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Bringing Home the Continuum Of Care

Delivering New Models of Care Under Health Care Reform

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"The rising cost of health care is the nation's number one deficit problem— nothing else even comes close."

– President Obama
Speech, September 9, 2009

The goals of the Patient Protection and Affordable Care Act ("The Affordable Care Act" or ACA) are clear: extend coverage to an additional 34 million Americans and improve the quality of health care, while simultaneously cutting $143 billion from overall health care costs. Difficult to achieve under the best of circumstances, this task is complicated by a rapidly aging population that disproportionately suffers from multiple chronic conditions.

While there are no magic bullets, the architecture of a solution is embedded in the ACA. The formula for success was articulated by the Institute of Medicine's characterization of appropriate and affordable care: "Deliver the right care at the right time by the right provider in the right setting."

ACA and the Open Door

The ACA is pursuing this goal by moving away from the current fee-for-service approach, and attempting to incentivize care decisions that are the most appropriate, regardless of provider and facility. As many of us across the health care provider spectrum have learned, not only does the system not pay for this kind of coordinated, cost effective, and patient-centered care, it frequently penalizes us when we try to deliver it. But with the advent of the Affordable Care Act, that too is changing.

A great deal is changing with the implementation. It can be scary, frustrating and overwhelming, but as inventor Alexander Graham Bell said, "Sometimes we stare so long at a door that is closing, that we see too late the one that is opening."

This paper looks with an inventor's eye at one of the doors that is opening. It discusses how state-of-the-art home health care providers are well equipped to partner with physicians to deliver the kind of high value coordinated health care management and coordination that the ACA requires.

The Growing Challenge: Managing Multiple Chronic Conditions

America's 77 million baby boomers will have a profound impact on the health care system, particularly the Medicare system. As the population ages, the health care system will encounter a greater number of patients who will have multiple chronic conditions, and therefore will be under the care of multiple providers. With more chronic conditions come higher utilization rates and higher costs.

Consider the impact that the anticipated rise in just one chronic condition – diabetes – will have on our health care system. Some health care experts expect that in the next 25 years, the number of people suffering from diabetes will nearly double, increasing from 23.7 million in 2009 to 44.1 million in 2034. Over that same period, the cost for treating diabetes in this country is expected to triple from $113 billion to $336 billion.[1] In the meantime, Medicare spending on diabetes is expected to nearly quadruple, jumping from $45 billion to $171 billion.[2]

The ACA Imperative: Manage Multiple Chronic Conditions

75%

The Challenge.

75 percent of Americans age 65 and older have multiple chronic conditions.

76%

The Cost.

Patients with multiple chronic conditions account for 76 percent of all hospital admissions and 72 percent of physician visits, and are 100 times more likely to have a preventable hospitalization than someone with no chronic conditions.

72%

60%

The Home-Based Solution.

There has been a 60 percent reduction in hospital costs for patients with multiple chronic conditions in The Virginia Commonwealth Medical Center house calls program.

A convergence of trends will accelerate the rise in the number of people with multiple chronic conditions – a patient group that already makes up the fastest growing segment of the Medicare beneficiary population.[3] A total of 83 percent of Medicare beneficiaries have at least one chronic condition, and 23 percent have five or more chronic conditions and account for 68 percent of Medicare spending.[4]

Under the current system, the care of Americans with multiple chronic conditions tends to be uncoordinated, inefficient and, all too often, ineffective. In a one-year period, the average Medicare beneficiary sees seven different physicians and fills at least 20 prescriptions.[5] But patients with multiple chronic conditions see an average of 13 different physicians and fill 50 different prescriptions a year, which represents about 88 percent of all prescriptions filled. Patients with multiple chronic conditions also account for 76 percent of all hospital admissions and 72 percent of physician visits, and are 100 times more likely to have a preventable hospitalization than someone with no chronic conditions.[6]

Largely at fault for this expensive, less-than-optimal care is our current fee-for-service health care system that pays providers per procedure and service, rather than for the outcomes they achieve, and compensates providers regardless of their ability to coordinate care.[7] Under this current fee-for-service model, providers who have tried the medical home model, such as Park Nicollet based in Minneapolis, Minn., have reported losing money on the program, because the resulting decline in hospital revenue far exceeded any extra payments in recognition of the patient benefits and cost savings of coordinated care.[8]

The Opportunity: Managing Multiple Chronic Conditions at Home

Research by AARP's Public Policy Institute found 89 percent of people age 50 and older want to remain in their homes as they age, including receiving treatment there.

