LeadingAge™
New York

February 6, 2015

Ms. Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attn: CMS-1461-P
P.O. Box 8013
Baltimore, MD 21244-8013

Re: **File Code CMS-1461-P**

Dear Ms. Tavenner:

I write on behalf of LeadingAge New York to comment on the Proposed Rule governing the Medicare Shared Savings Program: Accountable Care Organizations, published in the December 8, 2014 issue of the Federal Register.

LeadingAge New York's nearly 500 members represent the entire continuum of not-for-profit and public providers of continuing care, including home and community-based services, adult day health care, nursing homes, senior housing, continuing care retirement communities, adult care facilities, assisted living programs and managed long term care (MLTC) plans. LeadingAge New York is an affiliate of the national organization, LeadingAge, and we support the comments submitted by LeadingAge. We offer these additional comments to emphasize issues of particular concern in New York State.

Our comments focus on the regulatory waivers referenced in the preamble to the proposed regulations. In particular, we offer comments on the proposed waivers of:

- the skilled nursing facility (SNF) three-day stay rule;
- the coverage and billing requirements for telehealth services;
- the homebound requirement for home health care; and
- the prohibition on hospital recommendations of post-acute care providers.

We share LeadingAge's conviction that the availability and scope of regulatory waivers authorized under the Medicare Shared Savings Program should be guided by person-centered principles, based on the needs and preferences of individuals and the goal of delivering high quality care in the most appropriate setting.

I. Skilled Nursing Facility (SNF) Three-Day Stay Rule (Section II F 4 a (1), page 72817)

Summary: CMS indicates that it is considering waiving, for patients of qualifying accountable care organizations (ACOs), the three-day hospital stay as a prerequisite for the Medicare SNF benefit. This requirement has been waived in other risk-bearing models, such as the Pioneer

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ACO and some Medicare Advantage plans and PACE programs. In support of this type of waiver, CMS notes that financial incentives associated with two-sided risk in the ACO model can reduce inappropriate utilization. It also points to the potential to maximize savings by eliminating, where appropriate, the prior inpatient stay and admitting patients to a SNF directly.

Comments: LeadingAge New York supports making this type of waiver available to patients under the care of an ACO and recommends the following:

- **This waiver should be available to ACO s participating in all Shared Savings Program risk tracks.**

LeadingAge New York supports the availability of waivers of the three-day stay requirement in all Shared Savings Program risk tracks, whether one-sided or two-sided. Originally enacted in 1965, the three-day stay requirement is an artifact of a time when the typical acute episode could be treated properly only with a lengthy inpatient stay in an acute care hospital. With advances in medical care, many acute conditions that once required extended hospital stays can be treated on an outpatient basis or in a SNF. Increasingly, observation stays are replacing inpatient admissions, forcing beneficiaries with post-acute needs to pay for their own care or do without it. Even when an acute care hospital stay is indicated, the average length of stay for most medical conditions has dropped dramatically since the 1960s. [1] Thus, more beneficiaries are leaving hospitals today without a qualifying stay and coverage for needed post-acute care. The absence of Medicare coverage for post-acute care places these beneficiaries at risk of further hospital admissions and readmissions.

As CMS notes in its preamble to the proposed regulations, significant savings could be generated by avoiding hospital stays altogether and admitting Medicare beneficiaries directly to SNFs for treatment of acute conditions or retaining existing SNF residents, rather than transporting them to a hospital when they experience an acute episode. More importantly, avoiding unnecessary hospitalizations may improve quality and outcomes. Among frail elderly individuals and people with disabilities, a hospitalization can precipitate a decline in health status, exposing the patient to infections, disrupting established caregiver relationships and medication regimens, and raising the risk of hospital-related delirium and transfer trauma.

We understand CMS's concern that waiving the three-day stay requirement may trigger unnecessary utilization of SNF services. CMS suggests that the financial incentives associated with the two-sided risk model would reduce the potential for unnecessary utilization of SNF care and premature discharges from hospitals. We believe that even in the absence of two-sided risk, sufficient incentives exist within the ACO model to discourage unnecessary SNF care and premature hospital discharges. The opportunity to earn shared

[1] The U.S. Department of Health & Human Services Inspector General found that, in 2012, Medicare beneficiaries had 1.5 million observation stays and typically spent 1 night or more in the hospital. Beneficiaries had an additional 1.4 million long outpatient stays and 1.1 million short inpatient stays (of less than two nights), which were often for the same reasons as observation stays. Memorandum to Marilyn Tavenner, Administrator, from Stuart Wright, Deputy Inspector General, July 29, 2013.

savings, to avoid readmission penalties, and to perform well on quality measures (e.g., Five-Star Ratings and ACO quality measures) would all operate to deter the delivery of inappropriate care. Moreover, waiving the requirement would mitigate existing incentives that encourage hospital utilization.

