How Will Biden's $400B Home Care Plan Impact Your Organization?

5 Key Questions & Answers

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President Biden's American Jobs Plan designated $400 billion for home care. That allotment came with more questions than answers.

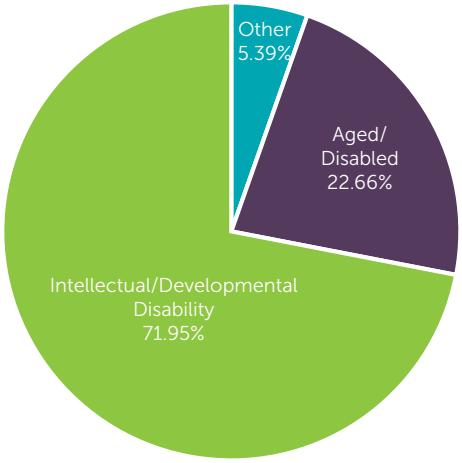
Does the plan help some of the most vulnerable? Yes, but not who you think.

While Medicaid does require states to offer limited home health services, many Medicaid recipients receive home care services by applying to their state's waiver program under section 1915(c). The waiver allows states to provide home and community-based services (HCBS) to groups that require long-term services who would otherwise require Medicaid-covered institutional care[2]. Since one of the aims of this waiver program is to contain costs, there are often caps on the number of individuals that can be covered by a state's waiver; once the cap is reached, individuals are put on a waitlist[3]. While individuals may spend an average of 4 months (HIV) to an average of 66 months (Intellectual/Developmental Disability) on a waiver waitlist, they are receiving care, though not at home. Although home care and long-term care are often associated with older adults, the waitlist is largely comprised of those with intellectual/developmental disabilities (72%) while the aged only make up a quarter of those waiting for waivers[4].

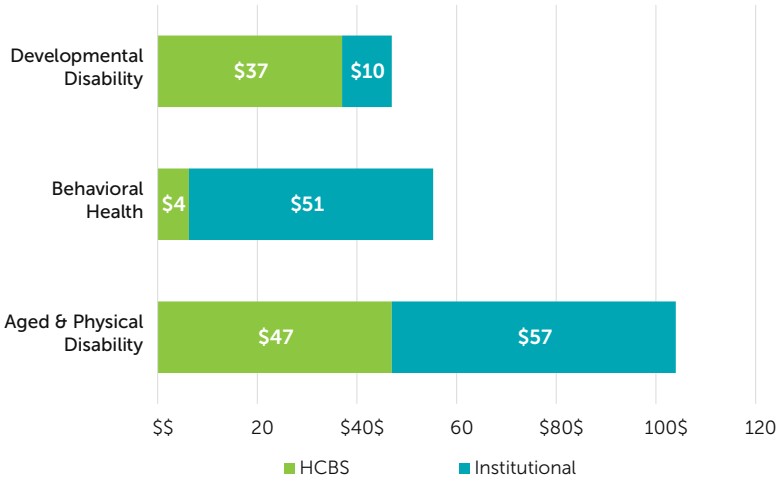
Outside of these waivers, state Medicaid plans are only required to cover part-time or intermittent nursing services, home health aide services, and medical supplies suitable for use in the home[5] for low-income seniors (varies by state by typically require a senior to make less than $800-$1000 a month[6]). For seniors on Medicare, to qualify for covered home care services, a doctor must certify that an individual is homebound and refer them for home care services, and will only pay for certain services, not including 24-hour care, homemaker services, or custodial/personal care[7].

As a result, funds going towards expanding Medicaid's HCBS program will have the most impact in allowing those with intellectual and developmental disabilities to move out of institutional care settings into community settings. Thus, any effort to create more home care for the elderly will require more investment by governmental or private payors. Congress increased funding temporarily as part of the Cares act. A more permanent increase could be coming in Biden's upcoming State of the Union address.

