Profiting at the Expense of Seniors: The Financialization of Home Health Care

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September 2023

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Contents

Acknowledgments

We are grateful to the Omidyar Network for generous funding of this study and to David U. Himmelstein, Steffie Woolhandler, Erin C. Fuse Brown, Dean Baker, Oscar Valdes-Viera, and Hayley Brown for helpful comments on an earlier version of the paper. We thank Brandon Novick for fact checking and other assistance. We are especially grateful to the experts who gave their time and shared their knowledge and experiences with us.

Executive Summary

Home health care for seniors, traditionally supplied by small- to medium-sized independent agencies on a fee-for-service basis, has changed dramatically in the past decade. Current payment models developed by the Centers for Medicare and Medicaid Services (CMS) privilege the interests of large health insurance companies and other financial actors seeking to maximize profits over those of providers of traditional Medicare services. In the traditional model, Medicare both pays for health care services and administers the program. Individuals can see the Medicare-approved provider of their choice, and Medicare pays the providers' fees for services rendered when a claim is submitted. In contrast, Medicare Advantage (MA) is a privatized form of Medicare that is paid for by Medicare but operated by private health insurance companies. Despite its name, Medicare Advantage is a private insurance product, not Medicare. CMS uses a "capitated" payment model (that is, flat, individual, per person payments) to pay for services provided by Medicare Advantage. CMS claims that the capitated payments improve the quality of patient care and reduce health care costs, and it refers to this payment system as "value-based care." But the preponderance of evidence shows the opposite: Privatized senior care has led to higher costs for Medicare and a drain on the Medicare trust fund. At the same time, it has increased the profits of insurance companies and reduced the quality of patient care by requiring preauthorization for treatment that may be denied and limiting patient choices to a narrow provider network.

In response, large health insurance firms that own large Medicare Advantage plans have entered the home health market. In the last decade, the insurers with the greatest number of Medicare enrollees — UnitedHealth Group, Humana, and CVS/Aetna — have acquired the largest home health agencies. Private equity (PE) has also responded to the growth and aging of the Medicare population. PE firms focus on agencies that serve the traditional fee-for-service Medicare population, rolling them up into large home health chains that can monopolize local health markets. PE has a longer history of buying up home health agencies than does Medicare Advantage, but it has a smaller presence in this market. Health insurance giants and PE firms are driving consolidation in home health markets, making it harder for independent agencies, whether for-profit or nonprofit, to compete.

Despite the evidence that Medicare Advantage costs substantially more on a per patient basis, CMS continues to promote the insurer-owned MA plans as cheaper than traditional fee-for-service Medicare. The nonpartisan Medicare Payment Advisory Commission (MedPAC) estimates that upcoding by MA plans that make enrollees appear to be sicker than they are costs CMS 106 percent of what traditional Medicare costs; adding in the quality bonus payments brings it to 108 percent. MA plans also enroll healthier Medicare beneficiaries, increasing their operating surplus by another 11 percent, making the payments to MA plans 19 percent higher than the payments to traditional Medicare. CMS's announced goal for traditional Medicare beneficiaries is to move all of them to Accountable Care Organizations, which use the valued-based payment model, or other similar care arrangements, by 2030. CMS's leading model to accomplish this shift is ACO REACH — a gentler, kinder version of the Trump administration's backdoor enrollment of traditional Medicare beneficiaries in a capitated payment model. According to CMS, 13.3 million traditional Medicare beneficiaries are already covered by various value-based payment models, including, in addition to ACO REACH, the Medicare Shared Savings Program and the Kidney Care Choices Model.

The evidence on the effects of capitated/value-based payments in MA plans on insurers' profits, on CMS's costs, and on patients' quality of care makes us skeptical of MA-like health care payment models. Medicare services are almost entirely funded by the payroll taxes of working people. They deserve a health care system in their older years that is patient-centered, not profit driven. They would be better served if CMS created a level playing field for traditional Medicare by allowing it to also offer vision and hearing care and by capping beneficiaries' out-of-pocket costs.

As CMS intended, value-based payments have promoted the growth of Medicare Advantage and the dramatic shift in the share of Medicare participants enrolled in the insurance-owned plans. As of August 2023, 51 percent of Medicare beneficiaries are now enrolled in MA plans, and the share is growing. The plans now serve a larger and older population than they did 10 years ago, driving the need for home health services.

There is much concern about overpayments in the MA program. MedPAC (The Medicare Payment Advisory Commission) reported that in 2020, Medicare spent $1,538 *more* per beneficiary in Medicare Advantage plans than they would have spent for the same patients if they were in

traditional Medicare — resulting in $12 billion in overpayments. Our synthesis of the available studies shows that CMS's use of claims data from traditional Medicare as the basis of the benchmark used to pay for Medicare Advantage inflates MA payments. We discuss several reasons for this. The first is that MA plans serve a senior population that is healthier and less expensive to care for than the population of traditional Medicare beneficiaries. Another one is that payments from CMS that are calculated in relation to the benchmark assume average health status for all MA enrollees. Plans receive additional money for higher risk, sicker members. This creates an incentive for profit-driven firms to inflate risk scores, and the top health insurance companies that own MA plans also own major risk assessment companies. This sets up a conflict of interest and leads to the potential for upcoding risk scores and overcharging Medicare. Indeed, all but one of the top 10 MA plans is now, or has been, under investigation for upcoding. Overpayments to MA plans due to upcoding can be used to increase benefits for MA plan participants. This makes Medicare Advantage a popular choice for seniors and creates unequal access to benefits between seniors enrolled in MA plans and those in fee-for-service Medicare.

Another feature of the CMS payment system is bonus payments for quality, as measured by the number of stars an MA plan receives. It reflects mixed results at best on quality, but "star inflation" increases rebates to Medicare Advantage plans at taxpayer expense. Unlike other rebates that MA plans receive, which must be used to reduce premiums and/or provide additional benefits, quality bonuses can be used to increase plan profits.

Higher CMS payments to MA plans are the result of quality bonuses, the upcoding of risk scores, and serving a healthier population of beneficiaries.

The financial position of Medicare has improved, and the Medicare HI trust fund is now expected to last through 2031, but upcoding of patients and overpayments to for-profit providers drain its resources and remain a threat to its longer-term viability.

Evidence regarding differences in the quality of home health care received by beneficiaries in traditional Medicare compared to Medicare Advantage is thin. But carefully done studies of post-acute care of Medicare beneficiaries find that MA plan enrollees are less likely to be cared for by high-quality home health agencies or skilled nursing facilities than are traditional Medicare beneficiaries. They are also more likely to be treated by lower quality providers in both settings. Administrative studies show that MA enrollees have less access to home health care and shorter

durations of care when they do get it than traditional Medicare beneficiaries, but the outcome — measured by hospital readmissions — is about the same for both groups. One study that surveyed patients about their experiences with home health care found that MA members reported less care and worse outcomes than fee-for-service beneficiaries.

Vertically integrated insurance companies that own subsidiaries that supply goods or services to their home health agencies are in an enviable position. The Affordable Care Act (ACA) requires MA plans to spend 85 percent of their premium income on patient care. Profits and administrative costs cannot exceed 15 percent. But, through the legal legerdemain of transfer pricing, insurance companies can earn profits that exceed the 15 percent cap. Transfer pricing occurs when an insurance company owns both a Home Health Aide (HHA) service and a pharmacy benefits manager (PBM). The PBM sells (transfers) pharmacy supplies to the HHA at a price set by the insurance company that owns both businesses, not by the market. The mark-up over cost is profit to the PBM and its insurance company owner. But it is a cost to the HHA. As such, it counts as spending on patient care. The insurance company's profit escapes the constraints of the ACA because the insurance company is not the health provider. The MA plan treats it as an expenditure on patient care and counts it toward the 85 percent requirement, even though patients get no benefit.

Fraud in home health care is another issue that confronts CMS. While enforcement has been lax in the past, home health providers have been put on notice that CMS is now cracking down on fraud. Although overcharging CMS is a violation of the False Claims Act, the MA plans have largely avoided fraud Investigation and prosecution. Billions of dollars that belong in the Medicare trust fund are on the line in a tug of war between an insurance industry that wants to protect the earnings from its extremely profitable Medicare Advantage plans and an under-resourced federal oversight system that, until now, hasn't pursued MA plans that exaggerate the poor health of their enrollees. CMS plans to claw back some of the money lost because of this practice.

For plan years 2023 through 2032, about $4.7 billion is expected to be returned to the trust fund. CMS is examining past claims by MA plans to identify any instances of fraud and reclaim the funds. In a concession to the powerful insurance companies that own the MA plans, however, CMS announced that audits would be carried out on past claims beginning in 2018 rather than

2011.The government is letting MA plans keep any ill-gotten gains as a result of erroneous codes they submitted between 2011 and 2017. That decision means that insurers will get to keep about $2 billion in overpayments made during those years.

Fraud occurs in fee-for-service Medicare as well. Unscrupulous providers bill Medicare for unnecessary procedures or for procedures never performed. One scheme used death records to send phony bills to CMS for services the providers claimed were performed in the last year of the individuals' lives. The red flags that suggest home health agencies are billing for unnecessary services in traditional Medicare has led to the establishment of fraud strike forces in hospital referral regions where overbilling is suspected.

CMS is to be applauded for getting serious about cracking down on fraud in both traditional Medicare and Medicare Advantage plans.

This report brings together a full analysis of the CMS policies that have led to the financialization of home health – the process by which financial actors with little or no experience in healthcare increasingly own and operate healthcare provider organizations, with the primary goal of maximizing shareholder profits . It synthesizes the evidence to date regarding the impact of the financialization of home health care on health-care costs, the solvency of the Medicare Hospital Insurance (HI) trust fund, and the outcomes for patients. It identifies the many mechanisms that large insurance conglomerates and private equity firms have used to benefit at Medicare's expense. Capitated payments, including Medicare Advantage and other value-based care, are especially vulnerable to abuse in profit-driven settings.

Introduction

In the fall of 2016, Steven Landers, Elizabeth Madigan, Bruce Leff, and colleagues published an influential paper that described their vision for the future of home health care. Building on themes from a 2014 Institute of Medicine (IOM) and National Research Council workshop on The Future of Home Health Care, the authors articulated the challenging needs of an aging population and the demands these put on Medicare and Medicaid funding. The authors envisioned a future in which Medicare certified home health providers would expand their capacity to provide a continuum of home-based services for seniors. Technology would enable these services to be provided at home with no loss of quality in the care of patients. While seniors would enjoy dignified aging at home with control over their treatment options, the Centers for Medicare and Medicaid Services (CMS) which pays for this care would reap cost savings. The costs of caring for patients at home are lower than the cost of care in brick-and-mortar facilities that have expenses for utilities, maintenance, and upgrades. Progress would be driven by an expanding role for Medicare-certified home health agencies.

But this idyllic vision of the transformation of health care has come up against the hard-edged reality of the financial transformation of the industry. That is, financial actors with little or no experience in health care increasingly own and operate health-care provider organizations, with the primary goal of maximizing shareholder profits — a process we refer to as financialization. This process has occurred in the home health segment that provides episodes of skilled nursing and therapy to Medicare beneficiaries. Today, home health is dominated by financial actors — publicly traded health insurance behemoths via Medicare Advantage and, to a lesser extent, by private equity-owned home health chains. The transformation of home health care elaborated in 2016 did not envision massive horizontal consolidation to drive revenue growth, vertical consolidation to control the supply chain, and substitution of inferior care for more costly care to drive profit margins.

In contrast to traditional Medicare, in which Medicare both administers and pays for the care seniors receive, Medicare Advantage (MA) is a privatized program operated by insurance companies and paid for by Medicare. The US Congress made this private insurance option available when it created Medicare Part C in 1997. The privatization of Medicare and CMS's use of

a value-based payment model — i.e., a capitated (flat, per individual participant) payment for each person enrolled in the privatized system — to pay for their services is behind the move toward profit-driven rather than patient-centered care. Medicare Advantage plans play an outsized role in the transformation of health care. The argument for value-based payments is that it will force providers to reduce costs to earn a profit by keeping enrollees healthier, intervening early to prevent more expensive care later, and coordinating patient care. The reality, as we demonstrate in this report, is that financial actors are able to exploit a value-based payment system to extract resources meant for patient care. Its use in Medicare Advantage has opened multiple opportunities for the insurers that own MA plans to increase their revenue and profits without providing better patient care or lowering the cost of care. Value-based care puts money on the table without sufficient monitoring and enforcement of quality care standards.

Dayen (2023) tells the important story of how one man, Tom Scully, worked tirelessly for over 20 years to privatize Medicare, campaigning for CMS to adopt a value-based model to pay for seniors' care. Over those years, Scully held positions at CMS; served on the boards of various health providers; and was associate director for health, education, and welfare at the Office of Management and Budget. He simultaneously worked in the White House, joined a private equity firm, led a trade organization for the pharmaceutical industry, and worked for a lobbying firm. Today, CMS pays out approximately $1.4 trillion for Medicare and Medicaid (CMS 2023a). Scully wanted financial actors to capture as much of this money as possible. Value-based care was the key to funneling worker-paid Medicare premiums to large insurance companies.

Scully's stated view was that privatizing Medicare and replacing its fee-for-service payment model with value-based payments would force Medicare Advantage to figure out how to keep patients healthy and deliver care more efficiently to maximize the margin they kept for themselves. This, he argued, would save CMS money. With the support of CMS insiders and a big push from the insurance companies, Medicare Advantage — a privatized insurance product funded by Medicare but no longer operated by Medicare — was created.

Contrary to the belief that MA would cost less than traditional Medicare, it has turned out to cost CMS more per patient.

As we detail in this report, health Insurance companies found ways to game Medicare Advantage's value-based payment model and divert funds meant for patient care to insurance

company profits and the pockets of company executives. This is a feature, not a bug, in value-based payment systems. In 2022, the CEOs of the seven major publicly traded health insurance and services conglomerates — which include United Healthcare/Optum, Humana, and CVS/Aetna — made a total of $335 million, which was 18 percent more than they reported in 2021 (Herman 2023). Herman tracked CEO pay in health insurance companies from 2012 to 2022 in this spreadsheet. The effects of financialization are apparent: Among the top seven insurance companies, the CEOs received roughly $4–5 million in salary and bonus pay, but multiples more in earnings from stock options and financial activities. Financial metrics drive a lot of decision making.

This report focuses on the home health-care segment of the health care industry. Home health agencies provide skilled medical services at home for homebound seniors following discharge from a hospital or for other serious health episodes. It is primarily funded by Medicare, either directly or indirectly as part of Medicare's funding of MA plans.

The first section provides an overview of the home health-care segment, including its funding mechanisms and regulatory standards in traditional Medicare. Section II focuses on the financialization of home health and the role played by two major financial actors. Most important are large insurers that own Medicare Advantage plans. We show in some detail how MA plans exploit capitated value-based payments to increase their revenue and profits. We then focus on the three leading insurer sponsors of MA plans — UnitedHealth Group (UHG), Humana, and CVS/Aetna — and their acquisition of the largest home health agencies. We illustrate this with the case of Amedisys, a large and successful home health company that was ultimately acquired by UHG. Private equity firms have a small but steadily growing presence in the traditional fee-for-service Medicare home health market through their buyouts of home care agencies. Private equity firms have also made inroads into the Program of All-Inclusive Care for the Elderly (PACE), which provides care for elderly poor people with complex medical conditions and is jointly funded by Medicare and Medicaid. It was originally limited to nonprofit providers but was opened to private equity ownership in recent years. Here again CMS's use of value-based payments, promoted by none other than Tom Scully, has provided PE firms with the opportunity to exploit this program for economic gain. We illustrate how this can happen through a case analysis of InnovAge.

We conclude with a discussion of policies that can improve patient care and reduce overall costs. The nonpartisan Medicare Payment Advisory Commission (MedPAC) provides evidence that MA plans are more expensive on a per-person basis than traditional Medicare. CMS should promote traditional Medicare, not undermine it. It should work with Congress to level the playing field for fee-for-service Medicare and MA plans. It should work with Congress to secure coverage of vision and hearing care for participants in traditional Medicare and place a cap on their out-of-pocket spending. While a recent decline in overall Medicare spending has extended the life of the Medicare Hospital Insurance (HI) trust fund to 2031, overpayments to MA plans continue to be a drain on it and contribute to a longer-term problem that is putting the future health care of Medicare recipients at risk. CMS can rein in unchecked profiteering by insurance companies that own MA plans; it should exercise that authority and make better use of the billions of dollars of savings from eliminating unwarranted payments to MA plans. Additionally, CMS should shut down, rather than perpetuate, Trump-era efforts to enroll traditional Medicare beneficiaries through the backdoor in MA-like plans, such as the Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) program, that reward providers for cutting costs and, potentially, undermines care for seniors.

The Home Health Care Industry

Home-based care has evolved to cover a wide array of medical and non-medical services to people in their homes. Non-medical care is typically referred to as "home care," "personal care," or "in-home care." Medical care for episodes requiring skilled services is referred to as "home health care" (sometimes referred to as "home health"). In addition, as shown in table 1, "home-based medical care," a smaller segment consists of clinical care for adults who cannot leave their home. While Medicaid covers some home care or personal assistance programs, most home care is provided by family members (unpaid), private pay home care agencies, or individual providers. Home health care and home-based medical care are primarily funded by Medicare or Medicare Advantage plans. In this report, we focus primarily on home health care.

