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Frontiers

American Academy of Home Care Medicine
Home Care Medicine's Voice

American Academy of Home Care Medicine

The AAHCM empowers you to serve patients who need health care in their homes through public advocacy, clinical education, practice management support, and connections to a network of over 1,000 professionals in home care medicine.

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Public Policy

Highlights of SGR Repeal Legislation and Growth of House Call Medicare Part B Service and Revenue Opportunities

by Gary Swartz, JD, MPA, Associate Executive Director

The President has signed "The Medicare Access and CHIP Reauthorization Act of 2015" (MACRA). The MACRA includes a permanent repeal of the SGR formula and its impact. A summary of MACRA prepared by the House Committees that worked on the Act can be found here: http://energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/114/Analysis/20150319SGRSectionbySection.pdf/.

Congress, as you know, had long grappled with the flawed Sustainable Growth Rate (SGR) formula. This formula had the potential to reduce Medicare Fee Schedule (MFS) payments by 21.2 % if not addressed for services after April, 2015.

Academy members and other medical professionals had long lived with the uncertainty brought by last minute "patches." This stressful history has crimped practice planning and development. The Center for Medicare & Medicaid Services (CMS) has also had to operate with the potential need to reduce MFS payments and then deal with the outrage from providers and beneficiaries. So, it was somewhat surprising that in recent months, in the most politically partisan of Congresses, that House Democratic and Republican leadership

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negotiated and passed a bill to permanently repeal the SGR.

This bill, HR 2 "The Medicare Access and CHIP Reauthorization Act of 2015" (MACRA), which includes a permanent repeal of the SGR formula and its impact, was then sent to the Senate for consideration.

It is also valuable to review where we have been in terms of Medicare payment particularly as it impacts house call practices. Here are services that have become covered and paid over recent years (see below).

The Academy posting of the Medicare Part B payment levels since MACRA has been signed into law is available on the Academy website. The posted payment table reflects coverage and payment of the Medicare program. Many of you have additional arrangements in place that pay for transitions of care, per-member, per-month or capitation for care management services, and some of you have already negotiated or are in the process of negotiating shared savings opportunities with health plans and other payors.

So we see that service and revenue opportunities for Academy members have become more diverse. One Academy member with a team-based practice over multiple locations observed "we provide as much service and obtain as much revenue non face-to-face as we do face-to-face." Indeed, house call practices and financial viability has grown considerably over the years.

The Department of Health and Human Services (DHHS), along with this background has recently set a goal of tying 30% of fee-for-service payments to quality or value through alternative payment models, such as Accountable Care Organizations (ACOs) or bundled payment arrangements by the end of 2016, and tying 50% of payments to these models by the end of 2018.The DHHS also set a goal of tying 85% of all traditional Medicare payments to quality or value by 2016 and 90% by 2018 through programs such as the Hospital Value Based Purchasing and the Hospital Readmissions Reduction Programs.This is the first time in the history of the Medicare program that the DHHS has set explicit goals for alternative payment models

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Academy advocacy has contributed to the following improvements to house call recognition and Medicare coverage and payment:

- Fee increase for house call evaluation and management codes;
- Annual wellness visit and other preventive and screening services;
- Transition care management;
- Chronic care management;
- Advance care planning - the Academy is working on having this service covered and paid effective 2016;

These services are in addition to:

- Time based codes;
- Home health certification and recertification;
- Hospice certification and recertification;
- Care plan oversight;

The Sea Continues to Rise

by Thomas Cornwell, MD, President

Thank you to our board and all our members who continue to raise the sea and lift up all of our house call practices. This is such an exciting time for home care medicine whose value is being realized by health systems, insurance companies and on Capitol Hill. Below are examples of how the sea is rising.

The annual meeting committee has planned an incredible event in May that includes:

- National speakers including our three keynote speakers Dr. Michael C. Burgess, Congressional Representative from Texas' 26th District; Dr. Diane Meier, Director of the Center to Advance Palliative Care; and, Sean Cavanaugh, the Deputy Administrator and Director of the Center for Medicare at CMS;
- Networking times including the all-member reception where we learn from each other and you can talk with board members and our national speakers;
- Table discussion groups with topics chosen by members;

The annual meeting sponsorship committee has done a phenomenal job at bringing in sponsors and exhibitors totaling over $175,000 dollars. This is 44% above last year's record. These dollars help keep annual meeting costs down, support the field of home care medicine and add to the educational experience. Please thank these wonderful sponsors and exhibitors.

