HOMECARE & HOSPICE
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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

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

Thank you for the opportunity to provide feedback as you weigh options for improving care for Medicare patients with chronic conditions. We applaud the Committee for creating a chronic care working group seeking recommendations from health care stakeholders based on real world experience and data-driven evidence that will improve care for this vulnerable population. With chronic disease now accounting for almost 93 percent of Medicare spending, we agree that the impact of chronic disease on the Medicare program and those it serves is staggering and must be addressed with better chronic disease management.

As you know, the National Association for Home Care & Hospice (NAHC) has been the leading association representing the interests of the home care and hospice community since 1982. Our members are providers of all sizes and types from the small, rural home health agencies to the large national companies, including government-based providers, nonprofit voluntary home health agencies and hospices, privately-owned companies and public corporations. They have been enthusiastically participating in demonstrations that test new models of payment and chronic care management, as well as investing in new technologies to improve care transitions and enhance care coordination with physicians. They have also been working with hospitals to reduce readmissions and funding research to analyze Medicare claims data to help find opportunities for improving efficiency and lowering costs.

Our past experience and the evidence from new promising models reinforces our belief that a system that shifts chronically ill patients from inpatient services and institutional care to home and community-based settings provides the best chance at extending the fiscal viability of the Medicare program while providing high-quality, clinically appropriate services for those with chronic illness. In addition to exploring new ways to improve care for patients moving from acute settings, our members are helping keep people with chronic disease out of the hospital. Chronic

disease is a major driver of health care costs currently and in the future. Without the critical services that home health agencies provide, more hospitalizations of patients with chronic disease would be necessary.

Therefore, at the outset, we would emphasize that home health services should be viewed as much more than a post-acute service. Today, nearly a half of all Medicare beneficiaries using home health services do not have a prior hospitalization. Home health services are much broader than just a service for post-acute care needs. Instead, it is an alternative to inpatient care in many situations, a primary care service that manages the care of individuals in their community settings, and a means of addressing chronic care needs clinically and economically and an end-of-life care service. Home health services offer a high quality, low cost effective means to meet these beneficiaries' health care needs while bringing dynamic value to the Medicare program as a whole. NAHC respectfully recommends that the Committee maintain a broad and appropriate view of the great value that home health services bring in the reforms needed to improve services to those with chronic conditions.

In addition, NAHC suggests that the Committee integrate hospice care into its analysis as well. End-of-life care for individuals with chronic illnesses is growing in importance every year as more and more beneficiaries face death from these illnesses rather than an acute illness episode. Hospice care provides a highly valuable option for care that should be part of any beneficiary's considerations in dealing with chronic illness. The Committee should take all steps appropriate to include hospice care into its review. Patients with serious, life threatening and/or advanced chronic illness should be provided the maximum opportunity to engage in the decision-making process relative to care options. The most comprehensive approach to addressing this would be through enactment of the Care Planning Act of 2015 (S. 1549).

We have put forth proposals that encompass home care as a way to reduce emergency room visits and initial inpatient care and readmissions by managing patients with chronic disease. Also, our proposals address ongoing care to individuals with chronic illness that may never need any inpatient care. We encourage the Committee to monitor the innovative programs being tested, including the Independence at Home Demonstration and the Community-based Care Transitions Program. Further, we recommend that the Committee support the care coordination of chronically-ill patients with home telehealth technology, as outlined by the Fostering Independence Through Technology Act of 2013, and the modernization of the Medicare home health benefit through the Home Health Care Planning Improvement Act of 2015 (S. 578). Both bills have strong bipartisan support.

The following are our thoughts on how home health care can help accomplish your stated goals of increasing care coordination among individual providers across care settings who are treating patients living with chronic diseases; streamlining Medicare's current payment systems to incentivize the appropriate level of care for patients living with chronic diseases; and facilitating the delivery of high quality care, improving care transitions, producing stronger patient outcomes, increasing program efficiency, and contributing to an overall effort that will reduce the growth in Medicare spending.

I. Evidence Around Home Health in Improving Patient Outcomes and Achieving Savings

Medicare beneficiaries have historically received widely varying services at varying costs, making it difficult to analyze whether the patient is receiving the right care in the right care setting at the right time. However, we were encouraged by the findings of the Centers for Medicare & Medicaid Services' (CMS) Post Acute Care (PAC) Payment Reform Demonstration, which found that consistent measurement across settings with adjustments for case complexity is possible, thereby allowing comparison of patient outcomes provided in different settings. The recently passed IMPACT Act will advance the development of comprehensive cross-continuum, post-acute care assessment tools even further.

Over the long term, we believe that outcome measurement across care settings will consistently demonstrate the superior value of home health care. We also believe that home health will become increasingly valuable and appropriate for greater numbers of patients with chronic disease as technological innovation continues to expand the ability of home health care to address patient needs, creating increased demand for home-based services.

Indeed, an examination of a growing body of evidence suggests that a vision of high-quality PAC is already emerging with home health care at the center. At every step of a patient's care pathway, home health care helps avoid costly institutional care. We encourage the Committee to examine this evidence as you consider the design of PAC payment incentives and structures, as it is our firm belief that any episode or bundled payment policies should recognize the central role that home health can and should play in improving health outcomes and reducing costs.

Following is a description of the patient care pathway and the evidence around the effectiveness of home health care. We follow this description with a series of proposals that can further the vision of a system with incentives aimed providing clinically appropriate care outside of costly inpatient settings.

a. Pre-Acute: Avoiding Hospitalizations

Many studies have found that home health care can prevent expensive hospitalizations and nursing home stays while providing cost effective care in the home setting that people prefer. Pre-acute care episodes are concentrated among patients with the highest severity chronic conditions, including congestive heart failure, diabetes, chronic obstructive pulmonary disease (COPD) and osteoporosis. Research has shown that each of these chronic conditions can be effectively managed at home. For example, the Clinically Appropriate and Cost-Effective Placement Project of the Alliance for Home Health Quality and Innovation analyzed the use of home health care over three years of Medicare claims data, for three distinct episodes, and including pre-acute care. They found that home health care can be used to better manage pre-acute episode patients with multiple chronic conditions and prevent avoidable hospitalizations.[1]

[1] "Payments for home healthcare, SNF, IRF, and LTCH account for only 2.3 percent of all pre-acute care Medicare episode payments, whereas hospital and physician services account for 92 percent of payments. These data suggest that there may be opportunities to invest in improved chronic care management to avoid preventable hospitalizations, thereby improving care and reducing cost. Home healthcare providers are well positioned to provide chronic care management in this context and have experience with managing patients with multiple chronic

The patient-centered medical home (PCMH) has emerged among primary care practices as a way to improve patient outcomes and keep patients out of the hospital by changing routine delivery of ambulatory care. PCMHs employ an active, planned process of patient education and motivation, and delivery of care through a multi-disciplinary team of care providers who are responsible for the "whole patient." Home care providers can be an effective partner to PCMHs by providing lower cost care coordination and home-based disease management.

