



January 29, 2016

The Honorable Orrin Hatch
Chairman, Finance Committee
U.S. Senate
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member, Finance Committee
U.S. Senate
Washington, DC 20510

The Honorable Johnny Isakson
Co-chairman, Chronic Care
Working Group
Finance Committee
U.S. Senate
Washington, DC 20510

The Honorable Mark Warner
Co-chairman, Chronic Care
Working Group
Finance Committee
U.S. Senate
Washington, DC 20510

Re: Senate Finance Committee Bipartisan Chronic Care Working Group
Policy Options Document

Dear Chairman Hatch, Ranking Member Wyden, Senator Isakson and Senator Warner:

I am writing on behalf of the Alliance for Home Health Quality and Innovation (the "Alliance") in response to the request for comments on the Senate Finance Committee's Bipartisan Chronic Care Working Group's policy options document. Thank you for the opportunity to provide comments.

About the Alliance for Home Health Quality and Innovation

The Alliance is a non-profit 501(c)(3) organization with the mission to lead and support research and education on the value of home health care to patients and the U.S. health care system. Working with researchers, key experts and thought leaders, and providers across the spectrum of care, we strive to foster solutions that will improve health care in America. The Alliance is a membership-based organization comprised of not-for-profit and proprietary home health care providers and other organizations dedicated to improving patient care and the nation's healthcare system. For more information about our organization, please visit: <http://ahhqi.org/>.

We appreciate the opportunity to provide comments and offer recommendations and considerations on: (1) the role of home health care in caring for patients with chronic conditions; (2) expansion of the Independence at Home (IAH) demonstration project; (3) waiver of Homebound Status in Accountable Care Organizations and Bundled Payment Models and Initiatives; (4) adapting benefits to meet the needs of chronically ill Medicare Advantage enrollees; (5) reforms to support use of telehealth in ACOs and

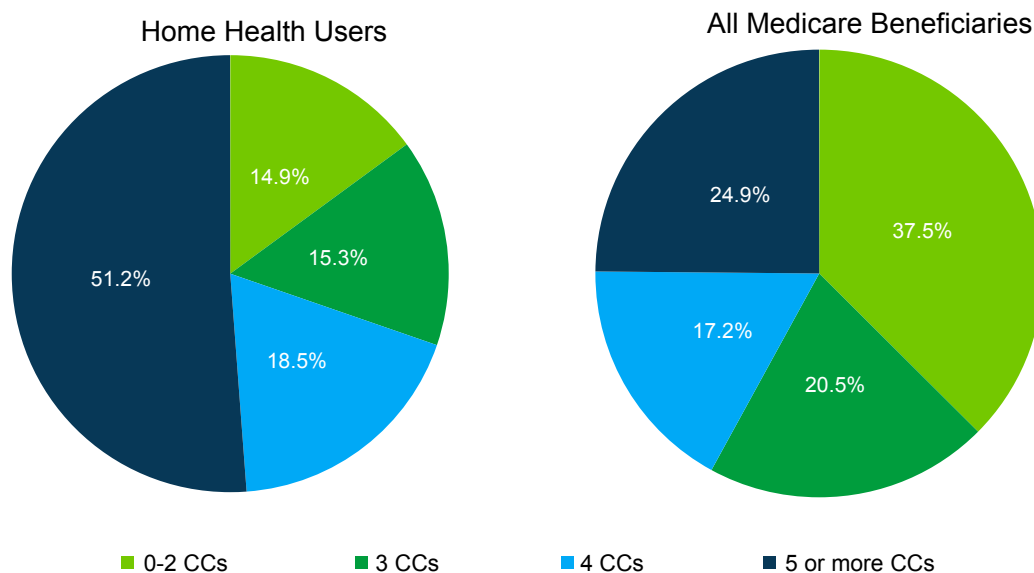
Medicare Advantage; (6) developing quality measures for chronic conditions; (7) expanding access to digital coaching; (8) increasing transparency at the Center for Medicare and Medicaid Innovation.

I. The role of home health care in caring for patients with chronic conditions

Medicare-certified home health agencies play a key role as specialists in providing in-home skilled nursing and therapy services to homebound patients who: (1) have had a prior hospitalization and are recovering from acute illnesses or conditions; and/or (2) need community-based care management to address their chronic conditions.

In relation to caring for patients with chronic conditions, home health agencies serve a disproportionate share of Medicare beneficiaries with multiple chronic conditions as compared with the general Medicare population. Among home health users, 85% have three or more chronic conditions, compared with only 62.6% in the general Medicare population. Moreover, the proportion of home health beneficiaries with five or more chronic conditions is twice as large as the proportion in the general Medicare population. Among home health users, 51.2% have five or more chronic conditions, whereas 24.9% of the general Medicare population have five or more chronic conditions.

