Testimony of Donna Debois
On behalf of MaineHealth Care at Home and the Home Care & Hospice Alliance of Maine

Before the Joint Standing Committee on Health Coverage, Insurance and Financial Services

In support of LD 1263, An Act Regarding Telehealth

Sponsored by Senator Gratwick

April 4, 2019

Senator Sanborn, Representative Tepler, and members of the Joint Standing Committee on Health Coverage, Insurance and Financial Services, my name is Donna Debois and I’m a resident of Hallowell. For the past five years, I have served as the President and CEO of MaineHealth Care at Home. MaineHealth Care at Home offers a full range of skilled home health services to children and adults that includes nursing care, nutritional counseling, emotional support, palliative care, rehabilitative therapies, and telehealth, as well as a full range of community health and wellness programs throughout our service area. We provide care seven days a week -- with 24/7 on-call services -- throughout York, Cumberland, Lincoln, Knox, Waldo, Sagadahoc and southern Oxford County. We also provide hospice services in Knox, Waldo and Lincoln counties with short-term hospice care and respite services at the Sussman House, a hospice facility located in Rockport, Maine. I’m here today on behalf of MaineHealth Care at Home and the Home Care and Hospice Alliance, the trade association for home care and hospice providers, of which we are a member, that serve more than 20,000 people every year across our State to testify in support of LD 1263, An Act Regarding Telehealth.

At MaineHealth Care at Home we have been developing a successful telehealth program since we received a federal grant in 2001 to work with patients who had congestive heart failure and COPD. The goals back then are the same as they are today: provide high-quality evidence-based specialty care to high-risk patient populations, improve coordination of care and communication with healthcare providers and support effective care management and treatment protocols and integrate delivery of services across the health care system.

Over that time, our telehealth program gradually expanded to cover a broader service area and additional disease groups. With the technology available today, we provide each patient in the telehealth program with a 4G tablet. The tablet is pre-loaded with a video education, health assessments, a direct telephone and video visit capacity. It provides real-time patient data, promotes adherence to treatment plan and engagement in self-care activities. Our patients can
immediately access their caregiver, clinician or tech support. The tablet receives patient data input that can track activity, diet, vital signs, weight and medications. Our caregivers and clinicians receive alerts to intervene if the patient is at increased risk for urgent care or hospital readmission. Most significantly, our telehealth program empowers patients to change the way they view their medical condition and to develop lasting healthy behaviors in a way that medicine has never allowed them to before.

Patient adherence, which is the degree to which patients follow clinical standards of care, is consistently better than 80%, and as high as 87%. We do regular patient satisfaction surveys to get feedback on whether the telehealth equipment easy to use, how invested patients are with their care and if they would recommend the use of the telehealth program to a family member or friend. On a scale of 1 to 5, with 1 being strongly agree and 5 being strongly disagree, our patients’ answers consistently land at an average of 1.8 to 1.9. The vast majority are very satisfied with the telehealth program.

We support LD 1263 because our health insurance construct needs to embrace the innovative, cost saving and patient centered changes that telehealth has already introduced – and will continue to introduce – in how we can care for our elder adults. The time to embrace these improvements is now. Our population is getting older and we cannot hire enough people to meet the demand. Today, the Maine Medical Center has 620 vacant positions. Next door in the Idea and Business Committee, the Home Care and Hospice Alliance is testifying on a bill to increase the nurse education loan forgiveness program, because by 2025 Maine will be short more than 2,700 RNs.

We have limited health care resources. Where we have the opportunity to use those resources in a way that provides better medical results to a broader group of people at a lower cost, we ought to make every effort to support it.

Thank you for the opportunity to testify. I would be happy to answer any questions and hope to be present at your work session.
A Case Study for Sustaining Telehealth in the Home Health Industry
Mia Millefoglie, VP Development & Marketing
MaineHealth Care at Home

Challenges Facing Home Health Agencies

In 2015, 11,400 home health agencies from across the country provided skilled care to 3.4 million people with a cost to Medicare of $17.8 billion. These agencies hold a unique position under Medicare to provide a full range of skilled services including nursing, physical therapy, occupational therapy, speech-language pathology, and social work to homebound patients who require care for acute, chronic, or rehabilitative conditions. The Medicare website references home health care as follows: “Home health care is usually less expensive, more convenient, and just as effective as care you get in a hospital or skilled nursing facility.”

