VNAA
Visiting Nurse Associations of America

January 26, 2016

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

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

The Honorable Johnny Isakson
Co-Chair, Chronic Care Working Group
United States Senate
Washington, D.C. 20510

The Honorable Mark R. Warner
Co-Chair, Chronic Care Working Group
United States Senate
Washington, D.C. 20510

Re: Comments on the Bipartisan Chronic Care Working Group Policy Options

Dear Senators,

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

VNAA is a national organization that supports, promotes and advances mission-driven providers of home and community-based health care, hospice and health promotion services to ensure access and quality care for their communities. 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.

We thank the Working Group for their strong focus on home-based services and encourage the Committee to include policies that will increase access to home health services for beneficiaries. Our specific comments and recommendations are offered below:

Receiving High Quality Care in the Home

Change the Medicare benefit to waive the "homebound" requirements for home health services

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." This change should be made in the context of traditional Medicare but it is critical that the "homebound" requirement also be waived in Accountable Care Organizations (ACOs) and other bundled models. This will allow new delivery systems to harness the efficiencies of care in the home for a wider population of beneficiaries as well as reduce the need for services in more costly settings.

Ease the regulatory burden placed on providers and home health agencies by clarifying the Face-to-Face requirement.

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.

Expand the Independence at Home (IAH) Model of Care

VNAA supports the conversion of the IAH Medicare demonstration project into a permanent program. Demonstration program results published by CMS show that the program significantly improved quality while reducing costs, and allows beneficiaries to remain in their homes. VNAA recommends that the definition of who may participate in the IAH be modified to encourage more participation and not be limited to beneficiaries who undergo a non-elective hospitalization within 12 months of IAH participation.

VNAA recommends that home health agencies with physicians be eligible to participate as coordinating providers in the IAH model. These agencies are uniquely positioned to implement care plans and make in-home visits and be available around the clock. Along with waiving the homebound requirement for home health services as discussed above, this will expand the number of patients able to access home health services and encourage more widespread provider participation in this emerging model.

Expand Access to Home Hemodialysis Therapy

VNAA recommends that the home be considered an originating site for the purposes of allowing beneficiaries to have a monthly visit with their clinician via telehealth. These beneficiaries are already receiving their dialysis treatment in the homes. As the Policy Options paper suggests, the monthly visit with a clinician is a service that can be safely and appropriately delivered through telehealth, and adding the home to the list of originating sites for this purpose would provide greater flexibility for beneficiaries.

Advancing Team-based Care

Providing MA Enrollees with Hospice Benefits

The Medicare hospice benefit provides beneficiaries a robust benefit package with strong consumer protections. VNAA members who provide high quality hospice services to patients at the end of life share a common goal of wanting to protect the Medicare hospice benefit and to ensure that beneficiaries and their caregivers get the care and support they need from the hospice provider they choose.

VNAA looks forward to working with the Chronic Care Work Group to ensure that if a hospice benefit is added to MA, it maintains the appropriate safeguards for beneficiaries and is a robust benefit offering access to a wide range of high-quality hospice providers. We appreciate that the Policy Options paper notes that the full scope of the hospice benefit, including the required care team and written care plan, would remain required. We also recommend that strong network adequacy standards be included to ensure that patients have access to a broad range of hospice providers. Beneficiaries must be able to access services from the provider of their choosing, including community-based providers. We encourage policymakers to carefully risk adjust payment systems to ensure MA plans have strong incentives to provide the full spectrum of hospice care. In addition, the 5-star rating system for MA plans must be updated to include specific measures on hospice care that include a measure of beneficiary and caregiver experience and satisfaction, goal setting and appropriate level of care.

If this proposal proceeds, VNAA recommends that CMS be required to include stakeholders and hospice providers in the planning process when designing the benefit and payment structures. We also encourage an appropriate on-ramp to allow hospice providers to adjust their administrative systems and contracting to participate in MA.

Address the Need for Behavioral Health among Chronically Ill Beneficiaries

VNAA supports integrated coverage of behavioral health services for chronically ill patients, which, in addition to improving patient health outcomes, can improve care coordination and decrease costs. We encourage policies that integrate behavioral health

services with primary care services. We also strongly support the delivery of behavioral health services in the home or via telehealth with the home as an originating site. To accomplish these goals, behavioral health must be included as part of the CMS Hierarchical Condition Categories (HCC) risk adjustment system. We recommend that CMS look at developing payment policies that promote better integration of behavioral health and chronic care services.

