March 6, 2015

Andrew Slavitt
Acting 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) 2016 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2016 Call Letter

Dear Acting Administrator Slavitt,

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 2016. The Academy represents physicians, nurse practitioners, and physician assistants 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.

To improve the care of these Medicare beneficiaries and the performance of the Medicare Advantage program (MAO), the Academy provides the comments in this letter that are summarized below. The Academy supports CMS:

1. Standardizing the Health Risk Assessment (HRA);
2. Guidance for In-Home Enrollee Risk Assessments including the development of best practices;
3. Provision to maintain the current HCC methodology and frailty adjustment for PACE organizations and FIDE SNPs. We also express concern regarding MAO transition to the 2014 HCC Model;
4. Interest in obtaining examples of alternative payment models from MAOs and also the CMS interest regarding the impact of the physician incentive regulation; and
5. Consideration to add care coordination measures to Star Ratings and we also note concern about the application of current Star Rating program to organizations with dual eligible beneficiaries.

Details of these comments are discussed below.

Standardizing the Health Risk Assessment (HRA)

The Academy, on behalf of its members, and their patients who are unable to access office based care, commends the CMS for maintaining the recognition of in-home assessments and for tying this to increased amounts of care planning, care coordination and care plan development. We also commend the

CMS for its proposal to standardize the HRA. We observe that the standardized areas of HRA align with the systematic assessment of medical, functional and psychosocial needs and receipt of preventive services that CMS is now covering and paying effective this year through Chronic Care Management - CPT Code 99490 under the Medicare Fee Schedule.

The Academy believes that it is important that Medicare beneficiaries receive at minimum the same range of services regardless of the model under which they receive their Medicare benefits.

Guidance for In-Home Enrollee Risk Assessments

The Academy commends the CMS for its finding;

"We believe that in-home assessments can have significant value as care planning and care coordination tools. In the home setting, the provider has access to more information than is available in a clinical setting. For example, the provider is able to evaluate the enrollee's home for potential risks, the need for supports to enable an enrollee to continue living in the community, and other relevant aspects of the enrollee's living situation. We expect plans to take advantage of the opportunities afforded by performance of in-home assessments to obtain and use that full spectrum of information to revise, develop, or implement comprehensive care plans for affected enrollees."

The Academy has a growing body of evidence across delivery models including the VA, MA plans and in traditional Medicare through shared savings programs (ACOs, and Medicare is currently conducting the Independence at Home demonstration), that supports the CMS comments regarding evaluation of the enrollees/beneficiaries ability to continue living in the community. Moreover, there is evidence that *ongoing* care that results from such assessments contributes to the triple aim of improved care, increased satisfaction and reduced cost.

The Academy, as a result, also commends and fully supports the CMS policy to "strongly encouraging plans to adopt, as a best practice, a core set of components for the in-home assessments they perform."

We believe that guidance on best practices for conducting in-home assessments and tracking subsequently provided care will support care planning and care coordination for enrollees. We also believe that the best practices will contribute to the revision, development, or implementation of comprehensive care plans for affected enrollees.

We also find that the best practices closely align with the CMS requirements for Chronic Care Management and again applaud the consistency of requirement across Medicare options for beneficiaries. The Academy recommends that the CMS require MA plans to implement the best practices as soon as permissible with publication of the Final Call Letter for 2016.

The Academy agrees that the best practices will support CMS tracking to assure that assessments are indeed used for ongoing care. To encourage that assessments are indeed used for care planning, care coordination and development of comprehensive care plans for affected enrollees, we recommend that the CMS require MA plans to expressly pay providers rendering the HRAs/in home assessments for the additional scope of service for the standardized HRA implemented in accordance with your proposed best practices guidance. This payment would be consistent with the requirement for MA plans to provide the Part A and Part B services, HIPAA, that is, as CMS adopts codes for Medicare, that other payors be required to use the same CPT and ICD codes as well, and this recommendation is consistent with the CMS FFS coverage and payment for CCM this year.

The payment for the best practices assessments would be added regardless of payment model in place (FFS, capitation, etc.) between the MA plan and the provider. This same approach should be followed as CMS adds other care management services in the years ahead that support the triple aim. This approach will also support the CMS initiative for practices to transform from FFS to population health management by providing practices with the means to develop the necessary population health management capacity.

