September 7, 2016

The Honorable Pat Tiberi
Chairman
Committee on Ways and Means
Subcommittee on Health
1102 Longworth House Office Building
United States House of Representatives
Washington, D.C. 20515

The Honorable Jim McDermott
Ranking Member
Committee on Ways and Means
Subcommittee on Health
1106 Longworth House Office Building
United States House of Representatives
Washington, D.C. 20515

Chairman Tiberi, Ranking Member McDermott and Members of the Subcommittee:

Almost Family, Inc., one of the nation's largest home health providers and one of the largest ACO managers, is honored to provide this testimony in response to the invitation of the Subcommittee to participate in a hearing on "The Evolution of Quality in Medicare Part A", in particular as it relates to post-acute care (PAC). The foundation of our Company is our mission of Senior Advocacy, through which we look beyond the obvious helping seniors manage the aging process, including chronic illness, and to remain in their homes for as long as possible. Our experiences in the provision of skilled in-home nursing care, personal care services, ACO management and health innovation strategies give us a unique perspective on Medicare (the Program), in particular post-acute care, and chronic conditions. Our experiences navigating changes in Medicare for over 35 years also position us well to advise on the evolution of the Program and proposed reforms to be discussed today.

Throughout the course of our testimony we focus on the following five points:

1. ***Medicare reforms should be patient-centric rather than provider-centric.***
2. ***Value-based purchasing (VBP) is the logical next step in managing care, but must be appropriately designed to include the right quality measures and properly-aligned incentives. Quality measures used in any VBP program should prioritize patient-based metrics.***
3. ***Home health patients would benefit greatly from regulatory relief in the form of legislative fixes to Face-2-Face, Pre-Claim Review and the ever-increasing backlog of ALJ appeals. Reducing administrative burdens helps providers focus on the needs of patients.***
4. ***Program integrity initiatives are an essential part of post-acute reform including our proposed Payment Safeguard which would save Medicare up to $600 million annually.***
5. ***We also propose several Medicare reforms to better meet the needs of patients, improve quality and lower cost.***

We Invite You to Read Our Previous Submissions

Much of what we share with you comes from a series of stakeholder comment letters we have provided for the past several years to Ways & Means, Senate Finance and CMS. We refer to these works below and provide links for easy retrieval:

- PAC Reform Stakeholder Letter – August 2013
- Chronic Care Stakeholder Letter – June 2015
- Medicare Shared Savings Program – February 2015
- Home Health VBP and Quality Reporting – September 2015
- Comprehensive Care for Joint Replacement Payment Model – September 2015
- Chronic Care Working Group Policy Options – January 2016

In this testimony we address how this work informs our views on the subject of the hearing.

The Evolution of "Quality" Should Drive Patient-Centric as Opposed to Provider-Centric Reforms

We believe patient-centric concepts must replace provider-centric concepts across the entire Medicare Program. The best definition of quality is one centered on patients, nearly all of whom really want to live in their own homes for as long as possible. When patients suffer an acute event or exacerbation of a chronic illness, they want prompt, effective medical care, in whatever venue is appropriate, and they want to return home to recover, to the extent possible, to their previous level of functionality – and to return to their normal lives. We strongly believe that the "Evolution of Quality in Medicare Part A" should deliver *this* result to America's seniors, and that one of the best ways to achieve this is through a well-designed value-based purchasing program.

Value-Based Purchasing – is the Next Step in Managing Quality and Cost

We have consistently supported value-based purchasing for several years. Quoting from our 2013 PAC stakeholder comment to House and Senate committees of jurisdiction:

> ***"We must embrace, 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. 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."***

We loudly applaud the efforts of the Committee, CMS and others to take full advantage of VBP to continue the movement from volume to value. We have long advocated developing payment policy around what the Program wants providers to do. This marks an important inflection point in the dialogue between the Program and providers. The Program can clearly say "This is what we want you to do" and providers are then charged to do that thing -- to be measured and held accountable through financial incentives, STAR ratings and other means, to perform to objective standards.

We must move from "reimbursing providers for costs" and towards "rewarding providers for creating value". If that creates inconsistent margins across payment silos, so be it. Lower value services *should* have lower margins to discourage their use. Higher value services *should* have higher margins to encourage their use. ***The quest for consistent margins will defeat aligning payments with value.***

Home health is currently subject to a CMS value-based purchasing demo, which impacts about half of our Company's business. I can assure you no reputable provider wants to be viewed as low quality. Across all demo states providers are working to excel at the measures set forth by CMS.

