MEMORANDUM

To: Interested Parties
From: Jonathan Gonzalez-Smith, Montgomery Smith, William Bleser, Robert Saunders (Duke-Margolis Center for Health Policy)
Date: November 20, 2021
Subject: Policy Agenda Brief on Opportunities for Expanding Home-Based Care for Medicare Beneficiaries and Increase Pilots Relevant to Home-Based Care

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Executive Summary

This policy agenda brief synthesizes research conducted by the Duke-Margolis Center and provides policy recommendations to increase access to home-based care for people with complex medical and social needs. This work was motivated by the significant opportunity to provide home-based care for millions of people in the United States, particularly individuals that are unable to receive health and health-related services in an office or facility setting due to health and functional limitations. While patients often prefer receiving care in the home setting, there remains a mismatch between the demand and supply of home-based care services.

To address these gaps, the Center conducted a literature review of existing home-based programs and interviewed and received feedback from a diverse group of leading experts, policymakers, and practitioners. This research was synthesized to outline potential actions that could be taken to improve home-based care, which is summarized in policy agenda briefs. Based on feedback on these policy agenda briefs, the Center will produce a final public issue brief for broad dissemination.

The current brief focused on actions to expand home-based care for Medicare beneficiaries, such as the Center for Medicare (CM) with the Centers for Medicare and Medicaid Services (CMS), as well as expanding pilots for home-based care, such as the Center for Medicare and Medicaid Innovation (CMMI). A subsequent policy brief will explore policy reforms for the Center for Medicaid and CHIP Services as well as ways for states to leverage their Medicaid programs and other state-based programs. The brief focused on policy activities that may be leveraged in the short term, especially given CMS' recently announced strategic refresh. The brief focuses on approaches to simplify and align existing value-based payment and care delivery models to achieve comprehensive, home-based care for people with complex health and social needs, including:

1) **Modify Existing Value-Based Payment Models to Provide More Care Options for People Needing Home-Based Care** – Interviewed participants emphasized new value-based payment (VBP) models are not needed specifically for home-based care, but there are unique issues for home-based care that are not well supported by current VBP models (e.g., services needed by people served by home-based models, home-based care not being captured by quality measures). One opportunity is to adapt or develop sub-tracks in existing VBP models customized for people with complex health and social needs that would benefit from greater home-based services. The sub-tracks can adapt model components (e.g., attribution, risk adjustment) to support the more intensive care needed, modify other components (e.g., quality measures) to recognize the care provided in the home, and couple accountability for total cost of care along with predictable cash flow (per-member per-month [PMPM] payments) for home-based care providers (who are often smaller practices more affected by cash flow disruptions).
2) **Explore Opportunities for Integration Between Episode-Based and Population-Based Models** – Home-based acute care, such as Hospital @ Home type programs, may be supported by payments centered around the acute episode. However, episodic payments need to be integrated with

population-based models to ensure seamless transitions in services when a person's acuity changes.

3) **Provide Upfront Infrastructure Investments to Help More Home-Based Care Providers Participate in Value-Based Care** – Given many home-based care providers, such as home-based primary care providers, are part of small practices with limited resources, there is a need to ensure providers can access the necessary resources to enter VBP arrangements.
4) **Provide a Core Set of Waivers Across Value-Based Payment Models** – To reduce administrative complexity and make it easier for home-based care providers to participate in multiple models, CMS can provide a core set of waivers for CMMI VBP models. The core set can build on the COVID-19 regulatory flexibilities, including common waivers that expanded access to virtual care and home-based care services during the public health emergency. By including the waivers within a model accountable for total cost of care, this approach will ensure the flexibilities will be appropriately applied and reduce chances for misuse or fraud.
5) **Leverage Medicare Advantage Flexibilities for Home-Based Care** –Medicare Advantage (MA) has existing flexibilities to test innovative home-based care approaches, such as supplemental benefits, VBP models, and special needs plans. The MA program can have greater incentives for home-based care with measures focused on the unique needs of people with complex health and social needs, more accurately collected data on function, and expanded publicly-available information on the quality and utilization of home-based services across MA plans.
6) **Leverage PACE to Expand Home-Based Care –** The Programs of All-Inclusive Care for the Elderly (PACE) enrolls the frailest Medicare and Medicaid beneficiaries with longer term needs, including in-home services, through a capitated full-risk model. Key policy adjustments, including risk adjustment modifications and integration with other CMMI programs, may address financial solvency challenges.

