



American
Academy of
Home Care
Medicine



Date: June 19, 2015

Dear Senators Hatch, Isakson, Warner and Wyden
Senate Finance Committee—Chronic Care Reform Working Group

The American Academy of Home Care Medicine is pleased at the efforts of the Committee to address chronic care reform. The Academy represents the many physicians, nurse practitioners, physician assistants and others who are bringing home care medicine to those who need it across the country. A nonprofit professional society, the Academy has been in existence since 1988.

The Academy is happy to make one central recommendation overall, to make specific recommendations for each of the topics outlined by the Working Group, and to add other recommendations related to chronic care reform we believe should be considered.

I. **Central Overall Recommendation: Make Independence at Home a central feature of future chronic care legislation of the Committee**

CMS has just released the wonderful news of the success of the IAH Demonstration, which even in the first year: <http://innovation.cms.gov/initiatives/Independence-at-Home> saved more than \$25 million while improving quality and reducing 30-day rehospitalizations, as well as reducing hospital and ER cost. Expansion of this Demonstration and making it accessible to all high cost chronically ill Medicare beneficiaries is our central recommendation, for IAH meets all of the critical criteria: better care at lower cost for health care the frailest, sickest Medicare recipients both want and need and that also benefits the Medicare program. This initiative has *always had bipartisan support*, and should be immediately considered including expansion to a permanent Medicare benefit based on this success.

Why IAH deserves support

In order for any legislation to reduce the high and rapidly growing cost to Medicare of chronic illness, it must target not only the high cost, but *persistently* high cost chronically ill beneficiaries with multiple chronic conditions. As included in the June 18 CMS announcement of IAH first year success:

"These results support what most Americans already want-- that chronically ill patients can be better taken care of in their own homes. This is a great common sense way for Medicare beneficiaries to get better quality care with smarter spending from Medicare" and, that

"The Independence at Home Demonstration is one of the tools.... that can bring down the long-term cost of care in a patient-centered manner."

And according to CBO, if those beneficiaries are successfully targeted, "even a small percentage reduction in the spending of that group of beneficiaries could lead to large savings for the Medicare program. See "High-Cost Medicare Beneficiaries", A CBO White Paper, p.1 (May 2005). The Independence at Home Medicare Demonstration at section 1866E of the Medicare Act incorporates the CBO suggestions that eligible beneficiaries be those who were high cost the previous year (by having both chronic conditions and functional disabilities), who were hospitalized in the previous year, and had two or more chronic conditions. Section 1866E (d) (1). The recently concluded 3-year IAH Demonstration confirmed that the eligibility criteria had successfully identified Medicare beneficiaries with HCC scores of 3.6—exceedingly high risk and persistently high cost beneficiaries.

The IAH model authorized by section 1866E of the Medicare Act has been thoroughly tested and found successful in the 3-year Medicare Demonstration and in the Department of Veterans' Affairs' Home-Based Primary Care program. So any legislation designed to increase care coordination among the highest cost Medicare beneficiaries with multiple chronic diseases should start, at its core, with the IAH model that has proven successful in "real world experience" and "data-driven evidence" from impartial sources.

As many Committee members are aware, the IAH program is focused on the 5% most costly Medicare beneficiaries with multiple chronic conditions who account for more than 50% of Medicare's costs and has proven to dramatically reduce costs, hospitalizations, ER visits and nursing home use. The Independence at Home Medicare legislation was introduced with broad bipartisan support in the House and Senate in 2009. Committee sponsors included Senators Burr (R-NC), Isakson (R-GA), Wyden (D-OR), Stabenow (D-MI), and Menendez (D-NJ). The IAH program was ultimately authorized as a demonstration in detailed legislation at section 1866E of the Medicare Act.

The IAH Medicare Demonstration completed its initial three year term on May 31. In April, Deputy CMS Administrator Dr. Patrick Conway, publicly stated that the Independence at Home Medicare Demonstration has been a success, and that conclusion was confirmed in the press release on first year of the IAH Demonstration on June 18. On April 23, the Senate, in a

unanimous, bipartisan vote, approved legislation (S. 971) to extend the IAH Medicare Demonstration for another two years. On June 12, the Congressional Budget Office, issued a report affirming that extending the IAH Demonstration for another two years would not increase Medicare costs due to, among other reasons, “the spending targets established in the demonstration”. And the IAH program is the only care coordination program that contains a “self-culling process” that ensures that only successful programs can participate.

The Work Group might want to consider how CMS can accelerate the delivery of information for beneficiary management to medical practices already in IAH and also to those who treat IAH beneficiaries and who could apply to participate in an expanded IAH program. Medicare in this way will help to prepare the medical workforce that will be required to take on the care of the growing Medicare beneficiary population (10,000 added beneficiaries a day) that will include an increased number of high cost chronically ill add. Section 1866E (i).

