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Alliance for Home Health Quality and Innovation

Centers for Medicare & Medicaid Services
U. S. Department of Health and Human Services
Attention CMS–1345–P
P.O. Box 8013, Baltimore, MD 21244–8013

Re: CMS–1345–P
Medicare Shared Savings Program: Accountable Care Organizations

The following comments are submitted on behalf of the Alliance for Home Health Quality and Innovation (the Alliance – see description below.) This is in response to the Centers for Medicare & Medicaid Services' request for comments on the proposed rule for Accountable Care Organizations (ACOs) as part of the Medicare Shared Savings Program. The members of the Alliance appreciate the Secretary's, Administrator's and CMS's efforts to fulfill the Affordable Care Act and to identify innovative solutions to improve the quality and efficiency of health care delivery. The Alliance looks forward to working with CMS to help develop this relatively new concept – and the opportunity to provide further comments as the initiative progresses.

Goals for Accountable Care Organizations

The Alliance is particularly encouraged by the following ***select goals for ACOs*** **identified in the proposed rule as the** ***Intent of the Medicare Shared Savings Program*****:**

- Put the beneficiary and family at the center of all its activities
- Ensure coordination of care for beneficiaries regardless of its time or place
- Attend carefully to care transitions, especially as beneficiaries journey from one part of the care system to another
- Offer capabilities with respect to prevention and anticipation, especially for chronically ill people
- Be proactive by reaching out to patients with reminders and advice that can help them stay healthy

Home Health's Ability to Help ACOs Meet the Goals

The comments offered in this submission will establish that **home health should be an integral part** of the development of, and delivery of services by, Accountable Care Organizations. Further, the absence of the valuable services that home health offers would be an impediment to the success of the program. The **home health provider community is well positioned to enhance and support the ACO initiative** for several important reasons:

- The home health community **already has the infrastructure in place** to facilitate the program's goal of improved coordination of care.
- The home health community **already provides Medicare beneficiaries with** a breadth of clinically sophisticated, **cost-effective and patient-preferred services**.

- The home health provider community **has had a long-term focus on patient and family engagement** and has always encouraged the promotion of self-management.

Background – Home Health Experience with the Medicare Population

The acuity level of home health patients has risen significantly in recent years, driven primarily by cost concerns that have shifted care away from the inpatient environment. Home health providers already care for patients with more complex conditions than the Medicare population as a whole. An average patient under the care of a home health clinician sees seven different physicians, has at least four chronic diseases, and takes thirteen medications. According to an analysis of the 2005 Medicare Current Beneficiary Survey, more than 74 percent of Medicare home health users report three or more chronic conditions, (compared to 53 percent of all Medicare beneficiaries), and nearly one-third (31.3%) have five or more chronic conditions. Among all other provider groups, home health care has the most "face time" with the patient and their family caregivers – on average, 16 hours or more in a 60 day period. Importantly, this interaction between patient and provider occurs *in the home – where health decisions are made.* Home health care is well positioned to work with primary care physicians and other providers in the continuum of care to meet the goals of Accountable Care Organizations.

With this background in mind, the following comments on select elements of the proposed rule are submitted for your consideration:

II. B. Eligibility and Governance
1. Eligible Entities:

Comment 1 – Home Health's Existing Infrastructure Will Facilitate ACO Success

> *"We have considered whether it would be advisable, at least in the initial stage of the Shared Savings Program, to—(1) Permit participation in the program by only those ACO participants that are specifically identified in the statute; (2) restrict eligibility to those ACO participants that would most effectively advance the goals of the program; or (3) employ the discretion provided to the Secretary under section 1899(b)(1)(E) of the Act to expand the list of eligible groups to include other types of Medicare-enrolled providers and suppliers identified in the Act."*

The Alliance is disappointed that the proposed rule does not specifically mention home health care as an "eligible participant" as well as designated provider category.

The proposed rule should encourage ACOs to include home health providers in their mix of providers. For the following reasons, we also strongly encourage CMS to include the mention of home health care and to exercise the Secretary's discretion to "*expand the list of eligible groups to include other types of Medicare-enrolled providers"*:

- The home health community already provides a nationwide infrastructure for delivering traditional Medicare services. Home health care is established in virtually every community's healthcare continuum.

