National Alliance for Care at Home

January 27, 2025

Jeff Wu
Acting Administrator, Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-4208-P
7500 Security Boulevard
Baltimore, MD 21244–1850

RE: CMS-4208-P, Medicare and Medicaid Programs; Contract Year 2026 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly

Dear Acting Administrator Wu:

The National Alliance for Care at Home (The Alliance) appreciates the opportunity to submit comments on the Contract Year 2026 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly proposed rule (CMS-4208-P).

The Alliance is the unified voice for providers delivering high-quality, person-centered healthcare to individuals, wherever they call home. Our members are providers of different sizes and types—from small rural agencies to large national companies—including government-based providers, nonprofit organizations, systems-based entities, and public corporations. Our members serve over 4 million patients nationwide through a dedicated workforce of over 1 million employees, staff, and volunteers. Formed through the joint affiliation of the National Association for Home Care & Hospice (NAHC) and the National Hospice and Palliative Care Organization (NHPCO), the Alliance is dedicated to advancing policies that support care in the home for millions of Americans at all stages of life, individuals with disabilities, persons with both chronic and serious illnesses as well as dying Americans who depend on those supports.

Home health care has proven value in Traditional Medicare both in the care provided and the ability to reduce healthcare spending. It is widely understood that home is the preferred setting to receive health care.[1] However, evidence shows that MA plan enrollees do not use home health

[1] Geng F, McGarry BE, Rosenthal MB, Zubizarreta JR, Resch SC, Grabowski DC. Preferences for Postacute Care at Home vs Facilities. JAMA Health Forum. 2024;5(4):e240678

services at the same level as beneficiaries under Traditional Medicare. Additionally, MA plan enrollees report having difficulty accessing home health care at higher rates than Traditional Medicare beneficiaries.[2] The reasons for the disparity are a combination of factors that include network inadequacies, payment and prior utilization policies that are inconsistent with Traditional Medicare, and a general misunderstanding of the value that home health care brings to the continuum of care for beneficiaries.

We applaud CMS in its effort to strengthen appropriate guardrails on Medicare Advantage (MA) to ensure care quality and access for MA enrollees. Accordingly, we support the proposed rule's provisions and respectfully submit the following comments that the Alliance believes will further protect MA plan enrollees.

Clarifying the Definition of an Organization Determination and Prior Authorizations

CMS proposes to modify the definition of an organization determination to clarify that a coverage decision made by an MA organization contemporaneously to when an enrollee is receiving such services, including level of care decisions (such as inpatient or outpatient coverage), is an organization determination subject to notice and appeal rights. Specifically, CMS clarifies at § 422.566(b)(3) that the definition of an organization determination includes decisions made before, during, and after the enrollee's receipt of the services at issue, and therefore the enrollee is entitled to notice and appeal rights.

CMS cross references the regulation at § 422.138(c) and proposes to also include concurrent reviews and that enrollees in receipt of inpatient or outpatient services are covered under §422.138(c) as follows.

> **§ 422.138(c) Effect of prior authorization, preservice, or concurrent approval.** If the MA organization approved the furnishing of a covered item or service through a prior authorization preservice determination of coverage or payment, or a concurrent determination made during the enrollee's receipt of inpatient or outpatient services, it may not deny coverage later on the basis of lack of medical necessity and may not reopen such a decision for any reason except for good cause (as provided at §§ 405.986 and 422.616 of this chapter) or if there is reliable evidence of fraud or similar fault per the reopening provisions at § 422.616. The definitions of the terms ''reliable evidence'' and ''similar fault'' in § 405.902 of this chapter apply to this provision.

[2] Research Institute for Home Care, Home Health Chartbook, 2024

The Alliance strongly supports CMS' proposal to prohibit MA plans from reopening a coverage decision and issuing an adverse organizational determination if the plan has approved coverage for an item or service through prior authorization or concurrent reviews. We also recognize that this has been long standing CMS policy for MA plans. However, there is confusion within the home health community regarding the application of the requirement at §422.138(c). We are aware that some MA plans requiring prior authorization are also conducting prepayment and post payment record reviews and denying claims for what they assert is a lack of medical necessity. Additionally, MA plans frequently authorize visits and later deny them claiming, without evidence, that no authorization had been granted. Prior authorizations and subsequent audits are often conducted by third party contractors that deny services typically covered under traditional Medicare.

Recommendations:

- The Alliance requests that CMS clarify the circumstances under which the MA plan is prohibited from reopening a determination for medical necessity when the MA plan has authorized the items or services.
- CMS should provide transparency to the provider community and enrollees in the enforcement activities around non-compliance with the requirements at §422.138(c)

Promoting Community-Based Services and Enhancing Transparency of In-Home Service Contractors and Defining Community-Based Organizations (CBO)

CMS expressed concerns that enrollees may not have information about who may have access to their home, personally identifiable information (PII), or protected health information (PHI). Specifically, entities that provide in home and/or at hone services as supplemental benefits. To strengthen beneficiary protections and transparency, CMS proposes to codify definitions of community-based organizations (CBOs), in-home or at home supplemental benefit providers, and direct furnishing entities.

