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Honeywell

Honeywell
101 Constitution Avenue, N.W.
Suite 500 West
Washington, DC 20001
202-662-2650

July 3, 2007

Leslie Norwalk
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1541-P
P.O. Box 8012
Baltimore, MD 21244-8012

RE: CMS-1541-P: Medicare Program; Home Health Prospective Payment System Refinement and Rate Update for Calendar Year 2008; Proposed Rule

Dear Acting Administrator Norwalk:

Honeywell HomMed ("HomMed"), a nationally recognized leader in telemonitoring technologies, submits these comments on the proposed rule released by the Centers for Medicare and Medicaid Services ("CMS") regarding revisions to the Home Health Prospective Payment System ("HH PPS") for Calendar Year 2008.[1] We applaud CMS for undertaking this initiative to improve the HH PPS and seek to work collaboratively with the Agency to improve the quality of home healthcare in a cost effective manner.

Our comments focus on two principal areas: the need for data to evaluate the role technology is playing in the delivery of quality health care to home health beneficiaries and the importance of developing a PPS system that appropriately incentivizes home health agencies ("HHAs") to choose the technological tools that improve patient outcomes and generate savings to the Medicare Program by reducing home health and hospital payments.

I. Background on HomMed's Products and Remote Monitoring

Over the past eight years, HomMed has invested a significant amount of research and development into telemonitoring technologies designed to improve patient care and to increase the efficiency of HHAs. The Company currently has two models of telemonitors – the Sentry and the Genesis – as well as Central Station software. These Food and Drug Administration ("FDA") Class II devices are being utilized by home health patients more than the products of all other device manufacturers of home telemonitoring combined.

Telemonitoring has proven to be a cost effective way to remotely monitor patients and is currently being used with great success by the Veteran's Administration where they have established

[1] 72 Fed. Reg. 25,356 (May 4, 2007).

"care coordination" programs in all 21 regions of the country as part of their Care Coordination Home Telehealth strategy. Several independent studies have shown that when the HomMed Health monitoring system is installed, hospital and emergent care utilization is significantly reduced, clinical outcomes improve and costs decline for HHAs.

Typically, once a telemonitoring unit is placed in the user's home or clinical environment, vital health status information – such as blood pressure, weight, oxygen saturation levels, glucose levels or temperature – is transmitted back to a Central Station on a daily basis. This Central Station receives the data and presents it to the appropriate clinical personnel for individualized monitoring and tracking. For patients with practically any major disease state, use of this remote monitoring technology has reduced hospital admissions and emergency room visits while facilitating clinically necessary face to face visits.

Unfortunately, many HHAs still do not utilize remote monitoring technologies despite the improvements in patient outcomes and the efficiencies achieved through the use of the technology. Since the capital cost of the technology and the accompanying services is not reimbursed by Medicare and is not included as an allowable expense on the cost report, providers have a myriad of incentives not to purchase these products – even though the Medicare Program may save significant sums of money if these products were more widely utilized. Equally problematic, today, the Medicare Program does not even know whether HHAs are using telemonitoring technology as part of their plan of care.

One of the principal challenges facing policymakers is the lack of Medicare data available to evaluate the degree to which remote monitoring reduces Medicare costs under both the home health benefit and the Medicare Program as a whole by eliminating unnecessary skilled nursing visits, and avoiding costly hospitalizations and emergent care. In the final rule, CMS has an opportunity to address these challenges without expending additional monies.

II. Proposal to Account for the Effects of Remote Monitoring

To account for the effects of remote monitoring on home health beneficiaries, HomMed encourages CMS to take two simple steps: 1) add one question to the OASIS instrument on whether remote monitoring is included within a patient's plan of care; and 2) require HHAs to report technology costs, including remote monitoring, as a non-reimbursable expense on the Medicare cost report.

A. Addition of Telehealth OASIS Question

The effectiveness of the HH PPS system is dependent upon the accurate collection of patient specific data in order to appropriately compensate HHAs for the resources used to provide care. Unfortunately, while approximately 15 percent of HHAs utilize remote monitoring technologies, the actual resources used in these episodes of care with respect to both input costs and savings achieved through reductions in nursing visits are relatively unknown. Further, the effect of remote monitoring on improvements in patient outcomes and reductions in hospitalizations and unplanned emergent care cannot be fully appreciated unless the HHA reports whether a patient has been remotely monitored.

We believe CMS can begin to collect Medicare data with respect to telemonitoring without adding additional burdens to the home health agency. Given that the proposed rule suggests modifying the OASIS instrument, HomMed suggests adding another question in the area of telemonitoring.

