# Characteristics of Home-Based Care Provided by Accountable Care Organizations

*Robert E. Mechanic, MBA; Jennifer Perloff, PhD; Amy R. Stuck, PhD, RN; and Christopher Crowley, PhD*

## ABSTRACT

**OBJECTIVES:** To describe the use of home-based services in accountable care organizations (ACOs).

**STUDY DESIGN:** Cross-sectional analysis of 2019 ACO survey.

**METHODS:** We analyzed surveys completed by 151 ACOs describing the characteristics of home-based care programs serving high-need, high-cost patients. We linked survey results to publicly available information about ACO characteristics, governance, and risk model participation.

**RESULTS:** Twenty-five percent of respondent ACOs had formal home-based care programs, 25% offered occasional home visits, and 17% were actively developing new programs. Home-based primary care was the most common program type. Half of programs were established within the past 3 years. The programs utilized multidisciplinary care teams, but two-thirds had fewer than 500 visits annually. Funding sources included direct billing for services, health system subsidies, and ACO shared savings. A majority of respondents expressed interest in expanding services but were concerned about their ability to demonstrate a return on investment (ROI), which was reported as a major or moderate challenge by three-quarters of respondents.

**CONCLUSIONS:** ACOs deliver a diverse array of home-visit services including primary care, acute medical care, palliative care, care transitions, and interventions to address social determinants of health. Many services provided are not billable, and therefore ACO leaders are hesitant to fund expansions without strong evidence of ROI. Expanding Medicare ACO home-visit waivers to all risk-bearing ACOs and covering integrated telehealth services would improve the financial viability of these programs.

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Improving care for high-need, high-cost (HNHC) individuals with multiple chronic conditions, functional limitations, and complex social needs is an issue of growing interest for policy makers, health systems, and payers.[1] These individuals account for a large proportion of Medicare spending generally and a disproportionate amount of potentially preventable spending.[2] The needs of HNHC individuals are frequently not well addressed by a health care system and culture that are focused on specialized and facility-based care.[3] Home-based care is increasingly recognized as an approach with potential to improve outcomes and patient experience for HNHC individuals.[4]

There are many different home-based care models: home-based primary care (HBPC), hospital at home (HAH), community paramedicine, postdischarge transitional care, and care coordination services that employ both clinical and lay personnel. These models are distinct from certified home health agency services, which are not covered in this paper.

HBPC is well established but regularly practiced by relatively few providers. In 2013, approximately 5000 primary care providers made 1.7 million home visits to Medicare fee-for-service (FFS) beneficiaries, but almost half of the visits were delivered by just 470 providers.[5] More than half of Americans live more than 30 miles from any of these high-volume providers, limiting Medicare beneficiary access to HBPC services.[5]

Medicare reimbursement affects the availability of home-based care. Medicare pays for HBPC delivered by physicians or advanced practice clinicians (APCs), but HBPC providers see far fewer patients than office-based providers because of travel time, which limits revenue. Medicare has not historically paid for HAH, but in late 2020, CMS established a waiver covering certain HAH services during the COVID-19 pandemic.[6] Transitional care management services are covered by Medicare when provided by a clinician but are typically offered in a provider's office or telephonically.

Home-based programs rely on multidisciplinary teams, and patients may be visited by nurses, social workers, paramedics, and community health workers—none of whom can bill for home visits in most circumstances. As a result, many programs rely on

financial support from a hospital, medical school, or philanthropic organization.[7]

Although not historically well reimbursed, studies have shown that HBPC,[8,9] HAH,[10] home-based care transition support,[11,12] and home-based programs led by registered nurses or lay health workers[13,14] can lower spending for complex patients. These savings do not accrue to providers under traditional FFS reimbursement but generate financial benefits under models like capitation that pay a fixed per-member per-month amount for covered beneficiaries.