Chart 1.6: Percentage of All Medicare Beneficiaries and Home Health Users by Number of Chronic Conditions (CCs), 2013



Source: Avalere analysis of the Medicare Current Beneficiary Survey, Access to Care file, 2013. Totals may not sum to 100 percent due to rounding.

Home health agencies are unique as the only Medicare-certified providers who are specifically certified to provide *skilled care* to beneficiaries *at home* for acute, chronic,

or rehabilitative conditions. Using *interdisciplinary clinical teams* of health professionals (including nurses, physical therapists, occupational therapists, speech language pathologists, medical social workers, and home health aides), they deliver the following aspects of skilled care to patients—

- Medical treatment in the home, including chronic disease management;
- Care to improve or stabilize the patient’s functional status;
- Care coordination services and management of care transitions (especially from hospital to home);
- Management of behavioral health conditions;
- Care that enables avoidance of unnecessary hospitalizations and rehospitalizations; and
- Support to patients and their family members to connect to community resources to enable and support independence.

In delivering this care, home health providers leverage technology to enable the provision of care at home. In varying degrees, home health providers use a diverse array of technologies from remote monitoring, to phone calls (including the growing array of mobile technologies and applications), to health information technology, to in-home therapeutic and diagnostic technologies. Such technologies are often key tools that enable home health providers to improve quality and reduce the cost of care delivered to patients.

Moreover, home health agencies are well positioned to facilitate population health management in the community because they deliver care pursuant to the orders of the patient’s own physician. Having a plan for patient care that is reviewed by the patient’s own primary care physician is key to providing coordinated, accountable care for the patient in the community.¹ Home health professionals often serve as extensions of the patient-centered medical home, able to observe and affect patient behavior in the home and ultimately improve health outcomes.

The Alliance supports the furtherance of alternative models of health care delivery and payment that are seeking to achieve the Triple Aim of improved population health, improved patient experience, and lower per capital cost of care. Many of the models being tested by the Center for Medicare and Medicaid Services (CMS) in the Center for Medicare and Medicaid Innovation (CMMI), such as accountable care organizations, independence at home demonstration sites, and bundled payment arrangements, are focused on improving care for patients with chronic conditions. These alternative payment models are finding value in leveraging home health and home-based care to achieve the Triple Aim and achieve shared savings. Although evaluation and analysis of these programs is ongoing by CMS, the Alliance has sought to better understand these programs. In that vein, the Alliance sponsored an Institute of Medicine and National Research Council workshop on the Future of Home Health Care on September 30-October 1, 2015 (“IOM Workshop”). The IOM-NRC workshop summary is now

available and can be found at: <https://www.iom.edu/Reports/2015/Future-Home-Health-Care.aspx>

The IOM workshop featured a panel on new models of health care delivery that are leveraging home health and home-based care.¹ These models included accountable care organizations, bundled payment arrangements, advanced illness management programs, home-based primary care, efforts by Medicare Advantage plans, and other programs to better manage the health of those with chronic and disabling conditions. Surfaced during this panel were the following elements that these programs have in common:

- Focus on caring for the sickest and most costly patients (who typically have multiple chronic conditions, multiple activity of daily living limitations and poly-pharmacy);
- Developed home health partnerships and programs involving primary care, palliative & end-of-life care;
- Use of care coordination, care transitions and care management approaches and programs, which focus on post-acute care and preventive maintenance and stabilization of chronic conditions;
- An interdisciplinary team approach to care as a critical component of successful program, with key roles for both nursing and therapy, and a growing role for home health aides;
- Optimized use of telehealth and remote monitoring to engage patients and increase efficiency; and
- Person-centered, not just patient-centered, care is the goal and family caregivers are seen as critical members of the interdisciplinary team.

Although these models are new and the evaluations are early, many are showing evidence of effectiveness in improving quality of care and reducing per capita cost of care through reduced hospitalizations & rehospitalization, ED visits, days in ICUs, total cost of care.

Home health and community-based providers are proving to be key players in these alternative payment and health care delivery models, in which there is growing interest in shifting care away from unnecessary institutional care and towards sites of care that are home and community-based. In this context, home health providers are well-

¹ Institute of Medicine (IOM) and National Research Council (NRC), 2015. *The future of home health care: Workshop summary*. Washington, DC. National Academies Press, Section 6 (pp. 55-74), and Section 9 (p. 97).

positioned and trained to coordinate care for those with chronic conditions in the place where these patients prefer to receive care: the home and community.

