



**American
Academy of
Home Care
Physicians**



September 6, 2013

Marilyn B. Tavenner
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: File Code CMS -1600-P. Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for CY 2014.

Dear Administrator Tavenner:

The American Academy of Home Care Physicians (Academy) appreciates the opportunity to provide our comments regarding the Centers for Medicare and Medicaid Services' (CMS) proposed **Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for CY 2014.**

The Academy represents those physicians and non-physician providers who are caring for some of Medicare's sickest and most costly beneficiaries—those with multiple chronic conditions who are home-limited due to illness and disability. The majority of our comments relate to the provisions to cover and pay for Complex Chronic Care Management Services (CCCMS) effective 2015. Our detailed comments and recommendations follow.

1) Complex Chronic Care Management Services (CCCMS)

The AAHCP commends CMS for its decision to begin to pay for complex patient care coordination as a non-face to face service. With providers caring for some of the most complexly-ill Medicare patients, we know well the range of needs that must be met if these patients are to be given the "triple-aim" goals of improved care that meets their needs with lower costs.

a. Background

Home-based primary care (HBPC) practices across the country focus on the sickest, frailest, and most costly of the chronic disease patient population you seek to target. Representing a small percentage of primary care practices, providers delivering primary care to patients in their homes or in domiciliary care facilities must be attuned to the social, environmental, financial and

ethical issues that surround the multiple medical concerns and as such, are “poster-child” practices for CCCM services. Although these practices often have or could acquire both the size and infrastructure to deliver the needed complex care coordination services, only a tiny fraction could afford or are even appropriate for PCMH designation. Thus, if CMS wants to have an impact with this code use, it needs to provide appropriate infrastructure specifications, clinical standards, and an alternative accreditation path to make that possible.

Second, it is important for CMS to recognize the importance of these codes as drivers toward a value-driven payment system, and take advantage of the chance to learn how best to connect the clinical delivery and payment systems to assure accountability and improved outcomes. However, CCCM codes as currently proposed are fundamentally “process” codes, but in order to have their full impact, need to become “outcome” codes. This creates two challenges:

- There is a practice management challenge in adding a charge capture process to include time-accrual from all clinical staff to meet the CCCM criteria. HBPC practices have had the most experience with Care Plan Oversight, a forerunner for time-based codes in primary care, and we have found that this is an entirely different approach on which to generate and document service on which to bill. As such, it will require direction for the intermediaries and significant administrative restructuring and expense for the practices.
- There is also a policy challenge in how to use these codes as a lever to tip the balance towards value-based services. In our view, this should be done by developing the criteria for scaling these payments according to the characteristics of the practices’ patient populations, to their clinical and cost outcomes, and to meeting certain quality metrics. Since HBPC patients are among the frailest and therefore the most likely to use ED, hospital or SNF services if care in the community falters, HBPC practices can provide the most data on health care delivery changes that will best meet the triple aim. For example, the home-based primary care equivalent of Open Access Scheduling and Extended Hours availability as fostered in the PCMH would be urgent house calls.

However, unlike the PCMH (practice), which only needs to extend its schedule and leave the “doors” open, for HBPC practices this would entail an expansion of our point-of-service diagnostic, therapeutic and monitoring technologies, more appropriate to the management of unstable patients with multiple chronic conditions. The costs are higher and the payment scale would need to reflect that reality, and yet the benefits could be measured in a reduction of avoidable or inappropriate use of more expensive institutional resources, as well as the substitution of less expensive home-based services, laying a foundation for transferring Part A payments to offset increased Part B costs, yet with an overall savings to Medicare. The Academy could also give CMS the guidance it needs to create a payment structure that takes into account the added technological and personnel costs, and stimulate policy changes to expanded range options, such as intravenous therapies in the home and waiver of the 3-day stay for access to institutional skilled care, that would be fully appropriate in this context. Finally, payment for these enhanced services could be adjusted according to the Physician Compare program scores to add further incentives for assuring patient and caregiver satisfaction.

