Duke | MARGOLIS CENTER *for* Health Policy

Virtual Workshop: Leveraging Policy Reforms to Scale Home-Based Primary Care

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

Key Takeaways

This document highlights key takeaways from the discussion during the workshop we hosted on May 30.

The current policy environment presents opportunities to scale home-based primary care (HBPC) and supportive modalities. Expanding HBPC fits into the Biden Administration's efforts to strengthen health equity and address the disparities homebound and home-limited populations face in accessing care. Alongside these efforts, the renewed focus on advancing accountable care models could provide flexibilities for providers to deliver HBPC services by tailoring care to address patient goals and needs (such as the forthcoming dementia and primary care models led by The Centers for Medicare & Medicaid Services).

Policies must address the unique considerations of populations that could benefit from HBPC. Participants noted that existing population-based payment models – like Accountable Care Organizations – could be modified to better account for older adults with complex health and social needs and homebound populations. Risk adjustment methods, for instance, may not accurately capture patient complexity and there is no widespread consensus on criteria to best define and identify eligible HBPC beneficiaries. Further, policymakers are often unaware of the nuances of home-based care modalities and the unique needs of the populations they serve, underscoring the importance of spreading awareness of the evidence behind HBPC models.

There are also opportunities to leverage best practices and lessons learned from the public health emergency (PHE). Regulatory flexibilities introduced during the PHE expanded the ability of health systems to provide remote care and enabled providers to practice at the top of their license. However, it will be challenging to sustain these flexibilities amidst a tightening fiscal environment.

Total cost of care models like Medicare Advantage could support a coordinated and comprehensive care experience, but additional attention is needed to ensure growth in Medicare Advantage supports high-quality HBPC. MA can support continuity in care as patients transition across different modalities and as their functional needs change. However, MA growth in rural areas remains uneven, creating disparities in access and calls into question the scalability of total cost of care models for HBPC in particular geographies. Further, publicly-available data on the use of home-based care services by MA enrollees is limited, which impedes research on the uptake of supplemental benefits and the quality of care furnished within MA.

HBPC faces unique challenges in rural settings. While many of the challenges in rural areas mirror those that health systems face across the country, they often are felt more acutely or are more pronounced in rural areas (e.g., workforce shortages, longer windshield time between patients). Additionally, adequately capturing patient needs in rural areas can be challenging given limited resources. For example, HCC scores for rural adults are lower than their urban counterparts, which contradicts evidence that rural adults have higher rates of chronic conditions and unmet social needs. These challenges have implications for rural engagement in accountable care arrangements. For instance, addressing unmet needs in rural communities could be expensive in the short term, making it harder to achieve savings or justify ROI from a business perspective. Participants also noted that these issues apply to providers serving homebound populations in urban areas, highlighting the importance of accurately evaluating providers supporting HBPC.

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As a result of these unique challenges, HBPC care delivery models may look differently in rural areas. These include:

- Creative workforce arrangements (e.g., leveraging community health workers retraining for positions like medical assistants);
- Slimmer care teams with just a nurse or single provider rather than large interdisciplinary care teams (though participants noted the risks for perpetuating inequities in care absent safeguards for quality and competency);
- More partnerships and collaboration with community organizations and home health companies to facilitate frequent touchpoints with patients;
- Reliance on existing infrastructure to bring care closer to patients (e.g., community paramedicine); and
- A multi-payer approach that uses Medicaid, Medicare, and Health Resources and Services Administration (HRSA) funding.

Overall, there is a need for balancing general policies that support HBPC and the homebound population as a whole with policies that also allow flexibility to tailor care to particular community needs (e.g., rural populations). The Duke-Margolis Center will continue to explore policies to scale HBPC and will share our fundings throughout the project.

Please reach out to Jonathan Gonzalez-Smith or Montgomery Smith with any questions or additional comments. We appreciate your engagement and welcome feedback.