II. Expansion of Independence at Home (IAH) demonstration project

The Alliance supports expansion of the Independence at Home model of care so that it becomes a permanent nationwide program. At the vast majority of sites in the IAH demonstration, the effectiveness of the model has been borne out in looking at the first performance year, both in terms of cost savings and performance against quality measures for patients served by the home-based primary care teams in the IAH demonstration project.

The Alliance supports continued use of the existing criteria for identifying complex chronic care beneficiaries for inclusion in IAH and believes that use of HCC scores is premature. The current IAH inclusion criteria has been shown select the 6% of Medicare beneficiaries that account for 30% of Medicare Parts A and B spending, 23% of all deaths in traditional Medicare, 24% of all hospitalizations in traditional Medicare, and 45% of all thirty-day readmissions. Although HCC scoring has often been useful in other settings (in payment rate setting for Medicare Advantage and special needs plans), the Alliance is concerned about the limitations of using HCC scores for eligibility. HCC scores are not truly meant to be used for clinical use and the scores fluctuate. There are also timing issues with the availability of data. The advantage of using the existing IAH inclusion criteria is that it enables real time, prospective physician validation of a beneficiary's condition, rather than relying on retrospective scoring. Moreover, HCC scores are dependent on coding and subject to potential inaccuracies; given the transition from ICD-9 to ICD-10 that began on October 1, 2015, coding accuracy may be a significant issue.

If, however, HCC scores are to be used, the Alliance recommends that such data be augmented with data on functional status. Such data may become more available as CMS implements the IMPACT Act. Information on social supports and overall socioeconomic status may also be instructive regarding whether a beneficiary might be appropriate for inclusion in IAH. The Alliance recommends that there be an ability to test and evaluate the usefulness and effectiveness of any new IAH inclusion criteria before using this methodology for an expanded, nationwide IAH program.

In relation to the Independence at Home (IAH) demonstration, waiving the homebound requirement for home health services provided to IAH program beneficiaries would facilitate improved opportunities for collaboration between home health agencies and home-based primary care practices that would improve patient care. The model that served as the primary inspiration for the IAH demonstration project was the Veterans Affairs (VA) home-based primary care (HBPC) program. In that program, the VA does not require patients to be homebound, but rather takes the

approach that if routine clinic-based care is not effective then the patient would qualify for VA HBPC.² The VA HBPC program has been successful at improving patient outcomes and lowering overall cost of care. A 2002 analysis found that the 11,334 veterans in HBPC had a 62 percent reduction in hospital bed days of care, 88 percent reduction in nursing home bed days of care, and an increase in home care visits by 264 percent. The mean total VA cost of care dropped 24 percent from \$38,000 to \$29,000 per patient per year.³ To the extent that IAH can shift care toward approaches that replicate the VA home-based primary care model, one would anticipate that there would likely be similar success in movement towards the Triple Aim of improved patient experience, improved population health and lower per capita cost of care.

In IAH, the home-based primary care practice is directly supervising and overseeing resource use in the context of the model and working closely with a team of health care professionals and providers, including home health agencies. Given this oversight and supervision, and the payment and quality performance incentives that drive IAH sites towards overall cost savings for Medicare and improved patient outcomes, the utilization concerns that are the rationale for the homebound requirement should not apply. The IAH demonstration thus far has not yet included a waiver of homebound status, but such a waiver would enable appropriate and beneficial use of home health care within IAH programs. As with other types of alternative payment models that also incentivize cost savings and performance against quality measures (such as ACOs and bundled payment arrangements), waiver of the homebound requirement would be an appropriate means of ensuring appropriate access to home health care for the patients who need it.

Finally, the Alliance recommends that in the context of IAH, the face-to-face encounter requirement for home health care be applied and implemented with a least burdensome approach. The documentation requirements today are overly burdensome given that the crux of IAH is that patients are being seen by physicians in their homes. The Alliance urges the adoption of modifications to the face-to-face requirement in the context of IAH that would alleviate the administrative burden associated with compliance and free up valuable time that could otherwise be spent on improving care for the chronically ill.

III. Waiver of Homebound Status in Accountable Care Organizations (ACOs) and Bundled Payment Models and Initiatives

In addition to the various proposed reforms in the policy options document, the Alliance urges recognition of the issues associated with the homebound requirement in the Medicare home health benefit, and the barrier it presents for alternative payment

² It is important to note, however, that there is no homebound requirement for a Medicare beneficiary to receive a house call.

