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January, 26, 2016

Chairman Hatch, Ranking Member Wyden, and Chronic Care Working Group Co-Chairs Isakson and Warner:

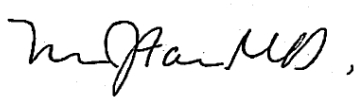
The American Academy of Home Care Medicine (AAHCM) is the national professional organization fostering the development of the field of home care medicine, and we respectfully submit this letter in response to the Chronic Care Work Group (CCWG) policy options document released on December 18, 2015. The AAHCM is dedicated to the vision of a health care system that provides home-based primary care to address the major unmet needs of ill elders and their families. In helping to meet this vision, we are proud to have played a leading role since 2007 with Congress and CMS in the collaborative development and implementation of Independence at Home (IAH). We applaud the work of the CCWG and its wisdom in including expansion of the IAH to a national program as a priority item.

Most importantly, we strongly support the conversion of IAH to a nationwide program:

- IAH provides home-based primary care and addresses a major unmet need for well-coordinated health care and social services for frail elders and their families, so that they can age in place and remain a part of the fabric of their community.
- IAH sites in the Medicare demonstration, and similar programs around the U.S., are proven to improve patient and family experience, achieve better clinical outcomes, meet rigorous quality standards and lower Medicare per capita costs by up to 30%.
- Conversion of IAH will revitalize the home as a dynamic setting for health care, become the vehicle for advancing mobile technologies and drive the Medicare system to reward value for patients and families.

We have included a more detailed memo for your consideration, including: 1) an overview of the IAH demonstration, 2) a legislative and regulatory history and research of the demonstration and extension, 3) analysis of benefits of conversion, 4) responses to CCWG inquiries posed in the option paper, and 5) other legislation that would improve IAH. Thank you for the opportunity.

Sincerely,



Mindy Fain, President

ACADEMY of HOME CARE MEDICINE AMERICAN

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1. OVERVIEW

The sickest and frailest of America's seniors want to age in place at home, setting their own goals and priorities, rather than cycling in and out of a fragmented array of doctor's offices, ERs, and hospitals. We all know that excessive care is all too common, unnecessary, and expensive. Independence at Home (IAH) is team-driven, home-based primary care, in which patient preferences are central, and medical care is delivered when and where it is needed – and delivered in the home as much as possible, reducing unnecessary emergency room visits and avoidable hospitalizations and readmissions.

In IAH, medical care is combined with coordinated social services for a comprehensive model that makes staying at home more feasible and safe. The holistic approach to care and voluntary nature of beneficiary participation are two defining features of the IAH design.

Genesis and Goals

Modeled after the highly successful Home-Based Primary Care program run by the Department of Veterans' Affairs (VA) for frail elders, IAH employs a unique shared savings model to provide high-quality care and lower costs for Medicare. The IAH demonstration was intended to test whether home-based primary care could reduce the need for hospitalization, improve patient and caregiver satisfaction, and lead to better health and lower costs to Medicare. It is succeeding.

Eligibility

IAH eligibility is strictly limited to beneficiaries who:

- Have two or more chronic conditions, expected to persist for more than a year,
- Have coverage from original, fee –for-service (FFS) Medicare A & B,
- Need personal assistance with ≥2 functional dependencies (e.g., walking or feeding),

- Have had a non-elective Medicare Part A hospital admission in the last 12 months, and
- Have received Medicare Part A subacute rehabilitation services in the last 12 months.

IAH Reimbursement Model

Medicare and the teams of healthcare providers earn savings when they meet quality requirements **and** are successful in lowering the cost of patient care. To qualify for incentive payments, the "practice's expenditures for participating beneficiaries must be lower than the calculated target expenditure," otherwise stated as expected (risk-adjusted) Medicare FFS expenditures of participating beneficiaries in the absence of the Demonstration. If practices do not meet strict requirements for quality and savings, they are disqualified from the program.

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%, but only if they have scored sufficiently high on six outcomes oriented quality measures.

Participants

Participating practices are required to demonstrate experience providing home-based primary care to high-cost chronically ill beneficiaries through multidisciplinary teams led by physicians or nurse practitioners available 24/7 to serve at least 200 beneficiaries. The IAH Demonstration includes 15 programs including one consortium of 3 practices for a total of 17 practices overall.

