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Home Is Where the Healing Happens:

Uniting Medicare Advantage Payers and Providers to Create Value

Market Corner Commentary
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Payers and providers are directing an increasing proportion of Medicare and Medicare Advantage (MA) patients into home health and fewer into traditional skilled nursing (SNF) and other post-acute care (PAC) facilities. This is a powerful trend. McKinsey estimates "up to $265B worth of care services for Medicare FFS and MA beneficiaries could shift from traditional facilities to the home by 2025." [1]

This shift to home-based care delivery is a once-in-a-generation opportunity for both payers and providers to seize market share. Health companies will win by delivering right-sized, right-site and right-cost care for millions of post-acute patients while enhancing quality, convenience and human dignity.

A convergence of forces is accelerating this return to home-based care. During the pandemic, demand for PAC facilities evaporated due to consumers' safety and quality concerns. Rapid provider and consumer adoption of digital tools for coordination, monitoring and virtual care facilitated remarkable shifts to virtual and home-based care.

Staffing shortages and ballooning labor costs compounded cost and quality challenges among traditional PAC providers. Finally, as Medicare Advantage enrollment has continued to increase among aging baby boomers, MA plan sponsors have financial incentives to steer chronically ill, aged and post-acute patients into home care – particularly since high percentages of aging boomers prefer home-based care.

The old model for care transitions – from hospital inpatient to post-acute — has been deteriorating for some time. Its opaque referral and payment characteristics frustrate both payers and providers alike. High-quality providers rarely receive adequate payment. Well-intentioned payers face challenges trying to consistently, accurately distinguish among high- and low-quality providers. Lacking alternatives, they often default to lowest-common-denominator payment mechanics.

For the movement to high-quality home-based care to take root and expand, payers and providers must align to serve patient/beneficiary needs and deliver high-quality, high-touch care. This requires better data and analytics and aligned payment incentives. Fortunately, informed and capable intermediaries are emerging to bring innovative payers and high-quality providers together to deliver superior outcomes, meet consumer demand and fuel growth.

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TRUTH & CONSEQUENCES OF FRAGMENTED POST-ACUTE CARE

A century ago, hospitals were a last resort, and most care took place in the home. The more affluent hired doctors, nurses and midwives, while benevolent societies employed traveling nurses to care for the sick-poor and contagious. As healthcare in America institutionalized, payment systems minimized the need for and funding of high-quality home-based care.

Medicare and Medicaid's enabling legislation, passed in 1965, included homecare as a "medically necessary" service for some patients but not the chronically ill. Subsequently, a convoluted system of public and commercial payment evolved to subsidize a fragmented system of providers delivering post-acute care services primarily in facilities but also at home.

In the ensuing decades, periodic efforts to integrate and coordinate more comprehensive home-based services for the aged and chronically ill failed to create an effective PAC system. Business models that optimized revenue generation over care outcomes predominated. Budget cuts in the late 1990s slashed public funding for home care, causing one in five traditional home health agencies to cease operations. [2]

The Affordable Care Act in 2010 reintroduced funding for home healthcare services for seniors and reduced extended hospital, SNF and PAC stays. By 2017, 3.4 million Medicare beneficiaries were receiving home-health care services. [3]

However, traditional Medicare and Medicaid fee-for-service (FFS) payment remains a major barrier to better home-health care. Policy makers have designed alternative payment models to lower costs, improve quality and encourage more integration between home-health agencies and health systems with mixed results. Providing widespread access to appropriate, holistic and coordinated PAC care remains a challenge.

Studies of Medicare's Shared Savings and Bundled Payments for Care Improvement programs have shown that providers achieve most of their overall savings by replacing institutional

post-acute care with home-health care. Similarly, Medicare Advantage programs also gain most of their savings (relative to traditional Medicare) by reducing utilization of post-acute facilities. [4] The authors of this New England Journal of Medicine study highlight the flaws embedded in this approach to cost savings,

> ***Why is post-acute care the "piggy bank" for savings in new payment models? Evidence shows that for most episodes of care involving a hospital admission, money spent on post-acute care represents the largest source of variation in spending… Where patients receive post-discharge care is driven as much by facility availability as by clinical severity, and in many borderline cases, patients can probably be discharged home instead of to an SNF.***
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> ***What's more, post-acute care providers typically aren't part of larger healthcare systems. If hospitals or physician group practices can reduce Medicare spending by lowering SNFs' revenue rather than their own, the result is a financial win–win for them and overall spending, albeit at the expense of SNFs. [5]***

The incentives and opportunities for directing more patients to home care are growing. However, quality remains inconsistent. Payment models can incentivize hospitals and MA plans to

direct patients to home-based care even when institutional care would generate better outcomes. Moreover, the quality of home-health care providers varies widely. Hospitals and health plans often lack the data to distinguish the difference.