The IAH Medicare Demonstration participants were confident that the first year results would be good, but when CMS released the first year savings sharing determinations on June 18, the participants found that they were generally better than expected. CMS has indicated that the second year savings determinations will be issued in November, and it is generally expected that those results will be even better. The third year savings determinations should be released soon thereafter. CMS has just lifted the embargo on the results. The IAH Medicare Demonstration is showing that it is possible to significantly reduce Medicare costs, not by cutting payment to providers or benefits, but by providing better health care tailored to the most complex patients in their home environment. IAH has proven to be a triple win—for patients and families, for practitioners and for programs such as Medicare, Medicaid and private insurance.

The IAH chronic care coordination program has also proven successful in the VA’s similar Home-Based Primary Care program which has operated for over 30 years and currently operates in over 300 locations in all 50 states and the District of Columbia and has a census of more than 34,000 high cost chronically ill patients. A recent peer reviewed study showed that the VA’s HBPC program reduced combined VA and Medicare hospitalizations by 25.5%, overall costs by 13.4% annually, combined VA and Medicare hospital days by 36.5% while achieving an 83% positive patient satisfaction rating—the highest achieved by a VA program.¹

¹ “Better Access, Quality and Cost for Clinically Complex Veterans and Home-Based Primary Care”, *Journal of the American Geriatrics Society* 62:1954-1961, 2014. Another peer reviewed study of an IAH-style program at the Washington Hospital Center in D.C. showed savings of 17%, and reduced hospitalizations by 9%, emergency room visits by 10% and skilled nursing facility days by 27%. “Effects of Home-Based Primary Care On Medicare Costs in High Risk Elders”, *Journal of American Geriatric Society*, 62:1825-1831, 2014.

Experts at the University of Pennsylvania School of Medicine have estimated that simply by making the existing IAH program accessible to all high cost chronically ill Medicare beneficiaries would save approximately \$60 billion over ten years, with about \$30 billion retained by the government. Based on the better than expected first year results of the IAH Medicare Demonstration, that estimate has been significantly increased and can be disclosed once CMS lifts its embargo.

The Medicare Independence at Home Demonstration also incorporates all of the lessons learned in the 34 chronic care coordination programs tested by CMS and determined by CBO to have failed. The IAH model (a) focuses on the highest cost beneficiaries with *multiple* chronic conditions, (b) requires close involvement of primary care practitioners (teams of health care professionals led by primary care practitioners providing care in the beneficiary's home), and (c) *minimum savings of 5% annually and no upfront payments*. See "Lessons from Medicare's Demonstration Projects on Disease Management and Care Coordination", CBO Working Paper, pp. 5, 10, 12, 25 (Jan. 2012).

The IAH model meets all of the three main bipartisan goals:

Increases care coordination- The IAH model provides for a primary care practitioner supported team of health care professionals tailored to the beneficiaries' chronic conditions to make house calls in order to provide care in the beneficiary's residence *and* coordinate the beneficiary's health care across all treatment settings, *and* to be available 24/7. Section 1866E (b) (1) (A)

Incentivizes appropriate levels of care-The IAH model does not disrupt the current Medicare payment or coverage provisions for services under Medicare but adds a savings sharing provision under which IAH programs that achieve minimum savings of 5% annually, may receive up to 80% of the savings beyond 5% if they have scored sufficiently high on six outcomes oriented quality measures. Section 1866E(c). This has the effect of reversing the incentive to avoid these highest cost, complex beneficiaries which avoidance has been identified with FFS, traditional managed care, bundling, and ACO models. It also eliminates the incentive to overutilize services which has plagued home based care under Medicare. Practitioners instead have an incentive to innovate and provide the care that will produce the best outcomes for individual beneficiaries since the practices' savings share is dependent upon both lower cost and good outcomes.

Facilitates high quality, good outcomes and reduces the growth in Medicare spending-The IAH model is the only Medicare health care delivery model that includes a requirement for minimum overall savings of 5% annually that is dependent upon high quality and good outcomes. Section

1866E (i). Nearly all of the 34 failed Medicare chronic care coordination demonstrations included some type of upfront payment. CBO has concluded that “requiring a net savings of 5 percent is less likely to encourage participation but creates a stronger incentive for programs to reduce costs and is more likely to generate savings for Medicare.” “Lessons from Medicare’s Demonstration Projects on Disease Management and Care Coordination”, p. 25.

Also, IAH advances all of the policy issues listed in the Committee’s letter.