- Platinum Sponsors: The Home Centered Care Institute; Kindred Healthcare; US Medical Management;
- Gold Sponsor: Visiting Nurse Association Health Group;
- Silver Sponsors: Aprima Medical Software; MedCerts; and, Visiting Physicians Association;
- Bronze Sponsors: Addus Home Care; The Health Law Partners; Hospice of Michigan; Humana at Home; JEN Associates; MedComp Sciences; ProAssurance; Visiting Nurse Service of New York;
- Exhibitors: Advanced Physicians Insurance; American Veterans Care Connection; Carelink Mobile Practice Manager; ExactCare Pharmacy; First Healthcare Compliance; MedComp Sciences; Runzheimer International; Ultralinq Healthcare Solutions; VITAS; Wachler and Associates;
- Awards & Other Sponsors: Lake Shore X-ray; Pinnacle Senior Care; Schnable in Home Primary Care Program;

The American Academy of Home Care Medicine continues to advance the field and work on your behalf.

- After successfully getting payments for the Chronic Care Codes, we are working collaboratively with other organizations to get the Advance Care Planning codes paid for in 2016.
- We continue to work on creating standards for the field of home care medicine and are reaching out to certification organizations to develop practice certification for home care medicine.
- We continue to advance IAH at the highest levels at both CMS and in Congress.

We are seeing the sea rise with all this hard work.

- The number of house calls and especially domiciliary visits continue to rise.
- US Medical Management has started the first home-based primary care ACO which has significant potential for advancing the field.
- We are seeing increased interest from Medicare Advantage plans such as Humana at Home which is a sponsor of our annual meeting.
- There is increased interest from large assisted living organizations such as Brookdale Senior Living (the largest in the country) who will also be sending leadership to our annual meeting.
- Venture capital is coming in such as with Landmark Health which is further spreading home care medicine and will be coming to the annual meeting.

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AAHCM Telemedicine Policy Statement Released!

At its last Board meeting, the Academy's Board approved its Telemedicine Statement. In it, there is a brief discussion of the current evidence base for the use of telemedicine in the frail, elderly patients cared for by you in your home-based primary care programs, and principles and practices that should guide the usage of the relevant technologies. Use this document as you look at companies that seek to provide services to your patients, or consider opportunities to contract with companies or provide services yourself.

AAHCM Telemedicine Statement Adapted from AMA Policy Statement with Additions

Definitions

Today, there are three broad categories of telemedicine technologies: store-and-forward, remote monitoring, and (real-time) interactive services.

Store-and-forward telemedicine involves the transmittal of medical data (such as medical images) to a physician or other medical provider for assessment. Both parties are not present at the same time.

Remote monitoring permits single patient self- monitoring or testing using various technological devices with transmission to the medical provider. This method is typically used to help manage single chronic diseases or specific conditions (e.g., heart disease, diabetes mellitus, or asthma), as devices that can be used by patients at home to capture such health indicators as blood pressure, glucose 4 levels, ECG and weight.

Interactive telemedicine services provide real-time, face-to-face interaction between patient and provider (e.g., online "portal" communications). Telemedicine, where the patient and provider are connected through real-time audio and video technology can be used as an alternative to office or outpatient visits to diagnose, treat, educate or provider care management.

Evidence Base for Use of Telemedicine in Home Care Medicine

The evidence base for the use of telemedicine in home care medicine is beginning to emerge.

Because home care medicine patients have multiple chronic conditions, are often cognitively impaired and have various kinds of functional limitations, they are not the same as the relatively healthy populations in which these technologies have been used. On the other hand, ways need to be found to improve and make more efficient the care model for these patients.

