

Memorandum

Date: December 7, 2021

To: Joanne Cunningham & the Regulations Team
Partnership for Quality Home Healthcare

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Subject: Choosing Home Care Act of 2021 Savings Estimate

The Partnership for Quality Home Healthcare (PQHH) commissioned Dobson DaVanzo & Associates, LLC (Dobson | DaVanzo) to estimate the budgetary impact of the *Choose Home Care Act of 2021* legislation. This proposed legislation would expand home health services to qualifying Medicare Fee-for-Service patients following an acute care hospital discharge. This expanded home care benefit is explicitly intended to substitute for institutional post-acute care (PAC) services currently provided in Skilled Nursing Facilities (“SNFs”), particularly for relatively low-acuity patients who may prefer to receive care in their place of residence. This add-on service is referred to as Home-based Extended Care Services (HECH) throughout this memo.

In order to enable a safe transition from hospital to home, the expanded home care service would provide HECH for one or more subsequent 30-day episodes or episodes up to a maximum of 100 days within a spell of illness. HECH services for each 30-day episode could include daily skilled nursing care as needed, daily therapy services as needed, personal care services as needed, transportation, meals, home modifications, remote patient monitoring, and/or telehealth services.

Information supporting this project came from four sources: 1) The bill text of the *Choose Home Care Act of 2021*; 2) 2018 Medicare administrative claims and functional status assessments (CMS DUA 54757); 3) 2020 100% Medicare claims data (CMS DUA 54757), and 4) the Congressional Budget Office 2020 Medicare baseline.

Study Findings

Overall, we estimate that the proposed legislation could generate Medicare savings of \$121-222M (4.4-8.6% savings of SNF 1st PAC payments), with \$2.6-4.8B in savings over

ten years. In simulations, HECH episodes tend to generate savings when substituting for SNF care as HECH payment rates do not include non-home facility costs. Total savings estimates are reliant on 1) the volume of current SNF cases to be substituted by HECH, 2) assumptions about how many hours per day and in total of personal care/medical supervision that would be required for patients substituting out of SNF care, and 3) the relative costs of care under the HECH add-on with HHA care substituting for SNF care. We limited SNF cases to only include relatively low-acuity, short length of stay cases for beneficiaries who would likely not qualify for IRF or LTCH care and who have indicators suggesting caregiver support or strong family care involvement – i.e., the current SNF patients who appear most suitable to substitute a home health episode with the HECH add-on benefit for a SNF stay.

Since the expanded home care services benefit would only be available to individuals who would otherwise need services in a skilled nursing facility and not an option for individuals who qualify for inpatient rehabilitation facility (“IRF”) or long-term care hospital (“LTCH”) services, we estimate that the potential “woodwork” effect will be minimal to none. Note that to be eligible for SNF, 1) the individual must have a qualifying hospital stay of at least three (3) days, 2) a physician must certify that the individual needs daily skilled nursing care or other skilled rehabilitation services that can only be provided in a SNF. As such, the “woodwork” effect will be minimized.

Interpretation of Choose Home Care Act of 2021

The *Choose Home Care Act of 2021* describes the intent, case requirements, and payment rates for the expanded “SNF at home” service, referred to as the HECH add-on for purposes of this memo. The HECH add-on service would be provided by participating Medicare-certified Home Health Agencies in addition to a concurrent 30-day home health period.

PURPOSE:

The purpose of *Choose Home Care Act of 2021* is to “improve extended care services and supports under the Medicare program in order to:”

“(1) provide eligible individuals with daily skilled care needs and functional limitations the option to choose care in the home to maintain their independence; (2) create choice for individuals and families who prefer to avoid an institutional setting and, at the same time, potentially reduce the chances for increased exposure to infectious disease; (3) alleviate burdens on family caregivers and provide in-home support services to individuals with limited clinically capable caregiver supports in the home; (4) allow eligible individuals to choose recovery in their own home upon discharge from an acute care hospital setting; and (5) reduce Medicare

beneficiary and program spending by allowing more beneficiaries to recover in a lower-cost setting.”

CASE REQUIREMENTS:

- Eligible beneficiaries are those who would otherwise qualify for a SNF stay (e.g., 3-day hospitalization, require daily skilled services).
- HECH care occurs concurrently with an HHA episode following acute care hospital discharge.
- Beneficiaries may not qualify for service in an IRF or an LTCH.