Beyond patient preferences, the comforts of home also have been proven to promote healing and reduce health risks. High quality home care can also reduce costs for these patients. Last year, a study sponsored by the Alliance for Home Health Quality and Innovation showed that early use of home health care services following a hospital stay, by patients with at least one chronic disease, saved $1.71 billion in 2005-2006 largely due to a reduction in preventable complications and re-hospitalizations.[9] The Congressional Budget Office (CBO) contends that even a small percentage reduction in Medicare spending for this group of high-cost beneficiaries would lead to large savings for the Medicare program."[10]

> A total of 83 percent of Medicare beneficiaries have at least one chronic condition, and 23 percent have five or more chronic conditions and account for 68 percent of Medicare spending.

Even before the ACA, there was growing acceptance of home health care as an alternative to lengthy hospital stays, nursing homes and other inpatient treatments. In fact, this type of care has seen a steady compounded growth rate of more than eight percent since 2000.[11] The growth is expected to increase to 10 percent through 2015 as baby boomers mature and government policies drive the use of home health care over higher cost inpatient care.[12]

A significant part of the ACA focuses on better managing chronically ill patients, and the evidence is telling us that delivering more of this care at home can benefit patients as well as physicians and health care facilities.

> *"According to AARP, 89 percent of people 50 years and older want to remain in their home as they age, including receiving their health care there."*

ACA Roadmap: From Fee-for-Service to New Delivery Models

Now more than a year since being signed into law, implementation of the ACA has already begun in a process that will accelerate over the next five years. The principal objectives of the ACA can only be achieved through new health care delivery models based on partnerships between primary care physicians and home care organizations prescribed in the legislation. It bears repeating that the ACA will extend health insurance to another 34 million Americans and add new coverage for chronic care coordination, preventive care, and mental health services to the three primary sources of health insurance—Medicare, Medicaid, and private insurance.

At the same time, the ACA is projected to reduce the overall costs of health care by an estimated $143 billion over 10 years. It does this by reducing projected payments to Medicare providers, reducing payments to Medicare Advantage programs, increasing taxes, and adding a federal Community Living Assistance Services and Supports program (the CLASS Act) that is designed to be funded by employee contributions.[14]

The ACA Expands Demand for Many Types of Care.

Unless new service delivery models are adopted, it is likely that primary care physicians will be inundated by increased demands for health care services expanded by the ACA. For example, private health insurance plans will be required to include "preventive and wellness services and chronic disease management" and "mental health and substance use disorder services including behavioral health treatment," as well as the usual medical/surgical coverage.[15]

The ACA also contains provisions adding coverage under Medicare, Medicaid and private insurance for preventive care and screening for physical and mental disorders, without cost sharing, beginning Sept. 23, 2010 for private insurance, Jan. 1, 2011 for Medicare and 2013 for Medicaid plans.[16] Medicare beneficiaries have a right, effective Jan. 1, 2011, to an annual wellness visit and a "personalized prevention plan" that includes a "health risk assessment" that identifies any chronic diseases, injury risks and urgent health needs by the individual.[17]

Unless new service delivery models are adopted, it is likely that primary care physicians will be inundated by increased demands for health care services expanded by the ACA.

Step back for a second and think about it. All of those requirements are on top of a physician's current workload during a time when there is a well-documented shortage of doctors and an aging population.

In order to meet this increased demand for services, something has to change.

More Focus on Managing High Cost Patients

In the past, private insurers have tried to avoid the high cost of caring for the chronically ill by not accepting them for coverage, rescinding coverage once they became chronically ill or by establishing annual or lifetime limits on payments. The ACA, however, prohibits health insurance companies from limiting their risk by denying coverage for pre-existing conditions, imposing lifetime or unreasonable annual limits on total payments, determining premium rates based on health status or rescinding coverage for enrollees.[18]

These reforms are creating a strong incentive for private health insurers to consider risk-sharing arrangements with practitioners and providers, and to explore lower cost service delivery models for the highest cost patients.

