Moving Health Home
An Alliance to Advance Home-based Care Policy

March 4, 2022

Submitted electronically via: http://regulations.gov/

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Advance Notice of Methodological Changes for Calendar Year (CY) 2023 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies

Dear Administrator Brooks-LaSure:

Thank you for the opportunity to submit comments on the Advance Notice of Methodological Changes for Calendar Year (CY) 2023 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies ("Advance Notice").

Moving Health Home (MHH) is a coalition of health care organizations with a bold vision to make the home a site of clinical service. Our members share in the belief that experience during the pandemic has accelerated the day when care in the home is an option for patients. We look forward to working with CMS to ensure that home is part of the health care options for patients in the future.

For our members, clinical care in the home refers to a spectrum of health services provided in the home or place of dwelling outside of a facility, such as hospital-level or acute care, primary care office, skilled nursing and therapy services, and hospice. Services may include routine physician visits, chronic disease management, laboratory and diagnostic services, home infusion, in-home dialysis, and other care provided in the home setting rather than a facility, and regardless of age and health conditions.

At the core, we want to remove regulatory barriers to ensure all patients may choose to receive clinical care in the home and take advantage of the convenient, high-quality care that comes when patients receive home-based care. Importantly, we believe that care in the home contributes to health equity by giving historically disenfranchised populations the option to receive care on their own terms. Providers will be guests in the homes of patients with the institutional aspects of the health care "system" taken away, which will promote trust and communication.

In this response, we will focus on how the Centers for Medicare and Medicaid Services (CMS), through its existing authority, could encourage home-based care through MA network adequacy standards. We believe CMS has an opportunity to better incentivize clinical care in the home by going beyond existing standards. However, in all our policy options, the existing process for requesting an exception to network adequacy requirements should remain for MA plans who are unable to offer in-home care, or who believe it is inappropriate for their patient populations.

Moving Health Home
An Alliance to Advance Home-based Care Policy

Encouraging Home-Based Care Through MA Network Adequacy

Rationale for More Home-Based Care. Patients have indicated that they want to receive care at home, with the demand for services provided in the safety of a patient's home soaring during the pandemic. In fact, according to a recent survey, 85 percent of adults say it should be a high priority for the federal government to expand Medicare coverage for at-home health care.[1] At the same time, an overwhelming majority of people who have received care in the home were satisfied (88 percent) and would be likely to recommend to family and friends (85 percent).[2]

Research confirms as much, showing that home-based models are at least as safe as facility-based inpatient care and result in improved clinical outcomes, higher rates of patient satisfaction, and reduced health care costs.[3]

Home-based health care spans an array of medical services delivered to a patient in their homes, including caregiving and personal care services, wellness and safety assessments, assistance with activities of daily living, medication management, care coordination, management of chronic conditions, skilled nursing or therapy services, home-based primary care, hospital-at-home, transition care, and hospice care.

The level of services provided depends on a patient's acuity; some patients may only need informal caregiving from family members or personal caregivers. Others who are post-discharge or with acute needs may require skilled home care or therapy from nurses or physical therapists. Patients with chronic conditions who choose to remain in their homes may benefit from more regular medical care often provided through team-based care using physicians, nurse practitioners and physician assistants alongside social service providers.

Providing home-based care services, whether informal services or hospice services is also more cost-effective than hospitalization or nursing home placements.

Medicare Policy Options to Encourage Broader Use of Home-Based Care. CMS should encourage plans to provide access to in-home care through the network adequacy standards. The scope could focus on certain specialties where in-home care is appropriate or on specific patient populations who may benefit the most from in-home care such as high-cost, high-need patients. The existing process for requesting an exception to network adequacy requirements should remain for those plans who are unable to offer in-home care, or who believe it is inappropriate for their patient populations.

We have identified three options that could be employed to achieve the goal of broader adoption of home-based care, including:

1. Replicate the MA telehealth bonus in which health plans would be eligible for a 10-percentage-point credit toward the proportion of beneficiaries residing within required time and distance standards when they offer in-home services;[4]

---

[1] "New Public Opinion Poll Finds Strong Support for Home Health, Choose Home Care Act." (September 2021). Access Here.

[2] "Moving Health Home Fields National Survey of Consumers." (December 2021). Access Here.

[3] Hospital at Home Users Group. "The Science of Hospital at Home." Access Here.

[4] Centers for Medicare and Medicaid Services. "Contract Year 2021 Medicare Advantage and Part D Final Rule (CMS-4190-F1) Fact Sheet." Access Here.