Introduction

The home-based setting is an untapped resource to provide services to the millions of individuals in the United States who are unable to access or have difficulty obtaining care due to frailty, functional limitations, or mental illness. Beneficiaries with complex medical conditions that need home-based care are among the highest-cost, highest-risk beneficiaries and require more specialized care and management. These individuals are also more likely to be people of color or reside in communities that are economically and socially marginalized. Despite evidence indicating strong patient preference for receiving care in the home setting, there remains a significant mismatch between the demand and supply of home-based care services.

The prevailing fee-for-service (FFS) payment environment poses challenges for delivering home-based care, as traditional FFS does not pay for many of the team members needed for home-based care services, does not necessarily support the time spent traveling to the home, and encourages fragmentation and siloes due to billing and coding practices. Value-based payment (VBP) models can help overcome these barriers, support expansion of home-based primary care, and have the potential to further advance home-based care. Though VBP models have the potential to overcome FFS challenges, existing VBP efforts are not strategically aligned to provide integrated care across models.

This policy agenda brief focuses on short-term policy reforms that can help simplify and align existing payment and care delivery models to achieve comprehensive, home-based care that addresses the needs of the whole person. The brief draws on research that includes a literature scan of existing home-based programs along with interviews and feedback from 40 stakeholders including federal and state policymakers, payers, providers, and academic experts. The research focused on the current policy

environment, given CMS' recently announced strategic refresh, with its greater focus on equity, meeting patient needs and preferences, and expanding access to care in home- and community-based settings, and recent legislative momentum to invest in home-based care.

Recommendations included in this policy agenda brief outline potential actions for the Center for Medicare and the Center for Medicare and Medicaid Innovation (CMMI) within CMS. A second policy brief will explore policy reforms for the Center for Medicaid and CHIP Services (CMCS) as well as ways for states to leverage their Medicaid programs and other state-based programs. Based on feedback on these policy agenda briefs, the Center will produce a final public issue brief for broad dissemination.

1. Modify Existing Value-Based Payment Models to Provide More Care Options for People Needing Home-Based Care

Interviewed participants emphasized new value-based payment (VBP) models are not needed specifically for home-based care, especially given the number of existing, large-scale VBP models. For example, the accountable care organization (ACO) model, the largest VBP model in use, covers almost 11 million Medicare beneficiaries across 477 ACOs. Further, CMMI's Primary Care First and Direct Contracting models are operational, with almost 900 organizations participating in one or the other.

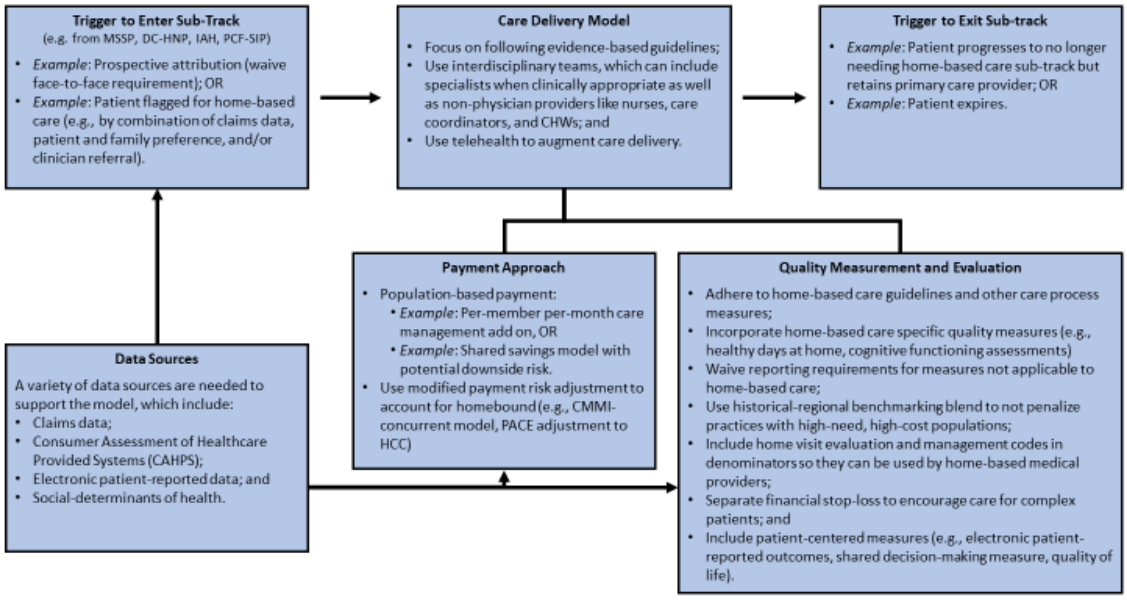
However, there are unique issues for home-based care that are not well supported by current VBP models. Stakeholders emphasized that VBP models often assume care is provided in facilities, and this is reflected in quality measures, risk adjustment, the associated regulations that assure quality, the list of services assumed to be provided, and other components of the payment model. For instance, half of the quality measures selected for the CMS' Merit-Based Incentive Payment System (MIPS) are unusable by home-based medical care providers, and common risk adjustment methods for VBP models, like CMS's Hierarchical Condition Categories (HCC) approach, can underestimate the needs of homebound patients living with serious illness. Another VBP challenge is that there are a number of home-based care delivery models (e.g., Hospital @ Home, home-based primary care, community paramedicine) and that people served by home-based care have differing needs that change over time. Prior research has also shown that ACO models may need multiple modifications to their payment model design (e.g., attribution, risk adjustment, outlier exclusions, benchmarks) to support home-based care for people with serious, complex illnesses, especially homebound populations.