In the next section, we detail a proposed home-based chronic care model, which we believe can maximize the care of "pre-acute" patients in their primary care and home-based settings and thereby reduce costs associated with institutional care. We also discuss a risk-based telehealth proposal, which targets high-cost patients who can avoid hospitalization with focused home care.

b. Post-Acute: Home Health is Cost Effective

Home care is a fraction of the cost of institutional PAC settings, and is likely to become an option for even more patients as technology-enabled home care increases. Soon, the delivery of health diagnostics or therapeutics in a patient's home will prevent or reduce the need for institutional care even further, thereby reducing the financial commitment needed for high-quality, clinically appropriate PAC.

In addition to being less costly than institutional care, home health care can address some of the key drivers of readmissions, including providing a continuum of care through transitions, improving medication adherence, improving nutrition and identifying depression and other behavioral health challenges associated with chronic disease and PAC.

Following are several studies showing the cost effectiveness of home care as it is currently provided. We are hopeful that the multiple technology-enabled home care pilots currently underway will demonstrate the increased ability of home care to deliver high-quality, clinically appropriate care to even more complex patients that have traditionally been treated in institutional settings.

A 2009 Avalere study found that the early use of home health was associated with a $1.71 billion reduction in Medicare post-hospital spending over the 2005-2006 period (in aggregate). If the lower period-of-care costs associated with early use of home health were applied to the periods of care for non-home health users, Medicare post-hospital spending over the 2005-2006 period (in aggregate) could have been further reduced by $1.77 billion. The use of early home health is associated with an estimated 24,000 fewer hospital readmissions. The fewer readmissions are associated with a $216 million reduction in Medicare spending over the 2005-2006 period (in aggregate). The $216 million reduction is a component of the $1.71 billion reduction.[2]

A second Avalere study in 2011 quantified the impact of PAC home health use, by comparing Medicare spending and readmissions for chronically ill beneficiaries who receive

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conditions."

[2] Medicare Spending and Rehospitalization for Chronically Ill Medicare Beneficiaries: Home Health Use Compared to Other Post-Acute Care Settings, May 2009, Avalere LLC.

home health care* after a hospitalization with Medicare spending and readmissions for comparable beneficiaries who use other PAC services** after a hospitalization Home health use was associated with a $2.81 billion reduction in post-hospitalization Medicare Part A spending over the 2006-2009 period. That is, Medicare Part A spending on these home health users was $2.81 billion less than it would have been if they had received other PAC services. This estimate controls for differences in beneficiaries' age, sex, race, urban/rural location, condition, severity of illness, dual-eligible status, and hospice utilization.*[3]

Savings Per Beneficiary**

Time Period 1: October 2006 – March 2008		Time Period 2: April 2008 – September 2009	
Diabetes	$6,281 – $12,267	Diabetes	$7,383 – $9,225
COPD	$6,098 – $11,928	COPD	$7,106 – $11,441
CHF	$5,020 – $7,879	CHF	$5,514 – $8,.883

* The extent of risk adjustment is still limited
** Savings vary by severity of illness level

Finally, a 2010 article in the New England Journal of Medicine entitled, "Why Healthcare is Going Home," Dr. Steven H. Landers of the Cleveland Clinic says "in the past century, health care became highly concentrated in hospitals, clinics, and other facilities. But I believe that the venue of care for the future is the patient's home, where clinicians can combine old-fashioned sensibilities and caring with the application of new technologies to respond to major demographic, epidemiologic, and health care trends." He describes demographic, clinical, economic, and technological forces that make home-based care "imperative." He cites oxygen as an example of advances in portable medical technology and cites parenteral nutrition and infusion as examples of care that are less expensive than and as equally effective as institutional care. "Many of these older adults will have limitations on their activities, including difficulty walking and transferring from bed to chair, that make leaving their homes difficult. Bringing care to the home improves access for such people."[4]

c. Transition from Inpatient to Post-Acute: Streamline Pathway to Home

The transition from hospitalization to PAC has been undermanaged and presents a continuing area of opportunity for cost savings in Medicare. A major national study spanning more than two decades tested better integration of home health with hospitals to form a "health care bridge" from hospital to home for four weeks after hospital care showed a 50 percent reduction in the re-hospitalization rate and a cost savings of approximately $3,000 per patient over 24 weeks.[5]

[3] Medicare Savings and Reductions in Rehospitalizations Associated with Home Health Use, June 2011, Avalere LLC.
[4] Landers, S. "Why Health Care Is Going Home," New England Journal of Medicine, October 20, 2010
[5] Naylor, MD, Brooten D, Campbell RL, Maislin G, McCauley KM, Schwartz JS. Transitional care of older adults

The Community-Based Care Transitions Program created under Section 3026 of the Patient Protection and Affordable Care Act of 2010 is beginning to take hold with early signs of considerable success. It is a valuable program that deserves expansion on an expedited basis.

Involving home health with discharge planners early in the hospitalization process can reduce transition challenges and readmission rates. One example is detailed in a recent paper published by the Cleveland Clinic. The paper described in-home care after knee replacement. It found that patient preferences often drive choices on PAC, not individual clinical need. The team at Euclid Hospital instituted a "Cleveland Clinic Total Knee Care Path" that puts home health aides in the lead in discharge planning and the transition of care management. "Every patient envisions a safe return home as a primary goal, with as short an exposure to inpatient acute and post-acute settings as is necessary." Since the implementation of the program, the average acute care hospital length of stay has been reduced by an average of 0.9 days, the discharge to home rate has risen from 32 percent to 74 percent and the readmission rate for patients discharged to home is significantly lower than before implementation of the home care protocol.[6]

Another example of integrating home health with hospital discharge is the success of Amedisys, a home health provider in Louisiana. Amedisys placed "care transitions coordinators" (CTCs) in acute care facilities to meet with patients before their transition out of the hospital. The CTC works with the patient in the hospital to help them understand medication, diet, lifestyle needs and identification of "red flags." The CTC also makes post-discharge follow up appointments for the patients. The CTC is available to the patient 24 hours per day in the hospital, during their transition and until the first home nursing visit, which typically takes place 24 hours after hospital discharge. The Amedisys model was tested in three large academic institutions for 12 months. The 12-month average readmission rate decreased from 17 percent to 12 percent.[7]

A final example comes out of the Virginia Commonwealth University Medical Center (VCU), which implemented a hospital-based transitional care program serving 500 patients. In this intervention, transitional care nurse practitioners (NPs) meet patients in the hospital to ensure appropriate referral, verify medical care plans and build rapport with the patient and family. After discharge, the NPs work with the home health agency very closely, sometimes conducting joint visits. A comparison of utilization data for 199 patients six months before and after enrollment in the intervention over a period of four years showed a decreased use of hospital resources, fewer inpatient dates, shorter lengths of stay, and fewer intensive care unit days. Aggregate cost was 38 percent less than the six month pre-enrollment baseline.[8]

Payment reforms that encourage better integration of home health and the hospital can

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hospitalized with heart failure: a randomized, controlled trial. J Am Geriatr Soc 2004; 52: 675-684.

[6] Froimson, Mark, MD, MBA, "In-home care following total knee replacement, Cleveland Clinic Journal of Medicine, Volume 80, January 2013.

[7] Fleming, Michael, Haney, Tara, "Improving patient outcomes with better care transitions: The role for home health," Cleveland Clinic Journal of Medicine, Volume 80, January 2013.

