



February 6, 2015

The Honorable Marilyn Tavenner  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Room 445—G  
Hubert H. Humphrey Building,  
200 Independence Avenue SW  
Washington, DC 20201

**RE: Proposed Rule on Medicare Shared Savings Program: Accountable Care Organizations**

Dear Administrator Tavenner:

I am writing on behalf of the Alliance for Home Health Quality and Innovation (the “Alliance”) in response to the Centers for Medicare and Medicaid Services (“CMS”) request for Public Comment on the proposed changes to the Medicare Shared Savings Program and Accountable Care Organizations (“Proposed Rule”).<sup>1</sup> Thank you for the opportunity to provide comments on the Proposed Rule.

**About the Alliance for Home Health Quality and Innovation**

The Alliance is a non-profit 501(c)(3) organization with the mission to lead and support research and education on the value of home health care to patients and the U.S. health care system. Working with researchers, key experts and thought leaders, and providers across the spectrum of care, we strive to foster solutions that will improve health care in America. The Alliance is a membership-based organization comprised of not-for-profit and proprietary home health care providers and other organizations dedicated to improving patient care and the nation’s healthcare system. For more information about our organization, please visit: <http://ahhqi.org/>.

We appreciate the opportunity to provide comments on the Proposed Rule, and offer recommendations and considerations to CMS on: (1) health information technology; (2) telehealth; (3) waiver of the homebound requirement; (4) waivers for referrals to post-acute care settings; and (5) waiver of other payment rules.

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<sup>1</sup> Medicare Shared Savings Program, Proposed Rule, 79 Fed. Reg. 72760 (Dec. 8, 2014).

## I. Health Information Technology

The Alliance supports CMS's proposal to require accountable care organizations ("ACOs") to describe "how the ACO intends to partner with long-term and post-acute care providers to improve care coordination for the ACO's assigned beneficiaries."<sup>2</sup>

As you may know, long-term and post-acute care providers were not included in the meaningful use program's incentive payments for adoption of health information technology. Despite the absence of meaningful use incentives, many home health providers have been making investments in health information technology to improve health care delivery in terms of quality, efficiency and coordination of care. Even for those providers who have made these investments however, most of the hospitals and physicians that care for the same patients as home health agencies have not been able to exchange health information electronically with home health agencies. As a result, requiring ACOs to specify how partnerships with long-term and post-acute care providers will take place in a manner that leverages health information technology should facilitate steps towards achieving health information exchange.

In furtherance of these goals, the most important step towards achieving health information exchange would be to have hospital and physician electronic health records that are interoperable with those of long-term and post-acute care providers. Considerable work has already been done in identifying key, standardized data elements for longitudinal care coordination and transitions of care through the Massachusetts IMPACT project, the Office of the National Coordinator for Health Information Technology (ONC), and the HHS Assistant Secretary for Planning and Evaluation. The Alliance recommends that CMS reinforce these efforts by aligning the Medicare Shared Savings Program requirements with these efforts. For example, CMS could require that ACOs to adopt HIT systems that are interoperable with post-acute care provider systems, consistent with the standard data elements that are being developed. Although such a requirement would be a significant change, it could be staged to enable implementation over an appropriate period of time.

Overall, the Alliance supports the direction that CMS has taken in relation to accelerating the adoption of health information technology. Alliance members stand ready to work with ACOs in the Medicare Shared Savings Program to use health information technology as a means to improve care coordination, quality and efficiency.

## II. Telehealth

The Alliance supports CMS's proposal to waive certain Medicare telehealth requirements, including a waiver of the originating site requirements (relating to

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<sup>2</sup> 79 Fed. Reg. 72760, 72779 (Dec. 8, 2014).

geographic site and specified types of settings). This change would enable the originating site to be the home or a home health agency. Enabling both the home and the home health agency to be originating sites would significantly improve the use of telehealth in the Medicare program.