- Boston Medical Center (Boston, MA)
- Christiana Care Health Services (Wilmington, DE)
- Cleveland Clinic Home Care: Medical Care at Home Program (Independence, OH)
- Comprehensive Geriatric Medicine P.C. d/b/a Doctors on Call (Brooklyn, NY)
- Doctors Making Housecalls, LLC (Durham, NC)
- Housecall Providers, Inc. (Portland, OR)
- Mid-Atlantic Consortium

    - Medical House Call Program at MedStar Washington Hospital Center (Washington, DC)
    - Schnabel In - Home Care Program, Division of Geriatric Medicine, University of Pennsylvania Health System (Philadelphia, PA)
    - Virginia Commonwealth University House Calls Program (Richmond, VA)
- National House Call Practitioners Group (Austin, TX)
- North Shore – Long Island Jewish Health Care Inc.: Physician House Calls Program (Westbury, NY)
- RMED, LLC (Jacksonville, FL)
- Visiting Physicians Association, P.C. – Flint/Saginaw/Marysville (Flint, MI)
- Visiting Physicians Association, P.C. – Lansing/Ann Arbor (Okemos, MI)
- Visiting Physicians Association, P.C. – Milwaukee (West Allis, WI)
- Visiting Physicians Association of Texas, PLLC – Dallas (Irving, TX)

Using an external grant, these demonstration sites organized an effective learning collaborative with well-attended monthly webinars and annual in-person meetings. The Learning Collaborative was then continued by voluntary 1.5% contributions of savings from all sites during the IAH extension period (see section 2, Legislative/Regulatory History).

2. LEGISLATIVE/REGULATORY HISTORY & RESEARCH

IAH was initially a three-year demonstration included in 1866E of the Medicare Act. The House and Senate unanimously approved a two year extension of the demonstration in the summer of 2015 with solid bipartisan support.

Chronology of IAH Demonstration and Extension

- March 2010: Three-year IAH Demo added to the Medicare Act.
- December 20, 2011: CMS announces Independence at Home Demonstration.
- April 26, 2012: CMS announces 15 original participating individual practices and September 2015 announces three consortium sites.
- April 21, 2015: IAH two-year extension passes on Senate floor by unanimous consent.
- May 31, 2015: Original IAH demonstration expires
- June 2, 2015: Ways and Means committee holds legislation hearing, passes two-year extension, approved by unanimous vote.
- June 18, 2015: CMS announces practice year 1 performance results.
- June 24, 2015: Energy and Commerce committee waives jurisdiction for IAH extension.
- July 15, 2015: IAH two-year extension passes on House floor on suspension.
- July 31, 2015: President signs two–year extension of IAH demonstration. As such, the Demonstration began on June 1, 2012 and will end on September 30, 2017.

Members of Congress advancing IAH extension for floor action were Senators Markey (D-MA), Wyden (D-OR), Burr (R-NC), and Isakson (R-GA), co-sponsors of the original IAH legislation. In the House, committee and floor efforts were led by Representative Roskam (R-IL), Burgess (R-TX), and Thompson (D-CA).

CMS Role/Savings Determinations

The Independence at Home Demonstration is being conducted by the Center for Medicare and Medicaid Innovation, a part of the Centers for Medicare & Medicaid Services (CMS). CMS screened potential applicants, chose programs to participate, and administers the program including calculation and distribution of savings. In June, CMS released the IAH demonstration

participants' Year 1 results, reporting that IAH practices saved over $25 million during the first performance year – an average of $3,070 per beneficiary – while delivering high quality patient care in the home. Year 1 cost savings were an average of 8% annually for 8400 elders, which translates into a savings of $2,676 to $12,804/patient year. Some programs achieved as much as a 30% savings. Second year results are expected to be released by CMS soon. In the June 2015 CMS release, the agency stated, "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."

Research

A large body of evidence spanning over 20 years and all 50 states and D.C., including 2 major peer-reviewed studies published in 2014, shows that Home-Based Primary Care, as applied in the IAH demonstration, enhances quality of care & reduces costs for chronically ill patients.

VA: The Department of Veterans Affairs' Home-Based Primary Care program, which is similar in design to the IAH chronic care coordination program, 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.

- The VA's HBPC program reduced costs by 12% ($5,000/ patient-year) and achieved an 83% positive patient satisfaction rating—the highest achieved by a VA program. ("Better Access, Quality and Cost for Clinically Complex Veterans and Home-Based Primary Care", Journal of the American Geriatrics Society 62:1954-1961, 2014.)
- 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%.

