Moving Health Home
An Alliance to Advance Home-based Care Policy

September 13, 2021

Submitted electronically via: http://regulations.gov/

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

RE: CMS-1751-P; Medicare Program: CY 2022 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; etc.

Dear Administrator Brooks-LaSure:

Thank you for the opportunity to submit comments on the proposed rule for the Calendar Year (CY) 2022 Medicare Physician Fee Schedule (PFS) and Other Changes to Part B Payment Policy.

Moving Health Home (MHH) is a coalition of health care organizations with a bold vision to make the home a site of clinical service. Our members share in the belief that experience during the pandemic has accelerated the day when care in the home is an option for patients. We look forward to working with CMS to ensure that home is part of the health care options for patients in the future.

For our members, clinical care in the home refers to a spectrum of health services provided in the home or place of dwelling outside of a facility, such as hospital-level or acute care, primary care office, skilled nursing and therapy services, and hospice. Services may include routine physician visits, chronic disease management, laboratory and diagnostic services, home infusion, in-home dialysis, and other care provided in the home setting rather than a facility, and regardless of age and health conditions.

At the core, we want to remove regulatory barriers to ensure all patients may choose to receive clinical care in the home and take advantage of the convenient, high-quality care that comes when patients receive home-based care. Importantly, we believe that care in the home contributes to health equity by giving historically disenfranchised populations the option to receive care on their own terms. Providers will be guests in the homes of patients with the institutional aspects of the health care "system" taken away, which will promote trust and communication.

Notably, MHH is concerned that the proposed rule did not include further action on Evaluation and Management ("E/M") codes used for home visits. We hoped that CMS would proactively realize the value of a home visit and re-value the codes for CY 2022 acknowledging the significant clinical value of doing so. We urge CMS to recognize the high value of domiciliary visits and home visits E/M codes in the same manner as other facility-based E/M codes. MHH is supportive of other efforts in the proposed rule, such as those to temporarily extend the COVID-19 public health emergency (PHE) telehealth flexibilities, furnish vaccinations in the home, and increase access to laboratory specimen collection in the home.

Moving Health Home
An Alliance to Advance Home-based Care Policy

A. No Action on Home-Based Evaluation and Monitoring ("E/M") Codes

As you know, in the CY 2021 PFS, CMS finalized a revaluation of several payment codes to providers for E/M codes.[1] For some E/M codes, such as office visits, transitional care management, and assessment and care planning, CMS increased payment to physicians. However, because payment adjustments in the PFS must be budget neutral, these specific increases triggered decreases elsewhere for providers. As a result, the final PFS included a nearly 10 percent cut to physician payment for E/M services around domiciliary visits and home visits, or what we refer to as Home-Based Primary Care (HBPC).

The CPT Editorial Panel recently recommended modifications to these codes, and it is our understanding that those modifications are in the process of being evaluated by the RVS Update Committee (RUC). The American Medical Association (AMA) estimates that their proposed changes to these codes would be ready for CY 2023, but we believe that CMS should proactively realize the value of a home visit and re-value the codes for CY 2022 recognizing the significant clinical value of doing so.

That said, we urge CMS to either reverse or lessen these downward adjustments in the CY 2021 PFS and recognize the high value of domiciliary visits and home visits E/M codes in the same manner as other facility-based E/M codes and the cuts remain in place.

Home-based care, often delivered through HBPC services, is an imperative alternative to facility-based care for many older adults – particularly post-COVID-19. Beneficiaries who receive HBPC services are typically among the sickest, most frail Medicare patients who are home-limited due to multiple chronic illnesses, frailty, and disability. While it is important to ensure accurate reimbursement for E/M services, it should not come at a cost to other E/M services. Appropriate reimbursement for E/M services is needed across the spectrum, and not just for some settings or specialties.

We know from countless studies that HBPC services, and home visits more generally, improve health outcomes while reducing costs.[2] CMS' own Innovation Center found that home visits as part of the Independence at Home Demonstration resulted in reductions in hospital admissions and emergency department visits.[3] That said, cuts to HBPC services will impact beneficiaries by reducing clinical outcomes and patient experience, all while increasing costs associated with higher rates of hospitalization and readmissions.

Even worse, it will significantly reduce access to care and compound existing health inequities, which the COVID-19 pandemic has both highlighted and exacerbated.[4] With lower reimbursement for HBPC services, it will incentivize fewer providers to offer these services and stymie innovation in care delivery where it is needed most. The populations benefiting from HBPC services are the most understudied, underrepresented patient groups where innovation is desperately needed to improve mortality and functional stabilization as well as reduce symptom burden.

---

[1] https://www.cms.gov/newsroom/fact-sheets/final-policy-payment-and-quality-provisions-changes-medicare-physician-fee-schedule-calendar-year-1

[2] https://www.healthaffairs.org/do/10.1377/hblog20210506.843768/full/

[3] https://innovation.cms.gov/files/reports/iah-fg-yr5eval.pdf

[4] https://www.ucsf.edu/news/2021/03/420101/how-inequities-fueled-covid-19-pandemic-and-what-we-can-do-about-it

For CY 2022, or CY 2023 at the latest, CMS must recognize the high value of domiciliary visits and home visits E/M codes in the same manner as other facility-based E/M codes. For our most frail and increasingly aging population, home-based cares services are needed now more than ever.

B. Telehealth Provisions, Including Allowing Home as an Originating Site

CMS is proposing to allow certain temporary Medicare telehealth services to remain effective until the end of December 31, 2023. CMS' rationale is that a glide path is needed to evaluate whether the services should be permanently added to the telehealth list of approved services following the COVID-19 PHE. Additionally, the Consolidated Appropriations Act (CAA) of 2021 allowed CMS to remove the geographic restrictions and add the home of the beneficiary as a permissible originating site for telehealth services when used for the purposes of diagnosis, evaluation, or treatment of a mental health disorder.

