Opening Statement
Senator Susan M. Collins
Senate Aging Committee

Home Health Hearing
February 12, 2020

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Good morning. Year after year, when seniors are asked how they want to spend their golden years, they overwhelmingly answer: at home. Today's hearing will focus on how we can better help our seniors achieve that goal.

I saw first-hand the importance of home care in my very first home visit during my second year of Senate service. In my hometown in Aroostook County, I saw how home health care allowed an older couple in their eighties to spend the rest of their lives together in the comfort, security, and privacy of their own home. They were worried that otherwise, they would be separated and one of them would be living in a nursing home. And I remember their telling me that all they wanted was to spend the rest of their lives together, in their own home. Highly skilled and caring visiting nurses make such a difference in the lives of patients and families, like this couple. In Maine, home health workers often go to extraordinary lengths for their rural patients, sometimes relying on lobster boats and mail planes to reach them.

Home health care not only helps seniors live in the comfort of their own homes, but it also saves money. According to research from the University of Rochester, older adults who receive one to two hours of in-home physical therapy, for example, are up to 82 percent less likely to face hospital readmissions 60 days after discharge. Studies on post-acute care discharge patterns have shown that clinically appropriate deployment of home health care can yield potential savings of more than $32 billion over ten years.

In the face of workforce shortages and payment cuts, today's hearing will highlight challenges that are facing the home health community. For those in rural areas, where more than one in five older adults live, home health can be a lifeline, and we must do more to meet growing needs.

As we look to the future, the demand for home health care services will only continue to grow as our population ages. According to the Bureau of Labor Statistics, the need for home-based aides is projected to grow by 97 percent over the next 10 years, making it the third fastest-growing occupation. Yet while we recognize the value that home health can provide, many home health agencies are struggling in the current reimbursement and regulatory environment, precisely at the moment when we need their services more than ever.

I am concerned about implementation of the new Patient-Driven Groupings Model and the ability of rural agencies to absorb pre-emptive rate cuts of more than four percent based on "assumptions that somehow agencies will try to maximize reimbursement." Agencies have weathered several years of reimbursement reductions through both regulatory changes as well as

sequestration, and we cannot assume that they can continue to provide the same level of home health services at reduced rates.

That is why I have introduced the Home Health Payment Innovation Act, which has been cosponsored by 31 Senators, including Committee Members Tim Scott, Jones, Sinema, Burr, Rosen, and Rubio. My legislation would prevent further inequitable payment rate cuts. It would provide flexibility on waiving the "homebound" requirement for services.

According to a survey of home health administrators by the Walsh Center for Rural Health, more than two-thirds reported that there were rural patients who could benefit from home health services but simply did not meet the criteria for being "homebound." Furthermore, one-third reported that it could be inconvenient or even dangerous for some senior patients to be driving; however, because they did drive, they did not qualify for services.

As home health agencies are adjusting to the new payment system, I believe that Congress should revisit the rural add-on payment. A well-targeted rural add-on payment is especially needed now. And it is needed to compensate home health agencies that are operating in vast rural areas, such as northern Maine, where they have to drive long distances between patients.

I have also introduced the Home Health Care Planning Improvement Act, which has 41 cosponsors, including Senators Casey, Sinema, and Gillibrand. This bill would improve the access Medicare beneficiaries have to home health care by allowing physician assistants, nurse practitioners, and clinical nurse specialists to order home health care services. That would be particularly helpful in rural and underserved areas of our nation.

In many instances, in rural areas, a patient's primary health provider may not be a physician. Yet today, only physicians are allowed to certify home health care for Medicare patients, even though they may not be the most familiar with the patient's case. In fact, they may not be familiar at all with the patient or his or her condition. These requirements create obstacles, delays, and administrative burdens to receiving home health care services.

Last summer, *Health Affairs* featured an article that put a human face on the unintended consequences of this policy. A rural patient waited several days before a physician was available to sign an order for home health care. By that time, an open wound on his hip had doubled in size and deepened. Instead of taking two to three weeks to heal, it took nearly three months. So this policy has real consequences for the health of our patients.

By helping patients to avoid more costly hospital visits and nursing homes, home health saves Medicare, Medicaid, and private insurers millions of dollars each year and allows seniors to age in the comfort and security of their own homes. I have never understood why administration after administration targets home health care for reimbursement cuts. If there are bad apples in the industry, go after those agencies. Don't penalize everyone. That makes no sense whatsoever when home health care reflects the choice that the patient wants and is the most appropriate care and saves money.

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