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The Value of In-Home Evaluations in Advancing CMS' Medicare Goals

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Introduction

In-home evaluations (IHEs) are an integral component of Medicare Advantage (MA) plans, giving MA plans a cost-effective way to identify and meet the medical and nonmedical needs of vulnerable beneficiaries in their own homes and communities to impact health outcomes. They are an important touchpoint to holistically and comprehensively assess individuals in their own environment and, whenever possible, connect them to needed community resources and community providers for ongoing care and care coordination.

IHEs have proven their value in Medicare Advantage.

This white paper demonstrates how IHEs deliver value consistent with the Centers for Medicare & Medicaid Services' (CMS) strategic goals for the Medicare program and offers recommendations for how CMS could extend that value beyond MA, particularly to Medicare enrollees who are served by Advanced Alternative Payment Models (AAPMs) such as Accountable Care Organizations (ACOs) like those under the Medicare Shared Savings program (MSSP) or the recently-announced ACO Realizing Equity, Access, and Community Health (REACH) Model.

Section 1 of the white paper explains how IHEs have been used by some MA plans to improve care and then examines how IHEs could advance CMS priorities for the Medicare program in four areas:

- **Health equity**. IHEs reach some of the most vulnerable Medicare populations—those who are cut off from needed services due to social determinants of health (SDOH) and/or other barriers—identify unmet needs, and help connect patients to primary care and other needed services.
- **Person-centered care**. IHEs identify social, economic, and environmental factors with the potential to impact health outcomes, not just medical ones, to facilitate the development of individualized care planning, patient engagement, and care coordination strategies.
- **Access to care**. IHEs are a cost-effective way to identify and potentially address care needs that may otherwise remain untreated for enrollees who face challenges to accessing care.
- **Cost-effective care**. IHEs help uncover care needs that can be addressed more upstream to avoid urgent and emergency care.

ACOs could benefit from IHEs if CMS promoted their broader use across all Medicare beneficiaries.

Section 2 of the white paper offers recommendations for CMS to promote the broader use of IHEs within Medicare. CMS can cover IHEs for all Medicare beneficiaries, use its authority to regulate ACOs to establish IHEs as benefit enhancements, or encourage the use of IHEs as beneficiary incentives in these AAPMs.

Section 1: Value of IHEs

The IHE

The IHE's purpose is to provide early, preventive health risk assessments within the home setting for MA beneficiaries. These are perhaps most valuable for those with challenges accessing care, including those who may face barriers to transportation or have physical limitations that prevent them from readily accessing essential health services, as well as those with complex medical and nonmedical health-influencing needs. IHEs are conducted by physicians and advanced practice providers (APPs) and can include:

- Comprehensive health evaluations
- Medication reviews and adherence checks
- Assessments of current and prior health conditions, including those that may not be well managed or are progressing
- Screening for mental health conditions and substance abuse
- Identification of patient safety hazards in the home, such as the absence of shower bars, inadequate lighting, or loose rugs, all of which can have significant impacts on patients' fall risks
- Connecting individuals to community and medical resources

IHEs can also include other in-home diagnostic and preventive services to address certain clinical needs, such as:

- Lab collection (e.g., HbA1c, LDL, microalbumin)
- Peripheral artery disease testing
- Bone density testing
- Diabetic eye exams
- Flu shot vouchers

Further, IHEs facilitate care coordination for beneficiaries by providing important SDOH data to providers and plans in order to support individualized care planning and connecting members to relevant community programs. IHEs can be adapted, modified, and/or expanded to meet the needs of the entity's attributed population, considering variations in geography, access to care, attributed physician availability to address beneficiaries' needs, and many other factors.

IHEs can provide important information about social determinants of health.

"Through the in-home evaluation, we provide a full head-to-toe assessment: We check the lungs, circulation in the legs, blood pressure levels while sitting and standing, and more. And we frequently find that patients have far more needs in the home than what they will tell their doctor in the office setting. When we're in the home, we realize that the patient doesn't understand their medications, or they require assistance with food or housing. And because we are connected to the local community, we know the community organizations that can provide the needed support, we can explain to their family members what is going on, and we can identify illnesses that the doctor wasn't able to catch before."