We also know that people, regardless of age, have an overwhelming desire to remain in the comfort of home and community. An AARP survey found that over three-quarters of its respondents, age forty-five and older, articulated a desire to age in place and to receive care at home versus institutional care. Despite the evidence that home health care is the most cost-effective and the preferred model of care among seniors, the industry continually adjusts to payment reform and regulatory restrictions on eligibility for the home health benefit.

Home health agencies also face increasing pressure to meet the care needs of a rapidly increasing elderly population with inherent chronic conditions. In 2012, 117 million people, representing almost half of all adults in the United States, had one or more chronic health conditions. According to the CDC, 71% of all health care spending in the US is associated with care for individuals with more than one chronic condition. Among chronic conditions, heart
failure is the leading cause of hospitalization among elders in the United States and exceeds $17 billion for total Medicare expenditures. Medicare hospital expenditures for heart failure approximates Medicare expenditures for the entire home health industry. The impact from chronic conditions will escalate in proportion to the number of Americans over the age of 65, which is projected to increase to more than 20% by 2030, a figure substantially greater than the 2017 estimate of 15.6%.

Coupled with these challenges are the aims of an evolving accountable care environment to demonstrate cost savings, to improve quality measures, decrease the rate of avoidable hospital readmissions, and reduce emergent care. Home health agencies recognize that meeting these goals is complex work, as variables such as medication management, biometric and symptom monitoring, and compliance with health regimens often cannot be easily controlled in the home environment. However, Home health agencies can improve both patient and quality-measure outcomes by leveraging the tools of technology.

Among these technologies is remote patient monitoring (RPM) that allows individuals, generally those with chronic disease, to transmit vital information securely to a provider in a separate location. The provider can track these statistics and, if necessary, intervene with the patient and augment care accordingly. This form of interaction benefits the provider due to the inherent cost reduction that results from fewer visits and less time required by clinicians providing care. RPM extends the scope of care to individuals that cannot easily access healthcare, and as a result provide services to those without quick or convenient access to in-person care.
Remote Patient Monitoring: An Evidenced Based Model of Care

Evidence in support of RPM services is widespread. An extensive meta-analysis of studies by the Agency for Healthcare Research and Quality (AHRQ) focused on the use of RPM in the management of chronic cardiovascular and respiratory conditions and found “the most consistent benefit has been reported when telehealth is used for communication and counseling or remote monitoring in chronic conditions such as cardiovascular and respiratory disease, with improvements in outcomes such as mortality, quality of life, and reductions in hospital admissions.” 8 Considering the broad scope of the study it would be safe to assume that RPM is a beneficial addition to normative care in most patients.

A California-based study looked into the 30-day, 90-day, and 180-day re-admission rates of patients with COPD and/or HF following an acute event. The researchers reported, “Program patients showed 50% reduction in 30-day re-admission and 13–19% reduction in 180-day re-admission compared with control patients. There was no significant difference in ED utilization. Patients were satisfied with telemonitoring services, and functional status improved by program end.” 9 The significant (50%) reduction in 30-day re-admission rates shows that RPM administered immediately after hospital discharge is very effective reducing the rate of re-admission.

MaineHealth Care at Home: A Case Study

MaineHealth Care at Home (MHCAH) is an early adopter of telehealth with more than seventeen years’ experience with integrating technology in the delivery of home health care. For MHCAH, the state’s demographic profile served as the initial catalyst to incorporate telehealth as
a method to expand access to care across a large and predominantly rural service region that held the largest elderly population in any one region of Maine.

According to the US Census, Maine has the oldest population in the country, with a median age of 43 compared to 37 for the United States. In Maine, healthcare challenges are compounded by adverse trends in chronic disease, a predominantly rural landscape, and significant levels of poverty. America’s Health Rankings’ 2017 annual report found that cardiovascular deaths in the state of Maine increased from 215.4/100,000 to 227.4/100,000 over three years, from 2014 to 2017. This increase, 12 persons per 100,000, is significantly greater than the reported increase in the nation’s cumulative cardiovascular death total during these three years of 3.2 persons per 100,000. These troubling figures provide evidence to support the fact that Maine communities are increasingly susceptible to cardiovascular events leading to death. Maine also is amongst the poorest states in the country. Maine seniors, ages 85 and older, have poverty rates 50 percent higher than younger Maine seniors.

