VNAA
Visiting Nurse Associations of America

June 22, 2015

The Honorable Orrin Hatch
Chair, Committee on Finance
United States Senate
Washington, D.C. 20510

The Honorable Ron Wyden
Ranking Member, Committee on Finance
United States Senate
Washington, D.C. 20510

The Honorable Johnny Isakson
United States Senate
Washington, D.C. 20510

The Honorable Mark Warner
United States Senate
Washington, D.C. 20510

Dear Chairman Hatch, Ranking Member Wyden, Senator Isakson, and Senator Warner:

On behalf of the Visiting Nurse Associations of America (VNAA), thank you for your leadership in developing solutions to improve health outcomes for Medicare patients with chronic conditions. VNAA appreciates the opportunity to provide input.

VNAA is a national organization that supports, promotes and advances mission-driven, nonprofit providers of home and community-based health care, hospice and health promotion services to ensure access and quality care for their communities. As safety net providers, VNAA members provide care to all patients regardless of their ability to pay or the severity of their illness and serve a mixture of Medicare, Medicaid, privately insured and uninsured patients. VNAA members provide high quality, patient-centered care at home as well as offer support for family caregivers. They primarily serve the most clinically complex and vulnerable patients who are by definition homebound and who will benefit from having closely integrated health exchange between all members of the care team. Home-based care providers work to improve the management of patients with chronic conditions, thus addressing some of the greatest challenges in healthcare today, including medication management, uncoordinated transitions of care, and high rates of unnecessary hospital and emergency department utilization.

Home-based care providers play a key coordination role for beneficiaries with complex care needs. They meet beneficiaries where they live and engage with patients more frequently than other parts of the healthcare system. Home-based care providers deliver and coordinate services that make sense in the unique context of a patient's life. It is within this context that we offer the following considerations for the Committee's work:

- **Update inconsistent regulatory requirements that hinder effective care delivery models.** The regulatory structure for the Medicare program has been unable to keep pace with the rapid transformation occurring in the healthcare system. For example, the home has been identified by both patients and many providers as a preferred site of care. Home-based care providers have demonstrated success in delivering high quality, safe, and low-cost care in a number of

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different delivery models. However, the traditional Medicare home health benefit package limits the use of home-based care to only those patients determined to be homebound and in need of skilled services. This greatly limits the ability of providers to use a low cost and effective setting to deliver high-quality care, especially for those beneficiaries whose mobility is limited but who are not technically "homebound." Other inconsistent and unnecessary regulatory burdens create a disincentive for providers to use home-based care services. The excessive documentation requirements related to the requirement that home health beneficiaries have a face-to-face encounter with an appropriate clinician as part of the certification for home health benefits negatively impacts their willingness to refer to cost-effective home health services.

VNAA recommends that the Committee consider a widespread evaluation and updating of Medicare regulations to align with new health care delivery models. This includes removing the rigid homebound and skilled services requirement as part of the home health benefit structure and implementing reasonable documentation requirements that do not inhibit providers' willingness to refer to home health services. As an alternative, the Committee may consider a new, more flexible benefit that enables a wider range of beneficiaries to receive cared for in their home.

- **Facilitate and expedite the widespread adoption of care coordination models.** Today, payers, including Medicare, Medicaid, commercial insurers, employers, and others are testing different models to manage the care of high-cost/high-need individuals. While variations exist, it appears that a consistent factor for success is ensuring coordination of care across all medical and social service providers supporting the patient. Patient-centered medical homes, accountable care organizations, managed care networks, bundled payment conveners and others are doing this in particular localities. However, we need to reach every high-risk, high-need beneficiary. We encourage the Committee to identify and advance the components of a strong, incentive-driven infrastructure that will facilitate the coordination of medical and social resources in every community in America.

  Home-based care providers are prepared to serve as care coordinators for a broad range of beneficiaries and we encourage the Committee to recognize home-based care providers as leaders in these models. Our providers are experienced and trusted partners in care coordination. They have knowledge of beneficiaries in the context of their daily lives and can support other providers in using that knowledge to shape care plans that make sense for beneficiaries. They also have deep experience coordinating care for beneficiaries directly. They provide transition of care support, conduct medication reconciliation, facilitate communication across providers about the beneficiary's health, conduct beneficiary and caregiver education, and assist in the organization of social services and supports, among other "care coordination" services. While often thought of as primarily as post-acute care providers, our members' experience also includes managing and providing care to pregnant women, new mothers and their children, individuals with chronic, but not acute disease, and individuals who are nearing the end of life.