1. IAH-style programs have entered into agreements with numerous Medicare Advantage programs to provide better care at lower cost for the highest cost beneficiaries in Medicare Advantage plans that represent the plans’ biggest financial risk.
2. The IAH Medicare Demonstration has proven that the alternative payment model of coupling FFS with savings sharing can preserve the capability that FFS provides to show what services are being rendered while incentivizing practitioners to avoid unnecessary services.
3. By allowing IAH programs to share in overall net savings beyond the first 5%, the IAH program incentivizes providers to coordinate care for patients with multiple chronic conditions. (The IAH model also allows hospitals, nursing homes and other providers to participate as partners in IAH programs, section 1866E(b)(3).)
4. The IAH program incentivizes the effective use, coordination and cost of prescription drugs because better medication coordination leads to fewer drugs and better outcomes for the chronically ill. One of the quality measures for the IAH program that determines the amount of savings sharing is “medication reconciliation in the home”.
5. IAH promotes the effective use of Telehealth and remote monitoring technology by requiring IAH practices to have the capacity to use “electronic health information systems, remote monitoring, and mobile diagnostic technology” if it is useful in producing better outcomes for individual beneficiaries. Section 1866E (b) (1) (A) (VI).
6. IAH creates an incentive for strategies to increase chronic care coordination in rural and frontier areas since the highest cost underserved beneficiaries represent the greatest opportunity for savings for Medicare and savings sharing for IAH practices.

7. IAH empowers Medicare beneficiaries to play a greater role in managing their health and engaging with providers by taking health care to them and their caregivers in their home environment and involving them in their care.
8. IAH creates an opportunity to more effectively utilize primary care coordination teams to maximize health care outcomes by expressly including both physicians and nurse practitioners (if permitted by state law) to lead health care teams and for those teams to be comprised of physicians, nurses, physician assistants, pharmacists, and other health and social services staff as appropriate. Section 1866E (b) (1) (A) (i).

Perhaps the most compelling reason (in addition to significant savings) for including the Independence at Home model in the Medicare program is that it addresses the three greatest concerns of older Americans with respect to chronic illness:

Inability to pay for care;

The loss of independence; and

Becoming a burden to family and friends.²

Separately, we will provide draft legislative language to convert the Independence at Home Medicare Demonstration into a Medicare benefit accessible to all high cost chronically ill Medicare beneficiaries nationwide.

IAH is the most thoroughly proven innovation in providing better health care at lower cost for the highest cost Medicare beneficiaries. Its time has come. Its time is now.

II. **Comments on Questions Raised by the Workgroup**

We answer each of the questions from the perspective of what we have learned about the opportunities to improve care and lower cost for the sickest, most costly Medicare beneficiaries.

- a. **Improvements to Medicare Advantage for patient living with multiple chronic conditions in the home.**

² Chronic Care: Making the Case of Ongoing Care”, G. Anderson, et al., Johns Hopkins Bloomberg School of Public Health, p. 27 (2010).

We can speak to the needs of the very sick home-limited population we serve. First, and important to understand is that, until the new provisions of the ACA that made them serve all populations, Managed Care Plans have in general avoided this sickest, most costly population because they could and it was to their advantage to do so because of their high cost coupled with the inadequate reimbursement due to the HCC scoring methodology that fails as validated and presented to you in recent testimony by MedPAC to capture the costs of the costliest patients.

Today, this has changed for some patients. Some leading health plans (United-Optum, Humana at Home, and to a limited extent, Cigna), are offering longitudinal home-based primary care to some patients. However, other Medicare Advantage plans had only offered (until the most recent Medicare Call Letter) assessment visits with no follow up, some offered nothing at all, some do not provide for the direct contracting of Nurse Practitioners (a vital part of the home care medicine workforce), from providing longitudinal home-based primary care, relegating their role to only doing assessments. And even within that very small group of providers, shifts are happening. One major provider in Chicago, that is now owned by a health plan, reports having made a strategic decision to move away from providing Medicare longitudinal home-based primary care for economic reasons in favor of more lucrative third party contracts limited to assessments, or short-term, focused chronic care management such as hospital transitional care contracts.

