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January 29, 2016

VIA EMAIL TO: chronic_care@finance.senate.gov

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

Re: Senate Finance Committee Bipartisan Chronic Care Working Group Policy Options Document

Dear Senators Isakson and Warner:

Amedisys, Inc. ("Amedisys"), a national home health agency ("HHA") and hospice provider providing care in 34 states through more than 450 Medicare-certified home health and hospice centers, appreciates the opportunity to comment on the Policy Options Document issued on December 18, 2015, by the Senate Committee on Finance – Bipartisan Chronic Care Working Group ("Working Group").

Amedisys is an active member of the Partnership for Quality Home Health ("PQHH"), the Alliance for Home Health Quality and Innovation (the "Alliance") and the National Hospice and Palliative Care Organization ("NHPCO"), each of which is submitting its own comments on the Policy Options Document on behalf of the members they each represent. Amedisys appreciates the Working Group for providing interested stakeholders with the opportunity to comment on the proposals and will remain engaged and active with the Working Group, the Senate Finance Committee and the Congress as the discussion progresses on how to care for those with chronic illnesses. We believe home health and hospice specifically are vital to improving the quality of care and lowering the costs of providing care to those with chronic illnesses.

HOME HEALTH IN THE CONTEXT OF CHRONIC CARE

Overall, the Policy Options Document presents a variety of potential policy solutions to combat the rising costs of caring for chronic illnesses in our aging population. Although home health is briefly mentioned in the document, we believe home health plays a significantly larger role in addressing the care needs of those with chronic illness than is reflected here. Therefore, home health must be central to any discussion addressing care needs for chronic conditions. Again, home health providers are already treating those with chronic conditions. Recent statistics on this topic

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evidence that over 85% of all Medicare home health users have three or more chronic conditions, compared to 65.5% for all Medicare beneficiaries.[1] This data demonstrates how Medicare-certified HHAs already have a statistically significant patient base suffering from multiple chronic illnesses. Clearly, HHAs are already at the forefront of providing care to these patients with chronic illnesses. Accordingly, it is in the best interest of patients, their caregivers, and the overall vitality of the health care system that HHAs play a more prominent role in the discussion on reforms to the delivery of care to those with chronic illnesses.

Home health agencies across the country are already serving this population and are in an ideal position to expand on the care management services already being provided. The title of the Policy Options Document section "Improving Care Management Services for Individuals with Multiple Chronic Conditions" speaks for itself. The unfortunate disconnect between the perception of the Medicare home health benefit and the reality is a problematic hurdle in recognizing the home health benefit's value to Medicare beneficiaries and to our health care system. One misperception is that home health care is only a post-acute care provider, when in fact, many home health patients are referred to agencies directly from physicians' offices without a preceding acute care stay. These physicians who refer directly to home health care recognize the value of skilled, professional nurses, therapists and social workers (and when appropriate, home health aides) as an appropriate follow up on the findings from the physician's office visit. Through skilled observation, assessment, teaching, training and care delivery, the home health clinician helps the patient to achieve self-management and to realize their goals of care.

The Policy Options Document states "[t]hese beneficiaries also have complex, time intensive, and labor intensive care management needs that extend beyond the time available during an in-person visit with a clinician."[2] We could not agree more. The good news is that home health nurses are already skilled care managers and can provide this service in the only place where health really happens – the patient's home. There are many examples of the patient's "picture" being significantly different in the physician setting with the doctor, physician's assistant or nurse practitioner than it is in the home. The eyes and ears of our talented home health care professionals help close this gap. We agree that 20 minutes per month is "insufficient to capture the time needed for a clinician to manage a complex patient's care."[3] However, it may be adequate time for the physician, physician's assistant or nurse practitioner to consult with the home health care professional who is seeing what is actually happening in the patient's home.

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1 Demographics of Home Health Users, Avalere analysis of the Medicare Current Beneficiary Survey, Access to Care, 2013.

2 United States Senate Committee on Finance – Bipartisan Chronic Care Working Group – Policy Options Document at p. 12, released for comment December 18, 2015.

3 Id.

Furthermore, the Medicare home health benefit already provides for managing chronically ill beneficiaries. Chapter 7 of the Medicare Benefit Policy Manual states:

> Skilled nursing visits for management and evaluation of the patient's care plan are also reasonable and necessary where underlying conditions or complications require that only a registered nurse can ensure that essential unskilled care is achieving its purpose. For skilled nursing care to be reasonable and necessary for management and evaluation of the patient's plan of care, the complexity of the necessary unskilled services that are a necessary part of the medical treatment must require the involvement of skilled nursing personnel to promote the patient's recovery and medical safety in view of the patient's overall condition.[4]

However, utilization of this part of the benefit is not without additional administrative burden, as "[w]here a patient's sole skilled service need is for skilled oversight of unskilled services (management and evaluation of the care plan as defined in §40.1.2.2), the physician must include a brief narrative describing the clinical justification of this need as part of the certification, or as a signed addendum to the certification."[5]

Because of this additional burden for physicians, and because it is difficult to demonstrate this skill through documentation, this is an underutilized feature of the Medicare home health benefit. Thus, simply modifying and reforming this administrative requirement contained in the current Medicare regulations could be a minor adjustment to achieve the Working Group's goals.