2. Add a 28th provider type for in-home primary care; or
3. Modify 42 CFR 422.112, Access to Services, to include new language.

Replicate MA Telehealth Bonus for In-Home Services

Beginning in CY 2021, CMS implemented several changes to strengthen MA network adequacy requirements aimed at improving access to care related to telehealth. First, CMS reduced the percentage of beneficiaries that must reside within the maximum time and distance standards in non-urban counties from 90 percent to 85 percent for an MA plan to comply with network adequacy standards. Second, MA plans are now eligible to receive a 10-percentage point credit towards the percentage of beneficiaries residing within published time and distance standards when they contract with telehealth providers in the following provider specialty types: Dermatology, Psychiatry, Cardiology, Otolaryngology, Neurology, Ophthalmology, Allergy and Immunology, Nephrology, Primary Care, Gynecology/ OB/GYN, Endocrinology, and Infectious Diseases. Finally, CMS now provides a 10-percentage point credit towards meeting time and distance standards for affected providers in states that have certificate of need (CON) laws. The telehealth and the CON credits can be combined together to reduce the percentage of beneficiaries that are within the maximum time and distance requirements (65 percent in rural counties, and 70 in non-rural counties).

Under this option, CMS could replicate one or a combination of these policies to encourage MA plans to cover in-home services. For example, MA plans could be eligible for a 10-percentage-point credit toward the proportion of beneficiaries residing within required time and distance standards when they offer in-home services. The qualified services could range across the spectrum of health services provided in the home or place of dwelling, such as hospital-level or acute care, primary care, skilled nursing and therapy services, and hospice. Services may include routine physician visits, chronic disease management (such as remote patient monitoring), laboratory and diagnostic services (such as blood draws and x-rays), home infusion (such as antibiotics), wound care, physical or occupational therapy, in-home dialysis, and other care provided in the home setting rather than a facility.

Add a 28th Provider Type for In-Home Primary Care

As you know, per MA Network Adequacy Guidance, CMS identifies provider and facility specialty types critical to providing services through a consideration of: 1) Medicare fee-for-service (FFS) utilization patterns; 2) utilization of provider/facility specialty types in Medicare FFS and managed care programs; 3) clinical needs of Medicare beneficiaries; and 4) specialty types measured to assess the adequacy of other managed care products.[5]

Currently, CMS measures 27 provider specialty types and 13 facility specialty types to assess the adequacy of the network for each service area. It requires that organizations contract with a sufficient number of providers and facilities to ensure that at least 90 percent of enrollees within a county can access care within specific travel time and distance maximums. MA plans must demonstrate that their networks have sufficient numbers of providers and facilities to meet minimum number requirements to allow adequate access that is broad enough to provide beneficiaries residing in a county access to covered services.

[5] Centers for Medicare and Medicaid Services. "Medicare Advantage and Section 1876 Cost Plan Network Adequacy Guidance." Access Here.

Moving Health Home
An Alliance to Advance Home-based Care Policy

Under this option, CMS could add a 28th provider type for in-home primary care, or extend it more broadly to other provider specialty types. Again, it is critical that MA plans who are unable to offer in-home care, or who believe it is inappropriate for their patient populations, can easily file for exceptions.

Modify 42 CFR 422.112, Access to Services

At 42 CFR 422.112, CMS outlines requirements MA plans must meet at all times to ensure access to services and continuity of care. Under this policy, CMS could add new language under subsection (b) at 42 CFR 422.112. If this option is perused, we recommend the following language:

> *Offering to provide each enrollee with multiple chronic conditions with an ongoing source of home-based care and providing home-based care to each enrollee who accepts the offer.*

If adopted, MA plans would be encouraged to cover more home-based care if desired by the beneficiary. Again, the types of services could range across the spectrum of health services provided in the home or place of dwelling. The guardrails to limit utilization to only high-need, most appropriate populations could vary, but we recommend focusing on beneficiaries with multiple chronic conditions. CMS may want to consider other factors impacting medical need, such as social determinants of health or income. Importantly, under this option and the others, the existing process for requesting an exception to network adequacy requirements must remain for those plans who are unable to offer in-home care, or who believe it is inappropriate for their patient populations

Thank you for considering our comments. We look forward to working with CMS and welcome the opportunity to provide further feedback on how to achieve our shared goals. Please do not hesitate to reach out to Jeremiah McCoy at jmccoy@movinghealthhome.org with any questions regarding our comments or if we can be a resource to you in any way

Sincerely,

Krista Drobac

Krista Drobac
Moving Health Home