[8] Boling, Peter, et al, "Improving outcomes and lowering costs by applying advanced models of in-home care," Cleveland Clinic Journal of Medicine, Volume 80, January 2013.

reduce costs and overcome some of the system fragmentation contributing to costly readmissions and preventable institutional care.

II. Specific Proposals to Achieve Evidence-based Reform

While we believe it would be best to wait for the results of the demonstration projects testing many new integrated care models and payment structures before reforming the PAC system, below are several proposals that could help achieve the evidence-based reform that realizes the promise of cost-effective, clinically appropriate care structures that avoid expensive institutional care.

a. Home-based Chronic Care Management Model – Integrated Care Model

The Home-based Chronic Care Management Model is a patient-centered, evidence-based model with care coordinated and supported across providers, sectors, and time. This model would benefit both homebound post-acute patients and pre-acute chronically ill patients. However, its real promise and greatest source of cost savings lies in keeping chronically ill patients out of inpatient settings. The model is a partnership between home health agencies and patient centered medical homes that more fully treat the "whole" patient. The home health agency shares responsibility for patient outcomes with the primary care provider. The home health agency carries out the physician care plan and orders for guideline-level assessments and therapies (i.e. blood glucose monitoring, lipid analysis, flu and pneumonia vaccines.) The home health provider also conducts in-home health coaching, motivational interviewing and patient education, as well as provides ongoing support and monitoring.

Over time, the Home-based Chronic Care Management Model has evolved to incorporate new evidence, including a greater focus on patient empowerment and patient-centered care principles and methods to support care transitions. This model is now referred to as the "Integrated Care Model," (ICM) as best practices are integrated into model tenets and care is integrated across providers and settings.

In a number of ways, the Model is similar to the highly successful Independence At Home demonstration program that the Centers for Medicare and Medicaid Services recently reported as saving in excess of $25 million in just 13 sites with a small patient population. However, it is different in that it takes a broader focus than IAH, which is limited to the top 5% of patient who are at-risk of hospitalization. Instead, it is a flexible model that sets the direction of an interdisciplinary team based on the specific patient needs allowing it to include the wide range of Medicare beneficiaries with multiple comorbidities rather than a small, high-risk population segment. Its flexibility is in a design that uses a physician-leader approach when appropriate to the specific patient, but employs the leadership of other health professionals and the patients' family when such leadership fits best as not all chronic conditions are best managed at all times by physicians alone.

The Model is also a modern method of providing chronic condition management in that advanced technological tools are incorporated into the care management to achieve greater efficiencies, accelerated care actions, and targeted remedial measures. This technology is boundless in its range of uses, limited only by barriers to innovation. However, current tools

that have been employed in trial programs include 24/7 remote monitoring of a patient's condition, two-way video conferencing for consultations and self-care education, and smartphone technology used by non-professionals to provide front-line review of the patient to detect early signs of clinical deterioration or change that warrants intervention. Personal care aides have been equipped with smartphones that connect to patient-specific assessment questions that do not require a health professional, but are designed to illicit evidence of changes in the patient that might signal clinical concerns. The information obtained is subjected to a risk analysis to trigger the appropriate interdisciplinary team response.

The Model also presents a payment method that fits with the direction of value-based payment and shared risk between provider and payer. Primary to such a payment model is that the provider's end revenue is dependent upon demonstrating real financial savings to Medicare. In concept, this payment model is comparable to that used in the IAH pilot program.

The draft of legislative language necessary to enact the Model is attached as Appendix A. The outline of the Model is as follows:

1. Subject beneficiaries must have more than one chronic disease or a dementia along with a chronic disease
2. The individuals subject to the pilot received Medicare-covered home health services within the previous 60 days, but are no longer receiving such covered services
3. It is a pilot program in a least 3 diverse locations subject to expansion by the Secretary of Health and Human Services
4. The home health agency as the provider must meet additional qualifications including the specialized capacity to provide care coordination, patient education and support, telehealth monitoring, and data supported, evidenced-based care management
5. A patient environmental assessment must be conducted with a management and improvement plan related to remediating any environmental barriers to care management, coordination, and success
6. A financial risk-sharing method provides that the participating home health agency receive at least 50% of the Medicare savings achieved through the program conditioned on the requirement that aggregate Medicare expenditures be no greater than would occur without the pilot program
7. Direct reimbursement to the participating providers is limited to per visit reimbursement for face-to-face patient visits by the Case Manager or Clinical Nurse Specialist.

We encourage the Committee to look at integrated care models that include home health care at the center as a way to improve care and reduce costs. Following are several specific homecare agency results from implementing ICM as a care delivery model:

Baptist Health Home Health Network, Little Rock, Arkansas

The ICM program was initially implemented in one HHA in 2007. Specific outcomes in re-hospitalization rates and patient satisfaction were tracked over 2,000 patients. At this agency, re-hospitalization rates declined from 29 percent to 13 percent, and patient satisfaction increased from 93 percent to 97 percent the year following training. The ICCM model's

authors have described model focus areas, outcomes data, and lessons learned in articles published in peer review journals (Suter, et al., 2008; Hennessey, et al., 2010), and this work was highlighted in a Joint Commission Case Study (2009).

Sutter Health

In 2009, Sutter Health developed its Advanced Illness Management (AIM) program using a cross-disciplinary teams that includes physicians, nurses, home health care and hospice personnel and data analysts to improve the integration and management of its home health population. Sutter operates in Northern California. The program, funded partly by a grant from CMS achieved a 59 percent reduction in hospitalizations for the enrolled population (approximately 2100 patients), a 19 percent reduction in emergency department use, and a 67 percent reduction in high-cost days in intensive care units. Sutter estimates that over the 3 year grant period it is on track to save Medicare $118 million.

First Health Home Care, North Carolina

First Health has embedded ICM best practices across a continuum of services in their system, including complex care management and telehomecare. Standardizing the delivery of care for patients with chronic disease led to the development of clinical pathways that incorporate the principles of ICM and also include use of the Patient Activation Measure and specific nutritional and therapy interventions for patients with heart failure, COPD, diabetes and cardiac surgery.

This approach has led to significant improvement in the home health hospitalization rate as well as the home health 30 day hospitalization rate as noted below: (fiscal year 2011, 2012 are October through September; 2013 is year to date October through June)

Home Health Hospitalization Rate (data not risk adjusted)

2011	26.47%
2012	23.87%
2013	20.76%

Home Health 30 day Re-hospitalization Rate (data not risk adjusted)

2011	17.41%
2012	16.92%
2013	10.85%

White County Medical Center Home Health , Searcy, Arkansas

The White County Medical Center Home Health trained all their clinical staff in ICM starting in 2011. They utilize ICM best practices in home care, care transitions, and for care coordination with other team members including physicians, pharmacists, and hospital case managers. Having a chronic care management program and requisite staff competencies has led to significant improvement in their acute care hospitalization (ACH) rates. The risk adjusted ACH rate has improved from 24.4 percent in June 2011 to 12.9 percent in April 2013. The agency is currently in the 1st percentile for the state rankings and 3rd in the nation for

preventing acute care hospitalizations.

