

Issue Brief: Medicare Advantage Facilitates Innovative Care in the Home

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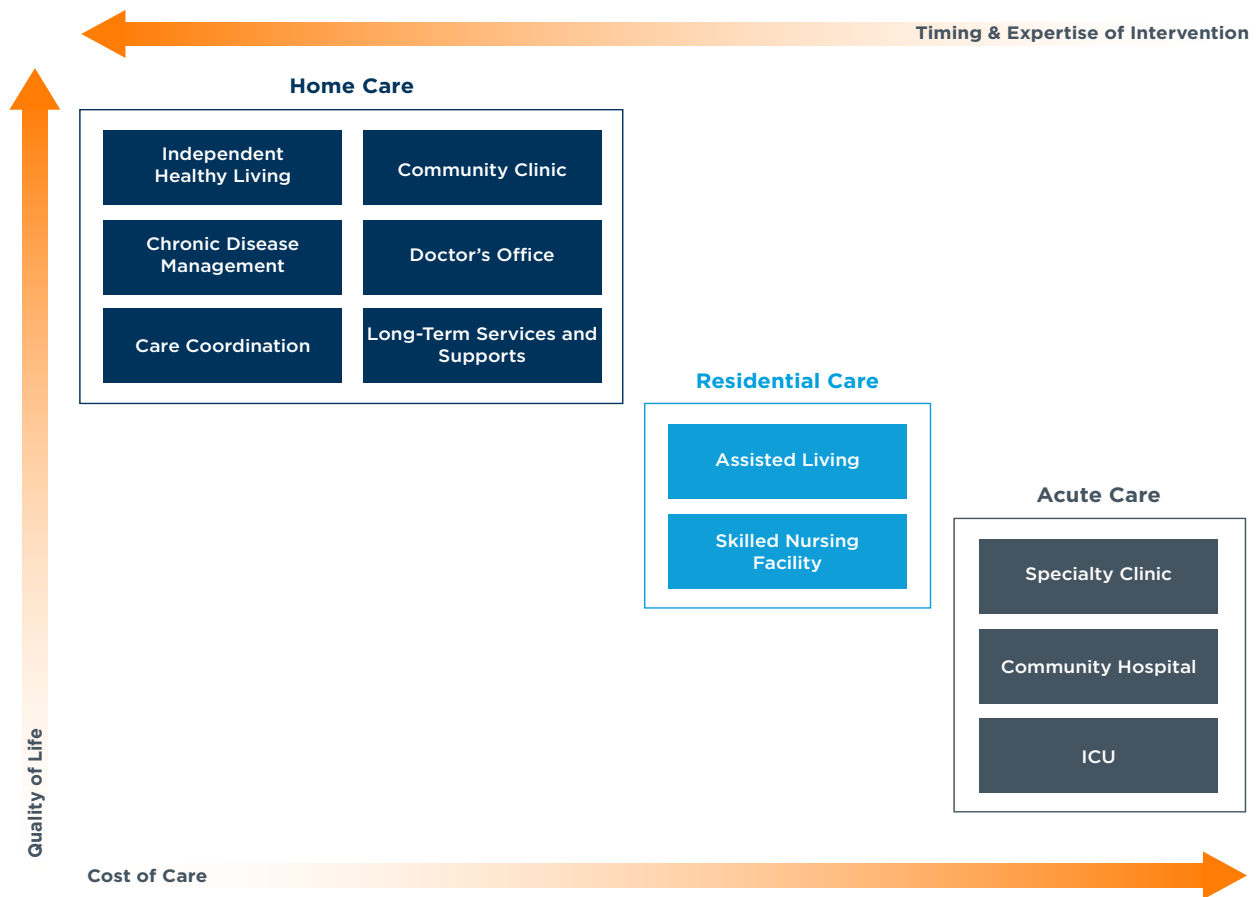
I. Overview

As the population in the United States ages, one of the greatest health care challenges will be ensuring older Americans can remain in their homes safely for as long as possible. Currently, an estimated 3.5 million seniors are homebound and in need of home-based care.¹ Research shows comorbidities, functional impairment, and inadequate social support can confine seniors to their homes. This population, particularly those who have one or more chronic conditions, is at a greater risk of hospitalizations and death.^{2,3} Care in the home is increasingly becoming a focus in the move to value due to increased quality outcomes, lower cost of care, and higher quality of life for patients who remain in their homes. Transitional care and care at home have proven to be effective ways of avoiding re-hospitalizations and improving outcomes.⁴ As figure 1 illustrates, home care can include independent living, to chronic disease management and care in the community.

