Testimony to the MA Health Policy Commission
of the
Home Care Alliance of Massachusetts
3/13/18

The Home Care Alliance appreciates this opportunity to present testimony to the Health Policy Commission, on home health care's relation to, and perspectives on, health care cost trends in the Commonwealth.

HCA of MA represents almost 200 home health and homecare providers, many with a century-old tradition of meeting the populations health needs in the communities that they serve. A review of the social and environmental factors affecting their patients' health is an integral part of their care planning process in home care. Interestingly, for many of these agencies, pursuing their community health mission has become more – not less – difficult, as payment models have been slow to change, and funding from philanthropic sources is less available.

HCA of MA is not in a position to speak to what, if any, modification should be made in HPC's Cost Growth Benchmark so as to incentivize change without excessive disruption in the health care market. But our members - as employers - are invested in all efforts to lower costs to the ultimate beneficiary – the consumer; and they are - as providers - committed to doing what they can to move the Commonwealth forward.

I would call attention to several areas where we believe we can have an impact:

1. Post-Acute Care

The HPC in its annual Cost Trend Reports to the Commonwealth has called attention to issues around the use of post-acute care and the need for more analysis to understand -- at the regional, hospital or diagnosis level -- utilization patterns that differ between our state and other states and hospital to hospital. We support that effort. Looking at Massachusetts data – by payor - in a

manner similar to the following chart from the federal MEDPAC might give a better picture of how post-acute dollars are distributed:

Table 1 - PAC Medicare Data (2011)

PAC Setting	Annual Medicare Expenditures	Annual Medicare Beneficiaries	Average Annual Spending per Medicare Beneficiary
Home Health	$18.4 billion	3.4 million	$5,411.76
SNF	$31.3 billion	1.7 million	$18,411.76
IRF	$6.5 billion	371,000	$17,520.22
LTCH	$5.4 billion	123,000	$43,902.44
TOTAL	$61.6 billion	5.6 million	$11,000.00

SOURCE - Medicare Payment Advisory Commission March 2013 Report to Congress

In this year's report, HPC targets a 5% reduction in the use of institutional post-acute care, while noting that we have already seen a 1.3% drop in such between 2014 and 2016.

Our member agencies have been responding to such changes in referral patterns, many incentivized by Medicare, that direct more people -- especially after orthopedic procedures -- directly to the home. I urge HPC to look more closely at this trend, as I think there is a lot to be learned and shared – in terms of workforce redirection, training, and communication practices - by those who are doing this well.

The Home Care Alliance is also working at present with our partners at MA Senior Care Association on care transitions protocols and best practices for transitioning patients from skilled nursing facilities to home and, perhaps more importantly, from home back to the SNF. We think with better information flow and communication practices *within the post acute sector*, we can lower ER visits and rehospitalizations, improve the better patient experience, and ensure system-wide cost savings.

2. Investing in New Models of Care

I said at the outset that many of our community-based agencies have a long history of investing in programs to fill gaps in care. A lot of this work has been philanthropically funded, but I think it's time we start looking at ways to better understand, support and scale-up the most effective of these programs. Here are a few areas:

1. As our patient population has become sicker and our need for creativity around readmission reduction has intensified, many of our agencies have come to see that stabilizing patients in the home requires using an advanced practitioner in conjunction with the traditional home care services of Nursing, PT, OT, ST, and Home Health Aide. The NP is available to make home visits for clinical issues that in the past were ordered to the ER by a physician. For example, the NP can write a prescription to change a medication dose; administer IV Lasix, as well as numerous other high-tech treatments. This simply helps keep a patient at home, avoiding an Emergency Room visit or hospital admission. This model is being tested from Partners HealthCare at Home in Greater Boston to Porchlight VNA in Lee.

   Because risk-based contracts are almost non-existent in the home care industry, agencies see little financial return on such investments. In some cases, agencies that have lowered their readmission rates to be top performers are being squeezed out by market consolidation – which is oftentimes is neither cost or performance based.

2. Behavioral health is another area where home health could – with some attention to funding or best practice dissemination – do more. With respect to the innovation that is already happening, we must invest in further innovation and scale-up for wider dissemination areas of success. I would call the Committee's attention to a $525,000 grant from Blue Cross Blue Shield of Massachusetts Foundation to Hebrew Senior Life to expand their Making Real Progress in Emotional Health (MARPEH) initiative to seniors living independently in the community who are receiving home care.
   All HSL Home Care staff are trained to screen patients for depression and other mental health issues.

   Patients who screen positive for mild to moderate depression receive basic problem-solving therapy from trained home care staff. Those with more advanced mental illness are referred for more intensive treatment with HSL advance practice clinicians, in conjunction with their PCC.

3. The final example I'll give is in an area were home care could be doing more to achieve the Cost Growth Benchmark is in palliative care. The MA legislature passed a law more than a year ago that required that hospitals and nursing homes to provide patients with information about palliative care. During the law's implementation phase, it was quickly learned that the issue wasn't educating patients about what palliative care is, but rather where they could find it - especially in the community.

   In the past year, we at HCA of MA have identified at least a dozen home health agencies, all community VNAs, that are listed on our website who have built palliative programs. They have do so without dependable reimbursement – which is the other palliative care challenge. These programs have high success rates in identifying and honoring patient's wishes around "What Matters Most" with a life limiting illness. The programs have high patient satisfaction scores, as well as commendable records of keeping people out of hospitals, and of transitioning clients at the right time into hospices. All things we say we want our system to be doing, yet we see little attention, to, or investment, in this service model. To do so, could make Massachusetts an example of what is possible when patient needs rather than outdated reimbursement models drive care delivery.

3. <u>Market Consolidation and Support for Essential Community Providers</u>

Market consolidation - We need to look in our sector at the impact of rapid market consolidation on patient choice, cost and access to quality providers for vulnerable patients. This is a sentiment that 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. This is something that HPC should analyze as the ACO model in Massachusetts takes effect.

Community 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. The nonprofit home health agencies with the

strongest local connections and community support are a tremendous state resource that once lost cannot be recreated. These agencies have 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. While preservation of community hospitals is important, home health needs to be a part of the conversation around endangered providers as a crucial aspect of the delivery system with an aging population.

Again, I thank you for the opportunity to testify on behalf of all Home Care Alliance of MA members. The HCA of MA stands ready to work with the HPC on any issues within this testimony, or issues that fall outside of it.

Sincerely,

Patricia M Kelleher
Executive Director