Atrius Health

Atrius Health is a non-profit alliance of medical groups in Massachusetts. Atrius has integrated home health services and hospice into its operation through the acquisition of the Visiting Nurse Care Network and Hospice to improve communication between physicians and home care personnel, develop a collaborative program and secure comprehensive metrics for care accountability. Using an electronic patient record, Atrius integrates members of a patient-centered team and includes staff education on palliative care and end-of-life care options. The range of patient care services and patient types is wide with programs directed towards post-joint replacement patients to those with terminal illness.

The care focus, coordination, and interdisciplinary team integration includes telehealth care, video visits between physicians, nurses, and patients. The most significant difference from traditional care is that the programs focus on care management, not medical management.

The emerging program results show decreased hospital readmissions through the increased use of home health services, fall and depression risk assessments, and patient communications regarding medicines, pain management, and home safety.

Visiting Nurse Service of New York

VNSNY uses a population health management model with a primary focus on care coordination. It is a program based on patient-centered goals and care plans, nurse-conducted assessment and care coordination, health coaching and support, collaboration with primary care medical providers, clinical and financial outcomes reporting and measurement, and predictive analytics and risk stratification.

Specially trained RN population care managers lead interdisciplinary teams that include Nurse Practitioners, psychiatric Nurse Practitioners, pharmacists, hospital liaisons, social workers, and health coaches who provide both coaching and care navigation.

Overall, the home care community has stepped up with innovation and investment to develop new models of care for the chronic care population with one common result—higher quality of care and lower health care spending. The home care platform is proving itself to be a wise and sensible starting point with its focus on the whole patient, its scalability, and its modern, technology supported care. Still, there are limits to what providers can do absent systemic change in programs such as Medicare.

b. Expanded Use of Existing Medicare Covered Services in Home Health Care

In some respects, the administration of the Medicare home health benefit by both Medicare itself and the home health agency providers has been a roadblock to improve care and care outcomes for individuals with chronic illnesses. Part of the problem is the inaccurate assumption that the Medicare home health benefit is a limited, post-acute short term benefit for individuals with an acute condition. However, it is one of the best designed benefits in Medicare, permitting coverage of patients with chronic illnesses in a coordinated and comprehensive manner.

Medicare home health services are covered provided the individual is "confined to the home," aka homebound and in need of skilled nursing care on an intermittent basis or physical therapy or speech language pathology, 42 USC 1395f(a)(2)(C) [Part A]; 42 USC 1395l(a)(2) [Part B]. Both Part A and Part B can cover non post-acute care services without a prior hospitalization.

Since the early 1990s, Medicare regulations have specifically indicated that coverage is available without regard to whether the individual has an acute, chronic, or terminal condition. Similarly, the rules permit coverage for care over the long term as well as the short term, dependent only on the existence of a skilled care need. Also, skilled care that is intended to maintain function or slow deterioration is within the Medicare coverage benefit standards. 42 CFR 409.42-409.44.

One particular qualifying skilled nursing service set out in the Medicare rules is worthy of note—skilled management and evaluation of a care plan. 42 CFR 409.44 incorporating 409.33. Specifically, the skilled service is defined as:

Services that could qualify as either skilled nursing or skilled rehabilitation services—
(1) Overall management and evaluation of care plan.

(i) When overall management and evaluation of care plan constitute skilled services. The development, management, and evaluation of a patient care plan based on the physician's orders constitute skilled services when, because of the patient's physical or mental condition, those activities require the involvement of technical or professional personnel in order to meet the patient's needs, promote recovery, and ensure medical safety. Those activities include the management of a plan involving a variety of personal care services only when, in light of the patient's condition, the aggregate of those services requires the involvement of technical or professional personnel."

The care coordination described in the earlier examples of successful home care-based chronic care management is the exact type of care that is embodied in the "overall management and evaluation of care plan" skilled service under current Medicare rules. However, it is rarely applied by home health agencies out of well-reasoned fear that Medicare will retroactively reject payment for the claim.

NAHC recommends that the Committee require CMS to engage in nationwide education of its contractors and home health agency personnel focused on this one basis for coverage. If needed, clarifying or expanded policy guidelines should be issued. In the end, an application of this covered service in home care can create the foundation for significant improvement in patient-centered, community-based chronic care management that benefits Medicare beneficiaries and the Medicare program bottom-line.

c. Post-Acute Community Based Care Bundling: Improving Care Transitions and Maximizing PAC

We believe it is important that bundling arrangements for PAC allow PAC providers to hold and administer the risk-adjusted PAC benefit, not the acute care provider. The expertise related to managing patients in a post-acute setting lies with PAC providers, not hospitals, and the

payment and accountability should be structured to reflect that. We are encouraged that CMS is testing a post-acute care bundling program where all provider payments are managed by home health agencies. We believe this will ultimately deter unnecessary re-hospitalizations, thus reducing administrative burden and cost. This approach is comparable to the tried and tested Medicare hospice program where payment is bundled to a community-based hospice program where hospitalization is the exception rather than standard practice.

Given the evidence described above regarding the importance of involving home health providers early in the care transitions process, the most effective bundling model would integrate home health providers into hospital discharge planning process upon the admission of a qualified patient to the hospital. The home health agency would be responsible for a comprehensive evaluation and PAC planning process that is designed to determine whether a patient is medically appropriate and feasible for discharge to the community.

Where the home health agency, in close coordination with the hospital, determines that community based care is not appropriate immediately upon hospital discharge, the responsibility for discharge to a post-acute inpatient setting is returned to the hospital. At that point, a post-acute inpatient care bundling may be triggered, if available.

With this model, the home health agency is responsible for any community-based care related to the patient's inpatient treatment including home health services, physician services, outpatient rehabilitation services, and any intervening stay in an inpatient rehabilitation facility (IRF), long term care hospital (LTCH), or skilled nursing facility (SNF). Post-acute inpatient stays immediately following hospital discharge are outside of the home health agency responsibility.

Benchmarks could be based on existing measurements of quality and patient outcomes in combination with cost avoidance outcomes that relate to re-hospitalizations and use of emergent care.

Under a post-acute community based care bundling approach, providers would receive a case mix related per capita payment that is calculated on the basis of the combination of services in the bundle, adjusted for performance in a positive or negative manner.

One key aspect of making a bundled payment work is ensuring the technological means to share information among providers. Seamless care transitions depend on physicians, hospitals and home health agencies having access to patient information. The home care community has been an integral partner within the Standards and Interoperability (S&I) Community-Led Initiatives, such as the Longitudinal Coordination of Care (LCC) workgroup, to develop standards for interoperable transitions of care and care plans additions to the Consolidated Clinical Document Architecture (CCDA). Our goal is to leverage the support of these important additions to the CCDA to encourage the adoption of electronic health records (EHR) and also to support the interoperable exchange of health information that is the foundation for building new models of care delivery in home care.

d. Value-Based Purchasing Proposal: Improving Performance & Achieving Savings

MedPAC recommended application of a "pay for performance" system for home health and

other Medicare provider payments. Starting in 2008, Medicare began the Medicare Home Health Agency Pay for Performance Demonstration project operating in seven states. Under the demonstration, home health agencies qualified for incentive payments based on high quality of care performance or improvement in performance from the previous year. The incentive payments are based upon the impact that the performance has had on reducing Medicare costs in other health care sectors, including hospital care. This approach recognizes the dynamic value that high quality home health services can have in reducing overall health care spending.