Susan Hubbard, MSN, ARNP, FNP-C, IHE Provider, Signify Health

These features are particularly important for the Medicare program, which covered nearly 61 million beneficiaries in 2021, including adults over 65 years old and younger adults with long-term disabilities, and accounted for a significant portion of the nation's health expenditures ($829 billion, or 20% of total national health expenditures in 2020).[1] The Medicare program's benefits and services should seek to positively impact the trajectory of beneficiaries' health care journeys, quality of life, health care spending, and the patient experience of care over time.

IHEs in Medicare Today

Currently, no-cost IHEs are frequently provided as a benefit of MA plans.[2] By using medical professionals to assess Medicare members' health needs in their homes, plans are using the IHE as the foundation for a broader solution to assess and engage an often vulnerable segment of the Medicare population in a comprehensive, person-centered way.

MA plans look to IHEs as a valuable tool for meeting patient needs.

By contrast, providing adequate preventive care—inclusive of patient engagement, annual preventive testing, connection to vital community resources, and education—is often a challenge within the confines of the original Medicare structure. No vehicle presently exists to offer IHEs on a broad scale in original Medicare or its AAPMs. As a result, the availability of IHEs currently remains limited to MA beneficiaries, who represent less than half (26 million people, or 42%)[3] of the total Medicare population.

Meanwhile, CMS has a goal of covering all Medicare beneficiaries in an accountable care relationship by 2030, which means a greater proportion will be part of an MSSP or REACH ACO, or another future model in addition to MA. Beneficiaries who have chosen to be insured through original Medicare and whose physicians participate in risk-sharing AAPMs should also have access to the IHE as a flexibility to meet the needs of their attributed population of beneficiaries. Adopting policies that provide for IHEs in fee-for-service Medicare, similar to that which is permitted under MA, can level the playing field for all beneficiaries regardless of which program they choose.

IHEs should be available to ACOs and other risk assuming entities.

IHEs Advance Medicare's Vision for a Patient-Centered, Cost-Effective, and Equity-Focused Program

In January 2022, CMS released a Health Affairs article, "Building on the CMS Strategic Vision: Working Together for a Stronger Medicare,"[4] which lays out four pillars that will guide the strategic vision of the Medicare program moving forward, in alignment with CMS' broader goals for all its public programs. These strategic pillars include advancing health equity; expanding access to affordable health coverage and care; driving high-quality, person-centered care; and promoting affordability and sustainability.

CMS' strategic pillars include health equity, affordable care, and person-centered care.

Accordingly, CMS continues to consistently emphasize the importance of pursuing new and innovative models of care that demonstrate value and incorporate a focus on health equity for the beneficiaries they serve. This means prioritizing care delivery models, benefits, and services that address health disparities, incentivize and facilitate whole-person care, and seek to improve the overall cost-effectiveness and long-term sustainability of our health care system. CMS also has committed to modifying AAPMs to address health equity issues. For example, the recently announced ACO REACH model test has several health-equity focused features, including a requirement that its participants adopt a health equity plan.[5] Allowing the IHE to be offered to original Medicare beneficiaries in total cost of care AAPMs would be a major step toward meeting that goal.

IHEs Advance Health Equity

IHEs are essential services that not only align with many of CMS' broader goals for the Medicare program as a whole but, most importantly, also support patients, providers, and payers. IHEs improve patient access to services by bringing care into the home setting, support patient-centered care coordination, and facilitate accountable care relationships between Medicare beneficiaries and their providers.

Establishing care relationships is especially important for the most vulnerable members of the Medicare population. These include individuals who face social factors that may affect their health and well-being; individuals with chronic conditions, including conditions and needs that may not always be identified in traditional care settings; and individuals who face barriers such as lack of transportation or even physical limitations. As reported by a Harris Poll survey of over 1,000 U.S. seniors (age 65+) in November 2020, over half (52%) say they face barriers to accessing medical or social services.[6] According to 2021 data from an IHE provider for MA beneficiaries, approximately one in three MA beneficiaries lives alone and may have limited transportation options for accessing care,[7] nearly one in five MA beneficiaries has trouble getting around the house, and more than one in five struggle with performing everyday shopping and errands.[8]

One in three MA beneficiaries live alone and may have limited options for accessing care outside the home.

For these populations, the IHE can help remove barriers to care and improve access to preventive care services while fostering long-term care relationships, which are essential in ensuring equitable access to care and improving beneficiaries' long-term outcomes.[9] Further, by conducting evaluations in the home, providers are able to directly observe, contextualize, and act on important social, economic, and environmental factors that contribute to patient health as strongly as do traditional medical factors. This facilitates the development of patient-appropriate care plans and care coordination strategies that take into consideration factors beyond patients' medical needs alone. Further, the IHE enables providers to connect members with much-needed resources to address issues such as food insecurity, lack of transportation, and other SDOH concerns.[10] Each of these steps represents an important way to address health inequities.