State Medicaid programs have also avoided high cost chronically ill patients, and have traditionally not included coverage for chronic care coordination or preventive care services. Under the ACA, states are mandated and incentivized to provide health coverage to the high-cost chronically ill in low-cost settings, and to adopt new reimbursement methodologies that reward practitioners for good results rather than volume of services rendered.

So the ACA provides numerous opportunities for primary care physicians to partner with home care providers to offer health care services to the highest cost patients. Most of the new health care delivery models provide authority for the waiver of the anti-kickback and anti-referral laws that have made such partnerships difficult to implement in the past.

These reforms are creating a strong incentive for private health insurers to consider risk-sharing arrangements with practitioners and providers, and to explore lower cost service delivery models for the highest cost patients.

New Delivery Models Mandated or Encouraged By the ACA

Independence at Home Program (ACA, section 3024)

The Independence at Home (IAH) program is a three-year demonstration project under the ACA, but it is significant because the elements of this provision appear in many of the other health reform models. As a result, an IAH-style health delivery model or models could qualify for a number of different reform programs.

IAH is the only health reform provision that targets the highest cost segment of the Medicare beneficiary population, requires minimum savings of five percent, and employs physician or nurse practitioner-directed teams of health care professionals, such as home care personnel, to provide care to these beneficiaries in their homes and coordinate care across all treatment settings.

The ACA states that IAH organizations must demonstrate an ability to make in-home visits and be available 24 hours a day, seven days a week to carry out care plans tailored to the individual beneficiary's chronic conditions. The demonstration project is intended to determine whether such physician-directed health care teams can reduce costs by reducing hospitalizations, hospital readmissions, duplicative diagnostic and laboratory tests and emergency room visits – all while improving outcomes commensurate with the beneficiary's chronic conditions and achieving patient and caregiver satisfaction.

Beneficiaries eligible for the IAH benefit are those who: (a) suffer from two or more specific high-cost chronic diseases; (b) have an inability to perform two or more activities of daily living without assistance, and (c) have used high-cost Medicare services (such as non-elective hospitalizations) in the past 12 months. These are the roughly five percent of Medicare beneficiaries who account for 43 percent of Medicare's costs. Existing programs have shown reduced costs in the range of 24 to 60 percent for such beneficiaries.[19]

> IAH organizations must demonstrate an ability to make in-home visits and be available 24 hours a day, seven days a week to carry out care plans tailored to the individual beneficiary's chronic conditions.

Physicians and providers participating in IAH programs are paid for services currently covered by Medicare and also paid a share of savings they achieve beyond the first five percent. IAH organizations are expected to be paid 80 percent of the savings they achieve. The applicability of the Medicare anti-kickback and anti-referrals laws can be waived to permit practitioners and providers to participate in IAH organizations.

The IAH program is based on the physician/nurse practitioner house call model, which has been operating for decades at numerous locations across the country. Some examples of this approach include:

The Veterans Affairs' Home-Based Primary Care program has been in operation for 32 years, currently exists in 130 locations in 48 states, treats 17,000 chronically ill patients and soon will be available at every VA facility. The HBPC program has reduced hospital days by 62 percent, nursing home days by 88 percent and overall costs by 24 percent.[20]

The Urban Medical Housecall program in Boston, Mass., has been operating for more than 30 years, treats nearly 600 Medicare high cost beneficiaries with multiple chronic diseases and has reduced hospital admissions for these patients by 29 percent and hospital days by 34 percent.[20]