Remote Monitoring Need: Does the care plan of the Medicare payment period call for daily monitoring of the patient's vital signs through use of remote monitoring equipment? If yes, does the plan of care include corresponding standing orders for patients with specific disease states and conditions?

By virtue of asking this simple question, CMS will acquire significant new data necessary for the development of an effective PPS system. Over time, the Agency may be able to ensure payment accuracy for episodes that technically require fewer in-home visits. If CMS does not ask a question about remote monitoring in the OASIS instrument, it will be unable to obtain data about the relationship between remote monitoring technology and improved outcomes and numbers of in-home visits. [2]

B. *Addition of Telemonitoring Expenses on the Home Health Cost Report*

Similarly, adding a provision on the HH cost report for remote monitoring equipment and services will be essential for CMS and policymakers to evaluate whether HHAs are using this technology, how much this technology costs HHAs, and the extent to which this technology is improving health care outcomes. Accordingly, beginning in CY 2008, the costs for remote monitoring equipment and associated services should be reported as a non-reimburseable cost center on all cost reports submitted by HHAs. Listing these expenses will allow the government and the private sector to better calculate the magnitude of the financial impact telehealth services has on home health care and hospital costs.

Ultimately, we believe that the costs of telemonitoring should be included as a reimbursable expense on the HH cost report given the improvements in clinical outcomes and reduction in labor costs that can be realized through the use of this technology. As skilled nursing care is directed by a patient's own vital signs, remote monitoring of those vital signs can eliminate unnecessary skilled nursing visits and enable a HHA to deliver only timely and clinically relevant care. We believe this will produce significant savings under the Medicare program. Given statutory constraints that prevent the Agency from allowing these costs to be reimbursed under the PPS system, we respectfully request that the Agency require HHAs to report the capital costs of the technology and the associated services on the HH cost report and that the Agency begin to track these costs in order to understand the benefits of telemonitoring as the Agency seeks to improve patient care in a cost-effective manner.

III. Impact of Visit-Based Payment Models on the Adoption of Technology

As CMS finalizes this rulemaking, we urge the Agency to closely review whether it intends to continue incentivizing behavior that moves the payment system away from a case-based model that rewards efficient and effective care toward a visit-based model that encourages more in-home patient interaction without any knowledge of whether this in-home interaction will lead to higher quality outcomes. Unintentionally, the current and proposed payment systems perpetuate this problem.

[2] We note that existing regulations already allow physicians to consider telehealth services when they develop patients' plan of care. Unfortunately, CMS is not tracking this information in the OASIS instrument.

To the extent that CMS continues to only evaluate the volume of in-home, personal therapy visits delivered without accounting for other types of patient interactions including remote monitoring, HHAs will have a direct economic incentive to continue focusing their service delivery resources solely on in-home, personal visits. To the extent that these in-person visits are the only interactions captured on the cost reports, they will be the data measured to determine how the refinement and updating of the PPS payments will occur in the future. Unless telemonitoring and related services are reflected in the cost report, many HHAs will lack the incentive to purchase a service delivery mechanism that will artificially deflate the agency's true costs of managing patient outcomes. In the future, why will HHAs purchase or rely upon technology that improves patients' outcomes if the purchase of such products will ultimately be used as a tool to reduce the HHAs' reimbursement?

The current and proposed data collection system clearly needs to be modified in order to avoid such a perverse policy outcome. HomMed's proposals are modest but they will begin addressing the long-standing bias against the use of technology in the home health setting. We would argue that, at the very least, the Medicare Program should begin collecting data on remote monitoring in order to better improve the accuracy of the home health prospective payment system and know whether CMS has unintentionally incentivized more costly behavior or a particular mechanism of delivering health care.

IV. Conclusion

HomMed fully supports CMS's efforts to make the HH PPS more accurately reflect the resources HHAs must use to deliver efficient and appropriate care to beneficiaries. Establishing a system that collects additional data related to remote monitoring through the OASIS instrument and the HH cost report will help accomplish that objective.

In the final regulation, CMS has a unique opportunity to encourage the appropriate use of technology without adding to the costs of the health care system. Thank you for your attention to the issues raised in this comment letter. We appreciate your consideration of our request. Please do not hesitate to contact Michelle Mackey at (202) 662-2638 or myself if you have any questions or need additional information.

Sincerely,

Terry Duesterhoeft
Vice President of Marketing, Honeywell HomMed