Almost Family, Inc.
9510 Ormsby Station Rd., Suite 300
Louisville, KY 40223
(502) 891-1000 Fax (502) 891-8067

February 6, 2015 via electronic submission

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

Re: CMS-1461-P

Re: Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations

Dear Ms. Tavenner:

On behalf of Almost Family, Inc. (AFAM), we appreciate the opportunity to provide comments to the Centers for Medicare and Medicaid Services (CMS) on the agency's proposed rule to adjust and improve the Medicare Shared Savings Program (MSSP) as it relates to Accountable Care Organizations (ACOs).

AFAM is the nation's fourth largest provider of Medicare-Certified home health services, operating in 14 states with over 240 offices and 12,000 employees. Two years ago, AFAM demonstrated its commitment as a leader in the industry to provide more cost-effective, better coordinated care to its clients by acquiring a majority-interest in Imperium Health Management (Imperium), an experienced provider of ACO health management services. Today, Imperium manages 11 MSSP ACOs in 10 states, representing approximately 600 providers and 80,000 Medicare beneficiaries. With 8 other ACOs under development, Imperium has emerged as one of the nation's largest ACO enablement enterprises.

With hundreds of home health locations and nearly a dozen ACOs under management, we feel we have a unique perspective to comment on the vital role home health agencies will play in ensuring the success of ACOs in generating savings to MSSP. As evidenced by our investment in Imperium, AFAM supports CMS' continued development of MSSP. However, we feel the agency must take care to implement regulations that will work in the real world and inspire the kind commitment to risk taking and innovation on the part of providers that will be necessary to effect significant reform to the system.

We are convinced the physician-led ACO should be viewed as a controlled environment for innovation. In the sections below, we make several recommendations to the agency involving, among other topics, the SNF 3-day rule, the homebound requirement, telehealth, and compensation for substitution services. Our recommendations are made in the spirit of innovation that we believe is at the heart of the ACO model**.** In finalizing this proposed rule, we would urge CMS to keep that same spirit of innovation in mind and consider MSSP ACOs as a testing ground to experiment with ways to eliminate barriers to the most cost effective site of care.

By and large, we view CMS' proposed changes as a big step forward for a solid program that is still evolving. We are in agreement with the majority of the agency's proposals and have set forth our comments to help improve the program below.

Principles of a Home Based, Patient Centric Post-Acute Care System

In searching for ways to improve MSSP ACOs, we encourage CMS to use physician engagement and innovation through the development of policies which focus on the patient and his or her primary care physician or physician extenders working in concert as patient advocates. New policies in this space should emphasize the management of patients through routine interventions while patients live in their own homes, so as to prevent the development or worsening of chronic conditions that may otherwise result in costly institutional admissions. Instead of focusing on systems that reduce hospital readmissions, cost effective homecare interventions can greatly reduce hospital admissions in the first place. In a paper we first presented to House and Senate leadership and committees of jurisdiction in August 2013 (attached Appendix 1), we set forth principles of a home based, patient centric post-acute care system. We are pleased already to see policy evolving in this direction. We support the following key features in an enhanced homecare program:

- Shifting policy and payment models away from institution centric programs and more towards a patient centric program, in which primary care physicians work with seniors to be sure their preferences are recognized and they are served in the lowest cost setting;

- Payment systems should move away from paying for cost to paying for value with an increased emphasis on institutional admission avoidance, as opposed to simply reducing re-admissions;

- Value-based purchasing models and shared savings programs, including the use of the ACO regulatory framework, should be further developed to allow homecare systems to partner with physician-led ACOs to reduce the Medicare spend and improve patient care;

- Program integrity initiatives should be implemented to address abusive billing practices.

Encouraging Participation in Performance-Based Risk Arrangements

As the agency noted in its proposed rulemaking, only 2% of current ACOs have opted for two-sided risk models, with the other 98% contracting for one-sided risk. In response, CMS proposes to strengthen MSSP by encouraging more ACOs to embrace two-sided performance-based risk. While we do believe there is an important role for two-sided risk models, we do not agree that all answers lie in a two-sided risk solution. Instead, we feel the success of MSSP depends on promoting physician engagement in the program. The way to strengthen MSSP is not to push all ACOs toward two-sided risk, but to find a way to align the information and funding that drive physician engagement in order to produce better quality care and more informed decisions.

a. Creating Parity Between Elements of Medicare

We believe a one-side risk model, coupled with appropriate funding and data-sharing, will enable primary care physicians working closely with home and community based service providers to significantly reduce total spending and generate savings for the program. To promote physician engagement, CMS should follow the recommendations below and place ACOs on a relatively equal footing with Medicare Advantage (MA) plans.

i. ACO Funding

As we have written previously (see Appendix 1), one of the fundamental challenges facing ACOs is a lack of funding. With the limited exception of 35 or so Advance Payment ACOs, there has been no source of funding to enable ACOs to execute their fundamental activities, much less to take on two-sided risk and pay CMS when an unintended rise in spending occurs. To be fully viable, we are convinced ACOs need to receive some kind of per-member per-month (PMPM) funding from MSSP. Commercial plans have already begun to recognize this and are starting to provide such funding.

ii. Enhanced Information Sharing

CMS has thus far been unwilling to share the same information with ACOs that it makes available to MA plans. Providing this information to MA plans, we believe, is an acknowledgement by the agency that such information is necessary to facilitate risk taking. In order to engage physicians and help them make informed clinical decisions, we believe there should be information parity between MSSP ACOs and MA plans. Only when the gap between MA plans and ACOs is narrowed, will CMS be able to fairly demonstrate the power of ACOs to drive savings.

In addition, we seek to maintain the ability of independent physicians groups, which are more thinly capitalized, to participate in MSSP ACOs. We are concerned the current approach is encouraging ACOs (and physicians) to partner with hospitals and large systems. Given that approximately 60% of the Medicare dollars spent goes toward funding services provided in hospital inpatient and outpatient settings—the most costly of all settings—we feel the primary efforts of ACOs to drive savings must be targeted at reducing the hospital spend. CMS should focus on making the independent primary care physician model work.

b. Focusing on Ways to Improve One-Sided Performance-Based Risk Models

We are convinced in order for any two-sided risk program to succeed there must first be a sustainable business model in place for the one-sided track. The leaders of our ACOs inform us they are cautious about taking on two-sided risk without first having a positive experience in a one-sided risk model. In addition to other proposals below, we recommend that CMS focus on improving the one-sided risk program in the following ways:

- Copayments should be waived for primary care and chronic care management in order to break down financial barriers to care in an ACO;

- There should be more flexibility in home health benefits, including the development of a program for Medicare beneficiaries in which currently non-covered but low cost services could be substituted for higher cost services that are covered;

- All ACOs should be allowed to utilize telehealth services, regardless of geographic area.