Table 1

Types of Home Healthcare

	Personal Care Services	Home Health Care	Home-Based Medical Care
What	Assists individuals with activities of daily living (ADLs) such as bathing, dressing, grooming, and mobility. Often provided for long periods of time.	Assists with skilled care and provides a range of services. Episodic care (60-day periods). For Medicare beneficiaries who have a skilled need, are homebound, and a physician approves care plan.	Clinical care to homebound adults provided by clinical practices.
Who/How	Home care aide, attendant, or family member	Skilled nursing care provided by a Registered Nurse, Physical Therapy, Occupational Therapy, speech, home health aide. Care delivered through Medicare certified home health agencies.	Physician, Nurse Practitioner, Physician Associate, Podiatry.
Funding	• Unpaid (if provided by a family member). • Medicaid - licensed or certified home care agency or Consumer Directed Personal Assistance Program. • Private pay (varies by state).	Medicare parts A & B. May differ for Medicare Advantage plans.	Medicare Part B.

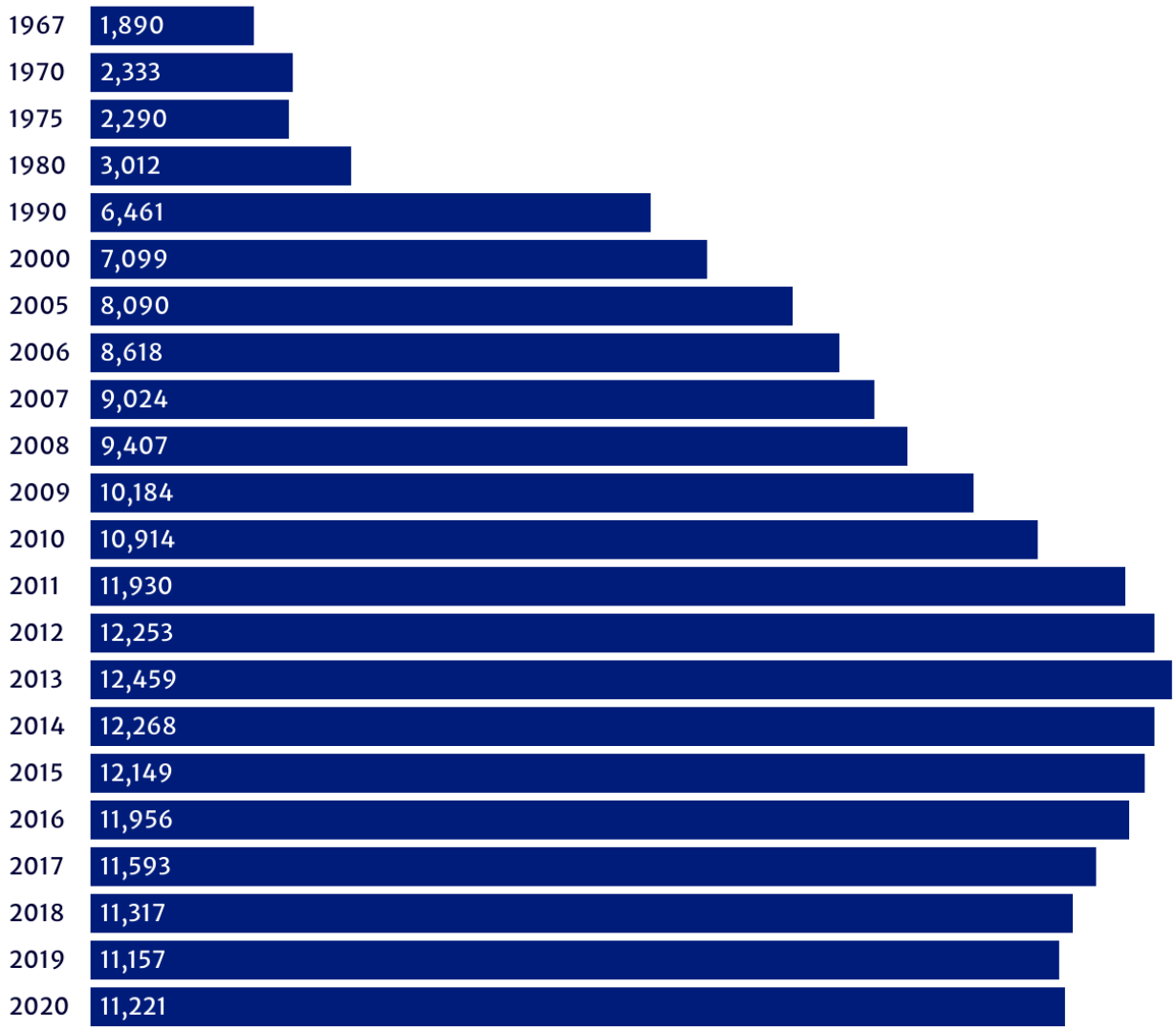
Source: Medicaid

Home Health Agencies: Growth and Funding Mechanisms

The term "Home Health Agency" (HHA) is used to designate an agency certified by Medicare to provide care to eligible Medicare beneficiaries who are unable to leave their homes and are experiencing an episode in which they need skilled nursing care or therapy. In 2016, 98.7 percent of all home health agencies were Medicare-certified (Statista 2020). Medicare certified HHAs receive payment from the CMS for these services. Data from CMS, reported in figure 1, shows the number of Medicare certified HHAs from 1970 to 2020. The number of HHAs rose from 2,333 in 1970 to a peak of 12,459 in 2013 before beginning a slow descent to 11,221 in 2020 as the industry began to consolidate. In its March 2022 report to Congress, MedPAC reports a slightly different number of HHAs in 2020, finding that 11,456 HHAs participated in Medicare, serving about 3.1 million Medicare fee-for-service recipients at a cost of about $17.1 billion (MedPAC 2022).

Figure 1

Number of Medicare Home Health Agencies in the U.S. From 1967 to 2020



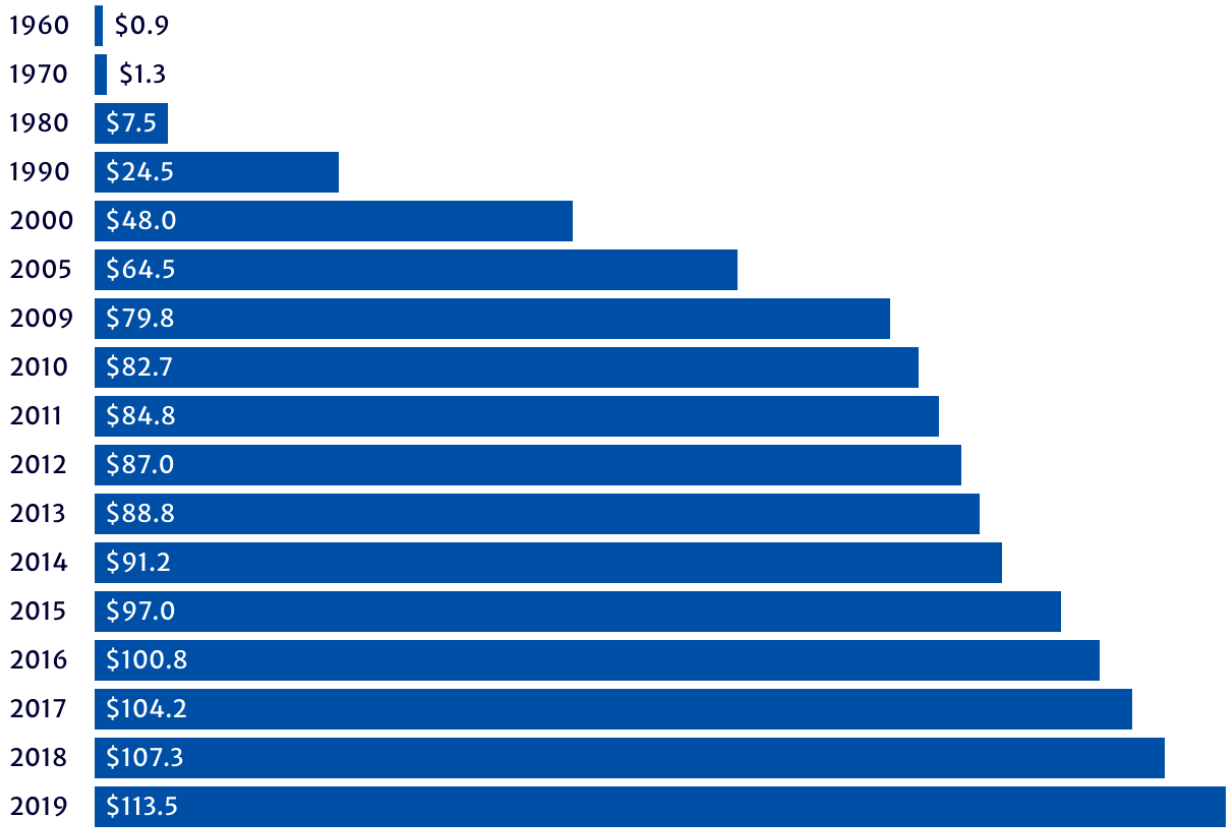
Source: Statista 2023, https://www.statista.com/statistics/195318/number-of-medicare-home-health-agencies-in-the-us/

Home health agencies sometimes provide other home-based services, such as non-medical home or personal services or hospice services. Figure 2 shows total expenditures on home health agencies between 1960 and 2019 — some of which funded services in addition to skilled home health services. In 1960, just $1 billion was spent on HHAs; that increased to $113.5 billion in 2019. Home health spending is projected to hit $141.5 billion in 2023. After staying relatively flat in 2021, the average annual growth in home health spending was roughly 5.1% in 2022. It is estimated to grow in the following decade at a faster rate than any other health-care category (Donlan 2023d).

Figure 2

Home Health Care Expenditure in the United States in Billions From 1960 to 2019

Inflation adjusted in 2019 dollars



Source: Statista 2022, https://www.statista.com/statistics/184783/home-health-expenditures-in-the-us-since-1960/

CMS tracks home health episodes and spending for beneficiaries in traditional fee-for-service Medicare. As CMS is the payer, it has this information. It does not currently track home health usage by participants in Medicare Advantage plans. Medicare pays for these services indirectly, but it does not collect information on the number of episodes or expenditures. We discuss the growth of Medicare Advantage and the implications for home health agencies at a later point in this report. CMS publishes a regularly updated list of all HHAs that have registered with Medicare (Data.CMS.gov 2023). As of July 5, 2023, there were 11,682 such agencies.

Home health care is covered by both Medicare Part A (Hospital Insurance) and Part B (Medical Insurance). Under Medicare Part B, someone qualifies for home health care if they are homebound and have a health episode that requires skilled care, even without previously being hospitalized. In certain cases, such as after a hospital stay or time spent in a skilled nursing facility, an individual can receive home health care coverage under Medicare Part A. (Medicare.gov n.d.b). The details of the services that fall under Home Health are outlined in section 1861(m) of the Social Security Act (US Congress 1934). Under both parts, a patient must meet the following criteria (National Council on Aging 2021):

1. Be considered homebound based on the Centers for Medicare & Medicaid criteria
2. Require skilled care on a part-time or intermittent basis to improve, maintain, prevent, or further slow the health condition by a home health aide who has successfully completed a training program approved by the Secretary
3. Be under the care of a nurse practitioner, clinical nurse specialist, physician's assistant, or doctor, who completes and documents an in-person visit with the patient either three months before the start of home health care or within one month after the home health care benefit has begun
4. Receive home health care from a Medicare-approved home health agency

Non-skilled in-home care is not covered by Part A or B and is not paid for by Medicare, as it is not considered a health care service.

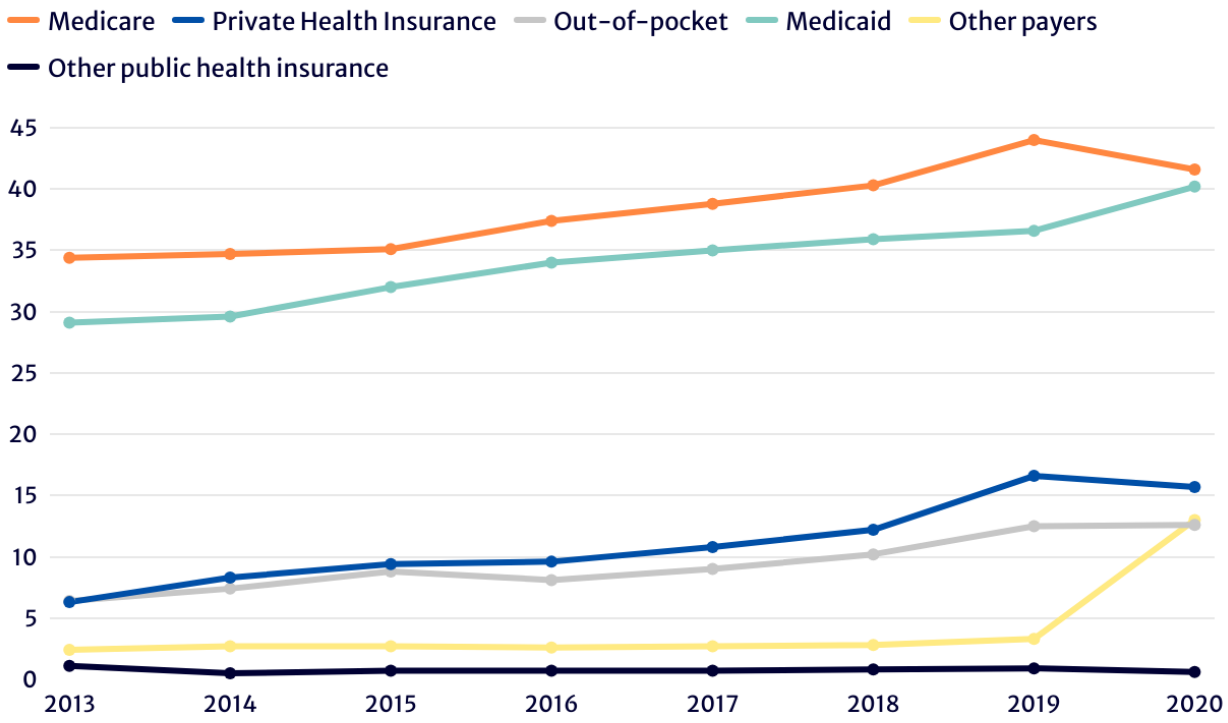
Home health agencies frequently provide additional services, such as personal care, that are not covered by Medicare. Figure 3 shows the distribution of home health spending in billions of dollars by payer over the period from 2013 to 2020 for all services provided by home health agencies. The overwhelming majority of funding for home health agencies comes from Medicare and Medicaid — whether directly or indirectly via Medicare Advantage. Figure 3 shows the

distribution of home health care spending by payer over the period from 2013 to 2020 for all services provided by home health agencies, including personal care services. Of the $113.5 billion spent in 2019 (see figure 2). Medicare accounted for $44 billion, Medicaid accounted for $37 billion, and other private insurers, including Medicare Advantage, $17 billion. About $1 billion came from other public health insurance: The Older Americans Reauthorization Act of 2016 (for complex medical needs and disabled people) and Veterans Administration payments for a person at least 50 percent disabled because of a service-related injury or illness. The remainder, about $13 billion, represented out-of-pocket spending. These figures changed slightly in 2020, with Medicare and Medicaid converging at about $40 billion each, and spending from other payers rising to the level of out-of-pocket spending (Statista 2020; Johns Hopkins Medicine n.d.a.).

Figure 3

Spending for Home Health in the United States From 2013 to 2020, by Payer

Billions of U.S. Dollars



Source: Statistica 2023, https://www.statista.com/statistics/247717/us-home-health-payments-by-insurance/?locale=en

PACE Program: Comprehensive Services to "Frail Elderly People Living in the Community"

PACE (Program of All-Inclusive Care for the Elderly) is a comprehensive set of services provided to certain people over the age of 55 with complex medical conditions. Most participants are dually eligible for Medicare and Medicaid (CMS.gov n.d.d). PACE programs are designed to provide a range of integrated preventative, acute, and long-term care services to manage the often complex medical, functional, and social needs of what the program refers to as the frail elderly (Scott 2021b). The typical participant suffers from chronic conditions and requires assistance with tasks that must be accomplished daily for an individual to thrive. According to its website, the PACE program "helps people meet their health care needs in the community instead of going to a nursing home or other care facility" (Medicare.gov n.d.a.). However, the programs are sponsored by a variety of types of non-profit organizations and for-profit companies. As we examine in the case study of private equity owned InnovAge later in the report, the type of owner that operates the PACE program can determine the quality of care.

Medicare Payment Methodology

In fee-for-service Medicare, as its name implies, CMS pays for part-time, medically necessary, skilled care (nursing, physical therapy, occupational therapy, and speech-language therapy) that is ordered by a physician as these services are provided. Since January 2020, HHAs that meet a certain number of home health visits in a 30-day period are paid a standardized 30-day period payment rate. The payment rate is adjusted for case mix — how sick the patients are — and for geographic differences in wages. If the visit threshold is not met, clinicians are paid a per-visit payment rate for the certification of the clinician providing care.