However, *we believe that CMS should go further than this in future proposals*. Assessments will make no difference if they are not followed by ongoing care that meets the enrollee's needs especially those that are home limited. Thus, to achieve its goals of improving care planning, care coordination and improved enrollee care and health outcomes the CMS should expressly inform MAs that house call providers should be added as providers to their networks to meet the needs of all enrollees including those who are unable to access office based care, that providers need not have an office to become part of a MAO network, and that accreditation and network participation with the MAO should be available to physicians, nurse practitioners and physician assistants alike. The increased involvement of housecall providers *rendering ongoing care* will produce triple benefits for enrollees, the MAO and for the Medicare program.

HCC Methodology and Frailty Adjustment for PACE organizations and FIDE SNPs

The Academy commends the CMS continuation of the PACE model for 2016. This model recognizes through inclusion of functional limitations and frailty adjustment that the care and cost for the frail elder (high-risk, high-cost), population is not fully explained by the MAO HCC (diagnostic) model. The Academy respectfully recommends that CMS apply this same recognition to all other models where frail elders may receive care through their Medicare benefits.

Thus, adjustment should be provided to recognize the additional cost whether the frail elder receives care through:

- Traditional Medicare, and risk adjustment that applies to the Value Based Payment Modifier program;
- Medicare Advantage, MA HCC model for those frail elders who receive care through MAOs;
- CMMI Shared Savings Programs, including ACO's, IAH and other evolving models and programs.

In this manner organizations will be encouraged to innovate and participate with the CMS in movement to population health management and providers will be encouraged to participate in the care of the growing population of frail elders.

MAO Transition to 2014 HCC Model

The Academy has concern regarding the transition to the 2014 MAO model. The Academy member beneficiary patient population encompasses many who require complex care. Specific concern is that the 2014 model would reduce recognition of the complexity and cost of care for beneficiaries/MAO enrollees with dementia, pressure ulcers, and real failure. We respectfully request the CMS to review the impact this model will have on those who treat the frailest MAO enrollees, such as those with multiple complex conditions that are residing in long term care facilities and in other residential settings.

Value-Based Contracting to Reduce Costs and Improve Health Outcomes

The Academy supports the CMS request that MAOs share data regarding their adoption of alternative payment models. We believe this will support the CMS interest in moving from FFS to population health management. Accordingly, we also support the CMS review of comments regarding the physician incentive regulations at 422.208 that MAOs must guarantee that stop-loss insurance is in place if their physicians are at risk for more than 25 percent of their potential income based on the use or cost of referrals they make.

The Academy has experience with its membership that are working with MAOs that this regulation is producing an obstacle to the design of alternative payment models that would support the triple aim.

Academy members who are producing triple aim results are uniquely situated to enter into such arrangements. Moreover, the ability to share in savings is necessary to support the growth not only within existing practices, but also of the nationwide workforce necessary to care for the estimated 4 million Medicare beneficiaries who are in need of home care medicine.

Given that approximately 30% of Medicare beneficiaries are in MAOs, one can see that this regulation is significant now and will become a growing hindrance to development of alternative payment models as MAO enrollment grows. Again, we commend the CMS for its interest in receiving information on alternative payments models and comments about the physician incentive regulations.

Similar to the CMS consideration of waivers to encourage ACO development the CMS may want to consider waivers under appropriate circumstances to address this issue. And based on the Academy member experience in shared savings programs and evolving alternative payment models, we look forward to contributing to this discussion.

Star Ratings

Dual Eligibles – The membership of the Academy is seeing an increasing population of dual eligibles. We have specific concern that programs and organizations with a high percentage of dual eligibles will be disadvantaged under the current STAR Ratings program. The Academy is also aware of a growing evidence base of the value of housecalls for the dual eligible population. Accordingly, we look forward to working with the CMS on Star Ratings and application to the dual eligible population to assure that increased access is available to this population as well as the benefits of housecalls for the dual eligible population.

Care Coordination Measures - The Academy commends and supports the CMS consideration to add Care Coordination Measures to Star Ratings. Our support is consistent with our comments above and that similar to standardizing the HRA and to providing best practices guidance for in home assessment, that adding care coordination measures will support care planning, care coordination and lead to improved enrollee care and health outcomes.

The Academy appreciates the opportunity to comment, and we would be pleased to answer any questions.

Sincerely,

Robert Sowislo Chair
Public Policy Committee