Of the approximately 330 ACOs currently registered with CMS, the National Association of ACOs reports that only 1/4 have received any financial return for their investment.[1] We urge CMS to make the necessary changes to the one-sided risk model first, instead of focusing the majority of its attention (as it did in the proposed rulemaking) on encouraging all ACOs to prematurely move toward two-sided risk. By failing to focus on improving the one-sided risk model at this juncture, we are concerned CMS will negatively impact

[1]PRESS RELEASE, "National Association of ACOs Comments on CMS Proposed Medicare Rules." National Association of ACOs, December 1, 2014.

the number of successful one-sided ACOs, thereby reducing the number of ACOs that eventually make the transition to two-sided risk. In order for any two-sided ACO program to succeed in the future, we urge CMS to focus on fostering industry buy-in and to build a path to success for the 98% of one-sided programs currently involved in MSSP.

c. SNF 3-Day Rule

Pursuant to section 1861(i) of the Act, beneficiaries must have a prior inpatient hospital stay of no fewer than 3 consecutive days in order to be eligible for Medicare coverage of inpatient skilled nursing facility (SNF) care. CMS proposes to waive the SNF 3-day rule for ACOs that take on two-sided performance-based risk.

AFAM believes CMS' proposal to waive the SNF 3-day rule should be made available to all ACOs, so long as the certification of SNF utilization is signed by an ACO-member physician and includes an attestation that the patient could not adequately be cared for in his or her own home under the Medicare Home Health Benefit. This will ensure that the ACO-member physician is actively engaged in the management of care for his or her patient and will remove barriers and allow that physician to move his or her patient to the appropriate setting at the appropriate time. Any SNF utilization ordered by non-ACO physicians must continue to be subject to the SNF 3-day rule.

d. Homebound Requirement Under the Home Health Benefit

Sections 1835(a) and 1814(a) of the Act require that a physician certify (and recertify) that in the case of home health services under the Medicare home health benefit, such services are required because the individual is "confined to the home" and needs skilled nursing care on an intermittent basis, or physical or speech therapy or has a continuing need for occupational therapy. CMS proposes to waive the homebound requirement under the home health benefit for ACOs that take on two-sided performance-based risk.

AFAM believes the homebound requirement under the Medicare home health benefit should be waived for all ACOs, so long as the certification of the care plan is signed by an ACO-member physician. As in the case of SNF 3-day rule, this will ensure the ACO-member physician is actively engaged in the management of care for the patient and will remove barriers and allow that physician to move the patient to the appropriate setting. Homecare ordered by non-ACO physicians, however, should continue to be subject to the homebound requirement.

Required Process to Coordinate Care

Section 1899(b)(2)(G) of the Act requires that an ACO "define processes to…coordinate care, such as through the use of telehealth, remote patient monitoring, and other such enabling technologies." In the November 2011 final rule (76 FR 67829 through 67830), CMS established requirements under §425.112(b)(4) that ACOs define their care coordination processes across and among primary care physicians, specialists, and acute and postacute providers. In response to CMS' request for comment on ways to improve coordination of care for MSSP ACOs, we offer the following.

- AFAM supports CMS' stance on the use of enabling technologies and encourages CMS to alter the application of HIPAA/EDI 270/271 transactions as a means of identifying patients being admitted to any inpatient facility. The reality is that primary care physicians are often not notified when their patients are admitted to or are treated in an inpatient facility, which we believe undermines CMS' goal of a proactive care coordination process. As a way to solve this problem, AFAM encourages CMS to implement a requirement that inpatient facilities must notify a patient's stated primary care

physician immediately upon presentation to the emergency department and, in any case, prior to admission and on a daily basis while admitted. The conditions of participation for any inpatient facility should also require those facilities to return patients to the follow-on care of the patient's stated primary care physician prior to discharge;

- As mentioned before, we urge CMS to consider offering a PMPM funding amount along with minimum standards to ACOs, so ACOs will have the proper guidance and proper means to do the work that is being required of them;

- While we recognize the many challenges associated with the current attribution models, we believe one significant improvement could be made with relative ease. We recommend CMS revise the attribution rules to permit (but not require) beneficiaries to elect to attribute themselves to a particular ACO or ACO-Physician. This, combined with our recommendation to tag beneficiary's ACO participation in the Medicare eligibility system (below), would greatly enhance ACO-physicians' ability to more effectively manage the overall care of the patient;

- CMS systems currently permit providers to verify an individual Medicare-beneficiary's eligibility to receive covered-services under either Original Medicare or under a MA plan, including the specific MA plan in which the beneficiary has enrolled. This enables providers to coordinate the provision of services with the MA plan. In order to facilitate similar coordination between providers and ACOs, we ask that CMS include in its systems whether a beneficiary is an ACO patient including the specific ACO. This will make administratively feasible the recommendations in the preceding paragraph.

Methodology for Establishing, Updating, and Resetting the Benchmark

To help ensure that the MSSP remains attractive to ACOs and continues to encourage ACOs to improve their performance, all design features should target physician engagement and informed clinical decision-making**.** We believe changes to the benchmarking methodology may further enhance physician engagement.

a. Equally Weighting the Three Benchmark Years

Pursuant to section 1899(d)(1)(B)(ii) of the Act, CMS adopted a methodology for establishing ACO benchmarks, under which the agency weights benchmark expenditures at 60 percent for benchmark year (BY) 3, 30 percent for BY2, and 10 percent for BY1 (§425.602(a)(7)).

AFAM does not support CMS' proposal to move away from the current 60/30/10 weighting and toward a three-year average. Health care is rapidly evolving and the current methodology gives more weight to existing health care practices. Further, the population attributed during BY3 is more likely to be reflective of the performance year population. For these reasons, AFAM advocates maintaining the current 60/30/10 weighted structure.

b. Use of Regional Factors in Establishing and Updating Benchmarks

AFAM is concerned about the existing benchmarking methodology. We do not believe the current methodology sufficiently accounts for the influence of cost trends in the surrounding regional or local markets on the ACO's financial performance. To address this concern, AFAM suggests a blended benchmark based on a combination of:

- Historical Average Cost of the ACO Population; and

- Regional fee-for-service (FFS) average cost (based on age, enrollment mix, and risk score—similar to Medicare Advantage premium rate setting).

AFAM works with many ACOs and some of them have significantly lower risk-adjusted costs compared to their markets. For example, the financial benchmark set for the beneficiaries of our Utah ACO, Physicians Accountable Care of Utah (PACU), was determined to be $7,113—15.1% below the average regional FFS cost for Salt Lake City, and approximately 27% less than the national average. Because it started with such a low benchmark, PACU argued it was at an unfair disadvantage when it came to generating shared savings for the program. PACU and some of our other ACOs urge CMS to adopt an alternative benchmark methodology based on regional FFS cost data, rather than an ACO's past performance. In this way, CMS would level the playing field for all MSSP ACOs and create a more sustainable program. We contend a move toward establishing a benchmark that is based on a blend of historical and regional characteristics would create a more balanced opportunity for all MSSP ACOs to demonstrate shared savings.

