June 22, 2015

The Honorable Orrin Hatch
Chairman
Committee on Finance
United States Senate
Washington, D.C. 20510

The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate
Washington, D.C. 20510

The Honorable Johnny Isakson
United States Senate
Washington, D.C. 20510

The Honorable Mark Warner
United States Senate
Washington, D.C. 20510

RE: Alliance Comments on Chronic Condition Management

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 issued by the bipartisan Senate Finance Committee Chronic Care Working Group. 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) support for alternative models of health care delivery and payment; (2) the need to advance health information technology; (3) the need to advance telehealth; (4) reforming current benefit structure and payment policy to support chronic condition management.

I. Support for Alternative Models of Health Care Delivery

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. Many of these arrangements 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 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 population health management 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 are poly-pharmacy);
- Developed home health partnerships and programs involving primary care, palliative and end-of-life care;
- Use of care coordination, care transitions and care management approaches and programs, which focus on post-acute care, but more importantly preventive maintenance and stabilization of chronic conditions;
- An interdisciplinary team approach to care as a critical component of successful programs, with key roles for both nursing and therapy, and a growing role for home health aides;

[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).

- Optimized use of telehealth and remote monitoring to engage patients and increase efficiency; and
- Use of a person-centered, not just patient-centered, care as the goal and family caregivers are seen as critical members of the interdisciplinary team.

Although these models are new and under evaluation, many are showing evidence of effectiveness in improving quality of care and reducing per capita cost of care through reduced hospitalizations and rehospitalizations, emergency department visits, days in intensive care units, and total cost of care.

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

Health information technology is critical to enabling an environment where care coordination is enabled for patients with chronic conditions. Without health information readily available to health care professionals seeking to help such patients, care will continue to be fragmented and inefficient.

Unfortunately, post-acute care providers, including home health agencies, were not included in the meaningful use program's incentive payments for adoption of health information technology. Despite the absence of meaningful use incentives, many home health providers have been making investments in health information technology to improve health care delivery in terms of quality, efficiency and coordination of care. Even for those providers who have made these investments however, most of the hospitals and physicians that care for the same patients as home health agencies have not been able to exchange health information electronically with home health agencies.

The most important step towards achieving health information exchange would be to have hospital and physician electronic health records that are interoperable with those of long-term and post-acute care providers. Considerable work has already been done in identifying key, standardized data elements for longitudinal care coordination and transitions of care through the Massachusetts IMPACT project, the Office of the National Coordinator for Health Information Technology (ONC), and the HHS Assistant Secretary for Planning and Evaluation.

Given the emphasis on alternative models of payment and health care delivery, the Alliance recommends requiring such models and programs that are being tested to adopt HIT systems that are interoperable with post-acute care provider systems, consistent with the standard data elements that are being developed. Although such a

requirement would be a significant change, it could be staged to enable implementation over an appropriate period of time.

III. Telehealth

The use of telehealth holds great potential to support efforts to improve chronic condition management. 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 a 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.

The Alliance would welcome the opportunity to work with policy-makers to develop approaches to billing and payment for telehealth services that enable home health professionals to contribute fully towards achievement of the Triple Aim of improved patient experience, improved population health and reduced per capita cost of care.

IV. Reforming Benefit Structure and Payment

In the context of alternative models of payment and health care delivery, there is increasing recognition of the role of home and community-based providers in supporting care for patients with chronic conditions to support the Triple Aim. However, the current Medicare benefit structure limits the ability to support those patients.

Homebound Requirement. As recently recognized as an issue CMS's proposed rule on the Medicare shared savings program, there are patients who are not homebound that would benefit from home health care's ability to provide support that can reduce the risk of hospitalization. By enabling alternative models to allow such patients to receive home health care, even if they are not homebound, overall health system cost can be reduced and patient care quality will improve. Appropriate use of home health care is associated with improved chronic condition management that can support avoidance of hospitalizations.