CMS shared more than $15 million in savings with 166 home health agencies based on their performance during the first year of the Medicare Home Health Pay for Performance demonstration in 2009. Another $15 million in savings was shared with the agencies in 2010.

As a result of demonstration's success, we believe that the Committees should consider authorizing a program that provides performance-based incentive payments to home health providers, taking into account readmissions rates and adherence to quality measures.

Unlike the CMS demonstration, the proposal we are putting forth contains both "carrots" and "sticks," i.e. home health agencies will see reductions in reimbursements if quality metrics are not met. If implemented, we believe this proposal could produce $2.5 billion in direct savings over 10 years. The estimate is based on a CBO projected spend of $250 billion between 2014 and 2023.

This estimate does not include the savings that the CMS demonstration showed would be generated from deterred impatient services. We believe overall Medicare savings, outside of the direct savings we propose, would be at least $600 million in the first year and more than $7 billion over ten years. That is calculated roughly based on demonstrated savings from the CMS initiative. The Medicare Home Health Agency Pay for Performance Demonstration showed $15M in savings with 166 HHAs. Currently, there are over 12,000 HHAs. If we conservatively assume that those HHAs generate a half of such savings, we would be looking at $50,000 per HHA in 2014 X 12,000 HHAs= $600M. Alternatively, if you assume that half of the HHAs garner equivalent savings to those in the demonstration it would come to the same dollar result. This estimate includes a small annual increase in savings due to the higher payments rates annually to hospitals, etc. and growth in Medicare enrollment.

We do not propose this value-based purchasing arrangement lightly, and given the drastic cuts in home health payments since 2009, we are hesitant about offering a payment withhold. However, we believe strongly that cuts must not be blunt or arbitrary. They must incentivize quality and maintain access to critical services for beneficiaries.

Proposal:

- Implement a phased-in 1.5 percent reduction in payments to skilled home health services over a 10 year period;
- Assess the total performance of a skilled home health provider using a methodology developed by the HHS Secretary and based on the Home Care Compare Hospital Rate and Emergent Care Rate established during the performance period, taking readmissions into account and recognizing both high performance as well as

improvements in performance;

- Determine quality incentive payments for a skilled home health provider using the median performance score of all home health agencies, using a sliding scale such as:
  - Scores equal to or greater than 75 percentile nationwide would receive a quality incentive payment equal to the full 1.5 percent withheld plus an additional 1 percent payment;
  - Scores equal to or greater than median, but less than the 75 percentile nationwide would receive a quality incentive payment equal to the full 1.5 percent amount withheld plus an additional .25 percent payment;
  - Scores equal to or greater than the 25 percentile median, but less than the median score nationwide, would receive a quality incentive payment equal to 50 percent of the amount withheld; and
  - Score below the 25 percentile shall not be eligible to receive a quality incentive payment and will have no opportunity to recoup the 1.5 percent cut.
- The Secretary should be given the opportunity to develop a waiver to ensure access to care, particularly for those living in health professional shortage areas.
- The specifics of the program should be developed in a transparent manner with the full engagement of all stakeholders.

Any legislative action in this area must be fair in its assessment of the quality of care provided to home health patients and incorporate pending changes to the OASIS assessment tool, as well as a mix of process and outcome measures. It should also be appropriately risk-adjusted and limit any expansion of data collection requirements and fully reimburse agencies for the costs of any additional data collection requirements that are imposed. Further, it should be tested before it is employed nationally as unintended consequences can be harmful.

e. Telehealth Risk-Sharing Proposal: Reducing Inpatient Care through Technology

We believe that the use of telehealth should be a high priority as Congress considers evidence-based reform proposals to advance the nation on the fast track toward a highly functioning, technologically enabled, modernized health care delivery system. When deployed in the home as a service of home health care, remote patient monitoring technologies greatly enhance the cost savings potential of PAC. Seniors are able to remain in their homes longer, delaying costly transfers to higher acuity settings, are more engaged with their care and have higher levels of care satisfaction. Providers are able to better manage the care of patients with chronic conditions by monitoring changes in health status with increased frequency and employing advanced analytic tools and data trends to improve service delivery, care coordination and reduce unnecessary emergency room visits and hospital admissions.

These benefits have already been demonstrated in a number of home health agencies across the country. When telehomecare interventions for chronically ill Medicaid patients were deployed at Windsor Place Home Health in Windsor, Kansas, for example, hospital readmissions, emergency room visits and nursing home admissions were reduced to zero over a one year period. Total cost savings over the same time period were approximately $1.3 million, while the per patient cost of the intervention was just $6 per patient per day. Similarly, at Forrest General Home Care and Hospice in Mississippi, targeted telehomecare interventions for

patients with congestive heart failure and chronic obstructive pulmonary disease caused hospitalization rates to drop from 20 percent to 3 percent and emergent care rates to fall from 7 percent to 2.5 percent over the course of a year. Finally, the Veterans Administration telehealth program is a model worthy of replication within Medicare as it has proven to be a tremendous tool in managing individuals with chronic or acute conditions.

We believe that results like those seen in Kansas and Mississippi could be experienced on a large scale if Medicare reimbursement policies supported the targeted use of telehealth in the home for both homebound patients and chronically ill patients who would benefit from "pre-acute" homecare.

To that end, we recommend that Congress consider legislation providing authority to CMS to test the value of care models that rely on the use of telehealth in home care settings.

One such bi-partisan legislative proposal is the Fostering Independence through Technology Act of 2013 introduced by Senators Amy Klobuchar and John Thune. It would provide authority for CMS to implement a shared savings pilot program for home care agencies using remote patient monitoring technology. Under this legislation, participating agencies would receive a 75 percent share of the total Medicare cost savings realized over a year relative to a performance target set by the Secretary of HHS. The legislation limits payments to the amount that would have otherwise been expended if the pilot project had not been implemented, making this proposal cost-neutral. This integration of telehealth combined with the use of health information technology would greatly modernize the service delivery of home health care and provide for additional cost savings.

f. Addressing Chronic Care Management through New Team Approaches

There are two strategies currently employed voluntarily by many home health agencies that should be considered as standard Medicare conditions of participation for all home health agencies. These two strategies require up-front and ongoing investment in resources and time on the part of home health agencies. However, as we have stated, we believe that changes need to encourage quality and these two strategies could reduce fraud and abuse while improving quality.

First, consistent with requirements for hospices and skilled nursing facilities, home health agencies should be required to include a Medical Director as part of its professional staff management. There is currently limited direct medical supervision of home health care services provided by non-medical personnel. A Medical Director would change that by participating in the formation of clinical policies and procedures while also assisting in utilization review to ensure necessary and appropriate level of care is provided to patients. Further, the Medical Director would act as a liaison with the physician community to improve proper patient care transitions. A Medical Director does not necessarily have to be a full time staff member to fulfill the role. There are many forms the inclusion of a Medical Director could take, including an affiliation or part-time clinician.

Second, the use of an interdisciplinary team approach to care planning, utilization, and oversight has proven valuable in hospice care and can have comparable value in home health

services. A team approach would be useful in determining the right combination of care at the right time for the patients to achieve optimal outcomes. Quality of care would be enhanced along with an improved process in care utilization. Specifically, the interdisciplinary team would be an added gatekeeper to guard against the provision of unnecessary care.