An unintended consequence of alternative payment models is that they incentivize SNFs and home-health providers to accept healthier, better-insured and higher-margin Medicare beneficiaries over sicker, less-well insured and lower-margin Medicaid beneficiaries. This structural defect in payment mechanics reduces care access and quality for lower-income individuals. It is also morally unacceptable.

BUILDING A HEALTHIER HOME HEALTH MARKETPLACE

In 2017, Humana (with PE groups TPG Capital and Welsh Carson Anderson & Stowe) acquired Kindred Healthcare for $4.1 B, making a significant bet that home healthcare would become an even more important component of coordinated care management. [6] In 2022, UnitedHealth Group (UHG) announced its deal to acquire LHC Group, the home-health provider, for $5.4B, creating the nation's largest home-health company.

More recently, CVS announced its acquisition [7] of Signify, a major player in home-health evaluations. While not a home-health care provider, Signify will help CVS's Aetna division determine the risk-adjusted total cost of care for MA beneficiaries. CVS expects to serve 2.5 million beneficiaries through annual in-person and virtual health assessments, and to leverage technology and analytics to coordinate follow-up care and social services. Ultimately, this may be a major step in CVS's expansion into the home health care delivery market.

National PAC platforms, such as those already assembled by Humana and United, can improve coordination, quality and accountability. Networks of higher-value providers facilitate patients receiving appropriate care. Payers contracting with high-quality providers can both reduce their total care costs and improve member experience. However, not even huge national players like Humana, United/LHC, Amedisys (and others) have sufficient geographic coverage and staffing necessary to serve all home-health patients. And many providers and plans will not see integration as desirable or even possible.

MA reimbursement rates are often lower than traditional Medicare FFS payments. MA plans see a need to more aggressively manage cost on post-acute care services while bearing higher total-care costs from acute readmissions. Raising payment to high-quality home-care providers can create value for MA plans and their members, particularly for more acutely and/or chronically ill patients.

For these value-driven care transitions to occur consistently, high-quality PAC providers need more cost certainty from MA plans as incentive to admit a higher percentage of MA plan beneficiaries. Otherwise, they'll default to serving more traditional Medicare patients. Likewise, MA plans need more information about providers to select, in a timely manner, those that can deliver quality outcomes while still maintaining reasonable margins.

The fundamental problem with the PAC market is information opacity, as the CVS-Signify deal indicates. With robust data on patients' medical status and history, MA plans and providers can set fair service prices, reduce risk and grow the market for value-based PAC services.

ONE PRIVATE EQUITY FIRM'S RISK-ENABLING PLATFORM

Chicago-based private equity firm, The Vistria Group, has assembled a platform of services positioned to bring value-based care capabilities to home-health providers and payers. Operating Partner Brandon Cady describes the opportunity in the following words,

> ***We saw a need in the market for a risk-sharing entity that can serve as a convener or collaborator for a reimbursement model that aligns incentives for payers and home health agencies.***

To that end, Vistria has made several significant investments.

In June 2021, Vistria invested in Medalogix and Muse Healthcare, two data-science and machine-learning technology companies. These companies use data to optimize individualized patient care within home-health and hospice/palliative care settings, while empowering providers' ability to succeed in a value-based care environment.

In March 2022, Vistria announced its investment in Professional Health Care Network (PHCN), a home-health, care-management-services company that partners with health plans and providers to increase access to quality home-based clinical care.

Vistria also has investments in California-based home-health and hospice provider Mission Healthcare; a Chicago-based provider of personal-care services Help at Home; and southeast-based, home-health and personal-care services provider The VitalCaring Group.

The Vistria Portfolio combines data analytics with home-health care provision to facilitate access to more appropriate, timely, quality care in the home. Here's how its component parts work together to create value.

Founded in 2013 on Nashville's Music Row, Medalogix helps home-health agencies identify patients at high risk of rehospitalization. The company has developed predictive models that offer practical and dynamic insights for clinicians to ensure the right care resources go to the right patient. The positive outcome is that fewer of these high-risk patients require dangerous and high-cost rehospitalization.

