MEDCHI, THE MARYLAND STATE MEDICAL SOCIETY
HOUSE OF DELEGATES

Resolution 7-18

INTRODUCED BY: Medical Student Section

SUBJECT: Expanding On-Site Physician Home Health Care to Low-Income Families and the Chronically Ill

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Whereas, In 2011, 2 million Medicare patients age 65 or older were homebound, many with severe chronic conditions and functional impairments making it difficult to visit a doctor[1]; and

Whereas, lack of transportation is the third-greatest barrier to care for disabled adults, with 12.2% percent of patients stating that they could not get a ride to their doctor's office as shown in a 2014 survey of Medicaid users[2]; and

Whereas, home health technology advancements have improved physicians' delivery of care outside the office, particularly for patients with multiple conditions and limited mobility[3-5]; and

Whereas, House call programs that target high-risk patients have significantly reduced healthcare costs and improved medical outcomes[6]; and

Whereas, The Patient Protection and Affordable Care Act established the Maternal and Infant Early Childhood Home Visiting program (MIECHV) in 2010, targeting high risk families and leading to reduced child health care costs and need for remedial education[7]; and

Whereas, Policymakers have increased support of home visits since 2012 when introducing the Independence at Home (IAH) Demonstration aimed at delivering comprehensive primary care for Medicare beneficiaries with multiple chronic conditions; and

Whereas, Based on findings from Centers for Medicare & Medicaid Services' (CMS) IAH demonstration, introducing medically necessary home visits saved $25 million in the program's inaugural year[8]; and

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[1] Ornstein, K. A., Leff, B., Covinsky, K. E., Ritchie, C. S., Federman, A. D., Roberts, L., & Szanton, S. L. (2015). Epidemiology of the homebound population in the United States. JAMA internal medicine, 175(7), 1180-1186.
[2] Health Care Experiences of Adults with Disabilities Enrolled in Medicaid Only: Findings from a 2014-2015 Nationwide Survey of Medicaid Beneficiaries. Nationwide Adult Medicaid CAHPS Analytical Brief. 2017.
[3]Hayashi J, Leff B. Medically oriented HCBS: house calls make a comeback. Generations. 2012. http://www.asaging.org/blog/medically-oriented-hcbs-house-calls-make-comeback. Accessed March 23, 2018.
[4]Landers SH. Why health care is going home. N Engl J Med. 2010;363:1690-1691.
[5]Kao H, Conant R, Soriano T, McCormick W. The past, present, and future of house calls. Clin Geriatr Med. 2009;25:19-34, v.
[6]De Jonge KE, Jamshed N, Gilden D, Kubisiak J, Bruce SR, Taler G. Effects of home-based primary care on Medicare costs in high-risk elders. J Am Geriatr Soc. 2014;62:1825-1831.
[7]Sarah Avellar et al., Home Visiting Evidence of Effectiveness Review: Executive Summary, Washington, D.C. U.S. Department of Health and Human Services, Office of Policy, Research and Evaluation, September 2013

Whereas, The Medicaid program allows states to develop 1915(c) home and community-based services (HCBS) waivers targeting specific high-risk populations who prefer to receive long-term care in their homes or communities rather than at medical institutions. Annual HCBS waiver expenditure of $25 billion in 2006 resulted in estimated savings of over $57 billion, or $57,338 per participant.[9] While health outcomes of HCBS programs are difficult to evaluate, as they are highly variable, it has been found that states that invest more in HCBS as a percentage of total long-term care spending produce lower rates of adverse health outcomes[10]; and

Whereas, Veterans Health Administration (VHA) created the Home-based Primary Care (HBPC) program in 1970 to provide comprehensive primary care in homes of veterans with conditions precluding them from clinic-based care. Targeting patients among the 5% highest cost, the model has been associated with 24% reduction in total cost of VHA care, 9% fewer hospitalizations, 10% fewer emergency department visits, and 23% fewer specialist visits[9]; and