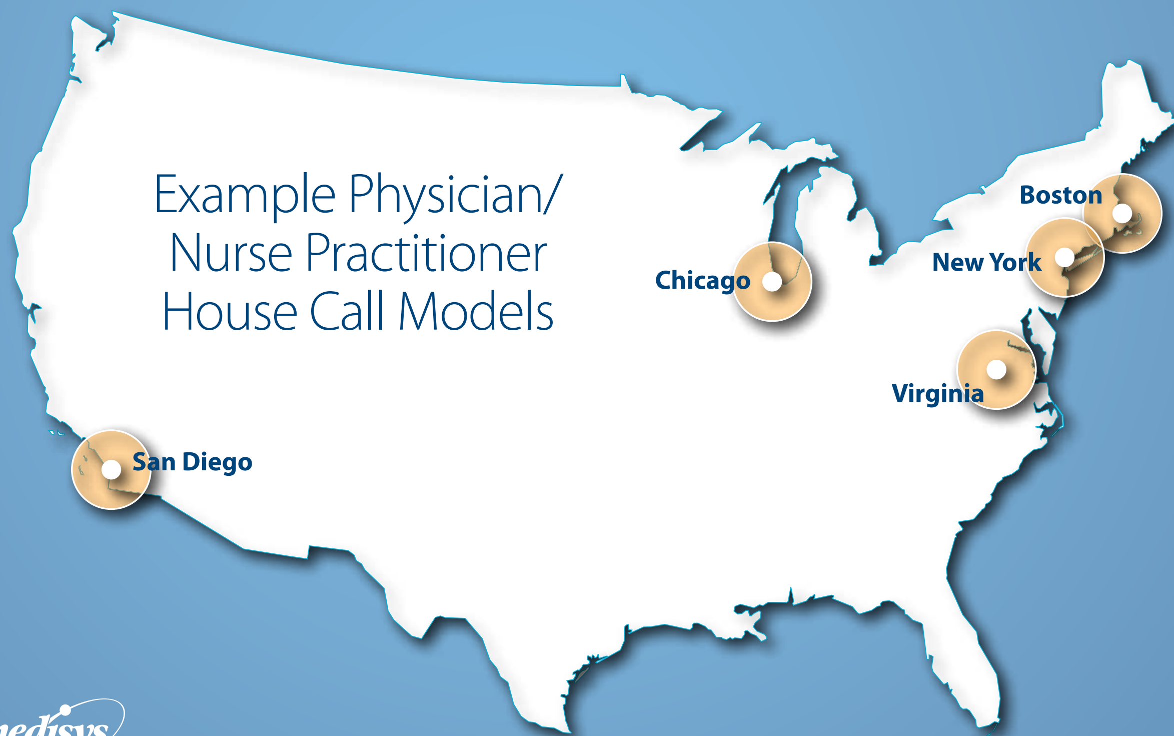
The Virginia Commonwealth Medical Center house calls program in Richmond, Va., has been operating for 23 years and has reduced hospital costs by 60 percent for high cost beneficiaries with multiple chronic diseases.[20]

The Call Doctor Medical Group has operated a physician house call practice for 25 years in San Diego, Calif., focused on Medicare beneficiaries with multiple chronic diseases and has reduced ER visits by 59 percent and generated per capita savings of $1,075.[20]

The Home Physicians program in Chicago, Ill., has been operating for 15 years and currently treats 7,000 high cost Medicare beneficiaries with multiple chronic illnesses. The program has shown reductions in ER visits and hospitalizations from 35 percent to as high as 60 percent over the years.[20]

The House Call program at Montefiore Health System in the Bronx, N.Y., has been operating for five years treating high cost elders with multiple chronic diseases. With an enrollment of about 400 patients, it has shown a 42 percent reduction in hospitalizations and a 33 percent reduction in total costs.[20]

The Independence at Home demonstration project is scheduled to begin by Jan. 1, 2012, but CMS has indicated that it plans to implement this program "as soon as possible."[21] The IAH demonstration can enroll up to 10,000 Medicare beneficiaries nationwide.



Health Homes Under Medicaid for Individuals with Chronic Conditions (ACA, section 2703)

States, at their option, may amend their Medicaid plans to provide certain services to eligible individuals suffering from chronic conditions. These services include comprehensive care management, care coordination and health promotion, comprehensive transitional care from inpatient settings, patient and family support, referral to community and social support services, and use of health information technology to link services. States that adopt this option must require hospitals that participate in Medicaid or a Medicaid waiver program to establish procedures for referring eligible individuals to home health if they "seek or need treatment" in the hospital's emergency room.

The services are to be provided through a designated provider or a physician, clinical practice or clinical group practice, home health agency or other entity or provider determined to be qualified by the state and approved by the Secretary of Health and Human Services (HHS). A "team of health care professionals" is to be described by the state.