II. Background

For decades, the United States has experimented with providing comprehensive and coordinated care at home to people with chronic illnesses. In the early 1900s visiting nurse associations provided life insurance company policyholders with care in the home to increase life expectancy. Then in the 1920s and 1930s institutions such as hospitals and private nursing homes began providing more care to chronically ill patients. Policies to formalize care in the home were adopted in the 1960s when Medicare, Medicaid, and the Older Americans Act (OAA)

FIGURE 1



Source: Eric Dishman, Intel Corporation (presented October 1, 2014, IOM-NRC Workshop on “The Future of Home Health Care”)

provided home health coverage to almost all Americans over aged 65.⁵ While home care opportunities were expanded, the scope of home-based care services was still limited. Home health care services through Medicare are limited to medically necessary, intermittent skilled care for homebound beneficiaries following a hospitalization. Medicaid did not add home and community-based services (HCBS) until the 1980s and then only through the waiver process for states. The OAA supports a wide array of programs and services, including in-home care, nutrition services, and transportation, however, funding is limited and there are often waiting lists for these services.⁶

Medicare payment and policy has an oversized impact on the use and availability of home-based services. In the 1980s and 1990s skilled home health care was one of the fastest growing services in Medicare. Rising home health spending led to changes in Medicare home health payments through the Balanced Budget Act of 1997. The law reformed the

Medicare home health services benefit, resulting in the development of a prospective payment system focused on a more targeted approach to home care.⁷ Health management organizations (HMOs) have been at the forefront of policy efforts to coordinate and integrate quality and effective home health services. Policymakers and practitioners continue to work on aligning fragmented finance and delivery systems across care settings and leveraging new flexibilities to attend to beneficiaries' health care needs.

“Home-based care” often refers to the spectrum of health and social services that can be provided in the home, and “home health care” often has the more specific meaning of the Medicare skilled home health benefit delivered by Medicare-certified home health agencies.⁸ Medicare Advantage, the managed care option in Medicare, provides access to a more integrated care system creating the opportunity to coordinate home health services with primary care. Unlike Traditional Fee-For-Service (FFS) Medicare, Medicare Advantage has the ability to partner with home health providers through risk-based contracts and community-based organizations to deliver care in the home to beneficiaries. Furthermore, beginning in 2019, Medicare Advantage health plans can take advantage of new flexibilities under the law to provide innovative care in the home as part of their benefit packages, with additional flexibilities expected in 2020 due to passage of the Bipartisan Budget Act.⁹

This issue brief discusses the types of care in the home available today under Medicare, Medicare Advantage, Medicaid, and the Older Americans Act, and highlights payer-provider partnerships with providers like the Visiting Nurse Service of New York (VNSNY) and Area Agencies on Aging (AAAs). These partnerships implement value-based care models that enable beneficiaries to age in place by addressing the health care needs of vulnerable seniors and people with disabilities. Given the expectation of future changes this brief describes the spectrum of home-based care innovations already under way.

III. Home Health Care Delivered Through Medicare and Medicare Advantage

How FFS Medicare Delivers Home Health Care

An estimated 90 percent of the nation's seniors would prefer to age in their own homes and communities.¹⁰ Many services once offered only in a hospital or doctor's office can now be provided in the home. The number of physician house calls to Medicare beneficiaries more than doubled between 2000 and 2006, although the percentage of physicians billing Medicare for at least one house call was still only around 5 percent.¹¹ Care in the home can help beneficiaries recover from an illness or injury while continuing to live independently. Examples of common skilled home health care services include wound care, nutrition therapy, and injections.¹² High-quality services can be delivered at a lower price when home is the site of care.

Home health care services may be covered under Medicare Part A (hospital) or Medicare Part B (physician) services. The FFS Medicare home health care benefit includes 60-days of services that can include skilled nursing care, home health aide services, physical therapy, speech-language pathology, and occupational services ordered by a doctor and administered by a home health agency. Medicare Part A and/or Medicare Part B may cover certain eligible home health services.

There are five basic requirements for a Medicare beneficiary to be eligible to receive home health care. The beneficiary must be homebound, require skilled care on a part-time or intermittent basis, have a plan of care with a doctor, have a face-to-face encounter with a doctor prior to the start of care or within 30 days, and the home health agency must be Medicare-approved. A Registered Nurse (RN) or Licensed Practical Nurse (LPN) can provide the skilled nursing services. The home health agency can also utilize therapists, home health aides, and medical social workers to meet beneficiaries' needs. Home health agencies specialize in providing in-home post-acute care as part of the hospital discharge planning process to prevent avoidable readmissions.¹³

Beneficiaries can search for home health agencies and compare quality ratings for different agencies through the “find a home health agency” tool on the [Medicare.gov website](#). The tool provides beneficiaries with ratings on how well a home health agency performs on nine quality measures that include how often the agency initiated patient care in a timely manner and how often the patient made improvements walking or getting out of bed. Beneficiaries have the right to choose their home health agency, receive a copy of their care plan, and participate in care decisions.¹⁴

Once a doctor refers a beneficiary for home health care services, the home health agency schedules an appointment to learn more about the beneficiary's needs. Home health staff evaluate beneficiaries' physical and emotional condition, pain level, nutrition, vital signs, prescription medications, and home safety. The home health care staff then work with the doctor to develop a care plan and keep the doctor updated on the patient's progress. The agency staff play an important role in providing care and educating beneficiaries and caregivers on how to continue care and identify potential complications.^{15,16}

The home health care agency provides the beneficiary with medical, nursing, rehabilitative, social, and discharge planning needs listed on the beneficiary's plan of care, while working with the beneficiary and their doctor to determine which services are necessary. The plan of care should include which services the beneficiary needs, which health care professionals should administer those services, and what medical equipment is needed to achieve the desired results from the treatment. Medicare home health care services are designed to deliver person-centered care and must be reviewed by the home health team and doctor at least once every 60 days.¹⁷