Accountable care organizations (ACOs) are well positioned to improve care for HNHC populations. ACOs are provider groups that take responsibility for caring for a specified set of beneficiaries. They are eligible to share in savings if they manage spending below a prospective budget target. Many ACOs have data systems and processes to identify high-risk beneficiaries and establish care plans to coordinate services for complex patients.[15] Prior research suggests that a majority of ACOs make home-based care transition visits, primarily conducted by nonphysician staff.[16] This paper offers a more comprehensive assessment of home-based care in ACOs.

**TAKEAWAY POINTS**

Many accountable care organizations (ACOs) provide home-based care to high-need patients, including primary care, acute care, support for care transitions, and interventions to address social determinants of health. However, many services are not well reimbursed, limiting program growth.

- There is no prior research describing the full range of home-based care programs in ACOs.
- With Medicare's expansion of mandatory downside risk, more ACOs are considering home-based programs.
- ACO managers are hesitant to expand these programs unless they can demonstrate a return on investment.
- Expanding home-visit waivers to all risk-bearing Medicare ACOs and covering telehealth for patients receiving home-based primary care would improve these programs' financial viability.

## METHODS

We conducted a national survey of ACOs to assess the prevalence and characteristics of home-based care programs. It targeted ACOs participating in the Medicare Shared Savings Program (MSSP) or Next Generation ACO (NGACO) model as of July 1, 2019, that remained in the program during 2020 (N = 505).

A web-based survey was sent to ACOs in September 2019. Weekly email reminders were sent to nonrespondents for the first 4 weeks, and biweekly reminders were sent over the next 4 months. Survey results were merged with information on Medicare ACO characteristics. Descriptive analysis of survey results focuses on ACOs with 1 or more home-based initiatives.

## RESULTS

We received 151 completed surveys for a 30% response rate. Respondents were larger, were more likely to be affiliated with a health system, and had more Medicare ACO experience than nonrespondents (**Table 1**). Forty-four percent of respondents were enrolled in a Medicare ACO track with downside risk compared with 40% of all Medicare ACOs.

Two-thirds of ACOs reported some home-visit activity: 25% had formal programs, 25% provided occasional home visits, and 17% were actively developing programs.

This paper focuses on the 40 ACOs with formal home-visit initiatives. Fifty-eight percent of them participated in a Medicare ACO arrangement with downside risk vs 40% for all ACOs. They were also more likely to participate in commercial and Medicare

**TABLE 1.** Characteristics of ACO Survey Respondents and All Medicare ACOs Participating in 2019 and 2020

| Characteristic | Respondent ACOs with home-visit programs (n = 40) | All respondent ACOs (n = 151) | All Medicare ACOs in 2019 and 2020 (N = 505) |
|---|---|---|---|
| Type of Medicare ACO contract | | | |
| Next Generation ACO | 20% | 14% | 8% |
| MSSP shared risk[a] | 38% | 30% | 32% |
| MSSP shared savings | 43% | 56% | 60% |
| Participation in commercial and Medicare Advantage ACO contracts | | | |
| Commercial shared savings | 66% | 61% | N/A |
| Commercial risk contract | 37% | 29% | N/A |
| Medicare Advantage shared savings | 46% | 56% | N/A |
| Medicare Advantage risk contract | 44% | 32% | N/A |
| Region | | | |
| Northeast | 23% | 19% | 21% |
| Midwest | 33% | 24% | 22% |
| South | 38% | 46% | 44% |
| West | 8% | 11% | 13% |
| MSSP start year | | | |
| 2012-2015 | 60% | 43% | 41% |
| 2016-2019 | 40% | 57% | 59% |
| Number of beneficiaries | | | |
| < 10,000 | 15% | 25% | 31% |
| 10,000-19,999 | 33% | 31% | 34% |
| ≥ 20,000 | 53% | 44% | 35% |
| ACO includes hospital | | | |
| Yes | 60% | 63% | 54% |
| No | 40% | 37% | 47% |

ACO, accountable care organization; MSSP, Medicare Shared Savings Program; N/A, not available.

