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**Home Care Alliance of Massachusetts**  
**Testimony to the Executive Office of Health and Human Services**  
***101 CMR 350.00 and the rescission of 114.3 CMR 50.00 – Home Health Services***

On behalf of the Home Care Alliance of Massachusetts, we appreciate the opportunity to offer comments on 101 CMR 350.00 and the rescission of 114.3 CMR 50.00 relative to Home Health Services.

The Home Care Alliance is a trade association of 200 home care agencies that are both Medicare-certified – authorized to provide medical services for reimbursement from Medicare and MassHealth – and privately-paid supportive services. Offerings provided by our members range from companionship and homemaking to skilled nursing and therapy.

Roughly half of our Medicare-certified agency members also offer remote patient monitoring (RPM) or tele-monitoring services so we are pleased to see proposed guidelines and reimbursement after years of working collaboratively with MassHealth and the legislature. Undoubtedly, the state’s support of tele-monitoring will lead to better health outcomes, including reduced hospitalizations and improved patient self-management. In short, it will strengthen the ability of home health agencies to carry out their mission of keeping people healthy at home.

We appreciate that Massachusetts is once again at the forefront of healthcare innovation, joining a group of forward-thinking Medicaid programs that reimburse for this type of service. The reason home health agencies in Massachusetts have adopted the use of remote patient monitoring without any reimbursement is because it works. Nearly 50 agencies have invested the resources in RPM equipment and programs for years without reimbursement because they know that it markedly improves the quality and efficiency of care.

With MassHealth reimbursement, these agencies can expand the number of patients able to receive tele-monitoring and the conditions they are able to monitor. In addition, agencies that have never been able to offer this service option can acquire the necessary equipment with less apprehension. This will all lead to better care in a less restrictive setting for MassHealth members.

The Alliance appreciates the work of MassHealth staff and leadership in moving this proposed change forward, and the Center for Health Information and Analysis staff for their investigation into rate structures. We enthusiastically offer the following comments and suggestions on the suggested payment rates and definitions.

### **Proposed Rates for Remote Patient Monitoring:**

The Home Care Alliance has found that the average payment to home health agencies for remote patient monitoring is about \$285 per month, although there is some variation to the timeframe at which rates are paid and how services are authorized. The proposed rate of \$10 per day is a strong starting point and the feedback on that piece of the reimbursement from our home health agency members has been generally positive. We do, however, seek a slight language change from a “per diem” rate to a “per day” rate. The reason this change is necessary is that a nurse is not performing a “visit” per se, but constantly monitoring the updated information of multiple patients each day.

The Home Care Alliance also seeks clarification regarding the “installation/removal” fee of \$50 in terms of whether it is a one-time payment for both installation and removal of the equipment or if the fee is billable for both the set-up and take-down. We strongly suggest implementing the fee on both ends and increasing the amount to \$75 for a total of \$150 for the “installation/removal.” This would certainly help agencies that must provide proper education to patients on the use of the equipment in order for it to be most effective. In addition, agencies must pay for the time clinicians spend with set-up and patient education, mileage to and from the patient’s home. Obviously, for infection control purposes, there also needs to be thorough cleaning and restocking of the equipment after its use.

Finally, we have received questions from our members that provide RPM services about how to proceed when an agency cares for multiple patients in a household. Guidance would be appreciated on whether there would be separate devices, separate rates and how to account for the installation/removal fee when education of multiple patients are involved. The General Definitions under section 350.02 mention a reduced rate for each subsequent member of the household receiving services so we are curious if that extends to RPM services.

### **General Definitions:**

In order to tighten up the definitions to ensure that RPM is included in a home health agency’s repertoire of possible offerings, the Home Care Alliance suggests that the definition of a “Home Health Agency” can be slightly changed to read: “An agency that provides *home* health services in the home setting.” We suggest this because “remote patient monitoring services” are included in the definition of “Home Health Services” and we want to ensure that loop is closed.