A physician prescribes a home health care plan. Then a nurse or therapist from the HHA uses the Outcome and Assessment Information Set (OASIS) to assess the patient's condition. The HHA then determines the skilled nursing care, therapy, social services, and home health aide service needs at the beginning, again after 60 days, and every 60 days thereafter as necessary.

The case mix adjustment is determined using certain OASIS items describing a patient's condition (12 clinical groupings) and comorbidity (none, low, or high), and other information

reported on Medicare claims are used to determine the case-mix adjustment to the 30-day payment rate. There are 432 case-mix groups for the purpose of adjusting the payment.

Additional payments will be made to the 30-day case-mix adjusted payment for beneficiaries who are outliers and incur unusually large costs (CMS.gov n.d.a).

Since 1999, CMS has required Medicare-certified home health agencies to collect and transmit OASIS data for nearly all adult patients whose care is reimbursed by Medicare and Medicaid. A subset of OASIS-based quality performance information is posted on the Care Compare website. According to CMS, these publicly reported measures include outcome measures, which indicate how well home health agencies assist their patients in regaining or maintaining their ability to function, and process measures, which evaluate the rate at which home health agencies use specific evidence-based processes of care. Home Health CAHPS (Consumer Assessment of Healthcare Providers and Systems) measures are also posted on Care Compare (CMS n.d.c.).

Regulation of Home Health Agencies

In this section, we describe the federal and state regulations that exist, including standards for professional occupational licensing and certification as well as standards of health and safety and record maintenance. These regulations, however, focus on eligibility requirements to receive federal funding in the first place, rather than the mechanisms for monitoring and enforcement of rules linked to the receipt of Medicare reimbursements, which are weak. In addition, state-level regulations vary substantially in the requirements for licensing and credentialing of home health agencies (HHAs). Overall, current federal and state regulations of home health agencies are insufficient to guarantee that patients receive high quality care or to counteract the financialization of the home health industry.

To be eligible for Medicare and Medicaid funding, HHAs must meet a series of conditions (Conditions of Participation) laid out by the federal Department of Health and Human Services (HHS). The regulations were last updated in January of 2017. Sections 1861(o) and 1891 of the Social Security Act establish the requirements that a HHA must meet to participate in the Medicare program (US Congress 1934). These include (CMS.gov n.d.b.):

- Has a group of professionals associated with the agency or organization that establish its policies and govern the services which it provides. The group must include at least one physician and at least one registered professional nurse.
- Maintains clinical records on all patients.
- Is licensed pursuant to state or local law or has approval as meeting the standards established for licensing by the state or locality.
- Has in effect an overall plan and budget for institutional planning.
- Meets the federal requirements in the interest of the health and safety of individuals who are furnished services by the HHA.
- Meets additional requirements as the Secretary finds necessary for the effective and efficient operation of the program.

State Level Regulation of Home-Based Care Including Home Health Agencies

As of June 2020, 30 states had some form of licensing and oversight systems for in-home care, but little consistency exists across states in documenting deficiencies or licensing providers of these services. This was the finding of a Massachusetts Department of Public Health study that investigated other state systems ("Report on Establishing a State-wide Home Care Licensing Process," 2021).

For example, the report found that in Pennsylvania, the Department of Health is in charge of 1) determining compliance with the home care licensure requirements through an on-site survey, interviews with staff, consumers, and individuals providing care, 2) conducting inspections at time of initial license and/or license renewal, 3) Identifying deficiencies and determining plans of correction, and 4) investigating complaints.

In Connecticut, the Department of Consumer Protection is in charge of overseeing home health agencies. They issue Certificates of Registration to HHAs and may also revoke, suspend, refuse to issue or renew any certificates of agencies they deem unfit. They can place an agency on probation and issue a letter of reprimand for various types of fraud. Similar to other states with these licensure systems, the CT Department conducts investigations into agencies.

In California, it is the Home Care Services Bureau within the Department of Social Services that oversees the industry. It is responsible for licensure, gathering complaints, conducting unannounced inspections, and issuing deficiencies and/or civil penalties. It also manages the

Home Care Aide application process and registry. There is a bi-annual licensure fee of $5,603 in California, which is much higher than the $100 fee in Pennsylvania and $375 fee in Connecticut. The Home Care Services Consumer Protection Act in 2016 secured many of these strong regulations; it requires that home care organizations be licensed and creates a public registry for home care aides who have completed background checks (AB-1217 Home Care Services Consumer Protection Act 2013). Overall, the 2021 Massachusetts study found that regulation of the home care industry varies greatly across the country.

At the federal level, as discussed in the section on fraud, oversight of home care, including home health agencies, has been lax, but this appears to be changing.

Wall Street Firms Move into Home Health Care

For-profit businesses were not allowed to own Medicare-certified home health agencies before 1980, but soon came to account for a majority of the agencies that provide such services (Cabin, Himmelstein, Siman and Woolhandler 2014). In the last decade, Wall Street firms have been active in acquiring home health capabilities over the entire continuum of care: personal care, home health, acute care, or hospital-at-home (a substitute for in-patient care), long-term care, palliative care, and hospice. Within the home health care segment, large insurance companies offering services under Medicare Advantage (MA) plans have dramatically increased their market share in recent years. By contrast, private equity firms have increased their role in home health care by steadily acquiring agencies that receive traditional fee-for-service funding under Medicare. Both large insurers with MA plans and, on a smaller scale private-equity-owned chains, are expanding locations and diversifying their services by buying up competing, often smaller providers. They also are creating vertically integrated companies by buying up companies that supply medical equipment, pharmaceuticals, and/or services that are inputs into home health care.

In the next sections we examine the roles of insurers with MA plans and, in turn, private equity firms in home health. In both, we provide evidence of the ways that these financial actors can game value-based (capitated) payment methods to enhance revenue and profits. The Medicare Advantage business model offers trade-offs for enrollees — more benefits but preauthorization requirements for services and constraints on provider options that may lead to inferior care. Another downside for beneficiaries is that upcoding of diagnoses in MA plans makes beneficiaries appear sicker than they are, and makes them unable to buy a Medigap plan if they want to switch to traditional Medicare. For CMS and taxpayers, the MA business model raises costs and is a drain on the Medicare Trust fund.

PE investors follow the typical private equity model of investing in health care. They begin with one company, referred to as a platform company, then use debt to acquire its competitors in a local health market. The home health agencies, and not the PE firm, are responsible for repaying the debt. This enables the PE firm to establish a local monopoly. The result is that patients have

few choices when they require home health services, and workers lack alternative options if they are dissatisfied with their wages or working conditions.

The Medicare Advantage Business Model and Consolidation of Home Health Care

Health insurance companies are more than passive payers for health services. Via their ownership of Medicare Advantage Plans, they have become large corporate financial actors. When people opt-in for Medicare Advantage plans over traditional Medicare, they are typically attracted to the fact that MA plans offer some benefits not covered by Medicare. The downside is that they must choose a provider in the insurer's narrow provider network. They are required to get pre-authorization to access more costly services available in traditional Medicare, such as seeing a specialist, or accessing a service such as home health care. Then, as the insurers that own MA plans gobble up more providers and diversify their offerings, for example acquiring home health agencies, they can require that their MA members use these agencies.

Table 2

Largest Health Insurers in Medicare Advantage at the National Level

2017		2021		2022	
Insurer	Market Share	Insurer	Market Share	Insurer	Marker Share
United Healthcare	25%	United Healthcare	28%	United Healthcare	27%
Humana	18%	Humana	19%	Humana	17%
Kaiser	8%	CVS	11%	CVS	11%
Aetna (CVS)	8%	Kaiser	7%	Elevance	7%
Elevance	4%	Elevance	6%	Kaiser	6%
WellCare HP (CNC)	3%	Centene	4%	Centene	5%
Cigna	2%	Cigna	2%	BCBS Michigan	2%
BCBS Michigan	2%	BCBS Michigan	2%	Cigna	2%
Highmark	2%	Highmark	1%	Highmark	1%
Centene	1%	Scan Group	1%	Scan Group	1%

Source: American Medical Association, 2017 and 2021 data. Mark Farrah Associates, 2022 data.

The largest 10 insurers with MA plans have considerably boosted their share of the MA market in just five years — from 73 percent in 2017 to 79 percent in 2022. The three largest — UnitedHealth Group, Humana, and CVS/Aetna — served 51 percent of MA participants in 2017, 58 percent in 2021, and 55 percent in 2022. CVS surpassed Kaiser Permanente in third place in 2021 (See table 2).

These health insurance companies each offer a variety of plans. According to MedPAC (2023a), there was a bewildering array of MA plans in 2022: 5,261 plan options offered by 182 organizations that enrolled about 29 million participants. Medicare paid these plans $403 billion not including payments for Part D drug plans.

The Medicare rules of the game for the privatized Medicare Advantage Plans — insurance products that can capitalize on the Medicare name without actually being operated by Medicare — are very profitable for the insurance companies that own them. Gilfillan and Berwick argue that Medicare Advantage is a "money machine," noting that "...MA harbors an arbitrage game in which CMS consistently overpays MA Plans with no demonstrable clinical benefit to patients" (Gilfillan and Berwick 2021; see also Cabin, Himmelstein, Siman and Woolhandler 2014). MA plans have higher profit margins than other insurance products, according to MedPAC (2023a); and a recent report by the Kaiser Family Foundation estimated that MA plans had over twice the gross profit margins of other health plans in 2021 (Ortaliza et al. 2023). Their profits are largely due to the capitated payment CMS makes to MA plans, a payment that consists largely of a base payment rate plus a payment based on a risk score that measures how sick the enrollee is. There is little data or evidence to compare the clinical quality of MA and traditional Medicare (Ginsburg and Lieberman 2023), but we summarize the available data below.

The privatized MA plans can use some of those profits to reduce premiums and/or add benefits that make the plans attractive to seniors, especially those on tight budgets. Other advantages are that MA plans have an out-of-pocket maximum, and they bundle Medicare Parts A, B, D, and Medigap into a single plan, which is administratively simpler for seniors to navigate. But the downside is that the MA plans come with incentives to restrict access to care, to undermine the quality of care, and are a serious drain on Medicare's finances. In this section we provide evidence on the ways that Medicare Advantage plans can game value-added (capitated) payment methods to enhance revenue and profits. The MA business model raises the cost to CMS, drains the Medicare Trust fund, and provides modestly, but statistically significant, inferior care (Cabin, Himmelstein, Siman and Woolhandler 2014). It requires preauthorization for treatment and provides narrow provider networks that have the potential to provide inferior and less costly care.

With insurance companies that own Medicare Advantage plans buying up home health companies and becoming major players in this market, it's important to understand the MA business model. The next sections examine the many ways that MA insurers make money. We then turn to their role in the consolidation of home health agencies. As we discuss, profit-motivated players can exploit value-based payments for financial gain; we examine how this works in MA. This is important to understand as CMS currently plans to move participants in traditional fee-for-service Medicare into value-based care via ACO REACH and similar payment models. CMS argues that this will reduce costs while maintaining the quality of care. But the evidence suggests exactly the opposite. Medicare Advantage can serve as a cautionary tale: its per patient costs are higher, not lower, than those in fee-for-service Medicare, and it has incentives to skimp on care to increase earnings.

Capitated Payments Increase Incentives of MA Plans to Deny Services or Provide Inferior Care

Profits in a value-based payment system are the difference between the capitated payments and the costs of providing care. MA plans can increase profits by limiting members' access to care or by providing less costly, inferior care. In this section we examine the use of these methods to increase profits.

CMS developed an MA payment system that differs from traditional Medicare in two important ways that create a very different incentive structure: First, MA plans receive capitated payments (flat fee per individual paid in advance of services) rather than, as in traditional Medicare, fee-for-service payments (paid after service-delivery for actual services provided). Second, unlike traditional Medicare, CMS allows MA plans to require pre-authorization (approval) for patient services before doctors can provide them. Together these features provide incentives for MA insurers to deny claims as an avenue to boost profits, a tool that is unavailable in traditional Medicare.

Enrollees in MA plans cannot go out-of-network if they want insurance coverage; they feel "trapped" in the system. According to one enrollee, "I'm stuck … I can't change to another Medicare Advantage plan at this stage. I can't go back to traditional Medicare because there's no way they'd accept me for Medigap [supplemental insurance], so it would be outrageously expensive. I'm pretty much trapped" (Cunningham-Cook 2023).

Capitated payments are viewed as value-based because they supposedly pay for outcomes and not the volume of services provided. The expectation is that MA plans will focus on high quality, patient-centered care and rely on wellness and early care and intervention programs to keep costs down and increase profits. However, the capitated payments to MA plans provide financial incentives to reduce costs and increase profits by denying plan members coverage during the preauthorization process (Ankuda et al. 2023).

This cost control mechanism is especially dangerous in the case of severely ill patients for whom delay may mean a worsening of their condition or even death. Medicare Advantage has enrolled a disproportionate share of Black and Latino people, which means deficiencies in access to necessary medical care are likely to exacerbate racial and ethnic disparities in care quality and health outcomes (Ankuda et al. 2023).

Evidence that MA insurers have in fact been denying claims at unreasonably high rates has emerged in recent years. Access to home health services was one of the key claims in which key services were denied. In 2019, Medicare Advantage plans denied 13 percent of requests for prior authorization for care, even though the requests met Medicare coverage rules, according to a 2022 report by the Office of the Inspector General (OIG) of HHS (Grimm 2022). OIG found that the requests were for medically necessary services, including post-acute home health care, that would have been covered in traditional fee-for-service Medicare. While many of those who requested a review of their denial were later approved, the delay put patients' health at risk and caused unnecessary administrative burdens for patients and providers. Furthermore, only a fraction of those whose preauthorization requests were denied, later actually appealed the denial.

Further evidence of incorrect denials by MA insurers comes from a study of CMS data on prior authorizations. An analysis of these data during calendar year 2021 found that Medicare Advantage enrollees submitted more than 35 million prior authorization requests to their MA plans. Over 2 million of these requests were fully or partially denied by Medicare Advantage insurers. Just 11 percent of denied requests were appealed. The vast majority of appeals (82 percent) were successful in overturning the denials, suggesting a high rate of incorrect denials (Biniek and Sroczynski 2023; see also Cunningham Cook 2023).

The MA plans have come under recent scrutiny by Congress for denying members' necessary care. In May, the Senate Permanent Subcommittee on Investigations held a hearing to examine whether MA plans were increasing their profits by denying plan participants access to care, in some cases using algorithms in place of clinical personnel to make decisions. Lawmakers in both parties have asked for documents from UnitedHealth Group, Humana, and CVS/Aetna that show how decisions are made when members request prior authorization for medical care (Lipschutz 2023; Pifer 2023b). CMS finalized a rule in April 2023 that warns MA plans against the overuse of utilization management policies such as prior authorization. In response to this scrutiny, many insurance companies, including Cigna, Aetna, and UnitedHealth, have made large reductions in the number of procedures and medications that require prior approval (Pifer 2023g).

OIG (2022) also found MA plans incorrectly denied medical providers' requests for payment 18 percent of the time (roughly 1.5 million claims) for services that were covered by Medicare and met the Medicare Advantage organization's billing rules. These decisions may discourage doctors from recommending costly care, for fear of not being paid, and may discourage some hospitals from being in-network for MA plans. The St. Charles Health System, serving three counties in central Oregon, for example, is evaluating its participation in all Medicare Advantage plans. The CEO of St. Charles explained that Medicare Advantage "just hasn't lived up to the promise. A program intended to promote seamless and higher quality care has instead become a fragmented patchwork of administrative delays, denials, and frustrations. The sicker you are, the more hurdles you and your care teams face" (St. Charles Health System 2023).

Apart from denying care to some MA plan enrollees, the plans can increase their profits by providing less costly, inferior care. The evidence on quality is thin (Ginsburg and Lieberman 2022). A few studies done using administrative data found that treatment is curtailed for MA patients, but outcomes as measured by hospital readmissions are not affected. However, a study that examined patients' self-reported experiences with post-acute care (i.e. home health agencies and skilled nursing facilities) found fee-for-service patients were significantly more likely to experience improvements. We review those studies here.

Meyers, Mor, and Rahman (2018) examined the quality rating of skilled nursing facilities (SNFs) used by fee-for-service Medicare beneficiaries and MA plan enrollees. The study controlled for patients' clinical, demographic, and zip code of residence. The authors found that the

probabilities of entering higher quality SNFs and those with lower hospital readmission rates were substantially higher for fee-for-service Medicare patients than for patients enrolled in MA plans. The differences in SNF quality between traditional Medicare beneficiaries and MA enrollees was lower for those in higher quality MA plans, but the authors found that "Medicare Advantage still guided patients to lower-quality facilities" (Meyers, Mor, and Rahman 2018, 1).

Findings are similar for quality of care by home health agencies. A study of more than 4 million Medicare home health admissions in 2015 examined the quality of home health agencies accessed by beneficiaries enrolled in traditional Medicare, high-quality Medicare Advantage plans, or low-quality Medicare Advantage plans (Schwartz et al. 2019). MA enrollees must utilize the plan's network of home health agencies; traditional Medicare beneficiaries can select any Medicare certified HHA. Medicare beneficiaries who receive HH care are older, and they are homebound because they are seriously ill or have a functional limitation. The risk of poor outcomes for this population may be exacerbated, as the authors note, by receiving care from low-quality home health agencies (HHAs).