The *Choose Home Care Act of 2021* describes discharge planning requirements to protect against the “woodwork” effect.¹ Eligibility for the program appears to operate on a case-by-case basis and would be controlled carefully through the use of an assessment tool—as required by the legislation—that includes consideration of an individual’s place of care preferences, functional ability, medical conditions, goals regarding care, and family caregiver concerns.

LIMITATIONS:

The HECH benefit is limited in several regards:

- 1) It may only be applied for one or more 30-day episodes immediately following acute care hospital discharge;
- 2) For each 30-day episode, the payment system accounts for a maximum of 360 hours of personal care services. Patients may reach this maximum as early as day 15 if they require 24-hour supervision and assistance. At this point, the model would pay for no additional hours under the HECH benefit.
- 3) For beneficiaries who end up needing care in a SNF after choosing to start care at home, days spent at home would count toward their otherwise-available Medicare SNF stay. HECH use ultimately counts toward the 100-day limit on SNF care those beneficiaries can receive, including the first 20 days before copayments are required.

¹The “woodwork” effect describes the increase in enrollment that can occur after programs are expanded or changed, encouraging eligible participants to “come out of the woodwork” to enroll in them.

Implications for HECH eligibility requirements on “Woodwork Effect”

The “woodwork” effect describes the increase in enrollment that can occur after programs are expanded or changed, encouraging eligible participants to “come out of the woodwork” to enroll in them. Since the expanded home care services benefit would only be available to individuals who would otherwise need services in a skilled nursing facility, we estimate that the potential “woodwork” effect will be minimal to none. Note that to be eligible for SNF, 1) the individual must have a qualifying hospital stay of at least 3 days within 30 days prior to the SNF admission and 2) a physician must certify that the individual needs daily skilled nursing care or other skilled rehabilitation services that can only be provided in an SNF.²

This means that any beneficiaries who may have chosen to use home care despite being certified for SNF care may be potential “woodwork” beneficiaries. To estimate the proportion of those potential “woodwork” beneficiaries, we analyzed 2020 PDGM claims to determine the proportion of cases with daily skilled nursing care or at least 5 days of therapy services each week. Our results showed that among the home health cases in 2018, approximately 2% received daily skilled nursing care or at least 5 days of therapy services each week, further providing evidence that the “woodwork” effect will be minimal to none.

We also reviewed the literature on the “woodwork” effect. In a widely recognized program subject to the “woodwork” effect, the home and community-based services (HCBS) evaluation literature provide evidence that the “woodwork” effect can be constrained through program design. In implementing HCBS, several states have developed a wide range of cost containment strategies to meet federal cost neutrality requirements and control state spending. For example, a 2016 Kaiser Family Foundation study³ found that approximately 25% of state HCBS programs used more restrictive financial eligibility standards than those used to determine eligibility for Medicaid coverage for institutional care. A few state programs used more restrictive functional eligibility criteria than those used for institutional care, while the majority of states with some form of expenditure restriction utilized service unit limitations.

Given the widespread use of financial control strategies, recent literature evaluating HCBS models using strict program design suggest a minimal “woodwork” effect. In a national study, Eiken et al.⁴ found that growth in Medicaid Long Term and Support Services (LTSS) costs after adjusting for inflation and national estimate of functional limitation was 1.8%

² Medicare Benefit Policy Manual Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance Table of Contents (Rev. 10880; Issued: 08-06-21), <https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c08pdf.pdf>.

³Terrence Ng, C. H. (2016, October 18). Medicaid home and community-based services programs: 2013 data update. KFF. Retrieved December 3, 2021, from <https://www.kff.org/medicaid/report/medicaid-home-and-community-based-services-programs-2013-data-update/>.