³ J. Beales & T. Edes, "Veteran's Affairs Home Based Primary Care", *Clin Geriatr Med* 25 (2009) 149.

models such as ACOs and the various bundled payment programs (specifically the bundled payments for care improvement initiative or “BPCI” and the comprehensive care for joint replacement model of “CJR”). There are Medicare beneficiaries who are not homebound that would benefit from home health care’s ability to provide support that can reduce the risk of hospitalization and support the ability to care for patients with chronic conditions. Selectively waiving the homebound requirement for home health care in programs that are subject to bundled payments, shared savings or other cost and quality related targets can facilitate and support better care for patients with chronic conditions.

As is the case for IAH, within ACOs in the Medicare Shared Savings Program, sites in the bundled payment for care improvement initiative (BPCI), and hospitals receiving bundled payments in the context of the comprehensive care for joint replacement (CJR) model, allowing patients to receive home health care, even if they are not homebound, will support reduction in overall health system cost and improvements in patient care quality. As stated above, there is substantial evidence that home-based care independent of requiring the patient to be homebound has already been proven to be cost-effective (see *supra*, Section II regarding the VA home-based primary care program). In the context of an ACO or other bundled payment arrangement, requiring that the patient’s health deteriorate to the point that he or she is homebound before eligibility for home health services is allowed, hinders the ability to optimally manage the care of patients with chronic conditions.

In addition, in the context of post-acute care, home health can be used as a cost effective site of service where it is clinically appropriate for the patient to receive care at home. Within Medicare today, for patients discharged for the same condition, there is considerable overlap in the sites of service that a given patient may receive care post-discharge. For example, for MS-DRG 470 (major joint replacement without major complications or comorbidities), Medicare patients often go to home health agencies, skilled nursing facilities, and inpatient rehabilitation facilities. To the extent that it is clinically appropriate to send such patients to home health care for post-acute care, analysis of Medicare claims shows that there would be considerable savings in Medicare expenditures. By placing patients in the most clinically appropriate and cost effective settings, the Medicare program could save \$34.7 billion over ten years.⁴

Most importantly, ACOs in *all tracks* of the Shared Savings Program, and sites in the BPCI and CJR model are incentivized to closely monitor resources and achieve specific quality objectives. As is the case with IAH, in the context of ACOs, BPCI and CJR, the concerns about overuse of home health care should not apply because of the strong, overarching incentive to achieve savings within each alternative payment model.

⁴ A. Dobson et al., “Clinically Appropriate and Cost-Effective Placement: Improving Health Care Quality and Efficiency,” www.ahhqi.org, October 2012.

Waiver of the homebound requirement should be considered a means to support better chronic condition management in alternative payment models.

The Alliance recommends waiving the homebound requirement in the context of ACOs in all tracks, as well as in the various bundled payment initiatives and models, including BPCI and the CJR model.

IV. Adapting benefits to meet the needs of chronically ill Medicare Advantage enrollees

Medicare Advantage (MA) plans have been growing in terms of enrollment of Medicare beneficiaries and CMS has signaled that the growth in MA is expected to continue. Although there are many innovative programs that Medicare Advantage plans are pursuing to support chronic condition management, the Alliance is concerned that MA plans place severe limits on home health care services that hinders a home health agency's ability to provide needed care for beneficiaries.

In the context of home health care, MA plans tend to limit the number of visits that home health agencies are able to provide to beneficiaries and MA plans pay home health agencies based on a per visit rate, rather than an episode basis. Such payment and utilization management practices are concerning because they may have a negative impact on home health providers' ability to deliver care comprehensively for the patient.

As policy-makers consider how best to care for Medicare beneficiaries with chronic conditions, the Alliance urges the Senate Finance Committee to make the data on MA plan encounters, utilization and patient outcomes available and transparent. Without the ability to analyze the use of services and items for Medicare beneficiaries in MA plans, and the impact of that care on beneficiaries, it is impossible to assess whether MA plans are the appropriate means of enabling the Triple Aim. Before making changes and investments in MA plans as a pathway to health reform are made, policy-makers and health care stakeholders should have access to such MA plan data. The Alliance urges the Senate Finance Committee to make transparency in MA plan data, and analysis of that data, a priority before policies are pursued to expand the scope and use of MA.

V. Reforms to support use of telehealth in ACOs and Medicare Advantage

The use of telehealth holds great potential to support efforts to improve chronic condition management and the Alliance supports reforms both in the ACO and MA plan context to support use of telehealth. Numerous forms of telehealth have shown promise. Telemonitoring has been used with some frequency by home health agencies to improve patient engagement and support self-management. Moreover, there is

increasing use of various forms of telehealth to support patients in between in-person home visits.