The analysis of HHA admissions controlled for patient demographics and clinical assessments using the Outcome and Assessment Information Set (OASIS). The main finding is that MA enrollees were significantly less likely than those in traditional Medicare to receive care from a high-quality HHA. Enrollees in low-quality MA plans were more likely to be cared for by low-quality HHAs and less likely to be treated by high quality HHAs compared to traditional Medicare beneficiaries. The pattern was similar for enrollees in high-quality MA plans, but the differences compared to traditional Medicare beneficiaries were smaller. Even after controlling for zip code, the differences, though smaller, persisted. The results are especially concerning since low-quality MA plans enroll a disproportionate share of Black Medicare beneficiaries — 20.8 percent compared with 12.8 percent in traditional Medicare and 11.3 percent in high-quality MA plans (table 1, page 4).

Studies of post-acute care and patient outcomes that use administrative data find that MA plan members make less use of post-acute care services and have lower durations of use. A study of home health use in 2018 found that MA plan participants were 31 times more likely to have only one home health visit than traditional Medicare beneficiaries; traditional Medicare beneficiaries were more likely than those in MA plans to have multiple home-based medical care visits (Marr,

Ritchie, Leff, and Ornstein 2023). The administrative studies focused on post-acute care for specific conditions — cardiac patients in one case and hip replacement in another. While access to post-acute care is lower for MA patients, the studies found no differences in deaths or hospital readmissions (Figueroa et al. 2020; Kumar et al. 2018). However, a recent study (Achola, Stevenson, and Keohane 2023) that compares self-reported data, rather than administrative data, on the use of post-acute care services finds differences in outcomes among traditional Medicare beneficiaries and those enrolled in MA plans. The study analyzed the experiences of a cohort of 2,357 Medicare beneficiaries who used post-acute services. The participants were community dwelling traditional Medicare or MA beneficiaries, 70 years of age or older. Data are from the National Health and Aging Trends Study (NHATS) with linked Medicare enrollment data from 2015 to 2017.

As in prior research the study found that MA enrollees reported statistically significant lower use of post-acute care services and shorter durations of services compared with traditional Medicare beneficiaries. But this study found differences in patient outcomes. Fewer MA enrollees reported improved functioning during or after using post-acute care compared with traditional Medicare beneficiaries (Achola, Stevenson, and Keohane 2023). Self-reported outcomes are especially important because the MA payment model seeks to reduce the cost of care while maintaining or improving quality. As this study shows, reducing the cost of care by discouraging the use of these services, limiting the duration of these services, or utilizing lower-cost/low-quality home health agencies when providing these services can negatively affect patient outcomes.

CMS's Basic Payment Method Results in Overpayments and Increased Revenue for MA Plans

There are a number of ways that CMS payments to Medicare Advantage plans result in overpayments that increase the plans' revenue. MA plans can then use some of this revenue to reduce premiums and/or offer benefits such as vision and hearing care. To begin with, MA plans are not measured against their own costs of providing care. Instead, they are measured against a benchmark based on the cost of providing care in traditional Medicare parts A and B. As we describe in this section, this leads to undeserved rebates to MA plans. CMS also pays MA plans a bonus for high quality care. There are questions about how well the star system for awarding bonuses measures quality of care. CMS is concerned that there has been a wave of "star inflation"

that exaggerates quality performance and results in higher than warranted payments by CMS to MA plans (Fuse Brown et al. 2023). Risk-adjusted capitated payments to MA plans for sicker plan members have also been used to enhance revenue. CMS's payments to MA plans per member are higher for sicker enrollees. Risk adjustments to capitated payments for enrollees likely to require more or more costly care were intended to remove the incentive for MA plans to cherry pick healthier Medicare beneficiaries. The evidence suggests that sicker patients prefer traditional Medicare, leaving MA plans serving healthier patients. What is clear is that the use of risk adjustment in calculating CMS payments to MA plans is fraught with problems. There is evidence of widespread upcoding of risk, with many MA plan enrollees rated as much sicker than they are (Fuse Brown et al. 2023). We examine these revenue enhancing payments to Medicare Advantage plans in a later section of the report. Here we examine the basic payments CMS makes to MA plans and the role of rebates and bonuses.

CMS establishes a benchmark based on the average cost of care for beneficiaries enrolled in traditional Medicare in a particular geographic area, based on claims data for fee-for-service Medicare. Medicare Advantage plans submit bids to CMS that reflect their annual costs for providing Part A and Part B coverage to average enrollees. The bids establish the MA plans' revenues, paid with taxpayer dollars. Most MA bids (87 percent) are below the benchmark, typically just 85 percent of it; yet recent analyses find that plan payments cost CMS substantially more than fee-for-service Medicare spending (MedPAC 2023b). When a bid is less than the benchmark, CMS typically keeps one-third of the apparent savings and rebates the difference to the MA plan. These rebates have doubled between 2015 and 2022, from $80 per beneficiary per month to $164. In terms of the drain on Medicare and the Medicare Trust fund, CMS paid out $12.7 billion in rebates in 2015 and $47.2 billion in 2022. MA plans must use the rebates to reduce co-pays, reduce premiums, or provide additional benefits such as vision and hearing. Nearly two-thirds of MA enrollees pay no premium at all. This fuels the growth of MA plans and the plans' revenue (Fuse Brown 2023; Gilfillan and Berwick 2023; CMS n.d.c. 2023 Trustees Report & Trust Funds | CMS, Table IV.C2; Frank and Milhaupt 2022).

Gilfillan and Berwick argue that there is a problem with this method of calculating rebates, however. These researchers argue that the comparison to the benchmark described above is not an apples-to-apples comparison. The benchmark based on the cost for traditional Medicare

beneficiaries is inflated, according to these researchers, because a majority of people enrolled in traditional Medicare also have supplemental plans that cover any costs for Medicare-covered services that are not paid by Medicare. This induces increased utilization of medical care and inflates the benchmark. An apples-to-apples comparison would use the cost to Medicare for enrollees in traditional Medicare who do not have supplemental insurance as the benchmark against which to consider the bid by MA plans, since their members do not have access to supplemental insurance. This comparison shows that on a per enrollee basis, the bids by MA plans are well above the cost of traditional Medicare. The rebates are actually a subsidy to MA plans and not a reward for better and more cost-effective care (Gilfillan and Berwick 2023).

Despite the fact that MA plans' bids for annual payment are below the fee-for-service benchmark, CMS's payments to MA plans on a per-person basis are usually higher and range from 95 to 115 percent of local fee-for-service payments (Medicare Trustees Report 2023). The bids for annual payments by MA plans are based on the costs incurred caring for average patients. MA plans receive higher payments for caring for patients that are sicker than average and likely to be more expensive to care for. This creates an incentive for MA plans to upcode risk scores, making patients appear sicker than they are, and increasing payments to MA plans. MedPAC's most recent estimate is that upcoding leads to payments to MA plans that are 106 percent of what would have been spent if these beneficiaries had been enrolled in traditional Medicare, up from earlier estimates of 104 percent. That is, Medicare spends 6 percent more for MA enrollees than if those beneficiaries were in traditional Medicare. This translates into a projected overpayment of $27 billion in 2023 (MedPAC 2023a). We discuss these risk adjustment payments — adjusted for the risk of caring for sicker patients — in greater detail in a later section.

Revenues of MA plans are also enhanced by quality bonuses. In addition to the MA plans' revenues established by the bid, plans can earn bonuses. The Affordable Care Act created the quality bonus program (QBP), with bonuses determined by a star-rating system, to encourage MA plans to compete on the basis of quality. CMS uses these star ratings in two ways. First, an MA plan with 4 or more stars gets a 5 percent quality bonus in the next year. Second, a plan with 4 stars or more is given a higher benchmark to bid against in calculating rebates in the next year. It will be easier for an MA plan with 4 or more stars to come in with a bid lower than this further

inflated benchmark, and the rebate paid by CMS to the MA plan will be larger. Unlike the benchmark rebates, the rebates from the quality bonus payments do not need to be spent on additional benefits or cost-sharing reductions for beneficiaries but can be spent on administrative expenses and plan profits (MedPAC 2019).

There is concern among health care experts and policymakers that the QBP can be gamed, that there is "star inflation," and that the stars do a poor job of measuring quality of patient care. MA bonus payments have quadrupled from 2015 to 2023, increasing 30 percent, or $2.8 billion, in just one year from 2022 to 2023. In 2023, CMS paid out $12.8 billion to Medicare Advantage plans, with UnitedHealth Group and Humana getting nearly half of the total. UnitedHealth, with the most Medicare Advantage members, will receive $3.9 billion from CMS for its participation in the stars program, the most of all health insurance companies (Skopec and Borenson 2023; Pifer 2023d; MedPAC 2023; Tepper 2023b).

How Demographic Changes among Traditional Medicare Participants Affect Payments to MA Plans

MA plans require preauthorization for higher cost care, have high rates of rejection of care covered by Medicare, tend to have narrow networks of providers, and may provide lower cost, lower quality care in post-acute and other care. As a result, sicker Medicare beneficiaries have been more likely than healthier beneficiaries to choose traditional fee-for-service Medicare. Significant numbers of those who enroll in Medicare Advantage plans who have complex or serious chronic conditions or require high-cost care switch to traditional Medicare. One study of nearly 14 million Medicare beneficiaries found that Medicare Advantage enrollees with complex medical needs were more likely than those without such problems to disenroll from the MA plan and elect traditional Medicare. Disenrollment was less likely for enrollees in 5-star MA plans. A second study analyzed whether MA plans retained their high-cost enrollees by examining the rate of switching from MA plans to traditional Medicare and vice versa for patients who used either skilled nursing facilities or home health care. They found among these Medicare beneficiaries far higher rates of switching from Medicare Advantage to traditional Medicare than the reverse (Meyers et al. 2019; Rahman et al. 2015; Fuse Brown et al. 2023).

Thus, the population of traditional Medicare beneficiaries is sicker and more expensive to care for than the population of Medicare Advantage enrollees. As the Medicare Advantage population

increases, this mismatch between traditional Medicare and Medicare Advantage is exacerbated. The net result is that MA plans were overpaid an average of $9.3 billion per year from 2017 to 2020 (Ryan et al. 2023). Using the costs of caring for traditional Medicare beneficiaries as the basis of the benchmark for paying Medicare Advantage payments inflates the amount of the benchmark. A recent study by researchers at USC's Schaeffer Center for Health Policy & Economics also found that patients in traditional Medicare are sicker and more costly to care for. CMS sets payments to Medicare Advantage based on expenditures from claims data for beneficiaries that remain in traditional Medicare, not based on expenditure data from Medicare Advantage. If the beneficiaries in traditional Medicare are sicker than those enrolled in MA plans, the MA plans can more easily bid under the benchmark and receive higher rebates from CMS. This payment mechanism, the Schaeffer Center researchers argue, is a cause for concern. Their research shows that it results in overpayments to MA plans markedly higher than other estimates. Combined with increasing enrollment in MA plans, these overpayments constitute a serious risk to the Medicare trust fund and threaten the long-term viability of Medicare (Lieberman, Ginsburg, and Valdez 2023a). Their results are confirmed in a recent MedPAC report (MedPAC 2023b). MedPAC found that MA spent 11 percent less on enrollees in 2019 than was spent on fee-for-service beneficiaries with the same risk scores. This was due to the favorable selection of beneficiaries; that is, healthier Medicare beneficiaries choose to enroll in an MA plan rather than traditional Medicare.

The 6 percent overpayment to Medicare Advantage Plans due to upcoding and the 11 percent overpayment due to enrollment of healthier beneficiaries in MA plans are additive: total overpayment from these two sources amount to 17 percent. Concerns that the current method for establishing the benchmark are leading CMS to make large overpayments to MA plans have led MedPAC to propose three alternative methods for calculating the benchmark (MedPAC 2023b, Chapter 4).

The Growing Dominance of UHG, Humana, and CVS in MA and Home Health

Given the financial incentives embedded in the Medicare Advantage payment system and regulations, coupled with the expanding desire for home-based care among seniors, insurance providers with MA plans have quickly moved into home-based health services — especially home health care. Indeed, Medicare Advantage has been a major driver of the consolidation of

home health agencies, as the case examples of UnitedHealth Group (Optum), Humana (CenterWell Home Health), and CVS/Aetna illustrate (Eastabrook 2023a). In 2023, these three corporations alone accounted for 58 percent of all MA enrollees nationwide (Ochieng et al. 2023).

The largest Medicare Advantage plans have acquired the largest home health companies. They argue that consolidating and acquiring home health companies enables them to provide beneficiaries with better access to post-acute care, improve health outcomes, save money, and boost patient satisfaction scores. But growing evidence suggests a different motivation, as described below.

UHG, Humana, and CVS/Aetna share several things in common. They each have a large captive clientele of millions of enrollees in their MA plans and have adopted a diversification strategy that enables them to require their MA members to use a variety of home-based services provided by other companies they also own.

Their vertical integration strategies include, in addition to home health and home care companies, other parts of the home health supply chain — in particular, the acquisition of risk assessment (RA) companies and pharmacy benefits managers (PBMs). As we discuss in this section, these acquisitions increase the profits of the insurers that own home MA plans. Using insurer-owned risk assessment vendors facilitates upcoding by the MA plan that exaggerates the seriousness of the enrollee's health status and higher capitated MA payments. There is a second way that insurance companies profit from owning subsidiaries that engage in transactions with each other. When the MA plan purchases services from a supplier that is also a subsidiary of the insurance company that owns the plan, the transaction is not a market transaction, and the price of the service is not set in a market. Economists refer to these internally set prices as transfer prices, and they loom large in the case of PBMs. Internal transfer pricing can be used to boost insurance company profits, as described below. In sum, insurers' growing market power combined with the size and scale of their MA plans has boosted the insurers' earnings by billions of dollars.

UnitedHealth Group entered the home health care market in January 2023, when it finalized its purchase of the for-profit home health company LHC Group for $5.4 billion. (This was just shortly after LHC Group's CEO had touted the company's success as an independent home health provider.) UnitedHealth Group CEO Andrew Witty explained his company's interest in home

health providers: "It's no secret that we believe that home health capabilities, when combined with other activities in terms of wrapping care around patients, is a really important element of the future of value-based care" (Filbin 2023c). Half a year later, in June 2023, UnitedHealth Group's Optum made a successful, all-cash bid for Amedisys that values the company at roughly $3.3 billion. Amedisys provides a range of services that include home health, hospice, and — since its acquisition of Contessa — hospital-at-home services. Amedisys operates 522 locations across 37 states and the District of Columbia (Holly 2023). LHC operates a similar number of locations. A combination of the two under UnitedHealth Group's roof will likely create the largest vertically integrated provider in the U.S. of health services in the home. The home health business alone of the combined company will surpass Humana's CenterWell as the largest US provider, with about 10 percent of the home health market (Famakinwa 2023b). The deal is not yet finalized; the acquisition of Amedisys still faces regulatory review by the Federal Trade Commission (FTC).

Humana partnered with private equity firms TPG and Welsh, Carson, Anderson & Stowe (WCAS) in 2017 to acquire home health provider Kindred at Home. In 2021, four years later, Humana purchased the remaining 60 percent interest in the company for $8.1 billion and rebranded its home health care services as CenterWell Home Health. CenterWell Home Health has 350 locations in 38 states. At the same time, Humana folded its primary care centers for seniors into CenterWell and rebranded it as CenterWell Senior Primary Care (Famakinwa 2022b). Humana also owns Onehome, an organization that serves post-acute home care organizations and operates under a fully capitated or full risk model (Holly 2022a).

Onehome began operating in 2018. WayPoint Capital Partners had a stake in Onehome and eventually took over ownership of the home health company. In 2021, Humana acquired Onehome (Pitchbook Humana Profile 2023). In addition to home health care, Onehome provides durable medical equipment to the home and home infusion services. Rather than being a management services organization, which oversees and contracts with a network of home health providers, Onehome is a vertically integrated provider with its own home health agencies, infusion services, durable medical equipment warehouse, and pharmacies. Its goal is to be a single point of accountability for services based in the home. Onehome is working on becoming the coordinating organization for home care for Humana Medicare Advantage plan members,

with a goal of serving 50 percent of members by 2027. The Medicare Advantage plan will contract with Onehome on a capitated basis for the services they provide. Onehome will then take care of referring MA plan members to all the home care services they require. In addition, Onehome will provide services to other insurers' Medicare Advantage plans, acting as a convener and facilitating interactions between MA plans and independent home health providers.

CVS Health began as a small health and beauty retail chain (Consumer Value Stores) in 1963 in Lowell, Massachusetts, and expanded through organic growth in the 1970s and, since 1988, several acquisitions of major drug store chains. It had some 5,500 outlets in 2005 and 9,600 in 2022. It positioned itself over time to become a vertically integrated provider of prescription drugs to retail customers and home health businesses by launching a pharmacy benefit company in 1994, which laid the groundwork for its acquisition of Caremark in 2007 – making Caremark now the largest pharmacy benefit manager in the country. It acquired a "MinuteClinic" in 2006 as a subsidiary, from which it built out its current network of 1,100 retail clinics. In 2018, it acquired health insurer Aetna for $69 billion (Pifer 2023c). In 2023, it ranked sixth on the Fortune 500 list of companies in terms of revenue, and it employs 300,000 workers, about three quarters of them full time.

