December 18, 2013

Chairman Bill Nelson Ranking
Senate Special Committee on Aging
Dirksen G31
Washington, DC 20510

Member Susan Collins
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Dear Chairman Nelson and Ranking Member Collins:

The Visiting Nurse Associations of America (VNAA) thanks the Senate Special Committee on Aging for continuing the conversation on reform of the delivery of long-term supports and services today and for future generations. Listed below is a profile of VNAA's non-profit members and the many ways they support the delivery of long term supports and services to homebound beneficiaries including those with serious and/or multiple chronic conditions.

At the end of this memo are VNAA's principles for long-term care reform, also offered to the Long Term Care Commission earlier this year. The principles promote policies that provide access to vital needed care for vulnerable beneficiaries. These principles are particularly timely as, earlier this month, CMS finalized a damaging rule that cuts payments to the home health industry and endangers access for homebound patients could lose the option of receiving skilled care at home.

About VNAA
VNAA represents community-based nonprofit home health and hospice providers throughout the United States. Its members care for homebound patients with serious and often chronic conditions by providing a full array of healthcare services along with care coordination, management and prevention. VNAA members provide a vital link between patients, physicians and acute care settings and serve all patients without regard to their ability to pay or the severity of their illness. VNAA members are a necessary part of the solution to improve quality and health outcomes and reduce costs in the nation's health system.

VNAA Members Drive Innovation
VNAA members' experience in providing care to people in their own homes and communities predates both the Medicare and Medicaid programs. VNAA's nonprofit agency members have a proven record of accomplishment of furnishing high quality, patient-centered care at home as well as supporting family caregivers who assist homebound patients.

Today, VNAA members are engines of innovation, actively engaged in Accountable Care Organizations (ACOs), bundled payment demonstration projects and innovations designed to resolve breakdowns in care for patients with multiple chronic conditions. In addition, many

VNAA member agencies devote already stretched resources to incorporate health information technology into their practice.

Home health care providers are key partners in transforming the delivery of long-term supports and services, and in keeping patients in their homes. Home health care providers are critical partners in teams that include physicians, nurses, therapists and home health aids. Home health providers:

- Ensure high-quality care for homebound patients;
- Provide critical care coordination for patients with chronic conditions;
- Deliver high-tech care including infusion therapy and home monitoring;
- Furnish skilled care for complex patients following an illness or surgery;
- Reduce costs across systems of healthcare; and
- Keep vulnerable patients at home and out of expensive acute care settings.

The Medicare Payment Advisory Commission (MedPAC) reports that 3.4 million, or 9.5 percent, of traditional fee-for-service Medicare beneficiaries used home health in 2011. CMS data shows that approximately 86 percent of home health users are age 65 or older, 63 percent are 75 or older and nearly 30 percent are 85 or older. Women make up a majority of home health users at 63 percent, and more than 35 percent of home health users live alone. Of the patients who received home health care in 2011, 83.2 percent have three or more chronic conditions. Roughly, 28 percent of home health users have two or more limitations in activities of daily living. Finally, 45.8 percent report fair to poor health.

Home health care services can play a critical role in achieving current health care policy goals to enhance care coordination among providers to extend care beyond the four walls of the physician office, to prevent initial hospitalizations and to avoid or prevent re-hospitalization of post-acute care patients. However, service providers cannot meet these goals without the support and intervention of skilled, high quality, community-based home health providers.

Reductions in hospital readmission rates and improved management of patients with chronic illness in their own homes are two of the most significant challenges in health care delivery today. Home health plays a critical role in coordinating care for vulnerable patients and provides medically necessary care to vulnerable patients to prevent a hospitalization as well as after a hospitalization. Home health providers work with physicians and hospitals and play an important role in helping keep patients in their homes longer. Home health also helps extend the reach of primary care practitioners, particularly in rural and underserved communities. All of these activities help support seniors and people with disabilities to receive care at home rather than in more costly institutional settings.

VNAA urges policymakers to “deem” home health care as the recommended site of care unless an assessment by the patient’s provider indicates that home health is not appropriate. This is consistent with the MedPAC recommendation in the March 2013 Report to Congress. VNAA strongly supports these goals and recommends that home health care be the recommended site of care unless an assessment determines otherwise and patient choice is maintained.