Also problematic has been the stance of major Medicare Advantage plans to require primary care practices including house call practices to be patient centered medical homes (PCMH). However, peer reviewed literature points out that being a PCMH saves little, raises practice cost and most importantly is not targeted to improve care and produce savings for the frailest most expensive patient population because the focus and standards of PCMH does not relate to the care and savings for those with complex chronic diseases and disabilities. Together, these factors above have had a tremendous dampening effect on the workforce that could be improving care and providing savings for this population. An additional finding from article in the September 2014 Health Affairs (Small Primary Care Physician Practices Have Low Rates of Preventable Hospital Admissions) is that practices with 9 or fewer physicians had lower preventable admission rates than did practices with 10 or more physicians in one location. The important takeaway here is that it has more to do with relationship established between provider and patient rather than process for process sake. This also indicates that particularly for the home limited population that the IAH model “can scale” as it is individual mobile providers seeing the high risk high cost beneficiary one on one in the low cost practice setting of the home. Given that thirty percent of Medicare beneficiaries are in Medicare Advantage plans and this percent is growing, these issues related to health plans need to be resolved. A fix needs to be

applied to the HCC issue (we have data and recommendations on how based on IAH), and all Medicare (and Medicaid) managed care plans need to be **required** to offer longitudinal home-based primary care to the high cost-high risk patients. This care needs to be provided by all *qualified* providers, including Nurse Practitioners.

Further, HCC risk adjustment models need to be fixed to more accurately predict the actual cost of the complex frail elders with disabilities, and this fix needs to be applied across the board—not just to Medicare Advantage but to all programs using HCC risk adjustment including the Value-Based Purchasing Program, the IMPACT Act, and Advanced Payment Methodologies, in place now and under development by CMS.

Academy analysis of beneficiaries similar to those in IAH practices confirmed that MedPAC's analysis that the HCC model under-predicts costs of the most expensive Medicare beneficiaries was correct. The reasons included the high mortality rate among IAH eligible beneficiaries combined with the poor performance of the HCC model in the terminal year, the relatively higher cost of IAH eligible beneficiaries in low cost counties, and the time-dependent nature of costs around the clinical events that lead patients to enroll in housecall practices.

CMS had the IAH Demonstration contractors evaluate those concerns, and confirmed the Academy analysis that the HCC model significantly under-predicted costs of IAH enrollees, with the overall under-prediction compared to propensity matched controls near 17%. The Academy analysis was conducted by JEN Associates, a contractor with whom CMS was familiar and in fact contracts with itself which also underscores the credibility of the work.

Acknowledging the validity of this analysis demonstrating the material under-prediction, CMS provided the practices the option of receiving IAH Demonstration savings computed from the evaluation methodology (regression based analysis using a propensity matched cohort) or the original IAH Demonstration Medicare Advantage HCC model based methodology. (14/15 practices chose the regression based evaluation methodology due to the more accurate projection of actual costs it provided and the resultant more accurate calculation of savings produced by the practice). These are included in the savings highlighted in the CMS June 18 press release.

Frailty adjustment methods also need to be considered as part of chronic care payment models. These will vary by population and analysis in this area again known to CMS reflects that upwards to 40 percent increase in actual cost needs to be addressed by the model in order to reflect the addition in actual cost that significant frailty produces. This is illustrated, as an example, in the results by patient population in the Independence at Home demonstration where there is

association between increased frailty of beneficiaries and increased actual cost. Thus, the payment model that includes HCC as it is further refined to more accurately calculate the savings share for IAH practices must be refined so that it includes an adjustment for this frailty (residual) that does not exist in the current model. .

We urge the Senate Finance Committee to make use of this CMS validated and externally validated analysis to improve the HCC risk adjustment methodologies to assure the availability of necessary services to the complex frail elders regardless of how they receive their Medicare benefits and regardless of the setting of care in which they receive their benefits. We are available to work with the Committee, Committee staff and CMS on this issue of sentinel importance to the care of our nation's seniors.

- b. Transformative policies that improve outcomes for patients living with chronic diseases either through modifications to the current Medicare Shared Savings ACO program, piloted alternative payment models (APM's) currently underway at CMS, or by proposing new APM structures.**

In addition to the announced improvements in IAH itself, IAH-style home-based primary care programs have been at the forefront in creating savings for Pioneer ACO's. Visiting Physician Association (VPA), for example, reports that it has saved sixteen percent for the Detroit Medical Center Pioneer ACO; Beth-Israel Deaconess' Pioneer program saved at least fourteen percent.

Nevertheless, in an unfortunate turn of events, **IAH Demonstration participants are being told to close down their IAH programs because the health system is applying to be a CMS MSSP ACO**, and there is currently a regulatory obstacle to providers participating in two shared savings programs under the same tax identification number even though beneficiaries would only be attributed (enrolled) in one of the programs. Before more programs are asked to close, or fail to be allowed to assist ACO's by caring for their sickest patients, **we urgently ask for your assistance in having CMS make it possible for Medicare beneficiaries to be enrolled in the Medicare shared savings program that best meets their needs. This can be done by eliminating the unnecessary obstacle to providers participating in multiple shared savings programs. Then the beneficiary will have the option of choosing (enrolling in the) Medicare program that best meets their needs with the provider of their choice.**

The transformative policy suggested? That ACO's be **encouraged if not required** to directly provide or contract for home-based primary care (ideally the IAH model), for their home-limited high cost/high risk patients, and that they be **encouraged, if not required** to compensate providers of these services for the **full costs and value** of their IAH model care. This is

important to develop, incent and retain the IAH practice workforce and is also reasonable as the IAH care for the home limited beneficiaries attributed to an ACO will produce a disproportionate share of the ACO savings. Thus, the IAH providers producing the results would be compensated on a basis commensurate with their performance as Congress established for IAH itself.