How Medicare Advantage Delivers Home Health Care

Medicare Advantage is required to provide all benefits covered by FFS Medicare. Home health care is provided based on specific criteria in FFS Medicare, which prevents Medicare from paying for long-term home health, meals, or personal care services.¹⁸ Unlike FFS Medicare, Medicare Advantage also provides early intervention, care coordination, and disease management based on a beneficiary's unique health care needs. Medicare Advantage health plans may also include additional, supplemental benefits that can improve care in the home, such as telemonitoring, in-home safety assessments, post-discharge in-home medication reconciliation, and home delivered meals immediately following an inpatient hospital stay.

Medicare Advantage also conducts health risk assessments (HRAs), commonly delivered in a beneficiary's home, to assess their health status and health care needs. HRAs are a tool that can help develop a care plan and address gaps in care through health education, preventive care, and follow-up care. The Affordable Care Act requires HRAs to be part of the FFS Medicare annual wellness visits.¹⁹ Medicare Advantage health plans often take a more proactive approach to offering HRAs. Many HRAs are conducted through a home visit with a nurse practitioner (NP) who reviews a patient's medical history, measures vital signs, reviews medications, conducts blood or urine tests, and assesses risks for falls or other hazards in a beneficiary's home.

An HRA conducted in the home can provide a more complete picture and a unique perspective of environmental and social factors that may be impacting a beneficiary's health. HRAs also aid in identifying the most appropriate care in the most appropriate setting. For example, a recent study found that in UnitedHealth Group's in-home clinical visit HouseCalls program participants experienced reductions in hospital admissions, lower nursing home admissions, and increased specialist visits.²⁰ Studies have also shown that HRAs can successfully identify and address unmet care needs by increasing the use of provider visits and improving medication adherence particularly for beneficiaries with chronic conditions.^{21 22}

Historically, Medicare Advantage health plans have been limited in their ability to offer supplemental in-home benefits and services beyond what is covered by FFS Medicare.²³ However, several policy changes enacted in 2018 will expand the types of benefits Medicare Advantage health plans are able to offer beginning in 2019, including more opportunities to facilitate and provide care in the home. On February 9, 2018, the Bipartisan Budget Act of 2018 was signed into law enabling Medicare Advantage plans in 2020 to provide supplemental benefits specifically tailored to chronically ill enrollees.²⁴ Furthermore, in April 2018, the Centers for Medicare & Medicaid Services (CMS) finalized proposals to allow health plans to tailor supplemental benefits to beneficiaries with certain disease conditions.^{25 26} This new rule also expanded the scope of allowable supplemental benefits in Medicare Advantage to include additional types of in-home supplies and services not currently offered.

Specifically, the supplemental benefits Medicare Advantage health plans can offer in 2019 may include non-skilled home-based support services and home modifications to assist beneficiaries with disabilities and or medical conditions in performing Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL). Allowable supplemental benefits must compensate for physical impairments, improve the functional/psychological impact of injuries or health conditions, or reduce avoidable health care utilization. Home-based palliative care services to diminish the symptoms of terminally ill beneficiaries with a life expectancy of more than 6 months not covered by Medicare, such as palliative nursing and social work services, are also allowable supplemental benefits. In addition, Medicare Advantage health plans will have the unique ability to reduce cost sharing and provide additional benefits to a targeted subset of their enrolled populations with certain medical conditions. The policy changes made by Congress and CMS provide Medicare Advantage with additional flexibilities to offer benefits that enhance beneficiaries' quality of life and improve health outcomes through care in the home.²⁷

IV. Models of Care in the Home

Visiting Nurse Service of New York

ABOUT VNSNY

VNSNY is the nation's oldest and largest not-for-profit home- and community-based healthcare organization, with more than 65,000 individuals under its direct and coordinated care on any given day. Founded in 1893, VNSNY is dedicated to improving the health and well-being of people of all ages and economic means through a continuum of high-quality, cost-effective home and community-based services with disciplines spanning the fields of skilled nursing, paraprofessional services, chronic and acute care management, rehabilitation therapies, behavioral health care, and palliative and hospice care.

Due to its size, scope and multifaceted role, VNSNY has years of experience as both a payer and provider. VNSNY's mission is to help the most vulnerable New Yorkers live safely and independently for as long as possible in their homes and communities, by:

- Promoting the health and well-being of beneficiaries and families by providing high-level, cost-effective health care in the home and community;
- Being a leader in the development of innovative services that enable people to function as independently as possible in their community;
- Helping shape health care policies that support high-value home and community-based services;
- Continuing a tradition of charitable care.

As a mission-driven provider of comprehensive community-based care, VNSNY comprises multiple entities that include:

- Medicare Advantage and Medicaid managed care plans (VNSNY CHOICE),
- VNSNY's Certified Home Health Agency (VNSNY Home Care),
- VNSNY Hospice and Palliative Care,
- Licensed Home Care Services Agency (Partners in Care).