Eligible individuals are those who: (a) are eligible for medical assistance under the state plan or under a waiver, and (b) have at least two chronic conditions, one chronic condition and the risk of having a second, or one serious and a persistent mental health condition.

The services are to be provided through a designated provider, or a physician, clinical practice or clinical group practice, home health agency or other entity or provider determined to be qualified by the state and approved by the Secretary of Health and Human Services (HHS).

Payments for the services are to be established by each state and are to include "alternate models of payment" in addition to monthly member payments. The payment methodology must prevent unnecessary use and be adequate to attract a sufficient number of providers.

For the first eight quarters the program is in effect, the federal government will fund 90 percent of the payments. States can amend their Medicaid plans effective Jan. 1, 2011 to provide for home health. The Secretary can also award planning grants of up to $25 million to states for the purposes of developing a state plan amendment.

Community Health Teams to Support the Medical Home (ACA, section 3502)

This is a grant program to fund health care teams to provide support services to primary care practices and provide capitated payments to primary care providers.

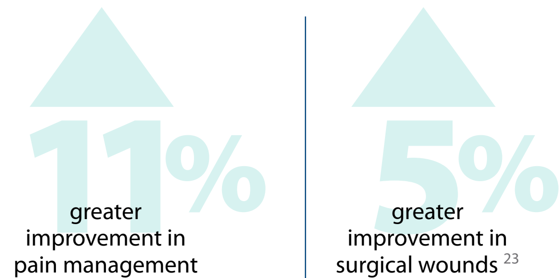
Eligible entities – states, state-based entities and Indian tribes – must submit a plan to the state for incorporating prevention initiatives, patient education and care management resources into delivery of integrated health care delivery. The plans must demonstrate long-term financial sustainability within three years.

The health teams are to include health care practitioners, medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral and mental health providers, doctors of chiropractic, licensed complementary alternative medicine practitioners and physicians' assistants. These team members agree to provide services to beneficiaries with chronic conditions, enter into contracts with primary care

physicians, support patient-centered medical homes and assist in coordinating disease prevention and chronic care management. They are also to provide 24-hour management and support during transitions in care settings.[22]

This program of support for primary care physicians can be implemented as soon as the Secretary of HHS issues implementing regulations.

According to Medicare data, Amedisys patients have better health outcomes than competitors' patients in areas including:



Primary Care Extension Programs (ACA, section 5404)

This program provides support and assistance to primary care practitioners with regard to preventive medicine, health promotion, chronic disease management, mental and behavioral health services (including substance abuse prevention and treatment services), and evidence-based and evidence informed therapies and techniques.

Grants are available for Primary Care Extension Hubs to assist primary care practitioners in implementing patient-centered medical homes and health homes, to share and disseminate lessons learned and best practices and to develop a plan for financial sustainability of the hubs after six years.

Support grants will be available to states to establish such hubs for a six-year period and planning grants will be available for a two-year period.

Preventive Care and Screening Services (ACA, TITLE IV, sections 4001-4401)

The ACA funds a great deal of disease prevention and screening work, much of which will likely have to be provided by primary care physicians in collaboration with home care providers. For example, the ACA authorized amounts ranging from $500 million in 2010 increasing each year to $2 billion in 2015, and each year after for "prevention, wellness, and public health activities including prevention research and health screenings."[24]

> Our Care Transitions program, which begins patient education prior to discharge from the hospital, shows preliminary pilot results of a 7.9 percent reduction in ACH. [26]

The ACA also requires new disease prevention, physical examinations and prevention plan services to be covered without co-payments or deductibles for Medicare, Medicaid and private insurance. All Medicare beneficiaries will be entitled to coverage of, and full payment for, "personalized prevention plan services," which will include "a health risk assessment," a creation of a health risk plan that identifies risk factors and contains a screening schedule for the next five to 10 years, personalized health advice and referral to preventive health programs and an annual physical.[25] These services can be provided by a "health professional," including a physician, physician assistant, nurse practitioner, or clinical nurse specialist.

Payment will be at 100 percent of the lesser of the actual charge for the services or Medicare's fee schedule for physician's services.

