Partnership for Quality Home Healthcare

THERE'S NO PLACE LIKE HOME

February 13, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4201-P
P.O. Box 8013
Baltimore, MD 21244

Submitted electronically via regulations.gov

Re: **CMS-4201-P: Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, Medicare Parts A, B, C, and D Overpayment Provisions of the Affordable Care Act and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specifications**

Dear Administrator Brooks-LaSure,

The Partnership for Quality Home Healthcare (the "Partnership") appreciates the opportunity to submit comments on the Contract Year (CY) 2024 Medicare Advantage (MA) Part D Proposed Rule published at 87 *Federal Register* 79452 on December 27, 2022 (the "Proposed Rule").[1] We submit the following comments to offer constructive feedback and recommendations related to access to home health care for Medicare beneficiaries.

As a national coalition of skilled home healthcare providers, we appreciate the fact that the Centers for Medicare & Medicaid Services (CMS) is pursuing efforts to ensure that MA beneficiaries can benefit from the value and quality that the Medicare home health benefit provides to patients in the same way as traditional Medicare beneficiaries. Home health offers value for beneficiaries across the Medicare program as a lower cost setting for patients to receive high quality skilled care.

With the growth of the MA program, an increasing share of the patients home health agencies (HHAs) serve are MA enrollees. While an HHA may not know that a beneficiary is enrolled in an MA plan at the time he or she is first referred to a home health agency, a beneficiary's MA enrollment status may impact whether prior authorization is needed before care begins or how long a patient receives home healthcare services.

The Partnership appreciates CMS's proposal to codify standards for coverage criteria to ensure that basic benefits coverage for MA enrollees is no more restrictive than traditional Medicare.

[1] 87 Fed. Reg. 79452 (December 27, 2022), *available at* https://www.federalregister.gov/documents/2022/12/27/2022-26956/medicare-program-contract-year-2024-policy-and-technical-changes-to-the-medicare-advantage-program.

We support CMS's intent to prohibit MA organizations from limiting or denying coverage when the item or service would be covered under traditional Medicare. Our comments below focus on CMS's proposals related to utilization management requirements, including CMS's request for comments related to early terminations of care in post-acute settings.

I. MA Organization Coverage Criteria for Home Healthcare

We support CMS's proposal that, when care can be delivered in more than one way or in more than one type of setting, and a contracted provider has ordered or requested Medicare covered items or services for an MA enrollee, the MA organization may only deny coverage of the services or setting on the basis of the ordered services failing to meet the criteria outlined in § 422.101(c)(1)(i), including the coverage and benefit conditions included in traditional Medicare. If a beneficiary's physician or allowed practitioner orders home healthcare, and the beneficiary would be eligible for the services under traditional Medicare, an MA organization should not be able to deny coverage.

CMS states that, if an MA enrollee is being discharged from an acute care hospital and the attending physician or allowed practitioner orders post-acute care at a skilled nursing facility (SNF), the MA organization cannot deny coverage for the SNF care and redirect the patient to home health care services unless the patient does not meet the coverage criteria required for SNF. Likewise, it is critical that if an MA enrollee is discharged from a hospital with physician or allowed practitioner orders for home healthcare services, the MA organization should not be permitted to reduce the number of visits specified in the plan of care, if such visits would be covered under traditional Medicare for the same patient.

Patients with a valid order from a physician or allowed practitioner should be able to receive home health based on traditional Medicare program requirements (e.g., homebound and skilled need), without an overlay of additional coverage criteria imposed by MA organizations. It is duplicative, unnecessary, and restricts a Medicare beneficiaries access to care for MA plans to apply self-determined additional coverage criteria via burdensome prior authorization processes.

We also support CMS's proposal to refer to Home Health Services in § 422.101(b)(2) as a specific example where traditional Medicare substantive coverage and benefit conditions apply to the MA program.

II. Continuity of Care for Home Health Services

CMS proposes at § 422.112(8)(i) that MA coordinated care plans must have policies for using prior authorization for basic benefits as part of their arrangements with contracted providers, and that all approved prior authorizations must be valid for the duration of the entire approved prescribed or ordered course of treatment or service. As an example, CMS states that, if the MA coordinated care plan approves a prescribed or ordered course of treatment for a series of five sessions with a physical therapist, the MA coordinated care plan may not subject this active course of treatment or service to additional prior authorization requirements. CMS defines "course of treatment" as a prescribed order or ordered course of treatment for a specific

individual with a specific condition, as outlined and decided upon ahead of time, with the patient and provider.

Currently, the criteria MA organizations use in authorizing or denying home healthcare services vary across plans, even within the same MA organization, and often differ from traditional Medicare. Even when a physician's or allowed practitioner plan of care calls for multiple home health visits, MA organization may not treat this as a home health episode or a single course of treatment. Some MA organizations use internal algorithms to determine how many home health visits will be allowed.

MA plan coverage limitations and prior authorization processes create administrative burden for HHAs and physicians or allowed practitioners and limit Medicare beneficiary access to care. For example, if a physician approves a plan of care that includes 12 visits, but the MA plan only authorizes 9 of the 12 visits, the HHA must contact the physician or allowed practitioner and get new orders signed. This would also mean that a patient who would receive 12 visits based on a physician's or allowed practitioner's plan of care that meets all requirements for appropriate payment under traditional Medicare could receive fewer home health visits based on an MA plan's coverage limitations. We are also aware of examples of MA plans placing an annual cap on the number of home health visits an MA enrolled beneficiary may receive. This type of limit is inconsistent with the scope of the traditional Medicare benefit.