The Alliance also recommends that remote patient monitoring be included in the definition of a telehealth service. Home health agencies are one of the few types of health care providers within the traditional Medicare program that have begun to make good use of telehealth in its delivery of care. The use of telehealth, particularly through remote monitoring, by some home health agencies has taken place because it is a useful tool that home health professionals use to improve patient engagement in self-care and self-management of various conditions as an adjunct to in-person home visits.

Nevertheless, because investing in remote monitoring technology can be costly, there are many home health agencies that have not invested in telehealth and remote monitoring technologies. Still others have limited use of this technology to a small sub-population of patients, even though a larger population of patients would also benefit.

The Alliance recommends that as part of the waiver of the originating site requirements within the Medicare Shared Savings program, CMS enable payment for remote monitoring services that are furnished by home health agencies to patients that need this service. Because there is already expertise that some home health agencies have with remote monitoring, such a change would enable ACOs to build on those competencies where remote monitoring is being used. In those agencies where remote monitoring is not yet used or is used in a very limited fashion, enabling payment for remote monitoring by home health agencies as telehealth in the context of ACOs would facilitate approaches to telehealth that are synergistic with the home health providers' efforts to coordinate care in the home.

The Alliance would welcome the opportunity to work with CMS to develop approaches to billing and payment for telehealth services in ACOs that enable home health professionals to contribute fully towards achievement of the Triple Aim of improved patient experience, improved population health and reduced per capita cost of care.

### III. Homebound Requirement Under the Home Health Benefit

The Alliance appreciates CMS's recognition of the issues associated with the homebound requirement for the Medicare home health benefit. The Alliance agrees with CMS's observation that there are patients who are not homebound that would benefit from home health care's ability to provide support that can reduce the risk of hospitalization. By enabling ACOs in the Medicare Shared Savings Program to allow such patients to receive home health care, even if they are not homebound, overall health system cost can be reduced and patient care quality will improve. Appropriate

use of home health care is associated with improved chronic condition management that can support avoidance of hospitalizations.

In addition, in the context of post-acute care, home health can be used as a cost-effective site of service where it is clinically appropriate for the patient to receive care at home. Within Medicare today, for patients discharged for the same condition, there is considerable overlap in the sites of service that a given patient may receive care post-discharge. For example, for MS-DRG 470 (major joint replacement without major complications or comorbidities), Medicare patients often go to home health agencies, skilled nursing facilities, and inpatient rehabilitation facilities. To the extent that it is clinically appropriate to send such patients to home health care for post-acute care, analysis of Medicare claims shows that there would be considerable savings in Medicare expenditures. By placing patients in the most clinically appropriate and cost effective settings, the Medicare program could save \$34.7 billion over ten years.<sup>3</sup>

The Alliance supports waiver of the homebound requirement in the context of the Medicare Shared Savings Program. Regarding CMS's proposal to limit waiver of the homebound requirement only to Track 3 ACOs, **the Alliance recommends that instead such a waiver should apply more broadly to all ACOs in the MSSP, regardless of track.** The Alliance recognizes that CMS is interested in making Track 3 attractive to those forming ACOs, however is concerned that very few organizations have been interested in entering into two-sided risk ACOs to date. If very few organizations pursue a two-sided risk approach, and waiver of homebound is limited only to these organizations, there will be a missed opportunity for patients to benefit from home health care to support improved quality and efficiency of care, as well as for the health system to benefit from improved cost effectiveness. Although Track 1 ACOs share only in savings and not losses, the incentive to generate savings should be significant enough to encourage appropriate use of home health care in the context of a waiver of the homebound requirement. If CMS is concerned about allowing Track 1 and 2 ACOs to waive the homebound requirement, the Alliance encourages CMS to explore testing waiver of the homebound requirement in a limited number of sites first, to ascertain impact and effectiveness. Consistent with the approach articulated in the proposed rule, CMS could ask such ACOs to provide more specific explanations of its plans related to use of home health care for those who are not homebound and closely evaluate the impact on the Medicare program and patients over time to determine the effectiveness of the waiver.

