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

August 31, 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: Request for Information on the Medicare Advantage Program (CMS-4203-NC)

Dear Administrator Brooks-LaSure:

Thank you for the opportunity to submit feedback to inform potential future rulemaking on various aspects of the Medicare Advantage (MA) program.

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 the experience during the pandemic has accelerated the day when care in the home is an option for patients.

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. It can mean a house call from a primary care doctor or nurse, a physical therapy session, a laboratory and diagnostic service, a home infusion, or a full complement of hospital-level services.

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 promotes trust and communication.

Going back to pre-pandemic institutional norms will waste the experience generated by the pandemic. No longer can the United States lag behind comparable countries in options for patients to receive primary care at home.[1] MHH's recent study shows that a majority (70 percent) of Americans are comfortable receiving care in the home, 73 percent are confident in the quality of receiving care in the home, and a bipartisan majority of adults (73 percent of Democrats and 61 percent of Republicans) say it should be a priority for the federal government to increase access to clinical care in the home.[2] Research confirms that home-based models are at least as safe as facility-based care and result in improved clinical outcomes, higher rates of patient satisfaction, and reduced health care costs.[3]

[1] https://www.commonwealthfund.org/publications/issue-briefs/2022/mar/primary-care-high-income-countries-how-united-states-compares
[2] https://movinghealthhome.org/national-survey
[3] https://www.hahusersgroup.org/about-hah/research/

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.

Expand Access: Coverage and Care

What factors do MA plans consider when determining whether to make changes to their networks? How could current network adequacy requirements be updated to further support enrollee access to primary care, behavioral health services, and a wide range of specialty services? Are there access requirements from other federal health insurance options, such as Medicaid or the Affordable Care Act Marketplaces, with which MA could better align?

CMS should encourage MA 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]
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

[4] https://www.cms.gov/newsroom/fact-sheets/contract-year-2021-medicare-advantage-and-part-d-final-rule-cms-4190-f1-fact-sheet

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.

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.

[5] https://www.cms.gov/files/document/medicareadvantageandsection1876costplannetworkadequacyguidance6-17-2020.pdf

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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.

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Thank you for considering our comments. We 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

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Moving Health Home