VNSNY has over 30,000 patients in its care through its provider programs and 40,000 members under its coordinated care through VNSNY CHOICE Health Plans. VNSNY staff speak more than 50 languages and include nearly 1,500 registered nurses and LPNs, over 400 rehabilitation therapists including physical, occupational and speech therapists, nearly 400 social workers, and over 60 other clinical professionals including physicians, psychologists and nutritionists. In addition, VNSNY operates a paraprofessional Home Health Aide workforce of over 10,000.

Home Health Services Delivered Through Medicare and Medicare Advantage

VNSNY provides home health care to seniors with complex medical needs, seniors returning home after surgery or an injury, and seniors with disabilities or chronic illness, who can live independently with some help. Home care services may include nursing, rehabilitation therapy, care coordination, and support from a home health aide for activities of daily living such as meals, bathing, and dressing. Skilled nursing services are designed to reduce avoidable re-hospitalizations and lower hospital lengths of stay by coordinating care, managing pain, and providing instructions for disease self-management. VNSNY also offers behavioral health and dementia management through evidence-based screening tools and individualized treatment plans with an interdisciplinary team that provides medication management, counseling, and community supports. Additional in-home telehealth solutions track patient's health information and monitors chronic illnesses to reduce hospitalizations. Other specialized care can include pain management, infusion therapy, and mental health counseling.

Innovations in Home Health Through Case Rate Payment Arrangements in Medicare Advantage

As health care payment moves toward a focus on value over volume, VNSNY plays an important role as the largest and broadest mission-driven home and community-based organization in the country with integrated care coordination expertise. Through its care management approach, VNSNY has demonstrated success in shortening the inpatient length of stay, increasing patient satisfaction, and reducing re-hospitalizations as well as avoidable hospitalizations. This organizational ability to connect community-based care on multiple levels with much-needed care coordination makes VNSNY a unique partner in the move towards value.

Across its affiliates, VNSNY is partnering with Medicare Advantage to forge innovative models of efficient, quality care delivery and provider and payer partnerships, including value-based payment models, bundled payment initiatives, utilization management, and a range of community-based behavioral health services. These models support various populations, including patients who are considered at high-risk levels, and provide “in-home and remote” care management services that provide clinical care coordination to patients with serious mental illness and multiple chronic conditions.

In 2016, VNSNY became one of the first home care providers to manage post-acute episodic care through managed care contracts. Today, VNSNY also manages post-acute episodic risk up to 90 days post discharge outside of a Medicare demonstration. Through this innovative model, VNSNY delivers efficient, quality care through a provider and payer case rate payment partnership for 90 days post-discharge, taking on both upside and downside risk.

Currently, more than 30% of managed care patients served by VNSNY Home Care are in one of these “case rate” financial arrangements, with a goal to reach 90% by the end of 2019. Through these arrangements, VNSNY is responsible for delivering post-acute interdisciplinary clinical care, as well as care management and utilization management for 30-, 60-, or 90-day intervals at a set payment rate. Case rate arrangements include evaluation based on quality metrics, primarily focused on reducing hospitalizations, tied to incentive payments. Based on performance against established benchmarks, VNSNY may receive bonus payments or incur penalties if targets are met or missed, adding both upside and downside risk to the value-based contracts with Medicare Advantage health plans. Preliminary results from VNSNY’s case rate contracts show that self-reported rehospitalizations were reduced, and that VNSNY’s care management program exceeds target engagement rates and reduces service utilization.

VNSNY ensures the patient’s recovery stays on track, and that complications — especially those requiring readmission to the hospital — are avoided. As a result, health plans benefit from higher quality patient care at a lower cost. To support this work, VNSNY has developed simple billing and payment systems with unique fee schedules, carve-outs, and protection from outliers. Finally, VNSNY manages internal cost controls around purchasing supplies, equipment and real estate to decrease operating costs and improve margins on shared revenue.

VNSNY has standardized and integrated real-time, near-time and lag-time data into trend dashboards to monitor care, hospitalizations, risk/acuity level, payment reconciliation, and utilization by provider. Data sources are integrated from patients, clinical care (medical, behavioral, lab, dental), claims, health risk assessments, biometrics, and socio-demographics. This data supports VNSNY’s proprietary predictive risk models by providing care managers with actionable intelligence. In addition, VNSNY shares data with health plans through secure messaging and data sharing agreements. Providing care coordination through a number of value-based payment initiatives, VNSNY’s innovative, integrated care management platform promotes accountability for the quality, cost and overall care outcomes for populations across the continuum of post-acute and community settings.