In 2001, MHCAH (formerly HomeHealth Visiting Nurses) launched southern Maine’s first telehealth demonstration project with grant support from Rural Utilities Services-USDA. This project introduced interactive video monitoring units, augmented with traditional home health services, to patients diagnosed with advanced congestive heart failure in remote areas of Maine. Early results showed reductions in costly hospital re-admissions and high patient satisfaction rates; however, “buy-in” from clinician staff and the physician community presented challenges to expansion. Recognizing the need to secure engagement, the agency launched an outreach campaign to the medical community and migrated to a new platform that offered a simplified installation process, patient-friendly color touch monitors, and portals for the exchange of information with healthcare providers.
From 2007 through 2014, MHCAH sustained its telehealth efforts through grants from USDA-RUS and local foundations that provided funds to deploy telehealth units to more than a thousand patients with advanced chronic disease. Consistently, telehealth patients experienced significantly lower rates of hospitalization, lower rates of emergent care, and improved ability to manage their chronic conditions when compared to home health patients who did not receive telehealth. During this period, MHCAH collaborated in a pilot project with MaineHealth, a not-for-profit health system in Maine, on a Home Diuretic Protocol for Heart Failure. The project aimed to demonstrate that interventions to avoid hospitalizations could be delivered safely and effectively in the home. Interventions included home-based nursing care augmented with telemonitoring services and IV diuretic protocols. Pilot findings resulted in lower hospital readmission rates from 20.5% to 10%. Telehealth technology was central to the success of this program as it provided caregivers the ability to assess evidence of volume overload and unstable vital signs at the earliest juncture. This project also marked a milestone for solidifying a telehealth partnership between the agency and affiliated healthcare providers that mandated the provision of telehealth in its protocol.

In 2015, the agency experienced vendor and equipment challenges that led to an expedited vendor search and a transition to Health Recovery Solutions (HRS). This platform utilizes an android tablet with 4G internet, wireless monitoring devices, self-assessment features, medication compliance modules, disease-specific educational video clips, and the ability for patients to quickly connect via voice or video to monitoring nurses. Caregivers and assigned family members can view the patient’s activity in the program as a measure of engagement. To further advance its work on provider coordination and communication, MHCAH finalized an
HL7 integration with EPIC—MaineHealth’s shared electronic medical record—for the transmission of demographics and biometrics.

In its first year with HRS, the agency achieved a 75% reduction in overall 30-day hospital readmissions. Telehealth patients (N. 478) experienced an average rate of 4.2% for hospital readmissions compared to the state average of 16.6% for hospitalization within a thirty-day period. Primary diagnoses included congestive heart failure, chronic obstructive pulmonary disease, diabetes, and post-surgical cardiac patients. As a measure of engagement, patients spent an average of 24.6 minutes a day watching educational videos, answering teach-back questions, reviewing biometric data, participating in video calls, and accessing their personalized care plan.

In 2017, MHCAH expanded its telehealth efforts and enrolled 725 patients who realized 30-day hospital admissions in the range of 0.07% — 5% per quarter when compared to non-telehealth patients with 17% re-admission rates. In this cohort, the average daily adherence for patients taking biometric readings was 85%. Patient satisfaction scores were in ranges of 3.35 — 4.0 (four = highest) for responses related to ease of use, willingness to recommend and how telehealth is helping manage disease.
A Business Case for Telehealth

A 2014 article by Deloitte, a large professional services and accounting organization, entitled “Virtual Health” investigated telehealth efficacy and specifically addressed the issue of 30-day re-admission penalties and the opportunity to leverage virtual health tools to support the development of effective value-based care organizations. The following table shows savings realized by reduced re-admissions for patients served by remote monitoring technology.
Impact of Virtual Health — Examples of Remote Monitoring and Remote ICUs

Remote Home/Mobile Monitoring
Health monitoring equipment such as blood pressure monitor, glucometer, ECG, is connected to a mobile/home network. Patient parameters from these devices get transmitted to a central hub either based on patient input or automatically. The central hub continuously analyzes the data and uses predictive algorithms to determine changes in patient condition. It also acts as a 'helpline' to initiate virtual visits/consults, sends reminders for follow-up if needed, and performs drug management and health education functions. Below is an example of use of Remote Monitoring technology for Congestive Heart Failure (CHF) patients.

