Pennsylvania Homecare Association

August 31, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-1766-P
P.O Box 8013
Baltimore, MD 21244-8013

Re: Medicare Program; Request for Information on Medicare; CMS–4203–NC

Dear Administrator Brooks-LaSure:

The Pennsylvania Homecare Association (PHA) is a statewide membership association with approximately 700 home health, homecare and hospice members across Pennsylvania. On behalf of our home health and hospice provider members, we appreciate the opportunity to offer comments on the Medicare Advantage Program. With Medicare Advantage approaching half of the entire Medicare beneficiary population, it is critically important MA plans and the provider community work together to ensure patient-centered, high quality health care for all participants.

The RFI sought input on (A) advancing health equity; (B) expanding access: coverage and care; (C) promoting person-centered care; (D) supporting affordability and sustainability; and (E) engaging partners. Our comments and recommendations are below.

Advancing Health Equity

CMS requests feedback on how to advance health equity for all enrollees, specifically identifying a number of enrollee populations. PHA recommends that all communications with enrollees be in plain language and in the medium of language understood best understood by specific enrollees. This should include all marketing materials, as well as service/claims determinations.

Expanding Access: Coverage and Care

MA Plan Marketing Materials & Tools
CMS seeks information on tools and marketing materials intended to assist beneficiaries in selecting a MA plan that best suits their needs. As you know, there are no uniform marketing requirements for MA plans. As a result, much of the information provided to the public regarding MA plans is confusing at best and does not allow a consumer to fully understand and compare individual plans, or MA plans to

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traditional Medicare. Plans should be required to use a uniform content format in describing the benefits and costs of each plan, including side by side comparisons for cost sharing, utilization data, and how a plan differs from traditional Medicare.

Enrollee marketing and plan information communications should be available on paper and electronically to ensure access, particularly in underserved and rural communities where internet access may be limited.

Marketing materials must also include a disclaimer that traditional Medicare plans are an option for beneficiaries. Enrollees must be assisted in understanding the differences between Medicare and MA, including that the election of an MA plan is completely voluntary.

Finally, MA plans should be required to submit their proposed marketing materials to CMS for approval. Doing so will ensure that all information contained in the materials is accurate, factual and will help beneficiaries to make the best decision for their healthcare.

Telehealth
CMS requests input on the role of telehealth in providing access to MA. As you know, telehealth plays an important role for both HHAs and the patients they serve. During the COVID-19 PHE, telehealth has allowed HHAs to care for patients that otherwise would have been unable to receive care. Telehealth should be equally available as a benefit under MA Plans and traditional Medicare, as it brings value to enrollees and improves access especially for the homebound.

Performance Measures
CMS requests information on factors considered by MA plans when making changes to their networks and how network adequacy requirements could be updated to support better access to care.

Unit price remains the dominant factor in accepting a provider into a network, and not enough plans are considering the quality-of-care performance of network providers. We believe that network adequacy standards should include some form of quality-of-care indices such as provider star ratings or performance measures.

Utilization Management
HHAs consistently report that MA plans are disallowing services that are billable under the Medicare home health benefit. CMS must ensure that MA plans follow the requirement that they provide services that are available under the Medicare home health benefit and hold them accountable when they do not.

Prior Authorizations
Prior authorizations are often misused by the MA plans, leading to delays in care. Agencies cannot afford to take the risks associated with prior authorization delays, putting access to care at risk. Some plans will not provide retroactive authorizations, and some are retroactively auditing and rejecting claims for services that had been previously authorized. These audits are often conducted by third party contractors that deny services typically covered under traditional Medicare.

CMS should require time limits for MA plan prior authorizations and not allow plans to refuse reimbursement for services provided under an untimely authorization. CMS should ensure the MA plans follow the same coverage criteria as traditional Medicare.

Driving Innovation to Promote Person-Centered Care

Value-Based Purchasing

CMS seeks information on value-based contracting and how MA plans engage providers with respect to value-based care. As mentioned above, MA plans have not focused sufficiently on value-based care, despite HHA efforts to engage. By using value-based models, both MA plans and Agencies can develop innovative plans of care that are goal oriented, patient centered, and cost-effective. CMS should require plans to offer one or more VBP option(s) to providers and should evaluate how plans are using supplemental benefits to allow for innovative care planning for home health patients.