Recommendation: Adapt or develop a sub-track within existing population-based VBP models customized to complex populations that would benefit from home-based services.

Given the desire to work within existing models but also the need to adjust for the nuance of home-based care, an opportunity is to adapt or develop sub-tracks in existing VBP models customized for people with complex health and social needs that would benefit from greater home-based services. The sub-tracks can adapt model components (e.g., attribution, risk adjustment) to support more intensive and home-based care services as needed, modify other components (e.g., quality measures) to recognize the care provided in the home, and couple accountability for total cost of care along with predictable cash flow (per-member per-month [PMPM] payments) for home-based care providers (who are often smaller practices more affected by cash flow disruptions). Incorporating home-based care within broader population-based models could enable beneficiaries to transition between payment "tiers" without creating separate payment models that can result in further care fragmentation and administrative complexity.

- A sub-track will help patients who require resources and services beyond what is provided in general population-based models. The goal would be for beneficiaries to seamlessly transition between the sub-track and the larger population-based model as their medical and functional requirements evolve over time.
- The payment model components of the sub-track (e.g., benchmarking and financial performance, risk adjustment, quality measures) should differ from the standard population-based model to match the high needs of the medically complex patient population who would benefit from the sub-track.
- There is precedent for designing specialty VBP sub-tracks and sub-programs, providing a framework from which to work. For example, CMMI launched a sub-track called Track 1+ for the Medicare Shared Savings Program (MSSP) to provide an on-ramp to ACOs interested in moving to risk. Additionally, there is a high needs population option under Direct Contracting, and there is a Seriously Ill Population Component of Primary Care First (*cancelled in November, 2021*).
- There are existing models that could serve as the base model for the sub-track. Population-based payment models may be most effective as they support coordination between targeted episodes (such as when patient needs and acuity changes), and example base models include the Medicare Shared Savings Program, Direct Contracting (building on its High Needs Population track), and Primary Care First (building on a re-tooled version of the now cancelled Seriously Ill Populations track). While each model carries distinct benefits and limitations, model-specific design changes would be aligned as much as possible. The Independence at Home model provides lessons for the sub-track design.
- Design considerations for home-based care sub-tracks, detailed in Figure 1, include the types of data sources to support the model, triggers for patients to enter and exit the sub-track, aligned quality measures, and payment model approaches. Examples listed in Figure 1 are potential approaches and are not intended to be exhaustive or prescriptive.

Figure 1: Design Considerations for Home-based Care Sub-Tracks



Drawing on our research (including stakeholder interviews), Table 1 below delves deeper into the details of the major components of the models that could be adapted to account for the unique characteristics and needs of medically complex populations. The model attributes discussed in Table 1 apply across population-based VBP models and serve to align models to provide parity in home-based care services.