- Home health is already providing services to help physicians and other providers within the continuum of care meet the challenges associated with c*are coordination, chronic disease management, and appropriate instruction and care for patients during the transition* from one care setting to another.
- Therefore, home health provides an ideal, existing organizational infrastructure to immediately help establish an ACO's capabilities to reach Medicare beneficiaries, facilitate continuity of care in the community, and collaborate with and assist other care providers.
- Innovative approaches are being used in home health care today that show great promise in addressing many of the concerns associated with chronic disease management, effective transitions between care settings, and disparities in access to care in rural and underserved communities.

Comment 2 – Home Health's Ability to Help Meet the ACO Goal of Reduced Inpatient Admissions

> In this same section, it is noted that the "*savings generated by ACOs, in many cases, are expected to result from reduced inpatient admissions"* (as pointed out in the June 2009 report by MedPAC.)

The Alliance completely agrees with this assumption and encourages CMS to recognize the important services that home health can provide to attain this goal in the ACO setting. The final rule should recognize how home health can be used within the ACO plan to improve care coordination and reduce facility-based care, for the following reasons:

- In many cases, home health serves as a liaison between primary care physicians or specialists and the patient at home, providing physicians and other care providers with "clinically trained eyes and ears on the ground."
- Home health providers have the ability to detect and analyze a patient's response to their care plan and changing clinical conditions.
- These current home health services help to monitor the patient's condition and to identify signs that an intervention is needed to prevent unnecessary emergent care visits or re-admissions to the hospital.

Comment 3 – Home Health's Success in Managing Chronic Conditions to Facilitate ACO Success

> The proposed rule suggests that *"(a)nother option for limiting eligibility would be to restrict eligibility to only those ACO professionals providing primary care services. Primary care professionals may have the best opportunity to reduce unnecessary costs by ensuring care coordination for beneficiaries with* ***multiple chronic conditions****. By coordinating with specialists to whom the beneficiary has been referred, primary care providers can reduce unnecessary repetition of laboratory testing or imaging."*

The final rule should indicate that multiple chronic conditions cannot be managed effectively solely by hospital and physician intervention. Care coordination for patients with multiple chronic conditions necessitates the effective and efficient utilization of therapists (physical therapy, occupational therapy, speech therapy,) social workers, dieticians and other clinicians.

The home health community brings a unique understanding of the Medicare population with chronic conditions and has a successful and growing track record for treating and managing chronic diseases. Therefore, the final rule should note the importance of home care and recognize the following factors:

- Every day, home health clinical teams must address the scope of a patient's chronic conditions; the complexity of their associated treatments; their multiple physicians and medications; and the often inevitable adverse impact of the diseases on their lives and the lives of their family caregivers.
- As previously mentioned, home health providers already care for patients who are more complex than the Medicare population as a whole. An average patient under the care of a home health clinician sees seven different physicians, has at least four chronic diseases, and takes thirteen medications.
- Nearly one-third (31.3%) of Medicare home health users have five or more chronic conditions.
- Many of these Medicare beneficiaries with multiple chronic conditions more frequently have limitations in their activities of daily living (ADLs) as compared to the total Medicare population. These patients are at higher risk for falls and for infection, not to mention the risk of medication confusion and error.
- The home care clinician currently helps manage all of these potential risks for patients with chronic conditions.

Comment 4 – Impediment to the Success of the ACO Initiative

> Finally in Section B. 1, the question is raised *"(i)n addition to requesting comment on this proposal generally, we are soliciting comment on the following: (1) The kinds of providers and suppliers that should or should not be included as potential ACO participants; (2) the potential benefits or concerns regarding including or not including certain provider or supplier types."*

The Alliance is concerned that the *success of the ACO program will be impeded* by not taking full advantage of the capabilities of home health providers. In our view, ACOs cannot meet the goal of improved quality of care for a given population while constraining expenditures below their benchmark targets without the involvement of cost-effective home health care.

The final rule should note that home health provides the ideal, existing organizational infrastructure to immediately help establish an ACO's capabilities, reach Medicare beneficiaries in their home settings and collaborate with and assist other care providers to facilitate and ensure the success of the ACO program. The home health infrastructure will help ACOs address the following concerns:

- Healthcare providers in the continuum of care – physicians, hospitals and sub-acute care facilities – often lack the resources and infrastructure to properly manage their patients' needs before, during and after the events of a patient moving from one care setting to another.
- Primary care physicians – already in short supply – do not have the resources to visit the patient's post-acute care setting and gain a complete picture of that individual's health status.