- **Long-term nursing home residents should not be excluded from three-day stay waivers.**

CMS has asked whether the same criteria used for the Pioneer ACOs' three-day stay waiver should be applied to the Shared Savings Program ACOs. We would like to comment on one of those criteria – the exclusion of long-term nursing home residents from three-day stay waivers. For the reasons discussed above, we believe that this waiver should be applied to both long-term and short-term residents of SNFs. The three-day stay requirement is outdated, in light of medical advances, whether the beneficiary is a long-term or short-term resident of a SNF. In order, to distinguish between post-acute and custodial care for long-term residents, in the absence of a hospital admission, CMS and ACOs should consider, in consultation with stakeholders, relying on case-mix classification system assignments (i.e., RUG-IV), diagnosis codes, other MDS data related to functional and health status, and/or care plan goals.

- **Three-day stay waivers should not be limited to SNFs that are ACO participants or providers/suppliers.**

If an ACO is granted a waiver of the three-day stay requirement, any SNF that meets specified criteria should be able to admit appropriate patients of that ACO. To limit these waivers exclusively to admissions by ACO participants or providers/suppliers would unduly restrict the beneficiary's freedom of choice. Qualifying criteria for SNFs should include the capacity to provide appropriate care to the patient and to participate in care coordination activities with the ACO. The policies and processes surrounding the implementation of such waivers should ensure that beneficiaries who are transferred to a hospital from a SNF are given the option of returning to the same SNF.

- **Hospital and emergency department utilization should be monitored to ensure that services are properly delivered to eligible patients.**

Hospital admissions and readmissions and emergency department visits from SNFs should be monitored as indicators of inappropriate use of the SNF as an alternative to hospital care and of premature discharges from the hospital. In addition, trends in SNF utilization and cost would inform the analysis.

II. Waivers for Telehealth Services (Section II F 4 a (2), page 72820)

Summary: CMS is considering waivers of telehealth billing requirements for patients receiving treatment under an ACO model. Currently, under Section 1834(m) of the Social Security Act, Medicare reimbursement is available for only limited Medicare Part B services delivered to beneficiaries at an "originating site" located in a rural Health Professional Shortage area or a county outside of a Metropolitan Statistical Area (MSA). Originating sites do not include the

patient's home; nor do they include sites in urban or suburban areas. Medicare payment requirements also allow reimbursement only for telehealth services that involve interactive audio and video systems and permit real-time communication. Reimbursement of remote patient monitoring and medication management telehealth services is not permitted.

Comments: LeadingAge New York supports waiving certain telehealth reimbursement requirements to expand access to telehealth services for beneficiaries served by ACOs.

- **Telehealth services eligible for reimbursement and eligible originating sites should be expanded.**

Reimbursable telehealth services should include remote monitoring, medication management, and e-consults and visits. In the home health arena, remote monitoring and medication management are effective and efficient tools to manage chronic and post-acute conditions. Using these technologies, vital signs and changes in health status can be monitored, and patients be reminded to take their medications at the right time in the right dosage, and medication adherence can be monitored. Hospitalizations and emergency department visits can be avoided, while staffing and travel expenses associated with home visits are reduced. As a result, patients can be served efficiently and effectively in the least restrictive environment appropriate to their needs.

In order to permit reimbursement of remote monitoring and medication management technologies, the requirement of real-time communication between a practitioner and beneficiary should be waived. Asynchronous "store and forward" technology should be permitted. In addition, waivers should permit reimbursement of services delivered by home health and hospice agencies.

While certain types of telehealth services may be particularly useful in rural areas where health professionals are in short supply, telehealth services that support post-acute care are valuable in all types of communities. Remote monitoring and medication management at home promote post-acute recovery and prevent hospitalizations in a cost-effective manner, whether a patient is in Brooklyn or in Speculator in the Adirondack Park. SNFs in urban and suburban areas, like those in rural communities, may be able to avoid emergency department visits and reduce hospital lengths of stay, if they are able to utilize telehealth consultations.

- **Hospital utilization and disease management metrics should be monitored to evaluate the quality of telehealth services.**

Hospitalizations, readmissions and emergency department visits should be monitored to ensure that telehealth services are being used appropriately and expected outcomes are achieved. Disease management measures, such as hemoglobin A1c values, could also be monitored.

- **Telehealth waivers should apply to all ACO risk tracks.**

Waivers of the telehealth reimbursement requirements should apply to all ACO risk tracks. The incentives associated with shared savings available in Track 1 and with both two-sided tracks are sufficient to promote appropriate use of an expanded array of telehealth services.

