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

May 12, 2025

Mr. Russell Vought
Director
Office of Management and Budget
Executive Office of the President
725 17th Street NW
Washington, DC 20503

Re: Comments on Request for Information on Deregulation

Dear Director Vought,

Care at home achieves so many of the health care priorities of this Administration. Caring for someone outside of an institutional setting promotes cost savings, patient empowerment, better chronic disease management, more effective post-acute rehabilitation, fewer infections, better mental health, less stress for caregivers, and more low-cost capacity in the system. However, there are so many regulatory and statutory barriers. While we work on Capitol Hill to address the legal barriers, there is so much the Trump Administration can do to pave the way for more seniors to receive care at home.

Moving Health Home ("MHH") is a coalition of health care organizations with a bold vision to make the home a site of clinical services. 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. Importantly, we believe that care in the home contributes to patient choice by giving patients the option to receive care on their own terms. Providers will be guests in the homes of patients with the institutional aspects of the health care 'system' taken away, which promotes trust and communication.

Below, we have identified rules and regulations that, if rescinded, would align Medicare reimbursement for expanded home-based services. We believe that removing these barriers will enable innovative, clinical models of care centered around the home.

Eliminating Regulations that are Biased Toward Facility-Centric Care

The United States lags behind comparable countries in options for patients to receive care at home. Research confirms that home-based models are at least as safe as facility-based care and result in improved clinical outcomes, higher rates of patient satisfaction, and reduced health care costs.

Patients have indicated that they want to receive care at home, with the demand for services provided in the safety of a patient's home soaring during the pandemic. According to a recent survey, 85 percent of adults say it should be a high priority for the federal government to expand Medicare coverage for care at home health care. At the same time, an overwhelming majority of people who have received care in the home were satisfied (88 percent) and would be likely to recommend to family and friends (85 percent).

We believe seniors should have the opportunity to choose the best site of care for their medical needs and preference, whether that be in the home or the facility.

Going back to institutional norms will waste the experience generated by the current care at home innovations, which flourished under the first Trump Administration. We believe deregulating facility-centric regulations would enable innovative care models that focus on patient and caregiver choice and allows for technology-enabled care tools like telehealth, remote patient monitoring, home infusion, home labs, home diagnostics, and primary care at home.

MHH requests OMB consider removing the following regulations, which would enable innovative care models centered around patient-choice to receive care at home.

- Removing visit time as a key factor in setting FFS reimbursement;
- Remove incident-to limitations for home visits, which prevented auxiliary personnel from performing "incident to" post-discharge and/or care management home visit services to non-homebound aligned beneficiaries under the general supervision (42 CFR § 410.26)
- Permanently strike the following conditions of participation to enable permanent hospital at home programs:
    - 24-hour nursing requirement (42 CFR § 482.23)
    - Hospital physical environment (42 CFR § 482.41)
    - Life Safety Codes (42 CFR § 482.41(b))

Examples of How Innovative Care Models Flourished when Restrictive Regulations Are Removed

Home-based health care spans an array of medical services delivered to a patient in their homes, including caregiving and personal care services, wellness and safety assessments, assistance with activities of daily living, medication management, care coordination, management of chronic conditions, skilled nursing or therapy services, home-based primary care, hospital-at-home, transition care, and hospice care.

The level of services provided depends on a patient's acuity; some patients may only need informal caregiving from family members or personal caregivers. Others who are post-discharge or with acute needs may require skilled home care or therapy from nurses or physical therapists. Patients with chronic conditions who choose to remain in their homes may benefit from more regular medical care often provided through team-based care using physicians, nurse practitioners and physician assistants alongside social service providers.

Hospital at Home

As you know, the Centers for Medicare and Medicaid Services (CMS) established the Acute Hospital Care at Home (Hospital at Home) program, which provided hospitals with unprecedented regulatory flexibilities to treat eligible patients in their homes. Using waiver authorities under section 1135 of the Act, CMS initially launched the broader "Hospital Without Walls" initiative in March 2020. Building on the initiative, CMS expanded the Hospital Without Walls initiative and suspended the requirements for nursing services to be provided on premises 24 hours a day, 7 days a week, and for a registered nurse to be immediately available, respectively. Additionally, CMS waived hospital physical environment and "Life Safety Code" requirements for delivering care in the patients' home. Hospitals providing care in patients' homes continued to meet all health and safety requirements that were not waived through the public health emergency waiver authority under section 1135 of the Act.

Research overwhelmingly demonstrates that Hospital at Home programs are at least as safe as traditional in-patient care, improve clinical outcomes and patient satisfaction, and reduce the total cost of care. One research article found that the total cost of hospital at home was 32 percent less than traditional hospital care ($5,081 vs. $7,480), the mean length of stay for patients was shorter by one-third (3.2 days vs. 4.9 days), and the incidence of delirium (among other complications) was dramatically lower (9 percent vs. 24 percent). Another study found similar findings.

