THE CHOOSE HOME ACT

The Choose Home Care (CHC) Act of 2021 was recently introduced in both the House (H.R. 5514) and Senate (S. 2562). The bill has the potential to make home health services the dominant option in post-acute care. This Marquette Debate examines the pros and cons of enacting the legislation. The Choose Home bill would incentivize home health agencies to provide SNF-equivalent nursing in the home, by providing Medicare beneficiaries with new, extended home care services.The bill has the support of the home health sector, while it has drawn opposition from the skilled nursing facility (SNF) sector. Other post-acute sectors - Inpatient Rehabilitation Facilities (IRF) and Long-Term Care Hospitals (LTCH) are still considering the issue.

Under current policies, approximately 60 percent of Fee-For-Service (FFS) Medicare beneficiaries are discharged "to the community" after a hospitalization, where they do not receive any further recovery services. Among the 40 percent needing short-term recovery care, half are discharged to Skilled Nursing Facilities (SNF). Medicare requires SNFs to provide a minimum of 8-hours of nursing care (registered nurse licensure or higher) per day while home care is not required to provide daily nurse visits

- PRO -

"Medicare beneficiaries have an overwhelming desire to receive care at home. The CHC Act removes several barriers that currently prohibit beneficiaries from exercising their preferred choice."

Today, 3.3 million (2019) FFS Medicare beneficiaries utilize home health care services.[P.1] In 2019, total FFS Medicare home health payments were $17.8 billion.[P.2]

CHC HONORS THE PREFERENCE TO RECEIVE CARE AT HOME.

Recovering in the home is very popular among Medicare beneficiaries, and all consumers. Public opinion polling suggests that nearly 95 percent of Medicare-age adults prefer receiving

[P.1] Home Health Care Services Payment System Basics. Medicare Payment Advisory Commission. November 2021.
[P.2] Ibid.

- CON -

"If enacted as introduced, the CHC Act will compromise the safety of Medicare beneficiaries and put them at greater financial risk."

Today, 1.5 million (2019) FFS Medicare beneficiaries utilize skilled nursing facility services.[C.1] In 2019, total FFS Medicare skilled nursing facility payments were $27.8 billion.[C.2]

CHC THREATENS THE SAFETY OF BENEFICIARIES.

Medicare beneficiaries eligible for facility stays, in a clinician's judgment, require a higher level of care – daily skilled care, under the supervision of experienced nursing staff. The beneficiaries

[C.1] Medicare Payment Advisory Commission March 2021 Report to the Congress. Chapter 7: Skilled Nursing Facility Services.
[C.2] Ibid.

PRO

care at home.[P.3] This support is also bipartisan, with 83 percent of Republicans and 92 percent of Democrats agreeing.[P.4] Recent experiences with the COVID-19 Public Health Emergency (PHE) have further shifted attitudes towards preferring home care.

Since the beginning of the PHE, nearly 800,000 Medicare beneficiaries have a confirmed COVID-19 diagnosis and over 142,000 beneficiaries have died as result of COVID-19.[P.5] The incidence of the confirmed COVID-19 cases among nursing home staff is similar (nearly 713,000), but staff mortality is nearly 63-fold less (approximately 2,300) than resident death.[P.6] Coupled with limited visitor access during the PHE, questions around staff vacancies, and waiting lists for access, this massive disparity in mortality outcomes has caused a major shift away from preference of care in nursing homes.[P.7, P.8, P.9]

CHC LEVERAGES NOVEL HOME HEALTH COVERAGE AND REIMBURSEMENT INNOVATIONS.

During the COVID-19 pandemic, the federal government has offered health care providers unprecedented flexibilities that allow more services to be provided to the patient in the home. While that transition was driven by necessity, it has also illuminated the potential to provide care in the home. Previously prohibited, COVID-19 PHE waivers have allowed the initial nurse screening visit within a home health episode to be completed via telehealth.[P.10]

P.3 Choose Home Care Act Polling Presentation. Morning Consult/ Partnership for Quality Home Healthcare. August 2021. Viewed on January 11, 2022.
P.4 Ibid.
P.5 COVID-19 Nursing Home Data. Centers for Medicare & Medicaid Services. Viewed on January 11, 2022.
P.6 Ibid.
P.7 Grabowski, D and Mor, V. Nursing Home Care in Crisis in the Wake of COVID-19. Journal of the American Medical Association. 324(1): 23-42. 2020.
P.8 Grabowksi, D. The Future of Long-Term Care Requires Investment in Both Facility and Home-Based Services. Nature Aging. 1: 10-11. 2021.
P.9 Abelson, R. COVID Forces Families to Rethink Nursing Home Care. New York Times. August 4, 2021.
P.10 COVID-19 Emergency Declaration Blanked Waivers for Health Care Providers. Centers for Medicare & Medicare Services. November 29, 2021. Viewed on January 11, 2022.