We have included draft legislative language the Committee can consider including in any legislation advanced to address the challenges of the Medicare PAC payment system (see Appendix B).

III. Miscellaneous Issues

a. Quality

As previously indicated, we support payment reforms that incentivize quality improvement across the care spectrum. We believe, however, that these reforms must go hand-in-hand with policies that remove barriers to quality measurement and improvement in managing individuals with chronic conditions. For example, the Home Health Care Planning Improvement Act of 2015 (S. 578) would allow certain providers, such as nurse practitioners, physician assistants, and certified nurse specialists, to provide the requisite certification needed before home health services may be provided to a patient under the Medicare program. As it currently stands, only physicians are able to certify that a homebound patient needs skilled nursing services, which often results in delayed access to care thus negatively impact the overall quality of care the patient receives.

In addition to addressing barriers to quality care, we believe that one of the most effective ways to improve health care is to link payment for acute and chronic care services to a patient-centered measurement system that assesses outcome-based measures across episodes of care. As such, we have suggested several options for re-structuring the current PAC payment system to align more closely with acute care quality-based payment programs, including post-acute, community-based care bundling and value-based purchasing. We stand ready to work with the Committee to further develop any of these policies.

Although Medicare home health payments are not currently tied to quality measurement, there are established reporting initiatives that could be partially leveraged to provide a starting point for further measure development for home-based care settings. CMS currently posts home health performance data on its Home Health Compare website, deriving HHA-specific performance ratings from data collected through the Outcome Assessment Information Set (OASIS) assessment tool and the Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) survey. While the OASIS tool collects patient-specific information on outcome, process and potentially avoidable event measures at the point of care, the HHCAHPS survey assesses patient satisfaction through survey responses provided by the patient, a family member or a friend at a later date.

Given these two data sources, we encourage the Committee to use the data collected through the OASIS tool as the primary starting point for the new measure development needed to advance any payment reforms. Our members have reported that there are some limitations associated with the HHCAHPS survey, as a patient's satisfaction with the care they receive may

not reflect the quality of care provided in some instances (for example, if a patient has multiple chronic conditions and the clinical goal is to maintain or slow the decline of the patient's health rather than improve it). Additionally, responses provided by a patient's friend or family member may not provide a true picture of the care received by the patient as many patients may not share complete details regarding their health condition(s) with others. As such, we believe that HHCAHPS results should be a small component of any system that links payment to quality, if at all.

Despite these reporting initiatives, gaps in PAC quality measurement continue to exist. The Measures Application Partnership (MAP), a public-private partnership between the National Quality Forum (NQF) and the Department of Health and Human Services (HHS), examined existing PAC measures, identifying areas where existing Home Health Compare measures should be updated, as well as six priority areas for new measurement development.

As an initial matter, MAP stakeholders recommended that Home Health Compare measures be updated to align with quality measurement principles being used in other care settings. The MAP advisory committee indicated that existing Home Health Compare measures should be revised to reflect data collected over a period of time rather than a single point in time, and be flexible enough to allow for customization to reflect the unique care provided within the home health care setting. Stakeholders also recommended that existing measures be modified to take into account health disparities, to reflect key structural and cost goals for home health care, and to address the unique care required by specific subpopulations who receive home health in significant numbers (e.g., patients with chronic disease, cancer patients, patients with dementia).

In addition to its examination of existing home health measures, MAP stakeholders also identified six priority areas for new measure development, focusing on those areas where current measures are either insufficient or non-existent, including:

- Function, including an assessment of functional and cognitive status;
- Goal attainment, including the establishment and attainment of patient/family/caregiver goals and advanced care planning and treatment;
- Patient and family engagement, including care experience and shared decision-making;
- Care coordination, including transition planning;
- Safety, including measures related to falls, pressure ulcers, and adverse drug events; and
- Cost/access, including measures examining inappropriate medication use, infection rates, and avoidable readmissions.

While we support efforts to update the home health quality measurement system, we would also like to draw the Committee's attention to two additional factors that significantly impact the viability of a system that links payment structures to quality measurement: the establishment of appropriate benchmarks and the adoption of technologies that can be used to provide a consistent data platform for the collection and measurement of quality information across PAC settings.

Establishing appropriate quality benchmarks is challenging, as the patient population is very

heterogeneous even within care settings. In home health, for example, the patient population is split between older individuals struggling with chronic disease and other patients who are recovering from a single acute episode. Although the same measures might be used to evaluate the quality of care provided to both of these patient groups, the use of same benchmarks or targets may not be appropriate given the diverse health needs of the two groups.

Likewise, varying levels of technological advancement within and among care settings make it challenging to consistently electronically capture and exchange the critical health information needed for quality measurement. This is a key barrier to the development of an outcomes-based quality system that spans episodes of care, including acute care. Many providers, including home health agencies, are not eligible for "meaningful use" incentives under the Health Information Technology Economic and Clinical Health (HITECH) Act and have thus lagged behind in health IT adoption, implementation and health information exchange.

We believe that key measurement gaps and barriers must be addressed before the health care system will be able to realize the Committees' vision of coordinated, patient-centric value-based care across care settings. We agree that the use of harmonized measures (or families of measures) at each level of the system could be useful in assessing care not only during an episode, but also in providing a comprehensive picture of the quality of care a patient has received throughout the course of a lifetime. We look forward to working with the Committees to advance this goal.

b. Beneficiary Protections

As the Committee seeks to increase care coordination for chronically ill Medicare beneficiaries, we believe that it should also take steps to ensure that beneficiaries are protected and receive care in the appropriate setting. Some policymakers have suggested adding copayments for Medicare home health and hospice services as a means of both reducing the deficit and preventing overutilization of home health and hospice services. The Administration and MedPAC have recommended a copay on home health episodes not preceded by a hospital or nursing home stay. We believe that a copayment would deter chronically ill Medicare beneficiaries from accessing home health care and instead create an incentive for more expensive institutional care. Numerous studies have concluded that a copayment would discourage the use of necessary and beneficial care, resulting in the deterioration of a patient's condition and ultimately leading to higher costs for the Medicare program through acute care interventions in higher cost settings.

For these and the reasons outlined below, we respectfully ask the Committee to protect Medicare beneficiaries with chronic disease by choosing not to implement cost-sharing policies that would impose a copayment for home health and hospice services.