Medicaid HCBS Wait List Makeup by Target Population

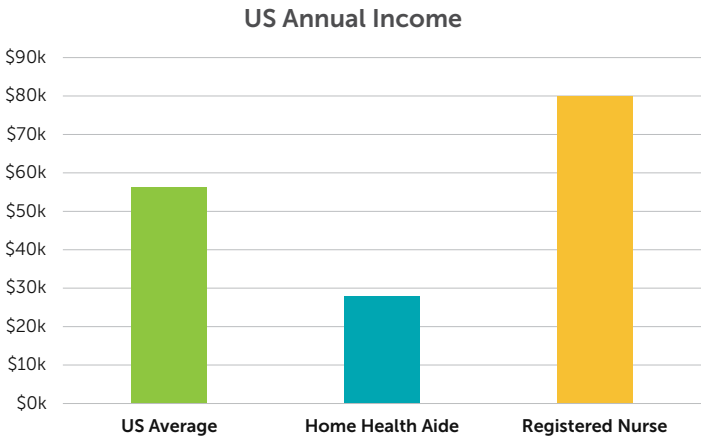


2016 LTSS Spend by Population (in billions)[1]



[1] Eiken et al. LTSS Expenditure Report 2016. Published May 2018.
[2] https://www.everycrsreport.com
[3] https://www.everycrsreport.com
[4] https://www.kff.org/health-reform/state-indicator/waiting-lists-for-hcbs-waivers/
[5]https://www.kff.org/report-section/medicaid-home-and-community-based-services-enrollment-and-spending-issue-brief/
[6] https://www.medicaidplanningassistance.org/in-home-care/
[7] https://www.medicare.gov/coverage/home-health-services

Does the plan reduce income inequality? In more ways than you might think.



The average employee in the United States makes $56K annually, the average hospital-based RN about $80K, while the average home health aide makes slightly over one-third that amount at $28K annually[8] without benefits[9]. The home care work force also face larger societal challenges to career advancement. Increasing demand for home care workers while increasing their collective bargaining potential will increase their wages while shifting demand away from relatively higher paid clinical workforce in an acute care setting.

Using HCBS funds to create well-paying caregiving jobs that provide benefits will not only lift this low wage group up, but also help bring sustainability and greater scale to the home care business. Lower turnover will facilitate greater clinical professional development. Scale will support technology deployment and process development to backstop particularly nonclinical care workers. All of this creates a virtuous cycle to increase home care workers productivity and ultimately their compensation.

Is the move to home care part of the administration's path to value-based care transformation? Yes, because it does not have a choice.

Home care was deeply popular well before COVID-19 highlighted some of the challenges with institutionalized care. For example, private pay patients had almost completely disappeared from Skilled Nursing Facilities before COVID and the vast majority of people clearly want to stay in their homes as they age[10].

Benefits of the home care model also extend beyond satisfying patient preferences. As America ages, it does so with less young, informal caregivers available. With the Medicare Trust Fund projected to be insolvent by 2024[11] and the U.S debt set to exceed the size of the economy for the first time since World War II[12], the need is more urgent than ever to prioritize value, like choosing quality care in the lowest cost setting. America simply cannot afford to institutionalize all its seniors who need medical care.

Meanwhile, hospital-at-home programs could begin to move low-acuity cases, which make up about 20% percent of all admissions, out of the inpatient setting[13] which represents about $70B[14] of hospital facility fees alone. Estimates show that the cost of acute care in the home can save between 30%[15] and 50%[16] per admission, which would mean between $21—$35 billion savings in place of inpatient acute care services. That is a floor for possible savings given the potential length of stay savings from simply shortening hospital stays, transitioning some patients earlier to SNFs and relocating some patients in SNFs to home care. There are not many places that public and private payors can squeeze out tens of billions of dollars of annual costs and improve the patient experience.

[8] https://www.bls.gov/oes/current/oes_nat.htm#00-0000
[9] https://datausa.io/profile/soc/home-health-aides
[10] https://www.aarp.org/research/topics/community/
[11] https://www.healthaffairs.org/do/10.1377/
[12] https://www.wsj.com/articles/u-s-debt-is-set-to-exceed-size-of-the-economy-for-year-a-first-since-world-war-ii-11599051137
[13] Calculated using a full listing of inpatient admissions for the state of FL; low acuity MS-DRGs were identified and then the overall percent of admissions was calculated for this subsection of cases
[14] Cost per DRG was calculated by applying each MS-DRG's weight to the base rate ($6,259; since no adjustments were made to the base rate, our model is likely a conservative estimate) and assuming that Medicaid paid at Medicare rates and Commercial paid 200% of Medicare rate. A 7.5% reduction was made to all case numbers since Florida has a higher inpatient use rate than the national average. Using the adjusted FL dataset, cost per DRG was calculated by multiplying total cases per DRG by cost – assuming a 60%/40% Medicare and Medicaid/Commercial split. The total national cost was extrapolated by using a per population factor.
[15] https://www.commonwealthfund.org/publications/newsletter-article/hospital-home-programs-improve-outcomes-lower-costs-face-resistance
[16] https://www.commonwisecare.com/cost-of-home-health-care-vs-hospital/

Are there barriers (beyond workforce investment) to making home care a bigger reality? Yes, but two are falling fast.

Three barriers not explicitly addressed in Biden's plan have stopped seniors from getting care at home, including: 1) a payment structure that favors institutionalized settings, 2) a lack of technology and processes to monitor clinical status and engage patients at home, and 3) homes that are not well equipped for senior living. A closer examination of these barriers is revealing.