In general, telemonitoring has been found to be of limited use, and a recent article from the Mayo Clinic and Purdue University seems to support this general finding. (http://www.fiercehealthit.com/story/Researchers - Fail- Find-Savings-Home Telemonitoring- Among-Older –Adults/2015-02—2?utm_campaign=+SocialMedia)

The VA HBPC program has been studying the effects of using telemedicine modalities. With regard to telemonitoring, in a study of 200 HBPC patients, first, when offered the chance only 30 of the 200 opted in. Of the 30, only 17 actually used the telemonitoring equipment. With this very small sample, the results were mixed. Both patients and staff felt the information contributed to more knowledge of the patient. However, patients disliked having to answer the telehealth questions. There was no change in utilization so no cost savings there. There may have been some reduction in ER/inpatient utilization so there may have been some cost savings from this source. The VA also has had some success in using Skype in rural areas, and are continuing their research on what is effective. The Washington Hospital Center also is studying the use of telemonitoring technologies, and we look forward to the results of their studies.

Factors to be considered include patient acceptance and desire to use the technology; whether the technology adds to or detracts from home care medicine staff efficiency (for example reducing the number of house calls that have to be made), and whether it adds to or detracts from quality of care. Getting specialist consults into the home via video conferencing is an example of a positive advance in quality of care for home-limited patients. On the other hand, just generating monitoring data with no dispositive value does not advance quality.

The Telemedicine Task Force is therefore very concerned at the assertions being made by some companies, particularly directed to managed care plans, that they can save the insurers money by substituting telemedicine for in person house calls when there is no evidence base to support that assertion in the frail elderly served by house call programs.

Principles for Use of Telemonitoring in Home Care Medicine

The Academy agrees in general with many of the statements made by the AMA in its policy statement, with some modifications for home care medicine:

a. Valid patient relationship: A valid patient-physician/provider relationship must be established by the primary care provider before the

provision of telemedicine services, which includes a hands-on relationship with the patient. It is up to the primary care provider to determine when a face to face visit is required. Exceptions to the foregoing include on-call, cross coverage situations; emergency medical treatment; and other exceptions that become recognized.

b. Patient choice: The patient must have a choice of providers.

c. Licensure: Physicians and other health practitioners delivering telemedicine services must be licensed by or otherwise abide by state licensure laws and state medical practice and scope of practice laws and requirements in the state in which the patient receives services. Their malpractice insurance must cover telemedicine services including coverage across state lines, if applicable. The Academy supports current efforts to make medical professional able to practice telemedicine without geographic restriction.

d. Transparency: Patients receiving telemedicine services must have access to the name, licensure and board certification qualifications of the health care practitioners who are providing the care in advance of their visit; cost-sharing responsibilities; any limitations in drugs that can be prescribed via telemedicine.

e. Environmental assessment: Before providing telemedicine services, the provider must be sure that safety is assured in the patient's environment, that usage of the equipment is feasible, and that the patient accepts and is willing to meet any cost-sharing requirements.

f. Documentation and Care Coordination: The patient's medical history must be collected as part of any telemedicine service; the provision of telemedicine services must be properly documented and include visit summaries to patients; care coordination must include at a minimum providing a copy of the medical record to the patient's treating physician if not the house call-making primary care provider; protocols must exist for emergency referral.

g. Patient Privacy: Delivery of telemedicine services must abide by laws addressing the privacy and security of patients' medical information.

Additionally,
The Academy supports additional pilot programs within Medicine to enable coverage of telemedicine services with the home being the originating site.

VA Perspectives: Building an Effective Partnership Between Telemedicine and HBPC

by Robert Kaiser, MD, Medical Director Home Based Primary Care Program, Washington, D.C. Veterans Affairs Medical Center, Associate Professor of Medicine, George Washington University School of Medicine

Telemedicine is rapidly expanding as a mode of clinical care in the public and private sectors.

The VA HBPC Program has had a long-standing association with the VA's telemedicine program, Care Coordination Home Tele-health (CCHT). All HBPC Programs are now required to have 1.5% of their patients enrolled in CCHT, according to Special Population PACT performance measures. CCHT enrollees have monitoring terminals, connected to a telephone line, installed in their homes. Clinical parameters are regularly monitored by a nurse and are shared with the HBPC Team by communicating through the electronic medical record, CPRS, and also by electronic messaging and by telephone.

In addition, the recent purchase and adoption of video tele-health technology in the VA Healthcare System will allow HBPC home visits to be conducted remotely, rather than in person, for those Veterans who have broadband connections. This new capability has added another important dimension to all HBPC programs. For those Veterans who live a long distance from VA medical centers, visits may be performed more conveniently, without team members having to spend significant amounts of time travelling to the home.