Expanding Innovation and Technology

Ensure that Home Health Providers are fully able to utilize technology to improve patient care and outcomes

- *Allow the "home" to be an originating site for telehealth.* Medicare should recognize the home as a site of origin for purposes of Medicare reimbursement for telehealth service. Today, the home is not recognized as a site eligible for reimbursement. This limits the vast amount of care that could be provided remotely in the home by home health, hospice and palliative care providers, among others. Medicare should also reimburse for home primary care providers or nurse practitioner visits via telehealth when the visits are initiated by home health.

- *Ensure home health providers are eligible for reimbursement for telehealth.* Home health agencies are not currently eligible telehealth providers despite the critical role that they play in improving both a patient's health and care, often as the lowest cost setting. To achieve the maximum impact of telehealth on improving care for Medicare patients, VNAA recommends Medicare certified home health and hospice agencies be included in the definition of eligible providers. It is also important that Medicare appropriately reimburse telehealth services to include set up, patient education and visit fees.

- *Allow home health and other long-term care providers to receive incentives and other support to maintain their electronic health record systems*. Home health providers were not eligible to participate in the Meaningful Use Incentive Program and, as a result, have had to make costly investments in health information technology with neither federal support for acquisition nor reimbursement for use or provision of services. Future rulemaking should consider how to provide financial and technical assistance to home health providers in a similar manner as other medical providers.

- *Require all Medicare and Medicaid providers to participate in the electronic sharing of interoperable clinical data, consistent with HIPAA*. 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 other federal/state privacy rules.

Adapting Benefits to Meet the Needs of Chronically Ill Medicare Advantage Enrollees/ Expanding Supplemental Benefits to meet the Needs of Chronically Ill Medicare Advantage Enrollees

VNAA members' experience with MA suggests that critical supports are needed to ensure that beneficiaries have full access to needed services. This includes providing a robust home health benefit including sufficient amount, duration and scope of services for the chronically ill.

VNAA supports the innovative delivery of services utilized by MA plans through the flexibility to establish benefit packages that tailor benefits to the needs of beneficiaries with specific chronic conditions. In practice, however, MA plans often impose limits on the amount of services a beneficiary can receive or use other utilization management practices that have a negative impact on beneficiaries and providers alike. VNAA members are concerned that barriers to accessing care in MA exist due to insufficient provider networks, low-provider reimbursement rates, and stringent prior authorizations requirements. The flexibility afforded MA plans should not be used to curtail or eliminate benefits but rather to provide value-add services, or services to additional populations. As an example, an appropriate use of this flexibility may be to allow MA plans to expand the definition of who is eligible for home health services (e.g., waive the "homebound" requirement) so that vulnerable beneficiaries with limited mobility are able to get needed skilled nursing services in their homes to manage their chronic conditions.

Providing ACOs the Ability to Expand Use of Telehealth

Telehealth can be an important tool for ACOs and other emerging delivery system models. VNAA supports the use of telehealth in these models, and reimbursement to providers for the delivery of telehealth and remote patient monitoring. As noted above, we also recommend defining the home as an originating site for telehealth and that home health providers should be made eligible providers of telehealth services.

Maintaining ACO Flexibility to Provide Supplemental Services

VNAA supports the clarification that ACOs may furnish a social service or transportation service for services not under traditional Medicare. Coordinating social services with health services can improve patient outcomes and lower total costs. VNAA members have served as a locus of coordination between available services and are deeply rooted in the holistic provision of needed care services. We strongly support allowing ACOs to provide these services and recommend that home health agencies partner with ACOs to provide this needed care.

Identifying the Chronically Ill Population and Ways to Improve Quality

Ensuring Accurate Payment for Chronically Ill Individuals

VNAA supports changes to the risk adjustment model to ensure that payment for the care of chronically ill patients accurately reflects their risk and severity of condition. 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 reimbursements. This is particularly critical for VNAA's members. VNAA members see all beneficiaries without regard to their level of acuity and can incur significant financial loss caring for high-needs patients if the payment does not accurately reflect the beneficiary needs. Strong risk adjustment modeling can help appropriately set rates to reflect beneficiary needs.