We offer our full support to help CMS reach the enormous potential of these codes to be a transitional platform to a value-driven payment system, if a significant number of HBPC practices are given an affordable accreditation pathway to allow them to render and document service, submit claims, and to be paid for these codes.

Now on to comments on the specific proposals made in the 2014 Payment Rule for CCCMS.

b. Setting Standards

CMS labels this section “complex chronic care *management services*” rather than complex care *coordination*. This change in terminology gives us the impression that CMS would prefer to only pay those operating practices or programs that provide a comprehensive array of care management services to meet the needs of complex patients. That is not what was included in the RUC survey, but we understand what may be CMS’ desire to gravitate to **program or practice** approval. However, we think that CMS should begin the process with a **patient** focus that will permit many providers in many models of care to participate, as long as they also meet CMS specifications through a mechanism that is more straightforward and less costly than for PCMH.

The primary reason is that patient definition is the key for determining how much care management is required, and at what expense. “Two or more chronic conditions” includes many patients who are not very ill and do not require much care management, let alone care coordination. In contrast, the patients of HBPC providers typically have many more concurrent chronic conditions that have had a significant impact on mobility, and they nearly always need ADL and IADL assistance. Most also have a prior history of institutional resource utilization that make obvious how sick and frail they are, and how much in need of complex care management services if they are to avoid ERs and inpatient hospital stays. If CMS wants to restrict the utilization of the complex care coordination codes, it would be far easier to do so by further defining complex chronic disease with disability and prior utilization patterns, than to do so by restricting the types of practices taking care of these patients.

Secondly, there is no detailed evidence as yet to support a “best practice model” by category of patient. For example, while the Medical Home may be a good model for many ambulatory patients, even Level 3 Medical Homes are not required to develop the capacity to provide care to home-limited patients.

The knowledge base for managing complex patient is rapidly evolving and includes not just the primary care demonstrations outlined in the proposed rule, but also **Independence at Home (IAH)** and **ACOs**, both of which are providing a test of models which save money, in addition to improving quality of care. IAH is based on the very successful nation-wide Veterans Administration program that has saved the VA 24%. We believe IAH, with its targeting of very sick, home-limited patients, rigorous program standards, and shared savings incentives may in fact be a better model than the current Medical Home. The results should be known starting this fall from ACOs and from the IAH Demonstration by spring, 2014.

Another concern is that the capacity to provide CCCM services costs practices time and money, and the accrual of time-based services requires a restructuring of the practice flow of information. Therefore the payments need to warrant the effort to transform the way health care is delivered and to make high-risk for high-cost patients attractive for primary care and specialty

practices, if CMS wants to promote practice capacity for present and future beneficiary needs. If the patient classification is carefully done and combined with a reasonable reimbursement, practices will increase their volume of complex patients and expand their services sufficiently to grow in their capacities over time.

Finally, we encourage that CMS practice standards be general to allow many kinds of practices to evolve, rather than to be overly prescriptive. This is especially for practice elements that are of high cost, yet of unproven outcome-related value. Accordingly, we oppose some of the standards offered as potential future requirements. For example:

- While electronic medical records may facilitate documentation, they are being replaced by “cloud-based” data repositories for beneficiary medical records and social media is being used for communication solutions and care management interventions as a more cost-effective strategy. Therefore, access to data is more important than a legacy EHR system that is far more likely to pose interoperability challenges.
- 24/7 availability through the practice with EHR access could be challenging and expensive and may need to be reconsidered, especially for solo or small practices in rural areas.
- APRN/PA: The requirement to hire clinical professionals such as NPs or PAs could obviate CCCM services for most solo, small and rural practices, both because of the costs and lack of availability. On the other hand, we believe NPs should be allowed to render and submit claims for care coordination, just as they do transitional care management services. Therefore, if solo or NP groups in independent practice states are not required to hire a physician, physicians should not be required to hire an NP or PA. However, we strongly endorse formal and informal agreements, when practicable, to encourage team-based care. We believe CMS must develop guidelines for these relationships and specify circumstances when such relationships can be waived.
- Annual Wellness Visit: While we believe at least an annual face to face visit is required (if not more often) to cement the partnership between the provider and complex patients, wellness planning or an initial preventive physical examination may not be appropriate, especially for those who are nearly at the end of life. We recommend that any face-to-face encounter be acceptable, so long as the beneficiary is informed of the potential for CCCM services and the associated billings.