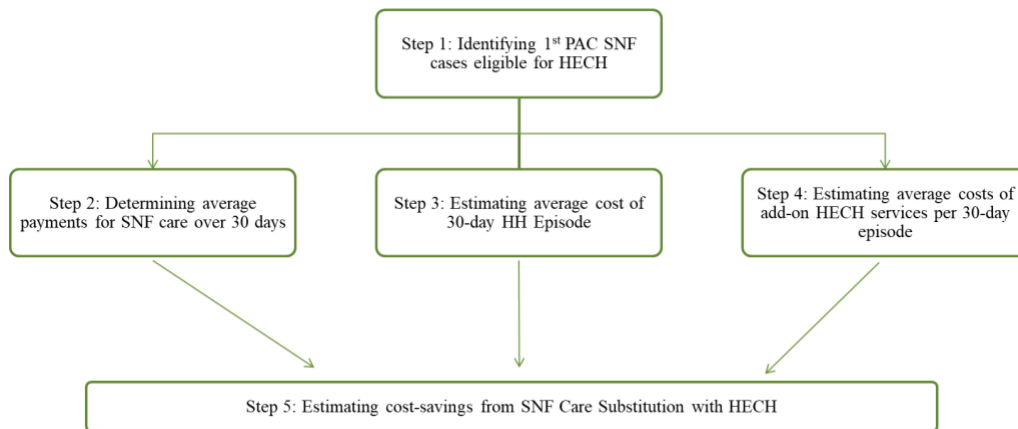
⁴ Eiken, S., Burwell, B., & Sredl, K. (2013). An examination of the woodwork effect using national medicaid long-term services and supports data. *Journal of aging & social policy*, 25(2), 134–145. <https://doi.org/10.1080/08959420.2013.766054>.

per year from 1999-2009, indicating minimal “woodwork” effect. Another national study by Kaye et al.⁵ found that although LTSS expenditures, on average across states, grew by 7.3% (with a large decrease in 2003-2005), the LTSS expenditure decreased by 7.9% in the established HCBS states—again suggesting minimal to no “woodwork” effect. Finally, Felix et al. examined the use of community health workers (CHWs) in Arkansas to find and help Medicaid beneficiaries access HCBS compared to standard HCBS outreach approaches. This study found that CHWs were very effective at finding persons with greater needs and were better able to help them access a wider range of HCBS services.⁶ Results showed no “woodwork” effect among low and high need individuals. Felix et al. estimated HCBS beneficiaries reduced long term care costs, ranging from \$3,687 to \$6,769 per client per year.

Methodology to determine the budgetary impact of the Choose Home Act of 2021

We determined the budgetary impact, i.e., cost-savings generated from the *Choose Home Care Act of 2021* through the following steps outlined in **Figure 1** below:

Figure 1: Flowchart Showing Methodology to determine Cost-Savings generated by using the HECH benefit



These steps are described in detail below:

⁵ Kaye, H. S., LaPlante, M. P., & Harrington, C. (2009). Do noninstitutional long-term care services reduce Medicaid spending?. *Health affairs (Project Hope)*, 28(1), 262–272. <https://doi.org/10.1377/hlthaff.28.1.262>.

⁶ Felix, Stewart, & Ali. (n.d.). Are community health workers more effective in identifying ... Retrieved October 21, 2021, from https://www.researchgate.net/profile/Holly-Felix/publication/332905405_Are_community_health_workers_more_effective_in_identifying_persons_in_need_of_home_and_community-based_long-term_services_than_standard-passive_approaches/links/5d5add0299bf1b97cf773ac/Are-community-health-workers-more-effective-in-identifying-persons-in-need-of-home-and-community-based-long-term-services-than-standard-passive-approaches.pdf.

STEP 1: IDENTIFYING 1ST PAC SNF CASES ELIGIBLE FOR HECH

We used 2018 Medicare administrative claims and functional assessments (CMS DUA 54757) to estimate which SNF cases may be substitutable for HECH. To do so, we examined characteristics prior to and during SNF 1st PAC cases.⁷

While Medicare Conditions of Participation partially govern which patients are eligible for care in each setting, SNF, IRF, and LTCH eligibility criteria partially overlap. Additionally, patients, their families, providers, and discharge planners may work together to choose an appropriate post-discharge care setting such that a given patient could come up in many settings. For example, typically, a beneficiary in an acute care hospital must have a 3-day acute care hospitalization prior to SNF admission to qualify for admission to SNF; this is also typical of IRF and LTCH patients though not required. LTCH patients generally must spend at least 3 days in the Intensive Care Unit, which we were able to identify in claims (in addition to other requirements of the LTCH stay itself). We applied available functional status data and recent findings from the Therapy Outcomes in Post-Acute Care Settings (TOPS) study on patient overlap across PAC settings to remove SNF cases that could potentially be eligible for IRF.⁸