With this extensive infrastructure in place, CVS/Aetna is now poised to expand into home health. To that end it acquired Oak Street Health, a value-based medical clinic, for $10.6 billion in early summer 2023, adding a chain of doctor-staffed primary care clinics for seniors (Pifer 2023c). Earlier in 2023, CVS bought out risk assessment company Signify for $8 billion. Signify adds 10,000 clinicians and new technology to CVS (discussed in greater detail below) (Pifer 2023a). Difficulty integrating these multibillion-dollar acquisitions put cost pressures on CVS, and the corporation decreased the number of jobs by 5,000 in 2023, with the cuts focused on corporate positions but no jobs lost in stores or clinics (Yeung 2023).

Case Example: UHG/Optum Consolidates Home Health, Expands Continuum of In-Home Care

UHG-owned Optum Health Services has positioned itself to be the largest provider of home-based care in the US through the 2023 acquisition of LHC Group and the acquisition of Amedisys Care, pending approval from the FTC. Optum acquired LHC Group, a Louisiana based home health and hospice industry leader, in February 2023, for $5.4 billion. LHC had more than 500 locations

in 37 states, with some estimates as high as 964 locations (Tepper 2023a; Famakinwa 2023b). Then, in June of 2023, Optum made a deal to acquire Amedisys (with 522 locations in 37 states and the District of Columbia) in an all-cash transaction of $3.3 billion (Holly 2023). Amedisys shareholders voted to officially approve the deal on September 8th, 2023 (Eastabook 2023b). Now the deal is subject to regulatory approvals and other customary closing conditions (Parker 2023).

If the deal is finalized, however, Optum would be the leading home-based health provider in the country, capturing about 10 percent of the market (Holly 2023). The combined LHC-Amedisys footprint would exceed the next largest competitor, Humana's CenterWell Home Health — formerly Kindred at Home (Holly 2021). They would also be well-positioned to offer a continuum of home-based care, including home health, hospice, personal care (from LHC's operations), and high-acuity care through Contessa Health (a subsidiary of Amedisys as of 2021) (Famakinwa 2023b).

As of August 2023, the deal was not yet finalized. On August 10 the Department of Justice issued a second request to Amedisys for more information. This does not necessarily derail the deal, but it pushes back the date of the possible merger. The deal had been expected to face antitrust scrutiny despite there being little geographic overlap between Amedisys and LHC Group, the other home health business UnitedHealth Group acquired earlier in 2023 (Pifer 2023e).

Amedisys is a home health, hospice, and personal care agency that had its beginning in Baton Rouge, Louisiana, in 1994 as a public company. Between 1998 and 2022, Amedisys grew into a diversified home health agency. It acquired 50 home health and hospice companies, attracted interest and funding from private equity firms, and positioned itself to provide a wide variety of home-based services for the elderly. As one of the largest home health agencies, Amedisys seemed capable of remaining independent and partnering with Medicare Advantage plans to provide in-home services for their members. But its acquisition by UnitedHealth Group's Optum in August 2023 followed closely behind the 2023 acquisition of another major home health provider, LHC Group (Pitchbook Amedisys Profile 2023).

Amedisys' first major acquisition was Beacon Hospice in 2011, for $126 million (Pitchbook Amedisys Profile 2023). Beacon had three free-standing locations and one inpatient unit and saw a daily patient count of 1,300 on average. The Optum deal would boost the number of

hospice patients under its care by about 40% and would complement its home health business with "many of its hospice locations matching the market presence of its existing home health care centers" (Fox Business 2015). Private equity firm Kohlberg Kravis Roberts (KKR) saw Amedisys's growth and provided development capital to the company in August 2013, taking an 8.5 percent stake in the company (Pitchbook Amedisys Profile 2023).

In May 2014, Amedisys settled a False Claims Act Lawsuit for $150 Million. Seven whistleblower (qui tam) lawsuits alleged that Amedisys made false claims to Medicare for ineligible home health care services and patients between 2008 and 2010 (Waters Kraus & Paul Law Firm 2014; DOJ 2014). According to the Department of Justice, Amedisys allegedly billed Medicare for nursing and therapy services that were medically unnecessary or provided to patients who were not homebound and otherwise misrepresented patients' conditions to increase its Medicare payments. This was a result of management pressure on nurses and therapists to provide care based on the financial benefits to the company rather than the needs of patients (DOJ 2014). Amedisys also violated the Anti-Kickback Statute by providing patient care coordination services at below-market prices to a private oncology practice in Georgia.

In 2019 and 2020, Amedisys acquired three more hospice organizations: Compassionate Care Hospice for $340 million which brought its patient census from 7,200 patients in 22 states to 11,000 patients in 33 states (Pitchbook Amedisys Profile 2023; Parker 2019); Asana Hospice for $66.30 million; and AseraCare Hospice for $230.0 million (Pitchbook Amedisys Profile 2023; Parker 2020).

In 2021, Amedisys acquired a home health and hospice care business, Visiting Nurse Association, for $20.1 million (Muoio 2021) and a home health care and hospital-at-home provider, Contessa, for $240.7 million. In the company's words, taking on Contessa would bring "tech-enabled, higher-acuity hospital at home and skilled-nursing facility at home services, advanced claims analytics platform, network management and additional risk-taking capabilities to Amedisys's range of home-based services" (Amedisys 2021; Parker 2021). In August 2022, Mount Sinai Health System and Amedisys-owned company Contessa partnered to create Mount Sinai at Home, a home-based care continuum that "includes home health, hospitalization at home, rehabilitation at home (in lieu of care at a skilled nursing facility) and palliative care at home" (Mount Sinai Health System 2022).

In April 2022, Amedisys acquired Evolution Health, a provider of home health services based in Dallas, Texas, for $67.8 million (Donlan 2022a). Evolution is a division of Envision Healthcare, a private equity-owned company with a long track record of loading patients with surprise medical bills. It has since filed for bankruptcy (Appelbaum 2023). Evolution brought 3,300 home health patients and 650 employees across 15 locations in Texas, Oklahoma, and Ohio to Amedisys. This deal was notable for two reasons: it marked a transition for Amedisys from hospice acquisitions to home health acquisitions, and it expanded Amedisys's access to Medicare and Medicare Advantage enrollees.

For UHG, the acquisition of Amedisys will cement Optum's dominant position in home health and expand its reach across the continuum of care.

Upcoding and Overpayments: MA Health Insurers Acquiring Risk Assessment Companies

A worrying development is that some of the large insurers with a major presence in Medicare Advantage have acquired companies that provide risk assessments for plans that provide value-based care. Recall that CMS pays Medicare Advantage plans on a per-member capitated payment basis. It then adjusts these flat payments based on the severity of a member's health status, with the status supported by diagnostic codes. Sicker members typically get higher risk codes, and the MA plan receives a higher payment for that person. When the insurer that owns the MA plan also owns the risk assessment company, the concern is that members will receive risk assessment codes that are higher than warranted by their health status (Pifer 2021).

Two of the three leading insurers with MA plans own risk assessment companies — UHG and CVS — while Humana is under contract with CVS's risk assessment company for services. UnitedHealth Group's Optum Services owns the risk adjustment company House Calls — the second largest of these companies in the US CVS-owned Aetna insurance acquired risk assessment company Signify in March 2023 (Donlan 2023b).

CVS-Aetna bought out Signify for $8 billion. In addition to risk assessment, Signify brings other diversified capabilities to CVS Health. It is a technology-based home care company with core capabilities in analytics and technology, coupled with a health care provider network and over 10,000 clinicians. Signify works with MA health plans and providers to deliver in-home care and

home health risk assessment for value-based care. It is payer-agnostic and provides patient risk assessments to Aetna's Medicare Advantage plans as well as to other value-based payment programs. At the time of its acquisition by CVS-Aetna, it was under contract with over 50 MA health plans in addition to Aetna – including some sponsored by UnitedHealth Group and Humana (Tepper and Perna 2022). While Signify Health had executed an IPO in early 2021 and was a publicly traded company at the time of the sale, it was 60 percent owned by funds affiliated with private equity firm New Mountain Capital. New Mountain Capital formed Signify by combining two other companies in 2017. Matt Holt, the chairman of Signify's board of directors, is also a managing director at New Mountain Capital. CVS Health funded the transaction with cash from its balance sheet plus "available resources," but did not use much debt (Tepper and Perna 2022). Signify was fully acquired for $8 billion by CVS Health in 2022 (Pitchbook Signify Health Profile 2023).

In February 2023, Signify acquired Caravan, a management services organization (MSO) that services Accountable Care Organizations (ACOs) for $250 million (Donlan 2022c). Caravan's clients serve about 700,000 traditional fee-for-service Medicare beneficiaries. Caravan currently partners with 170 providers in Medicare ACOs (Pifer 2022b). Signify believes there will be new opportunities to grow with Caravan as a result of the Biden Administration's ACO REACH direct contracting model. The direct contracting model, initiated in the Trump administration and continued with some modifications under Biden, opens the door to privatization of traditional Medicare without the informed consent of patients who may be invited to join by their primary care doctors (Cunningham-Cook 2023). Caravan's network of clinicians goes into patients' homes to assess their needs and connect them with the appropriate services.

CVS expects the acquisition of Signify to improve patient engagement and health risk assessments and to save money through "… improved care coordination and new care models that utilize Signify's home access and member connectivity." CVS also expects tax benefits from the transaction structure, though it is unclear what they are. Gains for CVS from pharmacy collaboration opportunities with CVS-Caremark's PBM subsidiary are more obvious (Donlan 2022c).

Insurance company ownership of risk assessment companies is a situation ripe for fraud, and the federal government has begun investigating. CMS pays MA plans fees based on the risk codes

assigned to patients according to their medical conditions. While most patients receive their risk codes through a doctor's examination, insurer-owned MA plans are increasingly using insurer-owned home care risk assessment companies to make the assessment. The Office of the Inspector General (OIG) at HHS has found that home health risk assessments are vulnerable to abuse by MA companies because the risk assessments are carried out by the companies themselves or by vendors they have hired (Abelson and Sanger-Katz 2022). Indeed, federal auditors began an investigation into Aetna for exaggerating Medicare Advantage risk codes in the summer of 2021 (Pifer 2021) while CVS (Aetna) was a client of Signify but before it acquired the company.

HHS is stepping up its investigation of how MA plans calculate patient risk (Pifer 2022c). The OIG believes it has evidence of overbilling by UnitedHealth Group, Humana, and CVS (Aetna) – and, indeed, at nearly all the top 10 insurers with Medicare Advantage plans (Abelson and Sanger-Katz 2022). Whistleblowers have also accused MA plans of deliberately engaging in the practice of upcoding the severity of patients' medical conditions. Only Centene, among the top 10 insurers, has not been accused of overbilling CMS. Humana settled in 2018; the other cases were ongoing as of August 2023. We discuss overbilling by MA plans more fully in the section on fraud in home health.

Transfer Pricing: MA Insurers Profit by Acquiring PBMs and HHAs, Game MLR Requirement

In addition to their acquisitions of home health agencies and risk assessment companies, insurance companies that own Medicare Advantage plans have also bought up pharmacy benefit managers (PBMs). Indeed, all of the top insurance companies that offer MA have an in-house PBM subsidiary. PBMs are "middlemen" that negotiate prices with drug manufacturers on behalf of insurers and then establish the price that retail dispensers of pharmaceutical products pay for the drugs. The PBMs owned by the large insurance companies own the pharmacies that deliver the medications to MA plan participants. The three largest PBMs, which control 80 percent of the pharmacy market, are CVS Caremark (owned by Aetna/CVS), Express Scripts (Cigna), and OptumRx (UnitedHealthcare). UnitedHealth Group created OptumRx in 2011 by combining its pharmacy and care delivery services, and then expanded it in 2015 with the acquisition of

CatamaranRx. Humana is served by its in-house PBM, Humana Pharmacy Solutions (Byers 2018; Rome 2023).

Vertical integration of health insurance companies that own both Medicare Advantage plans and companies that are suppliers to the plans are in an enviable position. Pharmacy benefits managers and other related businesses provide the insurers with another opportunity to profit at the expense of patients and CMS. The vertical integration allows MA plans to meet certain standards set by the Affordable Care Act that they might otherwise have difficulty meeting. Beginning in 2012, the ACA implemented the so-called 'Medical Loss Ratio' (MLR), which requires MA plans to spend 85 percent of premiums on enrollees and on care quality improvements and limits administration, marketing, and profits to 15 percent of premiums. MA plans that do not meet the MLR standard must rebate part of the premium. MA plan payments to PBMs for pharmaceutical products from pharmacies they own, as with purchases from other related businesses, count as health spending under the MLR. What makes this problematic is that the PBMs' profits from the MA insurance plan's payments for pharmaceutical products required by MA plan members flow through to the parent company that owns them both. What appears as costs for patient care to the MA plan are in part profits to the parent company. These profits are outside the MA plan and not subject to the MLR cap on profits (Frank and Milhaupt 2022).

As noted above, this vertical integration creates a situation that economists refer to as transfer pricing. One part of the integrated insurance company is supplying (transferring) goods and services to another part of the integrated company, the MA plan's participants. The price is set in a negotiation with the MA insurance plan, with both the MA plan and the supplier happy with a high price and a large margin over cost. Consider the case of an MA insurance plan and a PBM, both owned by the same parent company. Inflating the price the MA plan pays for pharmaceuticals increases the PBM's profits (and thus the profits of the parent company). But these profit payments are part of the cost of the pharmaceuticals to the MA insurance plan and count as spending on the care of MA plan participants. This also inflates the amount of the insurance premium that the MA plan spends on health care, allowing the MA plan to more easily meet the 85 percent threshold of the MLR standard. Recall that the MA insurance plan, but not its parent company, is limited to just 15 percent of premium income for profit and administrative

costs. Transfer pricing lets the vertically integrated company that owns both the MA insurance plan and the PBM to evade this constraint.

The Department of Justice and Congress are each investigating how PBMs operate. The FTC is examining the consolidation of PBMs into just a few large firms and the effect this is having on drug prices and insurance premiums. The House Oversight and Accountability Committee is examining the issue of transfer pricing and how this is impacting federal government-administered health care programs, ranging from the Office of Personnel Management to CMS and the Defense Health Agency. This will include a review of the effects on the costs of Medicare Advantage plans (Pifer 2022a; Mensik 2023).

Transfer pricing is also present when the insurer that owns the MA plan also owns the home health agencies that are in-network for its members. The price paid by the MA plan to the HHA is set by the parent company. The profit earned by the home health agency accrues to their insurance company. The lack of transparency in transfer prices makes it difficult to compare prices paid for services of high- and low-quality HHAs. The mark-ups on insurer-owned low-quality HHAs may mean higher prices and profits despite the lower costs of low-quality care.

Home Health Agencies Face Challenges When Partnering with Medicare Advantage Plans

Home health agencies, which traditionally have served fee-for-service Medicare beneficiaries, have identified the growth of Medicare Advantage — which now serves 51 percent of Medicare beneficiaries (Ochieng et al. 2023) — as a threat to their business model and to their plans for growth. They see partnering with Medicare Advantage plans to provide home health services as vital for growth, and even for survival (Donlan 2023e). Despite this, home health agencies see the growth of MA plan members as an important population to serve if they are going to prosper. Many are seeking to partner with MA plans and add plan participants in addition to the fee-for-service patients they have traditionally served.

The relationship between home health agencies and Medicare Advantage plans is fraught. When the MA plan offers the benefit via an independent home health agency, the plans drive a hard bargain. Under the rubric of value-based care, they pay rates far below what traditional Medicare pays for the same services. MA plans are reluctant to allow the Medicare dollars they receive to

leak out of the insurer-owned network to other organizations. Small and medium-sized home health agencies are at a clear disadvantage when negotiating fair rates of payment with insurance giants, but even larger health care agencies struggle with low rates. Dissatisfaction among home health care agencies, who understand that partnering with MA plans is vital to their future financial success, is widespread, with many finding the relationship to be toxic (Donlan 2022b).

Mediating between home health care agencies and MA plans are the "conveners." These are middlemen who facilitate negotiations between home health providers with MA plans, ostensibly to make it easier for these plans to engage with a large number of home health care agencies. But the home health providers complain that they are more of a hindrance than a help and are simply skimming their fees from the already low MA payment rates. The three major conveners are myNEXUS, naviHealth, and CareCentrix. Not surprisingly, in the seemingly incestuous health insurance industry, the three convener companies are owned by major insurers that have their own MA plans: myNEXUS is owned by Elevance Health, Inc., naviHealth is owned by UnitedHealth Group, and CareCentrix is owned by Walgreens Boots Alliance. This is not a level playing field for home health agencies, many of whom have been complaining angrily about unfair rates for the services they provide (Silverstein 2019).

The low payments from MA plans have put pressure on home health agencies' margins as these companies face other challenges from inflation and rising costs, cuts in Medicare fee-for-service payments, and difficulties in meeting staffing needs. Small and medium sized home health agencies often face a stark choice between being acquired by larger firms or facing a real threat of bankruptcy (Filbin 2023a). In September 2022, Trinity Health At Home in Springfield, Illinois, closed. In October of that year, Hospice and Home Care of Juneau shut down after two decades of providing these services. In January 2023, Oahu Home Healthcare announced plans to shut down. Mike Dordick, president of McBee Associates, a health care consulting firm, sees these closures as part of a trend and suggests there will be many more closures of small and medium-sized home health agencies due mainly to low reimbursement rates and workforce shortages (Filbin 2023a).

