how HH is implemented and less understanding of the role of HH in the care continuum. As a result, these plans tend to be more restrictive with respect to the number of HH visits. All interviewees suggested that educating MA plans about outcomes associated with skilled HH would help MA plans recognize the value of HH and potentially loosen restrictions to skilled HH services. One of the providers interviewed stated that they have been sharing analytics on outcomes with MA plans and have found it to be helpful in broadening the plans' understanding of the value of skilled HH.

Opportunities for Home Health Care Innovations

Recent regulatory and legislative changes have allowed MA plans to offer new supplemental benefits, including home care, to beneficiaries meeting specific clinical criteria. Although, the interviewees were excited about the impact and opportunities these new benefits could have on the HH industry, they noted that the implementation of this policy will take time. As one interviewee pointed out, MA plans are still deciding how to address social determinants of health. On one hand, these benefits can help patients more seamlessly transition into the community; and community-based preventative care services, such as education for preventative care, immunization, and chronic care, can all be offered through HHAs. On the other hand, MA plans may be thinking of social determinants of health in terms of food insecurity and other community-based issues that fall outside of the scope of HH services.

Interviewees indicated that through these policies, MA plans can help address the needs of an aging population, and potentially realize a return on investment. By providing assistive services at home such as home health aides, MA plans can prevent future hospital costs through avoided injuries and readmissions. Interviewees emphasized the significant impact these services could have for patients

who are treated in SNFs primarily due to lack of at-home support. For example, one interviewee noted that for a beneficiary who needs at-home assistance while his/her caregiver is at work, it would be more cost-effective to pay for the 8 hours of at-home care than SNF care.

Overall, these new assistive services represent a major opportunity for HHA and MA plan collaboration. The interviewee indicated that they expected these regulatory changes to lead to an increase in HH utilization. However, all interviewees agreed the uptake of these services will be slow, and it is currently too early to say with certainty how significantly these policy changes will impact the HHA industry. One of the interviewees also cautioned that there is nothing in place to integrate home care into the care continuum, further highlighting the potential challenges in implementing the new supplemental benefits.

In addition to the new supplemental benefits, an interviewee pointed out that alternative payment models present another opportunity for HH providers to innovate and expand their services and care delivery. The interviewee stated that some of the larger HH providers were willing to try new models and enter into agreements where they take on risk. However, the interviewee suggested that MA plans have been slow to develop new payment models and have a lengthy and multi-layered approval process for developing such models.

New Supplemental Benefits in Medicare Advantage

Medicare Advantage Plans' Response to New Supplemental Benefits

To incorporate MA plan perspective in our study, we reviewed reports that include interviews with MA plans on the new supplemental benefits.

As mentioned above, over the last two years, CMS expanded the scope of home-based care in MA, allowing services “that increase health and improve quality of life, including coverage of home care, in-home supports,” and “address social determinants of health for people with chronic disease.” Similar to our interviewees, MA plans have largely viewed this new flexibility as a positive development that has allowed them to provide services that better address the health of their beneficiaries.⁴⁵ For example, compared to 2018, there has been an increase in the number of plans offering home and bathroom safety devices and modifications, over-the-counter benefits, and transportation in 2019.⁴⁶ Despite the increase in the total number in-home care services offered, the number of plans offering these benefit in 2019 remained low.¹⁵ While the majority of plans attributed this limited uptake to the short time that plans had to respond to CMS’s new regulations, in a set of interviews conducted by the Urban Institute, MA industry experts expressed concerns regarding the upfront cost, tradeoffs, and potential return on investment associated with new benefits.

These sentiments were echoed by MA industry experts at the Better Medicare Alliance’s MA Summit. Panelists emphasized that MA plans were operating with the same budgets as previous years, and as a result identifying services that would have the greatest impact on beneficiaries and provide the largest

return on investment was essential.⁴⁷ The Urban Institute report revealed that many insurers considered the cost of offering an additional benefit, and if they could offer this new benefit without removing an existing benefit.⁴⁵ When considering the potential tradeoffs, insurers also thought about the benefit of offering lower-cost benefits that could appeal to a broader population or investing in higher-cost benefits that could reduce spending for very high-cost beneficiaries. Additionally, many of the health insurers interviewed by the Urban Institute considered the future cost-saving benefits of offering additional benefits. However, some interviewees were uncertain that these new benefits would produce a significant return on investment and reduce hospitalizations and other medical costs.