- **Support Independence at Home (IAH).** The IAH demonstration program allows interdisciplinary teams of professionals to provide primary care services to certain high-risk individuals in their homes. Recent demonstration program results published by CMS showed that the program improved quality while reducing costs. Through the program, Medicare saved an average of $3,070 per participating beneficiary, resulting in $25 million in savings in the first year alone. At

the same all 17 participating practices improved quality in at least three of the six quality measures in the first year. Four participating practices met all six quality measures. CMS also found that participating beneficiaries:

- Have fewer hospital readmissions within 30 days;
- Have follow-up contact from their provider within 48 hours of a hospital admission, hospital discharge, or emergency department visit;
- Have their medications identified by their provider within 48 hours of discharge from the hospital;
- Have their preferences documented by their provider; and
- Use inpatient hospital and emergency department services less for conditions such as diabetes, high blood pressure, asthma, pneumonia, or urinary tract infection.

Experts at the University of Pennsylvania School of Medicine independently estimate that a fully implemented IAH program would generate savings over ten years of about $60 billion. As the Committee develops legislation, we encourage including a conversion of the IAH Medicare demonstration into a permanent program.

- **Require all Medicare and Medicaid providers to participate in the electronic sharing of interoperable clinical data, consistent with HIPAA.** Providers must have accurate and complete patient records to best manage a patient's care and ensure the care plan is implemented, particularly for high-risk, high-need beneficiaries with chronic conditions. Interoperable health information facilitates more efficient care and earlier interventions.

  In order to achieve the promise of efficient health IT, systems must be interoperable. Standards must be in place for all members of a care team to securely send and receive information about a patient across different electronic health record (EHR) systems. In regions with heavy penetration by a single EHR software, or in the case of a hospital-led demonstration project, small providers are often pressured to purchase the same EHR as everyone else. For small providers and/or those who have already invested significant resources in a certified EHR, it may be financially out of reach to purchase a new program. Interoperability ensures that all authorized providers can securely access a patient's information even if they use a different system.

  For these reasons, VNAA supports a federal requirement that all Medicare and Medicaid participating providers engage in the exchange of interoperable patient data with all appropriate providers consistent with HIPAA and any other federal and state privacy rules. We recognize that there are barriers to true interoperability, including some technological standards that still need to be developed. But it is important to note that there are also strong incentives by vendors and some providers to keep their software and EHRs proprietary for market purposes. Providers may be influenced by financial incentives that are not always appropriately aligned with the broader policy goals to provide cost-effective and high-quality patient care. The federal government should play a strong role in breaking these perverse incentives to ensure that a patient's data is accessible by all members of the care team regardless of the software platform they use.

  VNAA is encouraged that many Members of Congress are interested in addressing the barriers to interoperability as there is much work to be done in this area.

- **Leverage telehealth.** Telehealth has the ability to improve patient care and reduce costs for beneficiaries with chronic conditions. VNAA members use technology to help identify changes in patients' conditions; identify patients in distress; allow family caregivers to consult with a provider instead of heading to the emergency department; and provide follow-up monitoring that can help prevent readmissions. In particular, telehealth includes technology that allows for biometric monitoring and self-management education for acute and chronic illness in high-risk populations. It can also be expanded to include use of teleconferencing for rehab services, patient education, mental health consultation and counseling, as well as remote physician visits to patients in their homes. For example, emerging technologies allow a home health nurse to transmit images—such as with wound care—to specialists for an on-the-spot assessment rather than arranging for an office visit or a specialist nurse to visit the patient. Basic video conferencing allows patients and caregivers to show members of the home health team how they are doing, enabling the teams to make better decisions about the right time for their next visit.