IRFs and SNFs sometimes compete for similar PAC patient groups. In a prior study (not yet published), we constructed a composite tool to compare patients' functional impairment scores (as measured in OASIS, MDS 3.0, and IRF-PAI). This tool reoriented and rescaled assessment scores for six core activities of daily living (ADL) items – toileting, bathing, feeding, transferring, walking/locomotion, and dressing – measured similarly across the settings. This resulted in a 0–36-point scale for functional status, with 0 indicating maximal assistance to perform all ADLs and 36 indicating almost complete functional independence.

As shown in **Figure 2** Error! Reference source not found., 1st PAC admission functional status scores overlap between IRF, SNF, and HHA. Therefore, we chose a cutoff admission score of 12 (SNF median and close to IRF 75th percentile least impaired) as a minimum level of independence to be considered in the model. This removes the SNF cases most similar to IRF cases (i.e., the most likely IRF-eligible cases).

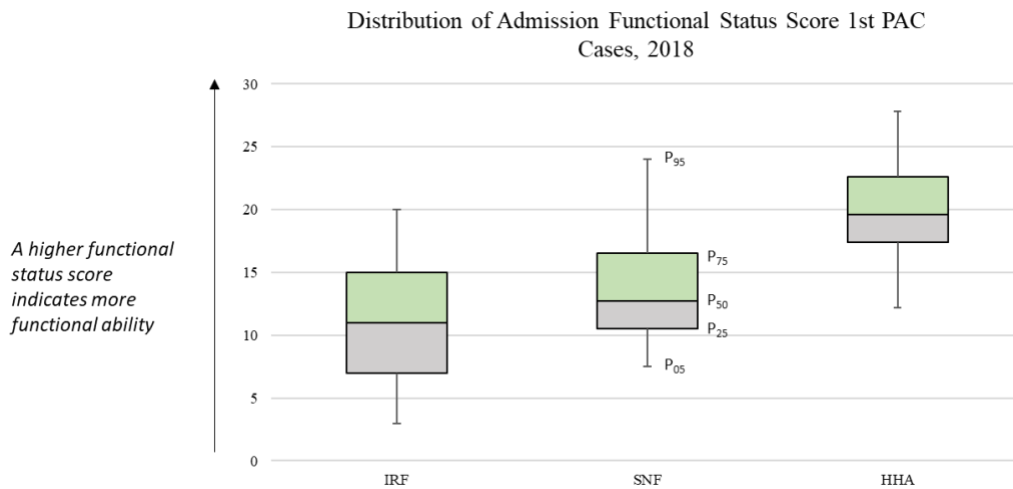
Note that we excluded any potentially eligible HHA cases from our analysis because to qualify for the Choose Home Care benefit, beneficiaries must otherwise be eligible for SNF

⁷ SNF admission must occur within 14 days of acute care hospital discharge and no other significant utilization occurred in between. See: CACEP2 Phase 1 report for additional detail.

⁸ The American Occupational Therapy Association and the American Physical Therapy Association. (2021, April 5). Therapy Outcomes in Post-Acute Care Settings (TOPS) Study: Physical therapy, occupational therapy provide rehab value in post-acute care. APTA. Retrieved December 6, 2021, from <https://www.apta.org/article/2021/04/05/apta-aota-joint-statement>.

care (which means they must have a prior 3-day hospital stay and require daily skilled care, not intermittent care).

Figure 2: Distribution of Admission Functional Status Scores [Based on a Composite Tool Developed by Dobson | DaVanzo] Across 1st PAC Cases



Source: Dobson | DaVanzo analysis of Medicare Assessment Data, CMS DUA 54757

Note: In the above figure, P_{95} represents the 95th percentile, P_{75} represents the 75th percentile, P_{50} represents the 50th percentile, P_{25} represents the 25th percentile, P_{05} represents the 5th percentile. Percentiles illustrated on the SNF cases are applicable across the other cases for HHA and IRF

We tested multiple variations on these requirements to arrive at our final overlap test groups. We finally used the following SNF case limitations:

- I. Acute care hospital discharge characteristics:
 - a. Minimum 3-day hospital stay to include typical SNF cases.
 - b. Maximum 2 days in the ICU to exclude LTCH-eligible cases.