<table>
<thead>
<tr>
<th>Source: Data: Analysis</th>
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<tr>
<td>* Based on total cost of CHF readmission for hospitals between $6,000 to $12,000. Savings are indicative only. Impact of initiative can vary significantly based on demographics, condition addressed, use of technology and operational structure</td>
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Although MHCAH did not conduct formal studies on its telehealth initiatives, internal comparisons were completed on hospitalization rates for two groups in 2017: Group A: All Medicare patients on traditional home health services and Group B: Medicare patients on traditional home health services supplemented with telehealth. Group A realized an average re-hospitalization rate of 17% within a 30-day period; Group B realized an average re-hospitalization rate of 2.3%. This comparison showed $475,000 in avoided hospitalization charges. In calculating savings for emergent care, MHCAH compared the agency’s average rate for emergency care for all Medicare patients on home health services at 14.5% against the average rate of 2.3% for patients with traditional home health services supplemented with telehealth. This comparison showed $318,500 in savings based on $2,818 as the average rate of emergency care in Maine.14

Reimbursement Challenges and Opportunities for the Home Health Industry

Despite the success and the opportunities for advancing telehealth, the limitation in reimbursement is a significant barrier for the home health industry. Among government payers,
Medicare is the most restrictive and offers limited coverage for telehealth in the home health environment. In its payment policy, Medicare defines eligible telehealth services as "interactions between a healthcare professional and a patient via real-time audio-video technology." 15 Although Centers for Medicare and Medicaid (CMS) acknowledges "effective adoption and use of health information exchange and health IT tools will be essential . . . [to] improve quality and lower costs," home health agencies were ineligible for incentive programs that allowed other healthcare providers to support the significant cost of deploying technology. 16 As a result, home health agencies absorb the associated costs in deploying telehealth, subsidize their efforts through federal and local grants, and/or offset costs through operations.

Proposed changes for 2019 indicate that the CMS landscape is changing and would offer significant opportunities for the home health industry. Currently, CMS recognizes RPM when it is a part of the home health plan of care and does not substitute for in-person care; however, the cost of RPM is not separately billable under the Home Health Prospective Payment System under Medicare. As a result of this restriction, the agency must subsidize RPM when independent of other care. 17

A proposal for 2019 seeks to amend the regulations at 42 CFR 409.46 that would allow home health agencies to augment the care planning process with RPM and report these associated costs as part of operating expenses in the cost report. As such, RPM would not be considered a billable service itself, but would be part of the comprehensive service that is billable as a whole. This change would have important implications for assessing home health costs relevant to the Medicare payment model, as the cost-efficiency of RPM would now be more pronounced.
Effective January 2018, CMS also began reimbursing providers for RPM services under CPT code 99091. This decision to directly subsidize RPM services on a monthly recurring basis signifies another shift in the way Medicare policy views this service. Although the application of the code only benefits physicians directly, the American Medical Association’s Editorial Panel has determined that this code (CPT 99091) is outdated in its applicability to modern RPM technology and has begun working on an update or replacement.

State Medicaid Programs

In reviewing reimbursement under Medicaid, the definition of telehealth and its coverage varies widely across the United States. In 2017, the American Telemedicine Association released an updated analysis of state-to-state coverage and reimbursement for telehealth services. States were assigned a letter grade, “A” through “F”, for performance in meeting thirteen standards that included parity laws, telehealth coverage in employee health plans, reimbursement, eligible technologies, informed consent requirements, and eligible providers. Maine is included in the 11 states that were given an “A” grade for Medicaid coverage, as seen in the map below.
Although reimbursement for telehealth services is relatively new and subject to qualifying criteria for home health agencies, MHCAH successfully submitted several claims for reimbursement and is completing a build in its electronic record to facilitate the reimbursement process.

In surveying the commercial market, 32 states have some sort of parity law requiring private insurers to cover telehealth services at reimbursement levels comparable to in-person services. Several large health insurers including Cigna, American Well, and Doctor on Demand are collaborating with third-party telehealth companies to offer interactive video care services primarily through physicians. Other insurance plans model their coverage similar to Medicare guidelines; therefore, excluding "store and forward" and restricting telehealth use only to live interaction between physician or practitioner at the distant site and the beneficiary at the originating site. Despite advances in the commercial market, the coverage provisions generally
do not apply to home health agencies. Holland Hospital Home Health in Michigan and Catholic Health in Buffalo, New York are securing reimbursement for beneficiaries enrolled with BlueCross & Blue Shield. Health Recovery Solutions (HRS), a leader in RPM platforms, reports that among its clients, encompassing sixty home health agencies and several health networks with more than 15,000 patients, only two home health agencies are securing reimbursement for telehealth services. These clients have a high reliance on grant funds to support their efforts. With a mounting necessity to adopt new technology that aligns with the emerging value-based payment system, the lack of insurance coverage is an enormous obstacle for home health agencies.