CMS also released initial findings from its congressionally mandated report on the Hospital at Home waiver and found, for Medicare patients, the median length of stay obtained from claims was 5 days. Another study found that early analysis of the waiver suggests rapid uptake, with the potential for significant capacity creation, but a slower uptake over time. This highlights the need for additional resources to launch this care model to address these barriers.

Currently, the hospital at home waiver program is dependent on temporary waivers, which is a bridge to enable care in the home to continue for a time-limited period post-pandemic, but does not fully leverage the promise of home-based care. The program continues to rely on fee-for-service payment, while our goal would be to integrate a value-based mechanism into the program. Hospital at Home programs have realized savings of 30 percent or more per admission, while maintaining equivalent or better outcomes. **We request permanently removing these regulatory burdens that limit a full Hospital at Home program.**

In addition to the permanently waiving the requirements for a Hospital at Home model, **MHH urges OMB to consider utilizing artificial intelligence to streamline the waiver request process.** CMS currently has to manually approve each hospital and health care system for participation in the waiver program. We believe this manual process can delay hospitals and health care systems from starting their hospital at home model, deterring participation in the model.

Skilled Nursing Facility at Home

Hospital overcrowding, patient and caregiver choice and the need for increased capacity for post-acute care make at home care an urgent need. Tens of thousands of patients are unnecessarily stuck in the hospital because there are not enough beds in skilled nursing facilities (SNFs) or home health providers in their area, thereby creating back-ups among patients in the ER waiting for admission.

SNFs commonly provide rehabilitative care for older adults recovering from hospitalization and at a level higher than what can typically be delivered with home health. A SNF-at-Home program would allow patients to access these services from the home using a mix of skilled care, personal care, and telehealth services. SNF-at-home provides opportunities for payers, health systems, and providers to lower costs, facility-associated infections, promote patient compliance, free up capacity in facilities, and address practitioner burnout. SNF-at-Home may not be a fit for every patient, but it is an important option for patients and providers to have.

An integrated SNF-at-home program can bring services directly to the patient, allowing them to recover in a familiar environment. A preliminary study found that patients using SNF at Home programs saw savings through shorter length of stay and decreased likelihood of rehospitalizations post 30-day discharge.

As we have learned from the Hospital at Home program, care at home is possible to take excellent care of patients with serious illness in the home. Burdensome regulations that propel bias towards institutional care prevent innovative models, like SNF at Home, to grow.

Primary Care at Home Model for Seniors with Chronic Conditions

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.

Home-based primary care (HBPC) services is an imperative alternative to facility-based care for many older adults. 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. We know from countless studies that HBPC services, and care at home more generally, improve health outcomes while reducing costs. 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. The populations benefiting from HBPC services include patients living in rural areas where innovation is desperately needed to improve mortality and functional stabilization as well as reduce symptom burden.

Primary care is essential in chronic disease management. Primary care providers are stewards of providing coordinated and comprehensive care. In a 2021 survey, 75 percent of clinicians did 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.

A monthly population-based payment in lieu of Medicare FFS reimbursement would allow primary care providers to better care for their patients in the home without the constraints of FFS billing and documentation. A population-based model would allow primary care providers to better care for their patients in the home without the constraints of FFS billing, documentation, and enable the home to be a clinical site of care, allowing 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 as older adults spend an average of three weeks every year on health care outside their homes.

Visit time/travel is one of the key barriers to increased use of home visits in Medicare FFS. 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.

Supporting Caregivers through Caregiver Training Services

In the CY 2024 PFS final rule, CMS finalized payment for caregiver training services (CTS), which allow treating practitioners to report the training furnished to a caregiver, in tandem with the diagnostic and

treatment services furnished directly to the patient, in strategies and specific activities to assist the patient in carrying out the treatment plan. Additionally, in CY 2025 PFS final rule, CMS added caregiver training services codes to the Medicare Telehealth Services List.

Caregivers play an irreplaceable role in a patient's treatment process and ability to recover in the home. Without a caregiver, many patients are not able to recover in the home, prolonging care in medical facilities, and resulting in high costs. With the ability to reimburse training for caregivers services and supports, reduced readmissions after discharge and care transition are possible. Our members have heard from caregivers that providing training to reduce UTIs and bedsores were critical after a loved one underwent surgery.

Several studies indicate the feasibility of delivering caregiver education remotely. In particular, one study found that 89% of caregivers reported high satisfaction using a remote caregiver education program. Caregivers completed an average of 8 hours of learning over a 30-day training, with a majority of participants reporting using at least one skill learned from the online platform.

While MHH supported these proposals, the limitation of certain providers that are permitted to provide caregiving training services via telehealth is burdensome. MHH believes expanding types of providers permitted to provide caregiver training services via telehealth can reduce barriers to accessing these services. Several providers work to ensure caregivers of Medicare beneficiaries feel confident and well supported to provide the care necessary to their loved ones. Ensuring these providers are able to bill caregiver training services via telehealth will increase communication between patient and provider and enhance care coordination and efficiency.

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Thank you for considering our comments. We look forward to working with OMB, and related agencies, and welcome the opportunity to provide further feedback. 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

Krista Drobac
Executive Director
Moving Health Home