c. Practice Recognition/Accreditation

Our view is that if CMS decides to make PCMH-accredited practices eligible for CCCMS payments, then it must also provide paths of recognition and accreditation for CCCM payments for other proven primary care models for managing the care of multi-morbid chronic care Medicare beneficiaries. This should include IAH and home-based primary care practices that, across the country, are caring for these patients and currently rendering CCCM services.

As the alternative pathway, CMS should use its good set of accreditation standards as outlined in the 2013 Payment Rule for the Advanced Primary Care Practice (APCP) as the foundation for practice eligibility, especially since there will be no other “advanced payment model”

demonstrations. The standards included 1) risk-stratified care management; 2) access and continuity; 3) planned care for chronic conditions and preventive care; 4) patient and caregiver engagement; and 5) coordination of care across the medical neighborhood. This can be accomplished through a “bottoms-up” approach like that of several programs that have served various fields well in their early stages, including CLIA and the CARF programs. It should also learn from its current experience with Registry development in the QA area. The keys for the beginning stage:

- Reliance on attestation in meeting all five standards,
- Followed by development of an inexpensive, timely peer-reviewed process that verifies implementation of the applicable standards.

To accomplish the above objective, and as it has recently done in the proposed rule for Registries, CMS should develop standards for approval of collaborations, and organizations (including professional associations) that seek to offer practice assistance, verification programs and accreditation for those providers who wish to render and to be paid for CCCMS. Accordingly, the requirement for review and accreditation should not begin until 2017 to allow professional associations to obtain funding such as grants for and to establish the programs, and for these programs to be coordinated with the value-based payment modifier program.

Initially, coverage and payment could be based on practice claim submission and attestation that the services are rendered as described by the code descriptors and that the 2013 Payment Rule standards for the APCP are in place. This would be verifiable by medical record audit and also by CMS practice evaluation in any instances of question. This stepped approach will enable practices, particularly those providing care to the most complex and costliest beneficiaries to develop the more extensive infrastructure, staffing and systems that CMS envisions.

d. 90-Day Requirement

We understand CMS’s desire to streamline administration of the CCCM codes. However, in our experience, the condition of these very sick and unstable patients changes rapidly. Many patients die within a 90-day period. We therefore strongly suggest that instead of 90 days, a 30-day service and claim period similar to that used with other codes such as CPO and TCM be employed. We also suggest that CMS specify that providers who incurred extensive CCCM service times in the last month of life be allowed to submit claims and to be paid for CCCMS even if their patient dies before the last day of the month, as long as the criteria for claim submission have been met.

e. CPT versus G-Codes

We much prefer the beneficiary descriptors, guidelines and a simplified non-face-to-face CPT code structure developed through the RUC that includes only a base code with add-on coding (irrespective of a face-to-face encounter during the month) that is currently in CPT, rather than the proposed G codes promulgated by CMS, for CCCM services. We intend to work with our fellow organizations to recommend changes to the existing CPT guidelines to address some of the issues raised by CMS in its proposed rule so that CPT can make any revisions within the 2015 cycle.

Now to continue to other parts of the 2014 Proposed Payment Rule:

2) Conversion Factor for 2014

We are pleased in general that the Proposed Rule reflects that primary care providers such as those that are included in Academy membership would experience an increase in Medicare payment absent the effect of the Sustainable Growth Rate (SGR) formula. We believe that improvement in primary care payment will contribute to the Medicare triple aim. However, we are concerned as discussed below, that reduction in practice expense RVUs will reduce the Medicare Allowed payment for the range of housecall codes by approximately 2% per code. This is discouraging for the existing workforce that provides primary care services for the sickest, most complex, isolated and costliest of Medicare beneficiaries.

