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

October 3, 2023

Submitted via email to: WMAccessRFI@mail.house.gov

Chairman Jason Smith
House Committee on Ways and Means
1139 Longworth House Office Building
Washington, DC 20515

RE: Stakeholder Input on Addressing Chronic Disparities in Access to Health Care in Rural and Underserved Communities

Dear Chairman Smith:

Thank you for the opportunity to submit input on addressing chronic disparities in access to health care in rural and underserved communities.

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 experience during the pandemic has accelerated the day when care in the home is an accessible 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. 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.

Patients in rural areas face unique challenges in accessing care and with 46 million Americans living in rural areas, these challenges are crucial to address.[1] Rural residents often face transportation difficulties and must travel long distances to reach a health care facility. They also tend to have a lower income per capita. Income in rural areas is $9,242 lower compared to the average per capita income in the United States.[2] These facts combined with cultural factors create a difficult reality. According to the Centers for Disease Control and Prevention (CDC), rural Americans are more likely to die from heart disease, cancer, unintentional injury, chronic lower respiratory disease, and stroke than their urban counterparts.[3] On the whole, rural Americans are typically older and in poorer health than urban Americans.[4]

MHH believes that broadened access to care in the home has the potential to improve access and outcomes for health care in rural areas. In recent years, we have seen the growth of a few tangible opportunities for increased care in the home. In particular, MHH supports H.R. 2853, The Expanding Care in the Home Act. Below, we provide recommendations that we believe should be taken into consideration

[1] https://www.cdc.gov/ruralhealth/about.html
[2] https://www.ruralhealth.us/about-nrha/about-rural-health-care
[3] https://www.cdc.gov/ruralhealth/about.html
[4] https://www.cdc.gov/ruralhealth/about.html

when developing legislative solutions to expanding and improving health care in rural and underserved areas.

Health Care Workforce

Recent projections from the Health Resources and Services Administration (HRSA) suggest that rural areas will be below adequacy for multiple provider types until 2023 or beyond.[5] Further, there are 65.3 registered nurses per 10,000 rural residents compared to 93.6 per 10,000 in rural areas.[6] To work toward ameliorating this access barrier, MHH recommends workforce investments as outlined in H.R. 2853.

Specifically, we recommend: 1) creating a nursing task force to develop standards for a home-based nursing board certification; and 2) forming a council to study the role of emergency medical service providers in the triage, treatment, and transfer of patients in the home.

1. **Establish Home-Based Nursing Task Force** – MHH recommends establishing a task force on developing standards for a home-based nursing board certification. The Task Force would develop and submit to the Secretary recommendations and strategies for HHS to:
    a. Identify key considerations and opportunities for a potential registered nurse board certification in home-based care;
    b. Develop the specifications and eligibility requirements that would need to be met for a nursing board certification in home-based care; and
    c. Outline the benefits and potential issues that would be associated with establishing a nursing board certification in home-based care.

2. **Expanding Emergency Medical Services Workforce Study** – MHH recommends establishing a council to study the impacts of expanding the role of emergency medical service (EMS) providers in the triage, treatment, and transfer of patients in both emergency and non-emergency encounters and associated impacts on the EMS workforce. The Council would prepare a study that:
    a. Details barriers to EMS providers to treating in-place;
    b. Outlines the benefits and other considerations associated with expanding the scope of services delivered by EMS providers;
    c. Examines the current EMS provider workforce's ability to expand their role in healthcare encounters;
    d. Evaluates best practices for nurse navigation programs that assist in triage and dispatch of appropriate level of EMS providers;
    e. Evaluates best practices for community paramedicine programs; and
    f. Assesses the impacts of the Expanding EMS Workforce Program on medically and socially underserved communities' access to care and emergency department utilization.

Innovative Models and Technology

In-Home Primary Care

[5] https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/hwsm-rural-urban-methodology.pdf
[6] https://www.ruralhealth.us/NRHA/media/Emerge_NRHA/Advocacy/Policy%20documents/NRHA-Toward-a-Sustainable-Rural-Health-Workforce-Policy-Brief-2022.pdf

Access to primary care providers (PCPs) in rural areas is significantly hampered. According to the National Rural Health Association, the patient-to-primary care physician ratio in rural areas of only 39.8 physicians per 100,000 people, compared to 53.3 physicians per 100,000 in urban areas.[7] MHH believes that expanding access to in-home primary care has the potential to increase rural access to routine medical visits. Specifically, MHH recommends creating capitated arrangements to allow primary care providers to better care for patients in the home without the constraints of fee-for-service (FFS) billing and documentation. These visits may happen via telemedicine or telephone check-ins with a physician, or nurse, group, and home visits. Identification and care management of high-risk patients and integration of mental health services may also be considered.

H.R. 2853 would direct the Health and Human Services Secretary to allow PCPs 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. MHH believes that this care model would increase access to primary care in rural areas, thereby increasing regular health checks and screenings that may help to address poor long-term health outcomes in rural areas.