Regarding alternative payment models, CMS has already recognized that they can learn from IAH as they design their APM program. We have submitted comments to them about what to consider, and are hopeful that their design will recognize the fundamental difference between the highest cost, highest risk **complex chronic care management** group of patients (multiple debilitating chronic illnesses plus disabilities) with average HCC scores above 3, and the general population of Medicare patients who, with average HCC scores of 2 or less do not have the same needs, and should not have nearly the same cost profile. We attach our comment letter on APM's for the Committee's use.

c. Reforms to Medicare's current fee-for-service program that incentivize providers to coordinate care for patients living with chronic conditions.

We have recommendations on this topic:

- One of the current disincentives for care coordination is that Medicare does not allow practices to directly bill for the expert care managers who ideally provide this service in many practices as many of these team members are social workers or nurses. Since, at least for the high cost, high risk patient group, these personnel are key to achieving cost savings; Medicare should consider payment for the cost of these services at least in risk-sharing models.
- CMS should consider dropping the co-pay provisions for care coordination services, as many patients are balking at paying the co-pay to receive the currently-provided chronic care management service. CMS may find that this beneficiary relations issue is an explanation for utilization of the CCM code that is below that forecast by CMS. Unfortunately, unless resolved, this beneficiary issue may also serve as obstacle to the goals of CMS to improve care and reduce cost.
- CMS should put in place a second level of chronic care management for the high cost, high risk beneficiaries whose practice costs far exceed the \$43 per month payment for the CCM. We appreciate that CMS had to begin here with the coverage and payment.

- CMS should review in conjunction with a technical expert input the administrative burden on Part B providers of documentation requirements for the new fee for service codes such as Transition Care Management (TCM), Chronic Care Management Services (CCM) and that may be required for Advance Care Planning when coverage and payment is established. These services are developed so that care is improved and that cost may be reduced. However, this can only occur if Part B providers are able to render and document the services on an efficient basis. This is not presently the case and is discouraging providers from offering and documenting the services. We encourage the Committee to work with CMS on appropriate documentation guidelines that do not undermine the important care and cost goals of the services.

This brings up a more general point for the Committee's consideration. We urge the Committee to take this opportunity while focused on chronic care services to review the documentation and coding requirements for Medicare coverage and payment. Such review is timely given that Secretary Sebelius has announced the goal of transforming Medicare from fee for service to value based payment. This transformation supported by the public/private Health Care Payment Learning and Action Network. So we are approaching a time when the utilization risk that was being balanced by the very detailed and voluminous documentation requirements will be offset by the shift of accountability for outcomes and value to Medicare providers. As we approach 70% of the market in shared savings or alternative payment models we are also reaching the point where the utilization risk is going away.

- More generally, the Committee and CMS will want to consider how to encourage beneficiaries to align (enroll) themselves with APMs, including ACOs, IAH and other programs that best meet their care needs by eliminating or reducing co-payments or otherwise permit beneficiary alignment and enhanced self management by permitting beneficiaries to share in some of the shared savings even if this is a nominal amount paid per month or annual enrollment period to the beneficiary or accomplished through credit, for example, to a beneficiary account which credit can then be used to pay for Part B premium or non-covered expenses such as hearing aids or eyeglasses This recommendation also has the effect of enabling beneficiaries to elect from models (Medicare Advantage, alternative payment models, etc. on an apples to apples basis).

d. The effective use, coordination and cost of prescription drugs:

The Work Group and Committee will want to consider several issues here. First is the role of timely medical reconciliation requirement which in IAH produces great benefits that should be included in other models. These benefits include beneficiary care and safety in that medications

are reconciled (and beneficiary education provided) when there is transition in care. Such timely reconciliation includes opportunity to reduce the total number of prescriptions when it is known that medications in concert may conflict with each other producing their own patient harm that then has to be counteracted. This effect then spirals and informed medication reconciliation can reduce this harm. The Work Group could recommend that expert panel from the nation's pharmaceutical companies and providers be established to develop approaches to reduce the actual and potential harm of such "polypharmacy." This will also serve to reduce cost.

