



Massachusetts Health Policy Commission: October 2013 Hearings

Exhibit B: HPC Questions for Written Testimony

BAYADA Home Health Care Responses:

Summary

BAYADA Home Health Care is a national provider of home health, rehabilitation, and hospice services to pediatric and adult patients. In 2012, over 80,000 patients were cared for by more than 18,000 BAYADA professionals serving communities in 25 states from more than 250 offices. Founded in 1975 by J. Mark Baiada, the company provides high quality care to patients covered by Medicare, Medicaid, managed care, private insurance, and self-pay. BAYADA has 10 offices providing home maker, skilled adult, and pediatric services throughout Cape Cod and eastern and central Massachusetts. BAYADA gives back to the communities it serves through numerous charitable programs including the annual BAYADA Regatta, an adaptive rowing competition for athletes with physical disabilities.

Responses to Questions

1. Health Care Cost Growth

- a. Actions Undertaken to Reduce Total Cost of Care: Over 62% of the services BAYADA provides are reimbursed through Medicare or Medicaid. Because these payers set the rates for which the services are paid BAYADA must maximize the effectiveness and efficiency of care it provides, particularly in the face of marked multiyear reductions in reimbursement. Actions undertaken include centralization of administrative, information, and purchasing services, automation of patient documentation by appropriate field staff, and the constraining of wages and benefits paid to the extent possible and reasonable in a highly competitive labor market. In addition we make a concerted effort to be certain that our care plans are appropriate and match the diagnoses and needs of the patients.
- b. Biggest Opportunities to Improve Quality and Efficiency, and Limiting Factors: From the company beginning BAYADA has implemented and maintained quality assurance and improvement activities throughout the entire organization for the purpose of identifying ways to improve care and contain costs. One example is developing software and maintaining computer infrastructure in-house. However, when the regulatory demands of the Medicare payment and documentation system necessitated unique and complex development BAYADA contracted with a leading home health software provider and automated skilled field clinicians. BAYADA uses the information contained in several large databases to analyze complex patient care issues and develop best practice protocols.

The greatest limiting factor BAYADA faces in improving care is coordination with primary and acute care providers. To address this situation BAYADA has partnered with other providers such as physician and hospital organizations with the objective of improving coordination across the patient continuum of care. BAYADA uses its information services



to provide patient assessment and outcome data to these integrated care providers, but would benefit from more electronic health record interchange with them.

Another limiting factor is the wide variation in billing requirements that exists among payers. While traditional Medicare employs a standard national system, Medicare managed care organizations do not; Medicaid practices vary from state to state and from traditional to managed care; and private insurers have little in common. These complexities and variances require a large administrative staff and complex information processing capabilities and lead to frequent delays in receipt of revenue and increased costs.

- c. *Systematic or Policy Changes to Operate More Efficiently without Reducing Quality:*
Considerable administrative effort is expended on the intake process for obtaining patient information as it remains a largely manual process. Requiring primary and acute care providers to provide electronic medical records would reduce costs, improve access to accurate and timely patient information, and expedite the development of best practice integrated care plans. In addition, increased payment rates for complex Medicaid patients would improve the ability of BAYADA to provide necessary care. Attracting and retaining skilled clinical staff is a major impediment because home health agencies (HHAs), who are at a competitive financial disadvantage in the labor market, cannot match the wages and benefits provided by large institutional providers.

There are several specific changes in Massachusetts government business that would help with increasing our efficiency and cost containment efforts. BAYADA is the largest provider of elder services in the state. Unfortunately, the Aging Services Access Points program has different sets of rules to follow across the 29 offices; standardization of the rules is needed.

The cost report submission required by the state Medicaid program is unnecessarily difficult requiring questionable detail that is time consuming and expensive to prepare and employs an archaic method for electronic processing. In addition, the requirement that we hire a certified public accountant to audit the reports for each location rather than the state accepting the company audited financial statements adds to our costs. Reporting requirements for many other states are less complex.

Another area deserving attention is the lack of a state requirement for licensure of non-Medicare certified home health providers. Home health care providers in Massachusetts must be Medicare Certified following the comprehensive Conditions for Participation for Home Health Care standards. However, at this time Massachusetts does not license home care providers. Licensure for home care agencies is another opportunity to improve quality throughout the Commonwealth. BAYADA believes in providing the highest quality of care for our clients. Licensing home care agencies ensures adherence to at least minimum quality standards. These standards will raise the profile of the industry as a whole and provide consumer protection throughout the Commonwealth.