IHEs are an important way to expand access to care and improve health equity.

In the context of original Medicare AAPMs, the use case and potential of the IHE to reestablish care relationships may even be greater, as all beneficiaries in an original Medicare AAPM have an attributing physician whose own success is predicated in part on meaningful engagement of all beneficiaries. These physicians are incentivized to review the IHE's results and any recommendations, and to provide close follow-up and outreach themselves or through the entity's care coordination team. In effect, the IHE can function as an extension of the ACO, addressing most wholly those beneficiaries whose needs can't be sufficiently assessed or met in the office and for whom an in-person, in-home visit is needed to initiate an ongoing relationship with the care coordination team.

> "In reality, a majority of our patients' care is conducted outside the walls of the practice and the hospital. During an in-office evaluation, there is minimal insight into a patient's life. We know so little about what is motivating their behaviors and impacting their choices. To design a comprehensive benefit that meets the needs of our patients and their caregivers, we have to look beyond the four walls of the hospital."
>
> Dr. Puneeta Sharma, MD, MHCM, CPE, Chair of Medical Subspecialties, Medical Director of Palliative Care, Valley Medical Group, Ridgewood, New Jersey

IHEs Drive High-Quality, Person-Centered Care

Ensuring high-quality, person-centered care requires the clear identification of patients' needs in order to support the development of individualized care plans and ensure appropriate care coordination strategies.

IHEs enable targeted medical evaluations, offer providers opportunities to initiate targeted interventions, and facilitate the development of person-centered, individualized care plans. Through IHEs, providers are able to identify a range of nonurgent patient needs, such as patient transportation needs, financial needs, having no primary care provider (PCP) or generally having poor access to primary care, fall risk and risk management opportunities, home safety concerns, noncompliance with medication or durable medical equipment use,

and many behavioral health issues, such as depression. Once these nonurgent needs are identified, engaging the beneficiary around them can begin and the evaluation findings can be incorporated into the patient's care plan for ongoing upstream health care monitoring and support.

Similarly, for urgent medical needs that are identified through an IHE, such as elevated blood pressure; severe, unmanaged major depressive disorder; low blood pressure; abnormal blood sugar levels; new onset of acute dyspnea or severe pain; and/or suspicion of adult or child abuse, providers can make an immediate care referral to the appropriate sources to ensure a timely response.

IHEs Improve Access to Care

For providers, IHEs provide a holistic view of their beneficiaries' health and social needs in a comfortable, secure setting; allow extra time for health care providers to evaluate and understand the needs of their high-risk members; and alleviate access and equity obstacles for patients by meeting them in the home and performing an evaluation in that setting.[11] IHEs also provide a rich source of mental, behavioral, medical, social, and demographic data that is generally difficult to collect comprehensively, particularly from certain beneficiaries who may not regularly access health care in their communities.[12] For example, information captured within the IHE follow-up documentation may include clinical findings, new diagnoses, additional testing needs, lab results, medication reviews with high-risk medications highlighted, environmental reviews, and/or functional assessments and frailty scores.[13] This is important information to facilitate a positive care trajectory and long-term health outcomes. This data is also critical for providers as they seek to develop individualized, patient-centered care plans, and can be an important data source for CMS to identify and quantify gaps in access to health care to inform future policymaking.[14]

> IHEs can be an important data source for CMS to identify disparities in care.

IHEs offer the chance to collect or act upon important medical and nonmedical patient-level information that can be used to connect beneficiaries with the right resources, as CMS is currently pressing participants to do in model tests. In the Center for Medicare & Medicaid Innovation's (Innovation Center) recently-announced ACO REACH model test, CMS will require participants to collect n beneficiary-reported demographic data and social determinants of health data on their aligned beneficiaries.[15] CMS' ongoing Accountable Health Communities (AHC) Model also seeks to promote clinical-community collaboration through the screening of beneficiaries to identify certain unmet health-related social needs, referral of beneficiaries to increase awareness of community services, and provision of navigation services to assist high-risk beneficiaries with accessing specific community services.[16]

"IHEs provide a comprehensive, proactive, and unique opportunity to systematically gather insights and address the health-related social, behavioral, functional, and clinical gaps in care. They also provide rich, actionable data collection opportunities that can be used to help design population-centric clinical-community collaborative programs and address person-centric, goal-concordant care. The AHC pilot is testing how capturing SDOH needs in the ED and connecting beneficiaries to local community-based organizations to address food and housing challenges, etc., has reduced medically unnecessary ED utilization in several cases. An important benefit of scaling the use of the IHE is the opportunity to offer this service upstream, helping avoid ED visits and impacting many more Medicare fee-for-service beneficiaries."