- **Home health copayments would create a significant barrier for those in need of home care, lead to increased use of more costly institutional care, and increase Medicare spending overall.** The Urban Institute's Health Policy Center found that home health copays "…would fall on the home health users with the highest Medicare expenses and the worst health status, who appear to be using home health in lieu of more expensive

nursing facility stays."[9] Similarly, a study in the *New England Journal of Medicine* found that increasing copays on ambulatory care decreased outpatient visits, leading to increased acute care and hospitalizations, worse outcomes, and greater expense.[10] The same adverse health consequences and more costly acute care and hospitalizations would likely result from the imposition of a home health copay. The National Association of Insurance Commissioners concluded that beneficiaries, in response to increased cost sharing, "may avoid necessary services in the short term that may result in worsening health and a need for more intensive care and higher costs for Medicare in the long run."[11] Studies have shown that Medicaid copays can backfire with beneficiaries avoiding care leading to higher Medicaid overall costs.[12] The Veterans Administration recently eliminated copays for in-home video telehealth care to prevent avoidable hospitalizations of veterans.[13] According to an analysis by Avalere, a home health copayment could increase Medicare hospital inpatient spending by $6-13 billion over ten years.[14]

- **The burden of a home health copayment would disproportionately impact the most vulnerable—the oldest, sickest, and poorest Medicare beneficiaries.** About 86 percent of home health users are age 65 or older, 63 percent 75 or older, and nearly 30 percent 85 or older. Sixty-three percent are women.[15] Home health users are poorer on average than the Medicare population as a whole. Home health users have more limitations in one or more activities of daily living than beneficiaries in general.[16] The Commonwealth Fund cautioned that "cost-sharing proposals, such as a copayment on Medicare home health services, could leave vulnerable beneficiaries at risk and place an inordinate burden on those who already face very high out-of-pocket costs."[17]

- **Most people with Medicare cannot afford to pay more.** In 2013, half of Medicare beneficiaries—about 25 million seniors and people with disabilities—lived on incomes below $23,500.[18] Medicare households already spend on average 14 percent of their income on health care costs, about three times as much as the non-Medicare population.[19]

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[9] Urban Institute Health Policy Center, "A Preliminary Examination of Key Differences in Medicare Savings Bills," July 13, 1997.

[10] Trivedi, Amal N., Husein Moloo and Vincent Mor, "Increased Ambulatory Copayments and Hospitalizations among the Elderly," *New England Journal of Medicine*, January 2010.

[11] National Association of Insurance Commissioners, Senior Issues Task Force, Medigap PPACA Subgroup, "Medicare Supplemental Insurance First Dollar Coverage and Cost Shares Discussion Paper" (October 2011).

[12] Leighton Ku and Victoria Wachino, "The Effect of Increased Cost-Sharing in Medicaid: A Summary of Findings," Center on Budget Priorities (July 7, 2005).

[13] U.S. Department of Veterans Affairs, Office of Public and Intergovernmental Affairs, "VA Eliminates Copayment for In-Home Video Telehealth Care," May 8, 2012.

[14] Avalere Health LLC, "Potential Impact of a Home Health Co-Payment on Other Medicare Spending," July 12, 2011.

[15] CMS Office of Information Services, Medicare & Medicaid Research Review/2011 Supplement, Table 7.2.

[16] Avalere Health LLC, "A Home Health Copayment: Affected Beneficiaries and Potential Impacts," July 13, 2011.

[17] The Commonwealth Fund, "One-Third At Risk: The Special Circumstances of Medicare Beneficiaries with Health Problems," September 2001.

[18] "Medicare at a Glance," Kaiser Family Foundation.

[19] "Health Care on a Budget: The Financial Burden of Health Care Spending by Medicare households"—Kaiser Family Foundation.

- **Low-income beneficiaries are not protected against Medicare cost sharing.** Eligibility for assistance with Medicare cost sharing under the Qualified Medicare Beneficiary (QMB) program is limited to those with incomes below 100 percent of poverty ($11,412 for singles, $15,372 for couples) and non-housing assets below just $6,940 for singles and $10,410 for couples. In sharp contrast, eligibility for cost sharing assistance for individuals under age 65 is set at 138 percent of poverty, with no asset test. Even among Medicare beneficiaries eligible for QMB protection, only about one-third actually have it.[20]

- **Individuals receiving home care and their families already contribute to the cost of their home care.** With hospital and nursing home care, Medicare pays for room and board, as well as for extensive custodial services. At home, these services are provided by family members or paid out-of-pocket by individuals without family support. Family members are frequently trained to render semi-skilled support services for home health care patients. Family caregivers already have enormous physical, mental and financial burdens, providing an estimated $450 billion a year in unpaid care to their loved ones,[21] and too frequently having to cut their work hours or quit their jobs.

- **Copayments as a means of reducing utilization would be particularly inappropriate for home health care.** Beneficiaries do not "order" home health care for themselves. Services are ordered by a physician who must certify that services are medically necessary, that beneficiaries are homebound and meet other stringent standards. There is no evidence of systemic overutilization. Adjusted for inflation, home health spending on a per patient basis and overall Medicare spending on home health is less today than in 1997. The Medicare home health benefit has dropped from 9.5 percent of Medicare spending in 1997 to 5.9 percent and serves a smaller proportion of Medicare beneficiaries today than in 1997.[22]

- **Home health copayments would shift costs to the states.** About 15 percent of Medicare beneficiaries receive Medicaid. Studies have shown that an even larger proportion (estimated to be about 25 percent by MedPAC) of Medicare home health beneficiaries are eligible for Medicaid. A home health copayment would shift significant costs to states that are struggling to pay for their existing Medicaid programs. In addition, states would have to pick up their Medicaid share of new QMB assistance obligations.

- **Medicare supplemental insurance cannot be relied upon to cover home health copays.** There is no requirement that all Medigap policies cover a home health copay and

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[20] "Government Accountability Office, "Medicare Savings Programs: Implementation of Requirements Aimed at Increasing Enrollment," GAO-12-871 (September 2012).

[21] L. Feinberg, S.C. Reinhard, A. Houser, and R. Choula, "Valuing the Invaluable: 2011 Update, the Growing Contributions and Costs of Family Caregiving," AARP Public Policy Institute Insight on the Issues 51 (Washington, DC: AARP, June 2011).

[22] CMS Research, Statistics, Data, and Systems/Statistics, Trends and Reports, Medicare Medicaid Stat Supp/2011 (Tables 3.1 and 7.1).

only 23 percent of Medicare beneficiaries have Medigap coverage. For the 26 percent of Medicare beneficiaries who have supplemental coverage from an employer sponsored plan, there is no assurance that these plans will be expanded to cover a home health copay or remain a viable option for beneficiaries, given the current trend of employers dropping or reducing retiree coverage.[23] Likewise, the 30 percent of beneficiaries enrolled in Medicare Advantage (MA) plans would not be protected from a home health copay, as many MA plans have imposed home health copays even in the absence of a copay requirement under traditional Medicare.

- **Copayments would impose costly administrative burdens and increase Medicare costs.** Home health agencies would need to develop new accounting and billing procedures, create new software packages, and hire staff to send bills, post accounts receivable, and re-bill. Also, unlike hospitals, there is no provision for bad debt from uncollected copays currently built into the base payment for home health care. Home health agencies cannot absorb these costs as CMS projects that 43 percent of home health agencies will be paid less than their costs by Medicare by 2017 (NAHC estimates in excess of 50 percent). Overall home health agency margins from a combination of Medicare, Medicaid, Medicare Advantage and other payment sources are estimated to be an average of zero or less.[24]

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In closing, we appreciate the opportunity to submit our comments as you consider ways to improve care for Medicare patients with chronic illness. If you have any questions or need any further information, please do not hesitate to contact us.

Sincerely,

Denise Schrader
Chairman of the Board

Val J. Halamandaris
President

[23] Kaiser Family Foundation, "Examining Sources of Supplemental Insurance and Prescription Drug Coverage Among Medicare Beneficiaries: Findings from the Medicare Current Beneficiary Survey, 2007," August 2009.
[24] National Association for Home Care & Hospice (NAHC) Cost Report Data Compendium, Through calendar year 2013.