Telehealth is an important enabler to facilitating and supporting the movement to home-based care. From remote patient monitoring for Hospital at Home programs to nurses using telehealth to bring specialists into rural areas during an in-home visit, telehealth must be part of the future of home-based care. That said, MHH supports efforts to extend the COVID-19 PHE telehealth flexibilities temporarily, and ideally permanently. Specifically, we applaud CMS' proposal to retain all Category 3 telehealth codes through the end of CY 2023 to provide an opportunity to collect and study data on the telehealth experience during the COVID-19 PHE. We request that CMS publicly release the data and corresponding reports on critical findings and lessons learned. Additionally, MHH asks that CMS focuses on the experience of telehealth for homebound beneficiaries and as an enabler to care in the home.

C. Provisions Related to Administering Vaccinations in the Home

On June 9, 2021, CMS announced an additional payment amount for administering the COVID-19 vaccine in the home of Medicare beneficiaries to better meet patients where they are.[5] In the PFS, CMS recognizes that this commitment needs to extend to other vaccines, such as those for the flu, pneumonia, and hepatitis B. In the proposed rule, CMS is seeking feedback on payment rates for administration of Part B vaccines; types of providers who may furnish vaccines; costs associated with doing so in the home and via different types of providers; and its recently adopted payment add-on of $35 for immunizers who vaccinate certain underserved patients in the patient's home.

MHH was supportive of CMS' policy to increase payment for at-home COVID-19 vaccinations for Medicare beneficiaries. We must meet patients where they are, whether that is in the community or their homes. Efforts to incentivize care in the home are welcomed changes to dismantle the biases that care can only be delivered in a facility-based environment. MHH applauds CMS for exploring other vaccines that should be eligible for reimbursement in the home and receive increased payment. Vaccine-preventable diseases, such as the flu, pneumonia, and shingles, cost our health care systems billions of dollars annually, and more importantly, thousands of lives each year.[6]

We must work diligently to remove all barriers to access to vaccines, ranging from cost to transportation. To do so, CMS should adopt a similar add-on payment for reimbursement of preventative vaccines in the home to cover the cost of travel and other investments to accelerate the movement to home-based care.

[5] https://www.cms.gov/newsroom/press-releases/biden-administration-continues-efforts-increase-vaccinations-bolstering-payments-home-covid-19

[6] https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.0462

Travel-related reimbursement should consider challenges to rural, urban, and suburban transportation, including geographic distance, traffic, and public transport systems. The rate should also take into consideration geographic variation in costs of transportation (e.g., gas, public transport access, etc.). Additionally, CMS should think broadly in terms of providers able to furnish vaccines, so long as they have the appropriate training and scope of practice in the state. For example, CMS should explore adding Emergency Medical Services (EMS) Providers, Nursing Technicians, Pharmacy Technicians, and other provider types.

Again, we applaud CMS for its interest in furnishing preventative vaccines in the home, and we urge CMS to move forward with efforts beyond vaccines, for example incentivizing primary care, dialysis, infusion, and more in the home.

D. Clinical Laboratory Fee Provisions Related to Laboratory Specimen Collection and Travel Allowance for Homebound Patients

Currently, the Clinical Laboratory Fee Schedule (CLFS) reimburses a nominal fee for specimen collection for laboratory testing as well as to cover transportation and personnel expenses. The additional payment allows trained staff to collect specimens from homebound patients and those in non-hospital facilities (e.g., skilled nursing facilities). During the PHE, Medicare provided payment to independent laboratories for specimen collection from homebound and non-hospital patients for COVID-19 testing under certain circumstances and increased payments. These provisions are expected to end after the PHE. However, CMS is seeking comments on policies for specimen collection fees and the travel allowance as they consider updating these policies in the future. Specifically, CMS is seeking feedback on the calculation of costs for transportation and personnel expenses for trained personnel to collect specimens from these patients.

MHH is pleased that CMS is seeking feedback to ensure appropriate payment for laboratory specimen collection in the home and the associated travel allowance. Similar to vaccine reimbursement in the home, travel-related reimbursement for specimen collection should consider challenges to rural, urban, and suburban transportation, including geographic distance, traffic, and public transport systems. The rate should also take into consideration geographic variation in costs of transportation (e.g., gas, public transport access, etc.). CMS should also consider reimbursement for tests that can be self-completed by the patient and mailed to the lab. In this care, CMS should include the cost of mailing completed lab kits and tier reimbursement on shipping based upon the nature of the collection/processing (e.g., cold chain requirements, time sensitivity, or infectious disease protocol). In addition, CMS should consider an add-on payment for pick-up of the specimen if the patient prefers or is not able to easily mail the specimen.

Finally, MHH urges CMS to consider reimbursing in-home specimen collection for patients beyond those who are homebound, or expand the definition to be broader. With health equity as a top priority, CMS should move away from only the traditional sense of “homebound” (i.e., difficulty getting in and out of the home) and include those who do not have access because of lack of feasible transport, lack of assistance to get into transportation such as a bus or car, non-drivers, and rural areas. If CMS wants to remove barriers to care and reduce health disparities, health professionals must be able to meet patients where they are, especially in the home.

Moving Health Home
An Alliance to Advance Home-based Care Policy

*****

Thank you for considering our comments. We look forward to working with CMS and welcome the opportunity to provide further feedback on how to achieve our shared goals. Please do not hesitate to reach out to Jeremiah McCoy at jmccoy@movinghealthhome.org with any questions regarding our comments or if we can be a resource to you in any way

Sincerely,

Krista Drobac
Moving Health Home