III. ENSURE THE APPROPRIATE USE OF TECHNOLOGY IN HOME CARE
RECOGNIZE TELEHOMECARE INTERACTIONS AS BONA FIDE MEDICARE AND MEDICAID SERVICES

ISSUE: Telehomecare is the use of technologies for the collection and exchange of clinical information from a home residence to a home health agency, a secure monitoring site or another health care provider via electronic means. The scope of telehomecare includes, but is not limited to, the remote electronic monitoring of a patient’s health status and the capturing of clinical data using wireless technology and sensors to track and report the patient’s daily routines and irregularities to a healthcare professional; electronic medication supervision that monitors compliance with medication therapy; and two-way interactive audio/video communications between the provider and patient allowing for face-to-face patient assessment and self-care education.

With increasing expectations for quality care delivery, the use of technology to deliver home health and hospice care is increasingly being recognized as an invaluable tool for an industry challenged by diminished reimbursement formulas. For example, the Veterans Administration (VA) continues to expand their now ten-year-old Care Coordination/Home Telehealth (CCHT) program. In fiscal year 2012, 119,535 veterans were enrolled in home telehealth services and home monitoring of their conditions enabled 42,699 of these patients to live independently in their own homes, rather than going into nursing homes. In 2012, the VA also eliminated copayments for veterans receiving in-home care via telehealth technology. Home care agencies have also been readily adopting remote monitoring technologies. There has been measured growth in telehealth use by HHAs from 17.1% in 2007, to 22.9% in 2009, and to 31.2% in 2013. (2007 and 2009 data is from independent studies conducted by Fazzi Associates; Philips National Study on the Future of Technology and Telehealth in Home Care (2008); The BlackBerry Report: National State of the Homecare Industry Study (2009); and National State of the Homecare Industry Study (2013)).

Despite significant progress that has been made in the development and use of advanced telehomecare technologies, the absence of a uniform federal Medicaid and Medicare telehomecare guideline that provides for comprehensive reimbursement mechanisms and a uniform certification process for certifying telehealth providers, is creating barriers to more widespread adoption of telehomecare and the establishment of services employing telehomecare. Currently, the Centers for Medicare & Medicaid Services (CMS) does not recognize telehomecare as a distinctly covered benefit under Medicaid, nor does it allow for telehomecare technology costs to be reimbursed by Medicare.

Small inroads have been made under Medicaid as at least 18 state Medicaid programs have passed waivers that include the reimbursement of telehomecare services. Unfortunately, CMS maintains that telehealth visits do not meet the Social Security Act definition of home health services “provided on a visiting basis in a place of residence” under the Medicare program. CMS regulations (42 CFR 484.48(c)) defines a home health “visit” as “an episode of personal contact with the beneficiary by staff of the HHA [home health agency].”

Over the past few years, Congress has taken integral steps to expand the access of technology into the delivery of home health care. Most notably, telehomecare champions Senator John Thune (R-SD) and Amy Klobuchar (D-MN) have taken up the cause and introduced the “Fostering Independence Through Technology (FITT) Act” to mandate that the Secretary of Health and Human Services (HHS) establish pilot projects under the Medicare
program to provide monetary incentives for HHAs to utilize home monitoring and communications technologies. The FITT Act was included as an amendment to the Sustainable Growth Rate “Doc Fix” bill that will be considered by the 113th Congress. In 2008, and again in 2009, Representative Mike Thompson (D-CA) introduced “The Medicare Telehealth Enhancement Act” which provided a number of provisions that addressed the need for enhanced telehealth services including, for Medicare’s purposes, reimbursement for home health telehomecare visits by home health agencies, coverage of remote patient management services including home health remote monitoring, and establishment of a demonstration project to evaluate the impact and benefits of including remote patient management services for certain chronic health conditions. In 2012, Thompson introduced “The Telehealth Promotion Act of 2012” which removes arbitrary coverage restrictions on telehealth from federal health care programs and also increases the Medicare prospective payment rates to home health agencies to include remote monitoring services for three years. In 2013 the “The Telehealth Promotion Act of 2013” was introduced to encourage the use of telehealth technologies in the certification of home care services and enable the home to be a telehealth site. Lastly, in 2014 the Telehealth Enhancement Act of 2013 and the Medicare Telehealth Parity Act of 2014 included phased in expansion of telehealth coverage, the definition of a “home telehealth site” and telehealth services for the remote delivery of home care and hospice services. In 2015, Congress will again be considering an approach to reimbursement of telehealth in Medicare.

In 2013, Congressional allies from both the Senate and the House also sent a letter to CMS conveying their support for the Center for Medicare & Medicaid Innovation (CMMI) created by The Affordable Care Act and recommending the FITT remote monitoring model as one of the pilot projects the CMMI should adopt to effectively test in both rural and underserved urban areas by home health care providers.

