January 27, 2014

Glenn M. Hackbarth, J.D.
Chairman
Medicare Payment Advisory Commission
601 New Jersey Avenue, NW
Suite 9000
Washington, DC 20001

Dear Chairman Hackbarth:

On behalf of the Visiting Nurse Associations of America (VNAA), please accept our comments on the recommendations of the Commission meeting held on January 16-17, 2014. VNAA is a national trade association that supports, promotes and advocates for community-based, nonprofit home health and hospice providers. 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 charity care patients.

VNAA is a resource for policy makers, providers and healthcare partners. For example, VNAA’s “Blueprint for Excellence” is an open access tool that assists home health organizations, payers, policymakers, researchers and others to improve care transitions and reduce hospital readmissions. VNAA produces a Clinical Procedure Manual, holds an Annual Meeting and a Public Policy Leadership Conference and offers Professional Lecture Webinars. Lastly, VNAA examines issues that affect access to care. In a study completed with research support from the Visiting Nurse Services of New York, VNAA identified both clinical and socio-economic characteristics of vulnerable home health patients who require additional skilled nursing care.

VNAA is a trusted leader in the health care policy and regularly recommends changes to the Medicare Payment Advisory Commission (MedPAC), Congress, the Centers for Medicare and Medicaid Services (CMS) and the Administration to address critical concerns in the home health and hospice services.

Please accept our comments in response to MedPAC recommendations to Congress.

**MedPAC Recommendation**
The Congress should direct the Secretary to reduce payments to home health agencies with relatively high risk-adjusted rates of hospital readmission.

VNAA and its members strongly support the reduction of avoidable hospital readmissions and agree that post-hospital home health episodes are the key to success. However, as noted by several Commissioners at the meeting, design of a home health hospital readmissions reduction
policy (HRRP) must ensure inclusion of the most vulnerable patients.

Currently, home health agencies (HHAs) face many challenges to achieving the best possible patient outcomes including avoidable hospital readmissions. For example, home health agencies may not receive complete patient records to coordinate care. Data systems between health care providers frequently are often not able to provide current and timely information during transitions of care due to the lack of interoperability of software systems. Nevertheless, VNAA members work to develop innovations to better support hospitals and patients with new models such as the integration of home health agencies in care teams both prior to planned hospitalizations or discharge from an acute episode.

VNAA strongly urges MedPAC and policy makers to consider the following principles when constructing new legislative and regulatory initiatives.

1. Measures must be risk-adjusted: Risk adjusted measures must be in place for special populations to account for conditions beyond the control of a home health agency, such as patients who are particularly vulnerable and are more likely to return to hospitals or emergency rooms at higher than average rates. VNAA agrees with Commissioners who noted that socio-economic conditions might contribute to higher rates of readmission.

The implementation of any home health HRRP requires a comprehensive study of risk adjustment measures. An article published in *Home Health Care Management and Practice* (O’Connor, M. 2012) summarizes 25 published articles with empirical evidence between 2002 and 2011 regarding re-hospitalization among home health care recipients receiving Medicare-reimbursed skilled home health. Beneficiaries with certain characteristics had a statistically significant greater chance of readmission to the hospital. These include:

- Have an OASIS functional score of two or greater;
- Are female of white or Hispanic racial/ethnic background;
- Are dually eligible or have Medicaid only benefits;
- Lack informal caregivers or live alone;
- Little to no help with activities of daily living or instrumental activities of daily living from primary caregivers;
- Have conditions such as chronic heart failure, HIV/AIDS, diabetes mellitus with a wound or renal failure, chronic skin ulcers or pressure or status ulcer;
- Have difficulty breathing, dyspnea or chronic obstructive pulmonary disorder;
- Suffer from depression;
- Have urinary incontinence or a urinary catheter;
- Have unhealed pressure and status ulcers;
- Require assistance with medication management and/or take more than five medications; and
- Have a referral from a skilled nursing facility or a hospital.
- Tracking for all of the above factors is available with data in the home health Outcome and Assessment Information Set (OASIS).
2. **Incentives must be consistent across sites of care:** VNAA disagrees with MedPAC’s recommendation that home health agencies are responsible for “all conditions- potentially preventable readmissions.” VNAA strongly believes there must be consistency across hospitals, home health agencies, physicians and other post-acute providers so that all partners are equally committed to reducing readmissions. Thoughtful alignment of incentives, measures, time frames, definitions is necessary and important to the reduction of readmissions.

VNAA agrees with the National Qualify Forum (NQF), which noted in a February 2013 report, that a “consolidated, evidence-based readmission measure should be developed to promote alignment and shared responsibility across the care continuum and the post-acute care and long-term care (PAC/LTC) settings.”

VNAA recommends a phase-in approach for any home health HRRP. In 2010, the Affordable Care Act (ACA) held hospitals accountable for three measures; three more measures will be required in 2015. For any home health HRRP to protect access for vulnerable patients, the same kind of thoughtful phase-in is necessary.