CON

who would be eligible for the new extended care benefit under CHC are a population in need of careful supervision. In 2019, the national average number of skilled nursing visits per Medicare FFS 60-day home health episode was 8.1.[C.3] In order to bring home health up to the same nursing standard provided by SNFs, there would need to be a 7.4-fold increase in the number of services provided today.

Medicare beneficiaries needing SNF-level care can't leave home visits to chance. Particularly as the home health industry endures a well-documented staffing shortage, a Medicare beneficiary's recovery cannot be left in doubt. Recovery in a facility, with trained professionals in full-time attendance, retains the safety of beneficiaries.

CHC PUTS ADDITIONAL FINANCIAL BURDEN ON BENEFICIARIES.

Beyond safety, CHC creates a confusing layer of financing for Medicare beneficiaries. Medicare's SNF benefit covers up to 100 days in a facility, with the first 20 days at no cost to beneficiaries. After the 20th day, beneficiaries are responsible for 20 percent of daily costs. In 2021, McGarry et. al. published a study suggesting Medicare SNF Average Length of Stay (ALOS) could be reduce without compromising safety.[C.4] The study highlighted the long-standing policy concern around the arbitrary and capricious nature of SNF cost-sharing rules dictating the national ALOS for SNF stays at 20 days.

The new CHC extended care benefit would count against a beneficiary's SNF benefit. The extended care provider would be reimbursed for a 30-day home health episode of care. Medicare beneficiaries would be responsible for 10 days of excess cost-sharing obligations, which could be as high as $1,800 out-of-pocket (OOP).[C.5, C.6]

C.3 Ibid.
C.4 McGarry, B. et. al. Outcomes After Shortened Skilled Nursing Facility Stays Suggest Potential for Improving Postacute Care Efficiency. Health Affairs. May 2021. 40(5).
C.5 Skilled Nursing Facility Services Payment System Basics. Medicare Payment Advisory Commission. November 2021.
C.6 10-day multiplication of the 2019 average SNF daily rate of $185.50.

PRO

Further, the definition of homebound has been expanded, for coverage of a home health episode, to include the need for medical or social isolation due to confirmed or suspected COVID-19 diagnosis.[P.11]

Through a PHE waiver, Medicare announced a new "Acute Hospital Care at Home Program." Touting nationally recognized health systems such as Johns Hopkins, Massachusetts General and the Mayo Clinic, participants are afforded unprecedented regulatory waivers, such as an exemption from the requirement for daily registered nursing services.[P.12] Building on these important waivers, the CHC Act would allow new beneficiaries to become eligible for care at home, when it was previously prohibited.[P.13]

CHC COULD POTENTIALLY SAVE TAXPAYER DOLLARS.

To the extent the extended benefit is a cheaper alternative to SNF services, CHC may produce programmatic savings. An external analysis by Dobson/Davanzo Health Economics Consulting estimates CHC could generate as much as $247 million in savings to Medicare each year for a total of approximately $2.5 billion in savings over ten years.[P.14] This would be a welcome outcome given current actuarial projections of the Medicare Part A Trust Fund's 2026 insolvency date.[P.15]

The source of potential savings could come from any of the following changes in behavior: 1) reduction in the overall volume of current SNF cases, 2) reduction in the number of hours of medical supervision associated with CHC extended benefit cases, and 3) reduced costs associated with the total cost of CHC cases that substitute for SNF cases. Upon modeling 2020

[P.11] Grabert, L. et al. COVID-19 Waivers of Medicare Post-Acute Waivers Increased Capacity but Should Not Become Permanent. Health Affairs. December 6, 2021.
[P.12] CMS Announces Comprehensive Strategy to Enhance Hospital Capacity Amid COVID-19 Surge. Centers for Medicare & Medicaid Services. November 25, 2020.
[P.13] Acute Hospital Care at Home. Centers for Medicare & Medicaid Services. Viewed on January 11, 2022.
[P.14] Choosing Home Care Act Savings Estimate. Dobson/Davanzo Health Economics Consulting Memo. January 26, 2021. Viewed on January 11, 2022.
[P.15] 2021 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.