In our view, there are two key aspects of good VBP design:

- **Quality Measures Should be Patient-Based:**
  - There should be fewer and smaller sets of measures more narrowly focused on the Program's desired goals. Specifically, we propose:
    a. Hospitalization;
    b. Emergency Room use without hospitalization;
    c. Restoring previous levels of functionality (primarily activities of daily living)
    d. All balanced against the costs incurred to achieve the goals.
  - We caution against using too many individual measures – this dilutes focus. With too many measures no one measure carries very much weight.
- **Financial Risk and Incentives for Providers Should be Properly Sized:**
  - We are big fans of providers bearing responsibility for delivery, the results and the cost of care. But, what is the right amount of financial risk?
  - Too little might be ignored by providers, too much could cause unanticipated behaviors and undesirable disruptions to good patient care.
  - In the early phase of this program we favor exposure in the 2%-5% range as being enough to get providers' attention without overdoing it.
  - We would not be in favor of more than 5% at risk.

We are a long-time supporter of the IMPACT Act as we wrote in two letters of support to Ways & Means and Senate Finance in 2014 and 2015. In particular, we support the goals of developing a consistent set of measures that enable meaningful comparison across provider "silos". However, we continue to have *serious* concerns about the unnatural grouping of dissimilar providers being categorized as "post-acute". We discuss this problem more below.

We strongly agree with the view that the set of measures used by CMS in its VBP programs should be reconciled with those of the IMPACT Act as soon as possible.

Legislation Should Fix Home Health Face-to-Face, Pre-Claim Review and the ALJ Backlog

The home health face-to-face physician requirement was not well implemented. Although now-reversed, the ill-advised subjective narrative requirement has created the *appearance* of sky-rocketing error rates in the Medicare Comprehensive Error Rate Testing process. CMS's own regulatory roll-back has addressed some of this, however, we are left with the legacy of an over-reported error rate in home health. While well-intended, CMS now seeks to address those flaws with an under-developed and potentially also flawed pre-claim review process. We expect this to cost the taxpayers over $300 million and create significant administrative burden, not to actually reduce improper payments, but rather to fix documentation issues created by the face-to-face regulations.[1]

Meanwhile the Administrative Law Judge dockets are still jammed with tens of thousands of appealed face-to-face denial cases that will almost certainly be overturned in favor of beneficiaries.

We strongly support any efforts of this Committee to resolve this unfortunate situation through legislatively driven corrections to the over-reported error rate and through a global appeal settlement as was done with the hospital appeal backlog some years ago.

[1] Centers for Medicare & Medicaid Services (CMS), "Supporting Statement Part A: Pre-Claim Review Demonstration for Home Health Services." CMS-10599/0938. July 1, 2016, page 6. Retrieved from: https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-10599.html.

Our Payment Safeguard Provides Meaningful Savings

We have a specific proposal to drive measurable savings through implementation of a home health payment safeguard. The home health outlier limit, proposed by the home health industry and implemented by CMS in 2010, clearly worked. It has saved Medicare approximately $1 billion per year. We have been persistent advocates of a similar reform in previous stakeholder comment letters to Congress and CMS. We estimate this reform, patterned after the outlier limit, will save another $600M per year. Since we have been advocating this second, equally practical payment safeguard, over $4.5B has gone out of the Federal treasury unnecessarily.

We urge the committee to consider our proposal on its merits for possible inclusion in any legislation.

We Must Move Toward Patient-Centric Payment Policies

We believe reform among post-acute sectors must shift from provider-centric to patient-centric policies. From its origin, the Medicare Program has been hospital-centric. Medicare's cornerstone, Part A, was hospital insurance designed first to cover inpatient care. This was a reflection of the state of the US healthcare system in 1965, the year of Medicare's foundation. In that year, fully one-half of our older population had no coverage at all. Everyone knew, if you got sick the first thing you did was go to the hospital. The legacy of this concept, combined with the economic gravity of the dollars involved in this highest-cost care setting has transcended the decades.

Hospitals, including LTACHs and IRFs, are valuable and important parts of our health care delivery system. Like all sectors, they must be maintained in a viable state through good policy and appropriate reimbursement, which means serving patients in the most appropriate and lowest-cost setting.

