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

September 4, 2025

Terry Mills and Soujanya Pulluru
Co-Chairs
Physician-Focused Payment Model Technical Advisory Committee (PTAC)
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Re: Using Data and Health Information Technology to Transparently Empower Consumers and Support Providers

Dear Dr. Mills, Dr. Pulluru, and Members of the Committee:

Moving Health Home ("MHH") welcomes the opportunity to provide comments on the PTAC's *Using Data and Health Information Technology to Transparently Empower Consumers and Support Providers Request for Information*. 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. As the Committee considers models that empower consumers and support providers, we urge you to consider care in the 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. 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.

In advance of our detailed comments, Moving Health Home would like to emphasize the following overarching priorities:

- **MHH urges the Committee to consider models that move away from regulations biased toward facility-centric care.** We believe that care in the home can only continue to grow if the Centers for Medicare and Medicaid Services (CMS) guidance provides opportunities for innovation in non-facility care settings. We urge the Committee to work with CMS shifting from facility-centric regulations to 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 urges the Committee to establish an in-home primary care reimbursement model.** We strongly recommend the Committee to work with CMS on allowing primary care providers to elect to receive a monthly population-based payment as an alternative to Medicare fee-for-service (FFS) reimbursement. Primary care is essential to whole person coordinated and comprehensive care.

Allowing Medicare beneficiaries with chronic disease to receive primary care at home offers enormous benefits that will improve outcomes.

- **MHH believes that in-home primary care incorporates many technology-enabled tools to empower patients to take charge of their chronic condition management.** Home-based primary care gives patients the resources to engage in shared decision-making with their providers, enabling them to manage their health on their terms.

The United States lags behind comparable countries in options for patients to receive care at home. Research shows that home-based models result in improved clinical outcomes, higher rates of patient satisfaction, and reduced health care costs. Current regulations are biased toward facility-centric care, inhibiting the growth of care at home innovations. We believe shifting from facility-centric regulations enables 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.

Care in the home can address economic, social, and administrative barriers to care, empowering patients to take charge of their health on their own terms. Primary care is essential for chronic disease management, and delivering these services outside of a traditional care setting can improve access for the beneficiaries who need it most. In-home primary care serves as an alternative to facility-based care for Medicare beneficiaries who are typically home-limited due to multiple chronic illnesses, frailty, and disability. Primary care at home can improve health outcomes while reducing costs of care. The CMS Innovation Center's Independence at Home Demonstration program found that home-based primary care led to reductions in hospital admissions and emergency department visits.

While the evidence is clear that in-home primary care is safe and cost-saving, there is no billing structure for the new at-home care model. An in-home primary care model would allow primary care providers to elect to receive a monthly population-based payment as an alternative to Medicare FFS reimbursement to increase the feasibility of home-based models. This payment model aligns with primary care providers' exiting roles as stewards of providing coordinated and comprehensive care. A 2021 survey revealed that 75 percent of clinicians did not believe that FFS reimbursement should account for a majority of primary care payment. Providers should feel that they are being reimbursed fairly for delivering care in the right manner at the right time in the right setting.

A monthly population-based payment would enable the home to be a clinical site of care, allowing primary care providers to better care for their patients in their setting of choice. Primary care at home empowers patients to confidently manage their chronic conditions through an evidence-based, high-quality, cost-saving care delivery method. MHH continues to encourage the Committee to work with CMS to adopt a population-based payment model for in-home primary care, designed to improve patients' ability to confidently manage chronic conditions in the comfort of their homes.

Home-based primary care shifts the power dynamic in the patient-provider relationship. By removing care from the doctor's office and into a setting in which the patient is most comfortable, the patient can feel like they are receiving care on their terms. Empowering patients to engage with clinicians on level ground can allow patients to take more accountability for their health management and enter more authentically into shared decision-making processes.

In-home primary care services give patients the resources to engage with their health care in a transparent manner. For example, remote patient monitoring (RPM) is a digital tool often used in in-home care. RPM, as defined by CMS, involves the collection and analysis of patient physiologic data that are used to develop

and manage a treatment plan related to a chronic and/or acute health illness or condition. By transmitting physiologic data from a patient's home to a care team in near real time, RPM gives clinicians the actionable insights they need to intervene early, adjust treatment plans promptly, and prevent avoidable hospitalizations.

RPM changes how patients interact with their health care information by allowing patients to see their chronic condition progression. This level of transparency, rarely found in facility-based care, empowers patients to work with their providers to manage their chronic conditions in an individualized manner without traveling to the doctor's office.

MHH appreciates the Committee's support of our shared goal of empowering patients to manage their chronic conditions using digital health tools. 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