Whereas, Although these house call programs have shown great promise in cutting healthcare costs while improving medical outcomes, their utility is limited by the small number of high-risk or low income patients they serve; and

Whereas, The MIECHV program represents the largest federal investment in home visits, the program reached only 145,500 parents and children in 2015, leaving many high-risk, low-income families without home visit resources[11]; and

Whereas, Patients must live near one of only 14 participating health care providers nationwide in order to be eligible for the IAH demonstration. Expanding project to all eligible beneficiaries could save Medicare up to $4.8 billion a year[12]; and

Whereas, Despite being the nation's largest house call program, HCBS provides home-and community-based services to only 4% of total Medicaid population, representing 2.2 million beneficiaries[13]; and

Whereas, As of 2010, HBPC only provided home-based care to merely 25,000 of the 8.1 million veterans VHA served annually, significantly restricting the program's cost-savings and impact[14]; and

Whereas, Ensuring that at-risk families have access to home visiting services even if they are not covered by Medicaid is critical; therefore be it

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[8] Centers for Medicare and Medicaid Services. (2016). Affordable Care Act payment model saves more than $25 million in first performance year. press release, June, 18, 2-15.

[9] Harrington, C., Ng, T., & Kitchener, M. (2011). Do Medicaid home and community based service waivers save money?. Home health care services quarterly, 30(4), 198-213.

[10] Burwell B, Sredl K, Eiken S. Medicaid long-term care expenditures in FY 2005. Cambridge, MA: Chronic Care and Disability Group, Truven Health Analytics; July 7, 2006.

[11] Herzfeldt-Kamprath, R.. Calsyn, M., & Huelskoetter T. Medicaid and Home Visiting Best Practices from States. www.americanprogress.org/issues/early-childhood/reports/ 2017/01/25/297160/ medicaid-and-home-visiting/ Updated January 25, 2017. Accessed March 23, 2018.

[12] Edes, T., Kinosian, B., Vuckovic, N. H., Olivia Nichols, L., Mary Becker, M., & Hossain, M. (2014). Better access, quality, and cost for clinically complex veterans with home-based primary care. Journal of the American Geriatrics Society, 62(10), 1954-1961.

[13] Konetzka, R. T., Karon, S. L., & Potter, D. E. B. (2012). Users of Medicaid home and community-based services are especially vulnerable to costly avoidable hospital admissions. Health Affairs, 31(6), 1167-1175.

[14] Kubat, B. (2016). For Veterans, Good Health Care Begins at Home. Caring for the Ages, 17(1), 18.

Resolved, That MedChi ask our AMA to amend On-site Physician Home Health Care, H-210.981 by addition and deletion to read as follows:

The AMA: (1) recognizes that timely access to physician care for the frail, chronically ill, disabled or low-income patient is a goal that can ~~only~~ be met by an increase in physician house calls to this vulnerable, underserved population.

(2) strongly supports the role of interdisciplinary teams in providing direct care in the patient's own home, but recognizes that physician oversight of that care from a distance must sometimes be supplemented by on-site physician care through house calls.

(3) advocates that the physician who collaborates in a patient's plan of care for home health services should see that patient on a periodic basis.

(4) recognizes the value of the house call in establishing and enhancing the physician-patient and physician-family relationship and rapport, in assessing the effects of the social, functional and physical environment on the patient's illness, and in incorporating the knowledge gained into subsequent health care decisions.

(5) believes that physician on-site care through house calls is important when there is a change in condition that cannot be diagnosed over the telephone with the assistance of allied health personnel in the home and assisted transportation to the physician's office is costly, difficult to arrange, or ~~excessively tiring and painful for~~ detrimental to the patient's health.

(6) recognizes the importance of improving communication systems to integrate the activities of the disparate health professionals delivering home care to the same patient. Frequent and comprehensive communication between all team members is crucial to quality care, must be part of every care plan, and can occur via telephone, FAX, e-mail, video telemedicine and in person.

