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CHRONIC CARE AT HOME: CRUMBS FROM THE eHEALTH TABLE?

Topic: Care Coordination and Chronic Care Management

Abstract:

eHealth initiatives for remote monitoring of the chronically ill have failed to move forward with the rapidity predicted five years ago. This trend persists despite vast unmet need in the care of the chronically ill.

Disease management research is attempting to demonstrate improved outcomes and cost efficiencies to skeptical payers. This paper proposes collateral political and regulatory factors may be slowing eHealth: persistence of acute medical models in homecare; tightened payment for Medicare homecare, diminishing dollars for agencies' hardware and software deployment; Congressional focus on *rural* health funding; and concern about medical equipment fraud, and mistrust of the homecare industry.

**CHRONIC CARE AT HOME: WHY CRUMBS FROM THE eHEALTH TABLE?©**

Deborah Randall, Esq.[1]

e-Health initiatives for remote monitoring of the chronically ill have failed to move forward with the rapidity predicted five years ago. This trend persists despite vast unmet need in the care of the chronically ill[2].

Disease management research is attempting to demonstrate credible data showing improved outcomes and cost efficiencies to a skeptical Department of Health and Human Services[3] and other payers. This paper proposes that collateral political and regulatory factors may also have slowed eHealth. These factors may include: (1) persistence of acute medical models in homecare reimbursement; (2) tightened payment methodologies for Medicare homecare, with resultant diminished dollars for agencies' hardware and software deployment; (3) the Congressional focus on ***rural*** health funding [through, for example, its targeted appropriations to the Office for the Advancement of Telehealth, HRSA]; and (4) Departmental alarm about the recent, dramatic durable medical equipment [DME] fraud scandals.

Chronic illness and disease management are the subjects of increasing numbers of scholarly papers and research endeavors. Nationally, and internationally, the perceptions are that the prevalence of chronic illness within the swelling ranks of the aging may cause catastrophic costs to the health services delivery systems of nations, as well as to States within the US or Provinces within other countries which are also responsible for funding care. Much of the recent disease management research focuses upon the possibility of eHealth and in particular, remote monitoring, to avert the tipping of a patient's chronic illness into acute mode. The instability of the chronically ill person may necessitate emergent and costly interventions, may threaten his or her wellbeing and perhaps survival, and may result in care delivery at institutional facilities rather than the home where the patient prefers. The maintenance of a patient at home, and an increased ability to function in and ambulate from such a base with electronic health data transmissions [through POTs, broadband, cell phone and sensor technologies], are proposed as keys to maintaining cost efficiencies in chronic care coordination.

Five years ago, many community-based care providers were inclined to try or recommend eHealth and remote monitoring to help sustain persons in homecare, but these providers lacked clear reimbursement sources. The first home electronic technologies were ones focused on safety in the home, alerting care providers and emergency systems in the event of a sudden acute symptom or a fall. These "home alert" systems were used by a variety of aged or frail individuals including those with coronary disease, serious pulmonary problems, and vascular and neurological disorders. Although largely privately paid[4], such devices were accepted by patients and families as reasonable costs to make personal residences safer for frail individuals. The second early device developed for at-home chronic disease management was blood glucose monitors. By 2003, these were well accepted by patients, and in a manual version (that is, without electronic data transmission) have been reimbursed as durable medical equipment under the Medicare Part B program, the Medicaid programs of most states and by many private third party insurers. However, five

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[2] A National Study of Chronic Disease Prevalence and Access to Care in Uninsured U.S. Adults, Wilper, A. et al, Annals of Internal Medicine 2008; 149:170-176.

[3] At a RAND conference in Winter 2008, an HHS spokesperson stated she had seen "precious little" evidence of cost savings in HHS-sponsored research in chronic disease management.

[4] But see discussion in footnote seven, *infra*.

years later, remote chronic disease monitoring is still in its infancy and pilot stage. Some homecare providers have given up attempts to implement it.

In the author's opinion, there are four significant factors affecting the regulatory and political environment in which eHealth has intersected with chronic disease management and care coordination. These are impediments to the natural progress of eHealth implementation which seemed imminent in 2003.

## Persistent Acute Medical Model in Homecare

There has been little movement away from an acute homecare model in the federal Medicare program. Despite the alteration of the Medicare Part A reimbursement methodology to an episodic, prospective payment in fiscal year 2000, and indications from the Centers for Medicare and Medicaid Service [CMS] that Medicare home health agencies were allowed flexibility to design visits and clinical disciplines as well as home health aide support services, the industry response has been fewer services to homecare patients, shorter lengths of stay overall [thus, little opportunity for any chronic care management other than brief teaching] and a much more "acute" Medicare benefit than before. This repositioning of home health back to an acute care model was one of the CMS goals during the Bush administration, and it has succeeded.

Unfortunately, the Administration's additional stated goal of increasing home and community-based services under Medicaid has received little targeted funding for telehealth and care coordination[5]. No successful case has yet been made to the Medicare Policy Office by the homecare industry that substituted remote monitoring nursing plus fewer nursing visits is equivalent to in-home visits of greater frequency for an acute medical model.

## Tightened Home Care Reimbursement

In the period since 2003, CMS has changed the Medicare homecare methodology a second time[6]. Instead of a ten-visit threshold of therapy visits determining a higher level of reimbursement per case[taking into consideration diagnoses, prior health services and needs for assistance with daily living], there are now three levels of reimbursement based on the numbers of therapy services per case. The monetary flexibility that was provided in the previous reimbursement system allowed some homecare agencies to utilize aggregated reimbursement from all patient care --the "profit" ---for creative deployment of otherwise more expensive care, such as telehealth equipment, to parts of their patient populations. Now, there seem to be no "extra" dollars in home health. The challenge of Medicare-eligible, chronically ill individuals whose care may be paid at the lower end of Part A reimbursement may make home health agencies less willing to accept these admissions. This occurs although these patients could be among the best candidates for remote monitoring of diabetes, hypertension, CHF, COPD and other conditions. The telemonitored visit does not count as a Medicare visit to the home health agency, but the remote nurse monitor of the care and the equipment and infrastructure costs would be borne by the home health agency.