At the same time, the Academy along with other medical and professional associations supports legislative action to provide a permanent fix of the effects of the SGR formula. We also hope the SGR will not be replaced by a system that includes reporting requirements that are not appropriate to the patient population of the Medicare Part B provider. In other words, any reporting requirement that is part of a professional fee schedule update factor must reflect the clinical status of the beneficiary and the professional medical services of the Part B provider that are applied to treat and manage the care of the beneficiary. This is particularly the case for the multimorbid home limited beneficiary population that Academy members see and treat.

This population is the most expensive cohort of Medicare beneficiaries from a program cost perspective. Appropriate reporting requirements and measures need to be developed and Part B providers not be penalized for not reporting on measures that are not relevant to the treatment of these beneficiaries. A number of the physician-researchers in the Academy are involved in the developmental work and we want to express our interest in providing this expertise to CMS and your contractors working on issues of the multimorbid patient.

3) Medicare Economic Index

We support the use of the most recent and relevant cost information in determining cost inflation in the Medicare Economic Index. We also support your use of data from the Medical Group Management Association's Cost Survey, the Bureau of the Census Services Annual Survey (SAS), and surveys you would develop with national, specialty, and professional associations. The Academy and these other organizations can assist CMS and we each have a close understanding of the organization and cost of practice of our members.

4) Geographic Practice Cost Indices (GPCIs)

We support the use of the most up to date practice expense data available to support GPCI updates as CMS discusses in the proposed rule. And while outside of the authority of CMS we support the continuation of the GPCI floors for the frontier states.

5) Practice Expense Relative Value Methodology

CMS, in 2010, completed a transition to a “bottom-up” practice expense (PE) RVU methodology, whereby actual direct practice expense costs for clinical labor, supplies, and equipment are artificially decreased to obtain the direct PE RVUs for each service. Actual labor, supply, and equipment costs are multiplied by a direct budget neutrality adjustment resulting in adjusted labor, adjusted supplies, and adjusted equipment costs; then converted into RVUs by dividing them by the current conversion factor. CMS considers this consistent with the overall Physician Fee Schedule budget neutrality requirements, and calls this direct adjustment in their methodology a “scaling” factor. We are concerned that this undervalues the actual PE direct costs to provide a service.

We are also concerned since this has produced inconsistency and unpredictability leading to a decrease in practice expense RVUs for the range of housecall codes (CPTs 99324-99350) for 2014. This reduction in practice expense RVUs will reduce the Medicare Allowed payment for these codes by approximately 2% per code. This is a material reduction in payment for primary care providers. This is discouraging for the existing workforce that provides primary care services for the sickest, most complex, isolated and costliest of Medicare beneficiaries.

The existing and growing home limited beneficiary demand as we know is unmet and such reduction in payment (also again, assuming no SGR related reduction), does not encourage the development of the workforce necessary to care for this co-hort of Medicare beneficiaries. Moreover, the reduction undermines interest of those considering entering or transitioning from another focus or site of practice to home based primary care. This compounds “practice expense” concerns when one considers that travel expense inherently required to go from beneficiary patient to beneficiary patient residence is not included as a practice expense is subject to forces outside the control of the housecall provider.

Moreover, this reduction in practice expense RVUs and payment also impacts the transition care management codes and home health services related codes (99495/6 and G0179-G0182). Such reduction in payment has to be viewed in context with the proposed reduction in payment for home health services (2014 and on), and will undermine efforts and policy to reduce admissions/readmissions and to encourage care in the least costly setting. Accordingly, we call upon CMS to revise its methodology to accurately reflect the actual PE direct costs to provide each service.

