Statement for the Record:
"Modernizing American Health Care: Creating Healthy Options and Better Incentives"
U.S. House of Representatives
Ways and Means Committee
Health Subcommittee

Moving Health Home
1100 G Street NW, Suite 420, Washington, DC 20005

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Moving Health Home (MHH) appreciates the opportunity to submit testimony for this hearing on examining ways to promote healthy living with more options, greater flexibility, and better incentives for patients. 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 population-based model payment for individuals with chronic conditions as an alternative to fee-for-service reimbursement.**

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

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.

Primary care is essential in chronic disease management. Primary care providers are stewards of providing coordinated and comprehensive care. Allowing Medicare beneficiaries with chronic disease to receive primary care at home can reduce the barriers to accessing health care such as transportation. Many of

the services that primary care providers offer their patients for chronic conditions do not require a physical examination, such as routine follow up visits, management of medications and lab work, and counseling and educational services.

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.

We believe a primary care at home model focused on seniors with chronic conditions will provide flexibility for primary care providers to create individualized care to meet patient needs. The model would allow Medicare-enrolled primary care providers to elect to receive a monthly population-based payment in lieu of Medicare fee-for-service (FFS) reimbursement to care for complex Medicare beneficiaries in their homes. 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.

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 a population-based model, it removes the constraint of visit time and travel associated with home visits in Medicare FFS.

We recommend that the Committee to pursue legislation that would 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 population-based model 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 population-based model 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 House Ways and Means 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,

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Executive Director
Moving Health Home