Second the Work Group will want to examine how Medicare Part D plans are increasingly limiting their formularies or adding increasing barriers for providers to obtain approval for necessary prescriptions. The same expert panel (or constituent workgroups) could be tasked with developing best practices or industry guidance. The Senate Work Group could also consider how incorporation of Part D benefits into IAH and other shared savings programs could also serve to incent the cost effective use of medications, particularly if accompanied with reduced approval requirements (akin to the waivers in ACO models and recommended below to encourage efficient medical care)

Lastly, there are evolving medication delivery models that again should be considered for incorporation into IAH and IAH like models and these would development of shared savings factors for the IAH practice to recover the cost of the service.

e. Ideas to effectively use or improve the use of Telehealth and remote monitoring technology.

Findings on this issue for "our" patient population (the home-limited frail elders), are beginning to emerge out of a combination of research being done in the Veteran's Administration, in IAH practices, and in the large, urban/rural health systems such as Kaiser and Intermountain Health. Our recommendations at this time:

- The home should be a covered site of service for the home-limited regardless of their geographic location because they are an underserved population.
- The waiver should be established and expanded to accomplish the above where a medical team (of whatever composition) is taking care of the chronic conditions of a home-limited beneficiary.
- A TEP or research task force should be established by CMS to review and develop coverage and payment policies to support the use of a) telemonitoring on a pre-acute basis to assure safety and to intervene to avoid sudden status change leading to

preventable admissions; and b) telemonitoring on a post-acute basis to assure a safe transfer to home.

f. Strategies to increase chronic care coordination in rural and frontier areas:

Again, with a focus on “our” population, we believe that we can learn from the experience of the VA and their pioneering programs in getting home-based primary care programming in to rural, frontier and other medically underserved areas.

Healthcare shortage areas as a group need to be given financial priority status, with financial incentives provided for service in these areas to those who will bring home-based primary care to the home-limited elderly. These shortage areas exist in metropolitan areas just as they do in rural and frontier areas.

The Committee and CMS as a means to overcome such shortage should consider a direct transportation allowance paid to providers (as an offset for travel cost and opportunity), as an effective addition to strategy to provide service in the community in both urban and rural areas. Our view is that the transportation allowance similar to other innovation and waivers under development will be more than offset through the reduced cost of services in the home setting as compared to institutional settings

g. Options for empowering Medicare patients to play a greater role in managing their health and meaningfully engaging with their health care providers:

We recommend that the Senate Finance Committee (and CMS), consider the following:

- Given that there is increasing recognition in the literature that the provision of Medicare services through a house call whether rendered by physician, physician assistant, or nurse practitioner engenders strong engagement between the beneficiary and the provider, support expansion of this service model through adequate payment.
- Waiver integration into all APM models such as those that have been proposed for the MSSP ACO program and that are also discussed below.
- Extend Stark relaxation to all APMS to allow for more full beneficiary engagement.
- Recognition of beneficiary survey results toward measure satisfaction and incentive payments.
- Recognition of patient generated information – such as that obtained through telemonitoring toward satisfaction of patient engagement under PQRS/MIPS.
- Requiring EMRs through ONC-HIT and CMS requirements to efficiently capture and

transfer patient preferences in order to become certified. Documentation of patient preferences (such as required in IAH), can then serve as a more meaningful and robust quality measure across payment models

- Coverage and payment for advance care planning as a Part B benefit. We recognize that there is legislation introduced by members of the Committee to provide for such coverage and payment. We also look forward to reviewing whether CMS has included coverage and payment for Advance Care Planning in its forthcoming Medicare Professional Services Payment Proposed Rule.
- Reduced/eliminated beneficiary co-payments for the CCM service and similar services and incentive as discussed above for beneficiaries to align and participate with chronic care provider models – be they IAH, ACO or other APM.

h. Ways to more effectively utilize primary care providers and care coordination teams in order to meet the goal of maximizing health care outcomes for Medicare patients living with chronic conditions.

We recommend the Committee and CMS consider the recommendations in areas of 3) reform of the Medicare FFS program such as payment for the services of those involved in care coordination (nurses and social workers), and 7) patient engagement and those included in the Waiver area.

Additionally, the Committee is encouraged to consider:

- Enhancing support for health information exchanges. This includes technical and administrative aspects. The technical aspects would be i) continued efforts for communities to establish accessible health information exchanges, ii) reduction in HIT (EHR) industry barriers to the sharing of information – such as the opening up of EHRs to provide for exchange of health information across settings and products, and iii) a requirement that staff in institutional settings communicate on a real time basis to community based primary care provider(s) every time a beneficiary is admitted or discharged from their facility.
- Developing a program of technical assistance for PCPs and their care coordination teams to adopt and implement data analytics that supports risk stratification and practice interventions to help maximize the outcomes for patient’s livings with chronic diseases.

