American Academy of Home Care Physicians

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By E-Mail

March 7, 2012

Dear Mr. Mills and Ms. Combs-Dyer,

This letter follows in appreciation to the *Reducing Improper Payments* presentation you provided to association representatives at the AMA office on Tuesday, February 29. The Academy supports efforts to assure that Medicare program dollars are paid appropriately, not in error and we are opposed to fraud and abuse. Accordingly, we want to work with you whenever there is a question relating to the services and utilization by Part B providers for whom housecalls is the basis of their practice.

For now, in follow-up to the presentation we provide the requests, observations and recommendations below for your consideration and response and each of these is discussed in more detail attached. As these issues relate to the responsibilities and outputs of the OFM Provider Compliance Group we would be pleased to meet with you in Woodlawn to review these in person. Moreover, The Academy is located near Baltimore and given that Innovation Center Independence at Home (IAH) and ACOs demonstrations discussed below and attached will increase access to housecalls and housecall utilization and these will begin the same time that the pre-payment review demonstration is to begin, it would be beneficial to meet to discuss desired and designed increase in utilization before the summer start of these demonstrations.

Academy Requests, Observations and Recommendations
Relating to the OFM and Housecall Utilization

1) Request for CMS or NGS formal posting of the end of the NGS CPT 99350 Pre-payment Review in Connecticut and New York.
2) Innovation Center IAH and ACO demonstrations by their legislative intent and design are to support and evaluate housecalls. Medical record reviews triggered by statistically significant, yet beneficial growth in housecalls would be counterproductive to beneficiaries and to the goals of Congress and CMS.
3) OFM staff working on payment accuracy and responsible for medical record reviews should meet with their counterparts in the Innovations Center to understand the beneficial impact of increased housecall utilization intended by these demonstrations to incorporate this information in their data analysis.
4) CMS, while such demonstrations are occurring should exempt house calls from medical record review, at least in the areas of the demonstrations.
5) CMS should also limit the aggregate number of reviews that any house call provider experiences over a rolling 12 month period from any CMS (MAC, RAC, for example) source.
6) The Academy supports CMS and MAC transparency as you heard last week. This includes providing prior notice and obtaining clinical input from relevant clinicians and associations to confirm the merits prior to any new service wide medical record review. We look forward to providing our expertise.

We look forward to hearing from you regarding these requests, observations and recommendations as well as the opportunity to discuss these in person.

Sincerely,

Gary Swartz

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1) **Request for CMS or NGS Formal Posting of the End of the NGS CPT 99350 Pre-payment Review in Connecticut and New York.**

You may recall that we previously wrote regarding the conduct of the CPT 99350 pre-payment review by NGS in Jurisdiction 13. That pre-payment review was temporarily turned off in the summer of 2011 only to be turned back on later in the year. As you may also know, we participated in a conference call on January 17 that included the NGS medical directors and medical review staff and subsequently received Email communication by NGS provider education staff the review ended pending consideration of the issues presented. *Your advice or communication that this pre-payment review is officially ended or the receipt or publication of such formal notice by CMS or NGS would be welcome.*

2) **Innovation Center IAH and ACO Demonstrations by Their Legislative Intent and Design are to Support and Evaluate Housecalls. Medical Record Reviews Triggered by Statistically Significant, yet Beneficial Growth in Housecalls would be Counterproductive to Beneficiaries and to the Goals of Congress and CMS.**

CMS was directed by Congress in the PPACA to test home-based primary care for Medicare fee-for-service beneficiaries with multiple chronic illnesses. Congress modeled the 3 year Independence at Home (IAH) demonstration on Veteran Affairs Home-based Primary Care program. Specifications for IAH were posted at the end of last year. Applications for practices to participate were due on February 6 and practices selected to participate will be announced soon for summer start. This is the same 3 year time frame as the pre-payment review demonstration.

The IAH Demonstration will add to an increasing body of literature that relates the provision of housecalls to reduction in 1) avoidable inpatient admissions, 2) emergency room visits and 3) skilled nursing facility admissions. Additionally, the provision of housecalls supports the CMS policy and payment changes being effected to reduce 30 day re-admissions.

As an example of the recognition of the importance of housecalls and support for utilization increase, one of the measures to be used to evaluate IAH program success will be practice *"Contact with beneficiaries within 48 hours upon admission to the hospital and discharge from the hospital and/or emergency department."* (See Attachment) Moreover, IAH practices must produce a savings of at least 5% of anticipated Part A and Part B expenditures before any additional savings are shared between CMS and the IAH practice. **Thus, *IAH by its design will encourage primary care visits to the home and assisted living facilities and there should be a significant and beneficial increase in the number of housecalls related to IAH.***

Housecall Practice Is Being Recognized for Contribution to Solution to Trust Fund Issues

A meeting with Richard Foster, CMS Chief Actuary is being established to review the evidence of the field with particular focus on the VA's Home-based Primary Care

program, that has been operating for 30 years and similar programs that have been operating across the country for decades. These programs focus on the highest cost patients with multiple chronic diseases and have reduced health care costs by 24%-60% by allowing these patients to avoid high cost hospitalizations, ER visits and nursing home use (see slide of VA evidence attached).

An important potential benefit to CMS as IAH begins is that as housecall volumes grow, the anticipated and overall savings to Medicare that such visits produce could be used to partially fund solution to the SGR issue.

3) OFM Staff Responsible for Medical Record Review Project Approval Should Meet with Their Counterparts in the Innovations Center to Understand the Design of these Demonstrations and the Beneficial Impact of Increased Housecall Utilization

We encourage you to meet with your peers in the Innovation Center to learn of the demonstrations such as IAH and ACOs that may similarly include housecall practice. This exchange of information would important so you can anticipate and incorporate the service and volume changes of housecalls under the demonstrations into your data analysis.