RECOMMENDATION: Congress should: 1) establish telehomecare services as distinct benefits within the scope of Medicare and federal Medicaid coverage guided by the concepts embodied in the Fostering Independence Through Technology (FITT) Act; these benefits should include all present forms of telehealth services and allow for sufficient flexibility to include emerging technologies; 2) clarify that telehomecare qualifies as a covered service under the Medicare home health services and hospice benefits and provide appropriate reimbursement for technology costs; 3) eliminate the list of authorized originating sites for telehealth services by physicians under section §1834(m)(3)(C) so that the home residence would be a covered telehealth site; 4) ensure that all health care providers, including HHAs and hospices, have access to appropriate bandwidth so that they can take full advantage of advances in technology appropriate for care of homebound patients and 5) Include telehealth equipment and service delivery as allowable costs in home health and hospice.

RATIONALE: Telehomecare is a proven and important component of health care today and vital to reducing acute care episodes and the need for hospitalizations for a growing chronic care population. Establishing a basic federal structure for Medicare and Medicaid reimbursement and coverage of telehomecare services will permit states to more easily add this important service to the scope of Medicaid coverage and benefit the entire Medicare program.

Studies indicate that over half of all activities performed by a home health nurse could be done remotely through telehomecare. Evidence from these studies has shown that the total cost of providing service electronically is less than half the cost of on-site nursing visits. Given
the financial constraints on agencies under the prospective payment system (PPS), providers of care should be granted maximum flexibility to utilize cost-effective means for providing care, including non-traditional services such as telehomecare that have been proven to result in high-quality outcomes and patient satisfaction.
PROVIDE FINANCIAL ASSISTANCE TO HOME CARE AND HOSPICE PROVIDERS TO EXPAND USE OF INFORMATION TECHNOLOGIES AND IMPLEMENT ELECTRONIC HEALTH RECORDS

ISSUE: Administrative costs and paperwork represent significant expenses in health care. The home care industry has been especially paper intensive. Medicare billing, OASIS assessment, patient charting compliance with the Health Insurance Portability and Accountability Act (HIPAA), and many other activities greatly increase administrative costs. The implementation of the Medicare home health prospective payment system has required a wholesale revision in agencies’ billing, documentation, data collection and data utilization.

While 80 percent of HHAs currently use an electronic fiscal, billing, and backroom system, changes in documentation responsibilities and advancements in technology will continue to challenge the ability of HHAs to maintain up-to-date systems. The purchase of multi-purpose, integrated clinical and financial systems with multiple electronic capabilities requires a significant capital investment. Traditionally, small business loans have not been readily available to most HHAs because agencies are not viewed as a good credit risk. Many are dependent on Medicare for most of their revenues. Keeping pace with these new technology needs has been beyond the financial capabilities of many HHAs.

HHAs are also readily adopting and using new electronic health records (EHRs) to respond to the Obama Administration’s call on health care providers to adopt EHRs by the year 2014. As compared to physicians and hospital discharge planners, HHAs are incorporating EHRs in their practices. According to the latest figures, it’s estimated that more than 78.1 percent of HHAs presently use electronic medical records. Therefore, while HHAs are responding to the need to implement EHRs, the great challenge to HHAs is to maintain interoperability with other health care providers.

RECOMMENDATION: Congress needs to continue to work with the Obama administration to provide financial support for HHAs to encourage the adoption of electronic health records by home care providers. The Office of the National Coordinator for Health Information Technology (ONC), should lend assistance to all health care sectors to support for the transition to interoperable EHRs across the continuum of care. This support to currently non-incentivized providers in post acute care settings should include monetary incentives such as small business loans, tax incentives, grants from the Medicare and Medicaid programs, partnerships with hospitals and physician practices, grants for the development of HIT standards for the Home Health Plan of Care (HHPoC) and Care Transition data standards. Lastly, ONC should also develop voluntary EHR certification guidelines for home care EHR products.

RATIONALE: Although not mandated by the HITECH Act to do so, in order to participate in the industry wide goal of implementing EHRs, HHAs and hospices will require financial assistance to purchase the necessary systems and adopt new certified electronic health information technologies. Current reimbursement standards under Medicare, Medicaid, and other payers do not provide the capital foundation for such purchases. As the opportunities for health information exchange increase home health agencies need to be able to meet these demands
function as a key component of longitudinal care coordination and patient centered care.
ALLOW PAYMENT FOR HOME HEALTH SERVICES FOR CENTER- BASED CARE FOR TECHNOLOGY-DEPENDENT CHILDREN

ISSUE: Medicaid waiver programs that provide funds for providing home and community-based services for technology-dependent children have not been sufficient to meet the demand for the delivery of care in non-institutional health care settings. According to a 2005 study it is estimated that 20 percent – 1 in 5 – of all the children discharged from the hospital were dependent upon technology in some way, and 1 percent needed a ventilator. The 2176 waiver program, often called the Kaite Beckett Waiver program that gained popularity in the 1980s, enables severely disabled children to be cared for at home and receive ongoing long-term care that is financed by Medicaid. However, even with the addition of Medicaid waiver services to provide home health and personal care benefits at home, additional resources are required to provide families means to care for technology-dependent children.

