VNAA
Visiting Nurse Associations of America

December 17, 2015

Andy Slavitt, Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
PO Box 8016
Baltimore, MD 2124408016

Attention: CMS–2328–FC

Dear Acting Administrator Slavitt,

On behalf of the Visiting Nurse Associations of America (VNAA), thank you for the opportunity to provide feedback on the Final Rule with Comment: Methods for Assuring Access to Covered Medicaid Services. Our comments on this rule closely mirror our comments on the pending Request for Information: Medicaid Program; Request for Information—Data Metrics and Alternative Process for Access to Care in the Medicaid Program.

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 Medicaid, Medicare, privately insured and uninsured patients. They primarily serve the most clinically complex and vulnerable patients who will benefit from care delivered in their homes. Data for 23 VNAA members included in the VNAA Non-Profit Industry Research Database show that VNAA members treat a higher percentage of Medicaid beneficiaries and individuals who are more functionally dependent and clinically severe than national average.[1] VNAA members provide high quality care, and, because Medicaid, unlike Medicare, does not include a homebound requirement for home-based services, our members are on the vanguard of providing innovative and efficient care to a wide range of beneficiaries with different acuities and needs for care.. In CMS' first release of the Home Health Compare Star Ratings, the percentage of VNAA members earning four to five stars was nearly double the national average.[2]

Medicaid provides critical insurance coverage to millions of people, including seniors, people with disabilities and pregnant women and children. However, an insurance card alone will not improve health outcomes. It is critical to strength federal oversight and data collection to help ensure that these beneficiaries actually receive critical health services including home-based services.

[1] The VNAA Non-Profit Industry Research Database includes clinical and financial data on 23 member organizations. This data is compared to the OCS national database of 1,160 home health agencies across the country.
[2] Home Health Compare

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VNAA thanks CMS for publishing this Final Rule with Comment. This rule takes important steps towards identifying beneficiary access issues and encouraging states to mitigate the barriers to access. VNAA encourages CMS to take stronger enforcement policies and to provide strong and uniform beneficiary access protections in future rulemaking.

VNAA strongly supports that access review requirements include specific service categories, including access to home health services.
The final rule specifies that states examine access to care for certain specific required Medicaid services including access to home health. Home health services provide the backbone of coordinated care for vulnerable patients and for long-term services and supports. Consistent with the goals of strengthening innovative and coordinated care for Medicaid beneficiaries, care in the home is an efficient and effective delivery system for beneficiaries with multiple chronic conditions. It is therefore critical that beneficiaries be able to receive these services in a timely and high quality manner. The collection and transparent reporting of these data will provide critical indicators of beneficiary access, establish a baseline of data and trends, and allow states to implement policy changes to improve access.

VNAA supports that states conduct an access review at a minimum every three years.
VNAA recommends that data is collected at a minimum every three years. The health care system is experiencing constant and rapid transformation every year and it may be necessary to assess the impact of state and national policy changes as they are implemented and in more frequent intervals thereafter. We encourage CMS to revisit this timeline in the future to assess if more frequent access reviews are needed.

VNAA encourages CMS to carefully define a suite of home health data elements to include in the access review requirements.
Consistent with our comments on the Request for Information: Medicaid Program; Request for Information—Data Metrics and Alternative Process for Access to Care in the Medicaid Program, VNAA recommends that CMS create a core set of access measures specific to home health rather than apply measures or thresholds designed for other services. Home health is different than other services offered by common Medicaid providers in that our providers travel to the beneficiary.

VNAA recommends that CMS collect a wide range of data that reflect the unique nature of home health services. A key indicator of access to home health is the ability to of a beneficiary to receive ordered services in the home at the time of discharge from an acute setting or when ordered by a community-based primary care provider. This suite of data measures will represent a feasible minimum set of data points on access to home health. Other indicators of access (e.g., waiting room time; office location) are inappropriate metrics for home health services.

Consistent with our comments in the recent Medicaid Managed Care Proposed Rule (80 Fed. Reg. 31098), VNAA supports that for services where the provider travels to the patient, including home-based care services, policymakers must use standards beyond travel time and distance to measure access. At a minimum, CMS should evaluate timely access to care. Standards related to timely access to care may evaluate:

1. Average amount of time between when the service was ordered and when it began (an alternative is between the time of discharge from an acute care setting and start of care),
2. Number of providers available to a beneficiary in their geographic region *who provide the specific services needed*,
3. Whether or not a provider is accepting new Medicaid patients, and

4. Whether providers serve all patients, including those who are complex and potentially costly.

Beneficiaries must receive home health services in a timely manner to improve health outcomes and reduce adverse events, such as readmissions. We recommend that CMS develop a standard measurement to capture how long it takes between when a service is ordered and when the service begins to make sure that home health interventions are delivered when needed.

Measures of access must be broader than the number of registered home health agencies in a zip code. Not all home care agencies provide the same scope of services. For example, not all home care agencies serve pediatric patients who are a significant population for Medicaid programs. States should consider whether the agencies serving a certain geographic area together provide adequate access to necessary services. If this standard is incorporated into the measures, VNAA recommends that home health agencies report the region they serve and all relevant zip codes—not just their mailing address. We also recommend that agencies report the number of patients served in each zip code in each quarter; while agencies may say they serve certain areas, it is important to demonstrate that they are able to serve—and do serve—beneficiaries in their full region.

CMS should require that that states measure whether providers are actually available to patients. Standards could be developed to determine the number of providers who are accepting new patients and who are willing to serve all patients who request services, including those who are complex and potentially costly. CMS may consider measuring the number or percent of mission-based providers and/or providers whose acuity case-mix is above a minimum threshold.

Finally, CMS should consider incorporating team-based measures on access to services, with a specific component for home-based care. These data will provide invaluable insight on how home health services are provided under different emerging delivery systems.

VNAA calls on CMS to collect data separately on fee-for-service and alternate delivery systems.
While we understand that this Final Rule with Comment applies only to traditional fee-for-service Medicaid, we strongly support data collection on all populations in the state who are eligible to receive home health services—without regard to the type of coverage in which they are enrolled. It is important not to allow state exemptions to collecting and reporting of home health data based on state program characteristics. A full picture of how all types of beneficiaries are accessing home health services is necessary to understand how a state Medicaid program working.

VNAA looks forward to working with CMS to implement this Final Rule With Comment. We are happy to provide technical assistance or insights into how our members serve Medicaid beneficiaries and how home health service are delivered in medicaid. We encourage CMS to allow ample time for public comment to work with the community, release measures sequentially instead of concurrently, and offer some technical assistance that would enable more informed input from the provider community. VNAA stands ready to assist as needed.

If you have any questions about our comments or would like to discuss them in more detail, please contact me at tmoorhead@vnaa.org.

Sincerely,

Tracey Moorhead
President and CEO