MA experts also expressed concern about the scalability of these benefits and the availability of community-based organizations that can provide these supplemental benefit services in the Urban Institute Report.⁴⁵ As one Better Medicare Alliance's MA Summit panelist pointed out, for MA plans to offer benefits on a national-level, they would have to contract with hundreds of community-based organizations and teach all of them how to work with insurers.⁴⁷ Many MA plans have also expressed concern that CMS only allows benefits to be targeted based on clinical criteria rather than social need. One of the MA plans interviewed by the Urban Institute indicated that "social determinants [of health], with some reasonable guard rails, should be a trigger for a benefit."⁴⁵ Therefore, this policy constraint may also affect the utilization of the new services.

Anticipated Impact of New Supplemental Benefits

Based on these concerns, most MA plans are excited by the new opportunities that they have in addressing beneficiaries' healthcare needs but anticipate being cautious in their implementation of these new supplemental benefits. Researcher Anne Tumlinson emphasized that supplemental benefits are currently a relatively low priority for MA plans.⁴⁸ Especially for larger insurers, adding new supplemental benefits requires them to consider the cost, benefit, and feasibility of adding new benefits. Some researchers have specifically pointed out larger insurers' concern regarding the scalability of community-based organization services. However, Nicholas Johnson, a panelist at the Better Medicare Alliance Summit, said that home health care providers could expect to see smaller MA plans experimenting with these supplemental benefits sooner. These plans may view the benefits as a way to increase enrollment and/or tackle social determinants of health.⁴⁷

Due to these new supplemental benefits, there has been significant discussion surrounding when MA plans will start offering these new benefits *en masse*. At the Jefferies 2019 Healthcare Conference in New York, president and CEO of Addus HomeCare Corporation, Dirk Allison expressed disbelief that MA plans would represent significant business growth for HHAs in 2020. Allison stated, "We believe it's more of a 2021 event... I don't think that MA plans have the time to really put the thought in for 2020... Now that they have much more discretion as to how they add this benefit, we believe starting in [2021] — and on through the next three to five years — you can see a real impact for Medicare Advantage with personal care."⁴⁹ These sentiments were aligned with the perspectives of the researchers and providers we interviewed. However, a survey of 105 home health care providers conducted by Home Health Care News, found that 59 percent of providers were contracted with MA plans in 2019 and 90 percent

anticipated being contracted with MA plans in 2020.^{49,50} Overall, researchers believe there will be a steep learning curve for MA plans in the next few years as they try to understand the value of not only home health care, but there is an array of services they can now offer under these supplemental benefits.⁵⁰

Kenny Kan, a former enterprise vice president and chief actuary at Humana, emphasized that HHAs will need a payer outreach strategy if they want to work with MA plans. He emphasized how important proof of concept and return on investment are to these organizations, and suggested that in discussions with MA plans, HHAs consider the “Rule of 8”, 8 questions he believes insurers should ask themselves before deciding to offer an additional benefit: “what is the benefit; what is the targeted sub-population; what triggers benefit eligibility; how long is the benefit; how to measure return on investment and price; how to file and submit bids; how to change IT systems and administer the benefit; what happens if ROI results are not good.”⁵⁰ Similarly, researcher Nicholas Johnson noted that the cost-savings many HHAs consider are long-term care costs that are not covered by MA plans. As a result, he stated these organizations must focus on their ability to deliver quality care and connect with patients, as these elements can be as important as potential cost-savings.⁴⁷

Research Priority: Demonstrating the Value of Home Health Care in Medicare Advantage

Our review of the existing literature and interviews with key informants revealed an important need to understand the value of skilled HH in MA and demonstrate it to MA plans and other stakeholders. The review of existing literature highlights this need as there is limited research related to HH in MA. Among the studies that examined patient outcomes for MA beneficiaries, we found only one study that focused on HH patients and examined outcomes associated with HH in MA. Most of the studies examining outcomes associated with HH among Medicare population focus on TM and do not address whether HH utilization differences between TM and MA lead to differences in patient outcomes.

