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-MC

Re: Medicaid Program; Request for Information—Data Metrics and Alternative Process for Access to Care in the Medicaid Program

Dear Acting Administrator Slavitt:

On behalf of the Visiting Nurse Associations of America (VNAA), thank you for the opportunity to provide feedback on this important Request for Information on data and measurement of access to Medicaid services. Our comments on this rule closely mirror our comments on the pending Final Rule with Comment: Methods for Assuring Access to Covered Medicaid Services.

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]

VNAA is pleased to comment on the importance of measuring access to home health services and for increased data collection. Our members serve Medicaid patients but face significant challenges due to low reimbursement, delayed payments, administrative burden, and the complex regulatory

[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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environment. Increased attention to beneficiary access to care is long overdue—and identifying the barriers to access and the challenges faced by providers is an important first step to mitigate them.

Our formal comments are listed below. In summary, VNAA recommends that:

- Data on access to home health services must be collected and measured;
- CMS should collect a suite of data points on access to home health including:
    - 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),
    - Number of providers available to a beneficiary in their geographic region *who provide the specific services needed*,
    - Whether or not a provider is accepting new Medicaid patients, and
    - Whether providers serve all patients, including those who are complex and potentially costly.
- Access to home health must be separately measured in both traditional fee-for-service Medicaid and in alternative payment models;
- CMS should collect survey and self-report data on beneficiary, provider and agency experience on access to home health;
- CMS should analyze access data by category of beneficiary and acuity;
- Additional data on home health should be collected, and harmonized with existing requirement to minimize burden on agencies;
- Transparency in provider reimbursement rates may clarify barriers to access.

Data on access to home health services must be collected and measured.
We thank CMS for including home health as a core service that must be analyzed for access in this RFI and in the companion Final Rule With Comment: *Methods for Assuring Access to Covered Medicaid Services*.

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, home care is an efficient and effective delivery system for beneficiaries with multiple chronic conditions or for patients following an acute stay.

To that end, VNAA strongly encourages CMS to maintain home health services as a specific service that states must collect data on.

CMS should collect a suite of data points on access to home health.
For home health services, CMS should target 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 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.

It is critical that beneficiaries receive home health services in a timely manner to improve health outcomes and reduce adverse events, such as readmissions. CMS must 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.

Access to home health must be separately measured in both traditional fee-for-service Medicaid and in alternative payment models (e.g., managed care arrangements; primary care medical homes).

Home health services must be measured in both traditional fee-for-service Medicaid and alternative payment models (e.g., Accountable Care Organizations; primary care medical homes). As importantly, these data must differentiate by the type of delivery system in which the beneficiary is enrolled. The provisions of the Final Rule with Comment only apply to traditional Medicaid and its proposed remedies will only improve access for those beneficiaries.

An increasing number of states are moving seniors and people with disabilities into managed care arrangements. This is a new construct in many states and best practices are still emerging for providing long-term supports and services to these populations. CMS and states must ensure that beneficiaries covered by managed care have access to the full range of services they need. Managed care companies must have a broad and adequate network of home health providers accepting new patients to ensure that beneficiaries have access.

It is critically important to identify the breadth and scope of access barriers for beneficiaries enrolled in alternative payment models. To accomplish this, the data must be specific to managed care. In our comment letter on the Medicaid Managed Care Proposed Rule, VNAA supported strong network adequacy provisions, as well as requiring a minimum number of nonprofit safety net providers be included in-network in managed care plans. While we hope that these recommendations are incorporated in the final rule and strongly enforced, it will be important to collect data on how implementation impacts access.

CMS should collect survey and self-report data on beneficiary, provider and agency experience on access to home health.

Home health services are typically provided by referral only. A beneficiary must qualify for needed services and have it ordered for them after a hospital discharge or by their community-based provider. This fact is critically important for considering how to measure access to care. While it may be desirable to identify a ratio between services ordered and services provided, home health agencies will not have access to those data. An individual home health agency will only know services have been ordered if (and when) an ordering provider, the beneficiary or their designee calls to request the services. Similarly, there will be no record of agencies that are unable to serve a patient.

There are three key ways to measure access to home health:

- Ask home health agencies about their participation and challenges;
- Ask beneficiaries about their experience accessing home health;
- Ask referring providers about their experience placing a referral.

