September 19, 2013

David Seltz, Executive Director
Stuart Altman, PhD, Health Policy Commission
Thomas O'Brien, Chief, Health Care Division, Office of the Attorney General
Aron Boros, Executive Director, Center for Health Information and Analysis

Dear Sirs:

Porchlight VNA/Home Care appreciates this opportunity to present testimony to the Health Policy Commission, Office of the Attorney General, and Center for Health Information and Analysis on home health care's relation to, perspectives on, and health care cost trends in the Commonwealth. Porchlight VNA/Home Care has been serving Berkshire County and the hill towns of Hampden and Hampshire Counties for over 100 years. Many of the patients we see are in very remote areas. They are unable, without considerable effort, to get to primary medical care. Our focus has always been on population health in our community and individual patient care.

With this history and mission, we cannot help but be enthused that our system is moving toward models in which care providers feel a shared sense of accountability for both resource utilization and patient outcomes. We have long been frustrated that misaligned incentives and insurance rules have hamstrung us when it comes to being creative in crafting a patient-centered care plan, delivering evidence based in-home services such as care transitions and patient teaching and providing medication administration, falls prevention and disease management.

This testimony reflects our responses to the specific questions from our perspective as a relatively small, but progressive, freestanding not-for-profit VNA operating in Western Massachusetts. At times, this testimony also incorporates our perspective from within the broader home health care community.

1. Chapter 224 of the Acts of 2012 sets a health care cost growth benchmark for the Commonwealth based on the long-term growth in the state's economy. The benchmark for growth between CY2012-CY2013 and CY2013-CY2014 is 3.6%.

   a. *What are the actions your organization has undertaken to reduce the total cost of care for your patients?*

      Summary Statement: The goal of Porchlight as part of the Massachusetts health care continuum is to deliver the highest value care to the highest needs individuals. The savings we produce in terms of "total patient costs" are often achieved by substituting high quality home care for higher level care (nursing home) or as a sentinel service to prevent Emergency Department (ED) visits and rehospitalizations. Therefore, the challenge for Porchlight VNA/Home Care has not been as much about getting our individual per service costs down, as it is putting in place programs that maximize our value to other parts of the system and getting our services appropriately utilized.

      Response: To add value to the health care delivery system in home care often means "subtraction through addition." To reduce both our cost per episode of home care and to increase our capacity to support evidence-based patient self-management and readmission reduction, we have incorporated remote monitoring, or telehealth, into our care for cardiac,

respiratory and all high-risk patients. Our internal studies for this technology show savings and a lower than average rehospitalization for these patients. Our numbers are small. The Center for Connected Health, as well as others, has validated the savings per episode of home care in terms of readmission reduction. (See http://www.commonwealthfund.org/Publications/Case-Studies/2013/Jan/Telehealth-Partners.aspx and http://www.hrsa.gov/healthit/toolbox/RuralHealthITtoolbox/Telehealth/howcantelehealth.html and *Attachment A*).

Additionally, we have added a Nurse Practitioner (NP) to our care team. The NP is available to make home visits that in the past were often reasons that patients were ordered to the ED by a physician. For example, the NP can write a prescription to change a medication dose or administer IV Lasix as well as other numerous high-tech treatments for patients to keep them at home avoiding ED visits. Stabilizing patients in the home requires using an advanced practitioner in conjunction with other home care services such as Nursing, Physical Therapy, Occupational Therapy, Speech Therapy, Home Health Aide services. This is an annual investment by our agency that returns dividends to the system.

Finally, it should be noted that Porchlight is a provider of non-clinical community-based services. In addition to providing homemakers, personal care attendants and companions to the Massachusetts Executive Office of Elder Affairs for state-funded programs and waivers, we provide families in Western Massachusetts ***affordable, privately paid*** home care services. Many of these families might well be turning to nursing homes and eventually MassHealth were it not for what we are able to provide. ***If only 10% of the patients and families for whom we provide this valuable service were instead to turn to a nursing and "spend down" to MassHealth, the annualized costs to the state would be approximately $1.8 million.***

a. *What are the biggest opportunities to improve the quality and efficiency of care at your organization? What current factors limit your ability to address these opportunities?*

Summary Statement: In home care, almost all costs (67% at Porchlight VNA/Home Care) are in our staff, our salaries and our benefits. Because our major payer (Medicare) is potentially going to reduce payments by 14% (prior to sequestration) over the next few years, we are always looking at ways to make operations leaner. Using benchmarking metrics (see question 5 response) is key, as is a focus on productivity. The degree of regulations in our sector is, however, a highly limiting factor in streamlining costs.