Current law relating to telehealth presents barriers to caring for patients with chronic conditions at home. The Alliance recommends waiving certain Medicare telehealth requirements, including a waiver of the originating site requirements (relating to geographic site and specified types of settings). This change would enable the originating site to be the home or a home health agency. Enabling both the home and the home health agency to be originating sites would significantly improve the use of telehealth for patients with chronic conditions in the Medicare program.

The Alliance also recommends that remote patient monitoring be included in the definition of a telehealth service. Home health agencies are one of the few types of health care providers within the traditional Medicare program that have begun to make good use of telehealth in its delivery of care. The use of telehealth, particularly through remote monitoring, by some home health agencies has taken place because it is a useful tool that home health professionals use to improve patient engagement in self-care and self-management of various conditions as an adjunct to in-person home visits.

Nevertheless, because investing in remote monitoring technology can be costly, there are many home health agencies that have not invested in telehealth and remote monitoring technologies. Still others have limited use of this technology to a small sub-population of patients, even though a larger population of patients would also benefit.

The Alliance recommends that as part of the waiver of the originating site requirements, payment policy should recognize remote monitoring services that are furnished by home health agencies to patients that need this service. Because there is already expertise that some home health agencies have with remote monitoring, such a change would enable alternative models to build on those competencies where remote monitoring is being used. In those agencies where remote monitoring is not yet used or is used in a very limited fashion, enabling payment for remote monitoring by home health agencies for telehealth in the context of alternative models would facilitate approaches to telehealth that are synergistic with the home health providers' efforts to coordinate care in the home.

VI. Developing quality measures for chronic conditions

The Alliance supports efforts to improve quality of care for patients with chronic conditions and the use of appropriate performance measures to facilitate such efforts. In relation to chronic conditions, the Alliance supports the use of quality measures in the topic areas specified in the policy options document.

Notwithstanding, the Alliance is concerned about the considerable number of quality measures already in existence and use. Home health agencies in particular have a large

number of quality measures. For the home health value based purchasing model that CMS has begun to implement as of January 1, 2016, CMS is using 24 measures to assess performance. CMS is also in the process of developing additional measures for home health care as it implements the IMPACT Act, and considers further home health-specific measure domains for the future. For providers, quality improvement against such a large number and array of measures is a daunting and difficult task. The ideal is a streamlined set of measures that is prioritized with an emphasis on outcomes measures. As new, prioritized measures are added, CMS should consider whether other measures may be retired (e.g., because they have topped out or are otherwise address aspects of care that might be addressed by new or other measures).

The Alliance is supportive of quality measurement and improvement, but strongly urges and recommends that the Medicare program use a streamlined and prioritized measure set. The Alliance urges the Senate Finance Committee to develop policy approaches that will emphasize the need for parsimony in use of measures.

VII. Expanding access to digital coaching

The Alliance supports the proposal to have CMS post on its website information and resources as a means to provide objective information for patients with chronic conditions to use. Information that can support patient self-management would be helpful.

However, it is important to note that changing patient and caregiver behavior, and enabling patient self-management, requires more than only digital and online resources. More often than not, changes in patient behavior are challenging to achieve, whether related to diet, medication use, exercise or other dimensions that affect health care outcomes. Home health agency professionals play a significant role as coaches to Medicare beneficiaries. Although online resources (such as videos) are often instructive, a home health nurse in the patient's home – who is able to look at the food consumed or the medications and how they are taken – is able to effect change in a way that online resources alone cannot.

VIII. Increasing transparency at the Center for Medicare and Medicaid Innovation.

The Alliance supports the proposal to increase transparency regarding the models that CMMI is testing. In models that are mandatory for providers to participate, the Alliance recommends that CMS be required to use notice and comment regulation, consistent with the Administrative Procedure Act.

Where participation is voluntary, however, a sub-regulatory process to permit thirty days of public comment on the specifications of such models would be appropriate, as long as CMS develops an appropriate means of widely publicizing where and when such specifications are available for public comment.

* * *

The Alliance greatly appreciates the opportunity to comment. Should you have any questions about the Alliance's comments, please contact me at (703) 863-2382 or tlee@ahhqi.org.

Sincerely,



Teresa L. Lee, JD, MPH
Executive Director

ⁱ By contrast, SNFs, IRFs and LTCHs each develop care plans for their patients, but it is the SNF, IRF or LTCH physician that develops the plan of care with the facility staff, not the patient's primary care physician.