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**STATEMENT SUBMITTED BY
THE NATIONAL ASSOCIATION FOR HOME CARE & HOSPICE
TO THE
HOUSE ENERGY AND COMMERCE
SUBCOMMITTEE ON HEALTH
APRIL 16, 2015**

The National Association for Home Care & Hospice (NAHC) is 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. NAHC has worked constructively and productively with Congress and the regulators for three decades, offering useful solutions to strengthen the home health and hospice programs.

As the House Energy and Commerce Subcommittee on Health reviews Medicare post-acute care delivery and options to improve it, including the Bundling and Coordinating Post-Acute Care (BACPAC) Act (H.R. 1458), NAHC appreciates this opportunity to provide our views. We agree with the Chairman and Ranking Member that we should develop the right reforms in post-acute care (PAC) that can both improve care for today's seniors and help extend the fiscal viability of the program well into the future.

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, keeping families together and preserving individual dignity. Our members are participating in the new innovations and demonstration projects with enthusiasm and good ideas, seeking greater efficiency while providing high quality services in the home. We pledge to continue to be good partners in finding solutions.

Significant health care delivery reforms that have the potential to alter how and where patients receive care are currently being tested through the Centers for Medicare and Medicaid Innovation. Overall, many of these reforms shift the focus of care from inpatient services and institutional care to the community setting. Further, these reforms provide a combination of incentives to clinically maintain patients in their own homes and penalties for excessive re-hospitalizations of patients. Importantly, these reforms also focus on individuals with chronic

illnesses, providing support for health care that prevents acute exacerbations of their conditions and avoids both initial and repeat hospitalizations. We believe the demonstration projects that are testing a variety of integrated care models and payment structures will provide valuable guidance on how to reform the post acute care system.

GUIDING PRINCIPLES FOR POST-ACUTE CARE PAYMENT REFORM

Post-acute care is growing in importance for our nation's Medicare beneficiaries as they age often with multiple chronic illnesses. As the Medicare population evolves, any post-acute care reform proposals should be evaluated under the following guiding principles:

1. Individuals should have access to care in the least restrictive and clinically appropriate care setting.
2. The original right of Medicare beneficiaries to have the freedom to choose any qualified provider should be preserved.
3. Payment and service model reforms should be developed with the participation and input of all stakeholders.
4. Any pre-existing, nonessential regulatory barriers to full success of the reforms should be removed.
5. With the great diversity in the Medicare population, any payment model should rely on a robust risk adjustment that fairly reflects the nature of the population served in the model.
6. Systemic reform should follow the pilot testing of multiple reform model options that are designed to determine the best path forward.

ENSURING THAT PROPOSALS TO “BUNDLE” POST-ACUTE BENEFIT PAYMENTS FOCUS ON COMMUNITY-BASED CARE OPPORTUNITIES: A MODEL TO CONSIDER

A central goal of any reform of Medicare post-acute care payment models should be to provide the greatest possible degree of support for care in the community rather than in an institution. People prefer care in the community in their own homes.

To achieve that end, we believe it is important that best PAC payment bundling arrangements are managed by post-acute care providers rather than acute care providers. The expertise in post-acute care lies in the post-acute care community. The payment model and care 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 post-acute care providers, including home health agencies. We believe this will ultimately deter unnecessary re-hospitalizations, thus reducing health care risks 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.

A community-based care model for PAC bundling can operate in a number of ways. Given the evidence regarding the importance of involving home health providers early in the care transitions process, the most effective bundling model integrates community-based care providers such as home health agencies into the 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 can be 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 editions 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.

We also believe that the use of telehealth should be a high priority in a PAC bundling system 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 care settings, while being more engaged with their care and having 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.

BUNDLING DEMONSTRATION PROJECTS

The Patient Protection and Affordable Care Act (PPACA) (H.R.3590; P.L. 111-148) called for launching a post-acute care bundling pilot program by 2013. Among the bundling

options that are being tested is one where the bundled payments for post-acute services would be held by home health agencies. The Medicare Center for Innovation initiated a four-model Bundled Payments for Care Improvement (BPCI) initiative in 2013. Models 2 and 3 included post-acute care services. Model 3 BPCI is focused on post-acute care services provided 30, 60, or 90 days following an inpatient stay. Currently, there are thousands of providers throughout the nation participating in bundling demonstrations. Among the participants are many home health agency-related organizations.

With Model 3 BPCI, there are 60 awardees with 142 providers actively engaged in Phase 2 bundling of PAC payments and services. Another 240 participants with 4,646 providers are in Phase 1 of the demos.

With Model 2 BPCI, there are 20 awardees with 81 providers in Phase 2 bundling of inpatient and PAC services. Another 364 participants with 2,036 providers are in Phase 1.

These demonstration programs offer the promise of increased understanding of what works and what does not. Proceeding otherwise creates avoidable risks for Medicare and vulnerable Medicare beneficiaries.

Congress should monitor the bundling pilot program authorized by PPACA to ensure that we learn all that is possible before instituting systemic reform. Bundling innovations should also be evaluated in terms of any change in administrative burden on beneficiaries and providers. One area of concern with the bundling of home health services stems from the fact that over one-half of home health patients do not come to home care through an inpatient hospital discharge. Instead, many start home health services following a referral from a community physician who is caring for the patient in a community setting.

Any PAC bundling system must be devised in a manner that recognizes that it might result in multiple payment systems for home health — one for post-acute patients and one for patients entering home care from the community. This multiple-track system could result in uneven Medicare coverage for patients with the same care needs. While bundled payments are a promising innovation, it must be carefully monitored to ensure no adverse unintended impact on care access and quality.

THE BUNDLING AND COORDINATING POST-ACUTE CARE (BACPAC) ACT

The “Bundling and Coordinating Post-Acute Care (BACPAC) Act” (H.R.1458) offers a model that adds to the dialogue on the many options available to reform post acute care payment. In line with NAHC’s longstanding position of advancing innovative reforms, we are supportive of the intended goals of BACPAC and appreciate the efforts of its sponsors. We applaud the fact that BACPAC would take advantage of home care innovations and would waive the homebound and face-to-face physician encounter documentation requirements.

We are concerned, however, that implementing nationwide post-acute bundling at this time would be a massive systemic change without the benefit of the knowledge we stand to gain through the thousands of providers engaged in ongoing PAC bundling models. As such, while BACPAC is an example of bundling to be considered, it is a time for learning what it takes to create the most successful reforms rather than for prematurely imposing an untried, systemic

model of payment and service that would affect the care and lives of over 5 million Medicare beneficiaries who use post-acute care annually.

The BACPAC bundling model addresses partially some of the most important issues presented in a bundling design. For example, BACPAC sets out the standards for what Medicare services are included and excluded in the bundle. However, with the exclusion of such items as physician services, BACPAC preempts alternative approaches in an area that is part of the learning expected from the current demonstration projects.

Another concern is that much of the design for PAC bundling is left to CMS and HHS. For example, the risk adjustment that is essential to the success or failure of a bundling model includes some parameters, but at a level of specificity that falls short of insuring that the congressional intention is secured in implementation.

Finally, any bundling reform should be integrated with the recently enacted IMPACT Act (H.R.4994; P.L.113-185) which has a deliberate timeline for developing the uniform assessment tools to enable bundling in the post acute setting. That assessment is a key component to effective care management of Medicare beneficiaries in need of post acute care. It will drive decisionmaking in terms of both care and the care setting.

CONCLUSION

NAHC wishes to thank the Committee for its leadership in this increasingly important area of Medicare policy. We are open and available to the Committee at any time to continue the dialogue on this vital subject.