Area Agencies on Aging

ABOUT N4A

The Older Americans Act (OAA)— enacted in 1965, the same year Medicare was established— provides funding for home and community-based services, such as home-delivered meals, in-home services such as personal care, chore and homemaker services, and caregiver support. The OAA is administered by the Administration on Aging (AoA), which is part of the Administration for Community Living within the Department of Health & Human Services (HHS), implemented by the state and local entities that comprise the Aging Network

The National Association of Area Agencies on Aging (n4a) is a membership association of these local Aging Network entities also known as triple-As (AAAs). AAAs provide access to local resources, programs and services to help to support older adults to remain healthy and independent at home and in the community for as long as possible. Working with local provider partners to deliver services, AAAs fund, develop and direct the distribution of supports such as nutrition, transportation, in-home help (e.g., bathing, chores), case management and much more. Additionally, AAAs can offer evidence-based health promotion and disease prevention programming to prevent falls, manage chronic conditions and address other issues common in the aging population that drive up costs. As more and more evidence connects the social determinants of health to overall health costs and outcomes, AAAs are increasingly working with health care partners (e.g., health care systems, plans and hospitals) to deliver these evidence-based programs and HCBS to Medicare beneficiaries with high-needs and complex health issues.

n4a leads the Aging and Disability Business Institute (Business Institute) to assist AAAs and other community-based organizations (CBOs) pursuing partnerships with health care providers and payers. The Business Institute helps AAAs capitalize on value-based care payment and delivery models, and think strategically about how to engage with Medicare Advantage plans on the new flexibilities related to health-related supplemental benefits. By developing relationships with Medicare Advantage plans, AAAs can provide expertise, data and relationships to help health plans better serve the community.

AAAs Partner with Managed Care Organizations Through Medicaid and Medicare

AAAs deliver home-based care through partnerships with managed care organizations. According to a national survey of AAAs from 2016 approximately 38% of community-based organizations have a contract with a health care entity, and roughly 5% of respondents currently contract with Medicare Advantage health plans. The most common services delivered include homemaker, personal assistance, and home repair or modifications.²⁸ AAAs have experience identifying environmental hazards, administering evidence-based disease prevention and health promotion programs, and delivering health-related social supports in the home. A recent study found areas where AAAs maintained partnerships with a broad range of health care organizations had significantly lower hospital readmission rates.²⁹

AAAs' experience and expertise provide valuable community-based insights for managed care organizations. Many of the managed care partnerships with AAAs serve beneficiaries who are eligible for Medicaid or dually eligible for both Medicaid and Medicare. Individuals eligible for Medicare and Medicaid due to income receive Medicare benefits, and wrap-around Medicaid benefits for additional services, such as long-term in-home and nursing home care. Dually eligible beneficiaries can receive care through FFS Medicare, or through Medicare Advantage and Medicaid. Specialized care can also be delivered through Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs). These Medicare Advantage health plans exceed core FFS Medicare benefits, by providing reduced cost sharing, individualized care plans, and other tailored benefits related to mental health, social services, and wellness.

Dually eligible beneficiaries are more likely to receive long-term in-home supports from Medicaid which is the primary payer for long-term services and supports (LTSS) that include HCBS to help seniors and people with disabilities remain in their homes. Some states have capitated (monthly payment) arrangements to provide managed LTSS through Medicaid. As of June 2018, 21 states had a managed LTSS program.³⁰ In 2014, 53% of all Medicaid long-term care spending was on HCBS.³¹ As the primary payer for LTSS, Medicaid works with states to support beneficiaries with disabling conditions and chronic illnesses to provide care that increases independence. HCBS have accounted for a significant portion of Medicaid LTSS growth in the past several years illustrating the movement towards care in the home.³² According to 2016 data, 54.6 million beneficiaries were enrolled in a managed care organization.³³ Increasingly managed care is becoming the mechanism to deliver Medicare and Medicaid in home services.

AAAs Partner with Managed Care Organizations Through the Financial Alignment Initiative

While over half of Medicaid beneficiaries receive coverage from a managed care organization, a barrier to coordinate care for dually eligible beneficiaries is financial alignment between the Medicare and Medicaid programs. The Center for Medicare and Medicaid Innovation (CMMI) Financial Alignment Initiative (FAI) for dually eligible beneficiaries, also known as the duals demo, is working to address this issue by testing models in states to better integrate primary, acute, behavioral health, and long-term services for dually eligible beneficiaries. Health plans offered through the FAI are called Medicare-Medicaid Plans (MMPs). These health plans are designed to deliver expanded home-based supplemental benefits to beneficiaries, often in partnership with managed care organizations. MMPs have additional flexibilities beyond FFS Medicare, Medicare Advantage and FFS Medicaid.

The FAI can be administered through either a Capitated Model between CMS, a health plan, and a state in a three-way contract, or a Managed FFS Model, between CMS and a state.³⁴ A 2017 report found low-income disabled beneficiaries said their care improved through MMPs health plans that coordinate care and integrate medical, LTSS, and behavioral health care services.³⁵ More coordinated care is also delivered through comprehensive risk assessments, navigation assistance to access services, and timely preventive care. The FAI also provides the opportunity to deliver expanded supplemental benefits that can include home health, dental coverage, and Part D prescription drug benefit cost-sharing reductions.³⁶

Key elements of MMP health plans like care coordination, increased preventive care, and flexible supplemental benefits are like elements found in Medicare Advantage health plans, which makes AAAs' experience with managed care organizations through the FAI valuable. AAAs are contracting with MMP health plans to deliver additional services to dually eligible beneficiaries.³⁷ For example, AAAs are providing beneficiaries with care management in Ohio, community outreach workers in Texas, and benefits counseling in Massachusetts. The FAI is providing AAAs with experience contracting with health plans to deliver services, report on outcomes, and expand networks.³⁸ The examples of AAAs working with MMP health plans below illustrate a growing number of opportunities to develop partnerships between health plans and community-based organizations.