6) Medicare Telehealth Services for the Physician Fee Schedule

We support the CMS proposal to cover CPTs 99495 and 99496 when rendered by telehealth. These services were developed to enhance care coordination and to reduce the likelihood of hospital readmissions. Academy members supported the development of the TCMS for 2013. CMS coverage of the TCMS rendered via telehealth will support the broader triple aims goals for beneficiaries who most need the benefits and these beneficiaries are often the isolated high cost beneficiaries who lack the mobility to be seen in an office. We know from results with similar populations and hoped to be shown with the Independence at Home Demonstration that proactive interventions with these beneficiaries such as required in the TCM service descriptors supports the triple aim goals of better care, higher patient and caregiver satisfaction and reduced cost.

This raises questions that we request that CMS address in the Final Payment Rule. Your discussion is that the components of the face to face encounter would be covered services when rendered for other telehealth covered services and thus justifies coverage of the TCM. Thus, our understanding will be that these services rendered by telehealth along with the other required descriptor services will then provide that one can submit a TCM claim.

Since members of the Academy render services in the private residence of beneficiaries (home and assisted living facility), and the beneficiaries are seen in these locations in lieu of the office setting due to home limiting conditions, then the TCM with components supported by telehealth and for beneficiaries with home and ALF sites of service the TCM will be covered and paid even though the home is not an originating site of service. Please confirm this understanding.

Is it also the case then that for other services provided in whole or part via telehealth that claims would be paid for these other services for claims with the home and assisted living facility sites of service? Again, thank you for confirming this understanding.

We also support your decision regarding originating sites to expand the definition of HPSAs to include those located in rural census tracts within Metropolitan Statistical Areas (MSAs) as determined by Office of Rural Health Policy. Our experience is that too often beneficiaries are isolated and have limited access to care even within a MSA. This proposal will enhance the opportunity for these beneficiaries to receive care.

7) Requirements for Billing “Incident to” Services

We support the CMS proposal so that the application of “incident to” policy and coverage is consistent across the states. We agree that consistency in policy can be obtained and the health and safety of residents protected on a state level. We also believe that is how states and providers should have been delivering medical services and operating all along.

However, we want to point out that practice staff may have the training and technical abilities to safely carry out the orders of a physician or non-physician provider under general supervision and yet this type of staff may not fall under state regulation.

The additional language that CMS proposes does not require that individuals be subject to state regulation, only that the individual performing “incident to” services “meets any applicable requirements to provide the services, including licensure, imposed by the state in which the services are being furnished.” This aspect that individuals may not have state regulation that attaches to them directly and yet may be providing services or components of covered services under the general supervision of a physician or non physician provider has application to the proposed Complex Chronic Care Management Services (CCCMS) in that we believe CMS should recognize that practice personnel can contribute to the service requirements of the CCCMS and to the triple aim. Our view is that the time and efforts of these individuals despite not being regulated by a state should still count toward “incident to” services including that such as the CCCMS.

8) Ultrasound Screening for Abdominal Aortic Aneurysms

We support your proposal to not limit the timing of the Abdominal Aortic Aneurysm to the year of the IPPE. We believe this will be of value to beneficiaries and also to the Medicare program.

9) Physician Compare Website

We support CMS efforts to provide beneficiaries with more information regarding quality of care and efficiency. This includes the provision of information on an individual eligible professional basis.

However, as we discussed in our comments above regarding CCCMS, evidence that would support measures relevant to the multi-morbid patient population is lacking and Academy leaders are working to develop such evidence and relevant measures. And at the same time the measures for which providers will be compared within one's specialty are often less relevant to the care of the sickest multi-morbid patients and such patients are the focus of home medicine providers.

Therefore, we recommend that as CMS further develops the Physician Compare site and adds individual level data that it also develop qualifying information such that beneficiaries/caregivers and other interested parties can understand the presented information in context. Otherwise, posted information may lead to false or misleading impression about the quality and efficiency of home care medicine providers whose quality and efficiency is high.

The reason this misleading impression could occur is that there is no specialty designation for medical home care providers by which CMS could present the results as compared to their peers. Home care medicine providers including members of the Academy are best identified by their practice patterns and the population they serve. Providers who make house calls to private homes and domiciliary care facilities are principally primary care physicians (including internists, family physicians and geriatricians) as well as ED physicians, nurse practitioners, and physician assistants.

