VNAA
Visiting Nurse Associations of America

February 6, 2015

The Honorable Marilyn Tavenner
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-3819-P, Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations; Proposed Rule

Dear Administrator Tavenner:

The Visiting Nurse Associations of America (VNAA) writes in response to the proposed Medicare Rule on the Medicare Shared Savings Program: Accountable Care Organizations (ACOs). VNAA is a national association that supports, promotes and advances mission-driven, nonprofit providers of home and community-based healthcare, hospice and health promotion services to ensure access and quality care for their communities.

The VNAA supports the continued development of population health models of care delivery and payment. Our members – both those which are independent and those that are part of health systems – are participating in a number of ACOs. We appreciate the opportunity to comment on these regulations and respectfully submit the following comments for CMS' consideration:

**Waiver of Homebound Status for Home Health Services**

VNAA strongly supports waiver of the homebound requirement for home health services for all ACO tracks. Care delivered in the home is safe, effective, efficient, and patient-preferred. The use of home-based services in lieu of institutional care both saves direct Medicare costs while averting potential future costs. For example:

> Concord Regional VNA in Concord, New Hampshire is partnering with the Dartmouth-Hitchcock Medical Center, Medical Center Primary Care Providers to provide medication reconciliation for 204 Medicare beneficiaries with chronic medical conditions. First year results showed a decrease in hospitalization rates from 27 percent to 24 percent and an increase in patient satisfaction from 81 percent to 87 percent.
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> Sutter Care at Home in Fairfield, California is using an Integrated Care Model for patients with chronic conditions. Two years after implementation, acute care hospitalizations decreased from 29 percent to 14 percent, nurse turnover rates decreased from 20 percent to 6 percent and patient experience scores also increased.

The Visiting Nurse Service of New York (VNSNY) in New York, New York is partnering with Mount Sinai Hospital in New York City to develop a hospital to home care program for patients following cardiothoracic surgery with the purpose of preventing 30-day readmissions. In a three-month period, 131 Mount Sinai patients included in the program were admitted to VNSNY and all 131 avoided SNF admissions.

VNA of Somerset Hills in Basking Ridge, New Jersey, partnering with a primary care group in a telehealth initiative, is providing a program to identify symptom severity in COPD and CHF patients for early interventions. This program yielded a zero percent 30-day readmission rate for the 27 patients enrolled.

Waiving the homebound requirement would provide ACOs greater flexibility to provide skilled preventive, curative, and rehabilitation services consistent with the needs of the patient. In all cases, clinicians, the patients, and caregivers would together decide the best course of care and ACOs would retain the ability to direct patients to settings other than the home if determined necessary or preferred.

The waiver of homebound status should apply to beneficiaries assigned to the ACO and not be limited to home health providers who are financially or otherwise aligned with the ACO. In other words, patient choice of provider – whether that provider is inside the ACO or not – should have no bearing on the waiver of homebound status. This will ensure that patient preferences are honored and encourage ACOs to coordinate care with a broader set of providers in their area.

We recognize that CMS may have concerns about an increase in utilization of home health benefits. We urge CMS to recognize that a simple increase in utilization is not necessarily an indicator of fraud. Data supports legitimate physician interest in using home health services for populations that are not eligible under current rules. In CMS' Report to Congress on access to home health care for vulnerable patients, physicians stated that the top reason that they could not place a patient into home health when they sought to refer to the service was because the patient did not meet the eligibility requirements.[1] Removing the homebound requirement would increase physicians' ability to refer to home health services when they deem the home to be the most appropriate setting for care. We also recommend that CMS evaluate the impact of waivers related to homebound status as part of the Bundled Payment for Care Improvement Initiative to assess whether or not utilization has increased in ways that may be inappropriate.

**Other Waivers**

*Face-to-Face Requirement for Home Health Services:* VNAA requests that CMS consider waiving 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

[1] CMS, "Report to Congress: Medicare Home Health Study: An Investigation on Access to Care and Payment for Vulnerable Patient Populations," November 2014.

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, VNAA 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.

*Payment for Palliative Care Services / Ability to Provide Hospice Services Concurrently with Curative Treatment:* Medicare pays for hospice services only when an individual meets certain criteria, including that the individual has been certified by a physician and hospice medical director as having a terminal illness with an expectation of having 6 months or less to live and that the individual has opted to forgo curative treatment for the terminal illness. Medicare does not reimburse for palliative care services. These two policies together create a bright line between curative treatment and holistic hospice care. As a result, entrance into hospice is often delayed and individuals receiving curative treatment fail to benefit from palliative care.

To obtain the full benefits of hospice, patients need to be enrolled for several weeks, if not months. Our members' experience shows that the minimum amount of time to benefit significantly from holistic services is 21 days (or three weeks). There is little spiritual or emotional work that can be meaningfully accomplished in less time. Today, half of all patients who enter hospice receive the benefit for less than three weeks. 35% are in hospice for less than one week.[2]

Hospice use is correlated with Medicare savings. Researchers at the Icahn School of Medicine at Mt. Sinai published a study in Health Affairs that found that if just "…1,000 additional beneficiaries enrolled in hospice 15 to 30 days prior to death, Medicare could save more than $6.4 million." The study also found that hospice patients had significantly lower rates of hospital and intensive care use, hospital readmissions, and in-hospital death when compared to the matched non-hospice patients.[3]

We therefore encourage CMS to consider options to increase the appropriate use of hospice. Palliative care could provide a logical transition from purely curative treatment to hospice and ensure that beneficiaries are receiving the benefits of the holistic services provided through hospice earlier.

