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Leveraging Policy Reforms to Scale Home-Based Primary Care: Enhancing engagement in CMS models

Tuesday, November 28th, 2023 | 12:00-3:00 PM ET

Workshop Briefing Materials

Key Takeaways

- Home-based primary care (HBPC) is important for addressing health needs and advancing health equity, particularly for the millions of older adults and people with complex health and social needs who struggle to access care in traditional settings. Yet there remains unmet demand for HBPC which will further increase with an aging population.
- At the same time, The Centers for Medicare and Medicaid Services (CMS) is committed to having all Medicare and most Medicaid beneficiaries enrolled in accountable care relationships. Achieving this goal will require increasing engagement of diverse provider groups, such as HBPC providers in CMS' accountable care models.
- As the demand for HBPC continues to grow, policymakers should ensure CMS-led payment models (including CMS Innovation Center demonstrations) are capable of supporting HBPC providers and the populations they serve to increase equitable access to health care and advance Age-Friendly Health Systems.

The Importance of Home-Based Primary Care

Home-based primary care (HBPC) is important for addressing health needs and advancing equitable access to health care, particularly for the nearly two million older adults who are completely homebound and the over five million with complex health and social needs who face difficulties seeking care in traditional brick-and-mortar settings. Over the past few decades, there has been a substantial shift to move care to the home. The COVID-19 pandemic accelerated the shift, with policymakers, payers, and providers rapidly pivoting to support care outside of clinical and institutional settings. However, only 12 percent of completely homebound individuals receive primary care in their home, and the prevalence of homebound adults aged 70 and older more than doubled during the pandemic.

Despite patient preference for home and community care and an increasing shift away from facility-based settings during the PHE, challenges remain to scaling HBPC. For example, the predominant fee-for-service (FFS) payment model does not adequately support HBPC providers, as providers operating under FFS are often undercompensated for travel time, not reimbursed for many home-based services, and face additional administrative burdens from billing and coding practices. However, the Centers for Medicare and Medicaid Services (CMS) is committed to having all Medicare and most Medicaid beneficiaries enrolled in accountable care relationships by 2030. Achieving this goal for homebound Medicare beneficiaries will require engaging diverse provider groups, such as home-based primary care providers, in CMS-led accountable care models.

During the November 28th workshop, we plan to hear from providers, researchers, policymakers and other health leaders on opportunities to increase HBPC provider engagement in payment models that reward value and can support comprehensive, longitudinal care in the home setting.

CMS Payment Models Supporting Home-Based Primary Care

Accountable care or "value-based payment" (VBP) models are increasingly seen as a pathway to support HBPC by supporting flexibility for providers to deliver clinically appropriate care and rewarding quality. CMS, particularly CMS' Innovation Center (CMMI), leads a variety of accountable care models that may directly or indirectly support HBPC for older adults and populations with complex health and social needs (highlighted in Table 1 below). During the workshop, we plan to discuss lessons learned and opportunities to adapt existing models to enhance access to HBPC.

Table 1. CMS-Led Accountable Care Models Supporting Home-Based Primary Care

Model	Description
Independence at Home	Upside risk model that supports HBPC and chronically-ill Medicare beneficiaries tailored to the beneficiary's needs. Participating entities must be provider- or nurse practitioner-led and serve patient panels of at least 200. There is one participating site as of January 2023.
ACO Realizing Equity, Access, and Community Health (REACH) – High Needs Population	Advanced risk-based model for Medicare beneficiaries with complex medical needs. The High Needs Population option (one of three participant options under ACO REACH) allows for smaller patient panels – with a glidepath from 250 to 1,400 required patients by 2026 – than the Standard track which requires a panel of 5,000.
Guiding an Improved Dementia Experience (GUIDE)	A condition-specific upside risk model for community-dwelling Medicare FFS beneficiaries living with dementia. GUIDE is an eight year model that will launch July 2024, and model participants will be able to simultaneously engage in other CMS accountable care models. There is no patient panel requirement for GUIDE.
Making Care Primary (MCP)	A 10.5-year advanced primary care model that is planned to launch July 2024 and builds off previous primary care models (e.g., Primary Care First). The model accounts for varying levels of experience in value-based care by offering three model tracks, each with progressive levels of population-based payments and opportunities for performance-based rewards. MCP differs from other primary care models by including Federally Qualified Health Centers (FQHCs). Participants must serve panels of 125 patients.
Medicare Shared Savings Program (MSSP)	Applies to the general Medicare population, but some Accountable Care Organizations (ACOs) have been providing HBPC. For performance year 2024, CMS will allow new entrant ACOs Advanced Incentive Payments to invest in infrastructure needed to engage in MSSP. MSSP participants must serve at least 5,000 patients.