At the same time, center-based care for technology-dependent children has developed in the United States as a means to provide relief to family caregivers; an opportunity for the technology-dependent child to avoid “institutionalization” at home; and as a means of meeting the medical and rehabilitative needs of the child. Center-based care provides a supplement to direct family services, allowing caregiving of technologically dependent children to receive care in a community-based location while still residing in their own home. However, Medicaid does not cover center-based care consistently across the nation.

RECOMMENDATION: Congress should pass legislation requiring mandatory Medicaid coverage of center-based care for technology-dependent children at day care centers. Medicaid administrators should also recognize the health and economic advantages of serving technology-dependent children in center-based care programs. In addition, more trained caregivers, better coordination of services, and improvements in the design of home-medical devices would all help to improve the lives of families with technology dependent children.

RATIONALE: Center-based care for technology-dependent children is a crucial care option which allows these children to be safely cared for and receive their medical and rehabilitative services in one central location. This coordination of care for technology-dependent children is also cost effective and optimizes outcomes. Further, it relieves families of their burden of 24-hour care.
COVER APPROPRIATE SELF-CARE TECHNOLOGIES UNDER MEDICARE

ISSUE: Internet-based self-care technologies—tools used by consumers and their nonprofessional caregivers to manage health issues either outside of formal medical settings or in collaboration with their health care providers—allow the disabled and infirm to gain increased access to health care professionals and self care management techniques while coping with acute and chronic illnesses. Individuals with diabetes, hypertension, COPD, and other chronic illnesses are their own primary care managers, at no cost to the health care system except when self-monitoring falls short of its capabilities. Applications that combine high-quality information with interactive components for self-assessment, decision support, or behavior change have the potential to reduce cost while maintaining the same or achieving better quality of care. Providing patients and their caregiver’s easy access to self-care technologies that make them less dependent on the health care system could reduce health care costs dramatically. Self-care technologies promise to improve quality of life for people with chronic health conditions and their caregivers, promote healthy communities by providing continuous personal health monitoring and individualized feedback and assure awareness of and access to continuous health data collected in nonclinical settings. Currently, Personal Health Records (PHRs) and Web-based monitoring technologies have interactive components, such as an “ask the doctor service” (via secure email consolation), wearable technologies for fitness, aging-in-place technologies, real-time monitoring, self-tests, online forms, and mobile health applications are evolving rapidly. Through the use of these technologies, individuals are able to self-monitor and obtain necessary insights as to when to contact professional health care providers. However, much of this technology is not covered under the Medicare benefit since it does not neatly fit within the benefit structure as “durable medical equipment” or otherwise.

RECOMMENDATION: Congress should provide Medicare coverage for medically-appropriate self-care technologies, support the availability and development of mobile health applications for use in the home and encourage the development and access to Personal Health Records and other technologies that will enable seniors to age-in-place.

RATIONALE: Self-care monitoring technologies can engage consumers to make better health care decisions, serve as a supplementary educational resource and help to prevent acute exacerbations of an individual’s condition thereby preventing or delaying costlier health care measures.
FINANCE A RESOURCE CENTER FOR HOME TELEHEALTH TECHNOLOGIES

ISSUE: Home telehealth technologies are quickly emerging in the marketplace. However, a comprehensive understanding of these technology options is not readily available to home health care and hospice providers. Therefore, NAHC through its affiliate Home Care Technology Association of America (HCTAA) has sought opportunities to increase resources available to home health care and hospice providers who are interested in health information technologies. HCTAA has sought funding increases for the Office of the Advancement of Telehealth (OAT) which provides funding for telehealth, telehomecare, home health grants, licensure, and home health demonstration projects. While congressionally-mandated projects have increased dramatically from 13 projects totaling $16 million in FY 2000 to 114 projects totaling $65 million in FY 2005, OAT’s programmatic budget has been inadequate to fund the demand for telehealth and telehomecare projects. The inadequate programmatic budget has prevented OAT from comprehensively funding either the Telehealth Network (THGP) or the Telehealth Resource Center Cooperative Agreement Programs (TRCCP), which would systematically collect best telehealth practices and serve as a repository for information on things such as licensure, reimbursement, malpractice, etc. Supporting programmatic budget increases for OAT would help provide grants to fund a Resources Center for Home Telehealth Technologies.

RECOMMENDATION: Congress should fund the development and maintenance of a national resource center for home telehealth technologies that is available on the Internet and otherwise to home care providers. The center could provide guidance on the availability of technology, the status of any relevant Food and Drug Administration approvals, links to product evaluations, and funding availability.

RATIONALE: The use of technologies in home care has the potential of creating cost saving benefits to Medicare, Medicaid, and other federal health programs. A resource center will help facilitate acquisition and supplementation of appropriate technologies by home health care and hospice providers.