3. **Appropriately applied quality evaluations are essential:** Agencies who appropriately discharge patients who no longer qualify for home health (are no longer homebound or do not require skilled care) should not be responsible if those patients return to the hospital or other acute setting. Other concerns include:

- Before putting into place any measurement and accountability, home health agencies (HHA) must have access to recent data along with detailed analysis of readmissions. Agencies must have information, training and technical assistance before levying any financial penalties.
- HHAs must be able to review readmission information and submit corrections before using rates to determine any penalties and before making any information public.
- If a home health HRRP is in effect, measurement (and potential penalties) should be proportional to the annual census of an agency.
- Before levying penalties, a phased-in stop loss should allow agencies to improve their performance and there must be a stop loss cap of no more than three percent.
- The nonprofit status of a provider must also factor into consideration.

**MedPAC Recommendation**

The Congress should direct the Secretary to implement common assessment items for use in home health agencies, skilled nursing facilities, inpatient rehabilitation hospitals, and long-term care hospitals by 2016.

VNAA agrees that the Centers for Medicare and Medicaid Services (CMS) should implement a common assessment tool for home health agencies, skilled nursing facilities (SNF), inpatient rehabilitation hospitals (IRF) and long-term care hospitals (LTCH) in a timely fashion. Such a tool could facilitate comparisons of patients, outcomes and costs across post-acute settings. However, the tool should undergo testing for all providers including long-term care hospitals before implementation. In addition, safeguards must exist to ensure that the tool is for assessment and not patient placement.
Since 1999, CMS has required Medicare-certified home health agencies to collect and transmit OASIS data for all adult patients whose care is reimbursable by Medicare and Medicaid, with the exception of patients receiving pre- or postnatal services only. OASIS data serves multiple purposes including calculating several types of quality provided to home health agencies to help guide quality and performance improvement efforts. OASIS is also a core element of Conditions of Participation for Medicare-certified home health agencies.

Considering the fifteen-year investment made by the Centers for Medicare and Medicaid Services and home health agencies in OASIS, a common assessment tool must incorporate its key elements. The same is true for assessment tools utilized by Long Term Care Hospitals (LTCHs), Inpatient Rehabilitation Facilities (IRFs) and Skilled Nursing Facilities (SNFs).

Implementation of a common assessment tool will require careful review to ensure that duplication of effort is not a result. In addition, there is a need for significant training, changes to operations and new software both within and between health care settings. A phase-in period, additional field testing and continuous training is essential to ensure adequate time for those adjustments as well as fine-tuning of the common assessment tool once it becomes operational.

**MedPAC Recommendation**

The Congress should include the Medicare hospice benefit in the Medicare Advantage benefits package beginning 2016.

VNAA understands addressing concerns to ensure continued access to the full hospice benefit for Medicare Advantage beneficiaries. VNAA members have experience providing managed hospice care through private plans to those under 65 but report that services are much less comprehensive than those provided for traditional fee for service beneficiaries. Under the current carve out hospice patients receive immediate and comprehensive care including pain relief medications, durable medical equipment (DME), counseling and other services.

VNAA is concerned that without appropriate and consistently monitored safeguards in place for all Medicare Advantage plans, hurdles to patient access may arise because of onerous managed care tools. Medicare Advantage plans use standard mechanisms to limit access to care including economic incentives for physicians to select less costly forms of care, preauthorization, utilization review, medical necessity requirements, selective contracting with a limited network of providers and increased beneficiary cost sharing. From a provider perspective, each managed care plan has a unique and sometimes complicated array of requirements, all of which translate into increased administrative and staff costs along with lower reimbursement.

MedPAC notes one possible benefit of this proposal is that Medicare Advantage plans can, at their own discretion, provide opportunities for concurrent care. If this occurs, it will create inequities because a core requirement of the hospice benefit is that the patient agrees to forgo curative treatment. If one Medicare Advantage plan elects some level of concurrent care, patients in that plan will be able to continue to receive curative care while patients in other Medicare Advantage plans or traditional Medicare will not.
One question not raised by MedPAC but implied by the discussion of concurrent care for hospice is the emerging role of palliative care. Hospitals are increasingly offering palliative care, which focuses on relieving and preventing the suffering of patients in all disease stages, including those undergoing treatment for curable illnesses, those living with chronic diseases and patients who are nearing the end of life. Palliative medicine utilizes a multidisciplinary approach to patient care similar to both homecare and hospice. VNAA urges MedPAC to consider ways to promote and reimburse palliative care in home setting.

**MedPAC Recommendation**

**Congress should eliminate the update to the hospice payment rates for fiscal year 2015.**

VNAA opposes this recommendation because of its impact on access to care for patients. Nonprofit hospices serve vulnerable patients including both short stay and more costly patients. VNAA’s nonprofit members, who care for short-stay and complex patients, report that their margins are low or negative and that charity contributions often subsidize care.

In addition, new requirements for the Hospice Item Set, quality reporting and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) will increase costs for hospice providers. An update to the hospice payment rates for FY 2015 is essential.

**Conclusion**

VNAA looks forward to the opportunity to work with MedPAC and its Commissioners to ensure that all beneficiaries, regardless of the socioeconomic status or the nature of their illness, have access to Medicare home health care and hospice. VNAA members are engines of innovation and are on the front line of serving patients and developing innovative solutions as healthcare evolves.

Please feel free to call upon us if you require additional information. VNAA members are also glad to meet with MedPAC and its Commissioners to further discuss issues.

Sincerely,

Tracey Moorhead  
President and CEO  
VNAA