Home-based Care Supported through Medicare Advantage

In addition to specific CMS-led models, there is opportunity to enhance home-based care supported through Medicare Advantage (MA). As of January 2023, MA covers 50 percent of Medicare-eligible beneficiaries, though there is limited data on home-based care utilization supported through MA. Medicare Advantage Organizations (MAOs) provide a variety of home-based services, with recent CMS and congressional action increasing opportunities for home-based care through supplemental benefits (see Table 2). For instance, one quarter of MA plans are leveraging new opportunities to offer home-based care through supplemental benefits. Although offerings and utilization of home-based care

services are increasing, it is not clear if they are meeting longitudinal care management needs. For instance, new research shows that MA beneficiaries are 30 times more likely to receive a single home-based care visit than traditional Medicare, but have lower rates of longitudinal home-based care visits. Additional guidance and policy changes may be needed to ensure MA beneficiaries receive comprehensive, longitudinal care in their home.

Table 2. Recent Expanded Authorities in MA for Home-Based Care

	Description
Special Supplemental Benefits for the Chronically Ill (SSBCI)	The Bipartisan Budget Act of 2018 expanded supplemental benefits available to "chronically ill" Medicare Advantage enrollees, and defined chronically ill criteria. SSBCI do not have to be primarily health related (though they must serve to improve or maintain health or function) nor do they have to be applied uniformly.
Uniform Flexibility Reinterpretation	CMS reinterpreted uniform flexibility for MA plans. Now plans can offer the same set services to enrollees with similar conditions, rather than all enrollees. Relaxing the uniformity requirement gives plans discretion to tailor services based on beneficiary need, which better aligns with the needs of beneficiaries with serious illness.
Expanded definition of "primarily health-related" benefits	CMS expanded the definition of "primarily health-related" benefits to include services used to diagnose, support beneficiaries' function and health, and avoid emergency and hospital visits. Permissible benefits now range from in-home supports that assist with activities of daily living (ADL) to home-based palliative care. In-home support services is the largest offering under the expanded definition, with 19 percent of plans offering the benefit, whereas only 3 percent of plans offer home-based palliative care.
Medicare Advantage Value-Based Insurance Design (VBID)	CMMI launched the VBID model in 2017 to test innovations within MA with an aim to reduce spending and improve outcomes and care coordination. VBID allows tailoring supplemental benefits by chronic condition and low income, and starting in 2025 VBID will test tailoring these benefits to those living in socioeconomically disadvantaged areas using the Area Deprivation Index. In 2021, CMMI launched the Hospice Benefit Component to test spending and health outcomes associated with including hospice (Medicare Part A benefit) in MA, through which some MAOs are providing home-based palliative and hospice care.

Opportunities to Scale Home-Based Primary Care

Below are a variety of opportunities to adapt existing CMS-led models as well as supportive policies that could help increase HBPC access. These recommendations are informed by previous work, a virtual convening we held in May, and conversations leading up to this workshop. During the workshop, we plan to explore the recommendations in more detail. We appreciate feedback on which of these opportunities are priority areas for scaling HBPC and whether there are particular areas not included. We will use your feedback to guide our research in the coming year around identifying supportive policy reforms to support HBPC.

Adapt payment models to enhance home-based primary care provider participation in comprehensive, longitudinal accountable care models.

- Provide flexibility to HBPC providers serving patient panels that do not meet the size requirement to engage in CMS- and CMMI-led models.
- Support small independent provider groups and providers without experience in accountable care arrangements through glidepaths to bearing risk or third-party entities to aggregate risk.
- Offer upfront infrastructure investments to build HBPC providers' operating capacity, such as the MSSP Advanced Incentive Payment.
- Adjust payments to account for higher acuity patients served at home and their varying level of need during condition exacerbations throughout a performance year.
- Test a monthly care management payment per-beneficiary for HBPC, similar to the GUIDE model.

Define and identify populations who require home-based primary care.

- Include social needs screening questions and functional status assessments in in-home wellness assessment.
- Encourage the use of social determinants of health codes (e.g., "Z codes") to increase data on Medicare beneficiaries' needs.
- Test ways to better capture beneficiaries who may need HBPC through CMMI models, such as testing ways to broaden SSBCI criteria through VBID.

Design policies to enhance access to home-based primary care services.

- Authorize the permanent use of virtual care services (e.g., allow providers to operate in the field under virtual supervision of their supervising clinician) with guardrails for appropriate use.
- Amend scope of practice policies to allow providers to practice at the top of their license and meet the needs of beneficiaries.
- Ensure reimbursement for allied health professionals (e.g., community health workers) who help facilitate and coordinate HBPC or other services that help people age in place.

Improve data quality for home-based primary care.

- Require providers (CMMI model participants or MAOs) to provide beneficiary utilization data for services provided to beneficiaries in their home, including supplemental benefits.
- Incorporate performance measures in models that capture care delivered in home settings, account for varying changes in patient acuity, and outcomes that matter to beneficiaries (e.g., healthy days at home).

Reduce the administrative burden for home-based primary care providers.

- Integrate home-based care modalities into a comprehensive, longitudinal model to reduce fragmentation and increase a seamless care experience.
- Address prior authorization barriers resulting in administrative burden for HBPC providers and delayed care for patients, such as shifting prior authorization for home-based services to providers in accountable care arrangements.

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