II. B. Eligibility and Governance
9. b. Processes to promote patient engagement

Comment 5 -- Home Health's Focus on Patient and Family Engagement to Facilitate ACO Success

> *"The term 'patient engagement' is the active participation of patients and their families in the process of making medical decisions. Patient engagement in decision-making requires consideration not only of the best scientific evidence concerning medical treatment, but also the opportunity for patients and families to assess prospective treatment approaches in the light of their own values and convictions."*

The Alliance applauds CMS's focus on patient and family engagement and we encourage the promotion of self-management – a long-time the goal of home care intervention.

The final rule should note the role of home health as a valid part of patient engagement and self-management; especially during the transition from acute or long term care settings. The Alliance encourages CMS to include an explicit acknowledgement in this rule of the contribution of home care for coordination within the continuum of care. The following capabilities and experiences of home health will enhance the success of the ACO program:.

- Among all other provider groups, home health care has the most "face time" with the patient and their family caregivers – on average 16 hours or more in a 60 day period.
- Importantly, this interaction between patient and provider occurs *in the home – where health decisions are made.*
- Home health care is well positioned within the healthcare continuum to understand the long-term experiences and needs of Medicare beneficiaries.
- Home care services provided to Medicare beneficiaries often include education, coaching, monitoring and assessment designed to improve the patient experience – and improve clinical outcomes. If offered deliberatively, the care provided would help to avoid hospital readmissions, control costs and, ultimately, help Medicare beneficiaries live more independently and with better quality of life.
- A significant event in most home health visits is coaching and educating patients on proper medication management and compliance. Home health visits regularly include reconciling medication lists so that patients and their families understand and are compliant with regimen ordered by their primary care or discharging physician.

II. B. Eligibility and Governance
9. d. Processes to Promote Coordination of Care

Comment 6 – Home Health's Success in Care Coordination to Facilitate ACO Success

"Coordination of care involves strategies to promote, improve, and assess integration and consistency of care across primary care physicians, specialists, and acute and post-acute providers and suppliers, including methods to manage care throughout an episode of care and during its transitions, such as discharge from a hospital or transfer of care from a primary care physician to a specialist."

As noted throughout these comments, home health serves as a liaison between primary care physicians or specialists and the patient at home, providing physicians and other care providers with "clinically trained eyes and ears on the ground." The proposed rule should indicate explicitly that ACOs' use of home health as partners with physicians can extend the role of primary care physicians who are in short supply in care coordination. Home health can enhance the success of the ACO's by facilitating care coordination through the following services:

- Home health providers have the ability to detect and analyze a patient's response to their care plan and changing clinical conditions.
- Home care services provided to Medicare beneficiaries often include education, coaching, monitoring and assessment designed to improve the patient experience – and improve clinical outcomes.
- Home care has long understood and worked with the family caregivers to support compliance and health behavior changes to sustain self-management. This is a unique capability that home care brings to the extension of the primary care practice into the community.
- The Alliance also supports the agency's emphasis in care coordination involving the use of health information technology, tele-health, and remote monitoring.
- A recent study released by Fazzi Associates on the current state of the implementation of technology in home health care reveals the following highlights:
    - 72% of homecare agencies currently use Back Office Practice Management Systems
    - 65% of homecare agencies currently have functioning EHR systems

II. E. Quality and Other Reporting Requirements
2 . Proposed Measures to Assess the Quality of Care Furnished by an ACO

Comment 7 – Quality Measures Inclusion to Facilitate ACO Success

"We invite comments on the implication of including or excluding any proposed measure or measures in the calculation of the ACO Quality Performance Standard. Commenters may suggest variations or substitutions that are substantially equivalent to the proposed measures. However, without future rulemaking, we cannot consider …

"However, we propose to align the quality measures specifications for the Shared Savings Program with the measures specifications used in our existing quality programs to the extent possible and appropriate for purposes of the Shared Savings Program."

The Alliance is encouraged by CMS's inclusion of quality measures that focus on care transitions; management of chronic illnesses and the frailty of seniors. Home health care provides valuable services in each of these areas, and many of the proposed quality measures mirror and compliment those used for home health services. The Alliance makes the following recommendations for the final rule concerning the inclusion of quality measures:

- CMS should include at the outset of the ACO program other quality measures currently used in the agency's other quality improvement programs; specifically the use of home health quality measures.
- Such measures will provide consistency in assessing the occurrence of hospital readmissions and/or emergency room visits.