To ensure that the MSSP remains attractive to ACOs and continues to encourage physician engagement, we believe that the revised benchmark setting process should use the higher of the ACO specific benchmark or the regional benchmark blend. This will provide the necessary incentive for high-spenders to reduce spending and encourage the already low-spenders to stay low, thus ensuring a "level playing field" for all providers who participate in the program. Otherwise, we fear some of the low-spending providers may lose interest in the program. Further, to not compensate low-spenders would be to establish a perverse economic incentive for providers to drive spending up, form an ACO, and then drive spending back down to take advantage of the "savings."

For the purposes of 1899(i)(3) of the Act, it is necessary to state that, over time, all of the above ideas to improve and update the MSSP ACO benchmarking methodology would improve the quality and efficiency of program and decrease spending.

Aggregate Data Reports and Limited Identifiable Data

In addition to our request for information parity with MA plans, we make the following specific recommendations:

- The claims data in the claims and claim line feed (CCLF) files should be made available to all new ACOs prior to their start date in the program. In the past, delays in the receipt of data in the process meant that new ACOs were well into the second quarter before the detailed analysis of their claims and utilization experience could be completed.

- The beneficiary demographic file in the monthly claims feeds should be included in the beneficiary's hierarchical condition category (HCC) score per CMS, because the aggregate HCC score is a very important element of the settlement process. This would also allow each ACO to audit all elements of the settlement process.

- The quarterly aggregate expenditure reports should include an update to the ACO's benchmark based on the change in HCC scores and enrollment mix relative to the benchmark period. This would greatly enhance an ACO's knowledge of how its costs are performing throughout the performance period.

- Many of our ACO physicians have reported significant challenges in accessing attributed patients during the patient's stay in in-patient facilities such has hospitals and SNF's. This seems to be particularly troublesome in more rural communities where there is only a single acute-care hospital. We recommend that CMS establish rules requiring ALL providers of all types who receive federal funding, as a condition of their participation, to coordinate care and provide ACO-access to patients under their care. This will facilitate better coordination of care and care transitions leading to higher beneficiary satisfaction, improved outcomes and lower costs;

- Lastly, AFAM compliments CMS' decision to move away from the beneficiary notification requirements so that the data will be received in a much more timely fashion and allow for better reconciliation against the quarterly aggregate expenditures report.

As an example of the need for information parity with MA plans, we share the following experience we had with our ACO in Owensboro, Kentucky. In its first year in MSSP, Owensboro ACO successfully lowered spending from $67.6 million to $63.8 million, saving the program $3.8 million in total spending. This should have entitled Owensboro ACO to a shared savings payment of $1.9 million. At the beginning of the process, in February 2013, CMS set a spending goal for Owensboro ACO of $65.3 million, which was reaffirmed by the agency as late as April 2014. In September 2014, however, 5 months after reaffirming the initial target and 19 months after setting it, CMS lowered the benchmark to $63.6M. This denied the ACO any shared savings payment and seriously discouraged the providers participating in the program.

In order to encourage the required risk-reward relationship necessary to drive physician engagement, we must have financial and clinical information that is sufficiently reliable and predictable to warrant the commitment of time and money that is necessary to generate savings. Physician trust in the credibility of the program must be maintained or we believe the program will ultimately fail. We are convinced implementing the changes listed above will strengthen the MSSP data sharing policies and processes to streamline access to such data, and better serve Medicare beneficiaries.

Billing and Payment for Telehealth Services

Under section 1834(m) of the Act, Medicare pays for telehealth services provided by a physician or practitioner under certain circumstances, despite the fact the physician or practitioner may be in a different location than the beneficiary. Under current law, telehealth services must be administered to a beneficiary located in one of eight types of originating sites specified in section 1834(m)(4)(C)(ii) of the Act and the site must meet at least one of the requirements included in section 1834(m)(4)(C)(i)(I)-(III).

We support CMS' proposal to waive certain Medicare telehealth requirements under section 1899(f), including waiver of the originating site requirements. The agency, however, can do much more to encourage the use of telehealth services. Technological developments are clearly playing a transformative role in how health care is delivered across the system. This is true in patients' homes as well, however we feel that CMS regulations are not currently keeping pace with these developments. Certain in-home technologies, such as telemonitoring of otherwise high-cost patients with chronic and complex disease states such as CHF, COPD and Diabetes are now available and they should be integrated in to the Medicare Home Health Benefit. These technologies complement rather than replace skilled home health services and for the protection and safety of patients they must be deployed under the professional care and supervision of skilled home health personnel of Medicare-Certified Home Health Agencies as an integral part of an overall plan of care. While we recognize CMS staff have not historically shared this view, we encourage CMS to renovate its regulations and seek such statutory changes as may be necessary to enable its policies to keep

pace with the rapid pace of technological innovation. This will permit progressive-thinking physicians such as those in ACOs to safely and effectively use these new technologies to deliver better outcomes at lower overall costs to the program.

Finally, we note several legislative vehicles have been presented in Congress that propose waiver of Medicare restrictions on telemonitoring for home care services provided through ACOs. Last session, the ACO Improvement Act of 2014 (H.R. 5558) did so, and, in the current Congress, the 21st Century Cures legislation, which has garnered significant bi-partisan support, invites innovation in telehealth services through new payment models. Whether through legislation or regulation, AFAM strongly supports waiver of Medicare restrictions on telemonitoring for home care services provided through ACOs.

Right to Appeal

In light of our experience with Owensboro ACO (above), we propose CMS consider creating by regulation a full and fair reconsideration and review process. While we recognize the lack of an appeals process has been codified in statute, this does not preclude CMS from establishing a system which provides participants an opportunity to present evidence to an impartial factfinder in support of their claim for a revised determination. The lack of a reconsideration and review process is arguably violative of the due process rights of MSSP ACO participants and such rights are enjoyed by Medicare-eligible individuals in a variety of circumstances in the face of adverse benefit determinations.

Consideration of Physician Specialties and Non-Physician Practitioners in the Assignment Process

Under §425.402, CMS employs a two-step approach as its basic beneficiary assignment methodology. With regard to this two-step approach, AFAM strongly supports the exclusion of non-physician specialties from Step 2 of the process. We support the current treatment of nurse practitioners and physician assistants in Step 1 of the assignment process, but do not believe CMS' proposal to disconnect these non-physician specialties from primary care physician billings in Step 1 is a move in the right direction. AFAM believes primary care physicians should always be given preference when assigning beneficiaries.

In addition, under the current attribution model SNFs are included as part of what CMS considers to be "primary care services." AFAM believes the definition of "primary care services" should exclude SNF services (HCPCS codes 99304 through 99318) because these services are generally performed by a person other than the patient's actual primary care physician, effectively re-assigning a beneficiary from their primary care physician over to the physician that sees them only during their SNF stay. This can cause unintended and undesirable de-attribution of ACO patients. By eliminating these codes, the patient's actual primary care physician and their associated ACO would retain responsibility for these SNF costs. We would suggest, however, that CMS' current treatment of home visits, domicile visits, and rest home visits remain the same.

