Understanding the Importance of Home Health Care In Medicare Advantage

A Growing Case for Medicare Advantage Plans to Better Manage Home Health Care

Home health care plays a crucial role in the healthcare continuum, offering essential services to individuals in the comfort of their homes (often their preferred site of care), particularly when they are at their most vulnerable, following an acute event or inpatient admission. Recovery in the home is often a more cost-effective setting (vs. a Skilled Nursing Facility (SNF) for example), achieving similar or better outcomes.

Despite this, Medicare Advantage (MA) plans often rely on outdated benefit management models for home health care, focusing primarily on Utilization Management rather than ensuring appropriate access and timely starts of care through a curated, high-quality network proven to drive outcomes and improve care.

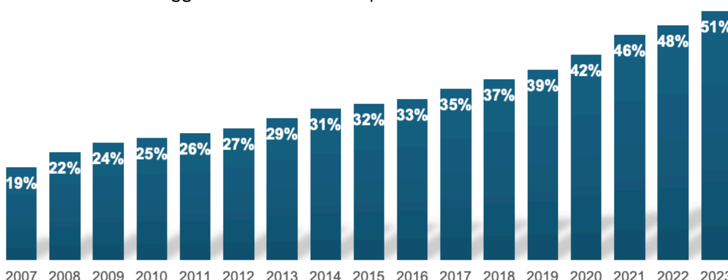
Emerging data also suggests that disparities in home health care access, quality, and outcomes persist, especially when evaluating differences between Traditional Medicare and MA beneficiaries. This is especially concerning as the popularity of MA plans has risen to an all time high.

Additionally, reimbursement dynamics between Traditional Medicare and MA create challenges that further contribute to these disparities. Coupled with home health staffing shortages and resource constraints, MA plans simply need to be more innovative and better engage home health care providers to build new solutions that can better manage the health and outcomes for their members.

This paper will review the unique challenges MA plans face and offer key considerations to inform new solutions needed to better manage home health in the future.

Medicare Advantage Penetration, 2007-2023

In 2023, Medicare Advantage enrollment surpassed Traditional Medicare, with MA now accounting for more than half of all Medicare beneficiaries (~30 million beneficiaries). Home health care is an important service that often is not needed until a patient is experiencing complex health issues. Discrepancies in access and outcomes for MA beneficiaries suggest it is time for MA plans to re-evaluate their home health models.



NOTE: Enrollment data are from March of each year. Includes Medicare Advantage plans: HMOs, PPOs (local and regional), PFFS, and MSAs. About 60.0 million people are enrolled in Medicare Parts A and B in 2023.

Source: Kaiser Family Foundation, August 2023

What is Home Health Care?

Home health care refers to skilled nursing and clinical services covered by Medicare and includes skilled nursing, rehabilitation services, physical, speech, and occupational therapy. Home Health care services are most often provided following a hospital admission (which typically accounts for 60% of home health admissions), or without a hospital admission as needs are identified and referred by a clinician. These services are covered by Medicare, and often considered medically necessary when ordered by a physician.

Skilled home health care can be confused with home care or custodial care, which is usually not covered by Medicare.

While home health care spend makes up a smaller portion of overall medical spend, the role it can play in managing total cost of care is critical and often overlooked. Not only can home health substitute for care in institutions such as skilled nursing or inpatient rehabilitation facilities, but it also plays a crucial role in helping vulnerable patients recover after an admission, preventing unnecessary hospital readmissions and emergency department visits.

Differences between Skilled Home Health Care, Home Care and Custodial Care

Skilled home health care is a Medicare covered benefit that offers supportive services that assist in functional and clinical recovery following and illness or injury.

Skilled Home Health Care	Home Care
• Provided by licensed healthcare professionals (e.g. nurses, physical therapists, occupational therapists, and speech therapists) • Typically prescribed by a physician for individuals who need medical treatment or rehabilitation services	• Refers to non-medical services provided to individuals • Provided to individuals who need assistance with daily activities but do not require skilled medical care • Home care aides or personal care aides usually provide these services
Example Services	
• Wound care • Medication administration • Monitoring vital signs • Physical, occupational, or speech therapy • Medical social services	• Assistance with activities of daily living (ADLs), such as bathing, dressing, and grooming • Help with instrumental activities of daily living (IADLs), like meal preparation, housekeeping, and transportation • Companionship and social interaction
Covered by Medicare	Typically, not covered by Medicare

Disparities in Home Health Care and Implications for MA Plans

A recent study published in JAMA Health Forum[1] by the University of Washington looked specifically at differences in home health care between Medicare Advantage and Traditional Medicare patients and found there were key differences in care and outcomes.

The study evaluated data from a large national home health care provider and concluded that "across the board, patients with Medicare Advantage plans are getting less home health care" than their peers in Traditional Medicare.

The data also showed that MA patients were less likely to make functional improvements than their Traditional Medicare counterparts, which can lead to poorer health outcomes and cause additional strain on the health care system and caregivers.

Across the board, patients with Medicare Advantage plans are getting less home health care - Study Author, Rachel Prusynski at the University of Washington School of Medicine

Shorter Lengths of Stay

Fewer visits by nursing, therapy clinicians and home health aides

Lower rates of improvement in self-care and mobility function

May receive care from lower-quality providers

While the study did not directly evaluate the impact on total cost of care, tango's experience suggests a well-managed MA home health care program that supports access and drives timely starts of care can lower re-admission rates and inappropriate ED utilization.

