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

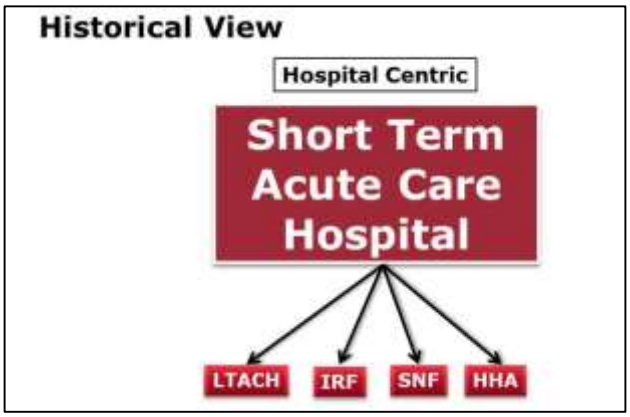
As an integral part of our response we think it is important to first broaden the contextual perspective of the issues facing the Program. As we proceed through this response we will seek to bring our comments and suggestions back to the specific focus of the Committees in your stakeholder letter dated 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-Ad**missions but in helping to avoid unnecessary **Ad**missions 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
	% Operating Within STACHs	FY 2011 Spend	Beneficiary Users	Avg Spend Per Beneficiary	STACH 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.

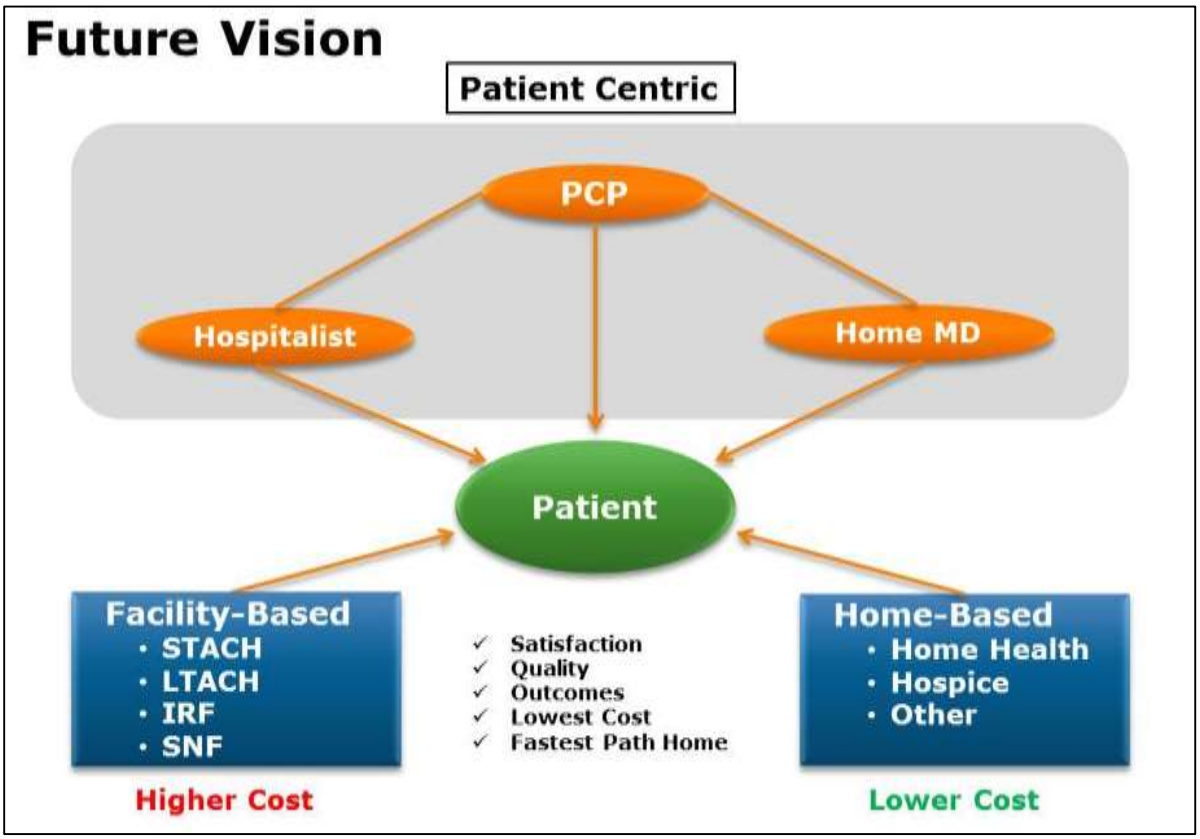
In support of this we refer to chapter 1 of MedPac's March 2013 report, pages 8-11 for a discussion of the driving forces behind the growth in Medicare spending. In particular MedPac's tables 1-1 through 1-5 highlight the need to focus on differences in patient populations. We think it is unlikely that 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-Ad**missions should be broadened to **Ad**missions, 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 needs 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, <u>much sooner than later</u>, 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