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Leveraging Policy Reforms to Scale Home-Based Primary Care

Tuesday, May 30th, 2023 | 1:00-3:00 PM ET

Workshop Briefing Materials

Key Takeaways

- There is significant interest and momentum in home-based primary care (HBPC), which can help ensure that millions of older adults and people with complex health and social needs who struggle to access care in traditional settings have access to Age-Friendly Health Systems.
- Recent policy developments will impact the HBPC landscape, including the ending of the public health emergency, potential forthcoming primary care models from the Center for Medicare & Medicaid Innovation, and legislative interest in home-based care more broadly.
- Additional reforms can help expand access to HBPC, such as moving away from fee-for-service payment models that are ill-suited to support HBPC services. However, expanding HBPC will require addressing the unique considerations of the community. For instance, delivering HBPC in rural settings may require a distinct care delivery model given the acute infrastructure and workforce challenges.
- As demand for HBPC continues to grow, policymakers should ensure payment models are capable of supporting HBPC and integrating home-based care modalities into comprehensive, longitudinal care models.

Changing Policy Environment for Home-Based Primary Care

Over the past few decades, there has been a substantial shift to move care to the home, particularly for older adults and people with complex health and social needs who face difficulties seeking care in traditional brick-and-mortar settings. The COVID-19 pandemic accelerated this shift, with policymakers, payers, and providers rapidly pivoting to support care outside of clinical and institutional settings. As the public health emergency (PHE) comes to an end, there is uncertainty regarding pandemic-related regulatory flexibilities that have been crucial for supporting the growth of home-based care. At the same time, there is continued momentum to support and scale home-based care, including: increased market activity and acquisitions of home-care providers; executive action from President Biden to support the long-term care workforce and unpaid caregivers; and proposed legislation that would change Medicare benefits to support home-based services and allow home-based primary care (HBPC) providers under Medicare Part B to be reimbursed through monthly capitated payments.

Despite these tailwinds, challenges remain to scaling HBPC. For example, the predominant fee-for-service (FFS) payment model does not adequately support HBPC providers, as providers operating under FFS are often undercompensated for travel time, not reimbursed for many home-based services, and face additional administrative burdens from billing and coding practices. There is a need to engage HBPC providers in payment models that reward value and can reimburse the interdisciplinary teams and services required to support primary care in home settings.

During the May 30th workshop, we plan to discuss the changing policy landscape for HBPC and opportunities to leverage payment and policy reforms to scale HBPC. We intend for the conversation to serve as strategic guidance to inform where further policy research is needed to scale HBPC and advance Age-Friendly Health Systems.

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Key Challenges to Scaling Home-Based Primary Care

Through previous work and conversations with experts in preparation for the May 30th workshop, we identified key implementation challenges facing HBPC. These challenges include:

- **Fragmentation** - There are a variety of siloed home-based care modalities supported by a variety of payers and regulatory pathways, which has resulted in a complex and uncoordinated care environment. For example, home- and community-based services (HCBS) are provided through Medicaid, home-based palliative care is offered as a Medicare Advantage supplemental benefit, and home health is a Medicare benefit.
- **Payment Models -** Volume-based payment environments, such as FFS payments, are not supportive of HBPC. For example, FFS payments do not adequately reimburse for travel time to conduct home visits or interdisciplinary care. Value-based payment (VBP) models can provide flexibilities for providers to allocate resources as needed to support HBPC services, but require technical capabilities and infrastructure that smaller providers may lack.
- **Workforce shortages** - Widespread workforce shortages, including primary care, home health, and HCBS providers, that hamstring HBPC delivery given the interdisciplinary nature of supporting people in home settings. Further, there are challenges facing the existing direct care workforce (e.g., inadequate pay, limited training and supports, and a lack of career advancement opportunities) contributing to high turnover.
- **Regulatory barriers** – Examples of regulatory barriers to delivering HBPC include restrictions around where care can be delivered, scope of practice limitations, and telehealth reimbursement constraints. Many of these restrictions were waived during the PHE, which enhanced access for older adults and populations with complex health needs who struggle to access care in traditional settings. However, only some of these flexibilities have been permanently authorized and many were temporarily extended through 2024.
- **Standards for quality** - There are no universal quality standards for HBPC and existing measures often do not account for care delivered in the home setting. For example, half of the quality measures from the Centers for Medicare and Medicaid Services' (CMS) Merit-Based Incentive Payment System that are potentially appropriate for HBPC are unusable by home-based medical care providers.

Payment Models Supporting Home-Based Primary Care

VBP models are a pathway to address some of the challenges, providing flexibility for providers to deliver clinically appropriate care and rewarding quality. CMS leads a variety of VBP models that may support HBPC for older adults and populations with complex health and social needs (highlighted in the table below). There are additional opportunities to adapt these models to enhance access to HBPC within comprehensive, longitudinal care models.

Table 1. VBP Models Supporting Home-Based Primary Care

Model	Description
Independence at Home	Upside risk model that supports home-based primary care and chronically-ill Medicare beneficiaries tailored to the beneficiary's needs. Participating entities must be provider or nurse practitioner-led and serve patient panels of at least 200.