Which patients will benefit most from more intensive clinical monitoring through CCHT or from remotely-conducted video home visits?

The answer to that question is not entirely clear, due to inconclusive evidence from clinical trials and systematic reviews on the efficacy and cost-effectiveness of telemedicine.

Within the VA, there are factors which limit the degree to which telemedicine can currently be widely employed. Not all patients can afford a broadband connection, which may be prohibitively expensive and is a requirement for video tele-health equipment to be used. Not every patient, or his or her caregiver, may be able to learn how to use tele-monitoring equipment of the CCHT program; patients and caregivers also may not be able to meet the considerable demands of entering clinical data on a daily basis. These are significant rate-limiting steps, and these barriers must be adequately addressed over the long term if telemedicine technology is to be effectively allocated and utilized.

Patients with poorly controlled, common medical conditions -- like diabetes, hypertension, or congestive heart failure -- who are at risk for frequent emergency room visits, hospitalization, or re-hospitalization, would appear to be those patients who might benefit most from more intensive monitoring. Referring these patients to CCHT would seem to make eminent good clinical sense. Such referrals should be made with the understanding that appropriate clinical outcomes should and must be closely followed, in the context of a well-designed quality improvement framework, in order to make certain that this technology is making a difference clinically.

Video home visits are a means of complementing in-home visits to Veterans, although remote visits cannot replace direct assessment when it is clinically necessary. Video visits might be most appropriate for certain professionals, like the HBPC Psychologist, Social Worker, and Dietician, who would be able to confer effectively with the Veteran and family over a video connection, and by so doing expand their geographic reach to serve more Veterans enrolled in the program. Again, identifying, measuring, and tracking appropriate quality improvement parameters would provide crucial data to assess the effectiveness of video visits and whether or not they are serving a useful purpose in clinical care.

As Dr. Eric Topol has noted in his recent book, *The Patient Will See You Now*, the rapid pace of change is placing more and more technology in the patient's hands, technology that is easily available in the home. Smartphone applications now allow patients to perform parts of their own physical examinations, check their own EKGs, interpret them, and email them to their providers for treatment recommendations. The use of home-based technology is expanding much more rapidly than we are able to study it and accumulate sufficient evidence to assess its clinical effectiveness. In such a dynamic world, clinicians must be ready and willing to partner with newly-empowered patients in the use of medical technology. Telemedicine is one way of enhancing that partnership.

Member News

Electronic Booklets NOW AVAILABLE!
Responding to member requests for increased speed, popular Academy publications are now available for purchase in electronic format to download and read or print. See the digital publications by going to our online store at www.aahcm.org › Online Store › Electronic Booklets.

Welcome, New Members!

The Academy would like to welcome the following new members:

ARKANSAS
Dr. Shekher Adolph

ARIZONA
Dr. Rosemay Browne
Roxane Butler, RN
Linda Cagle
Paul Gee, MD
Patricia Harrison-Monroe, PhD
William Jones, Rph
Jane Mohler, PhD, NP-C, MPH
Lisa O'Neill, MPH
Dorothy Terrazas, NP-C
Scott Van Valkenburg, MD
Nancy Wexler, MPH
Serani Wijesingh, MSW

CALIFORNIA
Dr. Michael Bordorsky
Roya F. Fathi
Dr. Geoffrey Kamen
Dr. Helen Kao
Dr. Annemarie Sheets
Paolo Zizzo, DO

CONNECTICUT
Patricia Casey, FNP-BC, CDE
John Charde, MD
Dr. Lee Forest

DELAWARE
Dr. Mark Trochimowicz

FLORIDA
Karin Armero
Greg B. Bellomy
Lee C. Levanduski
Sharon Russell, ANP-BC
Dr. Craig P. Tanio

GEORGIA
Reeder & Associates

ILLINOIS
Lidia Andruszyn, DNP, APN, CNP
Corazon R. Benig, MD
Michael N. Desvigne, MD
Pilarita Espinosa, MD
Jose Flores, MD
Alicia Joaquin, MD
Dr. Raza K. Khan
Glenn Manguerra
Maria Imelda Manguerra

INDIANA
Dr. Abdulateef Aregbe
Dr. Steve Counsell

KENTUCKY
Dr. Bennie Fulbright

MARYLAND
Amanda Goldfarb, MD
Dr. Foyinsayo Kumoluyi
Roza Masoumi
Dr. Daniel Threat, JR