Shared Savings and Losses

Section 1899(d) of the Act establishes the general requirements for payments to participating ACOs. Specifically, section 1899(d)(1)(A) of the Act provides that ACO participants will continue to collect payment "under the original Medicare fee-for-service program under parts A and B in the same manner as they would otherwise be made," and that an ACO is eligible to receive payments for shared Medicare savings provided that the ACO meets both the quality and performance standards established by the Secretary, and demonstrates it has achieved savings against a benchmark of expected average per capita Medicare FFS expenditures. In the two subsections below, AFAM comments on CMS' proposed modifications to the program tracks and the MSSP financial model.

a. Proposals Related to Transition from One-Sided to Two-Sided Risk Models

In the November 2011 final rule establishing the MSSP (76 FR 67909), CMS created two "tracks" from which ACOs could choose to participate: a one-sided risk model (Track 1) and a two-sided risk model (Track 2). Under the one-sided risk model, ACOs may qualify to receive a share in savings, but are not responsible for losses. Under the two-sided risk model, ACOs may qualify to receive a greater share of savings (based on an increased savings rate), but also run the risk of sharing in losses. While CMS reports feeling encouraged by the amount of interest and participation in MSSP, particularly in the one-sided risk model under Track 1, it continues to believe payment models where ACOs bear a degree of financial risk have the potential to induce more meaningful systematic change in providers' and suppliers' behavior. For this reason, CMS is intent on encouraging more ACOs to move toward Track 2 and Track 3 two-sided performance-based risk arrangements.

With regard to CMS' plan to encourage more ACOs to choose two-sided performance-based risk arrangements, AFAM recommends that ACOs where more than 80% of participating physicians are independent primary care physicians (family practitioners, general practitioners, and internists who are not part of a hospital or health system) be allowed to remain in Track 1 and continue to have the maximum sharing rate of 50%. There are two main reasons why we are advocating for this position. First, it has been our experience in working with independent primary care physicians that these doctors are not in a financial position to take on two-sided risk. Second, because MSSP is a voluntary program we believe that the shift toward two-sided performance-based risk arrangements will drive off independent primary care physicians, without whom MSSP will not be as successful. It is our belief that MSSP needs to keep as many independent primary care physicians in the fold as possible because it is these doctors who have the greatest financial incentives to reduce costs.

b. Modifications to Existing Payment Tracks

With regard to CMS' proposals to make changes to existing payment tracks, AFAM recommends that the actual ACO expenditures be based upon dates of service which *end* during the performance year (rather than *begin* during the performance year) to achieve the following objectives:

- More timely settlements by having a reduced run-out period; and

- More accurate and reliable settlement since CMS currently uses a national average completion factor of 1.013 for all ACOs based on a 3 month run-out period. (By calculating based on service end dates, a much lower completion factor would be necessary).

Certified List of ACO Participants and ACO Providers/Suppliers

CMS proposes to add a new §425.118 to reflect with more specificity the requirements for submitting ACO participant and ACO provider/supplier lists and the reporting of changes to those lists. As part of these proposed changes, AFAM offers the following recommendations:

- AFAM believes ACOs should be allowed to make participant list changes until November 30. We believe that CMS needs to develop the infrastructure to provide more real-time feedback on any data issues associated with participant list changes (e.g., legal entity name mismatches).

- Since CMS is considering the inclusion of claims billed by merged/acquired legal entities, AFAM proposes the attribution and benchmarking process reflect the historical billings of all primary care physicians associated with the ACO's participant list based upon their national provider identifiers (NPIs) regardless of which TIN they billed under during the benchmark period. We believe that this scheme would be consistent with the dynamic that occurs with merged and acquired entities. As primary care physicians move from one practice to another, their patient base tends to move with them. It is our opinion that the current attribution and benchmarking process does not account for this dynamic. Lastly, AFAM would propose that this change apply only to primary care physicians and not to nurse practitioners or physician assistants.

Development of a Medicare Waiver Program

Many years ago, CMS and the states developed certain "Waiver" programs under Title IXX Medicaid, in which previously non-covered lower-cost services could be substituted for covered but higher-cost services. This has been long and successfully used, for example, to grant states a waiver of the requirement to provide entitlement-based and high cost nursing facility in-patient services by providing instead a much lower cost package of home and community based services that are otherwise not a part of covered services (Section 1915c Waivers). In most states, home and community based waiver services are only covered if a physician certifies that, if not for their use, the higher cost entitlement services would be necessary.

We believe CMS should follow this well-traveled path and explore using this type of service-substitution approach to lowering costs under Title XIII. The controlled environment of the ACO, can be safely used to foster innovation in this area. For example, certain non-covered personal care and other low-skilled or unskilled services judiciously utilized and reimbursed could be effectively deployed to replace other higher-cost services that are currently being utilized because they are the only covered option.

We appreciate this opportunity to share our comments and continue to look forward to working with you and your staff. We would welcome the opportunity to participate in a stakeholder discussion of these and other policy options to further adjust and improve MSSP as it relates to ACOs. If you have any questions, please do not hesitate to contact us by phone at 502-891-1000, or by email at WilliamYarmuth@almostfamily.com or SteveGuenthner@almostfamily.com.

Sincerely,

William B. Yarmuth
Chairman and C.E.O.
Almost Family, Inc.

C. Steven Guenthner
President
Almost Family, Inc.

CC: Gary Thompson, President and C.E.O of Imperium Health Management.
Gary Albers, Jr., C.O.O. of Imperium Health Management.

Appendix 1.

VIA E-MAIL:
postacutecarereform@mail.house.gov; and
postacutecarereform@finance.senate.gov

August 19, 2013

The Honorable Max Baucus
Chairman
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Dave Camp
Chairman
Ways and Means Committee
1102 Longworth House Office Building
United States House of Representatives
Washington, D.C. 20515

The Honorable Orrin G. Hatch
Ranking Member
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Sander Levin
Ranking Member
Ways and Means Committee
1106 Longworth House Office Building

Dear Chairmen Baucus and Camp and Ranking Members Hatch and Levin:

Almost Family, Inc., the nation's fourth largest provider of Medicare-Certified home health services, is pleased and excited to have the opportunity to engage with the Senate Finance Committee and the House Ways & Means Committee (collectively, the Committees) in dialog regarding the future development of and improvements in the Medicare Program.