Source: [1] Prusynski RA, D'Alonzo A, Johnson MP, Mroz TM, Leland NE. Differences in Home Health Services and Outcomes Between Traditional Medicare and Medicare Advantage. JAMA Health Forum. 2024;5(3):e235454. doi:10.1001/jamahealthforum.2023.5454

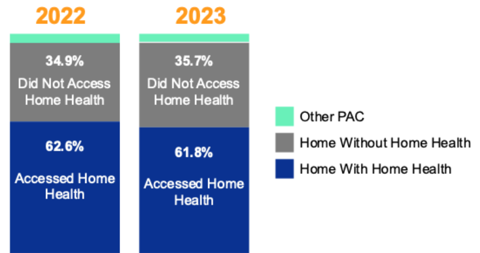
Additionally, data analysis from the Partnership for Quality Home Healthcare (PQHH) and CareJourney by Arcadia suggests many Medicare patients are not accessing home health care or are receiving it on a delayed basis, despite physician referrals (Graph 1). Perhaps even more concerning is the 22% increase in home health referral rejection rates from 49% in 2020 to 71% in 2022 (Graph 2). This is especially worrisome given the critical role home health plays in patient recovery, particularly for those in a vulnerable state.

The impact of missed or delayed home health care is often overlooked when assessing its role in managing total cost of care. Health plans frequently do not track the clinical and financial consequences of "services delayed" or "care not undertaken". As shown in Graph 3, Medicare beneficiaries who receive home health care within 7 days of discharge have a lower risk of readmission compared to those who did not receive care or received it later.

This missed opportunity is yet an additional reason why health plans must re-evaluate traditional ways of managing home health to include strategies that focus on access, quality network curation, and timely patient placement.

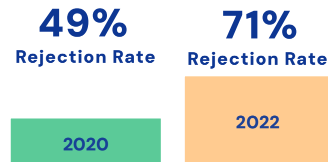
Graph 1

Home Health Access Worsens for Medicare Beneficiaries



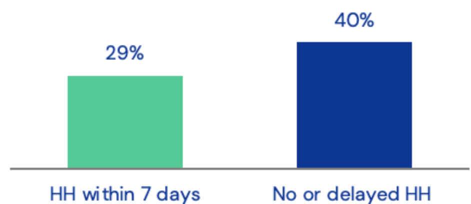
Graph 2

Rejection Rates for Home Health Increase for Medicare Beneficiaries



Graph 3

Patients Discharged with a Home Health Order with 1 or More Readmissions within 90 Days from Hospital Discharge



Note: the PQHH and CareJourney by Arcadia study examines Traditional Medicare home health claims from 2022-2023. Access, rejection rates, and outcomes for Medicare Advantage were not included in this study but are expected to be in-line or worse due to additional challenges of serving the MA population discussed in this paper.

Source: Partnership for Quality Home Health (PQHH) and CareJourney by Arcadia. Medicare Home Health fee-for-service claims 2022-2023.

Why is This Happening?

Staffing shortages and the lack of skilled resources to provide care are pervasive issues all home health agencies are grappling with. This issue, married with differences in payment policies for MA members compounds disparities in care between MA patients and Traditional Medicare.

Today, Traditional Medicare payment policies typically certify care for 60-day home health episodes and agencies are reimbursed for 30-day payment periods, with rates adjusted for patient characteristics (clinical category, functional status, and comorbidities), period timing (early vs. late), and admission sources (institution vs. community). Payment covers all visits during the 30-day period from all care providers.

In contrast, many MA plans may require preauthorization and/or frequent re-certifications to limit the number of visits or length of the home health episode. This, coupled with an already constrained resource environment, results in additional administrative burdens that can further limit access and/or delay starts of care for Medicare Advantage members.

For MA plans seeking to improve home health care management, new solutions are essential. These efforts must balance traditional fee-for-service and Utilization Management (UM) approaches, while focusing on building stronger provider networks and fostering payment innovations that create appropriate incentives for managing MA members. Value-based payment models and quality bonuses that acknowledge the role home health care providers play in managing total cost of care and delivering high-quality services will be crucial for establishing a more effective model for MA beneficiaries in the future.

The tango Way: New Solutions for Home Health Care

At tango, we believe that innovative home health management solutions start with a focus on enablement. Our approach centers on empowering key stakeholders—providers, payers, and patients—by offering payment innovation and value-based care that aligns payer and provider incentives. This creates a high-quality network of home health care providers essential for expanding access and delivering appropriate care to MA beneficiaries.

Our solutions achieve:

Critical changes in the payment dynamic for Home Health providers, including establishing episodic rates, reducing administrative and preauthorization requirements, and implementing value-based incentives for key outcomes such as reduced readmissions.

Curated and high-quality Home Health care networks. Our long-standing relationships with national and regional providers allow us to build the highest quality networks needed to improve home health care management.

Superior patient placement rates that ensure appropriate access and timely starts of care for MA beneficiaries – 100% of all qualified referrals are placed and 80% of all placed referrals begin care.

Advanced analytics that inform all aspects of our solution, from enabling our providers to rapidly identify high-risk members, to supplying data to payer partners for critical activities such as Star ratings and Risk Adjustments.

Key outcomes that improve member outcomes and total cost of care: up to 20% improvement in readmission rate and reductions in unnecessary ED utilization.

Interested in learning more about our solutions? Visit www.tangocare.com for more information or contact us today at hello@tangocare.com.