In addition, as CMS considers its approach to waiver of the homebound requirement, the Alliance urges CMS to consider other CMS demonstration projects, programs and initiatives that may be waiving the homebound requirement. For example, in the Bundled Payments for Care Improvement Initiative (BPCI), some participants are

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<sup>3</sup> A. Dobson et al., "Clinically Appropriate and Cost-Effective Placement: Improving Health Care Quality and Efficiency," [www.ahhqi.org](http://www.ahhqi.org), October 2012.

waiving the homebound requirement. The perspective and experience from BPCI and other CMS demonstrations, projects, and programs may be instructive as CMS seeks approaches to leverage the value of home health care in efforts to improve patient care and avoid unnecessary hospitalizations.

In addition, CMS proposes to only permit waiver of the homebound requirement for those home health agencies that have a quality rating of 3 or more stars. Recently, the Alliance submitted comments to CMS<sup>4</sup>, expressing concerns about the approach that is being used for assigning star ratings. The Alliance strongly recommends that CMS refrain from using the star ratings as a benchmark until the methodology used has been tested and considered a fair reflection of the home health agencies' performance against the home health compare measures.

In relation to Medicare physician home visits and the Independence at Home (IAH) demonstration, waiving the homebound requirement would facilitate improved opportunities for collaboration between home health agencies and physician house call practices that would improve patient care. The model that served as the primary inspiration for the IAH demonstration project was the Veterans Affairs (VA) home-based primary care (HBPC) program. In that program, the VA does not require patients to be homebound, but rather takes the approach that if routine clinic-based care is not effective then the patient would qualify for VA HBPC.<sup>5</sup> The VA HBPC program has been successful at improving patient outcomes and lowering overall cost of care. A 2002 analysis found that the 11,334 veterans in HBPC had a 62 percent reduction in hospital bed days of care, 88 percent reduction in nursing home bed days of care, and an increase in home care visits by 264 percent. The mean total VA cost of care dropped 24 percent from \$38,000 to \$29,000 per patient per year.<sup>6</sup> To the extent that ACOs can shift toward approaches that replicate this model, one would anticipate that there would likely be similar success in movement towards the Triple Aim of improved patient experience, improved population health and lower per capita cost of care.

It is important to note, however, that the IAH demonstration thus far has not yet included a waiver of homebound status. The Alliance recommends that for the IAH program, just as for the MSSP, waiver of the homebound requirement would be an appropriate means of ensuring access to home health care for the patients who need it.

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<sup>4</sup> Alliance for Home Health Quality and Innovation: Comments on Home Health Compare Rating (Jan. 16, 2015)

[http://ahhqi.org/images/uploads/Alliance\\_Final\\_Comments\\_on\\_HH\\_Star\\_Ratings\\_11515.pdf](http://ahhqi.org/images/uploads/Alliance_Final_Comments_on_HH_Star_Ratings_11515.pdf)

<sup>5</sup> It is important to note, however, that there is no homebound requirement for a Medicare beneficiary to receive a house call.

<sup>6</sup> J. Beales & T. Edes, "Veteran's Affairs Home Based Primary Care", Clin Geriatr Med 25 (2009) 149.

#### IV. Waivers for Referrals to Post-Acute Care Settings

The Alliance is concerned that the waiver of requirements relating to discharge of patients to post-acute care settings may pose a risk to beneficiary choice and result in issues with patient steering. The Alliance supports providing accurate information about post-acute care providers to patients and their families so that they can make informed decisions about the post-acute care providers they will be using. Sharing publicly available quality data is an appropriate means of providing patients with important data to inform their choices.

The Alliance also strongly supports CMS's statement that hospitals would continue to be required to, "inform the patient or the patient's family of their freedom to choose among participating Medicare providers of post-hospital care services ... In addition, the hospital must present a complete list and may not limit the qualified providers that are available to the patient." That is, that CMS would continue to require all hospitals, whether in ACOs or not, to provide a complete list of Medicare providers to the patient or patient's family and inform them of their freedom to choose from that list.