Likewise, the homebound requirement prevents the Medicare home health benefit from being utilized to meet the needs of chronically ill individuals who do not meet the CMS definition of homebound. We ask policymakers to continue to consider whether this distinction is a barrier to meeting the needs of the nation's aging population. The final report of the 2015 White House Conference on Aging acknowledges that "older Americans overwhelmingly prefer to stay in their homes and communities as they age."[6] There is an established cadre of skilled home health care professionals prepared to help all chronically ill individuals age in place. This is a workforce already possessing all of the competencies and skills to meet the needs of this population, and we ask the Working Group to consider how to better capitalize on these existing resources to meet its goals.

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[4] Medicare Benefit Policy Manual - Chapter 7, Section 40.1.2.2, "Management and Evaluation of a Patient Care Plan" (*Rev*. 179, *Issued*: 01-14-14, *Effective*: 01-07-14, *Implementation*: 01-07-14) A3-3118.1.B.2, HHA-205.1.B.2

[5] Id.

[6] White House Conference on Aging – 2015 Final Report – Released December 29, 2015, at p. 9.

Amedisys joins the Alliance in its comments about the overall role of home health in caring for those with chronic conditions, as HHAs already provide skilled care at home for those with acute, chronic and rehabilitative conditions. Further inclusion of home health in the discussion related to caring for those with chronic conditions will advance the Triple Aim of improved population health, improved patient experiences and lower per capita cost of care.

We would like to take this opportunity to make a brief comment on the technology discussion found throughout several of the policy options. We commend the Working Group for recognizing the critical role technology can and should play in addressing chronic diseases and for providing a variety of policy options for stakeholders and policymakers to consider as this dialogue on chronic care continues. We urge the Working Group to further engage stakeholders on this issue and specifically to work with other policymakers to include a Remote Patient Monitoring benefit for Medicare beneficiaries through the current fee for service system.

Finally, Amedisys welcomes any opportunity to work closely with physicians in an expanded Independence at Home model. Continued collaboration between physicians and home health agencies should only strengthen this model.

HOSPICE INCLUSION IN MEDICARE ADVANTAGE BENEFITS – THE UNINTENDED CONSEQUENCES

Additionally, as a provider of hospice services, Amedisys fully supports the role of the NHPCO and its comments directed to the proposed "carve-in" of the hospice benefit to Medicare Advantage ("MA") plans. NHPCO's thorough comments on this portion of the Policy Options Document are detailed and provide the Working Group with a significant and meaningful discussion on why the "carve-in" is not the best public policy option for Medicare beneficiaries facing difficult end of life illnesses. As NHPCO accurately articulates, any "carve-in" would adversely impact beneficiary access to the hospice provider of a beneficiary's choice, have the potential to dilute the quality and integrity of the hospice benefit, undermine the autonomy of the hospice Medical Director, increase the administrative burden of hospice providers and threaten the financial stability of hospice programs. Given these concerns, we strongly urge more research, caution and dialogue with hospice providers and patient advocacy groups on this policy option.

We agree with and strongly support the insight provided by the NHPCO in the following statement from its comment as prepared for submission to the Working Group:

> As you know, hospice has never been a covered benefit under Medicare Advantage (MA). MA enrollees who elect hospice revert to fee-for-service when they elect hospice care, allowing them to access the hospice of their choice without any network limitations, additional costs, or preapproval from the MA plan. Beneficiaries can continue to receive MA covered benefits (e.g., vision or dental care) through their MA plan and receive

care unrelated to their terminal illness under fee for-service. This allows beneficiaries a wide choice of hospice providers, streamlines administration for hospices, and ensures the integrity and quality of the hospice benefit.[7]

Alternatively, for our aging population that has not yet come to their final days but who are in need of services and support as they approach the end of life, the Working Group should consider including outpatient palliative care benefits in the MA plans.

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Amedisys appreciates the opportunity to comment on this Policy Options Document and hopes that you and your staffs find these comments instructive and useful as you continue your work in addressing chronic care across the health care delivery spectrum. We know the Working Group, the Senate Committee on Finance and the Congress share our goal of providing the highest quality of care to Medicare beneficiaries in the most cost effective setting – which is the home. If you have any questions, feel free to contact us at 225-292-2031.

Sincerely,

Kate Jones

Kate Jones, MSN, RN, CCM
Senior Vice President and Chief Clinical Officer
Amedisys, Inc.

[7] National Hospice and Palliative Care Organization (NHPCO) - Response to Bipartisan Chronic Care Working Group Policy Options Document, submitted January 21, 2016, at p. 1.