A broad range of preventative services will be covered by Medicare.[27] The Task Force recommendations specify the recommended frequency for such preventive services based on the age of the individual. It appears that practitioners and providers will be paid 100 percent by Medicare for identifying diseases to treat.

Similar preventative care requirements apply to all group health plans and insurers offering group or individual coverage.[29]

The ACA also provides incentives for states to include 100 percent coverage of a broad range of preventive care services, vaccinations and certain medical or remedial services."[28] States providing such coverage under their Medicaid plans will have federal matching funds increased by one percent. The Medicaid provision takes effect on Jan. 1, 2013.

Similar preventative care requirements apply to all group health plans and insurers offering group or individual coverage.[29]

Home care providers and practitioners could provide many of the preventive care and screening services under an agreement with a primary care physician group practice.

Physician/Home Care Models Under the CMS Innovation Center (ACA, section 3021)

The ACA provides a list of 20 types of health care delivery reform models that may be tested by the CMS Innovation Center. At least six of these types of models provide opportunities for physician/home care partnerships.

In deciding to test any of the programs, however, CMS is to consider factors that are similar to the requirements for the Independence at Home program referenced earlier.

Physician/home care collaboration could figure prominently in the following six types of health delivery models that may be tested by the CMS Innovation Center:

- Models that promote broad payment and practice reform, including patient-centered medical homes for high-need beneficiaries, medical homes that address women's unique care needs and models that transition primary care practices away from fee-for-service based reimbursement to comprehensive payment or salary-based payment.
- Community-based health teams to support small-practice medical homes by assisting the primary care practitioner in chronic care management, including patient self-management activities.
- Using geriatric assessments and comprehensive care plans to coordinate the care through interdisciplinary teams of beneficiaries with multiple chronic diseases who are unable to perform two or more activities of daily living and have cognitive impairment, including dementia.
- Supporting care coordination for chronically ill beneficiaries at high risk of hospitalization through the use of a health information technology-enabled provider network that includes care coordinators, a chronic disease registry, and home telehealth technology.

- Funding home health providers who offer chronic care management services to beneficiaries in cooperation with interdisciplinary teams.
- Using a diverse network of providers and suppliers to improve care coordination for beneficiaries with two or more chronic conditions and a history of prior-year hospitalization.

Any of the models tested by the CMS Innovation Center will likely have the Medicare anti-kickback and anti-referral statutes waived as necessary to allow the model to be tested. Models that are tested can be extended or expanded if the CMS Office of the Actuary certifies that the model will reduce costs or not increase spending.

Medicare Shared Savings Program (ACA, section 3022)

The ACA includes a permanent revision to Medicare that will allow the Secretary of HHS to enter into three-year contracts with Accountable Care Organizations (ACO). An ACO can be primary care physicians, hospitals and other providers and suppliers as appropriate that have established a mechanism for shared governance. These ACOs must agree to be held accountable for quality, cost, and overall care of Medicare fee-for-service beneficiaries who are assigned to it in 5,000 patient groups.

Providers and practitioners participating in ACOs will be paid for services on a fee-for-service basis, but also will be paid a share of any savings beyond a threshold amount subject to a limit. In addition, ACOs can be paid under a "partial capitation" model in which they are at risk for some, but not all, of the items and services furnished, including physicians' services. ACOs can also be paid under any payment model that the Secretary determines will improve quality and efficiency.

This program is to be implemented no later than Jan. 1, 2012. As with the IAH program and the models tested under the CMS Innovation Center, the HHS Secretary is authorized to waive applicability of the Medicare anti-kickback and anti-referral statutes as necessary to implement this program.

An ACO can be primary care physicians, hospitals and other providers and suppliers as appropriate that have established a mechanism for shared governance.

As the largest home care provider in the country, we have highly sophisticated coordination of care and transition to home programs, state of the art chronic care management programs, and health information technology platforms, all designed to keep patients healthy at home where they want to be, and help prevent unnecessary re-hospitalizations.

The Shifting Sands of Regulations Will Change the Face of Home Care

In recent years, the home care industry has been through a lot of regulatory changes. In an attempt to prevent conflicts of interest, Medicare has prohibited joint ventures between home health providers and physicians. To create an incentive for greater efficiencies, in 2000 Medicare switched from a cost reimbursement model to a prospective payment model. However, in the wake of this change, the Medical Payment Advisory Commission (MedPAC) and other groups recommended substantial cuts in payments due to "excess profits." MedPAC contends in a recent report that home health providers had profit margins in excess of 17 percent.