  VNAA encourages the Committee to pursue policies to advance the adoption and use of telehealth for a broad set of patients in both urban and rural settings. This includes revising Medicare payment policy. Failure to reimburse providers for the use of this technology limits their ability to put it to more extensive use. Medicare should recognize the home as a site of origin for purposes of Medicare reimbursement for telehealth services. Today, the home is not recognized as a site eligible for reimbursement. This therefore limits the vast amount of care that could be provided remotely in the home by home health, hospice, and palliative care providers, among others, and fails to recognize that health is "in your kitchen, bathroom, and bedroom."

- **Facilitate beneficiary and caregiver empowerment through training and education.** Beneficiary self-management can make an important contribution to health outcomes and patient satisfaction. Providers should empower beneficiaries to play a greater role in managing their health through patient and caregiver training and education, both of which can be aided by technology and telehealth. We recommend that the Committee facilitate reimbursement to providers for educating beneficiaries and their caregivers on chronic disease self-management.

- **Facilitate advanced care planning.** Beneficiaries with multiple chronic illnesses often face advanced illness or are nearing the end-of-life. These individuals need and deserve person and family-centered care that is well coordinated and honors their dignity, values, and health care choices at each stage of their illness. Today, the bright line between curative care and hospice limits providers' ability to provide comprehensive care. We encourage the Committee to support a holistic approach to patient care when an individual is experiencing advanced illness. In particular, the Committee should pursue policies that facilitate communication among individuals, their families, and their health care providers about care options. This will require provider education and training and reimbursement for advanced care planning.

- **Incorporate palliative care into the standard Medicare benefit package.** Palliative care is an interdisciplinary model of care focused on people living with serious and chronic diseases. It provides relief from the symptoms and stress of a serious illness – whatever the diagnosis. The

current Medicare fee-for-service system does not cover palliative care services unless an individual is in the last six months of life and has chosen to no longer pursue treatment. Many individuals with advanced or serious illness who could benefit significant from holistic care are unable to obtain coverage for these services. This can impact the quality of care they receive, their satisfaction, and the total cost of care, all of which haven shown to improve with the use of palliative care.

There is a significant opportunity to provide Medicare beneficiaries with multiple chronic conditions access to palliative care services. A number of innovative models that integrate palliative care services into curative patient care have been created in Medicare Advantage. We urge the Committee to provide greater support for palliative care services as it works to modernize the Medicare program for individuals with chronic conditions. In order to accomplish this goal, the Committee will need to address existing barriers in the current Medicare reimbursement structure. We urge the adoption of policies that will provide accurate reimbursement for non-physician professionals who perform care coordination services. While some members of the interdisciplinary palliative care team (such as palliative care specialists and nurse practitioners) are eligible to bill directly to the Medicare program, many members of the team including some nurses, social workers, and patient navigators are prohibited from directly billing Medicare. As a result, the lack of reimbursement negatively impacts the widespread use of these valuable members of the interdisciplinary team.

- **Consider Medicare risk adjustment methodologies.** VNAA recommends that Congress urge CMS to reexamine and improve the Medicare risk adjustment methodologies. Proper risk adjustment models help ensure access to care by removing the disincentive providers have to treat patients who may negatively impact their quality scores and reimbursement. MedPAC analysis demonstrates that the current case-mix system for home health payments is not adequate. Our members, industry experts, and corroborating studies in peer-reviewed journals suggest that the current risk assessment methodology for home health is missing several key factors. These include whether or not the beneficiary has a primary caregiver or lives alone, a more precise and complete assessment of beneficiaries' socioeconomic status, and the beneficiary's region or state. These factors are strongly linked to resource utilization, including real and significant differences between regions and states, and should be incorporated into the case-mix adjustment methodology. CMS in its Report to Congress on access to home health care for vulnerable patients noted that the results of the report's underlying study "argue for additional analysis of potential modifications to CMS' current HH PPS case-mix methodology."[1] We urge the Committee to require CMS to conduct those further analyses and update the risk adjustment methodologies appropriately.

[1] CMS, "Report to Congress: Medicare Home Health Study: An Investigation on Access to Care and Payment for Vulnerable Patient Populations," November 2014.

VNAA thanks the Committee for the opportunity to comment and respectfully requests further conversation in the future as you move through the legislative process. If you or your staff have any questions, please contact Sarah Bogdan at sbogdan@vnaa.org.

Sincerely,

Tracey Moorhead
President and CEO