MASSACHUSETTS
Constance D. Dahlin
Patricia Walker, NP

MISSOURI
Dr. Toby T. Turner

NEVADA
Maria Zarina Diao, NP

NEW JERSEY
Christine Forward, APN-C
Thomas Y. Lee, MD
Stephanie Moon, APRN-BC
Stephanie Sapio, APRN

NEW MEXICO
Eric W. Metzler, MD
Jill A Rhymes, MD

NEW YORK
Benson Babu, MD
Ashia Smith

OHIO
Eiran Gorodeski, MD
Linda Heigel
Tim Larsen, NP
Susan Reif, NP
Renato Samala, MD
Kathleen Taverneill, NP
Seth Vilensky

PENNSYLVANIA
Dr. Anna Doubeni
Jeffrey J. Liberati

TEXAS
Zainabu Koroma, NP
Leigh Ann Tipping

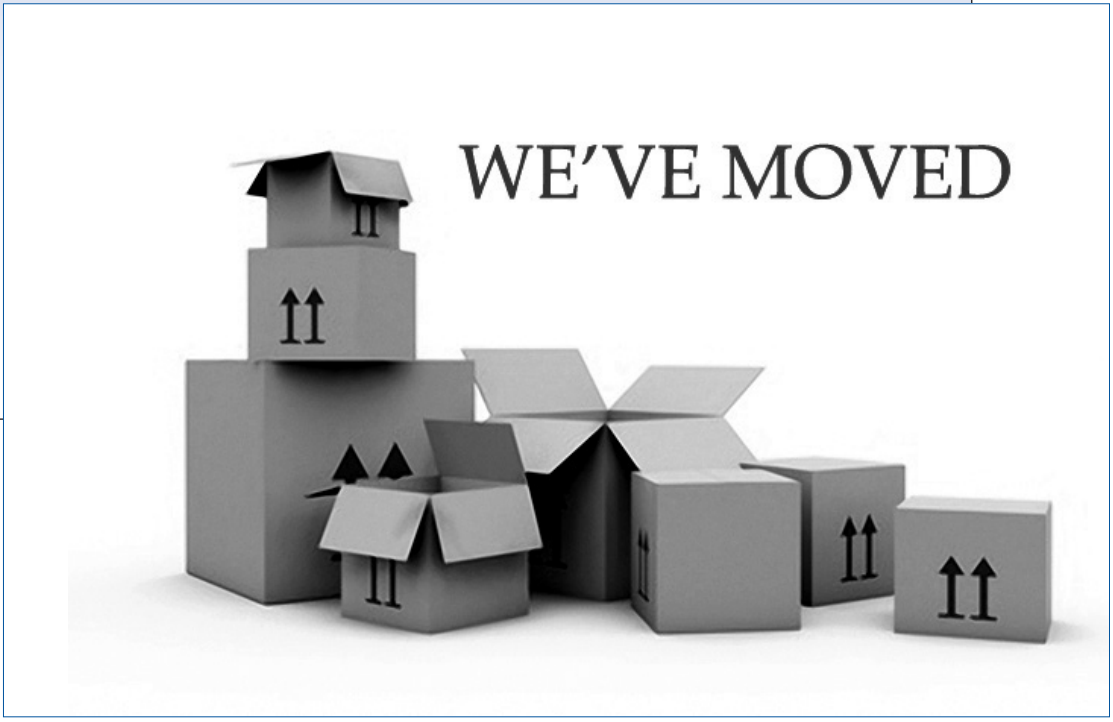
VIRGINIA
Dr. Aparna Ranjan
Dr. Menbere Bahru

The Academy office has moved to 11 E. Mount Royal Ave. Ste. 3C, Baltimore, Maryland 21202.

Our new telephone numbers are: 410-962-0565 and 410-962-0532 and our new fax number is 667-212-5794.

Our email addresses will stay the same: aahcm@aahcm.org, edrow@aahcm.org, gary.swartz@aahcm.org, and audrey.mcdonough@aahcm.org.

We will be close to the Baltimore train station, so if your travels take you our way, please plan to visit!