APPENDIX A

a) Pilot Program Authorized- The Secretary of Health and Human Services (in this section referred to as the `Secretary') shall initiate and carry out pilot projects (each in this section referred to as a `pilot project') in a variety of geographic locations as set out herein that provide Medicare coverage of chronic disease management by home health agencies that will--

(1) enhance health outcomes for individuals enrolled under parts A and B of title XVIII of the Social Security Act; and

(2) reduce part A and B program expenditures for institutional and other providers, practitioners, and suppliers of health care items and services.

(b) Individuals Within the Scope of Pilot-

(1) IN GENERAL- The Secretary shall specify, in accordance with this subsection, the criteria for identifying those individuals who shall be considered within the scope of the pilot projects under this section for purposes of the incentive payments under subsection (e) and for assessment of the effectiveness of the home health agency in achieving the objectives of the section. The individual must have at least 1 of the following present:

(A) More than one chronic disease;

(B) Dementia, as defined in the most recent Diagnostic and Statistical Manual of Mental Disorders, and at least 1 chronic condition;

(C) Any other condition, as determined by the Secretary

(2) PARTICIPATION OF INDIVIDUALS NOT RECEIVING HOME HEALTH SERVICES- Participation in these pilot projects shall be limited to individuals who received home health services under part A or part B of title XVIII of the Social Security Act within 60 days of the start of services under this Section and are no longer receiving home health services under part A or part B.

(3) WAIVER _ The Secretary may waive the qualifications for Medicare coverage of home health services under Section 1814(a)(2)(C), including the requirement that the individual is "confined to his home" to the extent necessary to further the purpose and intent of this pilot. Notwithstanding any waiver under this subpart, individuals participating in a pilot herein shall not be limited to individuals who are confined to home.

(c) Location and number of pilot sites-

(1) LOCATION- At least one of the pilots must be located in a primarily rural area, a primarily metropolitan area, and the state of Arkansas. The Secretary shall consider the prevalence of chronic diseases and density of Medicare beneficiaries in the location.

(2) NUMBER- There shall be at least 3 pilot projects and no more than 10 initially, subject to expansion under subsection (h). At least one pilot shall be a not-for-profit home health agency that is integrated with a comprehensive health system providing inpatient, outpatient, and physician services.

(d) Qualifications and Services of the Home Health Agency-

(1) IN GENERAL- The pilot home health agency shall have the capacity to provide:

(A) A registered nurse Case Manager experienced in care coordination;

(B) Clinical Nurse Specialists credentialed in the targeted chronic

diseases;

(C) Home telehealth monitoring with continual data; development and periodic data evaluation;

(D) Direct patient visits in the home as needed;

(E) Patient education, care coordination, and care; management that is evidence-based and data supported; and

(F) Active coordination and integration with the patient's physician.

(2) Any other criteria considered reasonable and appropriate by the Secretary.

(3) Chronic Care Management Services- The home health agency shall provide all the services in paragraph (1) as needed by the individual patient. The home health agency shall not be responsible to provide any necessary medical supplies or durable medical equipment.

(e) Payments-

(1) IN GENERAL- Subject to paragraph (2), the Secretary shall pay to each home health agency participating in a pilot project an amount for each year under the pilot project equal to at least 50 percent of the reduction in expenditures under such parts realized for such year due to the agency's participation in the project. The computation of such reduction shall be based on the Secretary's estimate of the amount by which the amount of expenditures under such parts for the individuals under the pilot project is less than the amount that would have been expended under such parts for such individuals if the project were not implemented. In determining the estimate, the Secretary may use estimates for expenditures for individuals who are not participating in the project and who are comparable to individuals participating in the project.

(2) LIMITATION ON EXPENDITURES- The Secretary shall limit incentive payments under this subsection as necessary to ensure that the aggregate expenditures under title XVIII of the Social Security Act (inclusive of such incentive payments and payments under paragraph (3)) with respect to patients within the scope of the pilot projects do not exceed the amount that the Secretary estimates would be expended under such title if the pilot projects under this section were not implemented.

(3) ADDITIONAL PAYMENTS- In addition to the incentive payment under paragraph (1), the Secretary shall pay a home health agency under this pilot:

(i) an amount equivalent to the skilled nursing per visit payment amounts established under 42 CFR 484.230 for each face-to-face visit with the patient by the Case Manager or Clinical Nurse Specialist; and

(ii) an amount, negotiated between the Secretary and a pilot home health agency, for daily monitoring of home telehealth services provided to an eligible individual participant in the pilot.

(f) Construction- Nothing in this section shall limit the amount of payment (other than under subsection (e) a home health agency may receive for home health services provided to eligible individuals under part A or part B of title XVIII of the Social Security Act.

(g) Implementation Date- The Secretary shall implement the pilot projects authorized by this section no later than nine months after the date of the enactment of this Act.

(h) Expansion of the Pilot Project- If the Secretary determines that any of the pilot projects--

(1) result in a decrease in Federal expenditures under title XVIII of the Social Security Act; and

(2) maintain or enhance health outcomes for the participating beneficiaries, the Secretary may initiate or extend comparable projects in additional areas.

(i) Effective date- The Secretary shall initiate the pilot program no later than _____ and shall select pilot participating home health agencies no later than __.

APPENDIX B

Section 1891(a)(3) of the Social Security Act (42 U.S.C. 1395bbb(a)(3)) is amended by adding at the end the following new subparagraphs –

(8)The agency must utilize an interdisciplinary team approach to care planning and management, modeled on 42 CFR 418.56, that includes the patient's attending physician and non-physician practitioner, the agency's medical director, and representatives from each clinical professional discipline provided by the agency

(9)(A) The agency maintains, except as provided in (B), a medical director, through employment or under contract, to provide or participate in—

(i) utilization review in collaboration with agency clinical staff;

(ii) medical direction and advice in the agency's comprehensive quality assurance program;

(iii) consultation on, development of, and presentation of agency in-service education and staff development programs;

(iv) development and maintenance of clinical policies and protocols;

(v) periodic patient care conferences with other agency clinical professionals; and

(vi) other duties and functions determined necessary and appropriate by the Secretary.

(B) The requirements of (A) shall not apply to a skilled home health care agency operating in a medi-cally underserved area or an agency where the annual unduplicated Medicare patient census in the preceding calendar year is 100 or fewer.

(C)Any compensation paid to the medical director shall be subject to the standards applicable under Sections 1128A, 1128B, and 1877 of the Act and regulations promulgated thereunder.

(D) Nothing in this provision shall be construed or in-terpreted to prohibit the employment of or contracting with more than one medical director when reasonable and necessary under standards established by rule by the Secretary.

(E) "Medical director" means a physician or nurse practitioner to the extent permitted under State law.

(F) The requirements for a face-to-face encounter by a physician, nurse practitioner, clinical nurse specialist, clinical nurse mid-wife, or physician assistant under Sections 1814 and 1835 shall be deemed to have been met in the event that a medical director participates in an individual patient case conference within 30 days of the start of care and certifies that the face-to-face encounter occurred for that individual.