Furthermore, critics argue that home health benefits contribute to the growth in Medicare spending because there is no co-payment, and further allege that home health is subject to fraud and abuse, and cannot show it produces savings.

These critics have had an impact on reform efforts. When it comes to this traditional home health provider model, the ACA reduces Medicare spending by $40 billion over the next decade.[13] At the same time, the ACA is clearly looking beyond the traditional home care model to one that effectively coordinates and manages the care of the chronically ill elderly.

Amedisys and other companies are well along in a diversification strategy that will enable them to make the transition from a home health provider to a chronic care management company.

Amedisys Prepared to Meet ACA-Generated Demand

Amedisys has developed an evidence-based, coordinated care model for chronically ill, elderly patients that combines the traditional home care structure with communications technologies and enhanced clinical capabilities.

This new model combines with a long history of success in several areas prioritized by the ACA. For example:

Wound Care Management

Amedisys has combined and integrated its expert clinical and support services with some of the most respected and recognized leaders in the wound management industry. Utilizing a multidisciplinary team approach led by the physician, the Partners in Wound Care® program provides treatment in a setting most preferred by patients - at home.

Fall Prevention

Amedisys' Balanced for Life® program is an advanced rehabilitation specialty program that evaluates each patient and develops a systematic approach to treatment so patients can manage their balance disorder, reduce fall risk and maintain safe and independent living. The program has proven clinical outcomes, with 94 percent of patients improving their balance by at least two points according to the Tinetti Performance Oriented Mobility Assessment, a widely recognized clinical instrument used to measure fall risk.[30]

Post-Surgery Care

Amedisys has developed a Surgical Recovery program designed to give patients back their functional independence and provide maximum clinical outcomes. Our protocols allow patients to recover at home with the reassurance that their post-operative care needs are being met by highly professional and skilled nurses and therapists in accordance with their physician's orders and nationally recognized standards of care.

Behavioral Health Programs

Amedisys' Behavioral Health at Home program is designed to provide transition from the hospital to the home with ease for the patient and family. The services also may facilitate adjunct therapy for patients with existing psychiatric needs. Our psychiatric nurses assess the home environment and provide coordination of care for the patient and family, along with the psychiatrist and/or primary care physician to make sure the needs of the patient are being managed effectively.

These programs and more are poised to be expanded and integrated with a broader team to meet the ACA-generated demand in the years to come.

While it is clear that health care in the post-ACA world will be more coordinated in the future, it is less clear who will do the coordinating. Primary care physicians teamed with home health providers are best positioned to do this coordination.

A number of ACA programs encourage this line of care. However, it is anticipated that institutional providers will try to retain their control over care coordination payments through models such as Accountable Care Organizations (ACOs) and bundling of payments for post-acute care with payment for hospital services.

If the home health industry becomes an industry characterized by high patient volumes and low profit margins, then it will be innovative companies like Amedisys – those that have the scalability and resources to invest in the technological and clinical infrastructure to implement high quality, high value models on a national basis – that will realize the potential of ACA.

Conclusion: ACA Opens Door Wide to Physician-Home Care Partnerships

According to the Congressional Budget Office, rising costs, especially under Medicare and Medicaid, is the single greatest threat to the country's economic stability.[31] Therefore, whichever way the political winds happen to blow in coming years, health care cost containment will continue to be a major focus for decades to come.

Under the ACA, the health care delivery system of the future will be centered on primary care practices in partnership with, or in some other collaborative arrangement with, home care providers. These proposed health care delivery models generally fit an overall approach embodied by the IOM counsel that the goal of health care is "to deliver the right care for the right patient at the right time, all the time."[32] It's an approach that is especially important when it comes to caring for patients who suffer from one or more chronic conditions.

The ACA presumes that it is only through the use of such models that better health care can be provided to more individuals at lower cost. Supported by a developing partnership between primary care physicians and home care providers, these new models hold bright promise to do just that. But it will take companies who can deliver on the promise of coordinated care for the chronically ill, delivered to them in the optimal environment – inside their front door.