Moreover, home medicine providers render services in a variety of models and across a variety of settings including urgent care, post-hospital transitional care, through team based comprehensive services including "hospital at home" and participate in Medicare Demonstrations such as ACOs and Independence at Home (IAH).

We know from prior studies in the VA, PACE and managed care organizations, and we anticipate will be confirmed through ACO and IAH reporting that home medicine providers offer efficacious, cost saving care. The patient and caregiver satisfaction scores for home care medicine providers is high as a general matter and is also found to be among the highest across practices, programs and specialties when evaluated by health systems.

Given this understanding, we are confident in how they would "compare" when the information on which it is based accounts for location of service, patient condition and social economic status, etc. Therefore, we believe that providers rendering home care medicine as the primary focus of their practice should have qualifying language for those reviewing their results or some means to segregate the review by place of service, such as the percentage of "housecall" CPT

codes used. This in turn would produce an “apples to apples” comparison of quality of care and efficiency within one’s specialty across this group of Part B eligible professionals. Importantly, beneficiaries and their caregivers would then have more accurate and useful information upon which to make decisions. We would be pleased to discuss other alternatives with you.

10) Physician Quality Reporting System and Electronic Health Record Incentive Program

We support CMS efforts to continue to harmonize the reporting requirements across the various reporting programs.

11) Value Based Payment Modifier

We support the development of additional means to support and assess value in the Medicare program. And thus, we support the Value Based Payment Modifier in concept in encourage value based care. However, as we commented last year we have a general concern that Part B physicians who treat the sickest of Medicare beneficiaries may be unintentionally yet, uniquely disadvantaged by the VBPM until applicable measures are developed. This concern extends to the addition of the Medicare Spending per Beneficiary measure, and specialty and risk adjustment process as proposed.

Providers who make housecall visits to beneficiaries in private homes and domiciliary care facilities come from various specialties to which they would be compared (e.g., family practice, general practice, internal medicine, emergency medicine). Such physicians treat the sickest and most high cost of Medicare beneficiaries. The beneficiary population is estimated around 4 million and this number will grow as the multimorbid population grows. Much of this beneficiary population is characterized by six or more chronic conditions and associated cost as reflected in the CMS Chronic Conditions Among Medicare Beneficiaries Chart Book. Thus, our concern is supported by the scale of its implication that physicians who render housecalls could as a group experience systemic reduction in payment according to the VBPM as proposed.

Such physicians, by focus of practice (location and services) are more likely than others in their specialty who are office or clinic based, to have 20 beneficiaries or more in their practice who have an attributable index admission or episode during the year. This likelihood is also reflected in the admissions rate information in the Chart Book. The result is that physicians practicing housecalls will appear to be high cost versus average or low cost providers when in reality the services of housecall physicians are among the most efficacious of any Part B providers. The evidence of the cost effective care of housecall physicians is being established through programs such as ACOs and Independence at Home (IAH). We will discuss this specialty concern in more detail below. We first note other general concerns with the implementation of the VBPM as proposed.

a) The VBPM methodology has not been tested in sufficient numbers to instill confidence. And we are concerned that it will ever be possible to develop a methodology that can accurately evaluate performance at the individual physician level for all specialties. Moreover, another variable, the Medicare Cost per Beneficiary measure, is being added without being tested for this purpose.

The methodological questions are magnified by the difficulties associated with educating hundreds of thousands of physicians about a complex requirement with which there are underlying questions. Implementation provisions also fail to incorporate the potential impact on patient access and care of a policy that by CMS' own projections would expose hundreds of thousands of physicians to reductions in payment of four percent (that is, two percent PQRS and two percent VBPM penalty for practices 10 and above) beginning 2016.

b) Methodological concerns and gap in timing undermine the intent of the VBPM - Due to gap in timing between the data year, and receipt and understanding of reports 2 years later it also is likely that many of the practices incurring penalties based upon 2014 performance won't even know that they were subject to the program until the reduction in payment occurs.