This could include for example a provider-equivalent to the beneficiary “blue button” by which patients can view their real-time Medicare claims data. A provider blue-button would allow pcps and their coordination teams to access the claims for their patients in real time.

- Developing beneficiary/consumer oriented "technical assistance" for beneficiaries and their PCPs/care coordination teams to assist beneficiaries become fluent with “enrolling with a chronic care medical practice team as their Medicare health plan.”
- Review the IAH Demonstration and other program results that reflect additional Medicare and Medicaid savings (beyond those of Medicare Parts A and B), that result from avoided or delayed nursing home admissions. We see that such review of nursing home cost savings is included in evaluation of the IAH demonstration. The Committee with these results of savings in hand should then consider, 1) formal recognition of these savings as part of the savings calculations under shared savings programs and other APMs, and, 2) funding be developed that could include the shared savings so that care coordination teams that are part of or associated with IAH type practices have the resources to pay for long terms support type services that enable beneficiaries to remain in their home. This could be done in two ways, one by including a portion of the federal and state nursing home savings into the savings share of IAH practices, and two by pairing IAH practices with Area Agencies on Aging to produce the equivalent of dual-integrated special needs plans that again would share savings with the government programs and the practices.

III. In addition, we recommend:

- a. Data sharing – We recommend that the Committee further encourage CMS 1) to respond to the need for routine management data for accountability, benchmarking, risk stratification, quality improvement, and reporting purposes, and 2) the need for real time data and communication to support patient tracking and management. We have provided specific recommendations to CMS in this area related to IAH in the past, and at minimum this should included the same real-time access to data provided to ACOs.

We are also pleased to see the announcement of more rapid data sharing and we would be pleased to review these needs and our recommendations to the Committee in detail.

- b. the Committee should review development of care coordination communication across medical neighborhoods including post acute settings (medical such as home health, rehab, SNF, LTC, as well as assisted living facilities, and nursing homes), and also including EMS organizations and staff. This care coordination may include

communication of information EMR to EMR and also through means outside of EMR to EMR interface. We have learned through our work with the IAH practices that encouragement of such communication by the Committee will help to meet the goals of increased care coordination among individual providers who are treating patients living with chronic diseases across settings, streamlined payment systems that incent the appropriate level of care for patients living with chronic diseases, improved care transitions, program efficiency, and reduced growth in Medicare spending.

- c. Quality measures – We recognize that there is new work being done to develop and test measures that reflect the multiple chronic disease status, functional impairments and social economic status of beneficiaries. We appreciate the new recognition that measure development has not until recently taken such factors and status into consideration. We encourage the Committee to support such measure development that aligns clinical relevance for the specific population with payment incentive, provider quality improvement, public information needs and purchaser utility.

We also encourage the Committee to assure that the considerations discussed above regarding risk adjustment for the complex frail elder population be integrated into the measure development, testing and validation process prior to implementation in payment incentive and programs such as developed for VBPM/MIPS, the IMPACT Act and those for APMs.

- d. Waivers – - The Committee should consider within the context of Chronic Care Payment Reform, shared savings and APMs waiver of the following:

The 3 day requirement for SNF admission if the patient is being admitted from the home or from a qualified urgent care facility to a SNF sub-acute unit in lieu of hospitalization. We understand that a waiver of this regulation has been recently finalized for Track 3 ACOs. However, we encourage that this be expanded across the other tracks and programs noted above.

Homebound definition for home health agency services. CMS should be able to pay for ordered home health services when ordered by one of the programs noted above without the requirement for the beneficiary to meet the Medicare Part A “homebound” definition.

Waiver of Certain Hospice Provisions to a) reduce the hospice conditions of payment provisions with relationship to limits to the amount of beneficiary expense and b)

exclude beneficiaries “enrolled” in the programs above from the hospice cap penalty calculation. Also, while not waivers of existing regulations the Committee should consider:

Referrals to urgent care centers related to Chronic Care Medical Practice Teams – a waiver of the Stark restrictions are granted for the provision of diagnostic and therapeutic services to the homebound and frail elderly by related entities.

Medicare Hospital Notification – A requirement of actionable notification of admission to both the ED and the hospital (possibly as a condition of payment) for all Medicare beneficiaries by the admitting institutions and that this database be available to shared savings/APM participants. Coverage and Payment for Home Infusion Services

Coverage and Payment for Home Infusion – The Committee and CMS should establish coverage and payment under Part B for all home infusion services in the context of the above advanced payment and shared savings models. This is in line with the waiver concepts in general where if Medicare and Medicare providers understand the general budget/revenue in advance then the specific restrictions and regulations that were put into place to avoid fee for service driven utilization can be removed thus improving care and enhancing provider accountability.