Table 1: Challenges and Recommendations for Model Attributes that Support Home-Based Care

	Challenges	Model Design Recommendations
Payment Model	Current payment approaches present numerous challenges to facilitating care for patients in the home. First, reimbursement often does not cover the range of services need for home-based care. Second, small home-based care practices may not have adequate cash flow that allows them to provide services immediately while waiting for shared savings (which can take 18 months to receive). Third, many home-based care providers have small patient panels, which means their costs are more likely to vary based on random statistical events (vs being reflective of performance in a VBP model).	Provide a two-part payment structure that balances performance-based payments and cash flow: - Shared savings bonus/penalty based on total cost of care, time and number of sub-track patients in the model, and quality. - PMPM payment for infrastructure and ongoing cash flow.
Risk Adjustment	Current risk adjustment methodologies, which often use CMS-HCC, may not adequately account for the needs of populations with complex health needs, particularly homebound patients. Additionally, the CMS-HCC model often uses retrospective approach, but people with complex conditions may see their health needs change dramatically from year to year.	- Incorporate additional factors into risk-adjustment methodology (e.g., frailty, functional limitations, utilization history). For example, the HCC Version 24 used in Fully Integrated Dual Eligible SNPs includes adjustments for frailty and dementia. - Utilize concurrent risk adjustment (like those being tested in the Direct Contracting – High Needs Population Model) to account for acuity changes during the performance year.
Benchmarking	Given the differences between people with complex needs and the general population, regional benchmarking may be challenging if an organization has a significant high-need, high-cost population. Given changing patient needs and the heterogeneity of populations with complex health needs, benchmarking often does not accurately capture the	- Use a separate benchmarking for the high-risk group that captures the clinical instability and social needs of that patient population. - Identify appropriate blend of historical and regional benchmarking, with appropriate risk adjustment of regional benchmark, so as not to penalize organizations with significant high-need, high-cost populations, - Consider separate financial stop-loss provisions structured to provide

	expected costs for complex patient populations. Traditional stop-loss provisions exclude people who receive the highest amount of health care, which can limit incentives for improving health care for complex patient populations.	incentives for continuing to improve care for complex patients.
Attribution	Accurately attributing patients can be a challenge for homebound patients since voluntary attribution is difficult for complex and frail patients (which now often requires an in-person visit) and substantial turnover in the population (due to high mortality) challenges claims-based alignment.	- Consider the tradeoffs in waiving face-to-face physician visits prior to patient attribution (which is critical given that the majority of home-care providers are not physicians).
Measures	Robust, standardized quality measures that are inclusive of home-based care are not widely used. Existing metrics often do not accurately reflect the level of complexity associated with managing homebound patient needs.	Adopt quality measures applicable to homebound populations, with particular attention to access and equity, patient and provider engagement and satisfaction, safety, and efficacy and affordability. Examples include: - The National Home-Based Primary and Palliative Care Network's quality-of-care framework and quality indicators, which provide relevant core measures for home-based care. - Clinical researchers at Massachusetts General Hospital and the Johns Hopkins School of Medicine have developed a mix of National Quality Forum endorsed quality measures that could be expanded and tested more rigorously. - Include measures related to home-based care (e.g., advanced care planning, healthy days at home, depression screening) in MIPS quality measures. - Include home visit evaluation and management (E/M) codes in denominators so they can be used by home-based medical providers. - Incorporate electronic patient-reported outcomes (ePROs) in the performance evaluation of home-

		based care model to account for patient-satisfaction. - Include relevant data from the Outcome and Assessment Information Set (OASIS) (where patients are receiving home health) for cognitive functioning assessments (e.g., improvement in confusion frequency). - Draw on the Serious Illness Survey for Home-Based Programs (currently being tested by RAND) to assess patient experiences with home-based serious illness programs.
Shared Savings	Home-based care providers are often small practices without access to capital or resources required to transition to downside risk.	Create a glidepath with asymmetric risk where providers could gradually assume more risk (e.g., move from upside risk to downside risk) after they gain experience with risk-bearing arrangements.
Minimum Beneficiary Threshold	Home-based care providers typically have small patient panels and may not be eligible for risk-bearing arrangements.	There are a variety of approaches to address the minimum beneficiary threshold, each with different tradeoffs. One approach is to lower the minimum beneficiary threshold to allow broader participation. However, this creates challenges ascertaining provider performance and promoting predictability, given the small panel size. In other programs, like MSSP, smaller provider groups have partnered with third party firms to aggregate risk and provide access to the resources and technical assistance necessary for participating in risk-bearing arrangements. A similar "aggregator" type organization does not yet widely exist in the home-based care market, though this may change as VBP penetration increases.