Finally, potential Medicaid recipients in Massachusetts are not presumed eligible for home care services after a hospitalization but are presumed eligible for skilled nursing facilities. As a result, needed patient care in the community is delayed by months or



patients are unnecessarily placed into higher cost settings such as skilled nursing facilities. Changing presumptive eligibility requirements to include home care services would reduce costs to the state by placing patients into lower cost home care and preventing rehospitalizations.

- d. *Steps Taken to Ensure Cost Reductions are Passed to Consumers and Businesses:* As indicated, BAYADA must take the rates paid by Medicare and Medicaid for over 62% of company revenue. For the remaining services BAYADA contracts with numerous commercial insurance payers who primarily authorize services on a per visit or hourly basis. BAYADA works closely with these payers to identify the number and type of services necessary to achieve the best outcomes possible for patients. When necessary, BAYADA offices may, at their own discretion, provide unreimbursed services.

To accomplish this work in an increasingly cost constrained environment, BAYADA works to contain and reduce costs through economies of scale, minimization of operating costs, and by identifying and implementing efficiencies in work processes. In addition, as members of the Massachusetts Home Care Alliance (as well as several national and numerous other state association) we work closely with the association to contain the costs of providing services within the state.

2. *Actions Undertaken to Address Growth in Medical Prices:* Personnel costs constitute a greater percentage of operating expenses for home health care providers than for acute and post-acute institutional providers because the care is provided in patient's homes and the need for office space is minimal. While this permits us to provide lower cost services per unit of care, because we must compete in the same labor market as other health care providers there is little leverage available for us to reduce this primary driver of cost growth. In the areas that are available BAYADA undertakes every possible effort to contain cost growth. For example, office directors seek the lowest cost rental real estate, maximize use of low cost corporate centralized services, and utilize office team improvement activities to identify and implement more efficient practices. The savings realized from these actions have enabled BAYADA to expand its economies of scale by growing in service scope, size, efficiency, effectiveness, and geographic reach at a time when other home health providers have contracted or closed. For example, BAYADA has acquired distressed HHAs in several states (such as the statewide Medicaid HHA in Vermont) where we have provided multi-year operating subsidies to these offices for the time necessary to reduce their operating costs and expand their referral base. In addition, BAYADA has devoted substantial resources to developing best practice clinical protocols, standardized operating methods, and a robust information services infrastructure necessary to realize and maintain maximum efficiencies. BAYADA is committed to finding ways to continue making home health care an affordable alternative to acute care services thereby allowing patients to remain in the safest and preferred location of care – their home.

3. *Actions Taken to Promote Integration of Behavioral and Physical Health:*

- a. *Potential Opportunities for Integration:* Home health care is a unique service because the majority of patients have chronic illnesses or disabling conditions that make them highly dependent on others for activities of daily living (ADL) support and other care services in order to slow or prevent further deterioration in health status. As a result, behavioral health strategies are an essential component of care planning and delivery. For

example, an elderly patient with a recent cerebrovascular accident that resulted in paralysis who wishes to return home must relearn ADL practices that require substantial behavioral and physical adjustments. Insisting on performing ADLs independently in a cluttered living space places the patient at greater risk. Or, caring for a pediatric patient with cystic fibrosis requires families to make substantial life-style adjustments from scheduling to dietary regimens to learning to perform respiratory treatments. Failure to provide consistent and timely respiratory therapy can lead quickly to health deterioration. Providing care to such clients requires close teamwork between skilled nurses and therapists, social workers, home health aides, and the patient's family and physician. Effective teamwork requires developing, implementing, and reinforcing behavioral strategies that assist the patient and family with adapting to the demands of and changes in the patient's health status. To achieve the necessary level of integrated care BAYADA staff receive targeted and specialized training, clinical oversight, expert consultation, and best practice clinical resources. BAYADA clinical specialists develop training and resource materials that integrate behavioral and physical treatment strategies.

Specific examples of activities we have undertaken to further behavioral and physical integration include adding the ability to track behavioral health visits in our information systems, development and use of new assessment tools that improve early identification of health and safety risks, and implementation of falls prevention and nutritional supplement programs for high risk patients.

