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

Statement for the Record:
"Modernizing Care Coordination to Prevent and Treat Chronic Disease"

U.S. House of Representatives
Ways and Means Committee
Health Subcommittee

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

November 19, 2025

Moving Health Home (MHH) appreciates the opportunity to submit testimony for this hearing on protecting vulnerable patients and preventing chronic disease by improving care coordination and delivery between health care professionals. MHH is a coalition of health care organizations with a bold vision to make the home a site of clinical service. Our members share 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 services, 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 with home-based care.

Care in the home is one of the most powerful drivers of effective coordination of chronic disease because it brings the clinical team into the patient's daily reality: where chronic conditions are managed day to day. Additionally, home-based models, enabled by telehealth and remote monitoring, create frequent touchpoints and real-time visibility into changes in health status, allowing care teams to coordinate proactively rather than react after a crisis. This creates communication and coordination between primary care providers, specialists, nurses, care managers, and caregivers. Care coordination for seniors with chronic conditions is transformed under home-based care models.

We share your commitment to working toward advancing policy solutions to address chronic care coordination and management challenges facing Medicare and its enrollees. To reach this 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, which would coordinate services across the care team and meet patients where they are.**

Urgent Action is Needed

While we deeply appreciate congressional action to extend Medicare telehealth provisions and the acute hospital care at home (AHCAH) waiver through January 30, 2026, **we urge the Committee to focus on a long-term extension through the markup of the *Hospital Inpatient Services Modernization Act (H.R. 4313)*.** The Centers for Medicare and Medicaid Services' (CMS) 2024 report to Congress found that

patients in Acute Hospital Care at Home (AHCAH) programs had lower mortality rates, fewer hospital readmissions, and more positive patient and provider experiences. Typical conditions treated in AHCAH programs included conditions that overlap with chronic disease. Hospital-at-home care resulted in lower average length-of-stay and decreased utilization of unnecessary services, in one study leading to 19 percent lower costs compared to similar inpatients. Multiple studies have found that care in the home leads to thousands of dollars in cost savings while enhancing and shortening the care experience.

Moving Health Home led over 140 leading health care organizations, including hospitals, health systems, and provider and patient advocacy groups, to send a letter to Congress urging leadership to pass at least a 5-year extension of the AHCAH waiver. By doing so, this Committee would give current and future programs the predictability and stability they need to continue to expand capacity and lead innovation in health care delivery. The AHCAH waiver extension will bring chronic care to patients, caregivers, and families who rely on high-quality health services at home in both urban and rural communities.

Home-based care, such as AHCAH, brings together the full clinical team in a way that no traditional setting can, creating stronger coordination and better outcomes for people with chronic and complex needs. By caring for patients in their home environment, clinicians gain immediate insight into real-world factors that shape a patient's health.

A Solution to Strengthen Care Coordination 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.

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. Additionally, delivering primary care in the home strengthens care coordination by connecting and communicating across the care team, preventing the fragmentation in chronic care management that we see today.

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. Having primary care at home creates additional touchpoints in between crisis episodes, facilitating proactive interventions before chronic

conditions worsen. These regular interactions help coordinate complex treatment plans, ensure adherence, and align all providers around shared goals for the patient.

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, enabling a team-based coordination necessary for complex chronic disease management.

We recommend that the Committee 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,

Krista Drobac

Krista Drobac
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Moving Health Home