Model Specific Changes. Our research also identified potential changes to existing models, which align with the challenges highlighted above. Some examples of feedback include:

- Independence at Home (IAH)

    - To address practice cash flow challenges, CMS can implement a PMPM payment (in addition to annual shared savings). One approach is to pair Primary Care First's monthly capitation with IAH's annual shared savings. Another approach is to modify IAH's shared savings, which is distributed annually, to a quarterly, partial payment with annual reconciliation.
    - There is a beneficiary limitation cap (currently at 15,000), which limits provider participation. Changing this cap would require Congressional action.
- Direct Contracting–High Needs Population
    - Given that many home-based primary care practices are small and have less experience with value-based care, revise the model to limit initial downside risk from a 5% to 2% quality withhold during the first few years of implementation (including up to the first full contract term) to allow practices without experience with risk-bearing arrangements to engage in the model.
- Primary Care First—Seriously Ill Populations (SIP) *(if the terminated SIP component is re-started in another form)*
    - Eliminate the stabilization graduation requirements (wherein patients that are clinically stabilized transition out of the SIP component). People with complex conditions requiring home-based care often need to remain in a high needs track for long time. SIP could be treated as a high-risk tier of PCF, allowing patients to move between Tier 4 and SIP risk groups as a patient's clinical instability and acuity level changes.
    - Include a shared savings component for SIP patients (currently SIP only includes a fixed quality payment).

2. Explore Opportunities for Integration Between Episode-Based and Population-Based Models

While creating a sub-track within existing population-based VBP models can ensure providers are accountable for their overall patient populations, bundled and episodic payments may be appropriate in certain instances to support some home-based services. An example of this approach is an ambulatory model with a more acute or post-acute episode (e.g., Hospital at Home, Medicare home health benefit for post-acute care). However, additional episodic payment models may contribute to further payment fragmentation, and, in many cases, organizations in population-based payment models could theoretically deliver the same services without a waiver or an episodic payment.

Recommendations

- Consider additional opportunities for leveraging episodic payments. For instance, creating a home-based care model where plans enter into percent-of-premium capitation sub-contracts with acute-care providers for episodes of care.
- Researchers will need to expand evidence on optimal episodic model designs. For instance, if CMS considers creating a bundle for an advanced care at home model building off the Hospital at Home concept, additional research is needed to define which conditions should be covered and the optimal reimbursement period (e.g. 30, 60, or 90-day bundles).

3. Provide Upfront Infrastructure Investments to Help More Home-Based Care Providers Participate in Value-Based Care

Many home-based care providers are small practices, which often lack access to upfront funding, resources, and administrative capabilities to transition into risk-bearing arrangements. Once in the risk-

bearing arrangement, providers will have more financial flexibility, which allows providers to determine what care is clinically appropriate and address social determinants of health. Further, VBP can help support interdisciplinary teams which are crucial for providing comprehensive, home-based care to patients with complex health and social needs. However, in order for providers to access these benefits, they need to first be able to make the upfront investments to join a VBP model.

Recommendations

- Provide upfront fixed payments to allow practices to invest in necessary infrastructure for advanced primary care practices, like in the Advanced Payment ACO and Comprehensive Primary Care Plus models. A similar program, the ACO Investment Model, successfully helped providers create ACOs in rural, underserved, and new areas with low ACO penetration while saving money to Medicare and decreasing unnecessary utilization.
- Create a "glidepath" for two-sided risk arrangements, enabling small providers to gradually transition into downside risk.
- Require practices receiving upfront investments to complete a readiness review detailing their operational capacity.
- For continued participation, incorporating a PMPM capitated payment into existing models can help address cash flow issues, which are significant impediment for small provider practices operating in value-based payment models.

4. Provide a Core Set of Waivers and Flexibilities to Allow for Home-Based Care Across Value-Based Payment Models

CMS introduced a range of regulatory flexibilities during the COVID-19 Public Health Emergency (PHE) to rapidly expand where and how care could be delivered (e.g., telehealth waivers, Hospital Without Walls, Acute Hospital Care At Home). CMMI should consider making these flexibilities permanent (if found to be positively impactful) through a core set of waivers for all of their VBP models, with modifications to promote accountability and reduce chances for misuse or fraud.