[a]Medicare shared risk contracts are defined as MSSP contracts that qualify as advanced alternative payment models.

Sources: Self-reported survey data from 151 ACOs, MSSP 2019 and 2019A ACO Public Use Files, and 2020 MSSP participation list.

**TABLE 2.** Home-Visit Program Characteristics[a]

| | |
|---|---|
| **Primary function of home-visit program (n = 46)** | |
| Home-based primary care | 37% |
| Coordinate patient care | 24% |
| Transition patients from facility to home | 13% |
| Address social needs | 13% |
| Deliver hospital-level acute care services | 11% |
| Palliative care services | 2% |
| Urgent care services | 0% |
| **Year program was started (n = 46)** | |
| 2013 or earlier | 24% |
| 2014-2016 | 26% |
| 2017-2019 | 50% |
| **Number of annual home visits (n = 46)** | |
| ≥ 1000 | 15% |
| 500-999 | 17% |
| 200-499 | 7% |
| 100-199 | 17% |
| 0-99 | 22% |
| Not reported | 22% |
| **Number of programs reporting clinical staff by type (n = 46)** | |
| Physician | 48% |
| Advanced practice clinician | 65% |
| Nurse | 85% |
| Social worker | 70% |
| Pharmacist | 35% |
| Paramedic | 30% |
| Community health worker | 37% |
| Other | 21% |
| **Duration of services (n = 45)** | |
| Single visit | 24% |
| 1 month or less | 13% |
| 1-3 months | 20% |
| 4-6 months | 22% |
| More than 6 months | 9% |
| Variable duration | 11% |
| **Sources of program funding (n = 43)** | |
| Reimbursement for billed services | 54% |
| Shared savings | 52% |
| Support from hospital or health system | 46% |
| Grant funding | 15% |
| Third-party payers | 7% |
| Other | 15% |
| **Use of video visits with home-based patients (n = 42)** | |
| Routinely conduct video visits | 7% |
| Piloted video visits | 17% |
| Haven't used video visits | 76% |
| **Use of remote patient monitoring (n = 44)** | |
| Yes | 30% |
| No | 70% |

(*continued*)

Advantage risk contracts than other respondents (Table 1). ACOs with home-visit programs were larger and had more Medicare ACO experience than other ACOs.

The 40 ACOs reported 49 distinct home-based initiatives that focused on home-based primary care (37%), care coordination (24%), care transitions support (13%), addressing social needs (13%), and acute hospital-level services (11%), as shown in **Table 2**. Respondents provided other services to supplement their program's principal function including care coordination (70%), addressing social determinants (65%), care transition support (59%), palliative care (41%), and acute urgent care services (24%).

Half of the programs were established between 2017 and 2019, and one-third of them reported 500 or more home visits annually (Table 2). Duration of services ranged from a single home visit (24%), 30 days or less (13%), 1 to 6 months (42%), to longer than 6 months (9%).

Most home-visit programs utilized multidisciplinary teams. Key staff included physicians (48% of programs), nurse practitioners (65%), registered nurses (85%), and social workers (70%). Approximately one-third reported using pharmacists, paramedics, or community health workers (Table 2).

The sustainability of home-visit models depends on funding. Major sources of program funding included billed services (54% of programs), shared savings from value-based contracts (52%), and institutional support (46%). Fifteen percent reported grant funding, and 7% reported direct support from health plans.

Respondents were asked whether they considered 6 specific issues as major, moderate, minor, or insignificant challenges (data not shown). The most common major challenge was demonstrating return on investment (ROI) (45%), followed by engaging physicians to refer patients for home-based services (30%). The most common major or moderate challenges were finding community resources for patients with social needs (72%), demonstrating ROI (70%), physician engagement to refer patients (60%), and targeting the right patients (58%).