Star Ratings

Many enrollees look to star ratings as a measure of quality-of-care, but additional metrics are required to provide the full picture. CMS should include provider relations metrics, including measures that address provider relations and/or provider satisfaction into the MA plan star rating program.

Hospice Benefit Component – MA Value-Based Insurance Design (VBID)

As part of the VBID Hospice Component model, CMS requires non-contracted hospice providers to submit, and participating plans to accept, Medicare hospice notices and claims. However, non-contracted hospices are widely reporting claim rejections. Hospices are also receiving partial payment on claims due to plans not paying the Service Intensity Add-on (SIA) or incorrect payment rates, and some plans are paying no claims at all.

Claims issues are made worse by challenges in reaching a representative who is knowledgeable about the VBID Hospice Component. Hospices have reported that even when contacting the plan representative identified in CMS documents, they are sometimes told that the plan "does not cover hospice," and there is a lack of familiarity with the model.

CMS should work to identify ways to educate plans about the need to coordinate with hospices, technology partners, and others to ensure that they have modified their systems to support smooth and timely processing of NOEs and claims. CMS should require plans to allow for an exception to timely filing requirements for hospices that erroneously received MAC payment.

Hospice Length of Stay

Hospices have reported a wide range of experiences relative to length of stay, raising concerns that some MA plans have not sufficiently educated staff about the VBID model or established effective processes for operating within the model. Referral sources, and as a result families, may not be sufficiently knowledgeable about the Model's benefits. CMS should work to ensure that all stakeholders, including beneficiaries and their families, are sufficiently educated on the Model.

Supporting Affordability and Sustainability

Payment Promoting High Quality Care

CMS requests information on policies to ensure that MA payments promote high quality care for enrollees. HHAs cannot continue to provide quality care with a payment model that does not support it.

HHAs continue to struggle with payment structures and rates for care by the MA plan, with MA Plan reimbursement for home health services often being below the cost of care. With the growing proportion of home health patients enrolled in MA, that level of reimbursement jeopardizes the ability of the HHA to continue to operate.

At the same time, administrative costs associated with delivering services through MA plans can be two to three times the cost of delivering home health through Medicare. Increased administrative burdens and overall costs to providers impact the availability of resources that can be directed toward patient care. This is in addition to a critical workforce shortage that will likely continue into the foreseeable future. These combined pressures further lower the margins that HHAs have available to provide adequate care for its MA plan members. CMS should focus on payment rates to home health providers, not just the number of providers in a plan's network.

MA plans should also be measured on the availability of quality providers within their networks, and CMS should include in a plan's star rating, the number of providers with star ratings above the mean.

Co-Payments for Home Health Services
Unlike Medicare Fee -For-Service, co-payments for home health services may be and often are imposed by MA plans, with the financial obligation of the patient explained as part of the pre-admission or admission processes. This can delay care, leading to higher downstream costs and negative outcomes.

Beginning in January 1, 2023, MA plans that establish a mandatory or intermediate maximum out of pocket (MOOP) amount may not require cost sharing for home health services. However, cost sharing is permitted for MA plans with a lower MOOP. CMS should eliminate all MA plan co-pays for home health services.

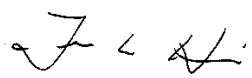
Barriers
CMS requests information on additional barriers to competition for providers. MA plans have the leverage in the contracting process, and HHAs often have little ability to negotiate. This dynamic inhibits innovation and does not best serve the patients' needs. Any margin from traditional Medicare patients is used to offset losses from MA rates and the higher administrative cost of working with the plans.

Fraud, Waste and Abuse
CMS requests input from stakeholders on how to best combat fraud, waste and abuse. The focus should shift to VBP and innovative care. As previously noted, utilization management methods used by the MA plans do not lead to the effective allocation of resources. Focusing on innovation will help to prevent waste, while promoting high quality care and system efficiencies.

Engaging Partners and Promoting Collaboration
Providers have limited data available to them to make informed decisions about the MA plans. CMS should require plans to report care utilization data comparable the data currently available for the traditional Medicare program. CMS could also require plans to have an Advisory Council made up of provider and enrollee representatives, similar to requirements for state Medicaid programs.

Thank you again for the opportunity to submit comments and for your consideration of these recommendations.

Sincerely,



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