Other Studies/Analysis

- A peer reviewed study of an IAH-style program at the MedStar Washington Hospital Center in D.C., operating in fee-for service Medicare, reduced hospitalizations by 9%, emergency room visits by 10% and skilled nursing facility days by 27%, and showed a 17% annual cost reduction ($4,000 / patient-year) as compared to case-matched controls under usual care. ("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 IAH-qualified high cost chronically ill Medicare beneficiaries, and making reasonable assumptions about program penetration based on existing house call practices would save approximately $37 billion over ten years, with about $17 billion retained by the government.

3) ANALYSIS OF BENEFITS OF CONVERSION

The IAH model meets the three major bipartisan goals enumerated by the Senate Finance committee's Chronic Care Working Group as IAH conversion:

- Increases care coordination through interdisciplinary primary care, mobile EHRs, & 24/7 access to achieve population health through integrated health care delivery;
- Promotes appropriate levels of care for the most complex beneficiaries and discourages overuse of services with the shared savings incentives; and
- Provides better outcomes and improved patient/caregiver satisfaction and promotes further development of health care technologies.

IAH conversion would increase care coordination through interdisciplinary primary care, mobile EHRs, & 24/7 access, pivotal means to achieve population health through integrated health care delivery.

- The Pareto Principle (otherwise known as the 80/20 Rule) shows that characteristics attributed to the whole are usually driven by a few, and therefore, in order to advance the care of all, health care networks must be able to attend to the needs of that narrow segment responsible for a disproportionate share —in this instance, health care utilization and costs.
- Studies done by the IAH Learning Collaborative using the Medicare 5% beneficiary file have shown that the IAH eligibility criteria identify a group representing the top 6.6% of the population, who were responsible for approximately 27% of all Medicare A & B expenditures (2012), 25% of all admissions and 46% of all readmissions, 24% of all deaths and 39% of those patients newly admitted for long-term institutionalization during the year.
- We found that IAH's unique set of eligibility criteria not only identifies the high cost—high risk population, but also promises to deliver outsized, positive impact in

reorganizing service delivery networks and the payment methodologies that support them because of this targeting.

- We concur with CMS' assessment of IAH's dual goals in population health and integration of care: "Home-based primary care allows health care providers to spend more time with their patients, perform assessments in a patient's home environment, and assume greater accountability for all aspects of the patient's care. This focus on timely and appropriate care is designed to improve overall quality of care and quality of life for patients served, while lowering health care costs by forestalling the need for care in institutional settings."
- The IAH Learning Collaborative was founded with the goal of coordinating and integrating practice participants with one another to share lessons learned. Initially funded through grants from The Commonwealth Fund and the Retirement Research Foundation, the legacy leaders of the IAH movement convened monthly conference calls and an annual meeting with representatives of the participating sites. In order to continue this valuable exchange of information and ideas, the practices combined contributions to continue the Learning Collaborative.

IAH conversion would promote appropriate levels of care for the most complex beneficiaries and discourage overuse of services with the shared savings incentives.

<u>Targeted Population/Team-Based Care</u>

- IAH is an excellent example of integrated health care delivery as it promotes interdisciplinary team-based care for a more holistic view of the patient, among some of the most sick and frail Medicare beneficiaries.
- In usual care, IAH-eligible individuals are seen by multiple providers, who do not often share information with one another, which can lead to waste through redundant testing and harm by failing to reconcile medications. IAH's team approach promotes continuity

and coordination of the medical care plan by including core team members, specialty consultants, ancillary services and community partners.

Discourages Over- and Underutilization/Promotes Efficiencies

- This model has the effect of reversing the incentive to avoid these highest- cost, complex beneficiaries. Avoidance of these challenging patients is evident in FFS, traditional managed care, and bundling models. IAH also eliminates the incentive to over-utilize services, which has plagued home health care services under Medicare. Practitioners instead have an incentive to innovate and provide the care that will efficiently produce the best outcomes for individual beneficiaries since the practices' savings share is dependent upon both lower cost and good outcomes.
- The "pay-for-value" payment model in IAH advances the transition from volume-based systems of service delivery. IAH is designed to create efficiencies to attain the best outcomes. Our experiences within IAH have shown that income is greater when patients are better managed, thereby encouraging the use of timely, less costly primary care services and obviating the need for expensive rescue interventions and institutionalization.
- The inclusion of fee-for-service income also allows for an important revenue base for the practices and provides a source of data for optimizing practice processes. This methodology aligns the incentives between providers and their patients and families, and creates a savings stream for Medicare —and potentially for Medicaid. The size of the savings could have a palpable impact on our national budget.
- The IAH program incentivizes the effective use of prescription drugs; medication reconciliation is a quality metric for the IAH demonstration.