Home health agencies should be surveyed regularly on their ability to serve all Medicaid beneficiaries, as well as to identify the barriers to providing care. VNAA members serve all beneficiaries without regards to their ability to pay—however our agencies face barriers with geography, work force issues, and low reimbursement. Results of the survey should be analyzed to identify factors influencing agency participation in Medicaid, and for participating agencies to examine factors influencing their capacity to provide timely access to care

VNAA recommends that home health agencies be surveyed on many topics including:

- Whether the agency participates in Medicaid, either directly or through an MCO
- Whether the agency has had to refuse patients because of time or distance
- Whether the agency is able to hire a qualified work force to provide quality services to all beneficiaries
- Whether payment rates or administrative burden impact the providers' ability to serve Medicaid patients
- Whether the agency is able to access resources and services necessary to provide care to complex populations such as those receiving HCBS
- Other challenges that cause barriers to accessing care

To collect these data, we recommend modifying the existing Medicare beneficiary survey or CHAPS survey rather than creating a new one.

VNAA recommends that CMS include surveys of referring providers and/or hospital discharge planners to identify if: they have difficulty placing a beneficiary with a home health agency; if there is a delay placing a beneficiary with an agency; or if discharge was delayed due to an inability to secure home based services.

VNAA also strongly recommends that beneficiaries be surveyed about their experiencing accessing home health services including:

- Whether they experienced any delay in accessing care,
- Whether they were directed to another type of care provider, e.g., skilled nursing facility, due to unavailability of home health, or
- Whether they were ultimately not able to access care.

CMS should analyze access data by category of beneficiary and acuity

Home health services are available to different types of Medicaid beneficiaries. Measures of access should differentiate between populations so that the information captures how each type of beneficiary has access to skilled services in the home. In order to understand access for each population, it will be necessary to collect separate data for several groups including seniors and dual eligibles, women, children, and people with disabilities.

We also recommend stratifying access data by patients who have come from a post-acute stay and those that who are referred from the community. The skilled nursing services needed after a post-acute stay may be different than the needs of a beneficiary with a chronic or permanent physical or intellectual disability. For all beneficiaries, a patient-centered approach based in the community is critical. However disparities may exist in access to these services between the types of beneficiaries. Collecting these data will help to distinguish between these populations and identify where additional supports are needed.

Additional data on home health should be collected, and harmonized with existing requirement to minimize burden on agencies

In addition to additional data on access, it is desirable to collect data on home health utilization in Medicaid. We recommend that CMS collect, synthesize and analyze all available existing administrative data sets on home health to better understand how home health is being utilized.

We stress that CMS should use all existing data sources. This will provide a robust picture of home health utilization while minimizing the administrative burden of new data collection on home health agencies. All efforts should be made to eliminate the need for additional chart reviews or data extractions.

CMS must harmonize data collection with Medicare's existing data collection requirements. In addition, as noted above, we recommend modifying existing Medicare beneficiary surveys to incorporate new Medicaid survey questions. This will dramatically reduce the amount of time, effort and burden on agencies as well as provide an efficient collection system for CMS. What is more, for beneficiaries who are dually eligible for both programs, a unified data collection would identify a holistic picture of access to home-based services.

There is a significant amount of measure development currently occurring within the Medicare program. While the benefits and populations can vary significantly between Medicare and Medicaid, we encourage CMS to identify opportunities to leverage what may work across both programs. In particular, the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) is intended to develop standardized quality measures across Medicare post-acute care providers. The measures required through the IMPACT Act do not measure access to services and do not address the full scope of measurement needs of Medicaid programs which may use home health services for different populations and under a difference benefit structure than the Medicare program. However, implementation of the IMPACT Act may create additional sources of data or reporting that may be applied to the Medicaid program.

Transparency in provider reimbursement rates may clarify barriers to access

VNAA supports transparency in provider reimbursement and in the timeliness of reimbursement. Home health agencies across the country report insufficient Medicaid reimbursements. They also identify long delays between submitting a claim and receiving payment. It is important that reimbursement transparency extend into managed care contracts to fully understand how providers are being paid across all models of delivery.

Conclusion

Medicaid provides critical insurance coverage to millions of people, including seniors, people with disabilities, 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. As health care delivery systems strive to provide services in the least restrictive setting, it becomes ever more important to ensure that beneficiaries have appropriate access to home-based care. VNAA supports additional data collection and measure development on access to home health to accomplish this goal.

VNAA looks forward to working with CMS to provide technical assistance or insights into how our members serve Medicaid beneficiaries. 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