President's Message

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- The Home Centered Care Institute is working with health systems in Chicago to start or advance house call programs such as University of Chicago, Rush University Medical Center, Northwestern Medicine and several others.
- There are talks going on in Virginia and Pennsylvania for home care medicine programs to target dual-eligibles.
- And the list goes on....

PLEASE be a part of helping the sea rise! Join us at the annual meeting and bring your expertise to share with others and also increase your knowledge. PLEASE RENEW your membership when it comes due. We are stronger in numbers. Your board members and Academy staff are putting in thousands of hours to support educational efforts and to help you get paid. Most important, continue the great home care medicine you are doing across the country whose value is being realized and which your Academy will continue to support.

Thomas Cornwell, MD

Tom Cornwell MD

Update of the Home Care Literature:
March - April 2015

by Galina Khemlina, MD, VA San Diego Healthcare

The goal of this column is to briefly review interesting articles appearing in the recent home care literature with a focus on articles relevant to physicians. The reviews are not meant to be comprehensive or stand alone but are intended to give readers enough information to decide if they want to read the original article. Because of the decentralization of the home care literature, there are likely to be significant articles that are overlooked and these categories are by no means set in stone. Readers are encouraged to submit articles or topics that may have been missed.

Assessment

Stewart-Archer LA, Afghani A, Toye CM, Gomez FA. Subjective quality of life of those 65 years and older experiencing dementia. Dementia (London). 2015 Mar 17. pii: 1471301215576227.

The goal of this cross-sectional study with one hundred and thirty six persons aged 65+ experiencing dementia, is to describe how people experiencing dementia define quality of life and how this may be supported. Participants characterized quality of life as: freedom, independence, having basic needs met, physical health, engagement in meaningful activities and tranquility. A need for self-determination/choice was evidenced across all domains. The authors concluded that enhancements in care environment, independence, engagement and meeting of life's goals merit urgent attention.

Home Care Research

Niklasson J, Hörnsten C, Conradsson M, Nyqvist F, Olofsson B, Lövheim H, Gustafson Y. High morale is associated with increased survival in the very old. Age Ageing. 2015 Mar 15. pii: afv021.

High morale is defined as future-oriented optimism. Previous research suggests that a high morale independently predicts increased survival among old people, though very old people have not been specifically studied. The goal of this study was to investigate whether high morale is associated with increased survival among very old people. The 5-year survival rate was 31.9% for participants with low morale, 39.4% for moderate and 55.6% for those with high morale. The authors concluded that high morale is independently associated with increased survival among very old people.

Article of the Month

Quality of Care

Kajonius PJ1, Kazemi A. Structure and process quality as predictors of satisfaction with elderly care. Health Soc Care Community. 2015 Mar 25. doi: 10.1111/hsc.12230

The current research presents findings from a national survey, including a wide range of quality indicators for elderly care services, conducted in 2012 at the request of the Swedish National Board of Health and Welfare in which responses from 95,000 elderly people living in 324 municipalities and districts were obtained. The results revealed that the only structural variable which significantly predicted quality of care was staffing, measured in terms of the number of caregivers per older resident. The findings from this large nationwide sample suggest that quality in elderly care is primarily determined by factors pertaining to process, that is, how caregivers behave towards the older persons.

and value-based payments. You can read more here: www.hhs.gov/news/press/2015pres/01/20150126a.html.

We believe that for practices that invest in their clinical and administrative staff, in their electronic health record (EHR), and in their information and technical infrastructure to support care coordination and care management, that the future moving to such value based and shared savings models is bright. This brings us to highlights of the MACRA that will while it eliminates the SGR and preserves fee for service, it greatly supports this transition to value based payment and alternative payment models.

What are the Most Important Elements in the MICRA for Academy Members?

1. The Sustainable Growth Rate (SGR) formula is repealed. Fee-for-service payments are increased by .5% through 2018 with existing quality and electronic incentive programs in place.
2. SGR is replaced after 2019 with two pathways to Medicare Part B payment. Medicare Part B providers will receive updates to their annual professional fee schedule payment through:

   MIPS: Fee-for-service (FFS) with a "merit-based incentive payment system" (MIPS) that will adjust payment plus or minus 4% beginning 2019 under harmonized reporting programs increasing to plus or minus 9% through2022 (see table below). The MIPS will apply to physicians, nurse practitioners, physician assistants, and others.