- b. *Implementing Integration:* The successful integration of behavioral and physical health care requires timely and patient application of skilled resources. The greatest challenge BAYADA staff face in achieving integration is with assisting families in adjusting to the demands of caring for the patient when services must be reduced as a result of cuts in authorization or in payments from payers. This problem is particularly acute in caring for complex pediatric patients.
 - c. *Systemic or Policy Changes Promoting Integration:* Cuts in service authorizations, requests for excessive and unnecessary documentation, and denials of payment for complex patients inevitably lead to health deteriorations and the resulting provision of higher cost acute care services. The problem is particularly acute for dually eligible Medicare/Medicaid patients. BAYADA urges the Commission to protect payments for care of home health care patients from harmful cuts and support and expedite completion and full implementation of the "One Care" demonstration program.
4. *Promotion of More Efficient and Accountable Care:*
- a. *Efforts to Promote Innovations and Alternatives:* BAYADA supports and is actively participating in the implementation of innovative and alternative care delivery and payment models (ACOs) in their various forms. At present BAYADA has contracts with 19 ACOs, or similar organizations, in nine states with 14 other proposals in various stages of development. Adam Groff, MD, MBA, of Dartmouth-Hitchcock Medical Center and Elizabeth Kebler, RN, PhD(c), of Rutgers College of Nursing, lead the BAYADA initiative to partner with physician and hospital groups that have organized ACOs. BAYADA development work has consisted of educating ACO leaders on the pivotal role home health care plays in improving care transitions and reducing rehospitalizations.



Internally, BAYADA staff are expanding best-practice care protocols, devising disease management programs, undertaking data mining and analysis activities, devising cross-continuum patient reporting systems, and training BAYADA clinical staff.

b. *Factors Limiting Promotion:* Factors hindering our effective participation in ACOs include exclusion from networks in geographic areas where we are significant providers, a too limited role for home health, inefficiencies in obtaining patient information, which remains a largely manual process, and inadequate reimbursement for services. Within many initiatives home health care providers are not shared risk partners and have a limited role in the management of risk. Improvements in the provision and integration of electronic medical records would enhance our ability to participate.

In Massachusetts, BAYADA is participating in the Physicians of Cape Cod and Jordan Hospital ACOs. We would like to participate in other ACOs; however, by excessively limiting patient choice several ACOs have prevented us from participating. This is an unfortunate and shortsighted exclusion as we have developed the ability to track and analyze patients and their diagnoses across the continuum of care through our Partner Portal program, which enables primary care providers to look up their patient information in our system. In addition, we have developed the BAYADA Touch program that follows up on patients after their home health discharge in order to prevent unnecessary re-hospitalizations.

- c. *Changes to Promote Efficient and Accountable Care:* Systematic or policy changes that would support our ability to promote efficient and accountable care include an expansion in the role of home health care in primary care and health promotion, and a more active and earlier role in post-acute care discharge planning. Ambulatory patients seen in primary care practices spend the majority of time in their homes where lifetime habits cause or contribute to deterioration in their health. For example, the elderly patient in early cardio-respiratory decline who experiences orthostatic hypotension that is exacerbated by poly-pharmacy and lives in a cluttered home environment is at high risk for accidents. The combined severity of these factors cannot be appreciated adequately by a primary care clinician during an office visit. Home health clinicians are skilled at assessing and working with patients to reduce such risks. Similarly, the patient who has been stabilized during an acute care episode may quickly lose the gains if home health care is not consulted early in the discharge planning process. Incentives for ACOs to expand the role of home health care would further the Commission's goal of promoting more efficient care.

In addition, there are two changes specific to Medicare home health that we believe are urgently needed. Currently, patients receiving home health services who are no longer able to remain at home safely, but are not in need of acute care, can only be admitted to a skilled nursing facility after a 3-day hospitalization. We believe that this requirement adds unnecessary costs to the Medicare program and exposes patients to needless iatrogenic and nosocomial risks. Waiving the rule would enable HHAs and primary care clinicians to more effectively manage chronic and disabled patients in the safest and most cost effective environments.