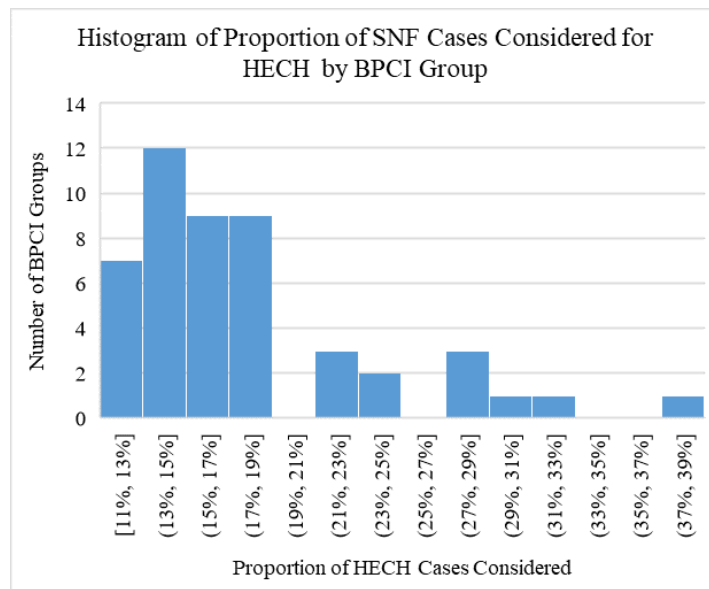
- II. SNF stay characteristics:
 - c. Maximum 30-day length of stay to match maximum episode length of a 30-day HECH benefit. Note that since the current HECH benefit can cover more than one 30-day HECH episode, we also explored criteria limiting cases to those with a maximum SNF length of stay of 60 days and 100 days, but ultimately chose the 30-day length of stay as those cases are likely to be of lowest acuity and thus most suitable for HECH.
 - d. Composite functional impairment admission score ≥ 12 (more functionally independent than about 75% of IRF cases on admission) to remove IRF-eligible cases. (See **Figure 2**)

- III. Home-life information:

- e. The SNF MDS 3.0 assessment tool includes two items that may be used to approximate whether the beneficiary has caregiver support – often a critical element for many beneficiaries to remain in-home without 24-hour professional medical supervision.
 - i. Marital status and Family Involvement in Medical Decision-Making were the two closest proxies available. If either had a positive indicator, we considered the beneficiary to have caregiver support at home.

Combined, these criteria identified about 17% of SNF 1st PAC cases that may be appropriate for the HECH add-on benefit. This varied by clinical group (we applied Bundled Payment for Clinical Improvement (BPCI) groupings from the acute care hospital) in **Figure 3**, with some groups indicating greater substitutability than others. For example, SNF Double Joint Replacement of the Lower Extremity shows 37.59% of cases could be substituted for by HECH, whereas more intensive or highly acute conditions like Cardiac Defibrillator, Stroke, Sepsis, and Other Respiratory diseases show between 12% to 13% of cases could be substituted for by HECH.

Figure 3: Portion of SNF Cases Considered for HECH Add-On Substitution, by BPCI DRG Group



Source: Dobson | DaVanzo analysis of data from CMS DUA 54757

STEP 2: DETERMINING AVERAGE COST PAYMENTS FOR SNF CARE OVER 30 DAYS

We used available 2020 claims (under CMS DUA 54757) to estimate the average cost of SNF care for patients eligible for HECH. This allowed us to make estimates of 2020 SNF prospective payment system (PPS) payments and length of stay. We determined that SNF

cases eligible for HECH had an early 2020 average payment per day of about \$546. Once we adjusted for the relative case-mix grouping of the SNF-HHA overlap cases, this rose to about \$580. In addition, we observed SNF per diem payments changing throughout the length of stay. For example, after day 20, the beneficiary copay accounts for 20% of payments. For an average per diem payment of \$580, this means that Medicare Trust Fund outlays could decline to about \$464 per day on day 21 and after. This translates to about \$12,348 for 30 days after accounting for beneficiary copays after day 20).