IAH conversion would provide better outcomes, improved patient/caregiver satisfaction and promote further development of health care technologies.

Outcomes/Patient Satisfaction

- As included in the June 2015 CMS announcement of IAH first year savings, "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."
- 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.
- 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.

Technology Advancement

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).

Current Uses

- Initiating treatments in the home reduces both costs and the avoidable harms and risks attributable to institutional settings. For instance, when intravenous therapies are indicated, IAH provides the wrap-around service that makes home-infusion both safe and cost effective.
- Home monitoring technologies are useful not only in assuring the safety of patients on a day-to-day basis, but also can be comparable to that in an intensive care unit of an acute care hospital.

Future Uses

- With shared savings for funding, point of service diagnostic testing and imaging become feasible in the home. Such technology assures knowledgeable decision-making for chronic illness management in home-based primary care and appropriate disposition in urgent care situations. In lieu of a transfer to an acute care setting, we can initiate therapies at home to assure comparable care.
- This approach to health care delivery also drives the development of a comprehensive electronic medical record system available to multiple providers (with proper safe-guards) and assuring that all members of the team are up-to-date with their patient's progress; this widely accessible repository of health care data promotes interoperability between systems and networks, another goal of the federal government. It also enables providers to bring in the expertise of consultants in real time, as well as documentation, and writing orders and prescriptions without delay.

4) RESPONSES TO CCWG INQUIRIES

The Options Paper asks for comments on two sets of questions surrounding IAH, as excerpted and addressed below.

The working group is soliciting feedback on any changes, should IAH be expanded nationwide, that could improve the current program design while still achieving savings. Are there specific modifications that could be made to encourage additional practices, beyond the 17 (15) entities that participated in the first performance year, to choose to participate?

Major Changes Not Needed

- The Independence at Home
- Medicare Demonstration is a targeted program that is backed by decades of evidence from all 50 states, meets the Senate Finance committee's Chronic Care Working Group's goals, and we predict will produce significant savings if converted from a demonstration into a Medicare program that is available nationwide.
- According to CBO, if these high-cost/high risk 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 inherent flexibility of IAH brings creativity and innovation, characteristics that should remain intact when moving from demonstration to conversion. We ask that the working group refrain from imposing overly prescriptive methodology for quality metrics on IAH practices, and that the program must not be expanded in such a way that savings are diluted. The metrics in place now are effective.
- 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).

- We support the efforts outlined by the CCWG to develop quality of care indicators to highlight family engagement, ascertainment of goals and preferences, shared decision-making, and coordination of care across transitions with teams held accountable for assuring continuity of the medical care plan.
- It is important to ensure that CMS applies the sanctions for practices failing to meet both the quality metrics and the savings thresholds in a transparent and thoughtful manner, ensuring that a reasonable process is created for participants to requalify, taking a remedial approach where possible and using a learning collaborative model to foster success.

Existing Capacity for Conversion

We are convinced that IAH is ready for nationwide conversion. According to a soon to be published study, approximately 3000 programs, and over 5000 providers distributed nation-wide, already provide home visits to over 40 patients each per year, representing a significant investment in this model of care. With the incentives inherent in IAH, these practices are poised to expand their services to a larger population.

Suggestions for Encouraging Further Collaboration

- The Learning Collaborative has proven very useful among IAH participants to advance best practices. CMS may seek to expand this approach to 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.

- In this way Medicare will help to prepare the medical workforce that will be required to take on the care of the growing Medicare beneficiary population (10,000 beneficiaries added a day) that will include an increased number of high cost chronically ill.

Transparency and Oversight

- We also endorse incorporation of an evaluation process such as Rapid Cycle Change into IAH conversion. Congress should be given formal updates from HHS on a regular basis as the program evolves – perhaps biannually, including changes in program design, progress in geographic adoption and scaling, and the fiscal impact.