Response: Our biggest issue in terms of improving efficiencies is to train staff to deliver the same quality experience with the same outcomes to patients in fewer visits. The telehealth system referenced above is critically important to this effort. Monitoring vital signs remotely gives our staff and the patient's physician objective and targeted vital signs data to support clinical decisions, schedule visits as needed, and most importantly, to identify *before a crisis* when a patient's condition appears to be worsening.

Limiting our ability is the fact that these telehealth systems that are so successful in improving both efficiencies and outcomes are not reimbursed by Medicare, Medicaid or private insurers. Massachusetts Medicaid and other insurers should take steps to incorporate telehealth home health as reimbursable services.

Also limiting the efficiency of our sector of the health care marketplace is unchecked growth in the numbers of home health providers. We have seen a greater than 30% growth in the number of federally-certified agencies in the past few years in Massachusetts, in a market with no uncovered areas. Many of these new entries have neither the volume nor the capital to invest in the staff training and capacity building needed to support the Massachusetts care transitions and patient-centered care agendas. Their outcomes (and readmissions rates) in their start-up years tend to be higher than more established agencies. They aggressively seek to provide care for patients whose profiles indicate a high Medicare profit margin, making agencies such as Porchlight VNA/Home Care, who takes all patients, more fiscally vulnerable.

b. *What systemic or policy changes would encourage or help organizations like yours to operate more efficiently without reducing quality?*

Porchlight VNA/Home Care believes that the state needs to do more to sustain and support efficient providers who are investing in innovation. On a state policy level, Massachusetts should follow the path of many other New England states and support, at least temporarily, the Certificate of Need or Moratorium on new agencies.

On the federal level, Porchlight VNA/Home Care and other Western Massachusetts home health providers would also like the state's support in getting our agencies access to "rural add-on" that Medicare provides for home health payment. . The federal Department of Health and Human Services (DHHS) has listed approximately 40 Western Massachusetts towns as "rural" for purposes of health care grant funding, The MA Special *Commission on Rural Access and Improving State Sponsored Services* designates 29 towns in Hampshire and Hampden counties as rural. Our Western Massachusetts hospital receives enhanced payments through wage index adjustments and critical access status. Yet, our Western Massachusetts towns are not considered rural for the purposes of home health payment, forcing us to lose access to a 3% federal add-on. We have sought the support of our Congressional delegation in changing this, but need Executive Branch Support.

Just as the HPC is looking to support our Accountable Care Organizations in waiving Medicare rules inhibiting creativity around needing a three day qualifying stay for nursing home covered care, so should the state look to eliminate home care regulations that drive costs and inhibit creative caregiving. We would suggest two areas where support for federal waivers would make us more efficient: 1) Waiving Medicare's homebound requirement for certain patients, as this rule too often creates for us a significant gap between need and coverage for some of the more complex patients, and 2) moderating the new Medicare Face-to-Face requirement coverage rule for accessing home care.

c. *What steps are you taking to ensure that any reduction in health care costs is passed along to consumers and businesses?*

This is less applicable to our business than to other sectors.

2. The 2013 Examination of Health Care Cost Trends and Cost Drivers by the Attorney General's Office found that growth in prices for medical care continues to drive overall increases in medical spending.

What are the actions your organization has undertaken to address the impact of prices on medical trends and what have been the results of this action?

Summary Statement: Porchlight VNA/Home Care agrees with the Attorney General, who has raised flags in her two reports on ***Health Care Cost Trends and Drivers,*** as to how the size and increasing market share of certain systems may be adding to, rather than reducing costs. Our experience in Western Massachusetts confirms that the increasing concentration in our market around a single system is, as the AG pointed out, "limiting options for vulnerable populations" for accessing certain services. The accompanying decrease in referrals to freestanding home care agencies is making it less and less possible for an agency, such as Porchlight VNA/Home Care, to fairly compete according to typical market forces, by offering either lower costs or higher quality. As this concentration continues, there seems to be less and less market pressure to achieve efficiencies and pass those on to consumers via lower rates.

Response: Attorney General Coakley's report includes the recommendation that because of "consolidation and expanding provider responsibility under alternative payment arrangements, regulators will need to ensure that providers do not engage in discriminatory, unfair, or predatory conduct that might improperly limit care options for vulnerable populations or place undue risk on providers themselves."

With the utmost respect for the parties concerned, we strongly support this sentiment and would urge that parameters be established for mergers and integrated care arrangements to monitor coercive behavior in use/nonuse of community agencies that meet quality standards, with particular focus on pressures on case managers, physicians and systems of care to restrict their referring practices.