The Takeaway

Large health insurance companies are becoming monopolistic owners of vertically integrated systems of Medicare Advantage, risk management companies, pharmacy benefits managers,

vision and hearing companies, doctors' practices, and home health agencies. This massive consolidation of services to the elderly provides the ample opportunities we examined for the extraction of oversized profits and the under provision of adequate care. The incentive to fail to approve necessary health services covered by Medicare, the windfall in the CMS benchmark and bidding process, the ownership of the companies that assess enrollee's health status and the opportunities that provide for coding them as sicker than they are, and the ownership of PBMs and other related businesses all provide the insurance companies that own MA plans with opportunities to increase their profits without providing more or better services to MA members. These incentives and opportunities to defraud Medicare or undermine patient care are not present in traditional fee-for-service Medicare. In the meantime, small and mid-sized home health agencies are pushed out of the market, accelerating the consolidation of home health care.

Private Equity in Home Health Care

For-profit companies dominate the home health market. CMS maintains a database of all home health agencies that have been registered with Medicare, updated as of July 5, 2023 (Data.CMS.gov 2023). Out of the 11,682 agencies, 78 percent were for-profit, and 22 percent were non-profit or government owned. The 78 percent figure includes the large home health agencies owned by the insurance companies that also own Medicare Advantage plans, but it also includes many small HHAs that find it difficult to compete against insurer-owned HHAs; are overwhelmed by government rules and regulations; and generally lack the technology that streamlines record keeping, compliance, and billing. This fragmented part of the home health market, competing to serve the half of the Medicare population that is still in traditional fee-for-service Medicare, has proven to be fertile ground for acquisition by private equity firms.

Private Equity in Traditional Medicare Home Health

Private equity firms' entrance into the fee-for-service half of home health and their rapid buying up of small agencies and consolidation into large providers is carefully documented in a new study by Moss and Valdes Viera (2023). Their analysis of private equity in home health includes a range of PE financial strategies — including leveraged buyouts, platform formation to build consolidated chains, growth investments, and private investment in public equities where the PE

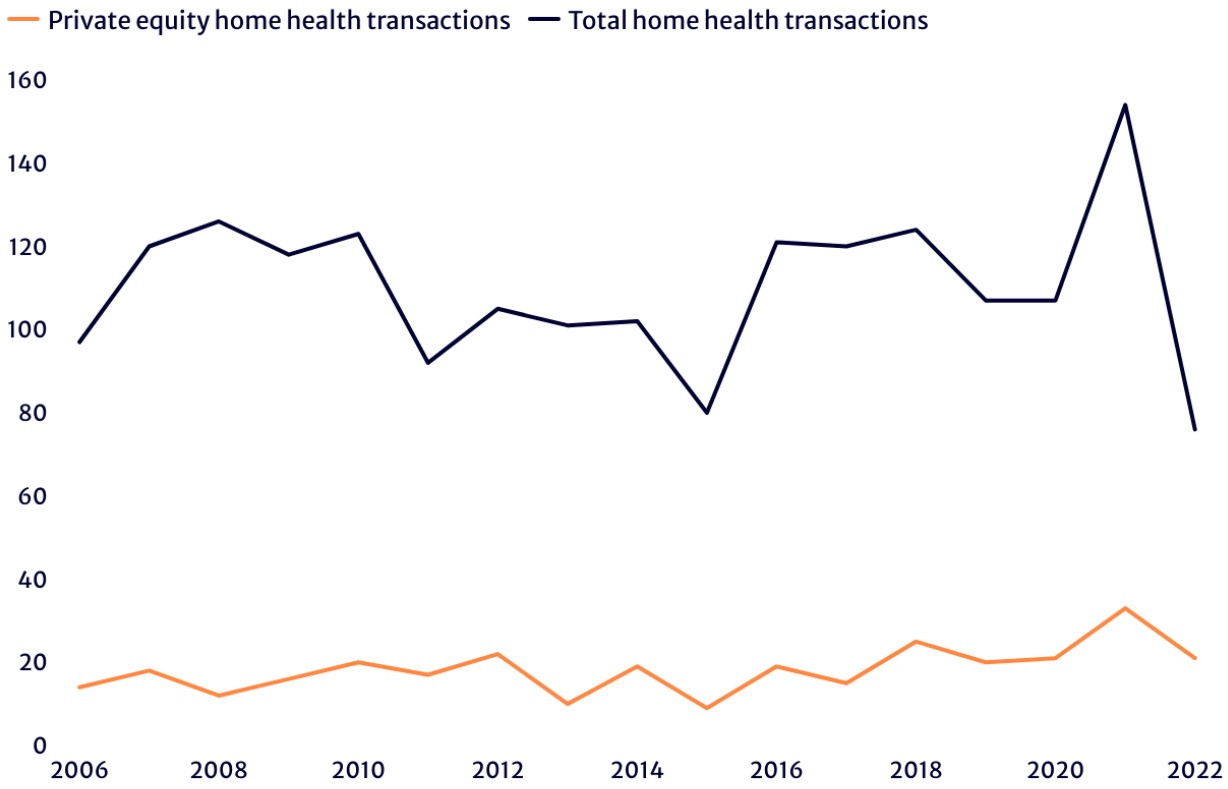
firm has a substantial holding or majority of shares. The authors examined a sample of 8,591 agency locations registered with CMS for which they could confirm Medicare beneficiary payments and an episode of care. Geographic location data is also available in CMS files. Matching these agency locations to other data, they found that, as of early 2023, 37 parent companies with some level of private equity ownership, ranging from owning shares to owning the agency, owned 492 home health agency locations. This is about 5.7 percent of the total agency locations. Of these locations, 330 were individual agencies, often small HHAs, acquired by the 37 parent companies that a PE firm owned or in which it had invested. A steady number of PE deals over the past two decades has contributed to consolidation of the home health segment. Many more agencies have passed through private equity ownership. As the authors note, InnovAge and CenterWell Home Health (formerly Kindred at Home) are among leading home health agencies that are or have been owned by PE firms.

Moss and Valdes Viera analyzed Medicare data to rank the five largest PE-owned HHAs by revenue in 2020. Advent-owned AccentCare, with 57 locations, is the largest. The others are Elara Caring (Kelso Private Equity and Blue Wolf Capital Partners), Interim Healthcare (Wellspring Capital Management), Aveanna Healthcare (Bain Capital and J.H. Whitney Capital Partners) and Mission Healthcare (Vistria).

Data from The Braff Group on home health care deals shows PE deals have largely been flat, with a slight upward trend in recent years. PE has engaged in a relatively low number of deals each year, even as the cumulative number of deals has been much higher and has trended slightly upward since 2016. The number of deals is not the same as the number of agency locations acquired. A single deal may involve a small HHA operator with one or two locations or a very large home health company with a hundred or more locations. Nevertheless, it does not appear that PE's ownership share of the growing national home health market has increased.

Figure 4

Home Healthcare Deals, 2006-2022



Source: The Braff Group

CEPR

Private equity's slow but steady accumulation of home health companies is concerning because of the nature of the private equity business model. For-profit home health companies will, of course, seek to maximize profits and may prioritize profits over clinical care. But the need to profit from investments in home health is far more pressing for PE owners. This is because PE-owned companies typically are acquired with debt that is repaid by the company, in this case the HHA, squeezing funds available for clinical care. Moreover, PE firms need to deliver outsized returns to their investors — returns that are far higher than can be earned from investments in publicly traded companies on the stock market. Moreover, PE firms hold the companies they acquire for just a few years before selling them at a profit — typically five years but in a preferred range of three to seven years. This puts enormous pressure on PE-owned home health agencies to show a large profit and raises concerns over how this will be done.

Organic growth — attracting more patients to existing facilities — will not enable the home health company to increase its revenue quickly enough to make it attractive to a future buyer. Instead, private equity firms expand their home health agencies by acquiring other, usually smaller, home health businesses, and they finance this buying spree with debt. The debt needs to be serviced out of operating revenue, which squeezes the ability of the home health agencies to invest in workers' training and wages and maintain adequate staffing levels to provide quality patient care. In a situation like the present, where interest rates are rising, highly leveraged companies may have difficulty refinancing their debt or keeping up with debt repayments. This threatens the financial stability of highly indebted companies and their ability to avoid default or even bankruptcy. In December 2022, Moody's Investors Service put formerly private equity-owned Aveanna Healthcare, a large home health agency mainly serving children with complex needs, on its list of 34 health care companies at risk for default. Moreover, the large scale of PE-owned home health agencies means that their practices and problems have effects on a larger number of workers and patients, compared to smaller, non-PE-owned agencies (Thomas 2022).

While private equity is involved with a fairly small proportion of home health companies, Moss and Valdes Viera (2023, Table 6) show that these national figures obscure a more complex reality: HHA locations backed by private equity are geographically concentrated, permitting PE-owned agencies to have a greater influence in some local metropolitan area health markets than the national figures suggest. The authors don't have total market share data for PE firms, but they suggest using Medicare revenue as a proxy. Using the Herfindahl-Hirschman Index (HHI), based on shares of Medicare revenue of firms, they find that of all the metropolitan areas with at least one PE-owned HHA, 32 percent have high levels of concentration (64 percent show high or moderate concentration). However, this is far less than the 79 percent of all metropolitan areas without a private equity presence that were highly concentrated (93 percent show high or moderate levels of concentration). Presumably, these areas are dominated by insurer-owned home health agencies, which play a larger role than PE firms in the consolidation of the home health market. Despite the continued existence of small, independently owned HHAs, the large agencies owned by financial actors provide much of the home health care in the US.

To gain access to the half of Medicare beneficiaries that are enrolled in MA plans, some PE-owned HHAs are trying to figure out how to partner with Medicare Advantage plans. Elara Caring

is in the forefront of these efforts to make the relationship work. Based in Dallas, Texas, Elara Caring has about 200 locations across 16 states. It employs 1,000 workers and serves around 60,000 patients annually. Not all of its locations house a home health agency — some are hospices and others may supply non-medical care to seniors in their homes. Daniel Schwartz, Elara's chief strategy officer, reports that he has observed a shift in the mindset on both sides. He notes that for many years the relationship with MA was confrontational. But now he finds that some MA plans are moving away from a view of home health providers as vendors of a commodity to be acquired at lowest cost and have begun to recognize that an effectively run HHA can add value to their members. On the home care provider side, agencies like Elara have been rethinking how they can deliver care and better collaborate with MA plans (Famakinwa 2023a).

There are still barriers to partnerships of HHAs with MA. To begin with, there are capacity issues. If an HHA is going to partner with an MA plan, it must be able to take all the patients the MA sends to it. The lack of adequate technology at the HHA can also interfere with these relationships. But for large PE-backed home health providers like Elara, these barriers can be overcome.

Another strategy that some large HHAs, including some owned by private equity, have used to gain access to patients is partnering with large hospital systems. Forming a joint venture (JV) has proven successful for some large home health companies. The JV enables the hospital system to offer a full range of health services — home health, hospital-at-home, palliative care, and hospice — and to retain elderly patients as their need for acute and post-acute health care services changes over their lifetimes. The JV is advantageous for home health agencies, as this facilitates their growth and puts them in a better position to partner with insurance company-owned Medicare Advantage plans. LHC Group's CEO, Keith Myers, for example, attributed his company's success in dealing with managed care plans to its joint ventures with hospitals (Donlan 2023a).

An example of this strategy in the private equity context comes from private equity-owned AccentCare, a major operator of home health and hospice services, with a large presence in South Texas where it is headquartered. AccentCare entered into a joint venture with non-profit Memorial Hermann hospital in April 2023. The new venture is the largest provider of home-based services in South Texas. Advent International-owned AccentCare, acquired from Oak Hill

Capital in a secondary buyout in June 2019 (Pitchbook AccentCare Profile 2023), has 30,000 employees that deliver home health, palliative, and hospice care to more than 210,000 people in 250+ locations across 30 states and the District of Columbia (Donlan 2023c). Memorial Hermann's network includes 6,700 doctors, 31,000 employees, 260 care delivery sites, 17 hospitals, and an accountable care organization. The new JV combines two AccentCare home health agencies — Texas Home Health and Season Hospice and Palliative Care — as well as Memorial Hermann into a single home-based care unit. AccentCare will manage the JV, now the largest provider of in-home health care in the Dallas metropolitan area. AccentCare is now investigating other major metropolitan areas to identify opportunities to form partnerships with large, anchor hospital systems in those communities.

The geographic concentration of PE-owned home health agencies in particular metropolitan areas, noted earlier, suggests that this may be a viable strategy for those that can identify a large anchor hospital system to partner with.

The Takeaway

Private equity has had a relatively small but steady interest in owning home health agencies, consistently making deals since 2006. The number of PE-owned HHAs has increased. But as the number of deals in this space has increased, PE has represented a smaller share of the deals. Deal data do not show the number of locations acquired in a deal. Humana's acquisition of Kindred at Home, the largest network of HHAs, it counted as one deal. The number of agency locations that are, or have been, under private equity control has increased. Private equity's presence and influence, especially in those areas where PE-ownership is concentrated, leads to consolidation through acquisitions of mainly small agencies. The largest of the PE-owned agencies are exploring ways to greatly increase their presence in home health. Overcoming barriers and partnering with Medicare Advantage plans is one such approach. Partnering with large hospital systems to create joint ventures that provide the full continuum of home health services — home health, palliative care, hospice, and hospital-at home — in a local health market is another. These initiatives are very recent; it is too soon to know for sure if they will succeed and extend the reach of already important PE players.

InnovAge Case: Private Equity and the Program of All-Inclusive Care for the Elderly (PACE)

The PACE model is a federal community-based home health program designed for what the program refers to as frail, elderly patients above age 55 who qualify for both Medicaid and Medicare. For many years, InnovAge was a home health nonprofit that successfully operated the PACE program. But private equity company Welsh, Carson, Anderson & Stowe (WCAS) saw a way to profit from the payments CMS made to PACE program providers. In 2016 WCAS acquired InnovAge and then used its connections inside CMS to open PACE to for-profit providers. Private equity owned InnovAge soon became the largest PACE provider in the country and profit became its north star; enrollment dramatically rose, patients received delayed and inferior care, and government inspections forced the company to suspend enrollment in six states. Private equity ownership has put a previously successful home care program and its patients at risk.

How PACE Began

PACE was created in 1973 to help the Asian-American community in San Francisco care for its elders in their own homes. Placing elderly relatives in nursing homes was not a culturally acceptable solution for families. To meet their needs, On Lok Senior Services ("On Lok" is Cantonese for "peaceful, happy abode") developed an innovative way to offer comprehensive medical supervision, physical and occupational therapies, nutrition, transportation, respite care, socialization, and other needed services using home care and an adult day setting (NPA 2023b).

A decade later, in 1986, the Robert Wood Johnson Foundation provided funding for six sites beyond On Lok in order to develop PACE demonstration programs. Based on its success, PACE transitioned to a permanent provider type. The Balanced Budget Act of 1997 granted PACE programs status as a Medicare provider and gave state Medicaid agencies the option of including PACE as a Medicaid benefit (NPA 2023b).

As of July 2023, there were 153 PACE Programs operating in 32 states and the District of Columbia (NPA 2023a). Patient census ranges from 12 at the ConcertoHealth PACE of Los Angeles, to 1,610 at PACE Southeast Michigan in Detroit, to 2,679 patients at InnovAge Colorado PACE in Denver, to 5,500 patients at CenterLight Healthcare in the Bronx. The Bronx center is the nation's largest provider of a federal community-based home health program for patients to receive nursing

home-level medical, behavioral, and social service care in their communities (Gyurmey and Kwiatkowski 2019).

There are four key components of the current PACE program. First are the Interdisciplinary Care Teams, which comprise physicians, nurse practitioners, nurses, social workers, therapists, van drivers, aides, and others. Second are the capitated payment arrangements and direct contracting relationships with federal and state governments. PACE receives a monthly lump sum of $7,500 per patient from Medicare, which includes payment from Medicaid or a participant's private pay resources. The PACE program covers all services to each participant from that payment (United States Security and Exchange Commission 2021). Third are the PACE Centers, which participants attend an average of three days per week; they are part of the community-based care delivery model. Fourth is the transportation component; all costs of transportation to and from the day centers are covered as well as travel to other appointments.

PACE has been called the "gold standard of long-term care" because of how much focus it puts on providing preventive, interdisciplinary, integrated care to elderly, low-income people so they can stay out of the hospital or nursing home and live safely in their communities (East Bay Times 2023). However, like so many other Medicare and Medicaid funded programs, PACE operates within a regulatory framework that was developed decades ago for non-profit organizations, based on the assumption that providers would be health care professionals committed to a mission of providing high quality care. Today's market is filled with for-profit or private equity actors focused on wealth extraction. And in 2015, CMS opened the PACE program to them.