1. **Payment Reform:** Medicare Advantage, PACE and other programs have made some progress, but as one member of a recent Urban Institute roundtable on Long Term Care said, "Plans have done an OK job, but they are not transformational[17]" and the PACE program only has 54K members nationally.[18]

   However, capitation is growing as a national trend that can fund home care. Four examples include:

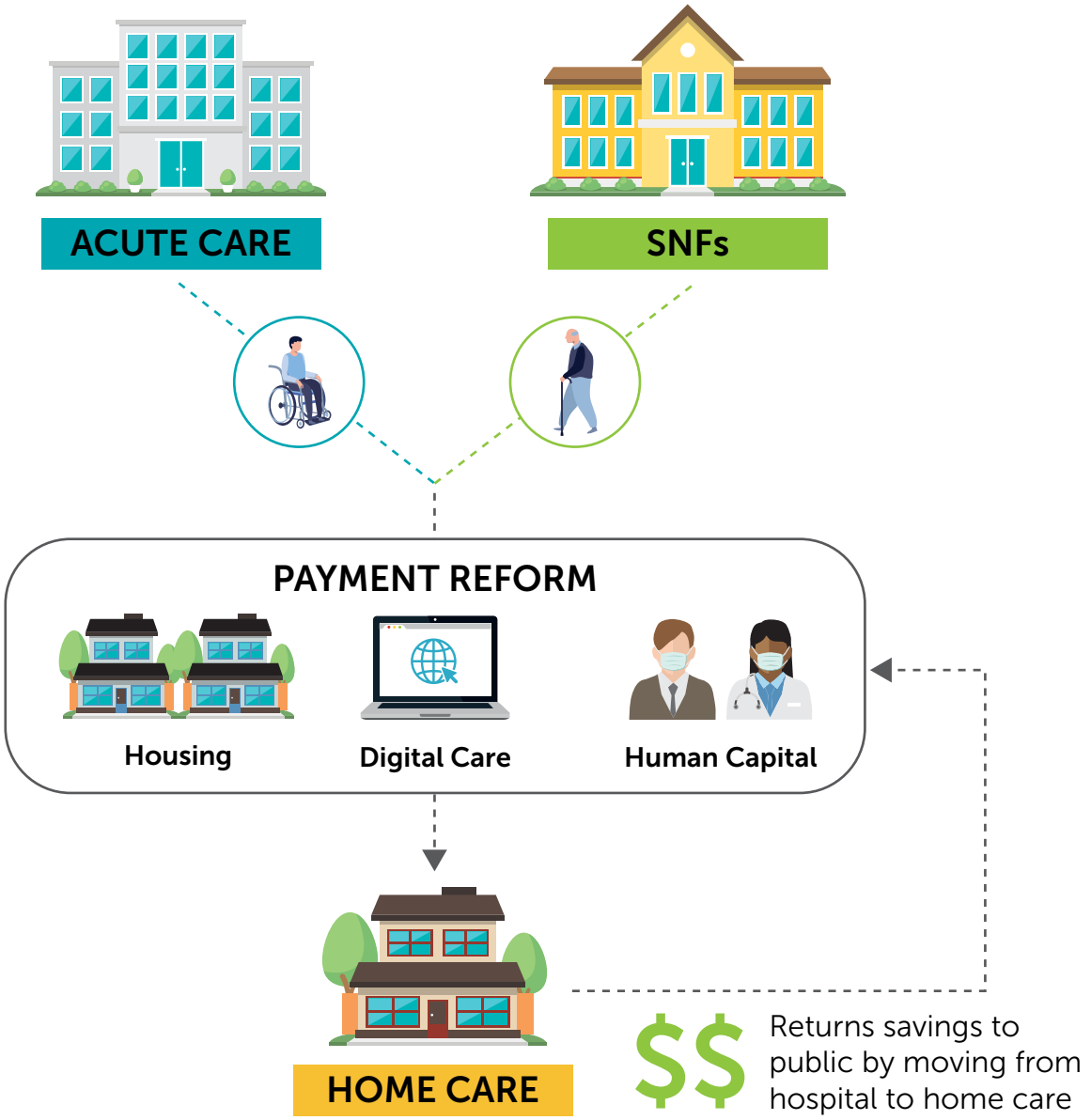
   - MA plans may not have been transformational yet, but they are relatively new and already won over ~40% of all Medicare beneficiaries[19],
   - Medicare Direct Contracting program (allowing seniors and providers to have capitated agreements without a MA plan)—51 entities were awarded in just the first round—before it was put on hold.[20]
   - Payors are vertically integrating quickly which will facilitate moving care to non-acute settings. Perhaps the hottest topic on United Health's most recent earnings call with investors[21] was how many lives they truly own risk and delivery for, how many more will they get, and when to expect them.
   - Integrated delivery systems are jumping on board. While home care represents a fundamental threat to the "heads in beds" business model of most acute care hospitals, a diverse group of providers and payor-provider players (Amazon Care, Intermountain Health, Ascension, Northwell and UPMC) formed the Moving Health Home coalition to advocate for federal and state policies changes that would allow for 1) Medicare coverage of higher-acuity home-based services, 2) flexibility to transfer or treat in the home when appropriate, 3) better reimbursement for home-based E/M codes, 4) bundled payments for extended home care, and 5) home-based care services to meet commercial and MA network adequacy standards.[22]