(7) recognizes the importance of removing economic, institutional and regulatory barriers to physician house calls, **INCLUDING THE DEVELOPMENT OF PROGRAMS FOR LOW-INCOME FAMILIES AND OLDER ADULTS.**

(8) supports the requirement for a medical director for all home health agencies, comparable to the statutory requirements for medical directors for nursing homes and hospice.

(9) recommends that all specialty societies address the effect of dehospitalization on the patients that they care for and examine how their specialty is preparing its residents in-training to provide quality care in the home.

(10) encourages appropriate specialty societies to continue to develop educational programs for practicing physicians interested in expanding their involvement in home care.

(11) urges CMS to clarify and make more accessible to physicians information on standards for utilization of home health services, such as functional status, ~~and~~ severity of illness, and socioeconomic status.

(12) urges CMS, in its efforts to redefine homebound, to consider the adoption of criteria and methods that will strengthen the physician's role in authorizing home health services, as well as how such criteria and methods can be implemented to reduce the paperwork burden on physicians.

As amended and adopted by the House of Delegates at its meeting on April 29, 2018.

Relevant AMA Policy

On-Site Physician Home Health Care, H-210.981
The AMA: (1) recognizes that timely access to physician care for the frail, chronically ill or disabled patient is a goal that can only be met by an increase in physician house calls to this vulnerable, underserved population.
(2) strongly supports the role of interdisciplinary teams in providing direct care in the patient's own home, but recognizes that physician oversight of that care from a distance must sometimes be supplemented by on-site physician care through house calls.
(3) advocates that the physician who collaborates in a patient's plan of care for home health services should see that patient on a periodic basis.
(4) recognizes the value of the house call in establishing and enhancing the physician-patient and physician-family relationship and rapport, in assessing the effects of the social, functional and physical environment on the patient's illness, and in incorporating the knowledge gained into subsequent health care decisions.
(5) believes that physician on-site care through house calls is important when there is a change in condition that cannot be diagnosed over the telephone with the assistance of allied health personnel in the home and assisted transportation to the physician's office is costly, difficult to arrange, or excessively tiring and painful for the patient.
(6) recognizes the importance of improving communication systems to integrate the activities of the disparate health professionals delivering home care to the same patient. Frequent and comprehensive communication between all team members is crucial to quality care, must be part of every care plan, and can occur via telephone, FAX, e-mail, video telemedicine and in person.
(7) recognizes the importance of removing economic, institutional and regulatory barriers to physician house calls.
(8) supports the requirement for a medical director for all home health agencies, comparable to the statutory requirements for medical directors for nursing homes and hospice.
(9) recommends that all specialty societies address the effect of dehospitalization on the patients that they care for and examine how their specialty is preparing its residents in-training to provide quality care in the home.
(10) encourages appropriate specialty societies to continue to develop educational programs for practicing physicians interested in expanding their involvement in home care.
(11) urges CMS to clarify and make more accessible to physicians information on standards for utilization of home health services, such as functional status and severity of illness.
(12) urges CMS, in its efforts to redefine homebound, to consider the adoption of criteria and methods that will strengthen the physician's role in authorizing home health services, as well as how such criteria and methods can be implemented to reduce the paperwork burden on physicians.

Providing Cost Estimate with Home Health Care Order Authorization H-210.996
The AMA urges physicians to request **home health care** providers to provide a cost estimate with the physician authorization form, when the form is sent to the physician for his/her signature.

Medicaid Patient-Centered Medical Home Models H-160.913
Our AMA: (1) recognizes that the physician-led medical home model, as described by Policy H-160.919, has demonstrated the potential to enhance the value of health care by improving access, quality and outcomes while reducing costs; and (2) will work with state medical associations to explore, and where feasible, implement physician-led Medicaid patient-centered medical home models based on the unique needs of the physicians and patients in their state