CON

This OOP expense exceeds the $1,443 average monthly social security amount a Medicare beneficiary receives.[C.7] This amount reflects only the initial 30-day episode, which if renewed multiple times, is possible the beneficiary could lose all 100 covered SNF days without setting foot in a facility.

In addition, beneficiaries could be liable for additional products and services typically included in the payment made to the SNF. CMS bundles the cost of a number of drugs, equipment and services into payments made to SNFs. Beneficiaries using the new extended benefit may become liable for new Part B or D cost-sharing or deductibles that would normally be included in the cost of the stay at a facility.

CHC IS BUILT ON TOP OF AN ALREADY COMPROMISED BENEFIT.

The CHC bill would provide an additional add-on payment on top of existing Medicare home health reimbursement. This is problematic because there is a long history of concerns with the home health payment system. For nearly two decades, policy makers have been concerned that Medicare home health payments have substantially exceeded costs with average margins of 16.2 percent between 2001 and 2018.[C.8] Further, over this same period, the average number of visits per episode of home health have declined 17.3 percent.[C.9] Simply put, the Medicare program continues to pay more for less service within the home health benefit.

In addition to providing less services for critical care, such as nursing visits, home health has had a dramatic shift toward community-based, rather than post-hospital discharge episodes. In 2001, 53 percent of home health episodes were not preceded by a hospital stay and this percentage grew to 66 percent in 2019.[C.10] This trend suggests the home health benefit has recently been catering to beneficiaries with

[C.7] Monthly Statistical Snapshot, November 2021. Social Security Administration. Viewed on January 11, 2022.
[C.8] Medicare Payment Advisory Commission March 2021 Report to the Congress. Chapter 8: Home Health Care Services.
[C.9] Ibid.
[C.10] Ibid.

PRO

data, the Dobson/Davanzo savings estimate found as many as 18 percent of SNF cases could be eligible for the new CHC extended home care benefit, representing over 13 percent of total SNF payments.[P.16] Further, the analysis showed the greatest opportunity for increased access to home care, under CHC, for beneficiaries with double joint replacement of the lower extremity—a potential of over 40 percent of SNF stays within this high volume Medicare surgical procedure.[P.17]

CONCLUSION

The CHC Act provides Congress with an extraordinary opportunity to modernize the Medicare program to better incorporate the preferences of beneficiaries. Opening new pathways for a beneficiary to recover in the comfort of the home, as opposed to a facility, is an important step in Medicare's movement toward patient-centered care.

[P.16] Choosing Home Care Act Savings Estimate. Dobson/Davanzo Health Economics Consulting Memo. January 26, 2021. Viewed on January 11, 2022.
[P.17] Ibid.

CON

much less acute recovery needs. Given these trends policy makers have been critical about the lack of alternatives for home health services, such as comparable outpatient services.[C.11] Many of these underlying issues concerning the current home health benefit should be addressed prior to the expansion of extended services contemplated in CHC.

CONCLUSION

There may be a need for beneficiaries to receive more care in the home – but the CHC Act is the wrong way to go about it. The legislation poses a threat to the safety of Medicare beneficiaries and their finances. Inefficiencies within the underlying home health benefit need to be addressed prior to introducing a new extended care benefit. The Medicare program should address the personal care needs of beneficiaries but building on a narrow home health benefit could exacerbate current disparities and access issues.

[C.11] Ibid.

MARQUETTE UNIVERSITY

BE THE DIFFERENCE.

ABOUT THE SERIES EDITOR: LISA M. GRABERT, MPH

Lisa M. Grabert, MPH, is a research professor at Marquette University College of Nursing. In addition to conducting health services and health policy research, she teaches graduate courses at Marquette on health policy. Her subspecialties are government regulatory and reimbursement systems and how those systems impact patient care and the supply of health care providers. Prior to joining the faculty at Marquette, Professor Grabert served as Senior Health Policy Advisor to the U.S. House of Representatives Committee on Ways and Means and held senior policy positions at the American Hospital Association and the Centers for Medicare and Medicaid Services (CMS) within the U.S. Department of Health and Human Services. Professor Grabert received her undergraduate degree from the University of Wisconsin-Madison, and her graduate degree from Emory University. To submit a potential topic for consideration for a future edition of this series, please email Professor Grabert at lisa.grabert@marquette.edu.