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.[2]

The Alliance supports waiver of the homebound requirement in the context of the alternative models of health care delivery. In these arrangements that are being currently tested and evaluated by CMS, one could require specific explanations of the organizations' plans related to use of home health care for those who are not homebound and closely evaluate the impact on the Medicare program and patients over time to determine the effectiveness of the approach.

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[2] A. Dobson et al., "Clinically Appropriate and Cost-Effective Placement: Improving Health Care Quality and Efficiency," www.ahhqi.org, October 2012.

As policy-makers consider an approach to waiver of the homebound requirement, the Alliance urges consideration CMS demonstration projects, programs and initiatives that may be waiving the homebound requirement. For example, in the Bundled Payments for Care Improvement Initiative (BPCI), some participants are waiving the homebound requirement. The perspective and experience from BPCI and other CMS demonstrations, projects, and programs may be instructive as policy-makers seek approaches to leverage the value of home health care in efforts to improve patient care and avoid unnecessary hospitalizations.

In relation to Medicare physician home visits and the Independence at Home (IAH) demonstration, waiving the homebound requirement would facilitate improved opportunities for collaboration between home health agencies and physician house call 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.[3] 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.[4] To the extent that various alternative models can shift toward approaches that replicate this 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. The IAH demonstration thus far has not yet included a waiver of homebound status. As with other types of alternative models, waiver of the homebound requirement would be an appropriate means of ensuring access to home health care for the patients who need it.

Face-to-Face Encounter Requirement. The Alliance also urges policy-makers to consider waiver of the face-to-face requirement in the context of alternative models of payment and health care delivery. Although well intentioned as a means to encourage appropriate physician interaction with home health patients and to improve program integrity, the face-to-face requirement instead has been highly burdensome to the point of hindering access to home health services. The face-to-face requirement has been the subject of much discussion, including in the Medicare home health prospective payment regulations over the last few years. The requirement continues to be one that both CMS and providers struggle to address. Most recently, CMS released a

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

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

draft template for use in documenting the face-to-face encounter and it is already the subject of concern about the burden it may present.

Moreover, there is an inherent challenge to obtaining a face-to-face encounter with a physician for patients who need home health care. Patients who use Medicare home health care by definition are homebound and therefore it is a considerable and taxing effort to go to a doctor's office. Although there are physicians who make house calls (or home visits), the vast majority of physicians who treat Medicare beneficiaries are office-based only. Even if the homebound requirement is waived, there will still be patients who are homebound, and for whom going to a doctor's office will be a barrier to accessing needed home health care services.

Given the value of home health care in preventing unnecessary hospitalizations, the Alliance recommends improving access by waiving the face-to-face encounter requirement in the context of alternative models of payment and health care delivery. The Alliance would welcome the opportunity to discuss further with policy-makers the details of how one would implement such a waiver.

Intermittent Care Requirement. In addition, currently a Medicare beneficiary must need skilled *intermittent* nursing or therapy services to qualify for the Medicare home health benefit. The Medicare policy manual states that "intermittent" skilled nursing care means: "skilled nursing care that is either provided or needed on fewer than 7 days each week or less than 8 hours of each day for periods of 21 days or less (with extensions in exceptional circumstances when the need for additional care is finite and predictable)."[5] This definition and the related guidance in the Medicare policy manual sets parameters that limit the ability of home health care to serve as an appropriate, efficient means of delivering care. At present, where the nursing care provided does not fit within this definition of "intermittent," patients would be forced to receive care from a skilled nursing facility, which is a more expensive site of service, or may even have to pay out of pocket for private duty services. Without this limitation, home health care could provide services that could be daily care, or simply care that is delivered in a fashion that is not as rigid and finite as the current law and guidance requires. Because there is an increasing emphasis on accountability for total Medicare spending, waiver of this requirement would be an appropriate means of enhancing the ability to achieve the Triple Aim.

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The Alliance greatly appreciates the opportunity to comment. Should you have any questions about the Alliance's comments, please contact me at (202) 239-3671 or tlee@ahhqi.org.

[5] Medicare benefit policy manual, Chapter 7-Home Health Services, 40.1.3
http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c07.pdf

Sincerely,

Teresa L. Lee, JD, MPH
Executive Director