Additional Recommendation Specific to Home Health Participation

Comment 8 – Clarification and Ease of Restrictions on the Home Health Benefit in the ACO Setting to Facilitate Care Transitions

CMS should clarify and encourage the feasibility of using home health with a physician referral to facilitate and promote care transitions and care management in the ACO setting. The final rule should specify the Secretary's waiver authority under the Medicare Shared Savings Program to better allocate care and enhance the flexibility needed to utilize home health in the following examples:

Hospital transitions and medication reconciliation

Clarifying the practice of allowing home health representatives to visit a patient in the hospital prior to discharge would realize the following benefits:

- Allowing home health representatives to gain access before the transition to the community would provide patients with a greater awareness of what will occur and what to expect prior to discharge.
- Allowing home health representatives to gain access before the transition to the community also would facilitate medication reconciliation for the patient. Medication reconciliation helps identify and clarify which drugs the patient receives at discharge and which need to be filled at a pharmacy thereby facilitating immediate medication compliance upon arriving home. Once home, the home health nurse can continue helping to reconcile the new prescriptions with those the patient already has at home. The home health nurse actively works with the patient to understand the variety of medications prescribed by a variety of physicians, and potentially multiple pharmacies.
- Such early access and patient interaction would also allow home health agencies to better identify and address the readmission risks each patient represents. The home health team – with the appropriate approval by the community physician – that addresses specific risk factors before the patient returns home.

- CMS also should clarify for hospitals within the ACO setting the privacy constraints of the Health Insurance Portability and Accountability Act (HIPAA) so that hospitals and home health agencies can collaborate on care transitions.
  (Note: These pre-discharge services are currently allowed with a physician referral. However, the practice is more of the exception because of the lack of clarity among hospitals in interpreting the hospital Conditions of Participation vs. facilitating an effective transition.)

Care management

CMS also should consider revising Medicare's "homebound" definition within the ACO setting to allow the flexibility needed to prevent episodes such as readmissions to institutions. The allowance of preventative and coordinated care services in the ACO setting would be similar to the following current practices within Medicare Advantage:

- Under the direction of several Medicare Advantage plans, the homebound status is waived for beneficiaries noted as at-risk for emergent intervention or hospitalization by the insurer's Case Managers.
- Home health nurses visit the patient in the home to assess, educate, coach and report back to the patient's Case Managers.
- The result is a home health intervention that prevents an impending crisis and avoids the cost of emergent care or an inpatient admission.

Face-to-face requirement

CMS also should consider waiving the "face-to-face" requirement within the ACO setting to allow greater flexibility for referring physicians:

- Such flexibility will enhance the stated goal for ACOs to deliver seamless, high quality care in a patient-centered setting where the patient and providers are true partners in care decisions.
- Such flexibility is similar to the current practices within the Medicare Advantage program.

Comment 9 – Additional Billing Codes Unique for ACO Participation to Facilitate ACO Success

Similar to the clarification above, CMS will need to create additional HCPCS codes in the final rule that accommodate home care services ordered by a primary care physician within the ACO setting to address the following concerns:

- New coding should consider home health services that facilitate care management and care transitions in the ACO setting and allow for services such as pre-operative hospital visits and home safety assessments.
- New coding also should consider home health services in the ACO setting that facilitate the coordination of care among people with chronic conditions, providing on-going support beyond the home-bound definition to prevent hospital re-admissions.

Summary

The Alliance supports CMS efforts to achieve greater efficiencies and lower costs for higher quality health care. Again, the Alliance looks forward to working with CMS in helping develop this relatively new concept – and looks forward to opportunities to provide further comments as the initiative progresses.

About the Alliance for Home Health Quality and Innovation

The leaders of several prominent home health care providers joined forces in 2008 with a common recognition and a shared goal. Their recognition – that that home health care should serve as a critical component of the health care system of the future. Their shared goal – to tell the story of today's modern home health care community – a health care system that can meet the needs of a rapidly aging population, keep pace with escalating health care costs, and serve patients' demands for high-quality health care within, all with the comfort and dignity of remaining at home.

Today the Alliance for Home Health Quality and Innovation (the Alliance) is comprised of more than 20 leading members of the home health sector – including the largest national trade association, the national association for the nonprofit agencies, and technology and educational services providers from around the country. The Alliance raises awareness about home healthcare and its proven ability to deliver quality, cost-effective, patient-centered care. Collectively, the members of the Alliance provide over 90% of all Medicare home health services nationwide. The Alliance supports education and research to demonstrate the value of home-based care to patients, their families, physicians and policymakers. The Alliance is dedicated to improving the nation's health care system through development of high quality and innovative solutions aimed at achieving optimal clinical outcomes. To learn more about the Alliance and home healthcare, please visit our website at www.ahhqi.org

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