Academy leaders would be pleased to join this meeting and have IAH and housecall volumes serve as focal point of discussion. The Academy supports IAH and the encouragement of a housecalls focused primary care workforce needed to provide service to the 4 million and growing beneficiaries whose multiple chronic conditions and disabilities make them home-limited. These mulitimorbid beneficiaries only ¼ of whom presently have primary care access in their homes are well established as the high cost beneficiary population and this information is summarized in CMS Center for Strategic Planning publication *Chronic Conditions Among Medicare Beneficiaries* https://www.cms.gov/TheChartSeries/Downloads/ChartbookFinal.pdf.

While the publication in general identifies the relationship of multimorbid condition to inpatient admissions and increased program cost – particularly telling is Figure 3.3 on page 27 ***Spending on Medicare Services as a Percentage of Total Medicare Spending Among Medicare FFS Beneficiaries by Number of Chronic Conditions: 2008.*** This bar graph reflects that as the number of chronic conditions increases the percentage of Medicare cost attributable to inpatient care increases (21 to 43%), and the amount of Medicare cost attributable to evaluation and management services decreases (from 20% to 10%).

A couple of examples powerfully demonstrate this Figure 3.3 in the real world including the financial benefit to Medicare of housecalls. One example, is a New York City based practice that applied for IAH and reports *a* ***per beneficiary savings of $27,000 per year based on the intervention and beneficiary visits of their home care medicine practice.***

A Portland, OR practice that has submitted applications to the Innovation Center is the second example. This practice also provides statistics reflecting a dramatic decrease in annual cost for patients who receive housecalls. As the table below reflects beneficiaries who have just come into the home care medicine program reflect *an* ***average annual program cost of $46,409.45 and this decreases $39,345.04 (84.78%) to an annual average cost of $7,064.41 for patients that have been under the care of the practice seen in the home for a year.***

Number of Months Under Practice Care for Patient Cohort	**Average CY 2011 Health Care Costs Per Patient**
Less than 1 Month	$46,409.45

1 to 3 Months	$18,847.45
4 to 6 Months	$17,704.45
7 to 9 Months	$15,500.34
10 to 11 Months	$7,899.02
12 Months	$7,064.41

As the administrator for the practice remarked “Often they (beneficiaries) are barely stable when we assume care, or have medical needs that have been neglected far too long.” Thus, the beneficiary clinical need in addition to the design and evaluation measures of IAH will drive beneficial increase in housecall utilization and reduction in Medicare program cost.

4) CMS Should Exempt Housecalls from Medical Record Review at Least In Relation to Innovation Center Demonstrations

The discussion with the Innovations Center could include this recommendation based on the growing evidence that *Medicare program cost decreases when housecall volume increases* that Medicare Part B providers of housecalls be exempted from pre and post payment medical (record reviews that are not based on fraud and abuse). This exemption could be established on any of the following basis that should be feasible for CMS to implement.

a) All Part B providers for whom housecalls are the majority of their evaluation and management practice.
b) All Part B providers selected to participate in the IAH demonstration.
c) All Part B providers for whom housecalls are the majority of their evaluation and management practice are established as a demonstration project within certain MAC jurisdictions or certain states. This would provide a complementary and parallel demonstration to IAH and add to the IAH demonstration results and Medicare program cost savings that at this time will be limited under the IAH limit of 10,000 beneficiaries.

5) Limit the Aggregate Number of Reviews that Any HouseCall Provider Experiences Regardless of the CMS Program or Contractor Source

We also recommend that there be established an overall cumulative limit to the number of medical reviews that a Part B provider of housecalls experience over any 12 month period. While we favor the development of overarching exemption for the field of home care medicine for the reasons noted above and attached – we seek a regulatory limit to the number of reviews these practices would experience.

We understand a limit may exist under the Recovery Audit Contractor program. However, providers particularly small providers rendering housecalls do not distinguish between the source (MAC or RAC), of medical record request nor is the cost of responding to a request different based on the source of the request. Therefore, *we recommend and we would appreciate the opportunity to work with you to establish a rolling 12 month cumulative limit to medical record reviews that would apply to housecall providers or to all primary care practices of limited scale.*

6) Academy Support for Transparency, Notice and Input Prior to Any New Service Wide Medical Record Reviews

The Academy joins the support you heard on Tuesday that notice and request for clinical input be provided prior to services being added to the pre-payment review demonstration. Moreover, we believe this should be the process before any service wide medical review is implemented regardless of whether the review is initiated by CMS, MAC or under any other Program contractor.

The Academy looks forward to providing its clinical, administrative and policy housecall expertise to you in support of the payment accuracy and other responsibilities of the OFM and the most effective use of the Medicare Trust Fund.

George Mills
Melanie Combs-Dyer
March 7, 2012
Attachment - IAH Demonstration Specifications

Table 1: Quality Measures

Quality measure	Measure tied to incentive payments
Number of inpatient admissions for ambulatory-care sensitive conditions per 100 patient enrollment months	Yes
Number of readmissions within 30 days per 100 inpatient discharges	
Number of ED visits for ambulatory-care sensitive conditions per 100 patient enrollment months	
Contact with beneficiaries within 48 hours upon admission to the hospital and discharge from the hospital and/or ED	
Medication reconciliation in the home	
Patient preferences documented	
Beneficiary/caregiver goals	No
Screenings/assessments	
Symptom management	
Medication management	
Caregiver stress	
Voluntary disenrollment rate	
Referrals	
Patient satisfaction	