The second policy is the CMS requirement for a face-to-face physician encounter with a patient in a period of time surrounding the home health admission. While this requirement may be a logical policy it was enacted for narrow anti-fraud reasons and has resulted in sizable additional costs and decreased revenue for HHAs as a result of denials of necessary services for needy patients that are not the fault of the HHA. Furthermore, it has resulted in some HHAs currying favor with physicians by violating CMS rules through writing authorization text for them while other HHAs, who abide by the rules, end up generating tension with referring physicians by pressuring them to comply with the CMS requirement. We believe there are other effective and less costly mechanisms available to the CMS for reducing the fraud for which this policy was enacted, some which the MA state surveyors could assist with enforcing and/or implementing.

While both of these policies are federal and outside the authority of the Massachusetts government, the Commission should be aware that they add to the cost of home health care services and hinder its effectiveness. We encourage the Commission to ask the state Congressional representatives to support legislative reform of both regulations.

5. Metrics BAYADA Uses to Track Operational Costs:

- a. Units of Analysis: While cost structures vary across the different BAYADA business lines, measurement is focused at the individual office level. Service office directors operate under a budget that they set and are responsible for managing their revenue and costs. Their performance primarily is measured by the gross margin of total revenue minus total direct costs.
 - b. Performance Benchmarking: Due to the nature of the home health business little reliable and meaningful cost structure data is available. While some HHAs are publicly owned or not-for-profit, most are private. Many not-for-profits include hospital owned and operated HHAs where administrative costs often are mingled. In addition, financial measures vary considerably across the business lines of private duty, staffing, personal care, skilled care, rehabilitation, and hospice. Public sources of cost data, such as the Medicare cost reports have been shown to be unreliable. The primary method of benchmarking operational costs used by BAYADA is internal with the performance of over 250 offices compared within business lines and across geographic locations. Additional performance benchmarking for the Medicare skilled care business takes place through analysis of Medicare national claims data.
 - c. Metric Management: BAYADA manages the performance of its metrics through quarterly and annual performance reviews of offices, service divisions, and at the company level. In addition, offices perform a variety of daily and weekly patient and business reviews all with the sole objective of ensuring that we are providing the compassionate, excellent, and reliable services our clients need. Measurement is a continual process at BAYADA with refinements of our metrics devised as necessary.
6. Plans to Undertake the Provision of Health Service Cost Information to Patients: BAYADA has not yet undertaken planning for the provision of specific cost information for patients and would greatly appreciate the guidance of the Commission on how to meet this requirement. While a



simple method might be to add the direct labor costs of every visit provided and add to it a reasonable administrative percent doing so could add substantially to our administrative costs. A review of the requirement suggests that it was devised with institutional providers in mind. For example, BAYADA does not have an “allowed amount or charge and any facility fee”, rather we have a standard charge. In the event that a non-contracted insurer or private payer requests services each of the BAYADA offices is free to use the company standard or charge the level the director deems reasonable and necessary.

However, upon their admission to services and after ascertaining the source of payment, we do provide a letter to each client informing them of their patient rights, copayment requirements, and potential liability for the cost of services. For our Massachusetts Elder Services patients we document eight direct and indirect costs of services including travel time, vacation hours accrued, in-service time incurred, etc., plus calculate a per hour administrative cost.

7. Comments on Report Findings: We think it good and constructive that the State of Massachusetts is using the CMS Hospital Compare and AHRQ HCAHPS data in evaluating the performance of health systems within the state. We have extensive experience with these systems as BAYADA Medicare services have been measured under the CMS Home Health Compare system since 2004, the HCAHPS system for four years, and have undergone CHAP accreditation (previously JCAHO) for many years. In addition, we always have undertaken internal quality assurance activities such as patient and employee satisfaction surveys and incident report analyses. We have expended considerable effort to utilize this information for the improvement of care for our patients. More recently, we have worked with hospital partners to help them understand the important role that home health care plays in reducing their 30-day rehospitalizations rates. This has included providing them with analyses of the outcomes of all their patients referred to home health care regardless of HHA provider.

We note with particular interest in Figure DA 14: HCAHPS Tables, the table representing the performance of the health systems in the section for the “% of patients who reported that they were given information about what to do during their recovery at home”. The statistics, which range in a narrow band from 84.6% up to 90.0%, likely conceal important failures in the measurement objective of improving transitional care. As home health providers we know only too well how patients that apparently had adequate education and discharge preparation when receiving institutional care are unable to remember, understand, or translate the instructions once they arrive at home. We are expert in assisting patients and their families with accomplishing this transition successfully.