Recommendations

- Allow organizations participating in total-cost-of-care VBP models to use a waiver modeled after the Acute Hospital Care at Home flexibilities to deliver hospital-level services in the home setting when clinically appropriate and when they have the clinical capabilities to do so.
- Allow organizations participating in total-cost-of-care VBP models to use telehealth flexibilities introduced during the PHE (either through a waiver or made permanent as part of the model design).
    - Establish telehealth guardrails to establish appropriateness of telehealth services and protect homebound populations (e.g., require face-to-face interactions for new diagnosis).
    - Consider allowing organizations in advanced alternative payment models (APMs) to automatically bill for a broader range of telehealth services instead of the traditional waiver application process which can be burdensome and discourage uptake.

5. Leverage Medicare Advantage Flexibilities for Home-Based Care

The continued growth of Medicare Advantage (MA) plans, as well as their flexible financing and benefit structures, provide opportunities to test innovative payment and care delivery approaches for home-

based care populations. Supplemental benefits also enable plans to furnish non-medical services (including in-home services) for people with serious illness, though adoption is limited. Additionally, publicly-available data on the use of home-based care services by MA enrollees is limited.

Recommendations

- CMS should identify further opportunities to publicly release information regarding MA program performance. The lack of available data impedes research on MA payment reforms. In particular, CMS should release additional data on home-based care services offered through supplemental benefits (utilization, quality, etc.).
- Augment MA quality measures for MA plans providing home-based care to be more relevant to homebound populations.
- Provide more clarity on what supplemental benefits are allowed (in SSBCI), how they can be used, and who is eligible. Lack of clarity can create impediments to providing non-medical supplement benefits. CMS could provide more clarity around the types of benefits that are permissible and case examples of allowable benefits.
    - Review the criteria for SSBCI to understand whether it includes the broad range of complex patient populations, or if the limitation to Chapter 16b of the Medicare Managed Care manual excludes some people with complex needs (such as those with substantial social needs).
- Examine risk-adjustment methodologies to ensure they accurately account for the needs of complex patient populations, including their changing health needs.
- Support beneficiary decision making on plans, such as understanding non-medical benefit eligibility and having clearer information about supplemental benefits, as beneficiaries face challenges navigating and comparing non-medical benefits across plans. New information can build on and be included in CMS' redesigned Medicare Plan Finder.
- Identify opportunities for providing home-based care for those who qualify for institutional level of care but still live in the community, such as through Institutional Special Needs Plans.

6. Leverage PACE to Expand Home-Based Care

The Programs of All-Inclusive Care for the Elderly (PACE) enrolls some of the frailest Medicare and Medicaid beneficiaries with longer term needs, including in-home services, through a capitated full-risk model. Although PACE models serve relatively few beneficiaries due in part to scaling limitations, interest in PACE programs has increased recently. Examples of key policy adjustments, detailed below, may address some of these limitations.

Recommendations:

- Improve risk adjustment methodology, as interviews highlighted several opportunities to improve the current risk adjustment methodology.
    - Update PACE's risk adjustment model from HCC v22 to use HCC v24 to better account for populations with complex health needs. For example, version 22 does not account for Alzheimer's disease or dementia.
    - Standardize routine assessment and reporting of Activities of Daily Living (ADL).
        - To assess a beneficiary's ADL, PACE uses the Medicare Health Outcomes Survey-Modified (HOS-M) instrument, a patient reported survey for Medicare

beneficiaries. However, HOS-M surveys have low response rates, particularly for frail older adults (half of whom have dementia). CMS should identify approaches to administer and routinely collect ADL and other frailty-related measure for risk adjustment methods.

- CMS should provide clarity on how encounter data from virtual care encounters will be used post PHE. During the COVID-19 PHE, CMS accepted diagnoses from virtual care and coding for risk adjustment. However, there is no clarity on how CMS will use encounter data after the PHE ends.
- CMS may consider additional approaches to expand access to PACE. For instance, enabling PACE centers to contract directly with MA plans or ACOs to provide subservices with highest cost enrollees, or enable institutional-eligible SNP beneficiaries access to PACE centers.

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