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ACO Realizing Equity, Access, and Community Health (REACH) – High Needs Population	Advanced risk-based model for Medicare beneficiaries with complex medical needs. The High Needs Population option (one of three participant options under ACO REACH) allows for smaller patient panels – with a glidepath from 250 to 1,400 required patients by PY 2026 – than the Standard track which requires a panel of 5,000.
Medicare Shared Savings Program (MSSP)	Applies to general Medicare population, but some ACOs have been providing home-based primary care. For performance year 2024, CMS will allow new entrant ACOs Advanced Incentive Payments to invest in infrastructure needed to engage in MSSP. MSSP participants must serve at least 5,000 patients.
Primary Care First (PCF)	Risk-based model to deliver primary care for people living with serious illness who lack a primary care provider and care coordination. PCF is not specifically a home-based care model, but allows providers to deliver care in home settings. PCF practices must have experience with risk bearing and can serve panels of 125 patients.

Tailoring Home-Based Primary Care to Address the Unique Needs of Rural Communities

The unmet need for HBPC is exacerbated in rural areas given the unique challenges these regions face. Rural adults are 78 percent less likely than those in the largest metropolitan counties to receive home-based medical care. Moreover, rural adults tend to have higher rates of chronic disease, are more likely to have a disability, and have greater unmet mobility needs. The unique challenges facing HBPC in rural settings that contribute to the gap in care for rural populations include (but are not limited to):

- Heightened workforce shortages, with rural primary care providers retiring at a higher rate than positions are being filled;
- Greater distances between patients, which is challenging for providers operating under volume-based payment environments; and
- Rural providers relying on multiple funding sources, including grant dollars, to remain operational.

Through conversations with a diverse group of rural stakeholders, we have heard the need for a broader care delivery model with modified touchpoints to better meet the needs of rural populations given the operating constraints. These include:

- Virtual care supports for remote patient monitoring given geographical challenges reaching patients;
- Leveraging community-based resources and infrastructure, such as physicians bringing mobile clinics to community hubs; and
- Building a non-physician workforce within a community to facilitate care (e.g., community health workers).

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Identifying Priority Policy Areas to Scale Home-Based Primary Care

There are opportunities to leverage payment and policy reforms to scale HBPC and advance Age-Friendly Health Systems. Below are a variety of opportunities that could help support scaling HBPC broadly as well as opportunities to support HBPC specifically in rural settings. During the workshop, we will appreciate your feedback on which of these opportunities are priority areas for scaling HBPC and whether there are particular areas not included. We will use your feedback to guide our research over the next year around identifying supportive policy reforms to support HBPC.

Building capacity and laying the foundation to support home-based primary care.

- Engaging HBPC stakeholders, as well as providers across the continuum of care, to secure buy-in for HBPC.
- Investing in the direct care workforce (e.g., enhanced reimbursements, training opportunities, and career advancement opportunities) supporting home-based care.
- Partnering with local colleges/vocational schools to develop a workforce tailored to the needs of a community, such as community health workers and paramedics.
- Developing and requiring competency/training requirements for home-based care providers.
- Supporting caregivers (e.g., increased respite care, caregiver trainings and support groups) and ensuring they are not burdened by additional responsibilities.
- Investing in the infrastructure needed to meet patients where they are and provide timely and high-quality care (e.g., broadband, remote patient monitoring, data sharing platforms).

Adapting payment models to enhance home-based primary care provider participation in integrated, longitudinal accountable care models.

- Providing flexibility to HBPC providers serving patient panels that do not meet the size requirement to engage in CMS-led models.
- Supporting small independent provider groups and providers without experience in accountable arrangements through glidepaths to bearing risk or third-party entities to aggregate risk.
- Allowing for upfront infrastructure investments to build HBPC providers' operating capacity, such as the MSSP Advanced Incentive Payment option that provides upfront shared savings.
- Adjusting payments to account for higher acuity patients served at home and their varying level of need during condition exacerbations throughout a performance year.

Designing policies to enhance access to home-based primary care services.

- Authorizing the permanent use of virtual care service with guardrails for appropriate use.
- Amending scope of practice policies to allow providers to practice at the top of their license and meet the needs of beneficiaries.

Defining and identifying populations who require home-based primary care.

- Developing eligibility criteria for HBPC models that capture homebound and home-limited populations.

Improving data quality for home-based primary care.

- Conducting an analysis of HBPC, including what services are rendered, how many beneficiaries are served, and gaps in access.
- Incorporating performance measures in models that capture care delivered in home settings, account for varying changes in patient acuity, and outcomes that matter to beneficiaries.

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Reducing the administrative burden for home-based primary care providers.

- Integrating home-based care modalities into a comprehensive, longitudinal model to reduce fragmentation and increase a seamless care experience.
- Addressing prior authorization barriers resulting in administrative burden for providers and delayed care for patients, such as requiring plans to provide rationale for denials.
- Streamline and coordinate grant application processes for which rural providers (e.g., Rural Health Clinics) must navigate to remain operational.

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