Additionally, CMS strongly encourages plans to do business with organizations deeply rooted within the community. CMS is seeking comments on the manner plans that would be required to identify in-home or at-home supplemental benefit providers along with notations as to which providers are CBOs.

CMS proposes to define CBOs in regulation, as there currently exists no definition in MA regulations. This definition would provide clarity to plans when adding the new proposed CBO notation to their provider directories regarding which direct furnishing entities are CBOs. The following definition is taken from the Calendar Year 2023 Medicare Physician Fee Schedule

proposed rule (87 FR 46102): “A public or private not-for-profit entities that provide specific services to the community or targeted populations in the community to address the health and social needs of those populations.’’

The Alliance has concerns with the proposed definition of a CBO because it limits CBOs to nonprofit organizations. The tax status of a CBO does not dictate the ability for the organization to provide appropriate and comprehensive health and social support services to individuals.

MA plans contract with for-profit certified home health agencies to provide basic benefits. It is reasonable to assume that MA plans might also contract with certified home health or for-profit licensed home care organizations to provide certain supplemental benefits. These providers are typically well established within the community they serve and provide high quality health and social services. If MA plans are required to notate in some manner those providers that are CBOs in accord with the proposed definition, it will send a message to enrollees that the nonprofit organizations are the preferred providers. Additionally, the proposed definition for CBO will be confusing to enrollees and their family members since home health and home care organizations by their nature are community-based organizations. By limiting CBOs to nonprofit organizations, CMS may be setting up avoidable psychological barriers for enrollees to access quality social and health services.

The Alliance, then the National Association for Home Care & Hospice, expressed the same concern when commenting on the definition for CBO in the Calendar Year 2023 Medicare Physician Fee Schedule proposed rule (87 FR 46102).

> **Recommendation:** CMS should not finalize the proposed definition or in any way limit CBO service providers to nonprofits.

The Alliance respectfully submits the following additional concerns and comments related to MA plans and prior authorization, and payment policies. We believe these policy modifications will help forward CMS’ goal to protect MA plan enrollees.

Prior Authorization

The Alliance encourages CMS to support initiatives aimed at ensuring timely access to home health care. CMS should consider categorizing prior authorization requests for home health care services as “urgent” which would require MA plans to process prior authorization requests within seventy-two (72) hours rather than seven (7) days for a standard request. Seven days for standard prior authorization requests will continue to cause delays in necessary care, particularly

for patients awaiting starts of care with the home health provider their physician or hospital discharge department recommended them to. Authorization is often delayed based on excessive documentation requests for prior authorization.

CMS and the MA plans must recognize that patients referred to home health care need clinically appropriate post-acute care and cannot wait 7 days for authorization to begin services. Studies have shown that delays in initiating home health service contribute to negative outcomes for certain patient populations.[3,4] Home health agencies (HHAs) frequently provide needed care while waiting for approval from payers, risking non-payment for the services.

If CMS fails to treat all patient referrals for HHA services as "urgent" and thus requiring authorization within 72 hours, patient care quality will be put needlessly at risk. HHAs that continue to provide unreimbursed care, or patients will have to forgo needed care, which could trigger avoidable re-hospitalization or other acute events.

It is important to note that the home health Conditions of Participation (CoPs) require HHAs to conduct an initial assessment within 48 hours of the referral, or the patient's return home, or on the practitioner's ordered start of care date. CMS developed the 48-hour policy in recognition that patients referred for home health services need sub-acute or post-acute care, and that timely initiation of care is critical.

Recommendations:

- CMS should require the MA plans to provide prior authorization determinations for home health services within 72 hours of a request for authorization.
- CMS should consider aligning the time frame for MA plan prior authorization with the CMS CoPs for home health services.
- CMS should establish policies that protect providers from the impact of delayed authorization decisions caused by the payer.

Another approach to ensure timely access for needed home health care is for MA plan enrollees in need of home health services immediately after a discharge from an acute or post-acute care facility be deemed as appropriate to receive the care, and therefore, forgo prior authorization.

[3] Amol M. Karmarkar, Indrakshi Roy, Taylor Lane, Stefany Shaibi, Julie A. Baldwin & Amit Kumar (2023), Home health services for minorities in urban and rural areas with Alzheimer's and related dementia, Home Health Care Services Quarterly, 42:4, 265–281, DOI: 10.1080/ 01621424.2023.2206368

[4] Examining the role of race and quality of home health agencies in delayed initiation of home health services for individuals with Alzheimer's disease and related dementias (ADRD) - Karmarkar - 2023 - Alzheimer's & Dementia - Wiley Online Library

This concept aligns with CMS' recommending that MA plans implement a ''gold-carding" process whereby the MA plan will relax or reduce prior authorization requirements for contracted providers that have demonstrated a consistent pattern of compliance with plan policies and procedures.[5] However, with this proposal, the gold card standard would be applied to a category of patient, specifically, those discharged directly from an acute or post-acute facility stay. The prohibition on prior authorization we propose would not apply to MA plans reviewing patient referrals to HHAs from the community.