When the Office of the Inspector General [OIG] of the Department of Health and Human Services considered the developing landscape of Medicare telehealth in an Advisory Opinion in 2003, OIG noted:

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[5] Some States have in the last two years begun to sponsor grants and pilots involving remote monitoring for chronic disease management. For example, the State of New York has numerous new funded projects and has issued HEAL grants to health consortia which have established local RHIOs; in Brooklyn, the Maimonides Medical Center heads up the HEAL project.

[6] For an intensive review of homecare and hospice reimbursement, see Randall, D, Home Health and Hospice Legal Issues: Reimbursement Changes, Growth and Quality Concerns", Chapter 10, Health Law Handbook 2008 Edition, Thomson, West publishers.

> "The Centers for Medicare and Medicaid Services (CMS) – construing congressional intent in 42 U.S.C. 1395fff(e)(1) – has provided that, as part of the benefits for which payment may be made by Medicare, a home health agency "may adopt telehealth technologies that it believes promote efficiencies or improve quality of care," HIM 201.13, although the use of such technologies may not substitute for services ordered by a physician. By ensuring prompt emergency assistance and potentially forestalling the need for more expensive care and services, the provision of the [electronic home alert system] is reasonably related to the delivery of home health services and to the fostering of efficiency and quality of care. Given ***CMS' express encouragement of innovative telehealth technologies in the delivery of home health care***, we conclude that the provision of the [electronic home alert system]…..in the context of home health services would not be an impermissible…[emphasis added]." [7]

By tightening the reimbursement system, CMS has now largely precluded the provision of "innovative telehealth technologies" if they are to be funded through the per episode Part A home health global payment.

Telehealth Funding Limited to Rural Providers

Another area which has not seen much positive development in the five years since 2003 is any loosening of the constraint that funding from the federal Office for the Advancement of Telehealth largely be to ***rural*** providers. While the history of the Congress's legislation and preferences for rural health provider funding goes beyond the scope of this paper, it is noteworthy that the concept of handicaps to care are no longer merely the function of geographic distances measured by country roads.

In fact, large clusters of chronically ill individuals reside in major urban areas, and are un-served or underserved. The fiscal prohibitions to companies' funding home care nursing adequately, or to finding home care nurses who are willing to work in urban areas, are as monumental as those in many rural or "professionally underserved" areas. In many urban areas with high costs of living, it is enormously difficult to attract and retain staff because they must live at such distances to the urban centers where rental and home ownership is too costly. If the reality is that Congress has favored rural telehealth in the telemedicine context for diagnostic and consultative ***physician to physician*** services, another and different look should be given to ***telehealth*** remote monitoring, which may be more nursing-agency driven or coordinated, and where urban centers are as needy as remote rural locales[8]. And perhaps the rural health focus of Congress is largely a matter of political history-- with those of the greatest seniority on the Congress's funding Committees coming from highly rural states. Advocates for eHealth technologies and remote monitoring may need to press for a reformed health delivery system based on demographic needs of the chronically ill regardless of geography.

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[7] Office of the Inspector General, Department of Health and Human Services, Advisory Opinion 03-4, February 2, 2003, www.oig.hhs.gov/fraud. OIG permitted home health agencies to provide free home alert devices and monthly service contracts to Medicare beneficiaries so long as these added benefits were not advertised and there was medical necessity demonstrated in each case where the agency placed units in a patient's home. Such arrangements were not interpreted to be illegal inducements to Medicare patients.

[8] The Office for the Advancement of Telehealth has indicated that it would welcome funding from Congress to enable more home telemonitoring grants in urban areas. One important home health study will be reporting data in the Fall of 2008, according to OAT comments made at the American Telemedicine Association's 2008 annual meeting.

Fraud in the Medical Equipment Industry

A fourth reality of the last five years has been a surge in cases involving fraudulent conduct by certain companies in the durable medical equipment area which have billed Medicare, Medicaid or both. “Operation Wheeler Dealer”, an OIG and Department of Justice major investigation, focused on abuses of certain equipment suppliers of power wheelchairs and scooters, which are among the most expensive equipment available for home use under the state and federal programs. These cases, many of which have resulted in large fines and jail sentences in Florida and Texas, revealed the degree to which patients in their homes are subject to being exploited with equipment provided they did not need, or equipment billed for a higher grade or complexity than was delivered.

While there is virtually nothing similar between a power wheelchair and, for example, a remote electronic transmission of blood pressure and glucose measurements, the site of the home as a private, largely unsupervised and “unseen” environment has always caused a degree of apprehension among the investigative committees of Congress and the fraud and abuse enforcement divisions of HHS and the States. This new set of medical equipment fraud cases, and OIG’s long-standing concerns about relationships between homecare service providers and their referral sources, could provoke additional government hesitation to coverage expansion and payment of home-based remote monitoring. When this integrity concern is combined with the long-standing and familiar “woodwork” arguments (that a new benefit such as telemonitoring would draw in countless new users and increased costs), it suggests a strong need for a pro-active, direct and solution-driven compliance approach by disease management companies, health IT equipment vendors and software developers, alike. Representatives from these interests groups should begin discussions of what the parameters would be for a cross-industry compliance program.

Respectfully Submitted,

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