Medalogix's President and CEO Elliott Wood describes the firm's supportive role:

> ***"We're not replacing clinicians, we're supporting them with evidence they've never had access to before."***

With Vistria's investment, Medalogix merged with Muse Healthcare under the Medalogix brand. Minority investors include some of the largest home-health and hospice providers in the country.

Today, one out of every three outpatients in home-health or hospice care is monitored by Medalogix analytics. The company actively supports over 325,000 home-health and 50,000 hospice beneficiaries each day.

Traditional home-based care delivery relies on the original diagnosis. Payers rely on the number of reimbursable visits to direct care. This model ignores the reality that patient diagnoses and service needs are dynamic. Payment models that cannot accommodate changing care dynamics lead to dispute when providers rightly want to increase care services in the short run to improve care quality and reduce costs in the long run.

Medalogix's system tracks individual patient progress according to care plans. Their technology flags patients whose acuity risk changes. This early-warning system enables providers to shift patients into an appropriate care setting in a timely fashion. When providers and payers share access to transparent patient-monitoring data, they collaborate rather than conflict with one another. CEO Wood explains the logic of this collaborative approach.

> ***There's no one-size-fits-all protocol for every chronically ill or post-acute patient. There are too many things happening along the way that the clinician doesn't have visibility into. With data, you can focus on bringing the patient through their impairments back to a state of independence. Or, if health status is not improving, it could indicate the patient is not in the right care setting and needs additional care or end-of-life care.***

Payers incur enormous costs when patients decline unexpectedly. Timely patient data improves real-time clinical decision-making and limits bad outcomes, reduces re-hospitalizations, keeps patients in their homes and improves member experience. With its wealth of data, Medalogix has been able to expand its platform.

The company can now create clinical programs for providers that help manage the care needs of large populations.

Phoenix-based PHCN is another key piece of Vistria's home-health platform. PHCN started as a home health provider in Arizona and evolved effectively into a Management Services Organization (MSO). The company now provides home-health-management solutions and care coordination to major health plans (Humana, Cigna, UHG) and providers throughout the western U.S. PCHN intends to expand into multiple new markets.

As the payer-provider convener and risk-holder, PHCN contracts with all the providers in an MA plan's network under a single contract. The company administers processes and pays all claims on behalf of the payer while continuing to measure performance across the provider network. This eliminates a complicated administrative challenge for health plans that typically work with hundreds of home-health providers.

To establish each network, PHCN's technology platform employs data analytics to match patients with providers based on care plan, diagnosis and health status. This approach identifies the ideal provider for each patient. It also ensures that selected providers' capabilities best meet patients' needs, while delivering timely care.

That data helps providers and payers generate more accurate clinical risk scoring and high-value, clinical-decision support. Having this information readily available significantly reduces the need for prior authorizations, a significant barrier to timely, appropriate care delivery.

As such, good data improves care delivery through reduced readmissions, lower total-care costs, reduced administrative burden and improved patient-satisfaction scores. Commenting on the platform's composition and orientation, Vistria's Brandon Cady notes, "We now have the key parts in place to make a value-based model work."

CONCLUSION: THE GREAT DECENTRALIZATION OF CARE

The movement of PAC/SNF services into the home is part of the healthcare industry's larger migration away from centralized, high-cost, institutionalized care modalities to more convenient, local, consumer-friendly venues. The historic lack of consistent, high-quality coordination between hospitals and post-acute care providers has made home health more financially precarious for payers. This has intensified negotiations over rates and care utilization at the expense of patient needs, outcomes and experience.

Robust patient data and aligned incentives reduce the fragmentation and opacity embedded within current PAC provider and payer business models. Under a scalable, risk-enabling model, it is possible to deliver and pay for high-quality PAC services for growing numbers of MA enrollees.

Under this value-driven approach, new payment dynamics replace lowest-common-denominator cost- and utilization-driven payment. Instead, MA plans pay providers fairly to deliver appropriate and high-quality care to patients in accordance with their needs. Patient outcomes improve while costs decline. This is a win for payers, providers and patients.

For many post-acute, aged and chronically ill patients, their home is their preferred venue for receiving care. Soon, it will also be clinically optimal. With robust analytics, aligned payers and providers and a market-based solution to the challenges of value-based care, PAC services will likely change more in the next ten years, for the better, than they have since the creation of Medicare and Medicaid.

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