Dr. Manjula Julka, Population Health Officer at Signify Health and practicing family medicine physician, formerly an ACO medical director and AHC participating provider

IHEs can also provide a source of evaluation, referral, and care alignment across clinical and community services to both collect information on patient needs and ensure patients are provided the appropriate clinical and nonclinical services to improve health outcomes. Preliminary findings from the AHC model have revealed important information on who the qualifying beneficiaries are, finding that many of them were disproportionately low-income, racial and ethnic minorities, and, among Medicare beneficiaries, disabled. And the AHC Model has allowed CMS to examine what qualifying beneficiaries' most common health-related social needs are, how qualifying beneficiaries connect to community services, and preliminarily, how connecting to important social services ultimately impacts utilization and health outcomes.[17] The IHE can provide CMS a similar platform for understanding Medicare beneficiaries' diverse needs and examining the most effective strategies for connecting them to essential community services.

IHEs can be an effective strategy for connecting people to essential community services.

Other studies also show the benefits of offering in-home visits that are paired with care coordination and systems for follow-up and referral, as IHEs offer. In a literature review on the benefits of home visits, researchers noted that "findings from this and previous studies on home visits give further support to the notion that frail older persons should have a periodic home visit, preferably tied to a comprehensive geriatric assessment and follow-up system."[18] The IHE can be the starting point for a series of high-value patient interactions by setting the care relationship in motion and in the right direction with follow-up plans and visits.

Studies suggest that frail older people should have periodic home visits tied to a follow up system.

Further, the COVID-19 pandemic has highlighted the growing preference among patients for more preventive and primary care services to be offered in the home setting for their own comfort and benefit. 2021 Health Risk Assessment Data from an IHE provider shows that seniors are interested in receiving health care in the home, especially primary care services and vaccinations. Survey respondents also expressed an interest

in having vital sign monitoring, physical therapy, and/or diagnostic testing services conducted in the home, demonstrating patient willingness to embrace the wide range of assessments and services that could be offered through an IHE.[19]

IHEs Are Cost-Effective and Can Improve Health Outcomes

By proactively identifying health care needs; providing high-value, preventive health care services and evaluations in home settings; and facilitating care relationships, IHEs facilitate cost-effective care by preventing downstream hospitalizations, reducing unnecessary emergency department (ED) use, and improving patients' health outcomes in the long term.

For example, based on data from an IHE provider, 11% of those who receive an IHE do not have a PCP. For those beneficiaries, an IHE may be the only time they are able to be with a clinician and, for many, may serve as the beginning of their reengagement with a care team overall. Individuals who receive the IHE benefit are also more likely to seek follow-up care in outpatient settings rather than use urgent care facilities, and are more likely to proactively interact with the health system for routine and preventive care.[20]

Additionally, the specific evaluations and services offered within an IHE have been shown to improve long-term outcomes for patients because they facilitate the behaviors and care practices that improve measures of health quality, utilization, and cost. For example, studies on in-home pharmacy evaluations, similar to the medication education and adherence check included within an IHE, have demonstrated improvements in patients' medication compliance and adherence in the long term.[21]

Case Study: United Healthcare HouseCalls Program

The UnitedHealthcare HouseCalls program—an annual, in-home health and wellness service offered by UnitedHealthcare for Medicare and Medicaid beneficiaries—was associated with statistically and clinically meaningful reductions in the use of institutional care for Medicare patients over a 12-month period after the intervention, relative to statistically matched comparison groups. Researchers of the UnitedHealthcare HouseCalls program noted that "the ability to reduce hospital admissions for high-risk Medicare patients with a scalable program represents significant progress, as attempts in the previous decade to achieve this goal have largely failed."[22]

IHEs can improve patient outcomes and reduce visits to the emergency department.

