March 6, 2014

Marilyn B. Tavenner
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: Advance Notice of Methodological Changes for Calendar Year (CY) 2015 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2015 Call Letter

Dear Administrator Tavenner,

We are writing on behalf of the American Academy of Home Care Medicine to comment on provisions of the Advance Notice and Call Letter for 2015. The Academy represents physicians and non-physician providers who provide house calls to some of Medicare's sickest and most costly beneficiaries—those with multiple chronic conditions who are home-limited due to illness and disability.

Also, as you know, a select number of Academy practices across the country participate in the Independence at Home Medicare Demonstration. We believe Demonstration results will reflect the intended goals of care, beneficiary and caregiver satisfaction and lowered Medicare program cost. We estimate that less than a quarter of those in need currently receive home-based medical care and our comments are based on our interest in providing access to care, improved satisfaction and cost savings for these beneficiaries and for the Medicare program.

Our comments focus on Section H of the Advance Letter regarding assessments.

We support your concerns regarding assessments. Our concerns are that assessments as currently practiced 1) may create confusion, sense of reliance and frustration particularly for the home limited population and may not contribute to ongoing beneficiary medical care and 2) distort the market for primary care providers in ways that do not support access to care nor support solution to the shortage of primary care providers.

1) Assessments may create confusion, sense of reliance and frustration particularly for the home limited population and may not contribute to ongoing beneficiary medical care.

We support your concern that assessments may not change or improve the care provided to beneficiaries as a result of the conduct of and information gained during the assessment, if the assessments are unconnected to the patient's regular sources of care. Moreover, the conduct of an assessment by a medical professional can serve to create the impression of a medical professional - patient relationship. This is particularly the case for the home limited beneficiary population. This population often has cognitive challenges and diagnosis in addition to their multiple physical chronic diseases.

As CMS data in the *CHRONIC CONDITIONS AMONG MEDICARE BENEFICIARIES, CHARTBOOK: 2012 EDITION* provides, the incidence of Alzheimer's disease is 13% among the general over 65 Medicare population and 20% for the dual eligible population. These rates are higher for the population served by our members whose average patient age is in the 80s. And many of the patients that our members see are dual eligible beneficiaries (for example, up to half of the patient population for certain of our IAH practices).

It is unreasonable for this potential confusion and reliance to be established that would easily lead to beneficiary and caregiver frustration for these beneficiaries to believe that the provider conducting the assessment would not then be the medical professional that would provide follow-up care for the very conditions that are being identified and discussed during the assessment. Your policy and our recommendations below would go a long way to reduce the potential for this beneficiary confusion and frustration**.**

While we support your policy that assessments should be integrated into ongoing medical care for the diagnostic codes to be recognized, care must be taken with how the resultant policy is implemented. We must assure that because these risk assessments occur in the home, that medical care delivered in the home ("housecalls") not be excluded from contributing to a beneficiary's clinical picture in terms of recognizing diagnostics codes obtained during ongoing medical care in the home and assisted living facility (ALF) places of service. There is increasing understanding that for many of Medicare's frailest beneficiaries, the private residence (home or ALF) is the most effective, efficient, and preferred site for primary care.

This is also the case for housecalls conducted out of MA organizations. As an example, we note that some MA plans are also provider organizations, such as PACE programs. PACE programs deliver primary care in the home to many of their frailest members, and the home is where the face-to-face primary care encounters naturally occur. Diagnostic codes from those visits, integrated into the PACE interdisciplinary team's care plan, are an exemplary example of integrated care, and the codes shouldn't be negated by policy or contractor instruction that follows the finalization of your policy on assessments.

CMS will hopefully be learning first hand of the cost effectiveness of ongoing home centered medicine as it evaluates the Independence at Home program. In terms of the assessment policy discussed in the Advance Letter, our support for the proposal that there be a follow-up medical visit within a specified time frame in order for the diagnosis codes identified during the assessment to be recognized, we recommend the following:

Requirement One - a medical visit that relates to the findings developed during the assessment, within a specified time period, by a primary care provider with ongoing responsibility for the beneficiary be required for the diagnostic codes obtained during the assessment to be recognized.

Requirement Two (as an alternative) - an MA organization could have the diagnosis codes recognized if the assessment was conducted by a primary care provider contracted as a participating provider with the MA organization and who is recognized by the MA plan and by the beneficiary as the beneficiary's primary care provider.

MA plans could make use of either requirement based on their network scope in a particular community. And both requirements would encourage the growth of the needed primary care workforce, particularly as medical care in the home is being recognized as the critical setting where quality care, patient and caregiver satisfaction and cost savings result for the beneficiary, the Medicare program and the country. The development of MA plan - home care medicine practice contractual relationships and in network participation will also support the development of relevant measures (currently lacking), regarding the care and outcomes for the multimorbid home limited Medicare population.

2) Assessments as currently arranged distort the market for primary care providers in ways that do not contribute to access to care and to solving the shortage of primary care providers.

Our concern is also that assessments as currently arranged (and as you indicate rendered by vendors versus an MA plan's contracted provider network) distort the market for primary care providers and this contributes to access issues for the vulnerable home limited population. Our understanding is that MA plans are paying per assessment fees that are 2 to 3 times the rates that a physician or nurse practitioner is paid for a visit under the Medicare fee schedule or that a medical practice could afford to pay one of its primary care providers if MA plan per assessment rates were annualized and used as the basis of provider compensation.

As a result, primary care providers who could provide ongoing primary care in the home as a member of a medical practice or on their own are being taken out of the primary care workforce due to the payments offered by MA plans for assessments. Given that, as you indicate in the Advance Letter announcement, MA enrollment has now grown to 30% of the Medicare population, the issue of access to primary care services for the growing multimorbid home limited Medicare population becomes paramount.

Our recommendations above would encourage MA plans to contract with these primary care providers to provide the ongoing medical care for these isolated, vulnerable home limited Medicare beneficiaries in addition to providing the necessary assessments. This should result in increased access, better care, improved satisfaction and reduced cost.

We appreciate the opportunity to comment and we would be happy to answer any questions.

Sincerely,

George Taler, MD
Chair, Public Policy Committee
American Academy of Home Care Medicine