STEP 3: ESTIMATING THE AVERAGE COST OF 30-DAY HH EPISODE

We also use available 2020 claims to estimate the average cost of Home Health care for a patient eligible for HECH. This data under CMS DUA 54757 (as used in the ongoing PQHH PDGM project) allowed us to make estimates of the base home health PDGM case payments. We found that the average 2020 home health episode payment under PDGM for ‘Early Admission Institutional’ cases was approximately \$2,297 for a 30-day episode. We estimated the home health payment for an ‘Early’ admission case as we are assuming SNF eligible cases are of low acuity and have an average length of stay of less than 30-days in SNF, translating to one 30-day HECH episode.

STEP 4: ESTIMATING AVERAGE COSTS OF ADD-ON HECH SERVICES PER 30-DAY EPISODE

The HECH would serve as an add-on payment to a normally paid home health episode under the HH PPS. Note that we consider the average home health payments calculated in Step 3 above in the final equation to calculate the overall HECH cost-savings. HECH payments are structured as a flat rate that can fall into one of four groups based on hours of additional personal care services provided during the episode, which is then wage-index adjusted based on service location:

HECH Payment Structure from Choose Home Care Act of 2021

1. 0-60 Hours - \$2,010.
2. 61-120 Hours - \$4,020.
3. 121-240 Hours - \$7,360.
4. 241-360 Hours - \$10,720.

Additionally, according to the *Choose Home Care Act of 2021*, the amount of the add-on payment would be capped at 80 percent of the national median 30-day payment amount for extended care services in a skilled nursing facility.

In addition, cost-savings are highly dependent on the total hours of personal care services used under HECH as HECH add-on payments are structured as a flat rate that can fall into one of four groups based on hours of additional personal care services used.

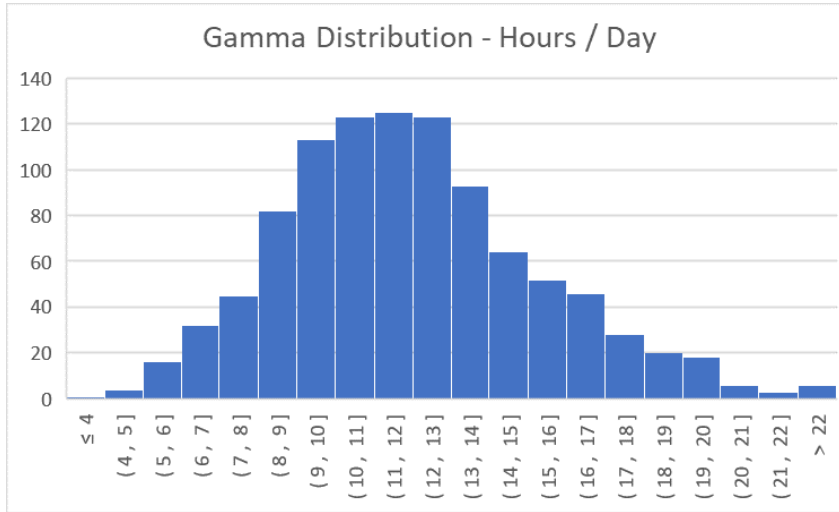
For instance, a beneficiary utilizing 24-hour personal care daily under the HECH benefit would exhaust the benefit by day 15, resulting in total home health and HECH add-on costs of \$13,017 (\$10,720 HECH + \$2,297 HH). In this case, no savings would be generated, and instead, an additional cost of \$669 would be incurred based on the estimated average cost of \$12,348.

a) Simulating Hours of Personal Care Based on a Gamma Distribution

Given the payment structure of the HECH benefit, estimated average costs of the HECH benefit for SNF eligible cases are dependent on the assumptions about how many hours of personal care services/medical supervision are required for each case. Since the HECH benefit would be new and we have no real data on the potential hours of personal care used within a 30-day HECH benefit, we simulated data to project the spread of hours per day across cases. First, we chose a gamma distribution because this tends to fit service utilization patterns (i.e., low median use relative to the mean). Note that the underlying length of stay distribution for identified HECH eligible SNF cases by BCPI groups also follows this distribution. We then randomly simulated the average hours per day during a HECH 30-day episode for over 1,000 cases based on a gamma distribution while varying the center point of the distribution.