Prefacing Comments – The View from Where We Are

As a preface to our responsive comments we would like to acknowledge the tremendous complexity of the issues, the even broader scope of topics past post-acute care, and the competing forces, political, social and financial that have lead the US health care system to evolve to its current state. Having had some meaningful opportunities to meet and work with the health care staff of the Committees, in addition to the staffs of CMS and MedPac, we would like to express our view that these are incredibly bright and talented people working on some incredibly difficult challenges. We do not propose in any way that we are any smarter, better educated, more capable or more informed in our views than these staff members.

What we do hope to add to the process is perspective; our view from where we operate, on what would seem to make sense. We do suggest that as the only provider group that actually goes into the patients' homes to help them deal with their health care needs we (the home health

industry) have a unique perspective and hopefully some useful insights that can help to inform good policy.

We would also point out that like the US health care system and public policy we too are evolving our understanding of how the system works and how the needs of patients can be best managed. We (Almost Family) will share with you our current views with the recognition that our views will evolve, in particular as we interact more with staff members and as we gain more facts as time goes on.

Finally, we seek to keep in the forefront that we are also a part of "We the People". As citizens, we are part of our own government and we embrace our obligation to help evolve good policy that protects and strengthens the promise of Medicare for our patients. We thank you for the opportunity to be heard and to be included as part of the solution.

Four Guiding Principles for Reform

As an integral part of our response we think it is important to first broaden the contextual perspective of the issues facing the Program. As we proceed through this response we will seek to bring our comments and suggestions back to the specific focus of the Committees in your stakeholder letter dated June 19, 2013, however, we believe it is critical to frame the reform thought process in the following four basic principles:

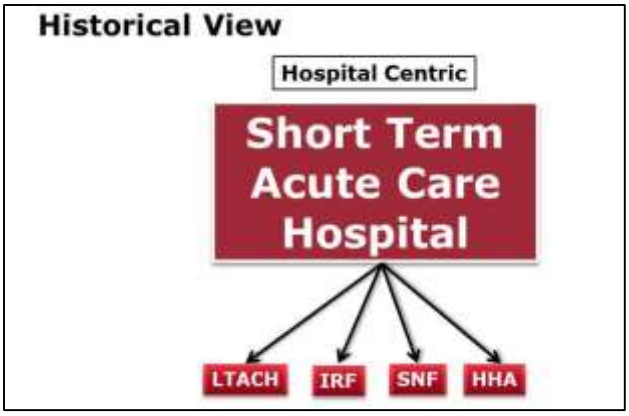
- **Principle #1: Focus on The Bigger Picture.** The need to maintain focus on managing the entire Medicare spend, rather than just fixing silo issues, must to be at the forefront. Initiatives to address the "issue of the day", whether it is the SGR fix, hospice reform, LTACH reform, scores of others, or in this case post-acute care reform can, if not managed carefully, actually replicate the very problems they seek to alleviate.
- **Principle #2: The Need For Trust.** We must address program integrity and the insidious impact caused by a fundamental lack of trust between the program and providers groups. This is most commonly articulated as "Providers all game the system." The lack of trust currently provides, and has for years provided, underlying energy behind a number of different and inconsistent initiatives which have and may continue to drive at least part of the "substantial variation" the Committees find troubling. We at Almost Family concur with the Committee's view that such substantial variation, in the absence of quantification of causes found in underlying patient populations, is in fact troubling. As your staff can attest, we seek to play a leadership role in working with the Program to implement solutions to build a foundation of trust between the Program and Providers so that care venue can be selected in the best interests of the patient and the Program worry-free from "gaming" or abusive practices.
- **Principle #3: Patients Matter More than Providers.** The focus of the program must be on managing the health care needs of patient populations rather than on managing

categories of providers. Accordingly, payment programs should be contemplated in terms of the types of patients we seek to serve and the results we seek to achieve. As we evolve our responsive thesis throughout the course of this document we seek to move the focus in this direction.

- **Principle #4: Payment Accuracy Matters.** The definition of "payment accuracy" as high when "payments align with providers costs" (the old definition) must be converted to high when "payments align with value received by the program" (the new definition). Value received by the program is better evaluated in terms of money saved by the program than in terms of money spent by providers. We must be far more interested in driving better outcomes at lower costs over time, more interested in the value we receive for the payments we make, than we are in framing payment accuracy in terms of alignment with costs. The old definition that future "reimbursement" should follow where and how providers have historically incurred costs presumes that those costs have historically been incurred in the right places. By its very nature this approach hampers progress and reform, by encouraging providers to continue historical practices.

The Shift from Hospital-Centric to Patient Centric

From its very origin, the Medicare Program has been hospital centric. Its very cornerstone, Part A is Hospital Insurance designed first to cover inpatient care. This reflected, we believe, the state of the US healthcare system in 1965, the year of Medicare's foundation. In 1965 half of our older population had no coverage at all and everyone knew, if you get sick the first thing you do is go to the hospital. The legacy of this concept, combined with the sheer gravity of the dollars involved in this highest cost care setting and the political realities of hospitals in local economies, has transcended the decades.



As we suggest elsewhere herein, hospitals are incredibly valuable and important parts of our health care delivery system. They like all sectors must be protected and maintained in a viable state through good policy which mostly means making sure patients are served in the appropriate lowest cost setting.

The economic, social and political realities of 2013 differ somewhat from those of 1965. While our commitment to caring for our senior population is unwavering, we now know that the current system is financially unsustainable. Additionally, we now have many tools and care venues available to us that simply didn't exist in their current form in 1965. Scientific and technological advances, together with new thoughts and ideas, like using risk-based predictive models, home health care interventions, and the sharing of information to support better clinical decision

making are now available to allow us shift from a hospital-centric to a patient-centric perspective. This is the central theme we support through the balance of this document.

Defining (More Importantly Redefining) Issues in "Post-Acute" Care

We believe proper treatment of this topic first bears closer inspection as to its definition and the implications of prevalent historical and contemporaneous discussions on this topic. We respectfully challenge that the following, while commonly discussed and suggested in numerous reports and literature should be carefully reconsidered:

- Health care services delivered up to and through an acute care hospital stay must be reasonable and necessary. By the time a patient has made it to a STACH they really needed it and it couldn't be avoided. Now we need only really concern ourselves with what to do post-discharge from the hospital.
- The health care "continuum" is somehow a sequential journey in which patients first must leave their homes and be admitted to a high-cost in-patient facility before their care needs can actually be legitimized. We believe reimbursement policy, including but not limited to the sequential way in which Medicare was developed, has caused this to occur. We would please to discuss this perspective and its underlying causes in more detail should the Committees or their staffs so desire.
- Home health care is a subset of Post-Acute Care. The reality is that Post-Acute Care is a subset of what home health care does. In fact we propose to the Committees that, while home health care is very effective in meeting post-acute care needs, it can be even more valuable in helping the program avoid not only unnecessary Re-Admissions but in helping to avoid unnecessary Admissions to start with.

Stated in plain English: <u>We believe the discussion must move directionally from "How do we manage the costs of care post-hospital discharge?" toward "How do we keep patients from winding up in the hospital in the first place?"</u>

One way to move this directionally is to refocus attention on the very definitions historically used when discussing post-acute care.