Home Infusion

Home infusion services can be delivered in rural areas, and with increased access, would help to alleviate the travel burden that many rural patients experience. A recent study showed that 13.1 percent of patients receiving home infusion services lived in rural areas.[8] The study concluded that home infusion use is well-established in rural areas and may increase accessibility to infusion services for rural Americans.[9]

To continue expansion of access to home infusion, the Medicare reimbursement structure must be completed. MHH recommends establishing Medicare Part B coverage of services and supplies associated with the delivery of home infusion. Currently, Medicare Part D covers the cost of most home infused drugs, but excludes the services associated with the delivery of the drugs, including equipment, supplies, and administration. CMS has determined that it does not have the authority to cover infusion-relat4ed services, equipment, and supplies under Part D. As a result, rural Medicare beneficiaries may be forced to travel to a hospital or other facility to receive infusion services. H.R. 2853 would require Medicare Part B to cover the services and supplies associated with the delivery of home infusion, thereby making it more accessible for rural patients.

Home Dialysis

22 percent of those on dialysis live in a rural area and those who live over 100 miles from a dialysis center have higher mortality rates than those who live in closer proximity.[10] Home dialysis offers a potential solution for rural Americans living with end-stage renal disease (ESRD), as they could complete dialysis in the home rather than traveling long distances to receive dialysis multiple times per week. This may also alleviate caregiver burden for those who provide transportation for a loved one on dialysis.

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[7] https://www.ruralhealth.us/about-nrha/about-rural-health-care
[8] https://nhia.org/a-multi-center-study-of-home-infusion-services-in-rural-areas/#:~:text=variation%20among%20providers.-,Home%20infusion%20use%20in%20rural%20areas%20is%20well%2Destablished.,of%20proximity%20to%20urban%20centers.
[9] Ibid.
[10] https://www.kidneyfund.org/article/care-all-kidneys-act-aims-assist-people-dialysis-rural-areas

MHH recommends bolstering access to home dialysis by providing Medicare reimbursement for staff assistance for home dialysis treatment. H.R. 2853 includes the Improving Access to Home Dialysis Act provides a framework for this model. Specifically, the legislation:

1. Provides for reimbursement through Medicare for in-home assistance by staff of the dialysis facility to patients on home hemodialysis and peritoneal dialysis for the first 90 days of their regimen;
2. Provides for in-home respite staff assistance under certain circumstances outside the initial 90 days;
3. Provides for the possibility of continuous staff assistance without a time limit for patients with certain disabilities;
4. Expands the types of healthcare professionals who can provide home dialysis training;
5. Provides for additional educational opportunities for patients to learn about the entirety of their dialysis options, including opportunities that can be provided in group settings or via telehealth; and
6. Provides for training on home dialysis to occur, when possible, in the location the patient intends to use to dialyze.

In-Home Labs

In-home lab testing also can increase access for rural patients who may have limited capacity for travel to a health care facility. Currently, Medicare does not provide ad additional payment for the collection of labs from non-homebound patients or costs of postage and supplies to mail labs. These costs fall on providers or laboratories when services are offered to non-homebound patients. Still, patients in rural areas may benefit from access to in-home labs even though they may not be considered home-bound. MHH recommends policymakers should ensure receiving preventative and diagnostic labs is as easy as possible for patients in rural areas.

H.R. 2853 would establish reimbursement of an add-on payment to cover travel costs and mail costs associated with specimen collection of in-home lab tests for certain beneficiaries. MHH recommends that the eligibility for this add-on payment be more comprehensive than the homebound status and take things like barriers to accessing care in rural areas into consideration.

Advanced Diagnostic Imaging in the Home

MHH also recommends legislation to permit the delivery and reimbursement of ultrasound imaging in the home for certain beneficiaries and require the Secretary of the Department of Health and Human Services to conduct an evaluation of Medicare in-home reimbursable advanced diagnostic imaging.

Currently, there is a Portable X-Ray Benefit in Medicare Part B but it is limited in types of diagnostics reimbursable. However, the Benefit was last updated in 2007. Technologies and capabilities have evolved significantly since then. Now, mobile imaging can provide comprehensive X-Ray, EKG, and ultrasound services quickly, safely, and affordably in the home.

H.R. 2853 provides a model for increased access to advanced diagnostic imaging in the home; it would require HHS to conduct an evaluation of Medicare in-home reimbursable advanced diagnostic imaging. It would permit the delivery and reimbursement of ultrasound imaging in the home for certain beneficiaries, which is currently restricted. Further, the Secretary of HHS would determine the screening tool or utilization management that would trigger beneficiary eligibility.

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Conclusion

Health care workers and patients in rural areas will continue to face a number of access barriers until a conscious effort is made to provide tangible solutions. MHH applauds the effort that the Committee is making toward gaining a greater understanding of the barriers and potential solutions in rural areas. MHH and its members are committed to improving access to care in the home, including for those in rural areas who are facing exacerbated access barriers. We hope that the potential solutions outlined in our response will lead to improved care and ultimately, better long-term health outcomes for those in rural areas.

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Thank you for the opportunity to provide feedback on this important issue. Moving Health Home greatly appreciate the Committee on Ways and Means's commitment to examining legislative pathways forward to expand access to health care in rural and underserved communities. We hope we can be a resource to you as you move forward in this work, and look forward to working with you to develop legislation around this important effort. Please contact Elizabeth Simpson at esimpson@movinghealthhome.org with any questions.

Sincerely,

Krista Drobac
Executive Director
Moving Health Home