Impact of Recent Rebasing Cuts on Home Health Delivery

In a November 22, 2013 final rule, CMS cut funding for the Medicare home health benefit by $200 million starting Jan. 1, 2014. This "rebasing" rule reduces base payments for home health services 3.5 percent annually for 2014- 2017 despite CMS's claims that reductions are only 1.05 percent in 2014. CMS finalized this rule despite substantive arguments and significant concerns about the impact on patient accessibility to home health services from VNAA and other home health industry organizations, patient advocacy groups, providers and a bi-partisan group of over 193 members of Congress. Fifty-one senators and 142 representatives signed on to two letters to CMS raising serious concerns about the home health benefit and its proposed implementation of the rebasing provision. These payment reductions most definitely will curtail access to the benefit.

CMS cuts in the Medicare home health mean that many homebound patients will lose the option of receiving skilled care at home and instead receive admission to high cost acute care, institutional settings, which is an outcome in direct conflict with the goal of reducing unnecessary care and costs. Cuts will affect elderly and disabled patients with multiple chronic conditions the hardest. VNAA's mission-driven nonprofit agencies serve all who need care but are often the only agencies that take high-cost, low reimbursement patients avoided by other providers.

Principles for Long Term Care Reform

In addition to our specific recommendations on transforming the delivery of post-acute care, VNAA offers the following principles for reforming long-term care, focusing on access and patient choice.

ACCESS: Beneficiaries should have access to the full range of home care and hospice services. Medicare and Medicaid each offer important benefits that are necessary to the care and management of the complex conditions; and these benefits should continue. It is important to retain these benefits in full including the levels of hospice care and the interdisciplinary team as well as skilled nursing and therapy for home health services.

COMPREHENSIVE BENEFITS: The benefits provided to beneficiaries should be comprehensive and include all necessary long-term services and supports needed for their care, including the care they receive in their home. Financial incentives should focus on providing care in home and community settings to the extent possible and as desired by the individual.

CHOICE: Beneficiaries should be able to choose their own providers for their care, as well as their preferred setting, and receive appropriate education about their options.

QUALITY AND EFFICIENCY: Coverage should emphasize quality, coordinated care provided in the most efficient setting and offer incentives to provide this type of care. Policies should not incentivize denials of, or stinting of, care. Home health provides a cost effective alternative to other traditional long-term care settings, and allows beneficiaries to receive their care at home.

NO COST SHIFTS TO BENEFICIARIES: Costs should not shift to beneficiaries in the form of new or additional copays.

MANAGED CARE: Prior authorizations, utilizations reviews and other managed care tools must be reasonable and not barriers to care. Payment systems should be seamless and focus on covering the care that beneficiaries need. Providers should not have to be at financial jeopardy when providing covered services and should instead focus on caring for beneficiaries. Beneficiaries should receive their benefits without worrying about benefit coverage by Medicare, Medicaid or by private insurance.

FAIR REIMBURSEMENT: Provider reimbursement must be fair and appropriate to ensure patients can maintain access to high-quality care. In order to ensure that payments reflect the complex needs of individual beneficiaries, the risk adjustment methodology must reflect the characteristics and functional capacity of the patients.

NO INTERRUPTIONS OF TREATMENT: Care should be continuous with access to current providers, services, treatments and prescriptions during any transitions.

CARE COORDINATION: Coverage should maximize care coordination, including early intervention. Home health plays an important role in the daily coordination of care for vulnerable patients.

STREAMLINE PAPERWORK: Avoid duplication of effort in all aspects of delivering care. Coordinated care should lead to reduced paperwork – not more. For example, patients and providers should not complete the OASIS as well as another assessment document. Prior to awarding contracts, an agreement must exist on universal format for submission of claims. Further, these systems should be set up in advance and based on electronic submission to prevent additional administrative burdens on providers. If for any reason the decision not to use the OASIS in lieu of another tool happens then waive the OASIS completion requirement to prevent duplication of efforts.

WORKFORCE: Implement workforce policies that expand and sustain the direct-care workforce.

VNAA members commit to serving all people who need our services, including beneficiaries eligible for both Medicare and Medicaid. Home health services are critical for coordinating and ensuring high quality care to these complex patients. Our principles seek to preserve beneficiary choice and preference, and access to the full range of needed long-term care services and supports.

Sincerely,

Tracey Morehead
President and CEO
VNAA