In our Table 1 below we re-present Table 1 included by the Committees in the June 19, 2013 request letter. Using MedPac source data we calculated the Average Spend Per Beneficiary for the categories of providers included by the Committees as "post-acute". Additionally, we added the percentage of each provider group that provides its services essentially inside the hospital setting and the percentage of the patients served in each setting that were sourced directly from discharges from short term acute care hospitals. Finally, to fill out the perspective a bit more we added information regarding the Medicare spend in hospice and the total spend paid to short-term acute care hospitals.

Table 1 -- What is the "Right" definition of "Post-Acute" Care?

		Summary Information (1)			Percent of Admits From STACH
	% Operating Within STACHs	FY 2011 Spend	Beneficiary Users	Avg Spend Per Beneficiary	Discharge (1)
Long-term Acute Care Hospitals	67%	$ 5,400,000,000	123,000	$ 43,902	100.0%
Inpatient Rehab Facilities	80%	$ 6,500,000,000	371,000	$ 17,520	95.0%
Skilled Nursing Facilities	5%	$ 31,300,000,000	1,700,000	$ 18,412	100.0%
Home Health (as shown)	0%	$ 18,400,000,000	3,400,000	$ 5,412	50.0%
		$ 61,600,000,000	5,594,000	$ 11,012	69.3%
Home Health (actual PAC) (2)		9,200,000,000	1,700,000	$ 5,412	100.0%
		$ 52,400,000,000	3,894,000	$ 13,457	99.5%
Hospice		$ 13,800,000,000	1,200,000	$ 11,500	
Short-term Acute Care Hospitals (STACH)		$ 158,000,000,000			

(1) Source: MedPac reports including presentation slides. 100% figures exclude deminimus numbers. In its January 2013 slides MedPac notes that approximately 50% of HH admissions are "community" and that approximately 64% of all episodes are not preceded by an inpatient stay. The difference here results from recertification episodes in HH which by definition are preceded by a previous home health episode.

(2) Based on note 1, actual home health PAC use is calculated as 50% of beneficiaries served and total spend as recertifications are appended to admissions following inpatient stays.

Note: in AFAM's population base 43.5% of admissions were community admissions (not preceded by an inpatient stay). Additional 63.6% of total episodes are not preceded by an inpatient stay, 35% of AFAM's episodes are recert episodes which is roughly equal to the national average.

We respectfully suggest that this revised Table 1 above calls for some redefinition of the phrase "Post-Acute" and some significant reconsideration of the goal of the exercise. We reordered the provider categories from highest cost per beneficiary to lowest cost per beneficiary. This immediately highlights a spectrum of provider groups currently categorized as "Post-Acute" in which both ends of the spectrum – the highest cost setting of LTACH's and the lowest cost setting of home care are not really post-acute in any pure sense. Further examination of the IRF setting raises a similar definitional question.

LTACH's are actually Acute Care. In the case of the LTACH's, the very name of the segment: "Long Term Acute Care Hospitals" articulates Acute versus Post-Acute wherein the only discernible difference in the qualifications for admission or services provided is in the length of stay.

Half of Home Health Care is Not Post-Acute. Using information presented by MedPac staff in their January 2013 meeting slides, we note that approximately one-half of the home health spend is on patients admitted from directly from the community rather than on discharge from inpatient facilities. We recognize that some, including MedPac and the Committees, have at times questioned the appropriateness of community based home health admissions (reference Principle #2 The Need for Trust). However, setting aside program integrity concerns, as stated above we believe home health care can add huge value to the Program when appropriately used to avoid unnecessary inpatient stays rather than having its use validated as "truly

medically necessary" by the fact that it is preceded by an inpatient stay. To do otherwise is to mandate that we must incur the high-cost charge before we can validate the possible use of the low-cost alternative.

IRF's and LTACH's are Mostly in Acute Care Hospitals. As shown above, (according to MedPac in the case of IRF's and CMS in the case of LTACH's) the vast majority of these are actually located within the four walls of acute care hospitals. So in these cases "post-acute" care doesn't involve the patient actually leaving the building but instead really involves moving the patient from one wing of the hospital designated as acute care, to another wing designated as "post-acute".

Respectfully, we suggest that this unnatural categorization or grouping of provider types has evolved from the "old definition" we described above under Principle #4 Payment Accuracy Matters wherein the Program has historically sought more to "reimburse" providers with payments "aligned" with costs rather than sought to "pay" providers for the value they add to patients and the Program.

Patients Matter More than Providers

Now, employing Principle #3 Patients Matter More than Providers, we will turn the discussion to the underlying patient populations at issue here. In this regard we offer the following basic common-sense thesis regarding all patients:

> ***For patients, health care begins, and ends, at home. We must recognize, and build our health care systems around the reality that patients start their health care journey at home. Whenever possible, we should seek to manage patients' care at home and whenever it's not possible our goal must be to return patients to their homes at the earliest, safest, most economical point in their journey. Once returned to their homes we should seek to keep them there and out of high cost institutions.***

In the context of "Post-Acute" care where "Post-Acute" means discharged from an inpatient facility reimbursed as a Short Term Acute Care Hospital (or STACH) we suggest that the following will prove very useful in contemplating the management of patient populations:

Table 2 -- A Suggested Frame-Work for Contemplating Patient Populations Rather than Provider Types in Post Acute Care	
Category 1: Shorter-term, procedurally "fixable" conditions, or those more discreetly identifiable to a particular sentinal incident such as a stroke, heart attack or fall.	Patients where the acute care preceding the "post-acute" care is either incidental to the disease state, or the patient was otherwise in reasonably good condition prior to the inpatient admission. These are predominatly surgical cases with post surgical follow-up care. The easiest example is the otherwise reasonably healthy senior who has a joint replacement. In these categories the acute care procedures largely "fix" the patient's issue and the patient recovers an returns to a normal life.
Category 2: Longer-term, clinically more complex, "non-fixable" conditions that must be managed more comprehensively.	Patients with disease states that will NOT go away following the acute care stay. In many, if not most, of these cases the acute care stay is a part of the disease state progression that could actually have been avoided with the right kind of PRE-ACUTE care. The easiest examples to understand in this category are Congestive Heart Failure, COPD and Diabetes where the acute care stay is a manifestation of a failure to otherwise manage the patient in their own home. The key to managing costs for this patient category is to "stay ahead" of the disease state and to avoid the acute care stay to start with.

In our practice at Almost Family, we see a broad variety of patients that can generally be categorized into the two groups outlined above. As suggested by the data analysis notes in Table 1 and by other analyses in which we are able to compare our metrics and demographics to national averages we believe our patient populations are fairly representative of the population as a whole and contemplation of what we see should prove useful. While arguably somewhat simplistic from a clinical science perspective, we believe this type of contemplation of the needs of the patients, rather than how to reimburse specific providers will inform superior policy formation.