III. Homebound Requirement for Home Health Care (II F 4 a (3), page 72822)

Summary: CMS is considering a waiver of the homebound requirement for the Medicare home health benefit for qualifying ACO beneficiaries. The rationale for this waiver would be to avoid hospital admissions through the expanded use of home health visits by non-homebound beneficiaries who are otherwise eligible for home health services.

Comments: LeadingAge New York supports making this type of waiver available to patients under the care of an ACO.

- **The waiver of the homebound requirement should not be limited to home health agencies that are ACO providers/suppliers.**

Any home health agency should be eligible to treat non-homebound beneficiaries assigned to an ACO, if doing so meets specified criteria intended to ensure the delivery of high quality care and to promote care coordination among settings. Specifically, any home health agency that is willing to participate in care coordination activities and share care transitions information and other patient information for treatment and quality assurance purposes should be eligible to provide services to non-homebound ACO patients.

- **ACO quality metrics used to evaluate quality of care for non-homebound beneficiaries should take into account differing levels of acuity and goals for care between the homebound and non-homebound populations.**

Quality metrics used for evaluating care delivered to non-homebound patients should recognize that non-homebound patients will tend to have lower acuity levels than homebound patients. In addition, they may have goals for care that that differ from homebound patients. Accordingly, quality metrics used for this purpose, like any quality metrics, should be appropriately risk-adjusted to account for these differences, as well as differences related to long-term versus short-term patients, and other relevant characteristics. This will permit accurate measurement and comparisons of quality and outcomes among different providers and populations.

- **Home health services should be available without being triggered by some health event, when medically necessary to manage a chronic or progressive condition and prevent hospitalizations.**

Medicare beneficiaries assigned to an ACO should be eligible for home health services to manage chronic or progressive conditions, in the absence of a health event, under certain circumstances. In accordance with the Medicare benefit package, only skilled services would be available under this waiver. For example, periodic nursing visits could be ordered without an acute episode in order to prevent hospital admissions of patients with conditions such as diabetes, congestive heart failure, and chronic obstructive pulmonary disease. Nurses can

assess patients for changes in condition or psychosocial issues that might precipitate an exacerbation, support medication management, and provide the patient with disease management education. Similarly, a physical or occupational therapist can help to prevent hospitalizations by conducting falls risk assessments in the homes of frail patients and providing mobilization, self-care training and recommendations concerning environmental modifications. Likewise, speech therapists can assess and treat patients to prevent exacerbations, such as those caused by swallowing disorders, that might lead to hospitalizations. By offering these services at home rather than in a facility or practice setting, practitioners can observe beneficiaries in their usual environment and avoid transportation issues that too often prevent beneficiaries from accessing needed services.

IV. Prohibition on Hospital Steering to Post-Acute Care Providers (Section II F 4 a (4), page 72823)

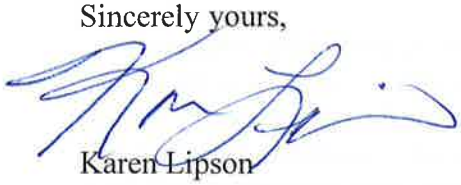
Summary: CMS has proposed allowing ACOs that participate in two-sided risk models to obtain a waiver of the regulation prohibiting hospitals from specifying or otherwise limiting the qualified post-acute providers that are available to patients. This waiver would allow ACOs and hospitals to make more specific recommendations concerning post-acute care based on the performance of available providers.

Comments: LeadingAge New York supports empowering beneficiaries to make informed choices about their care and providers. Objective and valid quality information should be a component of the beneficiary's selection process. However, we are concerned that this type of waiver might allow ACOs and participating hospitals to limit or improperly influence beneficiaries' choice of post-acute care providers. Beneficiary needs and preferences should drive the discharge process.

If this waiver is made available to ACOs, participating hospitals should be required to provide beneficiaries with a complete list of available post-acute care options. The list should not be limited to ACO participants and/or provider/suppliers. The list may include information relevant to the beneficiary's preferences and needs. Importantly, when a patient is admitted to a hospital from a long-term/post-acute care facility or home health agency, the option of returning to the originating facility or agency should be made clear to the beneficiary. The discharge planning process should ensure that referrals to hospice are made, if appropriate and consistent with the patient's preferences and goals for care.

We appreciate the opportunity to comment on the proposed waivers referenced in the Proposed Rule. Please do not hesitate to contact us, if you have any questions. We look forward to working with CMS on these and other issues. Thank you for your consideration.

Sincerely yours,



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