Beneficiaries must be in need of skilled nursing or therapy services and be homebound to receive Medicare home health services, suggesting that these patients have urgent care needs and are unable to leave the home to receive the care. Patients admitted to home health care directly from an inpatient stay are known to have high acuity and complex care needs. This is recognized in the Patient Driven Grouping Model whereby patients discharged from an acute or post -acute facility are assigned a higher case mix weight.

CMS has been promoting "gold carding" initiatives as a mechanism for reducing provider burden while ensuring appropriate use of Medicare dollars. In a 2020 proposed rule on prior authorization, [6] CMS sought stakeholder feedback on "gold-carding" within MA plans. Additionally, CMS often refers the Medicare Fee for Service (FFS) Review Choice Demonstration for Home Health Services as a successful example of "gold carding".

> **Recommendation:** CMS should require MA plans to consider waiving prior authorization requirements for enrollees in need of home health care immediately following an acute or post-acute care facility stay.

Payment Policies

Many MA plans reimburse HHAs on a per-visit basis rather than on episodes of care, the latter of which is standard in Traditional Medicare, for 30 days. Traditional Medicare's Home Health

[5] 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. (87 FR 79452)
[6] Medicaid Program; Patient Protection and Affordable Care Act; Reducing Provider and Patient Burden by Improving Prior Authorization Processes, and Promoting Patients' Electronic Access to Health Information for Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and CHIP Managed Care Entities, and Issuers of Qualified Health Plans on the Federally-Facilitated Exchanges; Health Information Technology Standards and Implementation Specifications (84 FR 82585)

Prospective Payment System was established to encourage efficiencies in providing home health services through service cost and utilization management. It also enables the HHA to develop a plan of care based on the needs of the patient projected for a prescribed period. The PPS provides flexibility for HHAs to manage visit allocations in accord with patient needs. For example, many patients that are admitted to home health care require more intensive services during the first one or two weeks. HHAs will "front load" visits during that time to mitigate a patient's potential decline and avoid hospitalizations. MA plans typically authorize a few visits at a time and limit the number and mix of services that are significantly less than what is covered and provided by HHAs under Traditional Medicare.

The value of home health care has been demonstrated through studies that show Traditional Medicare enrollees have better outcomes than MA plan enrollees.[7] MA plan enrollees had lower likelihoods of improving in self-care and mobility function. Additionally, MA plan enrollees have higher rates of emergency department (ED) use than beneficiaries with Traditional Medicare. Studies have also shown that home health care initiated directly from the ED using the Medicare-reimbursed home health benefit can be used as an alternative to costly hospitalizations.[8,9] CMS has long abandoned a per visit reimbursement model for home health services in Traditional Medicare yet permits the MA plans to continue with this outdated reimbursement structure.[10]

> **Recommendation**: CMS should require plans to reimburse HHAs on an episodic basis, consistent with Traditional Medicare, so that patients in MA plans receive the same level of services they would have received had they not enrolled in an MA plan.

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[7] Rachel A. Prusynski, DPT, PhD; Anthony D'Alonzo, DPT, MBA; Michael P. Johnson, PT, PhD; Tracy M. Mroz, PhD, OTR/L; Natalie E. Leland, PhD, OTR/L, Differences in Home Health Services and Outcomes Between Traditional Medicare and Medicare Advantage, health Forum JANA, March 1, 2024

[8] Howard, J., Kent, T., Stuck, A., Crowley, C. & Zeng, F (2019). Improved Cost and Utilization Among Medicare Beneficiaries Dispositioned From the ED to Receive Home Health Care Compared With Inpatient Hospitalization. AJMC, 7(1), https://www.ajmc.com/view/improved-cost-and-utilization-among-medicare-beneficiaries-dispositioned-from-the-ed-to-receive-home-health-care-compared-with-inpatient-hospitalization

[9] Crowley, C., Stuck, A., Martinez, T., Wittgrove, A., Zeng, F., Brennan, J., Chan, T., Killeen, J., & Castillo, E. (2016). Survey and Chart Review to Estimate Medicare Cost Savings for Home Health as an Alternative to Hospital Admission Following Emergency Department Treatment.. The Journal of emergency medicine, 51(6), 643-647

[10] *Cf.* Skopec, L., Zuckerman, S., Aarons, J., Wissoker, D., Huckfeldt, P., Feder, J., Berenson, R., Dey, J., & Oliveira, I. (2020). Home Health Use In Medicare Advantage Compared To Use In Traditional Medicare. Health affairs, 39(6), 1072-1079 ("Our qualitative interviews also indicated that MA plans frequently pay home health agencies per visit, instead of using traditional Medicare's sixty-day episode payment structure.")

We appreciate your consideration of our comments and welcome the opportunity to meet to discuss our recommendations. If you have questions or would like to schedule a meeting, your staff should feel free to contact Mary Carr, vice president of regulatory affairs, at mkc@allianceforcareathome.org.

Sincerely,

Steven Landers, MD, MPH
Chief Executive Officer
National Alliance for Care at Home