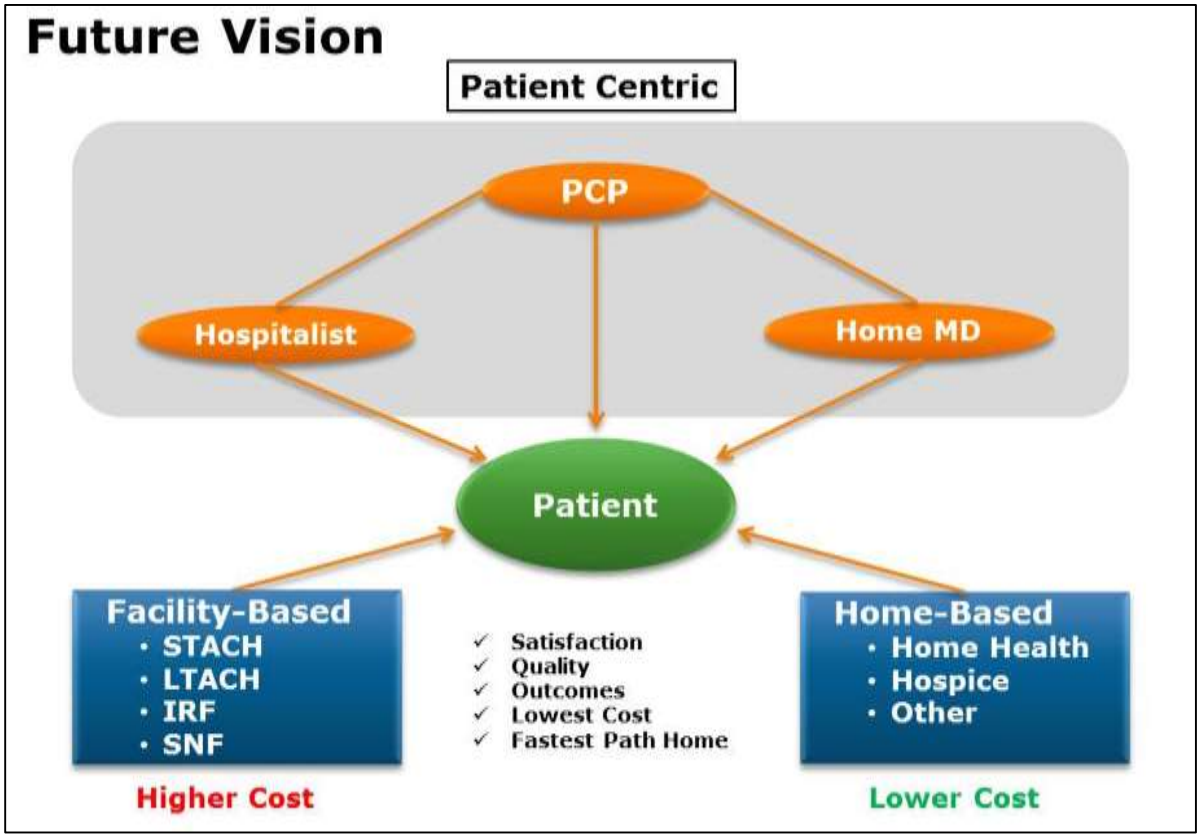
In support of this we refer to chapter 1 of MedPac's March 2013 report, pages 8-11 for a discussion of the driving forces behind the growth in Medicare spending. In particular MedPac's tables 1-1 through 1-5 highlight the need to focus on differences in patient populations. We think it is unlikely that a "one-size fits all" solution will work.

With this type of "patient-centric" perspective we can now begin to reshape our thoughts about the management of these patient populations, whether in a STACH, in some other institutional setting or in their own homes.

Table 3 -- A Suggested Frame-Work for Contemplating In-patient Hospital Stays and Categories of Patient	
Populations	
Category 1:	The initial admission (following 30 days or more with no previous admission): For this category of patients the in-patient stay is either a very positive step in "fixing" or curing a patient's condition or is a truly non-avoidable very appropriate intervention following a sentinal event such as a stroke, heart attack or fall. These admissions are generally a good use of health care resource dollars.
	Readmissions (30 day readmits): Avoiding readmissions for this group generally relies on the quality and success of the inpatient procedures along with a reasonable but not generally lengthy post-discharge rehabilitation period (in most disease states).
Category 2:	In this category of patients, given the chronic, non-curable conditions and the "frequent-flyer" nature of this population, in our view it is not useful or informative to good policy to try to separate admissions from readmissions. Rather, the key here is to focus on reducing hospital admissions of all types, not just readmissions. These patients have acute care inpatient stays when attempts to manage the patients in their own homes have failed to contain the manifestations of the disease state.
	Hospitals, and all Facility-Based provider types, by their very nature can only really affect improvements in patient conditions while the patient is resident in their facility. The key to managing this patient population is through routine interventions WHILE THE PATIENT LIVES IN THEIR OWN HOME.
	This can only really be accomplished through a coordinated effort lead by the patients' primary care physicians and physician extenders including nurse practicioners, physicans assistants and home health agencies acting in concert as patient advocates.

Getting it Right for the Patients – The Primary Care Doctor is Still the Key

Having re-framed the observed issues and challenges from a provider orientation to a patient orientation, we would offer the following specific thoughts on how to begin framing a solution. These are concepts around which Post-Acute Care reform (and health care reform broadly) can be ultimately be based.



While the request was specific to Post-Acute reform the same actions and concepts apply to management of all patients. The view is to manage the patient rather the provider type:

- For the protection of the Program and the beneficiaries, the traditional Medicare program must remain a viable long-term alternative to simply turning America's health care over to the insurance companies.
- Program integrity controls are essential to maintaining the trust relationship that enables utilization of low cost services unfettered by undue concerns over provider compliance. We must implement controls that facilitate a worry-free choice of venue based on what is best for the patient and the Program rather than what is best for a specific provider or category of providers.
- Case or Care management based on evidence based clinical standards must be integrated into the traditional Medicare program as an essential part of utilization management. This is a feature largely lacking in the current system.
- The Primary Care Physician (or PCP) rather than the payor must ultimately be the central control point for utilization management and must be adequately trained, informed, empowered, protected, compensated and incentivized to act as such. To ensure efficient

performance of this work, policies should encourage the use of physician extenders including Physicians Assistants (PA's), Nurse Practitioners (NP's), nurses, therapists, and other allied health professionals whether in the PCP's office or clinic practice, in the patient's home or in both, all under the supervision and control of the PCP.