3. C224 seeks to promote the integration of behavioral health and physical health. What are the actions that your organization has undertaken to promote this integration?

   a. *What potential opportunities have you identified for such integration?*
   b. *What challenges have you identified in implementing such integration?*

   Summary Statement: Given the population that we serve – often isolated, homebound and without local family support - there are tremendous opportunities for home health agencies to be at the forefront of the advancement of integrated behavioral and physical health care.

   Response: The challenges we face are primarily rooted in historical reimbursement structures that have essentially been ill-designed to support a behavioral health program at a VNA such as ours. MassHealth had, in the distant past, recognized with a higher rate per visit, both the cost and value of bringing psychiatric nurses into a home care team. MassHealth also had a rural add-on for nurses needing to travel long distances to see clients. Today's MassHealth per visit rate is the same for any nursing visit regardless of care or location. This rate has not been updated in more than five years and currently, barely covers our direct costs for a traditional nursing visit. Attracting nurses with psychiatric training at these rates is impossible.

   Most of the work we do with clients of private insurers who have unmet behavioral health needs is coordinated through a PPO. Porchlight and many other freestanding not-for-profit VNAs utilize the services of the Visiting Nurse Association of New England (VNANE) for negotiating private insurance contracts. They, too, have found insurers reluctant to engage in discussion that would enhance our ability to provide integrated care for this population, such as a blended per visit rate for medical and behavioral health care. These entities usually rely solely on outpatient psychiatric providers, such as the Brien Center in our area for these services. While we work closely to refer patients to the Brien Center, we see many patients for whom such a visit is not possible and remain frustrated by limited coverage and reimbursement policies.

   c. *What systemic or policy changes would further promote such integration?*

   One systemic change that we strongly support is specifying – in the state's qualifying credentials for an ACO, a Primary Care Medical Home (PCMH), or a One Care (duals) provider – that home-based behavioral health for isolated patients is an essential core competency. The state should also include in the infrastructure design some explicit direction on the use of home-based services that supports inclusion of *existing quality providers* and avoids development by ACOs of duplicative community care services. Our state needs to be much more explicit about using existing resources in new ways rather than "recreating" the wheel to meet identified needs.

4. C224 seeks to promote more efficient and accountable care through innovative care delivery models and/or alternative payment methods.

   a. *Describe your organization's efforts to support these goals.*

   In addition to what has been presented, Porchlight VNA/Home Care has been working with a number of peer agencies across the state and with physician practices to embrace the expansion of home care services beyond the traditional model in ways that meet the state's C224 goals. We have developed and submitted, in conjunction with Rx2 Educate, a grant application to the federal Center for Medicare and Medicaid Innovation that combines our advancements in working directly with physicians and our monitoring technology. Our "Structured Clinical Care Coach" would assist physicians in the management of patients with chronic disease by placing a specially trained Clinical Care Coach/Medical Assistant in the office to support clinical staff by monitoring high-risk patients with the use of an in-home telemonitoring system. This system is capable of monitoring vital signs, weight, blood glucose, and oxygen saturations and has been shown to be particularly effective in managing patients with diabetes and cardiac disease. In addition, patients would be progressively educated about their disease process and are continuously involved in the self-management of their own care.

b. *What current factors limit your ability to promote these goals?*

1. Lack of consistent reimbursement for home-based chronic care management.
2. Lack of grant funding to test innovation in home care.
3. High, non-reimbursable costs associated with the building of Electronic Medical Record (EMR) portals to accommodate different settings and EMR formats.
4. Lack of attention to modeling post-acute care (across all payers) that support best most cost-effective setting given the patient clinical needs.

c. *What systemic or policy changes would support your ability to promote more efficient and accountable care?*

I would mention three:

- Modeling Patient Centered Medical Homes (PCMHs) to use home care skills rather than recreating them

  The movement toward PCMH is generally a positive one. However, we work with many small practices and it seems that the way the criteria is either drafted or understood, these practices seem to feel the need to build, rather than buy existing experienced case management support (which we are already required by federal regulation to have). This practice threatens to add another layer of costs into the system. Likewise, an essential PCMH performance measurement may well be their success in keeping patients out of hospitals and emergency rooms on evenings and weekends. Yet, many practices may find 24/7 operation to be too onerous. At Porchlight VNA/Home Care, we see greater potential for practice transformation to a PCMH to be more successful and less costly if the practice qualifications established by Massachusetts explicitly direct that practices build on (rather than seek to recreate) the existing home health competencies in areas such as care management and 24-hour patient support.