We varied the center point of the gamma distribution from 4 to 18 hours per day to establish savings estimates for a broad range of assumptions. Ultimately, we used peaks of 8-12 hours of care per day to estimate savings. Based on these analyses, we identified 12 hours as the realistic average number of personal care hours per day. A beneficiary would have to use an average of 12 hours of personal care services per day to receive those services consistently throughout their 30-day stay. (Maximum of 360 hours of personal care services) This simulation approach also allows for potential outliers who would exhaust the benefit early.

Figure 4: Example of Gamma Distribution of Simulated HECH Hours Per Day, Centered at 12 hours Per Day



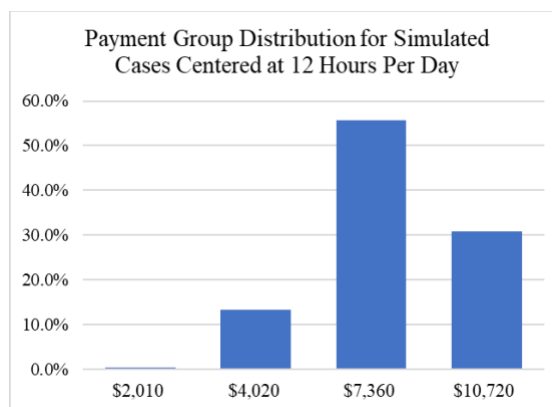
Source: Dobson | DaVanzo example gamma distribution

b) HECH add-on Payment Distribution from Simulated Hours of Personal Care

We then used the randomly simulated average hours per day from step 4 a) above to determine the average HECH add-on payment for each set of cases with the different center points of the distribution.

For example, **Figure 5** (on the next page) shows the HECH add-on payment distribution across the four HECH payment levels using the distribution of personal care hours per day centered around 12 hours. This translates to an average HECH add-on payment of \$7,740.

Figure 5: Example of Gamma Distribution of Simulated HECH Hours Per Day, Centered at 12 hours Per Day



STEP 5: ESTIMATING COST-SAVINGS FOR SNF CARE SUBSTITUTION WITH HECH

a) Estimating cost-savings from simulated hours of personal care under HECH based on the gamma distribution

Finally, we estimated the cost-savings from SNF care substitution from the difference in costs of SNF care and HECH care in addition to Home Health care for eligible beneficiaries as shown in **Figure 6** below:

Figure 6: Equation Used to Derive Cost-Savings for SNF Care Substitution

$\begin{aligned} & \text{Total Cost-Savings} \\ & = \\ & \text{Total 1st PAC SNF Cases Eligible for HECH (step 1)} \\ & \times \\ & \text{Average Payments for SNF Care over 30-days (step 2) - Average Cost of 30-day HH episode (step 3) - Average Cost of HECH per 30-day episode (step 4)} \end{aligned}$

We derived estimates based on simulations of gamma distributions centered around 8 and 12 hours of personal care services used per day under HECH. We also assumed that only 25% of the eligible beneficiaries would use the HECH benefit in year 1. **Table 1** below shows our results.

As shown in **Table 1** below, we estimated that the average HECH add-on payment amount for cases simulated with a gamma distribution centered on 12 hours of personal care per day was \$7,740, the average “Early-Institutional” home health episode was \$2,297, while the average SNF 30-day care cost was \$12,348. Assuming a take-up rate of 25%, only 52,510 of the original eligible beneficiaries would use the HECH benefit. The total cost-savings under this scenario are \$121,358,632. [52,501 x (\$12,348-(\$7,740+\$2,297))]

Table 1: Cost-Savings Estimates for HECH based on Simulations of 8 and 12 Hours of personal care use Per Day Under HECH

	Distribution centered on 8 hours per day	Distribution centered on 12 hours per day
Step 1: Total 1st PAC SNF Cases Eligible for HECH		
<i>Total 1st PAC SNF Cases</i>	1,235,530	1,235,530
<i>Proportion of 1st PAC SNF Cases Eligible for HECH</i>	17.00%	17.00%
<i>Take-up rate</i>	25.00%	25.00%
<i>Total 1st PAC SNF Cases Eligible for HECH</i>	52,510	52,510
Step 2: Average Payments for SNF Care over 30-days	\$12,348	\$12,348
Step 3: Average Cost of 30-day HH Episode	\$2,297	\$2,297
Step 4: Average Cost of HECH per Case per 30-day episode	\$5,825	\$7,740
Step 5a: Total Cost-Savings for SNF Care Substitution with HECH	(\$221,920,931)	(\$121,358,632)

Further, to determine the cost-savings over 10 years, we assumed uptake would increase to 50% by year 5 and then remain at 50% through year 10.