Other CCWG Options that Would Improve IAH

- **We support waiving the co-payments for this subset of beneficiaries**, as it encourages participation in a program that has clearly shown savings for Medicare and from whom billing for co-payments lacks a reasonable fiscal return for the practices.
- **We support the efforts to synchronize prescription delivery and promote education by pharmacy providers** and are in strong agreement that pharmacists are key personnel on many health care teams.
- **We also strongly encourage the involvement of mental health providers on IAH teams.** Such involvement is a mandated component in the VA-HBPC not only because these patients and families are often in crisis, but there is a high level of stress for providers. We encourage the development of a payment code for non-face-to-face counseling and consultation that would support the participation of mental health workers on the interdisciplinary care team in all Alternative Payment Model programs.
- **We support High-level Chronic Care Management Codes.**

Are more data needed to evaluate long term performance, outcomes, and savings potential? The working group is also seeking input on whether HCC risk scores are available for fee-for-service (FFS) beneficiaries, or if there are alternate methods in place to identify potentially eligible beneficiaries living with multiple chronic conditions.

<u>No, More Data Are Not Needed as Proof of Concept</u>

- CMS found that IAH practices saved over $25 million during the first performance year – an average of $3,070 per beneficiary – while delivering high quality patient care in the home.
- A large body of evidence spanning more than 20 years & all 50 states & D.C., including 2 major peer-reviewed studies published in 2014, shows that Home-Based Primary Care, as applied in the IAH demonstration, enhances quality of care and reduces costs for chronically ill patients. We are confident that subsequent year savings results will be equal to or better than Year 1.
- A soon to be published study in a leading professional journal will demonstrate that a large potential workforce throughout the nation is poised to embrace IAH.
- Numerous studies indicate that advances in mobile technology are readily available. These technologies await a vehicle for implementation to further improve patient care and realize technology's promise of cost reduction.

<u>Hierarchical Condition Category (HCC) Scoring as an Alternative Path to Eligibility.</u>

- The IAH demonstration eligibility criteria have proven successful in identifying a narrowly defined population of beneficiaries with a high-risk of high-costs. Further, the eligibility criteria are transparent in the normal course of patient care to both the beneficiary, his/her family and to the providers, and are easily verifiable through billing data by CMS. The clearest path to success is to retain current eligibility criteria.

- We believe there is utility for using HCC scoring to determine enrollment of a beneficiary into the IAH program and also to evaluate practices that wish to participate.
    - The first potential application for HCC scores is at the time of application for a practice wishing to join the IAH Program. We suggest that new IAH practices submit the identifiers for those individuals they hope to enroll in IAH and the NPI numbers of the providers. Practice participation could, in part, be determined by the practice's efficiencies and outcomes, based on the HCC scores and patient service use patterns, as compared to MA, SNPs and established IAH sites.
    - Second, it is important that the practice is not penalized for individual beneficiaries for whom they have been successful in reducing costs and improving outcomes. If the practice qualifies for IAH, then HCC scores could contribute to defining the beneficiary enrollment process, along with a history of multiple co-morbidities plus functional disability or the combination of an irreversible chronic illness and significant cognitive impairment. As an example, the HCC scores of beneficiaries who qualified for IAH was very high (3.4). Each practice found that less than 40% of its long term house calls patients qualified because many had not been in the hospital for some time, and they could not obtain shared savings, despite their successful management of these individuals.
    - We would still advocate for a remote history of hospitalization **plus** a post-acute service for established beneficiaries coming in with the practice, with other considerations, including: an HCC score of 3.0 or higher, a history of multiple comorbidities plus functional disabilities, a combination of irreversible chronic illness and significant cognitive impairment, or elements of the CARE Tool.

5) OTHER LEGISLATION THAT WOULD IMPROVE IAH

Support for Home Infusion

- We also highlight the efforts of the National Home Infusion Association in their efforts to promote the Medicare Home Infusion Site of Care Act of 2015 (S. 275 / H.R. 605). The legislation would ensure that Medicare beneficiaries can receive infusion treatments in the home.
    - The bill provides a pathway for reimbursement for the professional services, supplies and equipment associated with infusion therapy in the home under Medicare Part B, thus enabling the current Part D coverage of infusion drugs to become meaningful for Medicare beneficiaries. The bill also would require that HHS develop quality standards to ensure the safe and effective provision of such therapies.

Thank you again for this opportunity to respond to the Chronic Care Work Group (CCWG) policy options document.

Sincerely,

Mindy J. Fain, MD
President
American Academy of Home Care Medicine