August 1, 2022

Submitted electronically via: OASHPrimaryHealthCare@hhs.gov

Admiral Rachel L. Levine, MD
Assistant Secretary for Health (ASH)
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

RE: Request for Information (RFI); U.S. Department of Health and Human Services (HHS) Office of the Assistant Secretary for Health (OASH) Initiative to Strengthen Primary Health Care

Dear Dr. Levine:

Thank you for your commitment to strengthening primary health care in the United States, and we appreciate the opportunity to submit comments on the related request for information (RFI).

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 the experience during the pandemic has accelerated the day when care in the home is an option for patients. We look forward to working with the Department of Health and Human Services (HHS) Office of the Assistant Secretary for Health (OASH) to ensure home-based primary care is an available and sustainable model.

In our response to the RFI, we primarily focus on two policy options that would meaningfully strengthen primary care through expanded access to home-based primary care in Medicare and Medicare Advantage (MA). We also outline the unique benefits that home-based primary care offers and urge HHS to ensure in-home care is a central part of its strategy to strengthen primary care in the United States.

The Spectrum of Home-Based Care, Interconnected with Primary Care

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. It can mean a house call from a primary care doctor or nurse, a physical therapy session, a laboratory and diagnostic service, a home infusion, or a full complement of hospital-level services.

At the core, we want to remove regulatory barriers to ensure all patients may choose to receive clinical care at 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.

Primary care falls on the spectrum of home-based care, but it is also interconnected to other services on the care continuum of in-home care services. As an example, for home-based primary care to be successful, there must be appropriate reimbursement for at-home laboratory and diagnostic services. That said, when looking at solutions to increase access to home-based primary care, HHS should adopt a system-level approach to identify all of the barriers that exist.

Rationale for More Home-Based Care

Going back to pre-pandemic institutional norms will waste the experience generated by the pandemic. No longer can the United States lag behind comparable countries in options for patients to receive primary care at home.[1] MHH's recent study shows that a majority (70 percent) of Americans are comfortable receiving care in the home, 73 percent are confident in the quality of receiving care in the home, and a bipartisan majority of adults (73 percent of Democrats and 61 percent of Republicans) say it should be a priority for the federal government to increase access to clinical care in the home.[2] Research confirms that home-based models are at least as safe as facility-based care and result in improved clinical outcomes, higher rates of patient satisfaction, and reduced health care costs.[3]

Our Policy Priorities

MHH's focused policy priorities include, but are not limited to, the following:

- **Advocate for Hospital at Home authority and long-term Medicare program.** Advocate for permanent flexibility to transfer or treat patients in home-based settings, when preferred by the patient and clinically appropriate.
- **Ensure equal access for seniors through fair reimbursement for home-based evaluation and monitoring (E/M) codes.** Advocate for these codes to be valued in the same manner as facility-based E/M codes.
- **Advocate for a home-based Medicare post-acute care model.** Advocate for the creation of a post-acute care benefit that would serve as a home-based alternative for skilled nursing facility care.
- **Encourage greater flexibility for home-based care services to meet Medicare Advantage (MA) network adequacy standards.** Advocate for the home to be a site of clinical care for purposes of network adequacy.
- **Ensure home is an option for care in traditional Medicare.** Advocate to remove barriers in traditional Medicare to improve access to care in the home in areas such as home infusion, labs, dialysis, diagnostics, and primary care.

[1] https://www.commonwealthfund.org/publications/issue-briefs/2022/mar/primary-care-high-income-countries-how-united-states-compares
[2] https://movinghealthhome.org/national-survey
[3] https://www.hahusersgroup.org/about-hah/research/

Below, we focus on two areas that HHS could address to ensure greater access to home-based primary care, one focused on fee-for-service Medicare and the other on MA market.

Focus Area One: Ensure Equal Access for Seniors Through Fair Reimbursement for Home-Based E/M Codes in Fee-For-Service Medicare

In recent years, the Centers for Medicare and Medicaid Services (CMS) has finalized revaluations through the Medicare Physician Fee Schedule (PFS) of several payment codes to providers for E/M services around domiciliary visits and home visits, or what is often referred to as Home-Based Primary Care (HBPC).[4] Unfortunately, these payment updates are not adequate as they do not account for the time and travel investments unique to home-based primary care.

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.[5] 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.[6] 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.[7] 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.

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[4] https://www.cms.gov/newsroom/fact-sheets/final-policy-payment-and-quality-provisions-changes-medicare-physician-fee-schedule-calendar-year-1
[5] https://www.healthaffairs.org/do/10.1377/hblog20210506.843768/full/
[6] https://innovation.cms.gov/files/reports/iah-fg-yr5eval.pdf
[7] https://www.ucsf.edu/news/2021/03/420101/how-inequities-fueled-covid-19-pandemic-and-what-we-can-do-about-it

We urge HHS, as part of its ongoing efforts to strengthen primary care, to consider the important role of home-based primary care and appropriate reimbursement for these services. For more details, view MHH's response to the CY 2022 Medicare PFS.

Focus Area Two: Policy Options to Encourage Broader Use of Home-Based Care in MA

CMS should encourage MA plans to provide access to in-home care through the network adequacy standards. The scope could focus on certain specialties where in-home care is appropriate or on specific patient populations who may benefit the most from in-home care such as high-cost, high-need patients. The existing process for requesting an exception to network adequacy requirements should remain for those plans who are unable to offer in-home care, or who believe it is inappropriate for their patient populations.

We have identified three options that could be employed to achieve the goal of broader adoption of home-based care, including:

1. Replicate the MA telehealth bonus in which health plans would be eligible for a 10-percentage-point credit toward the proportion of beneficiaries residing within required time and distance standards when they offer in-home services;[8]
2. Add a 28th provider type for in-home primary care; or
3. Modify 42 CFR 422.112, Access to Services, to include new language.

To view these policy options in more detail, please see MHH's comment letter in response to the CY 2023 MA Advance Notice. We urge HHS to consider these policy options to ensure access to in-home primary care for all Medicare beneficiaries, including those in MA.

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Thank you for considering our comments. We look forward to working with OASH 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

Krista Drobac
Moving Health Home

[8] https://www.cms.gov/newsroom/fact-sheets/contract-year-2021-medicare-advantage-and-part-d-final-rule-cms-4190-f1-fact-sheet