- Recognize that the home is both the start and the end of the health care journey for patients. At every step treating clinicians must ask and answer: ***"How do I get this patient home as soon as safely possible?"***
- Low cost alternatives should be evaluated and eliminated, or tried and exhausted, FIRST before patients can be admitted to higher cost service settings. At every step, treating clinicians must ask and answer: ***"How do I safely care for this patient at the lowest cost possible?"***
- Two primary tools are available to the Program: 1) mandating certain provider actions including clinician attestations as to medical necessity and appropriateness and 2) establishing financial incentives that encourage desired behaviors. These can and should be embraced in concert to direct patients into the best and most appropriate settings. Success depends on an appropriate blend of these tools; neither can be relied upon exclusively. Examples include:
  - Provider Actions and Attestations:
    - Establishing requirements and payments for PCP's for providing case management services to their Medicare beneficiaries.
    - Requiring all inpatient facilities to timely inform PCP's regarding admission and discharge processes thus enabling PCP participation in clinical decision making. ***Amazingly, this does not happen with consistency in practice today presenting one of the more significant obstacles to care transitions. Many of our referring PCP's commonly state that a primary problem in managing patient admissions, post-acute care and readmissions is that they often don't even know it is occurring until after the fact.***
    - Requiring clinical certification as a part of all admission attestations that in the ordering clinician's judgment the patient cannot be cared for in a lower cost setting.
    - Requiring the use of clinical "indicators" developed from empirical claims and assessment data to assist or guide ordering clinicians towards lower cost care settings.
  - Financial Incentives:
    - Maintaining no or low patient responsible portions (cost sharing) in lower cost settings with directionally higher patient responsible portions in higher cost settings.

- Making bonus payments to PCP's for better risk adjusted outcomes relative to service utilization.
- Enabling PCP's to share in the cost savings for their patient populations through ACO or ACO-like mechanisms.
- When setting payment rates, allowing higher margins in lower cost settings and lower margins in higher cost settings to encourage patient flow to the lower cost settings.
- Establishing higher payment rates or bonus payments to non-PCP providers with demonstrably higher success rates. (For example HHA's or SNF's with lower risk adjusted hospitalization rates should receive more payments than HHA's or SNF's with higher risk adjusted hospitalization rates).

Principles of Payment Accuracy – Redefining from Cost Alignment to Value Produced

Lastly, we turn our attention to our Principle #4 Payment Accuracy Matters. As we stated previously, in addition to changing our focus from provider-based to patient-centric, we must discard the old definition of payment accuracy as "alignment with cost" and replace it with a modernized and more useful definition of "alignment with value added to the Program". In our view, value added falls into two basic categories. Either: a) the patient gets a better outcome at the same or lower cost or b) the Program spends less money to get the same or better outcomes. We offer the following <u>specific</u> ideas to achieve these goals:

- The current focus on RE-Admissions should be broadened to Admissions, especially for certain patient disease states (i.e. chronic high-cost patients suggested in our Category #2 above).
- Concepts such as Bundled Payments and Site-Neutral Payments, while interesting and understandably attractive ways to manage providers, are just two of many tools for getting patients directed to the proper care setting. We believe our approach to more fulsome engagement of PCP's in clinical decision making is far better policy because it moves the focus to the need2s of the patients.
- To attract and retain quality, innovative providers, we must allow for the concept of a *reasonable* margin in rate setting. Additionally, margins should be generally higher in lower cost settings and lower in higher cost settings to encourage provider efficiencies and patient flows directionally towards lower cost settings. While prudent purchasing principles in the public interest should continue to be exercised, excess focus on margin reduction through price cuts can lead, and have lead to very undesirable utilization changes. We contend that addressing the significant gap in utilization management in the current program will produce far greater value.

- Because of the sheer size of the Medicare Program payment parity is critical. Payor "cost-shifting" tactics where one payor seeks to gain pricing advantage at the expense of another payor are not in the interests of the Program or patients.
- We must embrace, much sooner than later, the principles of quality, assessment tools and value based purchasing. We have data to properly measure results and we need to pay for results, both quantitative and qualitative results. Rather than waiting for a perfect system we should get started with what we have and make improvements as we go. We believe providers will immediately respond to these new incentives which will significantly benefit the Program.
- Many State Medicaid programs have made great progress controlling costs and appropriately and safely directing patients to the lowest cost care venues. These present model case study opportunities for potential replication at the Federal level. For example, Ohio has very effectively employed controlled increased utilization of home and community based care services at reasonable rates to produce dramatic savings in institutional settings.

Questions and Answers

We believe we have addressed the most important concepts throughout our text above. However we have a few additional thoughts and cross-references in response to the specific categories of questions in your stakeholder letter:

Category	Responsive Comments
Quality	Quality measures and their linkage to value are key to good policy. Defining quality, however, must be done in the context of the goal of the particular type of patient and the particular type of service being provided.
Assessment tools	We feel the technical details of the specifics are best left to task forces of appropriately qualified professionals and will refrain from comment in this document. Generally, however, we believe strongly that the use of assessment tools is critical to informing physicians' clinical decision making. Uniform assessment data sets are necessary to take advantage of quantitative methods of data analysis for predictive modeling and correlating clinical practices with success.
Value based purchasing	We feel VBP is the second largest gap in the Program, second only to the absence of effective case management. We believe VBP programs should be initiated with great urgency, even if imperfect, so that the process of focusing on VALUE delivered to the Program can begin in earnest. We would be pleased to make very specific proposals on how this could work in home health care.
Reducing hospital readmissions	This is the right idea but off the mark a little. This works fine for our "Category 1" patients where the initial hospitalization is a good thing and a re-hospitalization should be avoided. It misses the mark though in for our "Category 2" patients where we should be seeking to avoid the initial hospitalization even more than the re-hospitalization. For these patients we should set the goal as "Reducing Hospital Admissions".

Bundled payments	Refer to our discussion above for a better approach to patient management through the PCPs. Inasmuch as the "post-acute" provider group is really a disparate group in which three of the four are institutional facility based providers, we are concerned that any "bundles" management by those providers will fill empty beds first and then send patients home when all capacity is full.
Site Neutral Payments	As we understand this issue it is really between types of inpatient facilities and is really more aligned to the "old definition" of aligning payments with costs. We believe our approach to requiring, as a condition of admission, a physician attestation that the patient cannot be cared for in a lower cost setting obviates the need to be overly concerned with this topic.

ACO's Show Great Promise

Finally, while Accountable Care Organizations are still in very early stages of development, we would like to express our current very positive thoughts with regard to the potential for the development of viable long-term success. We believe that integrating our principle-based conceptual framework and the specific recommendations above into the existing ACO frame work could potentially be of great value for the Program and for beneficiaries.

Closing

As we said in our preface, we at Almost Family feel we have a responsibility both as citizens (corporately and individually) and as advocates for the needs of America's seniors to work together with the public sector to evolve good policy that protects and strengthens the promise of Medicare for our patients. We thank you for the opportunity to be heard and to be included as part of the solution. We look forward to working with you in more detail in the evolution of these ideas.

William B. Yarmuth
Chief Executive Officer

C. Steven Guenthner
President