In fact hospitals, home health and other provider types must partner together to produce the high-quality, low-cost care-coordination and care-transitions patients truly deserve.

While our commitment to caring for our seniors is unwavering, we know the current system is financially unsustainable. Additionally, we have many tools and care venues available to us that simply didn't exist in 1965. Scientific and technological advances, together with new ideas, like using risk-based predictive models, home health care interventions, and the sharing of information to support better clinical decisions are now available to allow us to shift from a hospital-centric to a patient-centric perspective. This is the central theme we support through the balance of this document.

One Payment System for all "PAC" Providers -- As Defined -- Is Not a Good Idea

The unnatural grouping of dissimilar provider types included in most PAC discussions has evolved from historical rate-setting silos and practices designed to "reimburse providers for the costs they incur" rather than "reward providers for the value they add". Attempts to bundle payments within this unnatural group of dissimilar providers may be unlikely to achieve the desired result and other options should be contemplated.

Under a different definition more appropriately aligning actual PAC providers -- SNFs, Home Health and Hospice -- a single PAC payment system may be appropriate.

We Should Challenge the Definition of "Post-Acute" Care

We respectfully suggest that the following, while commonly used in numerous PAC reports and literature, should be challenged:

- Challenge Point: Health care services delivered up to and through an acute care hospital stay are essentially deemed reasonable and necessary. By the time a patient is admitted to a hospital 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.
- Challenge Point: 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. This is even rooted in the Medicare statute -- a "spell of illness" begins on the day of admission to a hospital (SSA Sec 1861(a)).
- Challenge Point: Home health care is a subset of post-acute care. <u>In reality post-acute care is a subset of home health.</u> We propose 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.

<u>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>

This calls for redefinition of the phrase "post-acute" and reconsideration of the goals of payment policy.

<u>LTACHs are Hospitals, Not "Post-Acute".</u> The very name of the segment, "Long Term *Acute Care* Hospitals", articulates acute versus post-acute. The only discernible difference from short term acute care hospitals is in the required average length of stay.

<u>Half of Home Health Care is Pre-Acute.</u> CMS data indicates that one-half or more of the home health spend is on patients admitted directly from the community rather than on discharge from inpatient facilities. We recognize that some have questioned the appropriateness of community based home health admissions. However, when appropriately used, we know home health care adds significant value to the Program <u>to avoid unnecessary inpatient stays.</u> In contrast, having its use validated as "truly medically necessary" by the fact that it is preceded by a high-cost inpatient stay would mandate incurring the high-cost charge to validate the use of the low-cost alternative.

<u>IRFs are Mostly in Acute Care Hospitals.</u> According to MedPAC and CMS the vast majority of IRFs (and LTACHs) are actually located within the walls of acute care hospitals. So in these cases, so-called "post-acute" care just moves the patient from one part of the hospital designated as acute care, to another part of the hospital designated as "post-acute". The distinction is meaningless to the patient who has not even left the building, to them, they are still in the hospital.

<u>Hospice is Post-Acute.</u> We object to the routine absence of hospice from the discussion of PAC. Hospice should be a critical part of this discussion. Many a patient has been "sent home with hospice" after acute care solutions have been exhausted. Nothing could be more "post-acute" from the patient's perspective and yet it is absent from nearly every PAC discussion. Notably, 96% of all hospice days of care are provided in patients' homes.

Patients Matter More than Providers – Which Should Guide Medicare Reform

We offer the following common-sense thesis regarding all patients:

> ***<u>For patients, health care begins, and ends, at home.</u> 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 that'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 discharge from an inpatient facility reimbursed as a short term acute care hospital, we suggest that the following framework prove very useful in contemplating the management of patient populations. The following graphic portrays steps towards a unified system of assessment and management of chronic illness.

A Suggested Framework to Move Toward Patient-Centric Reforms	
Category 1:	
Shorter term, procedurally "fixable conditions, or those more discreetly identifiable to a particular sentinel 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 predominantly surgical cases with post-surgical follow-up care. The easiest example to understand 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 and 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. ***<u>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.</u>***

In our practice at Almost Family, we see a broad variety of patients but they can generally be categorized into the two groups outlined above. We believe our patient populations are fairly representative of the population as a whole. Thus, contemplation of what we see should prove useful. While this is arguably clinically simplistic, we believe considering the needs of the patients, more than how to "reimburse provider categories for their costs", will drive superior policy.

