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### Value of Discharging Heart Failure Patients Home

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# Letters

## COMMENT & RESPONSE

### Value of Discharging Heart Failure Patients Home

**To the Editor** Figueroa and colleagues<sup>1</sup> reported that fee-for-service (FFS) Medicare and Medicare Advantage (MA) inpatients with heart failure shared similar complexity, clinical interventions, and outcomes but raised concerns that more MA inpatients were discharged home (adjusted odds ratio, 1.16; 95% CI, 1.13-1.19;  $P < .001$ ) compared with a skilled nursing facility (SNF) as a quality difference driven mainly by MA plan cost interest. I would suggest clinically appropriate hospital-to-home discharge is a potential quality indicator aligned with Medicare patient interest.

Allen et al<sup>2</sup> observed that from 2005 to 2006, FFS Medicare inpatients discharged to SNF after heart failure hospitalization had greater adjusted hazard ratios for all-cause mortality (1.76; 95% CI, 1.66-1.87;  $P < .001$ ) and all-cause rehospitalization (1.08; 95% CI, 1.03-1.14;  $P = .001$ ) compared with home discharge despite similarities in inpatient care and adherence to cardiac treatment guidelines. Gupta and colleagues<sup>3</sup> found that from 2006 to 2014, FFS Medicare heart failure inpatients had overall declines in adjusted hazard ratios for all-cause readmissions (0.91; 95% CI, 0.87-0.95;  $P < .001$ ) and increases in mortality (1.18; 95% CI, 1.10-1.27;  $P < .001$ ) with associated declines in home discharge (69.0% to 63.7%) and increases in SNF discharge (18.8% to 20.3%). Werner et al<sup>4</sup> observed that from 2010 to 2016, among Medicare patients discharged from the hospital, including those with heart failure, that those discharged home with home health care compared with SNF had an adjusted 5.6-percentage point absolute increase in readmissions (95% CI, 0.8-10.3;  $P = .02$ ), no statistical difference in mortality, and postacute payment savings of \$5384 (95% CI, -\$6932 to -\$3837;  $P < .001$ ). However, further sensitivity analysis of MA patients showed no statistical differences in readmissions or mortality.<sup>4</sup>

With more than 22 million enrollees and 34% of Medicare beneficiaries in 2019, MA continues to grow while redirecting premium to offer broader benefits distinct from FFS Medicare, including caregiver support, home personal care services, home-based palliative care, adult day care, and other evolving supplemental benefits expanded in 2018 by

the US Centers for Medicare & Medicaid Services.<sup>5</sup> These long-term supportive services could allow more MA patients to stay safely home as opposed to at SNFs following hospitalization.

Figueroa and colleagues<sup>1</sup> correctly point out that MA plans practice utilization management to help guide hospital discharge disposition, which may promote more appropriate home discharges and lower postacute costs, while also noting MA plans leverage additional care coordination services to support patients. Considering that the Centers for Medicare & Medicaid Services continues to regulate quality performance of both MA plans and hospitals, including all-cause readmissions, MA plans should continue partnering with hospitals and clinicians to support evidence-based inpatient management while studying and aligning benefit design for optimal patient outcomes along the continuum of care.

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