Findings

To estimate the potential impact and reach of the HECH add-on benefit as proposed, we applied the specifications outlined in the *Choose Home Care Act of 2021* rule text to identify SNF cases that could potentially be appropriate HECH cases to our 2018 Medicare Claims and functional assessments databases. We applied the proportion of cases eligible to the total number of 1st PAC SNF cases in 2020 and used the payment levels found in the 2020 database to determine the average SNF payments within a 30-day period as well as the average 30-day episode payment for an “Early Admission” home health case in 2020.

We evaluated the net impact of a potential HECH implementation approach with several criteria in mind including: 1) the expected change in Medicare outlays and 2) how would this affect home health case load relative to the current volume.

Overall, the most critical analytic assumption is how each day of SNF institutional care would translate to hours of care in HECH. To project the spread of hours per day across cases, we applied over 1,000 randomized simulations of gamma distributions while varying the center point of the distribution and estimated cost-savings based on 8 and 12 hours of daily personal care use under HECH.

Last, we applied the 2020 Congressional Budget Office SNF Medicare baseline to estimate long-term savings. These estimates were made prior to a broad understanding of the effects of COVID-19 on the healthcare system. While we did examine early action 2020 claims (and found SNFs with 19% reduced volume but 1.5% increased payments in the first 6 months of 2020 relative to 2019), we ultimately did not alter the 10-year CBO outlook from which we draw savings estimates.

Key findings:

1. We identified that 17% of SNF cases (210K) would be potentially eligible for HECH accounting for 15.5% of simulated 2020 SNF payments (\$2.6B). However, we assumed that only 25% (52K) of those eligible SNF cases would use HECH in year 1.
2. Substituting SNF care with HECH for eligible cases would increase home health 1st PAC case volume by about 15.7% if all eligible cases enrolled and by 3.89% if only 25% of eligible cases enrolled.
3. Total cost savings from SNF care substitution with the HECH add-on varies depending on the assumptions. After applying a gamma distribution and varying assumptions on average hours of personal care use per day, we estimate this could generate savings from \$121-222M (4.4-8.6% savings on matched cases) per year.
4. These annual cost-savings would accrue to \$2.6-4.8B over ten years assuming the uptake rate increased to 50% by year 5. This represents a 1.5-2.8% overall reduction relative to SNF expenditures over the period.

Discussion

The HECH add-on would meaningfully expand the Medicare home health benefit and allow an expanded choice of care setting for qualifying beneficiaries, specifically allowing more beneficiaries to remain in their place of residence following a hospital discharge. This is particularly important during the ongoing COVID-19 public health emergencies, wherein poor infection control in SNFs and nursing homes have been a contributing factor in patient mortality. In simulations, the HECH add-on could provide significant Medicare savings when substituting for SNF institutional care.

We made multiple analytic assumptions to identify appropriate patients and simulate the care they might need under the HECH add-on if they substitute this for SNF institutional care. We assume that patients and their providers, discharge planners, and caregivers will work together to make clinically appropriate judgments and will understand the limitations (and care implications thereof) of the new benefit when they make such decisions. We simulated this in a relatively nuanced way by limiting SNF substitution cases to those with a SNF length of stay of 30 days or shorter, setting a maximum level of assessed functional dependence, and requiring some manner of family or caregiver involvement.

Finally, we did not estimate the potential “woodwork” effect from beneficiaries that may be currently eligible for SNF care but opt for home health. Our analysis shows that only a small fraction (2%) of cases met SNF requirements for daily skilled care or therapy services at least 5 days a week existed in the 2018 home health database. Given that we assume an uptake rate of 25% in year 1 of the program, the potential “woodwork” effect would be further reduced to 1%. Further, the strict requirements that eligible cases be otherwise eligible for SNF care described in the *Choose Home Act of 2021* suggest that patients must meet SNF eligibility requirements before qualifying for the program.

Dobson | DaVanzo will continue to monitor the developments relative to this proposed legislation as well as any cost-savings implications of the Medicare home health benefit.