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

October 31, 2022

Submitted electronically via email: macra.rfi@mail.house.gov

The Honorable Ami Bera
U.S. House of Representatives
172 Cannon House Office Building
Washington, D.C. 20515

The Honorable Larry Bucshon
U.S. House of Representatives
2313 Rayburn House Office Building
Washington, D.C. 20515

RE: Congressional Request for Feedback on Medicare Payment System

Dear Representatives Ami Bera, Larry Bucshon, Kim Schrier, Michael Burgess, Earl Blumenauer, Brad Wenstrup, Bradley Schneider, and Mariannette Miller-Meeks:

Thank you for the opportunity to submit feedback on actions Congress could take to stabilize the Medicare payment system and ensure the success of value-based care.

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 the belief that the experience during the pandemic has accelerated the day when care in the home is an option for patients.

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.

We fundamentally believe home is the future of care delivery, which has been revitalized by growth in value-based care and alternative payment models. When models of care make the provider accountable for the quality and total cost of care, we see more care delivered in the home and community because providers understand that it is the better site of care for the patient.

We share in your commitment to working toward a more affordable, sustainable, and patient-centered health care system. To reach that goal, Congress must invest in the drive toward home-based care coupled with the movement in the direction of value over volume. Unfortunately, our system is biased against home-based care, and Medicare physician payment keeps it that way. Our long-term goal is to dismantle that bias. In our response, we focus on opportunities to drive more value-based care to better enable in-home care and highlight misalignment in Medicare reimbursement for home-based services.

A Solution to Broader Adoption of Value-Based Care in Fee-for-Service; Drive Toward In-Home Care

Based on pandemic experience, 75 percent of clinicians polled in a March 2021 survey do not believe fee-for-service (FFS) should account for the majority of primary care payment. Depending on how they are categorized, primary care providers (PCPs) and other primary care clinicians provide more than 40 percent of all office visits. Primary care constitutes less than 10 percent of total spending, but has an important

influence on referrals for specialist care, emergency department use, and hospitalization. If redesigned correctly, delivery of effective primary care services should be an effective way of reducing spending.[1]

Capitated, value-based arrangements allow primary care providers to better care for their patients in the home without the constraints of FFS billing and documentation. This could include routine telemedicine visits and telephone check-ins; more nurse visits, group visits, and home visits; identification and care management of high-risk patients; and integration of mental health services.

One of the key barriers to increased use of home visits in Medicare FFS is that visit time is used as a key factor in setting FFS reimbursement. The time factored into the reimbursement amount is only an estimation of the time it takes for the actual visit; reimbursement amounts do not include the time it takes to drive to and from a patient's house, which often makes house calls cost-prohibitive for a primary care provider. If we shift toward capitation, it removes the constraint of visit time and travel associated with home visits in Medicare FFS.

We recommend that Congress direct the Secretary of the Department of Health and Human Services (HHS) to allow primary care providers enrolled in Medicare Part B to elect to receive a monthly capitated payment for Primary Care Qualified Evaluation and Management Services (PQEM) as an alternative to FFS reimbursement. This would allow primary care providers enrolled in Medicare Part B to elect to receive a monthly capitated payment as an alternative to FFS reimbursement to increase the feasibility of home-based models.

Addressing Reimbursement Issues for Home-Based Evaluation and Management Codes in FFS Medicare

As a health care system, we should be focused on value-based care as the future but we cannot forget about FFS. 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 Evaluation and Management (E/M) services around domiciliary visits and home visits, or what is often referred to as Home-Based Primary Care (HBPC).[2] 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.[3] 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.[4] That said, low reimbursement for HBPC services impact beneficiaries by reducing

[1]https://deepblue.lib.umich.edu/bitstream/handle/2027.42/167001/C19%20Series%2027%20National%20Executive%20Summary%20vF.pdf?sequence=1&isAllowed=y
[2] https://www.cms.gov/newsroom/fact-sheets/final-policy-payment-and-quality-provisions-changes-medicare-physician-fee-schedule-calendar-year-1
[3] https://www.healthaffairs.org/do/10.1377/hblog20210506.843768/full/
[4] https://innovation.cms.gov/files/reports/iah-fg-yr5eval.pdf

clinical outcomes and patient experience, all while increasing costs associated with higher rates of hospitalization and readmissions. Even worse, it could significantly reduce access to care and compound existing health disparities, which the COVID-19 pandemic has both highlighted and exacerbated.[5]

In the pursuit to address physician payment issues, we urge Congress to consider the important role of home-based primary care and appropriate reimbursement for these services. That may require needed reform to how CMS establishes the value and reimbursement rates for home-based E/M services, or elimination of the budget neutrality requirement to avoid devastating automatically triggered cuts in the future.

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

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