



January 26, 2016

The Honorable Johnny Isakson
Co-Chair
Committee on Finance
Bipartisan Chronic Care Working Group
131 Russell Senate Office Building
Washington, DC 20510

The Honorable Mark Warner
Co-Chair
Committee on Finance
Bipartisan Chronic Care Working Group
475 Russell Senate Office Building
Washington, DC 20510

Dear Senators Isakson and Warner:

The Partnership for Quality Home Healthcare, a national coalition of skilled home healthcare providers dedicated to advancing policy solutions that will result in improved quality of care and quality of life for all home healthcare patients, appreciates the opportunity to comment on the Bipartisan Chronic Care Working Group's Policy Options Document, issued in December 2015.

The costs associated with caring for the increasing number of Americans living with chronic illness is among the top challenges facing the U.S. healthcare system. We commend the Working Group for its focus on this critical issue, as well as for the transparency and openness with which you have undertaken this important task, and we wish to take this opportunity to share our perspective on several of the important issues being addressed by the Working Group.

The Value of Skilled Home Healthcare Services

Home healthcare adds significant value to America's healthcare system by improving patient outcomes while simultaneously reducing patient costs. Thanks to important clinical and technological advances, many treatments and therapies that were once only available in an institutional setting are now safely and effectively administered in a patient's home. As a result, home healthcare is a readily available solution to many of the challenges facing America's healthcare delivery system.

Today, an estimated 3.5 million seniors and disabled individuals who are homebound and require skilled care to treat illnesses related to acute, chronic or rehabilitative needs rely on the Medicare home health benefit. Their ability to receive the care they need in the safety and dignity of their homes means that they are also able to maintain close to their family and community supports. Not surprisingly, surveys routinely document that more than 90 percent of seniors wish to age in place and remain in their home.

Home healthcare is also a vital resource for America's rural and underserved communities. Lacking ready access to healthcare facilities, more than 600,000 of the seniors residing in such communities depend on Medicare home health services, which are provided by some of the smallest Home Health Agencies (HHAs) in the nation. Overall, Medicare home health beneficiaries are documented as older, poorer, sicker and more likely to be disabled, female, and a member of an ethnic or racial minority than all other Medicare beneficiaries combined.

Last but by no means least, home healthcare has also been well documented as a key source of program savings. For example, the Department of Veterans Affairs (VA) has reported that its Home-Based Primary Care program has reduced costs by a significant 24 percent. Home healthcare also reduces costs by enabling patients to effectively manage their chronic conditions and avoid preventable hospitalizations. Further, recent research suggests that Medicare could save more than \$5,000 per major joint replacement patient when home health is the first post-acute care setting utilized following hospital discharge.

For these reasons, home healthcare is widely recognized as clinically advanced, cost-effective and patient preferred and is enabling the Medicare program to realize efficiencies that would be impossible if home health were not available. By incentivizing greater opportunities for home healthcare, policymakers can achieve positive clinical outcomes for patients while simultaneously reducing costs. This is why we respectfully urge the Working Group to expand home health access for individuals with chronic conditions through means such as those discussed below.

Waiver of the Homebound Restriction

First, we encourage the Working Group to examine waiving the homebound limitation that restricts patient access to home health. The Comprehensive Care for Joint Replacement (CJR) program offers a useful illustration of the value of such a waiver. While many lower extremity joint replacement (LEJR) patients are eligible for home health due to their homebound status, that status may not persist throughout the 90 days post-discharge in which they will participate in CJR. Still other discharged patients may not meet Medicare's homebound criteria at all.

In both cases, CJR hospitals will be unable to engage home healthcare services even though such services can help achieve optimal outcomes within CJR's target pricing structure. Even more important, continued imposition of the homebound restriction will mean that many Medicare beneficiaries will be unable to receive home health services as they transition in and out of homebound eligibility, even if they wish to receive treatment in their home and if doing so would help them avoid institutionalization and infection.

By contrast, waiving the homebound restriction for patients who no longer meet the homebound definition would allow them continued access to home health and prevent institutionalization and the complications and cost that can result from it. As a measured approach to this important reform, we also recommend that the Working Group consider leveraging the new Star Rating program such as by linking the homebound waiver for beneficiaries who are served by HHAs with a Star Rating of 3 or better.

Independence at Home Demonstration Project

Second, we are pleased that the Working Group recognizes the value of incentive payments available under the Independence at Home (IAH) demonstration project. The early evidence suggests that this project is yielding very positive results, including savings of \$3,070 per beneficiary. We support expanding the reach of the current program by making it a permanent, nationwide program as discussed in the Working Group's policy options document and expanding its reach by broadening opportunities for service providers beyond primary care professionals to participate in this program.

We are concerned that the IAH demonstration project may currently be too narrowly focused. Broadening the current scope of the program to emphasize greater coordination between physicians

and HHAs will significantly enhance the program's impact for its target population, namely patients who may have limited mobility or who require routine care for their conditions.

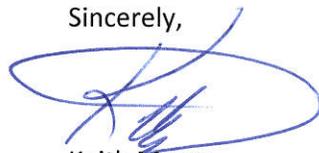
HHAs employ skilled professionals who are well-suited to providing clinically advanced, cost effective care to patients. We therefore believe that HHAs can and should be permitted to play an expanded role in the delivery of care to IAH participants. As a result, the Partnership urges the Working Group to expand both the reach and the scope of the IAH demonstration in order to deliver the best value of care to individuals with chronic conditions.

Post-Acute Care Services

Finally, the Partnership supports efforts to foster improved coordination and collaboration so that patients with chronic conditions receive the most clinically appropriate care in the most cost effective setting following discharge from the hospital. We have been proud to engage in and support discussions focusing on the creation of a clinically- and cost-effective site-neutral post-acute care (PAC) system. We also recognize from the experience of other sectors and Centers for Medicare and Medicaid Services (CMS) initiatives that bundling may have the potential to strengthen the delivery of value by fostering improved outcomes at reduced cost. As a result, we urge the Working Group to examine bundled payments for PAC services for individuals with chronic conditions and to engage stakeholders in this important exploration.

Thank you for your attention to the improving healthcare for individuals with chronic conditions. The importance of this work cannot be overstated, and we commend the Working Group for the thoughtful and open manner in which it has engaged stakeholders and the public on these issues. Our members appreciate the opportunity to provide additional input and look forward to working with the Committee as this process continues.

Sincerely,



Keith Myers
Chairman

cc: The Honorable Orrin G. Hatch, Chairman, Committee on Finance
The Honorable Ron Wyden, Ranking Member, Committee on Finance