**MHCAH’s Current Model of Sustainability**

Despite the limitations of reimbursement, MHCAH has sustained its telehealth services primarily through grants and private donations. The following graph describes the course of funding and development of the telehealth program:
Strategies for Sustainability

MaineHealth
CARE AT HOME

While the trajectory seems to indicate a smooth, gradual increase in funding that correlates to development and expansion of MHCAH’s telehealth services; that is not the case. USDA-RUS grants—primary funding source for program—is a competitive process that requires frequent proposals that evaluate and score on measures related to need, rurality and poverty. Although low-income, rural populations benefit greatly from telehealth technology, RUS-USDA funds are not leveraged for those in non-rural areas who may present significant barriers to accessing healthcare. Securing grant funds required ongoing investment of resources that, at times, competed with other agency priorities. In addition, MHCAH experienced several years without new grant funds that diminished its scope and decreased the number of patients served through telehealth. What can be concluded is that organizations are likely to encounter
obstacles when relying on granting foundations or government entities to maintain a successful telehealth program.

Advocacy

MHCAH believes that organizations need to engage a clinical team who is committed to expanding their role and developing their skills for optimal delivery of telehealth services. Equally important are advocacy efforts from senior leaders who can champion the value and benefits of telehealth to local, state, and national stakeholders. At a minimum, organizations who are leveraging the tools of telehealth should be active members of their state and national trade organizations.

Donna DeBlois, Chief Executive Officer for MHCAH, is the President of the Homecare and Hospice Alliance of Maine and actively participated in advocacy efforts with the Department of Health and Human Services to modify regulatory language allowing home health agencies to submit claims for remote monitoring. On a national level, she has advocated for the Fostering Independence through Technology bill sponsored by Senator John Thune from South Dakota. We advise agencies are to take advantage of the wealth of resources offered by organizations such as American Telehealth Association and National Consortium of Telehealth Resource Centers.

Partnerships and Collaborations

In June 2016, MHCAH collaborated with Avesta Housing and the Caleb Group—two housing organizations in southern Maine—in a partnership to improve the health and well-being of their elderly and disabled residents. An incentive program through Maine State Housing
offers tax credits for housing projects that build the infrastructure and space for a telehealth office. This partnership launched *Connected Care Clinics* offering on-site, pre-scheduled video visits with a nurse to conduct multi-dimensional individual health/risk assessments to ascertain health challenges, goals, needs, and deficits including psychosocial/behavioral health concerns. Nurses offer biometric screening, support implementation of current prescribed therapies and education, identify and support residents in reaching their self-management goals, educate on the use of telehealth, and provide education and coordination with community referral services. This project incorporates a telehealth kiosk that allows patients to monitor and transmit biometric data and voice/video chat with remote nurses at MHCAH seven days a week. The telehealth kiosk utilizes the HRS monitoring platform located in a common area to ensure access with attention to protecting the user’s privacy. The primary goal is to assist vulnerable seniors and disabled people with multiple chronic conditions and to improve their self-management skills and health status through access to on-site nursing and telehealth services. Services are negotiated and reimbursed through contractual agreement.

**Considerations for Sustainability**

Central to success in this environment, home health agencies are advised to align with affiliated healthcare providers in addressing the federal regulatory limitations for telehealth reimbursement, seek telehealth platforms that are flexible and scalable, advocate with state and industry leaders to champion provisions for telehealth reimbursement in the private insurance market, aggressively pursue federal, state, and private grant opportunities, develop fee-for-service initiatives with community providers, articulate the value proposition to its affiliated
health system, and creatively engage a more diverse profile of patients to gain the benefits and access to health inherent with telehealth.


7 U.S. Census Bureau


11 Maine’s State Plan on Aging, 2016-2020, Aging and Disability Services, Department of Health & Human Services. (April 2016)

12 Home Diuretic Protocol for Heart Failure: Partnering with Home Health to Improve Outcomes and Reduce Readmissions, Permanente Journal/Summer 2014/Volume 18 No. 3

13 Hunt D, Scheinrock M, Vyas S. Virtual Health- Can it help your organization create a transformational culture while bending the cost curve
14 Analysis of Emergency Department Use in Maine – Muskie School of Public Services, January 2010

15 CFR Title 42, Part 410.78, “Telehealth Services

