Primary Care at Home for Seniors with Chronic Disease

More than **two-thirds** of Medicare beneficiaries, or 21.4 million, have two or more chronic conditions, and more than 15 percent have six or more. The Centers for Medicare and Medicaid Services (CMS) found that as the number of chronic conditions increased, so did hospitalizations. Ninety-two percent of beneficiaries with six or more chronic conditions had a doctor visit during the year and almost half (46 percent) had 13 or more visits. Older adults spend an **average of three weeks every year** on health care outside their homes.

Allowing Medicare beneficiaries to receive care at home can reduce the barriers to accessing health care, including high costs, low health literacy, poor care coordination, a lack of social and psychological support, and transportation barriers.

What is Care in the Home?

Home-based care refers to a spectrum of health services provided in the home or place of dwelling, such as hospital-level or acute care, primary care, skilled nursing and therapy services, and hospice. Services may include routine physician visits, chronic disease management (such as remote patient monitoring), laboratory and diagnostic services (such as blood draws and x-rays), home infusion (such as antibiotics), wound care, physical or occupational therapy, in-home dialysis, and other care provided in the home setting rather than a facility, and regardless of age and health conditions. Although "home-based care" is traditionally associated with services provided by home health agencies, home health services are just a small slice of what could constitute "home-based care" services.

In-Home Primary Care would allow primary care providers enrolled in Medicare Part B to elect to receive a monthly capitated payment as an alternative to Medicare fee-for-service (FFS) reimbursement to increase the feasibility of home-based models.

- Capitation contracts would allow primary care providers to better care for their patients in the home without the constraints of FFS billing and documentation.
- For example, 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.
    - Additionally, it removes the constraint of visit time/travel associated with home visits in Medicare FFS.

We propose including legislative language that directs the Secretary 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.

Why does this matter? Care in the home can help address economic, social, and administrative barriers to care, increasing access to chronic care for Medicare beneficiaries.

About Us: Moving Health Home (MHH) is a coalition of health care organizations with a bold vision to make the home to be a clinical site of care. 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 more information, visit https://movinghealthhome.org/.