We urge CMS to clarify that a home health plan of care, ordered by a physician or allowed practitioner, which would be covered under traditional Medicare as a home health episode, should be considered a "course of treatment" for which prior authorizations must be valid for the duration of the entire plan of care.

III. Termination of Services in Post-Acute Care

CMS states that it has received complaints about potential quality of care issues regarding early termination of services in post-acute care settings by MA organizations.[2] We seek to provide constructive feedback related to the questions CMS poses related to incentives between MA organizations and post-acute care providers to deliver the best possible care for Medicare enrolled beneficiaries.

CMS solicits input on whether MA plans often preauthorize treatment in discrete increments. In order to appreciate the effects of MA plan authorization processes, it is important to first understand that MA organizations often pay for home healthcare in ways that differ fundamentally from traditional Medicare.

While experiences vary across plans and across HHAs, Partnership companies have observed that the vast majority of MA plans provide per-visit payment for home healthcare services. One

[2] While CMS expresses concern regarding MA organizations terminating beneficiaries' coverage of post-acute care "before the beneficiaries are healthy enough to return home," we note that the home is often the preferred setting for post-acute care patients. Early termination of home health care negatively impacts homebound patients, even if they are already home.

Partnership member company reports that they understand that MA organizations do not negotiate episodic payments because their computer systems cannot process the episodic structure in payment arrangements with providers.

This model is substantially different from the 30-day episodic payments traditional Medicare makes for traditional Medicare beneficiaries. While PPS Medicare home health PDGM episode rates are adjusted based on patient-specific clinical characteristics (diagnosis, functional impairment, co-morbid conditions, geography, complexity, etc.), per-visit payment rates more often vary based on the discipline of the clinician providing care (RN, PT, OT, etc.). In contrast to traditional Medicare PPS, clinical acuity and patient presentation often has no impact on the amount MA plan pays per visit. Visits are essentially treated as interchangeable units of care, rather than part of a wholistic physician or allowed practitionerordered plan of care. In most cases, MA plans treat a start-of-care visit the same as all other visits. Episodic payments for home heath episodes are rare in MA, with very few MA plans mimicking the Medicare PPS payment structure for home health.

MA organizations often require pre-authorization for each home health visit. Some plans require pre-authorization for a bundle of visits (e.g., six visits at a time), whereas others require pre-authorization before every visit. Some plans require prior authorization to be granted within 24 hours of when a visit occurs, but may take up to two weeks for the plan to respond to a pre-authorization request. This puts HHAs in a difficult position of either not delivering care until the authorization has been received or performing a visit without knowing whether the visit will eventually be paid. Most MA plans require some type of initial authorization before the start of care, often with a limited initial number of visits for each approved clinical discipline. Among the plans that do not require prior authorization for home healthcare services, some require HHAs to provide visit notes before payment, which also created substantial administrative burden.

In practice, MA organization coverage policies and authorization requirements may artificially limit MA enrollees' access to home healthcare services. This equates to early termination of care, as compared to what traditional Medicare beneficiary might receive. Anecdotally, while home health clinicians are agnostic to payer and treat all patients based on their needs, the administrative burden of managing authorizations can lead care teams to plan ahead to do fewer visits to avoid needing to seek more authorizations. This produces the same effect of discharging earlier than may be ideal. In these circumstances, MA organization policies can reduce the total amount of care patients receive.

These issues can be further complicated by the role of "convenors" in home healthcare. MA organizations work with convenors to outsource the management of home health networks and payment negotiation processes. Convenors can also insert themselves into care management or coverage processes. In one example, one convenor asks a Partnership HHA to submit photos of every wound, on every visit, for every patient, in order to then give treatment instructions. The HHA then needs to call the ordering physician or allowed practitioner regarding the plan of care. When prior authorizations flow through convenors acting as middle-men, the process often creates an added layer of burden for HHAs and physicians or allowed practitioners.

In the experience of Partnership members, with some regularity, MA plan coverage criteria or authorization processes can lead to home healthcare services ending before the physician's or allowed practitioner care plan has been completed with some frequency. A HHA may be forced to stop providing services due to inability to obtain additional visit authorizations from the MA organization. One Partnership member noted a noticeable uptick recently of MA plans trying to encourage discharges before HHA clinicians and physicians or allowed practitioners deem patients ready.

CMS seeks comments on potential changes CMS could make to existing rules that define what constitutes a termination as well as whether enrollees should have additional time to file appeals. We urge CMS to clarify the permissible criteria for MA plans to terminate home healthcare services and to make appeals easier, more objective, and have more regulatory enforcement. While we understand that CMS does not interfere in MA plan payment structures, CMS should consider whether requiring MA plans to cover home healthcare services on an episodic basis that would serve to better align benefits for MA enrollees and traditional Medicare beneficiaries.

IV. MA Network Requirements (§§ 422.112 and 422.116)

CMS notes that § 422.112(a)(1) requires MA organizations to maintain and monitor a network that provides access to typically used services, including home health agencies. While CMS makes several network adequacy proposals related to access to behavioral health services, it does not propose to update access adequacy rules related to home health. We urge CMS to consider ways to support access to MA enrollees' access to high-quality home healthcare providers, including through updates to networking requirements.

We look forward to continuing to work with CMS in our efforts to provide quality home healthcare services to all Medicare beneficiaries.

Sincerely,

Joanne Cunningham
Chief Executive Officer
Partnership for Quality Home Healthcare
202-684-5497
JCunningham@PQHH.org