The MIPS consolidates and improves on the three distinct current incentive programs:

- The Physician Quality Reporting System (PQRS) that incentivizes professionals to report on quality of care measures;
- The Value-Based Modifier (VBM) that adjusts payment based on quality and resource use in a budget-neutral manner; and
- Meaningful use of EHRs (EHR MU) that entails meeting certain requirements in the use of certified EHR systems.

The MIPS will assess the performance of eligible professionals in four categories: quality, resource use, EHR Meaningful Use, and clinical practice improvement activities. The measures for these categories will come from the existing programs and through updates that include notice and comment rulemaking.

Eligible professional organizations and other relevant stakeholders will identify and submit quality measures to be considered for selection and to identify and submit updates to the measures. Any measure selected for inclusion in such list that is not endorsed by a consensus-based entity must be evidence-based. The measure update process should provide opportunity for the Academy and field to promote measures that are relevant to your multi-morbid patient population.

APMS: The other means to obtain increases to your Medicare Fee Schedule payment amounts is through participation in alternative payment models (APMs). If you are practicing under the APM pathway then updates will be based on increasing the percentage of Medicare (or all payor) revenue beginning 2019 through 2024 that meets the qualifying elements for APMs.

Eligible APMs will include those that use certified EHR, meet quality standards and bear financial risk in excess of a nominal amount; or are a medical home. Qualifying practices will receive an additional 5% payment. As a result, those of you gaining experience through IAH, ACO, and other public or private shared savings programs will have an advantageous head start with the implementation of this provision.

Medicare Annual Payment Updates to Professional Fee Schedule Under MIPS Pathway

Years	Fee for Service - MIPs Pathway
July 2015-2018	0.5% annual update
2019	+/- 4 percent
2020	+/- 5 percent
2021	+/- 7 percent
2022	+/- 9 percent

The April 29 Academy webinar on SGR Repeal and what comes next has been posted to the Academy website. Please see this material for additional details of the immediate and long term impact of MACRA. This also discusses how your support of the Academy will remain critical in the years ahead to support the interest of you and your patients, as well as the continued growth of your practice. Also, there is

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still the opportunity to learn the latest about Medicare policy, payment changes, and the developments in the private market at the Annual Meeting. Registration remains available on-site and this is also the annual opportunity to network with your house call colleagues from around the country.

Academy Advocacy for You to Obtain Coverage and Payment for Advanced Care Planning

The *Frontiers* you are reading went to press in late April. The Academy, for months prior to press, had been working with a multi-specialty group to have CMS provide coverage and payment for Advance Care Planning (ACP) codes effective 2016. While CMS has recognized 2 codes for ACP, they have not provided coverage and payment for the codes. The two ACP codes, one for the first 30 minutes, and the second an add on code for ACP service that extends beyond the first 30 minutes, would each be in addition to existing evaluation and management services coverage and payment. This would recognize your additional work, time, and expense involved in ACP. This would also reflect the importance of the service to Medicare beneficiaries and again send a signal to other payors who may not be providing payment for ACP or similar service.

The Academy advocacy and work with the multi-specialty group is similar to the work which led to the coverage and payment for transition care management and chronic care management. Dr. George Taler represented the Academy as part of a multi-specialty coalition that met with Medicare Director Sean Cavanaugh on March 20. Dr. Linda DeCherrie of the Public Policy Committee is also involved with this effort. Mr. Cavanaugh was appreciative of the information provided by the group.

This advocacy was then followed up by multi-specialty sign on letters sent to Congressional and Medicare leaders, as well as in-person Hill visits. Follow up by the multi-specialty group is focused on overcoming residual political objection to ACP that may exist in Congress. You know how important ACP is in the care and treatment of your patients. You also know that ACP is associated with increased patient satisfaction, quality of life, and lowered cost. Please include support for ACP in your communication with your elected officials.

CMS coverage and payment for 2016, if proposed, would be published this summer in the proposed professional fee schedule payment rule for 2016.The Public Policy Committee, chaired by Mr. Robert Sowislo, together with Academy staff will review the proposed rule and provide comments on your behalf.

AAHCM Forum Launched

Dear AAHCM Members:

This summer, one of the requests from the membership was for improvement of the current list-serv. Thanks to the generosity of Dr. Erik Gulbrandsen who has worked with AAHCM staff, we are pleased to announce that the new AAHCM Forum is live and ready for you to use!