In a randomized trial examining the impacts of the "GRACE" Model of In-Home Assessments for Dual Eligibles, an in-home assessment similar to the IHE, researchers found that in-home assessments using a nurse practitioner and social worker resulted in fewer visits to EDs, hospitalizations, and readmissions as well as reduced hospital costs compared with the control group. Additionally, the model improved quality of life for beneficiaries and increased positive ratings from physicians compared with the control group.[23] Other home-based primary care programs, such as CMS' own Independence at Home demonstration, have also shown some positive outcomes for targeted beneficiaries.[24] For example, in CMS'

Year Six Evaluation of the Independence at Home demonstration, findings showed that while the model did not demonstrate decreases in total Medicare, total Medicaid, or combined expenditures, there was a decrease in expenditures for skilled nursing and other institutional facilities for dually eligible beneficiaries who received home-based primary care after one year compared with dually eligible beneficiaries who did not.[25]

Case Study: The IHE's Potential

As a palliative care physician, Dr. Puneeta Sharma regularly cares for elderly patients with significant and complex physical and behavioral health care needs. For these patients, being evaluated in the home setting and outside the "four walls" of the office or hospital provides Dr. Sharma with an opportunity to observe a wide range of factors that might have significant impacts on her patients' outcomes and/or their ability to meet established care goals. These factors include the physical home environment, such as the presence of shower bars, adequate lighting, supportive stair railings, etc. They also include the social and personal supports available to the patient, such as caregivers and their physical capacity or availability to meet the patient's needs, and the dynamics of such supports.

As Dr. Sharma notes, "It takes being in [the patient's] own environment and having intimate conversations to create meaningful impacts on patient outcomes." Dr. Sharma's practice enables her to occasionally provide basic home assessments for her patients. But without a steady and reliable funding stream, her practice relies heavily on a patchwork of volunteer social workers, hospice teams, and other available APPs to conduct the home visit and identify and document patient needs, and only in a limited way. Yet when her most complex patients are provided the appropriate physical and behavioral health care and connected with the appropriate community agencies, and environmental changes are made to enable a patient to be more functional and independent in their own home, significant improvements are observed in her patients' outcomes and satisfaction with their care.

Having a Medicare-supported IHE benefit would enable Dr. Sharma and her multidisciplinary team to take the time to communicate with their patients and establish a patient-centered plan of care that takes into account these important environmental, psychosocial, and physical factors that are so significant to her patients' well-being.

Section 2: How CMS Can Expand the Benefit of the IHE to a Greater Number of Beneficiaries

In light of the important benefits that IHEs offer the Medicare program through MA as well as the additional benefits that could be codified for broader use in original Medicare AAPMs, CMS can authorize Medicare coverage of IHEs for all Medicare beneficiaries. Or it can establish their coverage for MSSP and REACH ACO-aligned beneficiaries as a payment waiver or beneficiary enhancement. And it can clarify that these ACOs can offer IHEs to their patients as a beneficiary incentive.

There is currently no covered service or constellation of covered services that encompasses the broad scope of services performed by a health professional during an IHE and that adequately compensates providers or their staff for the investment of time and resources to perform them. CMS has made limited steps toward providing services in the home, yet a vehicle like an IHE to comprehensively assess all medical, social, and functional contributors to poor health outcomes that is part of a care continuum of services does not exist in the original Medicare benefit. As Anne Tumlinson said in her recent article published in Health Affairs, lamenting the general lack of in-home support available for Medicare beneficiaries, "the health care at home promise is tantalizing," but the current Medicare home-based benefits of hospice and home health are not "up to the task."[26]

> There is no covered service in the original Medicare program that adequately compensates providers for performing IHEs.

The lack of a covered IHE benefit is particularly meaningful to providers in AAPMs. ACOs in the MSSP and REACH model test rely on flexibilities built into the program to help manage risk and engage beneficiaries proactively. Yet these AAPMs don't presently offer the flexibility and support to perform an evaluation. This represents a missed opportunity for CMS to meet the needs of providers to be successful in the program, and it prevents the beneficiaries from benefiting from them.

CMS Can Cover IHEs as a Benefit in the Original Medicare Program

The most direct way for CMS to address the gap in original Medicare beneficiaries' access to IHEs is to establish the IHE as a covered service in original Medicare. In the past decade, CMS has established care management as a physician service eligible for coverage under Part B, so as to "appropriately value primary care and care coordination within Medicare's statutory structure for fee-for-service physician

> CMS could establish IHEs as a covered service in original Medicare.

payment and quality reporting."[27] Likewise, CMS could establish the IHE as a physician service for the same purpose: to appropriately value the time a health professional spends in a beneficiary's home performing a comprehensive evaluation of the beneficiary's needs.

