

**Responses to E&C Questions by Dr. Steven Landers**  
**President & CEO**  
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- 1) Shifting more long-term care and post-acute care services into the home setting should result in lower costs and better care experience. The per user costs for home-based care will certainly be lower than institutional care users. The risk of an unsustainable increase in utilization are more apparent in a fee for service model, and these risks should be diminished by moving to a value-based bundled payment model, such as the Bundling and Coordinating Post Acute Care (BACPAC) model recently introduced by Reps. David McKinley and Tom Price, where the providers must generate savings from the expected costs in order to succeed, thereby achieving alignment of between the payment model and the policy goal of cost reduction. In addition, we strongly recommend adoption of targeted program integrity reforms — such as those which we have proposed in the *Skilled Home Healthcare Integrity and Program Savings (SHHIPS) Act* (summary attached) — which we believe would be very effective in preventing the utilization issues about which the Committee is properly concerned.
- 2) Although I have no direct experience in post-acute care bundled payment models (largely because the model does not yet exist in Medicare), I have a lot of experience in the current fragmented and poorly aligned post-acute system. Based on this experience, I believe there is strong evidence that enhanced care coordination and new payment incentives could result in lower costs and better care. In managed care arrangements that are more flexible, I have seen how nursing facility length of stay can be reduced through enhanced care coordination and expanded home and community-based options. These arrangements were not bundled models, but the incentives more closely matched those in the proposed bundled payment arrangements than the fee for service program.
- 3) At present, the Medicare program specifically excludes telemedicine services to the patient's home. Current policy does permit-home health agencies to use telehealth monitoring as a means to improve quality and efficiency when ordered by the treating physician — however, the Medicare program currently does not provide any reimbursement to home health providers for the deployment and use of such technologies. There is also seemingly contradictory policy guidance that these telehealth services cannot replace any covered home health visits. By explicitly supporting the use of new mobile and digital technologies as a strategy within a post-acute bundle, providers will be empowered to find ways to use such technology to enhance access and connectedness with patients while lowering costs. In addition, the BACPAC proposal explicitly permits the use of savings to fund investments — such as care delivery and management technologies — that can improve outcomes and efficiency.
- 4) Helping the high risk, high cost beneficiaries succeed at home is the best strategy for lowering costs while promoting dignity, independence, and keeping families in-tact. Post-acute reforms, such as BACPAC, that promote enhanced home care within an accountable payment model are very promising. Indeed, the BACPAC model is structured to capture substantial savings by establishing that total program spending may not exceed 96% of the applicable baseline, thereby ensuring that billions of dollars in savings will be achieved. I am also very enthusiastic about the impact of in-home primary medical care in an analogous shared-savings model to the Independence at Home Demonstration Program that is currently being tested by CMMI. The Independence at Home Model has been studied in the VA system as well as in several communities and managed care plans and it shows substantial savings to Medicare by increasing home-based care resources. The overall cost of care is lowered due to reduced hospitalization and institutionalization.
- 5) I believe combining A/B cost-sharing would add new barriers to home health care and result in more unnecessary and costly hospitalization and institutionalization. Past efforts to include co-pays for home health care resulted in more emergency room and hospital use. As the Committee is aware, the Medicare home health benefit was subject to cost-sharing from the program's inception in 1965 until 1972 — when Congress explicitly repealed this policy due to the fact that it was indeed causing the program to bear greater institutional treatment costs and placing an unsustainable burden on the beneficiaries who, per Medicare data, are older, poorer, sicker and more likely to be female and minority than all other Medicare beneficiaries combined. Combining A/B cost-sharing would therefore pose the very same risks as the failed policy which Congress wisely repealed, unless the reform you're suggesting ~~could~~ was designed to be accomplished without adding new barriers to home health care.

# Skilled Home Healthcare Integrity and Program Savings Act (SHHIPS)

The Partnership for Quality Home Healthcare has been working for more than a year to develop policy solutions that are designed to protect Medicare beneficiaries, cost-effective providers, and American taxpayers by preventing fraud and abuse before it occurs.

The SHHIPS proposal is largely based on a successful precedent to prevent aberrant outlier payments. In 2009, the home health community proposed that a 10 percent cap be placed on Medicare outlier claims to stem what

was considered an example of unchecked fraud and abuse. Adopted by the Centers for Medicare and Medicaid Services (CMS) and included in the Affordable Care Act (ACA), this single reform is on track to generate a total of 11 billion in taxpayer savings over the next decade.

Building on the positive outcomes of its outlier proposal, the home health community has developed a comprehensive set of additional program integrity reforms.

## Program Integrity Reforms to Protect Beneficiaries and Prevent Fraud and Abuse

- Prevent entry of individuals with criminal backgrounds: Require criminal background checks for all home health employees with direct patient contact or access to patient record
- Verify competency through improved standards: Require background screening of owners and managing employees
- Enforce provider integrity: Require providers to have a compliance and ethics program to prevent and detect criminal violations
- Ensure operational capacity to serve beneficiaries: Require all new providers to secure a 100,000 surety bond
- Temporary entry limitations to prevent excess growth: Suspend issuance of new provider numbers in over-saturated counties

## Payment Integrity Reforms to Ensure Accuracy, Efficiency and Value

- Prevent payment of aberrant claims: Limit reimbursement of episodes to an aggregate annual per-provider average based on beneficiary location and establish a minimum annual Low-Utilization Payment Adjustment (LUPA) claim rate of 5 percent
- Ensure accuracy of all claims: Establish a uniform process to ensure claims are valid prior to payment

## Quality Outcomes Improvement

- Improve care planning for Medicare skilled home healthcare services: Permit non-physician providers, operating under a physician's direct supervision, to complete initial patient assessments and coverage certifications to ensure beneficiary access to care