However, the waiver would allow discharge planners in ACO participating hospitals (or ACO provider/suppliers) to recommend "high quality post-acute care providers with whom they have relationships (either financial and/or clinical) for the purpose of improving continuity of care across sites of care." Such a waiver raises the issue that post-acute care providers of equal quality might not be presented similarly to patients, simply because the hospital has a financial or clinical relationship with certain providers. Consistent with the conditions of participation, where a financial or clinical relationship exists between the hospital and the hospital-recommended post-acute care providers, this relationship should be clearly disclosed to the patient so that he or she is made aware of the potential conflict of interest that exists. It may also be protective to require an "informed consent" form that is signed by the patient or family member, documenting awareness of such conflicts. Given the risks associated with waiving these requirements, the Alliance recommends that CMS closely monitor the practices in this area to protect patient choice and access to high quality care.

In addition, any quality data shared by hospitals to patients should be based on publicly reported data (such as Medicare Home Health Compare). Data analysis that is based on Medicare claims or other government sources of data would also be appropriate to share with patients, but must be shared in a manner that is transparent regarding the methodology of analyzing the data.

As mentioned above, the Alliance has concerns about CMS's proposed methodology for calculating star ratings based on home health compare scores. If star ratings are to be used as a benchmark to recommend post-acute care providers in ACOs, the star ratings methodology must first be tested and considered a fair and accurate reflection of home health quality of care.

## V. Waiver of Other Payment Rules

*Face-to-Face Encounter Requirement.* Beyond the waivers mentioned in the ACO proposed rule, the Alliance urges CMS to consider waiver of the face-to-face requirement in the context of the Shared Savings Program. Although well intentioned as a means to encourage appropriate physician interaction with home health patients and to improve program integrity, the face-to-face requirement instead has been highly burdensome to the point of hindering access to home health services. The face-to-face requirement has been the subject of much discussion, including in the Medicare home health prospective payment regulations over the last few years. The requirement continues to be one that both CMS and providers struggle to address. Most recently, CMS released a draft template for use in documenting the face-to-face encounter and it is already the subject of concern about the burden it may present.

Moreover, there is an inherent challenge to obtaining a face-to-face encounter with a physician for patients who need home health care. Patients who use Medicare home health care by definition are homebound and therefore it is a considerable and taxing effort to go to a doctor's office. Although there are physicians who make house calls (or home visits), the vast majority of physicians who treat Medicare beneficiaries are office-based only. Even if the homebound requirement is waived, there will still be patients who are homebound, and for whom going to a doctor's office will be a barrier to accessing needed home health care services.

Given the value of home health care in preventing unnecessary hospitalizations, the Alliance recommends improving access by waiving the face-to-face encounter requirement in the context of an ACO in the Medicare Shared Savings Program. The Alliance would welcome the opportunity to discuss with CMS further the details of how one would implement such a waiver.

*Intermittent Care Requirement.* In addition, currently a Medicare beneficiary must need skilled *intermittent* nursing or therapy services to qualify for the Medicare home health benefit. The Medicare policy manual states that "intermittent" skilled nursing care means: "skilled nursing care that is either provided or needed on fewer than 7 days each week or less than 8 hours of each day for periods of 21 days or less (with extensions in exceptional circumstances when the need for additional care is finite and predictable)."<sup>7</sup> This definition and the related guidance in the Medicare policy manual sets parameters that limit the ability of home health care to serve as an appropriate, efficient means of delivering care. At present, where the nursing care provided does not fit within this definition of "intermittent," patients would be forced to receive care from a skilled nursing facility, which is a more expensive site of service, or may even have to pay out of pocket for private duty services. Without this limitation, home health care could provide services that could be daily care, or simply care that is

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<sup>7</sup> Medicare benefit policy manual, Chapter 7-Home Health Services, 40.1.3  
<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c07.pdf>

delivered in a fashion that is not as rigid and finite as the current law and guidance requires. Because ACOs are being held accountable for total Medicare spending, waiver of this requirement would be an appropriate means of enhancing the ACO's ability to achieve the Triple Aim.

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The Alliance greatly appreciates the opportunity to comment. Should you have any questions about the Alliance's comments, please contact me at (202) 239-3671 or [tlee@ahhqj.org](mailto:tlee@ahhqj.org).

Sincerely,

/S/

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Executive Director