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

Avoid the Acute Care Stay and Avoid Post-Acute Care Costs – Through Chronic Care Management

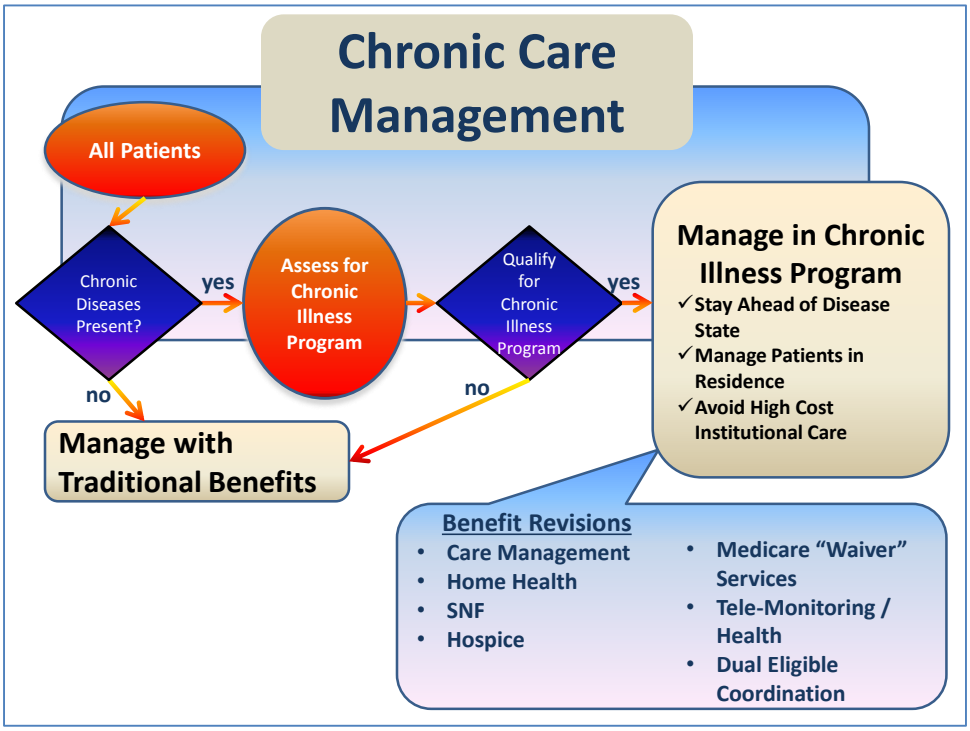
There are two fundamental gaps in Traditional Medicare that must be addressed:

- Medicare was designed primarily to be a short-term benefit, but the chronic conditions that drive much of Medicare's costs are in fact *long-term* conditions that must be managed.
- The absence of objective assessment and care management processes in Traditional Medicare to manage these chronic conditions leaves the Program with the obligation to pay claims, but minimal opportunity to manage costs other than by managing provider categories and cutting rates.

Treatment of chronic illnesses such as heart disease, diabetes, and cancer- just to name a few - now accounts for almost 93 percent of Medicare spending. Beneficiaries with six or more chronic conditions accounted for 46 percent of all Medicare spending in a recent year. Finally, Traditional Medicare spends an average of over $32,000 per beneficiary with six or more chronic conditions compared to an average of less than $10,000 for all other beneficiaries.

We simply cannot solve the post-acute care problem without addressing management of chronic conditions.

In our June 2015 Chronic Care white paper we proposed establishment of a new benefit within Traditional Medicare specifically for the management of chronically ill patients, depicted in the following graphic:



Our view is to manage the patient rather the provider type with the following *package* of services:

1. **Primary care is central.** The Primary Care Physician (or PCP) rather than the payer must be the central control point for utilization management and must be adequately trained, informed, empowered, protected, compensated and incentivized to act as such. Policies should encourage the efficient use of physician extenders whether in the PCP's office, in the patient's home or in both, under the supervision and control of the PCP.
2. **Care management must be integrated.** Care management, using evidence-based clinical standards, must be integrated into Traditional Medicare as an essential part of utilization management. This is a feature largely lacking in the current system. In our 2015 Chronic Care white paper we made specific proposals for

implementation into the traditional program in a section labeled "Chronic Care Management – A Model for Consideration". We encourage the Committee to consider this proposal as it pursues its work.

