Pennsylvania Homecare Association

The Pennsylvania Homecare Association Comments on the Policy Options Proposed by the U.S. Senate Committee on Finance Bipartisan Chronic Care Working Group

Expanding the Independence at Home Model of Care

This model has been tested by 17 physician practices serving over 8,400 Medicare beneficiaries and has already shown savings to Medicare of about $3,070 per beneficiary in the first year. The model uses physician and nurse practitioner-directed home-based primary care teams to tailor care to individuals' chronic conditions. Care teams are available 24 hours per day, seven days per week and are required to make in-home visits to provide care. To be eligible to participate, physician practices or other multidisciplinary teams must be:

- Led by physicians or nurse practitioners
- Organized for the purpose of providing physician services
- Experienced in providing home-based primary care to patients with multiple chronic conditions and
- Able to serve at least 200 eligible beneficiaries

PHA position: PHA supports the great work of the Independence at Home model, which allows more Medicare beneficiaries to receive care at home where they want to be. The success of the model proves that healthcare provided at home gives physicians and nurses invaluable information about the patient's environment and daily life, providing them with a better understanding of the person's overall health.

Expansion of the model will benefit patients and providers looking to tailor care to the individual's specific needs, however it is important to preserve the role of home health agencies in providing skilled care in the home. PHA recommends adding a requirement for eligible practices to incorporate home health agencies as part of their in-home care team. Home health providers are already doing great work coordinating interdisciplinary care in the home from skilled nursing care to social work to physical, speech and occupational therapy. This care should not be duplicated by the Independence at Home model but enhanced through the addition of physician and nurse practitioner care. In addition, patients with chronic care needs should be able to receive home health care as part of this model regardless of whether they meet typical Medicare coverage guidelines such as being homebound.

Providing Medicare Advantage Enrollees with Hospice Benefits

The current Medicare Advantage (MA) benefit package does not include hospice care, and so patients must choose an out-of-network provider when they elect to receive hospice services. MA plans are not required to assume financial risk for these patients and they continue to receive a reduced capitation payment to cover any care unrelated to the terminal diagnosis. The workgroup is considering requiring MA plans to offer the full scope of the hospice benefit as part of the plan.

PHA position: PHA members **oppose** this change which could limit patient choice and shrink hospice and palliative care benefits that are not traditionally covered by Medicare but are nevertheless offered by hospice providers. The Medicare hospice benefit should remain a separate

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Part A option outside of MA. If hospice care is "carved in," plans would be able to restrict patients' choice of providers within the network. Hospice care is unique to the emotional and spiritual needs of the patient and family, needs that might not be met within the network of available providers. MA beneficiaries make the decision to enroll in a health plan based on current and anticipated healthcare needs, not a future need for end-of-life care.

In addition, hospice agencies generally offer patients supplemental services that are not covered by Medicare such as spiritual care and bereavement counseling. Wrapping the hospice benefit into the MA plan could encourage plans to cut these essential services in the interest of cost savings.

Waiver or Elimination of "Originating Site" Requirements for Telehealth Visits
Many options discussed in the document would promote greater use of telehealth by either waiving or eliminating the restriction that patients must travel to certain authorized locations called "originating sites" in order to receive video conferenced consultations with their physician. For instance, renal disease patients who receive dialysis therapy in their homes must have a monthly clinical assessment with their physician. Currently, this monthly visit can be accomplished through telehealth but only if the patient travels to an authorized originating site such as a hospital-based dialysis facility or if the patient lives in a rural area. The workgroup proposes to expand the originating site definition to include free-standing renal dialysis facilities located in any geographic area.

Other telehealth expansion proposals include:

- *Add telehealth services into the MA plan's annual bid submission*. MA plans are able to offer certain Part B services via telehealth but they cannot be reimbursed. The proposal is to permit all plans to include these services in their annual bids to CMS to have this included in their capitation payment calculation.
- *Eliminate origination site requirement for stroke aftercare.* Similar to home dialysis care, patients recovering from a stroke can only receive telehealth consultations with a physician if the originating site is a rural hospital. The proposal would eliminate the originating site restriction for these patients.
- *Allow ACOs to waive originating site requirements*. Accountable care organizations (ACOs), similar to MA plans, are able to offer telehealth services but are not separately reimbursed for this type of care. The proposal would allow ACOs to waive originating site requirements to offer telehealth more widely.
- *Promoting ACO Use of Telemedicine.* The proposal is to clarify and educate ACOs on their ability to offer other telemedicine including remote patient monitoring, social services and transportation although this care will remain unpaid.

PHA position: We strongly believe in the vital role that health information technology has in improving the lives of the patients we serve, especially those with chronic care management issues. Any proposal that expands the use of telehealth helps to achieve the goal of patient-centered care by accommodating the unique social and environmental needs of the patient. Take for instance home health patients, who must be considered homebound to receive Medicare home health benefits. That is, it must take a considerable and taxing effort for these individuals to leave their homes without assistance. Advancements in telehealth and flexibilities in regulations would better address the needs of this population and guarantee they can receive more care at home.

It is important to allow for reimbursement to MA plans and ACOs for offering telehealth. Otherwise, these entities could view the cost as outweighing the potential benefit to patients and these services will not be widely offered.

In addition to originating site reform, the workgroup should consider expanding the scope of federal funding that is available to Medicare providers wishing to adopt healthcare technology to better coordinate care and prevent acute episodes resulting from unmanaged chronic conditions. Many home health agencies currently offer telemedicine tools such as remote vital signs and medication monitoring, even though these services cannot be billed to Medicare. Using electronic devices in the home allows the agency to adjust treatments and visit frequency as needed to avoid deterioration of the patient's condition that could lead to hospitalization, in effect preventing additional Medicare spending. In a 2008 national study of home health providers, 76.6% said telehealth led to a reduction in unplanned hospital admissions, 71.3% said telehealth improved patient satisfaction, and 49.7% said telehealth services reduced the number of visits per patient. Most importantly, nearly 90% of agencies in the survey reported telehealth services led to an increase in quality outcomes. We appreciate the workgroup's proposal to educate ACOs about telemedicine options like these, but until there is full Medicare funding for these interventions, they will not reach their potential for keeping patients safe at home and out of the hospital.