Elder Services of the Merrimack Valley

Beneficiary Story

The Elder Services of the Merrimack Valley is working with Mr. D. He is 59 years old, single, and a heavy smoker. He suffers from a herniated disc, curvature of the spine, anxiety disorder, and poor nutrition. Mr. D is socially isolated and lacks interaction with family members. He was referred to Elder Services of the Merrimack Valley because he faced eviction due to hoarding, collecting large snakes, and removing smoke detectors placed in his apartment.

After several home visits the LTSC built a relationship with the beneficiary and helped him realize that without further assistance he would be evicted. Together they developed care goals to help him avoid eviction, which included identifying a new primary care physician, eye doctor, and dentist, in addition to improving his eating habits. The LTSC shared the care goals with the CCA care manager, NP, and Health Outreach worker care team.

With the help of his care team, Mr. D now has a primary care physician and his nutrition has improved. The LTSC has set up heavy chore services and secured the services of a Hoarding Specialist to visit him once a week to get his apartment up to code before his housing inspecting. The LTSC and Health Outreach Worker from CCA continue to spend time with Mr. D to ensure he has access to the health care and emotional support he needs to remain in his home.

In 2012, CMS announced a partnership with Massachusetts through the FAI to test a new model for providing more coordinated care to dually eligible beneficiaries aged 21 through 64. The demonstration, called “One Care: MassHealth plus Medicare,” enables CMS to enter into three-way contracts with the state of Massachusetts and One Care plans to test a capitated financial alignment model. The demonstration facilitates the use of additional health care, behavioral health care, and care coordination services to disabled beneficiaries in Massachusetts.³⁹

The Commonwealth Care Alliance (CCA) offers an MMP plan in Massachusetts, which provides certain services outside of the plan network and has over 17,000 beneficiaries.⁴⁰ The plan delivers integrated Medicare and Medicaid benefits to help beneficiaries live safely and independently at home. The CCA One Care health plan is one of the top-rated MMP plans in the country with benefits that range from dental care, to transportation, to behavioral health and long-term home services at no cost to beneficiaries.⁴¹

Elder Services of the Merrimack Valley, an Area Agency on Aging in northeastern Massachusetts, works with CCA to provide care coordination services through the FAI. The AAA based in Lawrence Massachusetts serves seniors and disabled adults in the northeast portions of the state to support individuals’ desire to live independently in their community in safe living arrangements with access to quality health care services. The AAA provides a Long-Term Support Coordinator (LTSC) to develop an individualized care plan and coordinate the services that enable individuals to continue living at home through a range of high-quality and low-cost in-home services.⁴²

Elder Services of the Merrimack Valley estimates that at any given time there are between 7,000 and 8,000 people in the community that could be enrolled in the services they provide. The challenge is not identifying the people in need, rather in comprehensively addressing their needs. The AAA plays a valuable role in the community coordinating services such as in-home meal delivery, homemaker assistance, and personal care services to help people maintain their independence and live safely in the community. The health system is increasingly looking to community-based organizations to manage social determinants of health. These programs present opportunities to learn from the dually eligible population to leverage additional flexibilities and deliver high-value care to Medicare Advantage beneficiaries.

Direction Home Akron Canton

In 2012, CMS announced a partnership with the State of Ohio to test a new model to deliver more coordinated Medicare and Medicaid benefits through contracts with health plans. The demonstration called MyCare Ohio is an integrated delivery system that manages Medicare and Medicaid benefits, including long-term care and behavioral health services. The FAI demonstration was launched in Northeast Ohio in May 2014 and now serves over 100,000 residents in 29 counties.⁴³ MyCare Ohio MMP health plans provides an interdisciplinary care team with care managers, primary care providers, and specialists available through a single point of contact.⁴⁴

Beneficiary Story

Direction Home Akron Canton is working with a senior gentleman who lives alone in his own home. His family lives in the state, but not nearby. He has Congestive Heart Failure and Chronic Obstructive Pulmonary Disease. A care manager with the AAA works with him to manage his chronic conditions.

Last fall his furnace went out. The care manager was able to connect him with community resources to repair his furnace, so he could stay in his home. Working with the community, health plan, and state, the AAA made the case that the furnace costed \$5,000 and a nursing home could cost \$5,000 every month. The investment is helping the beneficiary successfully age in his community.