## DISCUSSION

Our survey shows that ACOs are involved in a diverse range of home-based initiatives. ACOs' programs differed in size, staff mix, type of care provided, duration of services, and funding sources. Half of the programs were established in the past 3 years. This may reflect increasing pressure to develop initiatives that moderate spending growth as more ACOs enter risk contracts. ACOs that reported home-based programs were more likely to participate in payment models with downside risk, suggesting that more ACOs may adopt home-based care as CMS expands mandatory risk requirements.

Forty percent of respondents reported plans to expand their home-based programs, whereas 38% percent reported they would expand only if they could demonstrate positive ROI. However, measuring ROI was identified as a major challenge by 45% of programs and a moderate challenge by 26%. This is critical because many organizations are reluctant to invest in new programs designed for cost savings rather than revenue generation.

Measuring ROI is complicated by the financial structure of shared savings models. The MSSP establishes spending targets for each ACO while paying FFS for the care provided. Even if home-visit programs generate savings, the ACOs won't benefit unless they generate sufficient overall savings. Historically, 30% to 50% of MSSP ACOs earn shared savings in any given year. These payments aren't made until 9 months after the performance year ends, so ACOs need to fund new programs with their own capital.[17] The business case is stronger with prospective monthly payments per beneficiary, which is an option under Medicare's new ACO Realizing Equity, Access, and Community Health (REACH) model (formerly called Direct Contracting).

During the COVID-19 pandemic, Medicare began reimbursing for a wide range of telehealth services. Continued telehealth coverage beyond the pandemic could be a game-changer for HBPC because providers could reduce travel time and see more patients through a mix of virtual and in-person care. Although frail older patients often have difficulty with telehealth technologies,[18] practices can send medical assistants or paramedics to patients' homes to set up video visits and assist in exams using remotely enabled devices.

Although physicians and APCs can bill for home-based services, personnel like paramedics and nurses cannot. Medicare has been more willing to pay for services from nonclinician staff when organizations accept financial risk for the total cost of care. The NGACO and ACO REACH models offer waivers that authorize payment for up to 9 postdischarge home visits by licensed clinical staff under the general supervision of a physician.[19]

### Limitations

This study has several limitations. First, the survey response rate was low (30%). Second, respondents were larger and more likely to participate in risk contracts, so our results may not be representative of all ACOs. Finally, ACOs may have added or dropped home-visit initiatives since completing the survey because of the COVID-19 pandemic.

## CONCLUSIONS

Home-based programs are a promising strategy to improve care for high-need patients while reducing preventable hospital and emergency care. Policy changes to strengthen the financial viability of home-based care for ACOs include expanding home-visit waivers to MSSP ACOs taking downside risk; expanding the new HAH waiver, now available only to acute care hospitals, to independent medical groups; and paying for telehealth in conjunction with HBPC services on a permanent basis. These steps could help ACOs lower rates of preventable acute care services for HNHC patients and provide more personalized care in the comfort of their homes. ■

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***Author Affiliations:*** Brandeis University (REM, JP), Waltham, MA; Institute for Accountable Care (REM, JP), Washington, DC; The West Health Institute (ARS, CC), La Jolla, CA.

**TABLE 2.** (*Continued*) Home-Visit Program Characteristics[a]

| Do you plan to expand the program? (n = 45) | |
|---|---|
| Yes, definitely | 40% |
| Yes, but only if we can demonstrate ROI | 38% |
| Not sure | 20% |
| No, program is at optimal size | 2% |

ACO, accountable care organization; ROI, return on investment.
[a]Data reported are from 49 home-visit programs operated by 40 ACOs.
Source: Self-reported survey data from 151 ACOs.

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***Authorship Information:*** Concept and design (REM, JP, ARS, CC); acquisition of data (REM, JP); analysis and interpretation of data (REM, JP, ARS, CC); drafting of the manuscript (REM, JP, ARS, CC); critical revision of the manuscript for important intellectual content (REM, JP, ARS, CC); and statistical analysis (JP).

***Address Correspondence to:*** Robert E. Mechanic, MBA, Brandeis University, 415 South St, MS035, Waltham, MA 02454. Email: mechanic@brandeis.edu.

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