Under the definition of “Remote Monitoring Device,” we encourage MassHealth to switch the term “user-entered” with “*user generated*” to more clearly reflect that some data is manually entered and some data is automatically collected. Both are generated by the patient either actively or passively. The purpose of RPM is to accurately track patient vital signs and other health diagnostic information to intervene when necessary and improve care plan compliance. Therefore, we believe promoting the data as user-generated in the language is a more pure and precise term as it relates to the service.

Regarding the actual definition of “Remote Patient Monitoring (RPM),” the Home Care Alliance appreciates that MassHealth put forth broad terms, which we believe will allow home health agencies to utilize different equipment for a variety of services. Not only will traditional vital signs monitoring equipment be immensely effective in improving patient care quality, but so too will blood glucose monitors for diabetics, live video for wound care patients, and other methods still in development. With the constant improvement in technology, we expect even greater potential for RPM in terms of better managing chronic illnesses and treating different conditions, including behavioral health.

To that end, we strongly suggest that the definition reflect that mental health and not just physical health conditions can be addressed by RPM. The enclosed study demonstrates that a daily questionnaire incorporated with RPM to certain eligible patients with mental health conditions reduced hospitalizations by 86 percent. The potential of addressing both the mind and body through RPM services is enormous and we encourage MassHealth to incorporate that thinking into the definition.

We also appreciate that MassHealth’s proposed definition embraces “store and forward” capabilities of RPM equipment. This will allow a deeper understanding on the part of clinicians of the day-to-day changes in patient health and may also improve collaboration between home health and other providers who would value such information.

Once again, we suggest MassHealth change the term “user-entered” to “user-generated” under the RPM definition and also add the word “dashboard” to the following sentence: “*These systems can transmit user-generated data, store the data in secure records systems accessible to clinicians, flag abnormal readings or responses, and alert clinicians to abnormalities via e-mail, dashboard or text messages.*” Most, if not all, home health agencies employing RPM track patients via a dashboard that will alert clinicians to changes in the patient’s condition or daily measurements. Although emails and text messages are a helpful part of the RPM equation, the dashboard at the home health agency’s end is the tool that allows for workability and greater efficiency for a group of patients.

### **General Comments:**

The Home Care Alliance has been advocating for RPM services for many years. The proposed changes are a victory for patients and the healthcare system, not to mention home health agencies struggling to remain viable in the face of myriad fiscal pressures.

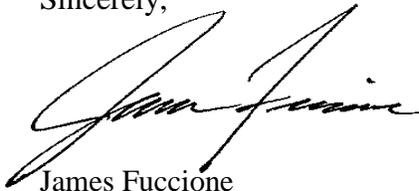
Although we greatly appreciate the step forward with MassHealth reimbursing agencies for RPM services, we remain extremely concerned with payment levels for nursing, therapy, and home health aide services from the state that come nowhere near covering the costs of providing care. Home health agencies in the state continue to struggle with payment rates that have not been rebased since 2005 (the therapies since 1994), were frozen in 2007 and cut in 2008. This is a travesty that is forcing quality home health providers to cut back services to those that need them most because agencies can

no longer remain viable while doing so. Obviously, this only creates access issues and forces patients to more expensive settings.

It is time MassHealth revisit payment for all home health services so home health agencies can take a greater role in managing care for MassHealth members at home to help control overall costs and improve program efficiency. We strongly urge that a review of these rates be a top priority, and we stand ready to provide any assistance we can to expedite that process.

We greatly appreciate your consideration of our comments and suggestions. Please do not hesitate to contact us ([jfuccione@thinkhomecare.org](mailto:jfuccione@thinkhomecare.org), 617-482-8830) with further questions.

Sincerely,

A handwritten signature in black ink, appearing to read "James Fuccione". The signature is fluid and cursive, with a large initial "J" and "F".

James Fuccione  
Director, Legislative & Public Affairs  
Home Care Alliance of Massachusetts