- Recognize the Role of Home Care in ACOs

  Require community-based providers on governing boards of ACOs. Recognize and encourage for new models of payment that embrace a methodology for fair allocations of global payments, the testing of creative, non-fee-for-service payments that are appropriately severity/risk adjusted, and pay/bonus for improvement. The CMS episodic method of reimbursement, which is used in fee for service as well as some Medicare managed care arrangements, should be used as the basis with the addition of a pay-for-performance risk pool.

- Rethink the State's Definition of Safety Net Providers

  The HPC and other state agencies need to expand their thinking as to what constitutes a safety net or endangered essential community provider, which at this point appears to be primarily defined as a community hospital. Porchlight VNA/Home Care and agencies that look and operate like us are, and can be even more supportive of, efforts to address not just patient care, but population health. We have strong local connections and community support based on a history of providing significant free care (that is not tracked in any community benefit database), of conducting public health clinics, administering flu shots, hosting community education, and sponsoring support groups on everything from bereavement to management of diabetes.

5. What metrics does your organization use to track trends in your organization's operational costs?

As a high-performing home health agencies, Porchlight VNA/Home Care has a complete management dashboard to measure our performance against like agencies locally, in New England, and nationally. See *Attachment B* for an example of our auditors New England operational indicators financial metrics.

Porchlight uses a host of productivity measures including time spent per visit on direct care, travel and administrative paperwork. We track visits per day for the agency and individual clinicians, visits per episode, and cost per visit per discipline. We track our census, our referrals, our short-stay episodes (called LUPAs by Medicare) as well as the case mix acuity of our patients.

Because payment from our largest payor, Medicare, are fixed per episode and dropping annually, we have had to remain extremely cost conscious. For example, in our care for wound care patients, we seek the most effective products at the lowest costs to deliver quickest healing time.

a. *What unit of analysis do you use to track cost structure?*
The key variables in our industry that we track are our cost per episode and cost per visit for all disciplines of services we provide.

b. *How does your organization benchmark its performance?*

All certified home health agencies are required to report clinical outcomes and process measures to CMS. Fifteen of these measures are posted on the federal Home Health Compare site. These are updated quarterly and available for benchmarking against state and national metrics. (See Appendix C example of report provided by our state Association Home Care Alliance of MA). Subsets of these measures are also available and updated quarterly on the Mass Hospital Association website Patient Care Link www.patientcarelink.org.)

c. *How does your organization manage performance on these metrics?*

Porchlight VNA/Home Care, like many in our sector, uses a private company Strategic Health Partners (SHP) for benchmarking our clinical performance. We are able to track our readmission rate per episode of care. Our rate at present is 11.3% versus a statewide rate of 17% and a national rate of 17%.

6. Please describe actions your organization has undertaken or plans to undertake to provide patients with cost information.

Whenever a patient is admitted to our services we provide them with a consent form (*Attachment D*). Details of the patient's costs and copays are completed upon the opening of a case. The patient signs this acknowledgement after reviewing it with the practitioner and validating an understanding of the costs.

7. After reviewing the reports issued by the Attorney General's Office and the Center for Health Information and Analysis, please provide any commentary on the findings presented in light of your organization's experience.

Porchlight VNA/Home Care has previously in this letter indicated support for the Attorney General's expressed concerns about the impact of rapid market consolidation on patient choice, cost and access to quality providers for vulnerable patients. This is a sentiment that most of the 60% of home health agencies that are unaffiliated with any health system share. We strongly believe that allowing ACOs to be too tightly formed along current hospital or organization-based alignments could consolidate market power in too few organizations and be a death knell for many of the state's oldest and most community-focused agencies.

The ACO architecture we believe must support broad participation possibly in a virtually integrated model from a broad portfolio of home health providers provided that they demonstrate quality outcomes and are able to engage in and support an ACO's performance measurements.

The market analysis of the Center for Health Information and Analysis (CHIA) has yet to fully look at post-acute services supply, demand, cost and quality. We recognize that this is on the agenda for the state's Health Planning Council, but the current composition of the home health care industry, their unique patterns of care delivery and their dual role as providers of both post-acute services and long-term care support services may need immediate attention.

On behalf of the patients, staff of Porchlight VNA/Home Care and other Massachusetts home health agencies, I appreciate the opportunity to offer this testimony.

I certify that I am legally authorized and empowered to present this testimony on behalf of Porchlight VNA/ Home Care. I sign it under the pains and penalty of perjury.

Holly Ann Chaffee RN BSN MSN

Holly Chaffee, RN, BSN, MSN
President, Chief Executive Officer

Attachments:

A. Telehealth Study
B. New England Operational Indicators
C. Samples Outcomes Dashboard
D. Patient Consent and Disclosure Form