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[2] National Association of Hospice and Palliative Care Organization, "2012 NHPCO Facts and Figures: Hospice Care in America," Accessed at:
http://www.nhpco.org/sites/default/files/public/Statistics_Research/2012_Facts_Figures.pdf

[3] Kelley AS1, Deb P, Du Q, Aldridge Carlson MD, Morrison RS. "Hospice enrollment saves money for Medicare and improves care quality across a number of different lengths-of-stay," Health Aff (Millwood). 2013 Mar;32(3):552-61. doi: 10.1377/hlthaff.2012.0851.

With respect to this proposed regulation, we urge CMS to provide a waiver that would allow ACOs to either a) enroll individuals in hospice while concurrently receiving curative treatment, or b) bill for palliative care services.

**Patient Attribution**

VNAA acknowledges the challenge of patient attribution and agrees with CMS' move towards prospective patient attribution. However, we remain concerned that by limiting prospective attribution to Track 3 only, the vast majority of ACOs will not benefit from knowing exactly who is in their patient population. ACOs will continue to struggle with monitoring the cost and fully managing care for beneficiaries that are only confirmed retrospectively. We therefore recommend that CMS also provide prospective enrollment as an option for ACOs in Tracks 1 and 2 based on historic utilization.

VNAA strongly supports CMS' proposal to recognize the primary care services provided by nurse practitioners and physician assistants for patient attribution purposes.

**ACO Network Development**

Patients should retain the right to choose their preferred Medicare provider, whether or not that provider is aligned with an ACO. We are concerned that the proposed waiver to allow hospital discharge planners to recommend certain post-acute care providers over others could undermine patient selection of the highest quality providers unless certain protections are put in place. While we expect that many ACOs would recommend the highest quality providers in the patient's area, there is sufficient evidence in the market today to warrant concern. Today, many hospitals steer patients to providers within their systems or with which they have financial relationships. If hospitals within ACO arrangements are now able to recommend certain post-acute care providers over others, they should apply uniform criteria and be required to recommend all providers that meet the minimum performance standard. We urge CMS to require ACOs to establish criteria related to value, which would include measures of clinical quality, patient satisfaction, cost, and access and to prohibit criteria solely related to cost or financial relationship to the ACO. If ACOs are not required to hold post-acute care providers to uniform criteria related to performance in several domains, we anticipate that steering based on cost and financial relationship will only grow.

CMS indicated in the proposed rule that it is considering such a requirement focused on quality and value and consistent with our recommendation above. CMS used the example of permitting ACOs only to recommend Skilled Nursing Facilities that have a Star Rating of 3 or more stars under the CMS 5-Star Quality Rating System. While we think that the Star Ratings could ultimately be a helpful tool for ACOs to develop networks of home health providers, we urge CMS to allow the home health 5 Star program to be tested for at least one year prior to tying it to payment or network development.

**Coverage of Telehealth Services**

Telehealth can play an important role in supporting the delivery of needed health care services in the home while also improving patient care and reducing costs. Home health agencies are uniquely able to provide telehealth services. They are a trusted part of a patients' care team with first-hand knowledge of the patient. Frequent, face-to-face contact is the corner stone of the relationship of the skilled care the patient receives; telehealth furthers the relationship and does not replace it. Instead, telehealth assist home health providers in maximizing the effectiveness and efficiency of limited healthcare resources. For example, home health providers often use telehealth to monitor patients remotely and intervene at the most appropriate time, which may be different than the initially prescribed schedule. Some examples of the innovative ways VNAA members incorporate technology include:

- Consult with a patient's primary care provider while in the home using secure live video.
- Provide rehabilitation sessions and other consults via live video conferencing.
- Use telehealth for "comfort checks" to assess the patient (and/or caregiver) on a daily basis on a number of areas such as pain control, mental status, emotional support, bowels, and skin condition. This data is used to drive when home visits are made.
- Provide wound care management.

VNAA supports a waiver to allow providers in ACOs (and ACOs) to bill for telehealth services provided by home health agencies with "telehealth" defined in such a way as to ensure that current and future technologies can be included. (We propose defining telehealth as any piece of technology that is used to provide health services, monitoring and interventions to a patient in their home in addition to (or as compliment to) a patient's in-person care.)

Reimbursing for telehealth services will accelerate adoption. Telehealth often requires a significant initial investment to acquire in-home monitoring equipment and train staff. Lack of reimbursement has hindered adoption among smaller home health agencies. We urge CMS not to restrict telehealth payment to services furnished within specific geographic boundaries as many patients, particularly those who are frail and/or home bound, can benefit from such services regardless of the geographic area in which they reside. We also encourage allowing payment for telehealth for ACOs in any track. Furthermore, CMS should not limit reimbursement to certified episodes of care, but rather broaden eligibility to frail and/or home bound patients in general with certain parameters established by CMS.

Thank you again for the opportunity to provide our comments. VNAA is committed to supporting its members in implementing value-based, population health management models such as ACOs. Please contact Molly Smith, Vice President for Policy and Regulatory Affairs, at VNAA should you have any questions on these comments. She may be reached at msmith1@vnaa.org or 571-527-1529.

Sincerely,

Tracey Moorhead
President and Chief