To formalize the benefit, CMS could establish a standardized G-code or codes that would identify the required services in an IHE and their use. This would allow CMS to track the proliferation of IHEs while being assured that IHEs are performed with sufficient rigor. For example, CMS could detail the elements of an IHE and required follow-ups, such as connecting to each patient's physician and the clinical care coordination team supporting them. As a form of care management service, IHEs could be performed by auxiliary personnel under the general supervision of the beneficiary's PCP.

CMS Can Create an IHE Benefit Enhancement for Use by Accountable Care Organizations in the Medicare Shared Savings Program (MSSP) and ACO Realizing Equity, Access, and Community Health (REACH) Model

As a more limited approach to supporting IHEs, CMS could use its regulatory authority to cover the IHE as an original Medicare benefit when it is performed for beneficiaries attributed to MSSP and REACH ACOs.

CMS has broad regulatory authority to enhance benefits for beneficiaries in these AAPMs. Under the Medicare Shared Savings Program (MSSP) regulations, CMS has the authority to waive payment rules or other Medicare requirements.[28] CMS has leveraged this authority to allow for payment of skilled nursing facility services without application of the usual required three-day hospital stay for beneficiaries in two-sided model ACOs.[29]

The Innovation Center has gone even further in using its model test authority.[30] Participants in the sunsetted Next Generation ACO Model test, the current Direct Contracting model test, and the recently-announced ACO REACH model test may offer benefit enhancements in exchange for assuming significant financial risk. To date, CMS has used this flexibility to allow benefits similar to the IHE (though smaller in scope), such as post-discharge and care management home visits of auxiliary personnel under general supervision.[31]

These payment waivers and benefit enhancements are notable and important steps in acknowledging and acting on the unmet needs of beneficiaries. CMS could follow these precedents and establish IHEs as an allowable, Medicare-covered benefit for beneficiaries aligned to MSSP ACOs or participants in the ACO REACH model using payment waivers or benefit enhancements authority. This strategy would provide funding and/or flexibility for a comprehensive IHE, enabling ACO providers to leverage this service while CMS observes its proliferation in the limited setting of AAPMs.

CMS could make IHEs a covered benefit enhancement, starting with the Medicare Shared Savings Program and ACO REACH model.

CMS Can Clarify That IHEs Are Permissible ACO Beneficiary Incentives

Another option for CMS to consider is to issue regulatory guidance clarifying that ACOs may offer IHEs as a beneficiary incentive.

> CMS should clarify that ACOs may offer IHEs as a beneficiary incentive.

Medicare ACOs may offer beneficiary incentives to their aligned patients.[32] Within the limited framework of CMS regulations, ACOs can offer in-kind items or services that might otherwise be considered prohibited inducements. ACOs may offer these in-kind services so long as there is a reasonable connection between the items and services and the medical care of the beneficiary, the items or services are preventive care items or services or advance a clinical goal for the beneficiary, and the items are not Medicare-covered services.[33]

The provision of IHEs falls squarely within the ambit of permitted beneficiary incentives. In this scenario, following issuance of favorable guidance from CMS, ACO providers would deliver IHEs as a beneficiary incentive, yet cover the cost of providing them with their own funds.[34] This strategy may lead to lower proliferation of IHEs than do the other alternatives presented. But it would offer an opportunity for CMS to observe a limited number of IHEs, demonstrating the potential shared savings value of the IHE.

Conclusion

IHEs are an integral component of MA plans and can help CMS deliver on its promise to provide equitable, cost-effective, and person-centered care, but they need the support of CMS in order to take root in the original Medicare program, and in AAPMs in particular. CMS can support IHEs by covering them as a benefit in the original Medicare program or in certain AAPMs.

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[28] 42 C.F.R. § 425.612.

[29] While the Medicare "SNF 3-day rule" ordinarily requires that a patient have a medically necessary three-consecutive-day inpatient hospital stay before Medicare will cover skilled nursing facility extended care services, Medicare has waived this rule for ACOs, allowing ACOs to more efficiently treat patients in a lower level of care setting. 42 C.F.R. § 425.612(a).

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[33] 42 C.F.R. § 425.304(b).

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