Additionally, it is unreasonable to increase the potential VBPM penalty to the mix when many physicians are struggling to manage organizationally and financially with the vast array of other new burdens such as resource-intensive new EHR systems, increased quality measurement activities that have been imposed in recent years, and the implementation of ICD -10 that represents a material undertaking for practices of all sizes.

c) Cost and outcome measures have not been developed with sufficient input from the physician community. Moreover, the measures have not been tested for use in physician practices. The Measures Application Partnership (MAP), whose recommendations CMS has cited elsewhere in the rule, has recommended against including selected measures in the calculation of the value modifier because they have not "been tested and endorsed for clinician level reporting."

For calculating costs, CMS plans to keep the five current measures and add a sixth, Medicare Spending Per Beneficiary (MSBP) that includes costs from three days before to 30 days after a hospital admission. CMS is proposing to use an attribution method that would include the full costs of care during the period to every group where any practitioner submitted a Medicare claim during the covered time frame. While the rule promotes this measure as a method of addressing geographic variation in the use of long term care services, the use of this measure also would enable CMS to produce cost measures for a large number of groups. As of the publication of the proposed rule, neither the MAP nor NQF had approved the use of this measure in the physician setting.

d) The specialty adjustment process as proposed is appreciated. However, the specialty adjustment process as proposed will only mask the difference in cost and will not resolve the cost issue. For example, the specialty impact table included in the discussion of this issue indicates that even with the proposed specialty adjustment, VBPM penalties are likely to be concentrated in certain specialties such as geriatrics (within which for example, some physicians exclusively practice housecalls), that treat patients with multiple chronic and costly conditions.

The Academy is greatly concerned that absent a more reliable adjustment for beneficiary patient focus that includes specialty location and service focus (housecalls), this proposal could systemically penalize physicians whose practices are focused on these sickest and most vulnerable home limited beneficiaries. These beneficiaries by definition of their multiple chronic care condition as identified in the CMS Chronic Care Conditions Chart Book are those that are

hospitalized more frequently than less sick office based beneficiaries that would be seen within one's "specialty."

These beneficiaries are also more likely in the (increased rate due to condition of) index admission period to require rehabilitation or nursing home care that will add to the necessary cost of care for these beneficiary patients and have the physicians (and in time NPPs) reflected as high cost and vulnerable to VBPM decrease in payment, when in fact these providers are among the most efficacious providers in the Medicare program. This effect of the VBPM must be avoided so as not to systematically penalize a subspecialty set of physicians nor undermine access to care and obtainment of the triple aim.

e) Moreover, risk adjustment as proposed may not completely adjust for practice focus. We are learning through the Medicare Independence at Home Demonstration (IAH) that the Part A and B cost of beneficiaries may not be fully explained when looking at only the factors of age and severity of illness. And the existence of need to explain residual differences in cost not explained by age, severity of illness, and geography, etc. has also been observed and addressed in the PACE program. And the housecall beneficiary population shares characteristics of the PACE population and is expected to be shown to exceed the HCC scores of the PACE population.

This is the reason a "frailty factor" to explain the residual cost is included in the IAH legislation and the CMS specifications for the Independence at Home Demonstration. Accordingly, we recommend the study of a similar frailty factor be conducted prior to the inclusion of the MSPB measure to accurately account for the difference in beneficiary cost within a specialty when the factors of age and severity of illness in and of themselves do not fully explain the difference.

Another alternative and there could be others we would be pleased to discuss with you include sub-specialty designation and adjustment by place of service. This would produce the result of apples to apples comparison within one's specialty across this group of Part B physicians.

We look forward to working with you to assure that the VBPM program produces the most accurate and optimal result of encouraging and rewarding efficient, value based practice as possible.

We appreciate the opportunity to comment and we would be pleased to answer any questions.

Sincerely,



George Taler, MD
Chair, Public Policy Committee
American Academy of Home Care Physicians