Medicare covers infusion therapy in offices and institutional settings. Studies estimate that 23% of beneficiaries receiving antibiotic infusions would begin receiving services in the home setting if Medicare adequately covered infusion in the home. Estimated savings to the Medicare program for the 10-year period from 2015 to 2024 are \$80 million (12.6%), of the overall cost of infusion services that would migrate from HOPDs, physician offices, and SNFs to the home. This does not include travel cost and inconvenience to beneficiaries. This also does not include potential additional savings that could result from the avoidance of hospital stays, hospital-acquired infections and SNF admissions.

Under this proposal Medicare Part B should cover the professional services, including nursing services (other than nursing services covered as home health services), administrative, compounding, dispensing, distribution, clinical monitoring, and care coordination services that are necessary for the provision of infusion therapy in the home. Part B payment would also cover all necessary supplies and equipment (i.e., medical supplies such as sterile tubing and infusion pumps) as well as other items and services that the Secretary of the Department of Health and Human Services deems

necessary to administer infusion drug therapies safely and effectively in a patient's home. Home infusion therapy providers would need to be accredited.

We recognize that legislation regarding coverage and payment has been introduced in the past and we support the passage of such legislation.

- e. Risk based or shared savings programs outlier policies – We also encourage the Committee to review the development of outlier policies both currently in effect in shared savings programs and those that will be developed under APMs. This is further discussed in the Attachment.

We appreciate this opportunity to provide input into Chronic Care Payment Reform and we look forward to speaking with you in greater detail regarding the recommendations in this letter.

Sincerely,

A handwritten signature in black ink that reads "Constance F. Row". The signature is written in a cursive, slightly slanted style.

Constance F. Row

Executive Director

American Academy of Home Care Medicine

**Attachment Excerpt from Academy February 6, 2015 Submission Re. File Code CMS–1461–P
Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations;
Proposed Rule**

Alternative Performance-Based Risk Options

Based on its experience with ACOs through the VA, and Independence at Home, the CMS should consider development of an alternative performance and risk adjusted option with a frailty adjuster for the medically complex that do not meet all of the clinical criteria for IAH and, yet, remain high risk and high cost. This option would reflect some of the regulatory elements and lessons learned of both ACOs and IAH, in particular it would add the discipline that Track 2 now has through enforced risk, but without the discouragement that having actual dollars at risk creates. Instead it would use the “opportunity cost” of potential shared savings as the penalty for poor performance, as in IAH, by excluding ACOs that do not meet their MSR for 2-3 consecutive years.

These elements are as follows:

- a. Assignment - Beneficiaries should be permitted and encouraged to attest to ACO assignment for the reasons discussed above;
- b. Permit beneficiaries to share in shared savings - This would encourage beneficiary alignment with an ACO and support the beneficiaries receiving care within the ACO; as well as encourage beneficiaries to align with more efficient providers.
- c. Limit quality metrics, particularly those related to payment, to those clearly identifiable as relating to the outcomes of improving care and lowering cost for the medically complex population;
- d. Establish local benchmarks - For the reasons discussed above that for a population susceptible to “high churn” it is reasonable to be compared to a local matched fee for service population that is not receiving care within this risk option ACO;
- e. Risk adjustment – Related to the benchmark and based on analysis shared with CMS regarding IAH shared savings calculations. CMS should use the V21 HCC model with a locally determined adjuster from calibration to locally assembled controls. This option would not need to be rebased nor have structured term limits to ACO agreement as with the other tracks, as again, for this high risk population the comparison is to the non assigned fee for service control population. Appropriate inclusion of the recognition of the impact of beneficiary frailty would complement this effort. Accurate risk adjustment will also provide confidence of the ACOs to increase the number of medically complex beneficiaries they are able to manage (without having to be concerned about underestimate of projected cost);

- f. Performance requirement /minimum savings requirement (MSR), in lieu of structured track terms. This is similar in concept to IAH though at lowered rate due to lowered medical complexity/expected cost. CMS could establish an MSR beyond which the ACO keeps the savings share. Moreover, to encourage the participation of additional ACOs of varying sizes (and the evidence from ACO experience to date is that small flexible ACOs are as capable or more as large and system based ACOs to achieve savings), CMS should consider a fixed MSR and simply recoup this savings as an automatic function. This is respectful, as reflected in the IAH model to first provide savings to the Medicare Trust Funds, encourages participation and innovation by a variety of sized and modeled ACOs, and serves to encourage year over year performance as the ACO has shared savings opportunity relative to the non ACO population. This underscores the importance of accurate risk adjustment for the medically complex, high risk population;
- g. Waivers – each of the waivers for the reasons discussed should also be available to this ACO risk option. And the waivers are all the more relevant to improve care and lower cost for the medically complex population.