Through MyCare Ohio, health plans must contract with AAAs like the Direction Home Akron Canton Area Agency on Aging & Disabilities (Direction Home Akron Canton) to coordinate benefits for enrollees who are 60 or older. The AAA works in partnership with health plans that also offer Medicare Advantage to deliver care coordination services. Direction Home Akron Canton is a private, non-profit organization specializing in serving as a central access point to help older adults and people with disabilities meet their long-term care goals and remain in home or community-based settings. Health plans must conduct beneficiary assessments to develop care plans and may use AAAs to conduct comprehensive assessments on behalf of the health plan.⁴⁵

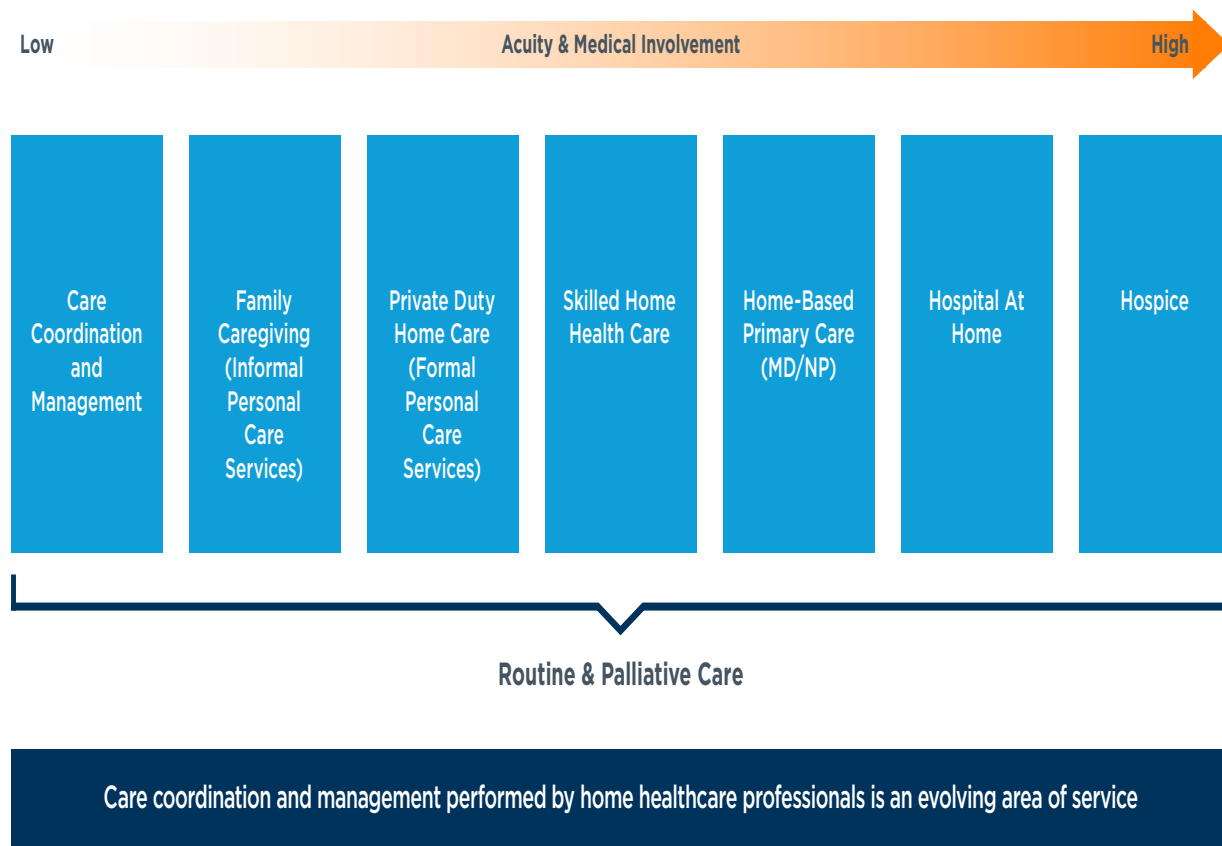
As a contracted provider for MyCare Ohio, Direction Home Akron Canton is working with beneficiaries to assess eligibility for assistance and managing and coordinating long-term care services.⁴⁶ The AAA provides care management services by helping beneficiaries enrolled in a health plan, developing a care plan and ensuring the beneficiary receives necessary services like home delivered meals, an emergency response system, and personal care services. Direction Home Akron Canton works with the beneficiary to develop a person-centered care plan that is shared with the health plan and care team. Their care managers are uniquely positioned to monitor the beneficiary's health at home and provide boots-on-the-ground insights into necessary health and community services. Care managers are either licensed social workers or RNs that coordinate services and help make clinical decisions to ensure all aspects of a beneficiary's life, from bathing to pet care, are captured in the care plan.

Through work with managed care plans, Direction Home Akron Canton has transitioned to a pay-for performance risk-based mindset. Now that health plans are the organization's primary funder, the AAA is working to get the health system to break down operating silos to better coordinate care for beneficiaries. After 4 years of experience Direction Home Akron Canton is seeing progress integrating the person more effectively with the medical system. The AAA has seen non-medical interventions deliver value-based care, and hospital readmissions and emergency department visits go down due to capitated (per member per month) payments and alternative payment models. Medicare Advantage can continue to drive these positive outcomes by expanding available care in the home and leveraging Direction Home Akron Canton learnings from MyCare Ohio.

V. Innovations in Care in the Home For Older Adults

Policy shifts toward more value-based, integrated care are enabling innovative delivery models, around hospital in the home, care management in the home, and telemedicine and remote patient monitoring, increasing interest in delivering care in the home. As a result, consumers and caregivers are increasingly demanding tailored and on-demand home-based services. As figure 2 shows, home-based care can range from care coordination, to more intensive hospice. Home as the site of care is expected to grow in popularity as the baby boomers age in place.