How do I log in? Some AAHCM members established usernames and passwords while the Forum was being tested, if you are one of those members, simply go to aahcmforum.org (bookmark this page!) and log in. If you did not set up your own username and password, don't worry the Academy has done that for you. Go to aahcmforum.org > click log in > enter your email address > enter "password1". Once you are logged in you can update your profile and subscription to the forum. If you are still having problems logging in to the new forum contact Audrey McDonough at audrey.mcdonough@aahcm.org.

Do I have to log in to see messages? No, each user will receive a once weekly digest of new discussions, however, if there is a topic that you are interested in you can "watch" that thread and receive daily notifications if something new is posted.

Do I have to log in to reply to messages? Yes, a forum is different than our old list-serv in that way. In order to post new topics or reply to posts simply go to aahcmforum.org > log in > and reply. Simple!

What will happen to all the messages on the old list-serv? For now, nothing. The Academy will maintain the old list-serv for the time being, we hope that we can start to archive some of those old discussions on the new forum manually this summer.

Are there rules about what types of messages I can post? Yes, all the rules of usage are at http://homecareforum.org/index.php?help/terms. These rules include what we do and do not allow on the forum, discussion group etiquette, and legal notes and disclaimers.

Still have questions? Email the Academy at aahcm@aahcm.org.

We at the Academy are always looking for new ways to enhance your membership experience. We look forward to ALL of our members using and enjoying the new forum.

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Permit No. 5415

Share AAHCM's mission and encourage colleagues to join

The American Academy of Home Care Medicine is an organization of physicians and other home care professionals dedicated to promoting the art, science, and practice of medicine in the home. Achievement of that mission will require that providers be educated regarding home care; that they be actively involved in the evolution of home care medicine procedures, their delivery, and management; and that provider interests in the delivery of home care be voiced and protected. We urge membership and participation in the long-term future of home care.

AAHCM intends to provide the structure through which providers can evaluate home care and their position in it. It will monitor emerging technologies and appropriate delivery systems for the practicing physician, as well as the legal and regulatory environment. The Academy will be in a position to present providers' views regarding their interests and concerns in home care. Finally, the Academy will actively collaborate and cooperate with other organizations wishing to enhance the quality of home care. With these intentions for the Academy in mind, we hope to enlist physicians and home care professionals who will actively support and promote these changes in home care.

Home care medicine is one of the most rapidly expanding areas of health care. These changes are occurring because:

- Changing demographics demand a responsive health care system.
- Technology is becoming more portable.
- Home care medicine is a cost-effective and compassionate form of health care.
- Most persons prefer being treated at home.

Who should join?

- Practicing physicians.
- Nurse practitioners and physician assistants (associate membership).
- Practice administrators.
- Medical directors of home care agencies.
- Students and physicians in training.
- Other home care professionals (associate membership).
- Home care agencies (affiliate membership).
- Corporations (sponsor membership).
- Groups of MDs, NPs, PAs or a mixture; or home health agencies and their medical directors (group membership) - *Discounts available.*

Benefits:

- Public Policy representation; revenue-related regulations and legislative representation such as IAH.
- Practice Management publications, website and technical assistance.
- Information on clinical, administrative, regulatory and technology issues, and the academic literature through our Newsletter and e-Newsletter.
- Standards of excellence, including the Academy's Guidelines and Ethics Statement.
- For house call providers, listing in our online Provider Locator.
- Consulting and networking through our members-only list-serv.
- Clinical guidelines and communication templates.
- Discounted attendance to Academy meetings.
- "Members-only" prices on educational media and publications.
- Assistance for faculty who train residents in Home Care.

2015 Membership Fees*

Physicians	$250
NP/PA	$200
Groups (MD, NP, PA or combination)	Custom**
Associate (RNs, SWs, PTs, etc.)	$115
Residents/Students	$75
Affiliate (home care agency employee)	$195
Practice Administrators	$195
Corporate Sponsor Membership	$2,750

*For international membership, add $15
**Special discounts and flat rate options available - call 410-676-7966

2015 Membership Application

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Email: _____

Make checks payable to:
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☐ New membership ☐ Renewing membership

Please state your area of expertise or specialty: _____