Becoming a For-Profit Program

As result of the lobbying efforts of former CMS regulators in collusion with for-profit providers and private equity firms, PACE didn't remain a non-profit provided service. Tom Scully, former CMS administrator, former board member of PACE provider InnovAge, and sitting general partner at private equity firm Welsh, Carson, Anderson & Stowe (WCAS), was interested in opening up the PACE program to for-profit and private equity ownership. Amongst other incentives, profit margins in PACE programs could be as high as 15 percent (Varney 2016). Scully was the top Medicare and Medicaid official under President George W. Bush (2001-03), during which time he spoke frequently about involving financial companies in the delivery of health care. According to interviews with Scully (Dayen 2023), he contacted his friend Marilyn Tavenner

— the CMS administrator from 2010 to 2013 — and encouraged her to have the CMS agency reconsider permitting for-profit companies to be PACE providers (Dayen 2023; Laise 2021).

The CEO of InnovAge, Maureen Hewitt, was looking for capital to expand the home health agency and its services at the time. Scully and Hewitt began working together in 2013 (Laise 2021).

In May 2015, CMS lifted the restriction on a trial basis, and PACE was opened to for-profit companies (CMS 2015). A for-profit PACE pilot or "statutorily mandated demonstration" had found that for-profit PACE plans provided care that was comparable in quality to their nonprofit counterparts (CMS 2015).

Before the for-profit participation in PACE could permanently be embedded in law, it had to be reviewed by the Colorado Attorney General, because InnovAge was technically a state asset. The Colorado Center on Law and Policy (CCLP), the Colorado Cross Disability Coalition, the Chronic Care Collaborative, and the Colorado Consumer Health Initiative were outspoken opponents of the change and spoke out during the public comment period (Arenales 2016; Attorney General of Colorado 2006). Specifically, CLLP expressed concern that InnovAge's assets were substantially undervalued, objected to InnovAge transferring its assets (upon conversion) to a foundation with strong ties to the new for-profit company, and pushed the Attorney General at the time — Cynthia Coffman — to exercise oversight over the new company so PACE participants were protected (Arenales 2016).

Private equity firms were quick to lobby for what they wanted. Lobbying disclosures reveal that InnovAge spent hundreds of thousands of dollars annually, from 2012 on, to lobby both Congress and the Colorado legislature to open the PACE program to for-profit corporations (The Capitol Forum 2021; Open Secrets 2023). During the trial year in which the for-profit restriction was lifted, Scully made a deal with Colorado attorney general Cynthia Coffman: the state would sell InnovAge to a private foundation he created called NextFifty for $216 million, on the condition that the non-profit provision in the PACE law be changed (Dayen 2023).

In March 2016, Attorney General Coffman officially agreed to the InnovAge conversion to for-profit status, but this came with a long list of stipulations that were a direct response to the strong push from public commenters. The opinion appointed an ombudsman in the Colorado Department of Health and Human Services to oversee the quality of care at for-profit PACE

locations for three years after the conversion, restructured the foundation's mission to include disabled individuals and both rural and urban areas of Colorado, put a non-voting community representative on the board, required the foundation to set aside 80 percent of the value of the transaction plus future earnings for Colorado, and requested that the new InnovAge Foundation file conflict of interest forms annually through 2021 (Attorney General of Colorado 2006, 20).

Two months later, in May 2016, Welsh, Carson, Anderson & Stowe acquired the nonprofit InnovAge for $204 million (Pitchbook InnovAge 2023). The deal made InnovAge the first PACE organization with for-profit ownership status. InnovAge is now publicly traded, but while under the ownership of private equity, it became one of the largest home health care providers in the country.

The InnovAge case illustrates how easily the value-based payment system can be gamed by profit driven owners. While federal and state authorities may attempt to monitor and enforce care quality standards, the resources are typically inadequate, actual sanctions take years to enforce, and some practices that undermine patient care are nonetheless legal. This means that programs like PACE are relatively easy prey in the current period of financially driven health care.

PACE is innovative because it allows home health providers to combine Medicare and Medicaid funding into one revenue stream to serve people who are eligible for both programs. The provider takes complete control over patient outcomes and costs of care, and in theory the value-based payment structure provides incentives for cost-effective preventative care. PACE pays providers a fixed monthly per-client fee of $7,500 on average (United States Securities and Exchange Commission 2021), and the provider covers all participants' needs, including personal daily care; medical, occupational, and behavioral services; medications, hospitalizations, and transportation. PACE is the insurer and provider and as such, serves as a model for "value-based care" today. But the fixed per-patient payment scheme may also provide incentives to enhance revenues by increasing the volume of patients and decrease costs by cutting staff or services. Once InnovAge was taken over by financial actors, evidence clearly shows that the latter logic took over.

Following its acquisition of InnovAge, private equity firm Welsh Carson went on a buying spree, purchasing nonprofit PACE programs in Colorado, Pennsylvania, Virginia, California, and New Mexico and doubling the company's client enrollment nationwide between 2016 and 2021 (Laise

2021; Pitchbook InnovAge Profile 2023). During this time, the company's revenues more than doubled. In May 2019, Welsh Carson used the proceeds of an upsized term loan facility to fund a dividend recapitalization and pay out of about $66 million to its shareholders. Tom Scully commented that, "PACE is like community co-op grocery stores. I'm hoping someday it becomes Whole Foods" (Laise 2021).

Value-Based Payments Are Susceptible to Profiteering

The capitated payments to PACE providers make owning a PACE agency attractive to private equity firms. The lump sum per patient payment provides incentives to cut corners in patient care and staffing while pocketing $90,000 per year (United States Securities and Exchange Commission 2021).

Once InnovAge was taken over by Welsh, Carson, Anderson, & Stowe, services and operations shifted. The company began to prioritize growth in enrollment with the goal, it claimed, of providing health care to the massive and growing US senior population. Of course, increasing enrollment hiked revenue, but InnovAge wasn't held accountable to make sure quality of care was maintained. CMS actually wrote regulations in June 2019 that lessened oversight for the sake of flexibility; key provisions allowed PACE organizations to hire staff with less experience and made the on-site review process less prescriptive and frequent (Federal Register 2019).

In July 2019, Karen Lapcewich — former company executive — brought a False Claims Act case against InnovAge. She accused the company of preying on Medicare and Medicaid programs at the expense of quality care. According to the plaintiff, soon after arriving in the position in June 2017, she noticed that the company had systemic compliance problems. Patients were waiting over a year for promised services and medications, which left room for additional injury, pain, or exacerbation of chronic conditions (Osher 2021). When she requested reports of internal audits, the InnovAge CEO rebuked her and had her investigated. Lapcewich was "… disturbed to find that InnovAge was laser-focused on growth" even though it could not meet PACE requirements for the participants who were already under its care (*United States v. Total Community Options, Inc.*, slip op. at page 4, C.D. Cal. July 25, 2019).

Lapcewich claimed that InnovAge knowingly billed the government while "… denying [patients] access to thousands of medically necessary services" (U.S. v. Total Community Options, 3). This

case alleges that InnovAge "... routinely refused to set up appointments for them, failed to deliver their medications on time, or denied them an opportunity to question why they were not receiving requested services" (U.S. v. Total Community Options, 3). Furthermore, given PACE participants' election to be in the program, they had given up the option to use other non-emergency or urgent medical care. This 2019 case was dropped by the employee when the federal government didn't intervene, but patterns identified in this complaint appear in subsequent complaints and investigations (Dayen 2023).

Eight former employees of InnovAge spoke to The Capitol Forum for a 2021 article and shared their experiences with InnovAge's profit-oriented practices. The employees overwhelmingly reported that the company sought to enroll as many patients as possible in order to increase the Medicare and Medicaid funds coming from PACE. However, the company did not have the ability to properly care for all these patients (The Capitol Forum 2021).

> "One way to think of it is that before the switch," a former employee who worked in enrollment said, "the enrollment and Medicaid eligibility departments worked for the operations group. After the change, we answered to the finance and investment group.... The investment group told us to stop caring for people that the state was late in paying for. But we never disenrolled someone because the state wasn't paying for them. It wasn't their fault. I don't think the investment group understood that we owned all the care for the participants."

Similar to hospice organizations that also received capitated payments and came under private equity control (Appelbaum, Batt, and Curchin 2023), employees were offered bonuses if they exceeded their monthly quotas for enrollment. Another employee explained in The Capitol Forum article that enrollment starts on the first of the month, since that's when you get PACE funding. The expectation is "you are working until 11:59 PM the day before, if need be, no matter what day it was, to sign people up." According to these former employees, increasing patient census would come from enrolling more and sicker patients who had health needs that PACE knew it couldn't meet (The Capital Forum 2021).

Complaints from patients about InnovAge have been numerous and federal inspectors have consistently found lapses in care at InnovAge's Denver PACE center. A July 2020 inspection found

a client with diabetes wasn't routinely getting home care and had gone without insulin injections and blood sugar checks for 14 days over the course of three months. A July 2021 inspection found multiple patients were not routinely visited by PACE staff to get them out of bed (Wingerter 2022).

Shortly after InnovAge went public at an enterprise value of $3 billion in March 2021, regulators in Colorado and California imposed sanctions on InnovAge operated PACE programs in those states. PACE facilities are (supposed to be) routinely audited by CMS and are largely regulated and licensed by the state health agencies. Both regulatory levels can suspend the program's ability to enroll new participants if they find issues (The Capitol Forum 2021). That same month, the Colorado Department of Health Care Policy and Finance released information about complaints at the InnovAge center in Thornton, Colorado, where operations were understaffed and "… clients had experienced preventable harm such as infections after surgery and dangerous blood clots" (Wingerter 2022). A physician noted that there weren't enough schedulers to handle the volume of clients and that each doctor was responsible for twice as many patients as the national average for PACE (Wingerter 2022).

On December 22, 2021, CMS suspended enrollment of new patients at InnovAge Colorado PACE locations in Aurora, Denver, Lakewood, Northern Colorado, Pueblo, and Thornton (Scott 2021b). The Colorado locations generate roughly half of InnovAge's annual revenue (Osher 2021). During its routine inspection as well as an audit and impact analysis validation, CMS found that InnovAge wasn't delivering the full services PACE patients were due. Violations included failure of the interdisciplinary team (IDT) to coordinate 24-hour care, failure to provide all Medicare and Medicaid covered services, and failure of the primary care providers to manage participants' medical situations. This suspension remained in effect until January 2023 (Scott 2023). Even though the sanctions were imposed after InnovAge went public, the bad practices occurred during its time under private equity ownership.

In the wake of these audits, the Colorado attorney general, Phil Weiser, started an investigation. In July 2021, the AG sent the company a civil investigative demand for information regarding patient services, referrals, and Medicaid billing (Laise 2021; Wingerter 2022).

Also, in the wake of poor audits in California, CMS stopped InnovAge's Sacramento offices from adding new Medicare clients in September 2021 — citing its failure to provide participants with

medically necessary services. The sanctions were lifted a year later, in November 2022 (Scott 2021a; Scott 2022). The audit found that InnovAge failed to ensure participants received necessary services from certain specialists, and failed to coordinate care, review specialists' diagnoses, and provide services recommended by specialists. It also found unwarranted delays in care delivery and a failure to provide specialists services, including ophthalmology, optometry, dermatology, and nephrology (Commins 2021).

More evidence of poor patient care practices emerged in 2022. In the first six months of 2022, CMS limited enrollment or canceled contracts with new InnovAge PACE centers in Florida, Indiana, New Mexico, and California. A class action lawsuit was filed on behalf of shareholders of the company in June 2022. They include El Paso Firemen & Policemen's Pension Fund, the San Antonio Fire & Police Pension Fund, and the Indiana Public Retirement System. The shareholders claimed InnovAge was putting rapid enrollment ahead of the care of seniors enrolled in its PACE program. As a result of this backlash against InnovAge practices, Maureen Hewitt stepped down as CEO (Cohen Milstein Sellers & Toll PLLC 2022).

While the quality of jobs and patient care suffered, Welsh, Carson, Anderson and Stowe made out very well. The PE firm collected a dividend from InnovAge soon after acquiring the company. It exited the company in just a few years through an IPO in which they sold just 12.5 percent of the company to the public. The IPO raised $350 million, well beyond the initial WCA&S investment (Pitchbook InnovAge Profile 2023). Under the terms of the IPO, Welsh Carson still owned 87.5% of InnovAge's shares (Pitchbook InnovAge Profile 2023). The company performed poorly after its initial IPO. Undeterred, InnovAge quickly set its sights on expansion. Scully remains a board member of InnovAge.

PACE is a successful model for low-income seniors who can receive quality care at home in their own communities when it is not being run by the "poster child for how companies can take advantage of complex federal programs for profit" (Bannow and Herman 2022). During the pandemic, the rate at which PACE enrollees contracted the COVID-19 virus or died as a result of it was one-third the rate of nursing home residents. Prior to the pandemic, the program had a proven track record of providing care to elderly individuals who wished to stay in their community (Filbin 2023b). It remains an important and necessary program that needs to be tightly regulated if it is to be open to for-profit and private equity owners.

Back Door Efforts to Undermine Traditional Medicare

The capitated payments in Medicare Advantage plans, like the capitated payments in the PACE program, encourage fraud, drive up the cost of health care, and undermine care quality for patients. On a per patient basis Medicare Advantage costs CMS on average more than traditional fee-for-service Medicare. This, even though beneficiaries in traditional Medicare can choose their own health providers and have greater control over health care treatment options. Nevertheless, the mythology that value-based payments save money for Medicare has led CMS, through its innovation center, to find and promote alternatives to the fee-for-service model.

ACO REACH (Accountable Care Organization Realizing Equity, Access, and Community Health Model) is the latest payment model designed to shift traditional fee-for-service Medicare patients into privatized medical care based on a value-based model (Hartnett 2023). ACO REACH is an updated version of the Trump Administration's Global and Professional Direct Contracting Model. It replaces that discontinued direct contracting model, which had been criticized by progressive lawmakers as a back door version of privatization of fee-for-service Medicare. Lawmakers noted that it provided greater incentives for profit-driven care (Goldman 2022). CMS is redesigning direct contracting into an ACO model. In ACO REACH organizations, doctors' practices and other providers benefit financially by holding down the costs of caring for patients seen by physicians in the ACO REACH organization (Cunningham-Cooke 2022; Hartnett 2023).

CMS's announced goal for traditional Medicare beneficiaries is to move all of them to accountable care organizations or other valued-based care arrangements by 2030. According to CMS, 13.3 million of these beneficiaries are already covered by various value-based payment models, including the Medicare Shared Savings Program, ACO REACH, and the Kidney Care Choices Model. The lobbying organization Accountable for Health, which represents UnitedHealth Group's Optum and Amazon's One Medical, welcomed the ambitious plan and the use of policy to accelerate the transformation of fee-for-service Medicare. Hoangmai Pham, president and CEO of the Institute for Exceptional Care, urged CMS and the federal government

to make the current fee-for-service model less attractive to Medicare beneficiaries in order to give providers a better path to value based payments (Devereaux 2021; Tepper 2023c).

CMS views ACO REACH as the most promising of the new payment models that its innovation center has been testing. The payment model is expected to increase quality and reduce unnecessary spending through better communication and care coordination — the same claim CMS made for Medicare Advantage. Recent evidence suggests that the cost savings and improved care may fail to materialize (Sinaiko et al. 2023). This study found no benefits of coordination as measured by hospital readmission rates.

Meanwhile, CMS has had trouble attracting enough physician practices and other providers to the program. It has had to tweak the model to lure more providers to it. In August 2023, CMS relaxed some program requirements. It lowered enrollment minimums for patients covered by accountable care organizations. It also changed the risk adjustment methodology to align it with that used in Medicare Advantage (Pifer 2023f; Tepper 2023).

CMS is relying on potential cost savings it imagines it will realize from ACO REACH to reduce Medicare's costs and to shore up the Medicare Trust Fund. This report provides reasons to be skeptical of Medicare payment models that introduce the profit motive, allow providers to pocket the savings from holding down costs, and provide payments based on an assessment of patients' risk factors. Experience suggests that, as in the case of MA and PACE, incentives to profit by holding down costs will lead unscrupulous providers to deny patients care that fee-for-service Medicare would have paid for.

Fraud Threatens Medicare's Solvency

Medicare is the second largest social insurance program in the US after Social Security. In 2022, Medicare covered 65.0 million people. Medicare is paid for through two trust funds. The Hospital Insurance Trust Fund (HI) is mainly funded by payroll taxes paid by most employees, employers, and people who are self-employed. It pays for Medicare Part A (hospital insurance) benefits — inpatient hospital care, skilled nursing facility care, home health care, and hospice. The second trust fund is the Supplemental Medical Insurance Trust Fund (SMI). It is financed by premiums paid by Medicare recipients and general tax revenue. It pays for Medicare Part B, which mainly

covers physician services and medical supplies, and Part D, the prescription drug program. The Hospital Insurance Trust Fund also pays for Medicare Advantage plans that pay for Part A and Part B services. The SMI trust fund does not face the possibility of bankruptcy, as the shortfall each year is covered by general tax revenue. Not so for the HI trust fund. If it develops a shortfall, then benefits will need to be trimmed to match the receipts from payroll taxes. In 2022, the HI fund had expenditures of 905.1 billion and recorded a surplus, as its total income was $988.6 billion. Since 2010 Medicare's costs have come in far below Congressional Budget Office (CBO) projections (Sanger-Katz, Parlapiano and Katz 2023; Baker 2019; Baker 2022). However, in their most recent report, issued on March 31, 2023, the Medicare trustees anticipate that the fund will face shortfalls later this decade, and they estimate that the HI trust fund will be depleted in 2031 (CMS.gov n.d.e.). Fraudulent charges to Medicare take money out of the HI fund and move it closer to depletion.