FIGURE 2



Source. Avalere Health, 2016.

Hospital at Home

Health systems are increasingly offering a hospital-level care in the home, even though reimbursements may not cover the full cost of care. Mount Sinai's seven-hospital system in New York has had a Hospital-at-Home program since 2014. The program, which includes VNSNY as a home care partner, has involved more than 700 patients who have chosen home instead of hospital care, resulting in 2.2 fewer days of acute care, and 8.5% lower readmission rates over two years.⁴⁷ In addition, Boston Brigham Health is one of several health systems in the country that encourage frail patients who are stable and don't need intensive care to choose hospital-level care in the home. A study of the program found home-hospitalization reduced costs, utilization, and improved physical activity.⁴⁸

In 2005, researchers at the Johns Hopkins Schools of Medicine and Public Health successfully tested a hospital at home model with Medicare Advantage health plans. Nearly 70% of patients in health systems where hospital at home care was offered chose to receive care in the home over acute hospital care. The results of the test found the model of care was practical, safe, and effective for community-dwelling seniors who required admission to an acute care hospital for pneumonia, exacerbation of chronic heart failure, exacerbation of chronic obstructive pulmonary disease, or cellulitis. The average cost was lower to deliver hospital at home care and there was evidence that patients had fewer complications.⁴⁹ A 2012 study at Albuquerque, New Mexico-based Presbyterian Healthcare Services provided acute hospital care to Medicare Advantage and Medicaid beneficiaries in their homes. The study achieved 19 percent savings and advanced the quality and affordability of patient-centered care in the home.⁵⁰ Another study published in 2018 found hospital at home care bundled with 30-day postacute transitional care was associated with better outcomes compared to care with inpatient hospitalization.⁵¹ Increasingly payers and providers are learning about the benefits of care for beneficiaries through a hospital at home.

Care Management in the Home

There are a number of innovative care in the home options and Medicare Advantage is at the forefront of integrating home and community-based services into Medicare. In April 2018, Humana announced a partnership with Landmark, a leader in the delivery of home-based medical care for beneficiaries with complex chronic conditions. Beneficiaries will be able to receive in-home medical, behavioral, and palliative care coordination programs through Humana Medicare Advantage. Expanded services will include 24/7 house-call visits, post-hospital visits to assist with transitions back into the home, care coordination with the primary physician or specialist, and maintenance visits to proactively monitor the beneficiaries home to make sure conditions are suitable for in-home care. The partnership is another step toward integrating care that is expected to increasingly include in-home care and technology through health system partnerships with the community.⁵²

Temple Health, one of Philadelphia's leading academic medical centers, has several innovative programs that utilize community health workers to manage care for high-risk patients in the home. The Community Health Worker Program utilizes non-clinical staff trained to assist beneficiaries with navigating the health care system. Temple identifies patients at risk of utilizing the ER or being readmitted to the hospital and assigns a community health worker to manage the patients' care in partnership with Medicare Advantage health plan care managers. The community health worker does an assessment of the patients' home and helps address social determinants of health such as food insecurity and transportation, while managing follow-up care with providers. In addition, the Longitudinal Care Management Program assigns a nurse navigator and community health worker to a patient before they are discharged from the hospital to manage care once the patient is back at home. These programs in partnership with Medicare Advantage have led to lower hospital admissions, lower readmissions, and cost savings for the health care system. It's expected that programs like this will grow and expand as the health care system continues to shift from volume to value.

Telemedicine and Remote Patient Monitoring

Telemedicine is changing the way high-quality care in the home is delivered. Remote patient monitoring, and real-time telehealth visits can prevent seniors and people with disabilities from leaving their home to receive care. Technology can deliver actionable information to beneficiaries, providers and health plans. Access to the internet, particularly among older adults is continuing to expand and data-driven care delivery models utilizing telemedicine and remote patient monitoring are showing progress. For example, remote monitoring can track intracardiac pressures and heart rate in patients with congestive health failure that can facilitate early intervention and help avoid hospitalizations.⁵³ The expansion of care in the home will depend on health care systems' ability to leverage technology, data, workforce and payment policies to deliver high-value home care to consumers

VI. Conclusion

Care in the home is being increasingly utilized to deliver care efficiently and deliver high-quality health outcomes. As care in the home continues to expand, Medicare Advantage health plans are well positioned to leverage new flexibilities around supplemental benefits and benefit design to integrate community-based care in the home. Organizations have experience delivering evidence-based health interventions in communities across the country to facilitate expanded home-based care. New models outlined above suggest innovative ways to deliver care in the home and link patients to needed medical care.

The evidence clearly shows partnerships between Medicare Advantage health plans and community-based organizations or private vendors can improve outcomes for beneficiaries and lower costs for the health care system. These partnerships address social risk factors and manage chronic conditions to meet beneficiaries' expectations of receiving the necessary care to remain in their own homes. Medicare Advantage provides a more flexible framework with opportunities to expand the delivery of innovative care in the home that allows seniors and people with disabilities to live healthier lives in their homes and communities.

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