June 13, 2024

The Honorable Ron Wyden
Chair, Senate Finance Committee
United States Senate
Dirksen Senate Office Building
Washington, DC 20510

The Honorable Mike Crapo
Ranking Member, Senate Finance Committee
United States Senate
Dirksen Senate Office Building
Washington, DC 20510

Dear Chair Wyden and Ranking Member Crapo,

Thank you for the opportunity to provide comments on the Senate Finance Committee Request for Information on bolstering chronic care through physician payment. We appreciate your commitment for reforming the way physicians are paid by Medicare and meeting the needs of those with chronic illness.

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 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.

We share in your commitment to working toward advancing policy solutions to address challenges facing Medicare and its enrollees, from the prevalence of chronic diseases, to primary care payment policies. 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 outline a primary care at home capitated payment for individuals with chronic conditions as an alternative to fee-for-service reimbursement.**

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

More than two-thirds of Medicare beneficiaries 65 years or older have two or more chronic conditions, and more than 15 percent have six or more. Yet, this population faces several barriers to access care, including transportation barriers. Being the oldest, and sickest population, Medicare beneficiaries with chronic conditions spend an average of three weeks every year on health care outside their homes. Despite these factors, there is no billing structure for new care models, in particular for seniors that want to receive medically necessary services in their homes and age in place. With the advent of telehealth, shifting care to the home saved an estimated 204 years of travel time, $33,540,244 travel-related costs and 42.4 injuries and 0.7 fatalities.

In a March 2021 survey, 75 percent of clinicians 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.

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 or a home-based care entity 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.

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

Sincerely,

Krista Drobac
Executive Director
Moving Health Home