And to hearken back to Mr. Bell's earlier counsel, that is one of the most critically important "open doors" in the post-ACA world.

(Endnotes)

[1] Huang ES, et al. Projecting the Future Diabetes Population Size and Related Costs for the U.S. Diabetes Care (Dec. 2009): 32; 12:2225-2229.

[2] ibid.

[3] "Rising Out-of-Pocket Spending For Chronic Conditions: A Ten Year Trend," K. Peaz, et al., p. 22, Health Affairs (Jan./Feb. 2009).

[4] "Medicare and Chronic Conditions," New England Journal of Medicine, Gerald F. Anderson, p. 305 (July 21, 2005).

[5] Leff B, et al. Hospital at home: feasibility and outcomes of a program to provide hospital-level care at home for acutely ill older patients. Ann Intern Med. 2005 Dec 6;143(11):798-808.

[6] Testimony of Gerard F. Anderson, Ph.D., Johns Hopkins Bloomberg School of Public Health, Health Policy and Management, before the Senate Special Committee on Aging, "The Future of Medicare: Recognizing the Need for Chronic Care Coordination," Serial No. 110-7, pp. 19-20 (May 9, 2007).

[7] CMS finding, 69 Fed. Reg. at 22,066 (April 23, 2004); "Medicare and Chronic Conditions," supra, at p. 305.

[8] Meyer H. Home Sweet Medical Home. Trustee (Nov. 1, 2208) 61;10.

[9] Aguiar C, et al. Medicare Spending and Rehospitalization for Chronically Ill Medicare Beneficiaries: Home Health Use Compared to Other Post-Acute Care Settings. Avalere Health.LLC and Alliance for Home Health Quality and Innovation. May 11, 2009.

[10] "High-Cost Medicare Beneficiaries," Congressional Budget Office, p. 4 (May 2005).

[11] Congressional Budget Office. Baseline Medicare, MedPAC March 2009 Report to Congress.

[12] ibid.

[13] CBO Letter, Table 5, p. 3 (March 20, 2010).

[14] Congressional Budget Office letter to the Honorable Nancy Pelosi, Speaker of the House of Representatives, pp. 2, 9 (March 20, 2010).

[15] ACA, section 1302.

[16] ACA, sections 1001, 4103, and 4106.

[17] ACA, section 4103.

[18] ACA, section 1001.

[19] See, e.g., Veterans' Affairs Home Based Primary Care, 25 Clinics in Geriatric Medicine, 1, 153 (Feb. 2, 2009).

[20] Independence at Home Act. A Chronic Care Coordination Program for Medicare That Has Proven Effective in Reducing Costs and Improving Quality for Highest Cost Patients. Accessed at *http://www.nyam.org/policy/testimony/aging-federal03.pdf.*

[21] Letter from Congressman Ed Markey and Senator Ron Wyden to CMS Acting Administrator, Marilyn Tavenner (June 29, 2010); Reply from Marilyn Tavenner (July 20, 2010).

[22] In addition, they must provide support for primary care to offer access to individuals that implement plans of care, collect and report outcomes data, establish a coordinated system of early identification and referral for children at risk for developmental or behavioral problems, provide 24-hour care management and support during transitions in care settings, serve as a liaison to community prevention and treatment programs, demonstrate a capacity to implement and maintain certified electronic health information technology, and report to the Secretary on quality measures.

[23] Home Health Compare. Accessed at *www.medicare.gov/homehealthcompare/search.aspx*.

[24] ACA, section 4002.

[25] ACA, section 4103.

[26] "A Nationwide Approach to Care Transitions and Health Coaching." The Remington Report, Sherry Dukes. p. 27 – 28 (Nov/Dec 2010).

[27] ACA, section 4104.

[28] ACA, section 4106.

[29] ACA, section 1001.

[30] Amedisys analysis of patient outcome data conducted on a quarterly and annual basis, 2008 - 2011.

[31] "Budget and Economic Outlook: Fiscal Years 2010 to 2020," the Congressional Budget Office, p. 21 (Jan. 2010).

[32] Institute for Health care Improvement. Idealized Design of Clinical Office Practice. Boston, MA: Institute for Health care Improvement; 2000.