Our interviewees further underscored the need for a better understanding of the value of skilled HH in MA. One of the interviewees stated that there is no shared understanding of the role of HH among stakeholders of home-based care. Several interviewees stressed that MA plans, particularly those that are not integrated with a healthcare delivery system, do not have a full understanding of HH’s role in the broader care continuum and the benefits it offers to the MA beneficiaries and the MA plans. One of our key informants pointed out that the majority of MA plans are either unaware or do not understand that HH, specifically HHA, can improve patient outcomes (i.e. reduced readmissions or improved transitional care).

Demonstrating the value of skilled HH in MA could have implications on MA beneficiaries’ utilization of HH. As MA plans better understand the effects of skilled HH on patient outcomes and the cost savings that it generates within the broader care continuum, they may more effectively harness HH in the care of MA beneficiaries. For example, data that demonstrate the impact of skilled HH in reducing

readmissions can help MA plans more effectively use HH to support hospital discharges and transitional care. Furthermore, data on cost savings associated with skilled HH can show MA plans that HH can act as a lower-cost alternative to institutional care settings like SNFs, rather than an additional cost.

Assessing the value of HH would also help us better assess the utilization of HH in MA. Current literature suggests that HH utilization is lower among MA beneficiaries when compared to TM beneficiaries. However, it is not clear whether lower utilization among MA beneficiaries is a result of limited access to necessary care or appropriate care provision. An examination of patient outcomes among MA beneficiaries receiving skilled HH would reveal whether lower HH utilization in MA is associated with reduction in care quality.

Demonstrating the value of HH in MA involves addressing questions related to both quality and cost associated with HH. On the quality side, it would involve understanding the effect of skilled HH on patient outcomes, such as mortality and readmissions after hospitalization. On the cost side, it would involve estimating the cost savings that may result from reduced readmissions or other healthcare utilization associated with skilled HH use. This comprehensive approach to assessing the value of HH would show the extent to which HH is associated with improved patient outcomes and quality of care and the extent to which its costs are offset by any healthcare savings that it provides.

Data on healthcare utilization and outcomes of MA beneficiaries have been limited, partially contributing to the lack of research in this area. Researchers studying MA beneficiaries' utilization and outcomes have used MedPAR claims and assessment data (OASIS for HH assessments). Recently, CMS has started making MA Encounter data available. The availability of MA Encounter data provides an important opportunity to examine patient outcomes related to HH use among the MA population. A primary advantage of the MA Encounter data is that it provides information on healthcare utilization across the care continuum, including inpatient, outpatient, and professional services. Therefore, it allows one to examine the role of HH within the broader care continuum by examining outcomes and care costs over episodes of care and across care settings.

Conclusion

HH is an important care setting for Medicare beneficiaries. Prior studies on the TM population have found HH to be associated with lower readmissions and mortality following hospitalization or inpatient post-acute care stay. Studies on alternative payment models in TM further suggest that HH is a lower-cost alternative to institutional care and has the potential to reduce health care spending. Although MA currently covers about a third of Medicare beneficiaries and is expected to cover about half of the Medicare population in a decade, most of what we know about the role of HH in treating Medicare beneficiaries focuses on TM. Our review of the prior literature and interviews with key informants revealed an important need for a better understanding of the value of HH in MA.

Demonstrating the value of HH in MA from both the patient and payer perspective is a principal research priority for AHHQI. Research to date has found that the use of HH is lower in MA relative to

TM. Future research examining patient outcomes associated with HH in MA and TM is needed to understand whether this lower HH utilization in MA represents an efficient use of health care resources or barriers to access HH for MA beneficiaries who need HH.

Such research would also lead to a better understanding of HH's role in the broader care continuum, which would allow MA plans and other payers to use HH effectively in designing care delivery and payment models. Recent regulatory and legislative policy changes to MA supplemental coverage rules expand the scope of care that can be covered by MA beyond skilled HH. As MA plans implement and consider broadening the provision of HH services, it is crucial to have a clear understanding of what works and to disseminate these effective practices. Evidence on the value of HH can help MA plans identify the patient populations most likely to benefit from HH care and ensure their access to HH.

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