3. **Home first and always.** Recognize that the home is both the start and the end of the health care experience for patients. At every step, treating clinicians must ask and answer: ***"How do I get this patient home as soon as safely possible?"***
4. **Low cost before high cost.** 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?"***
5. **Attestations and incentives should be used in concert.** 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 must be embraced in concert to guide patients to the most appropriate care settings. Examples include:
   a. **Provider actions and attestations:**
      i. Establishing requirements and payments for PCPs and others to provide care management services.
      ii. Requiring all inpatient facilities to timely inform PCPs regarding admission and discharge processes enabling PCPs to participate in clinical decisions. ***Amazingly, this does not happen with consistency in practice today presenting one of the more significant obstacles to care transitions. Our ACO physicians commonly state that a primary problem in managing patient admissions, post-acute care and readmissions is that they often do not even know it is occurring until after the fact.***
      iii. 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.
      iv. Requiring the use of clinical "indicators" developed from empirical claims and assessment data to assist or guide ordering clinicians towards lower cost care settings.
   b. **Financial incentives:**
      i. Maintaining no or low patient-responsible portions (cost sharing) in higher value settings with directionally higher patient-responsible portions in lower value settings.
      ii. Making bonus payments to PCPs for better risk adjusted outcomes relative to service utilization.
      iii. Enabling PCPs to share in the cost savings for their patient populations through ACO or ACO-like mechanisms.
      iv. Establishing higher payment rates or bonus payments to all providers with demonstrably higher success rates. In other words "value-based purchasing".
6. **Use Non-Covered Services.** Formal establishment of a Medicare "Waiver" program in which CMS approves the provision of otherwise non-covered services to patients with high case-management risk scores and specific chronic disease states where those services can be shown to reduce the overall costs of care and increase patients' ability to remain in their homes. This would help avoid the current reality in which physicians and providers *must* choose from list of Medicare covered services those which are the closest fit, even though much lower cost non-covered services could do.
7. **Renovate Home Health Benefit.** Renovate the Medicare home health benefit currently at section 1861m of the SSA to include:
   a. Bifurcation of the benefit based on patient types, disease states and assessed risk scores. Patients with selected chronic disease states and risk scores would be eligible to receive a bundle of home health services paid on daily rate that varies with acuity. This would work like the hospice benefit, but better because payment rates would be based on disease states and the assessed risk scores. This approach could also be applied to the hospice benefit.

b. Modify regulations to provide more flexibility regarding home-bound status and skill requirements again based on disease states and risk scores.

8. **Renovate Skilled Nursing Facility Benefit.** In like fashion to home health, removing arbitrary barriers such as the 3-day rule in cases where disease states, care management assessments and provider attestations indicate temporary exacerbations can be more efficiently managed through initial admission into the SNF setting rather than the current requirement to first route the patient through a high-cost acute care stay.
9. **Coordinate Dual-Eligible Benefits.** Coordinate Medicaid Benefits for Dually Eligible patients by transfer of Medicaid funds into the Medicare benefit for chronically ill patients much like the SLMB and QMB programs currently function. Require dually-eligible patients to use the same care management provider for Medicaid services that the patient selects for Medicare services in our chronic care proposal. Medicaid programs would be required to make all claims data available to the Medicare program to facilitate coordination. This would allow the care management provider to assist the patient in the coordination of benefits.

ACOs Provide Valuable Lessons and Opportunities

Accountable care organizations are demonstrating that home health and hospice services lower total Medicare spending. ACOs also provide a vehicle to address the objections of some policymakers to our policy proposals outlined above.

While ACOs are still in the early stages of development, we remain very positive with regard to their potential for long-term success. We believe integrating our patient-centric conceptual approach into the existing ACO framework would be of great value for Medicare, for beneficiaries and for taxpayers. Through our Imperium subsidiary, which currently manages 15 ACOs with over 125,000 lives, we now know increased used of home health and hospice services has a high correlation with a decrease in *both* total PAC spending and total Medicare spending. We encourage the Committee to consider this information as it continues its work.

Thank You for the Opportunity to be Heard

We at Almost Family embrace our responsibility as corporate and individual citizens to advocate for the needs of America's seniors and to work with you to evolve good policies and legislation that protect and strengthen the promise of Medicare for America's seniors and for future generations. 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.

On Behalf of Almost Family, Inc.,

C. Steven Guenthner

President