2. **Digital Care:** Investment in digital medicine is booming as over $14B was invested in digital health in 2020 alone and 2021 is on track to far outpace that.[23] The supporting infrastructure of call centers and remote providers is also booming. Investment in medical grade technologies as well as those that help monitor daily activities will truly enable care to be brought home more readily. Some examples include:

   - VitalConnect's Vista Solution – a wearable biosensor and monitor that can track 11 unique vital signs including EKG, heart rate, heart rate variability, respiratory rate, and blood oxygen levels[24]
   - InfoBionic's MoMe Kardiac Remote – remote ECG monitoring that can send telemetry-like data safely to a physician's phone in real time[25]
   - Sequencehealth – Outsourced call centers help to increase patient engagement, patient satisfaction, and patient management[26]
   - Hinge Health – offering a digital MSK clinic by pairing clinical experts, health coaches, and wearable motion sensors and nerve simulation technology
   - Medallia – helps to integrate CRM and EHRs to turn operational data into actionable insights using AI and couples this with a call center solution[27]

[17] Reforming Long-term care with Lessons from the Covid-19 Pandemic, Urban Institute, February 2021
[18] https://healthdimensionsgroup.com/pace-service-areas-growth/
[19] https://www.kff.org/medicare/issue-brief/a-dozen-facts-about-medicare-advantage-in-2020/
[20] https://openminds.com/market-intelligence/bulletins/medicare-announces-51-entities-participating-in-the-direct-contracting-model-for-global-professional-options-implementation-period/
[21] https://www.unitedhealthgroup.com/viewer.html?file=/content/dam/UHG/PDF/investors/2021/UNH-Q1-2021-Remarks.pdf
[22] https://movinghealthhome.org/policy-priorities/
[23] Q1 2021 Funding Report: Digital health is all grown up | Rock Health | We're powering the future of healthcare. Rock Health is a seed and early-stage venture fund that supports startups building the next generation of technologies transforming healthcare.
[24] https://www.healthcareitnews.com/news/guide-connected-health-device-and-remote-patient-monitoring-vendors
[25] https://www.dicardiology.com/article/new-technology-allows-direct-transmission-remote-cardiac-monitoring-data
[26] https://www.sequencehealth.com/blog/top-5-healthcare-and-medical-call-center-advantages-and-benefits
[27] https://www.medallia.com/solutions/healthcare/

3 **Housing:** Simply put, while many individuals want to age in place, their homes are not safe to do so. About 90% of housing units have at least one aging-accessible feature, but less than 10% of homes across America are safe for aging in place.[28] Individuals can make incremental modifications to their homes to increase safety, but to make a home fully accessible can cost up to $100k[29] which is a large financial hardship on people that typically have a limited income. While the federal government (through HUD) and some states do provide grants to help seniors make their houses accessible (i.e. Maryland's Accessible Homes for Seniors program), this is another infrastructure investment needed to truly transform home care.



[28] https://www.census.gov/content/dam/Census/library/publications/2020/demo/p23-217.pdf
[29] https://www.aarp.org/caregiving/home-care/info-2019/safety-tips.html

What could win and lose with these changes?

Winners

1. Home care companies that are able to scale and partner, e.g., call centers, remote providers, integrated technology for both patients and staff, specialized staff
2. Telehealth companies. More patients at home = more customers
3. Value based care companies. Major lower cost venue = proof point on business model
4. Payors who actual manage care – vs. just good marketers and actuaries
5. Providers who are not acute care heavy. Home care helps take out the competition

Left Behind

1. Heads in beds dependent acute care systems. High fixed cost meets lower demand
2. Some providers (groups or hospitals) who have created local monopolies. Counter intuitively people at home are empowered with more choice
3. Hospital based provider groups. They could ultimately have less customers.
4. Unions. Virtual organizing will be a big lift and companies will tend to take support services to non-union markets.
5. CONs and the people who write them. These will be less relevant by the day, and patients won't take state governments dictating who and what they can't buy in their house.

About Array Advisors

Array Advisors is a healthcare strategy consulting and operations optimization firm dedicated to both improving the way healthcare is delivered and helping clients overcome their business challenges. The team can help clients with strategic plan development including market analysis, ambulatory and service line planning, provider strategies and integrated capital and facility planning as well as operational analysis including scenario modeling, benchmarking, and lean design.

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