February 9, 2024

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1770-P
P.O. Box 8016
Baltimore, MD 21244

Re: O/O E/M Visit Complexity Add-On Code (G-2211)

Dear Administrator Brooks-LaSure:

We write to express strong support for the inclusion of home-based primary care (HBPC) clinicians in billing the office/outpatient (O/O) E/M visit complexity add-on code (G-2211) for the Calendar Year (CY) 2025 Medicare Physician Fee Schedule (MPFS). While the undersigned organizations are appreciative of the addition and implementation of the complexity add-on code, we believe it is imperative to allow G-2211 to be applied to home visit codes (i.e., 99341-99342, 99344-99345, and 99347-99350) to ensure HBPC clinicians can sustainably continue delivering high-quality, patient-centered care to the most complex Medicare beneficiaries.

Our Population and the Value of HBPC

The HBPC population includes the 2 million older adults who are homebound, as well as the additional 5 million who have difficulty leaving their home without help.[1] The homebound population has more than doubled in the past decade, with many identifying as racial and ethnic minorities.[2] Many suffer from multiple chronic health conditions, which may be compounded by psychiatric or cognitive disorders, functional impairments, and disabilities.[3] In fact, the homebound population has twice as many chronic conditions as those who are homebound, and is significantly more likely to be depressed, have possible or probable dementia, and be hospitalized.[4] This population is 2.5 times more likely to be dependent in one or more activities of daily living.[5]

A key competency of the HBPC practice is the use of interdisciplinary teams, which include primary care physicians, geriatricians, nurse practitioners (NPs), and physician assistants (PAs). HBPC provides comprehensive care directly in the home setting which reduces the necessity for remote consultations, reduces the burden on the healthcare system, and contributes to patient and caregiver satisfaction. An analysis of a Veterans Affairs' home-based primary care program found that patients had high satisfaction with their care.[6] Hospitalizations were 25.5% lower than expected, and fewer exacerbations and emergency department visits were reported. An analysis of Geisinger's home care program noted a 35% drop in emergency department visits, a 40% decline in hospital admissions, and an average annual reduction in spending per patient of almost $8,000.[7] Additionally, Medicare's Independence at Home demonstration

[1] K. A. Ornstein, B. Leff, K. E. Covinsky et al., "Epidemiology of the Homebound Population in the United States," *JAMA Internal Medicine*, July 2015 175(7):1180–86.
[2] https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2783103
[3] https://effectivehealthcare.ahrq.gov/products/home-based-care/research-protocol
[4] https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2296016
[5] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7251502/
[6] https://agsjournals.onlinelibrary.wiley.com/doi/abs/10.1111/jgs.13030
[7] https://hbr.org/2019/11/geisingers-home-care-program-is-cutting-costs-and-improving-outcomes#comment-section

generated over $209 million savings over an eight-year period and reduced expenditures for Medicare beneficiaries by 21.3% per year.

It is evident that this unique and vulnerable population represents some of the sickest and most medically complex patients. Further, a substantial portion of patients who meet the criteria for the complexity code are precisely those who require home care services. The undersigned organizations highlight that by not allowing G-2211 to be applied to home visit codes, CMS is overlooking the needs of this challenging and complex population. While we appreciate CMS's commitment to supporting medically complex and unique patients, it is imperative to recognize the value of home care in payment structures to best support these patients in a sustainable manner for years to come.

Evaluation of E/M Services

As you may be aware, in 2021 the American Medical Association (AMA) Relative Value Scale Update Committee (RUC) conducted a revaluation of home visit codes and shared recommendations with CMS on resource inputs for work and practice expense valuations. However, within this revaluation, the RUC did not properly consider all the practice expenses that HBPC clinicians must consider when operating their practice. HBPC clinicians typically spend longer time during face-to-face encounters to appropriately address all the patients' and caregivers' needs. This includes working with patients to coordinate throughout the entire care continuum with necessary short and long-term social supports and assessing safety, nutrition, and medication adherence. Additionally, the survey itself was very complex and respondents had difficult experiences filling it out accurately to reflect how much work goes into home visits. As a result, the AMA RUC received data that falsely informed their recommendation to decrease the RVUs for most home visit codes.

Furthermore, an internal analysis from the Home Centered Care Institute (HCCI) found that if G-2211 were allowed to be applied to home visit codes, there would be a marginal impact on the conversion factor. HCCI estimates on average there are 6.3 million HBPC visits per year and 80% of these billings are eligible for the modifier. This would add around $69 million (i.e., 6,329,867 visits x 85% eligible = 5,380,387 eligible visits for the payment x $16.05 Medicare allowable = $86,355,211 allowable. Medicare pays 80% of allowable = $86,355,211 x .8 = $69M) in payments or 14.5% of the E&M payments to HBPC, which would have an insignificant impact on the conversion factor.

Conclusion

The undersigned organizations thank you for your ongoing leadership to improve our nation's health care system to ensure the highest quality health for all Americans. We look forward to working collaboratively with the Agency to advance policies supporting comprehensive care in the home setting. If you have any questions regarding this letter, please contact Megan Cohen at megan@aahcm.org.

Sincerely,

American Academy of Home Care Medicine

American Academy of Family Physicians

American College of Physicians