VNAA supports the inclusion of additional factors in the risk adjustment methodology, including social determinants of health. The Institute of Medicine has recently identified a wide range of social risk factors, including socioeconomic position, social relationships and health literacy for consideration in Medicare payment[1]. VNAA supports these and additional factors as well, including 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. We urge the working group to require CMS to include these factors into the updated risk adjustment methodologies.

Developing Quality Measures for Chronic Conditions

VNAA supports the recommendation to develop quality measures that focus on improving health care outcomes for individuals with chronic disease. We suggest that any initiatives to develop and implement new measures be carried out as part of a broad-based initiative to examine and update existing health care quality reporting programs. MA plans, hospitals, and post-acute care providers are currently responding to a tremendous number of wide-ranging quality measures, many of which have been adopted as a result of legislative initiatives. Compliance with a large number of measures contributes to administrative costs, provider dissatisfaction, and proliferation of confusing reports to consumers. A streamlined quality measurement approach should identify an appropriate, limited set of high-value measures, important to patients, providers, and payers, for use in both quality reporting and value-based purchasing.

We encourage the Working Group to develop a program to review measures in use, identify those of lesser utility, and identify measures that are: a) evidence based; b) actionable by providers; and c) meaningful to patients. We support the topic areas proposed by the working group, including issues such as patient/family engagement, shared decision

[1] Institute of Medicine. *Accounting for Social Risk Factors in Medicare Payment: Identifying Social Risk Factors.* National Academies Press. 2016

making, end-of-life decision making and care coordination. We recommend that CMS be encouraged to develop such measures for use across all populations, with the capacity to 'drill down' to look at performance for specific populations such as people with Alzheimer's, diabetes or other chronic conditions. We advocate limiting the number of disease-specific measures that are implemented. These measures are challenging for providers, who are required to collect data on multiple individual conditions and are also confusing to patients, who want to know how they will be cared for as a person, potentially with multiple conditions, rather than simply receive disease by disease information.

Empowering Individuals & Caregivers in Care Delivery

Encouraging Beneficiary Use of Chronic Care Management Services

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 Working Group facilitate reimbursement to providers for educating beneficiaries and their caregivers on chronic disease self-management.

Other Policies to Improve Care for the Chronically Ill

VNAA supports improvements to the Medicare benefit package for beneficiaries with advanced illness or who are nearing the end-of-life.

- *Facilitate advanced care planning*. VNAA encourages the Working Group to support a holistic approach to patient care and 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. VNAA specifically supports the Care Planning Act of 2015 (S. 1549) introduced by Members of your Working Group and urges the Working Group to include this legislation in the chronic care proposal.

- *Incorporate palliative care into the standard Medicare Benefit Package.* VNAA urges the working group to provide greater support for palliative care services as part of the care continuum with hospice. We urge the adoption of policies that will provide accurate reimbursement for non-physician professionals who perform care coordination services, including some nurses, social workers, and patient navigators. In particular, VNAA supports the Medicare Patient Access to Hospice Act of 2015 (S. 1354). This legislation would increase access to care by recognizing physician assistants as attending physicians and eligible to serve hospice patients.

VNAA supports giving Nurse Practitioners (NPs) the ability to order home health services under the scope of state law.

VNAA strongly supports the ability of NPs to order home health services and specifically supports the Home Health Care Planning Improvement Act of 2015 (S. 578). This legislation will increase access for beneficiaries who may regularly see NPs but have more limited access to physicians by allowing nurse practitioners to certify patients for home health services.

Increase Transparency at the Center for Medicare and Medicaid Innovation (CMMI)

VNNA supports and acknowledges the important contribution that CMMI is making in advancing new and promising delivery system designs. We strongly support a robust and public stakeholder comment period before a demonstration begins—and throughout the course of the project. This should include stakeholders in impacted states, as well as a wide variety of national organizations and stakeholder representatives.

We thank the Working Group for the opportunity to comment on the Policy Options and welcome the opportunity to work with you on the best approach to achieve these goals. If you have any questions about these recommendations, please contact me at tmoorhead@vnaa.org or (571) 527-1524.

Sincerely,

Tracey Moorhead

President and CEO