Overbilling by Medicare Advantage Plans

Earlier in this report we documented the ways that Medicare Advantage plans have enriched themselves at CMS's expense. The government pays MA plans a flat rate per enrollee, risk adjusted for the person's medical condition. Medicare pays more for sicker patients. The large private insurance companies that run these plans have developed elaborate systems to make their patients appear as sick as possible, often without providing additional treatment (Abelson and Sanger-Katz 2022). This is probably the largest source of Medicare fraud, but it largely goes unprosecuted.

Since 2004, CMS has paid Medicare Advantage plans based on a risk score that is supposed to assess the overall health of each patient. Upcoding the risk adjustment and overpayments to Medicare Advantage plans have been well documented (Jacobs and Kronik 2020). Risk scores for MA members rose much faster than the national average in hundreds of US counties between 2007 and 2011, costing Medicare $36 billion over that period. But these actions have not been subject to DOJ fraud investigations. The federal government and health insurance companies have been arguing for more than a decade over how MA plans should be audited and how those overpayments should be clawed back for the HI trust fund (Schulte, Donald, and Durkin 2014).

Billions of dollars that belong in the HI trust fund are on the line in a tug of war between an insurance industry that wants to protect the earnings from its extremely profitable Medicare

Advantage plans and an under-resourced federal oversight system that, until now, hasn't pursued MA plans that exaggerate the poor health of their enrollees. This struggle finally came to a head in January 2023 with the federal government announcing it will aggressively audit MA insurers. The audits, known as risk adjustment data valuation audits, are expected to recoup billions of dollars in overpayments for the Medicare HI trust fund. For plan years 2023 through 2032, about $4.7 billion is expected to be returned to the trust fund. In a concession to the powerful insurance companies that own the MA plans, the government announced that audits would be carried out beginning in 2018 rather than 2011. The government is letting MA plans keep any ill-gotten gains resulting from erroneous codes they submitted between 2011 and 2017. That decision means that insurers will get to keep about $2 billion in overpayments during those years (Herman and Bannow 2023a, 2023b).

Although falsely inflating the flat fees an MA plan receives is a violation of the False Claims Act, the large insurer-owned Medicare Advantage plans, with some exceptions, have largely not been subject to prosecution. Misdeeds identified in the audits will only require MA plans to make restitution and pay back to the Medicare fund some of the money they obtained under false pretenses. Nevertheless, the insurance companies are expected to fight the audits, and litigation is likely to delay repayment to the Medicare fund.

On August 9, 2023, the Department of Justice announced a $22.5 million settlement in a case related to using risk adjustment scores that exaggerated the poor medical condition of enrollees and overbilled Medicare. Surprisingly, perhaps or not, the case was not brought against any of the large insurance-owned MA plans. Instead, the case involved overbilling by a 5-star quality rated nonprofit MA plan in Maine, Martin's Point Health Care. The former manager in charge of Medicare risk adjustment operations was able to show that Martin's Point fraudulently submitted exaggerated risk codes for participants enrolled between 2016 and 2019. Company internal audits revealed that there was upcoding of risk factors, but nothing was done to correct the situation (DOJ 2023).

Fraud in Home Health

The home health sector has become an area of focus for the Health Care Fraud and Abuse Control Program run by the US Department of Justice and US Department of Health and Human Services (HHS) (Famakinwa 2022a). As the industry has grown, so has federal oversight and scrutiny. The

HHS Office of Inspector General (OIG), which started by focusing on fraud in the hospice industry in 2021, only now in 2023 is cranking up its efforts to focus on the home health industry (Filbin 2022). For hospice, the OIG examined whether beneficiaries met the definition of being confined to home; whether they were truly in need of skilled services; whether the OASIS information (a group of standard data home health agencies report to CMS) was being submitted in a timely fashion; and whether services were properly documented and met the patient's plan of care. Experts believe similar pieces of information will be collected for home health (Filbin 2022). Companies in both hospice and home health have been found to accept kickbacks, bill for services not provided, and admit patients who do not meet eligibility criteria (Constantine Cannon n.d.).

A study from O'Malley, Bubolz, and Skinner (2023) found that there has been a rapid increase in billing for Medicare home health care expenditures in traditional fee-for-service Medicare, but the increase isn't evenly distributed across the nation. The spending in some regions of the country has far outpaced spending in others. For example, between 2002 and 2009, the average billing per Medicare enrollee in McAllen, Texas, and Miami increased by $2,127 and $2,422, compared to an average $289 increase in other hospital referral regions, or roughly six times the average rates of those hospital referral regions. The authors argue that this spending differential cannot be explained by the public's changing home health needs or the substitution of home health care for in-patient care in a facility. Instead, they argue, it is the consequence of widespread fraudulent behavior. This was a red flag that ultimately attracted the attention of the Department of Justice, which established a fraud strike-force office to detect and prosecute fraud.

The Annual Report of the Departments of Health and Human Services and Justice for 2021 (latest available) outlines five significant criminal and civil Investigations in the home health sector carried out in 2020 and 2021. Except for Bayada, these are small home health agencies. The five cases are summarized (DOJ 2022) as follows.

- In November 2020, a physician-owner of a home health agency was sentenced to five years in prison and ordered to pay $9.5 million in restitution after conviction for a conspiracy to commit health care fraud, conspiracy to solicit and receive health care kickbacks, and making false statements. The individuals operated three sham home

health agencies that never treated a single patient, yet billed Medicare for over $80 million in fraudulent claims and received approximately $50 million.

- In August 2021, a residential care company based in Oregon, At Home Care LLC, and its owner agreed to pay $2.9 million to resolve civil False Claims Act allegations that between March 2013 and September 2018 it billed the Oregon Medicaid program for services not provided.
- In September 2021, a Las Vegas resident was sentenced to 144 months in federal prison and ordered to pay $4,321,590 in restitution to the North Carolina Medicaid Program. He and his wife conspired to defraud the North Carolina Medicaid Program of over $10 million between 2017 and 2019, using deceased individuals' identities to "back-bill" for up to one year of fictitious home health services that were allegedly rendered prior to the death of the individual.
- In September 2021, BAYADA Home health care companies, headquartered in New Jersey, agreed to pay $17 million to resolve civil False Claims Act allegations that they violated the Anti-Kickback Statute by paying a kickback to a retirement home operator by purchasing two of its Arizona home health agencies.

The red flags that suggest home health agencies are billing for unnecessary services in traditional Medicare has led to the establishment of fraud strike forces in hospital referral regions where overbilling is suspected. To date the strike forces have failed to identify notable examples of fraud. HHS may have chosen to focus its fraud investigations on hospice, where audits have found that the payment levels on a per-claim basis are much higher than for home health.

The recent increased scrutiny of financial players in Medicare Advantage and home health may provide new information on the extent of fraudulent behavior.

Conclusion

Health insurance giants and, on a smaller scale, private equity firms are buying up large home health agencies, bolting smaller providers onto them, driving the massive consolidation of home health agencies, and making it difficult for smaller HHAs to compete. Medicare and Medicaid, funded by payroll deductions from employees and the self-employed, shoulder the lion's share of the costs of home health care. The payroll taxes are intended to cover Medicare Part A and B benefits. Any surplus goes into the Medicare hospital insurance (HI) trust fund; any shortfalls are covered by that fund. The trust fund is currently projected to run out of money in 2031. Upcoding and overbilling by Medicare Advantage and billing for unnecessary procedures by fee-for-service providers hastens the date the trust fund will be exhausted. At that time, beneficiaries' taxes will go up or benefits will be cut. Transforming costs into profits via transfer pricing among PE- or insurer-owned subsidiaries enriches the Wall Street owners of home health agencies but drains the Medicare trust fund. These financial firms are profiting at the expense of Medicare beneficiaries who will pay the price in the future.

Competition in home health markets is undermined by these large financial players. Private equity firms have a relatively small share of the national home health market, but they have established a dominant presence in some local markets, giving them the potential to raise prices. Their business strategy is to recruit patients for the entire continuum of care they provide — in-home help, home health services, palliative care, and hospice. Some also provide in-home primary doctors for seniors or partner with hospital-at-home programs to care for the acutely ill.

Medicare Advantage plans are a different kind of threat to independent HHAs. They control the use of home health for half of Medicare beneficiaries, so independent agencies need to find a way to do business with them. When MA plans contract for HH services with independent providers, they pay a capitated rate that the home health agencies complain are far below the fee-for-service payments from Medicare. The rates dictated by the MA plans are not fair, and the HHAs complain that their situation is dire. If these smaller agencies close, access to home health services, especially in poor or rural communities, may be undermined.

CMS promotes the insurer-owned Medicare Advantage plans as cheaper than traditional fee-for-service Medicare, even though they cost more on a per patient basis. MedPAC estimates that MA costs CMS as much as 119 percent of what traditional Medicare costs – an overpayment of 6 percent due to upcoding (up from 4 percent in earlier analyses), plus 2 percent for the quality bonus payments, plus 11 percent due to enrollment of healthier beneficiaries in MA plans (MedPAC 2022; MedPAC 2023b). Under the Trump administration, and now more gently under the Biden administration, CMS is promoting back door ways to move fee-for-service beneficiaries into value-based (i.e., capitated) payment models. This report took a necessary detour into value-based care. In the hands of mission-driven organizations, value-based care leads to improved care of beneficiaries to avoid more expensive procedures later. Our case study of InnovAge before its takeover by private equity demonstrates the potential to improve care in value-based payment models. In the hands of profit-driven owners, however, value-based care opens up opportunities to game the system and profit at Medicare's expense. We document this in detail in the case of insurer-owned Medicare Advantage plans.

Evidence regarding differences in the quality of care of Medicare beneficiaries in traditional Medicare compared to Medicare Advantage is thin. But carefully done studies of post-acute care of Medicare beneficiaries find that MA plan enrollees are less likely to be cared for by high quality home health agencies or skilled nursing facilities, more likely to be treated by lower quality providers, have less access to home health care, and experience shorter durations of care when they do get it than traditional Medicare beneficiaries. Hospital readmissions are at a similar level for both groups. Home health care patients enrolled in MA plans in another study reported less care and worse outcomes compared to fee-for-service beneficiaries. We were not able to locate a scientific paper that found better health outcomes for MA enrollees.

Fee-for-service Medicare is less costly than Medicare Advantage, and it should be supported by CMS, not undermined. The nonpartisan Medicare Payment Advisory Commission (MedPAC) reported that, in 2020, Medicare spent $1,538 more per beneficiary on Medicare Advantage plans than they would have spent for the same patients if they were in traditional Medicare — resulting in $12 billion in overpayments. According to MedPAC, policies governing payment rates to MA plans have never produced savings for Medicare (MedPAC 2022).

Expansion of traditional Medicare would also benefit independent HHAs who have long relied on a now-shrinking fee-for-service Medicare patient population and on Medicare for fair payments for services provided. Expanding traditional Medicare is not a panacea. CMS will need to provide necessary support to smaller HHAs so they can meet technology requirements and deal with the increase in patient protection and other regulations. Fraud needs to be ferreted out, and agencies that engage in fraudulent activities should have their Medicare certification revoked.

Policy Recommendations

As Medicare approaches its 60th Anniversary, the debate over its long-term future has garnered greater interest, especially in the context of the mounting evidence that large Medicare Advantage insurers and other financial actors have profited at the expense of taxpayers. This is the result of loopholes in the existing CMS payment system as well as fraudulent activities. A majority of Americans believe that the government should ensure health coverage for all Americans (Brenan 2023). Whether Medicare should be offered through government or private insurance providers is still hotly debated, but a 2021 national survey found that 84 percent of Americans favored adding dental, vision, and hearing benefits to Medicare (Copeland 2021). A 2023 national survey also shows that Americans overwhelmingly want Congress and the Biden Administration to crack down on abusive billing practices by Medicare Advantage insurers (Jacobs 2023). CMS Watchdog groups, advocates, and members of Congress have called for reforms of Medicare to strengthen the program and curb the current abuses in Medicare Advantage (Archer, Lawson, and Potter 2022). They have called for reforms to the risk adjustment system to address persistent problems with risk adjustment and overbilling (Lieberman, Ginsburg, and Lin 2023), prior authorization (Southwick 2023), MA plan star quality ratings (Skopec and Berenson 2023), and favorable selection (Lieberman, Ginsburg, and Valdez 2023b).

CMS has begun to respond to these calls for reform and pressure from members of Congress whose constituents have struggled with the system. Two decades after it first took up the issue of faulty risk adjustments and overbilling, CMS has finally moved to make some headway on ending the practice. It finalized a decision to audit MA plans and claw back money obtained illicitly. CMS has made some movement on other fronts as well following years of inaction. In April 2023, it introduced reforms to the star ratings for MA plans, changes to preauthorizations, and new advertising requirements (CMS 2023b). Lobbying against these reforms and against the White House and Democratic members of Congress who support them has been intense. As a result, these reforms have been watered down considerably; efforts to weaken them further before they are implemented are underway (Choi and Evers-Hillstrom 2023). Much more needs to be done.

Agenda for Reform

Our analysis suggests that these are the core reforms to shore up Medicare in the short term and address the problems we have identified in home health care.

Strengthen Traditional Medicare

Traditional Medicare has advantages for some beneficiaries that are unheralded, including a wider choice of home health agencies if they need skilled nursing or therapy care. Fee-for-service beneficiaries are not limited, as MA members are, to narrow networks that may include HHAs that provide lower quality care. Traditional Medicare beneficiaries have a wide choice of home health providers and are more likely than MA members to be treated by a high quality home health agency. CMS should take action to:

- Eliminate the preferential subsidies that it currently provides to Medicare Advantage plans via its poorly designed benchmark and rebates. Consider alternatives proposed by MedPAC (2023b) to the current benchmark based on spending on traditional Medicare beneficiaries.
- Limit out-of-pocket expenses for traditional Medicare beneficiaries. This will reduce concerns that medical bills will bankrupt them. In 2023, the out-of-pocket limit for Medicare Advantage Plans is $8,300 for in-network services. The total for the combination of in-network and out-of-network services is $12,450. In contrast, traditional Medicare does not have an out-of-pocket limit.
- Level the playing field for traditional Medicare. CMS should work with Congress to allow CMS to pay for health and wellness benefits, such as vision and hearing care, and establish an out-of-pocket cap in traditional Medicare. CMS should investigate the deductibles and copays in some low premium plans. Medicare beneficiaries are attracted to MA plans by the low premiums but may have to forego medical care because they cannot afford these expenses.
- Clamp down on false or aggressive advertising by MA plans. Many patients, especially sicker patients, leave MA plans when they belatedly discover that the MA plan creates barriers to care — care that is readily available in fee-for-service Medicare. This includes pre-approval for more expensive treatments and narrow provider networks for specialists and home health care.
- Eliminate ACO REACH and similar payment models that aim to undermine traditional Medicare and move its beneficiaries into Medicare Advantage-like arrangements that limit their provider choice without their informed consent.

Keep Financial Firms that Own Home Health Agencies Honest

CMS should:

- Crack down on MA firms that engage in upcoding and overbilling by making members appear sicker than they are. MA plans are not the only offenders. CMS should also hold providers that treat fee-for-service patients accountable for billing Medicare for unnecessary or never-provided services. Although Medicare's spending has been below projections since 2010 and the life of the trust fund has been extended, it is expected to be exhausted by 2031. Fraud and overbilling are a drain on the Medicare hospital trust fund and may make it more difficult for beneficiaries in the future to obtain full benefits.
- Require that MA plans provide their members with a greater choice of post-acute facilities, both home health agencies and skilled nursing facilities. MA health care networks should include more high quality (4- or 5-star) providers of home health services and other post-acute care as rated by CMS.

Vertical Mergers Reduce Competition in Home Health Markets

The Federal Trade Commission (FTC) and US Department of Labor (DOL) should:

- Monitor future vertical mergers by PE firms and health insurance companies carefully for their effects on competition in home health markets.
- Consider unwinding or requiring disinvestment of some home health assets by the largest vertically integrated PE and health insurance firms to increase competition and improve the competitive environment for independent HHAs.
- Together with CMS, examine transfer pricing that enables the profits of suppliers to MA plans to count as costs of patient care by the MA plan when both are owned by the same health insurance company. This is both anti-competitive and evades health regulations that govern the Medical Loss Ratio.
    - Medical Loss Ratio issues arise when an insurance company owns both an MA plan and an HHA that serves its plans' members. The MA plan pays the HHA for its services. The profit on this transaction accrues to HHA and to the parent company. Because the parent company is an insurance company and not a health provider, it is not constrained by the limits on profit set by the Affordable Care Act's Medical Loss Ratio, distorting the MLR.

CMS and State Public Health Agencies Should:

- Increase monitoring and enforcement of home health standards and requirements in agencies owned by for-profit entities.

- Strengthen enforcement measures applied when egregious violations are uncovered. The current practice of suspending new admissions until the agency provides a plan for improving operations, as happened in the PACE program in the InnovAge case, is not sufficient to deter injurious or fraudulent practices that are highly profitable.

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