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Bringing HEART to Home Care

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**REPORT TO DSS
REQUEST FOR MEDICAID RATE RELIEF
JUNE 11, 2008**

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EXECUTIVE SUMMARY

WHO ARE WE?

- ❖ One of the largest home health care provider's in the State of Connecticut.
- ❖ Providing quality home health care since 1909 as a community based, voluntary, not-for-profit, 501(c)(3), non-stock Corporation.
- ❖ Services provided 7 days a week, 24 hours a day, 365 days a year.
- ❖ Medicare certified, and licensed by State of Connecticut Department of Health as a home health care provider.
- ❖ Certified Medicare Hospice Provider since 1982.
- ❖ Accredited by the Community Health Accreditation Program (CHAP).
- ❖ Received acclaimed recognition as a "HomeCare Elite" provider, designating VNS as one of the nation's top 25% of home care agencies recognizing quality of care and quality improvement.
- ❖ Exemplary patient care and medical community satisfaction results, consistently exceeding state and national benchmark data.
- ❖ Excellent quality measurement standards results as reported by the Center for Medicare and Medicaid Services (CMS) through Outcome Based Quality Improvement (OBQI) and Outcome Based Quality Monitoring (OBQM) for adverse events and Home Health Compare Reports for specific indicators; consistently exceeding state and national benchmark data.

WHERE ARE WE?

- ❖ Five (5) offices: Bridgeport, Norwalk, Oxford, Torrington, and Trumbull.
- ❖ Directly serving forty-nine (49) communities of the diverse population we enjoy in Connecticut: the rural communities, suburbs, and our unparalleled commitment to the inner city with the many issues and implications that surround patient care, safety, and complex patient care needs.

PATIENT CARE SERVICES.

VNS is a progressive leader in developing community health programs, and providing extensive and innovative home care services to the population served.

VNS is responsive to patient care needs and the services and programs needed.

The agency offers a comprehensive scope of services from the traditional, to the high tech, to the cutting edge. VNS takes pride on being a center of excellence with its uncompromised commitment to quality and response to patient care needs.

VNS is dedicated and proud to offer our patient care services utilizing state of the art and best practice protocols to ensure the highest level of excellence in caring. Our highly competent staff is driven to help our patients reach their highest attainable health care outcomes.

Today, VNS admits approximately 10,000 patients per year, providing over 250,000 patient care visits. The average daily census is greater than 2,000 patients under our care.

OUR STAFF.

- ❖ Employ more than 600 talented and valued employees with a wide range of advanced credentialing, training, expertise and cultural diversity.
 - Skilled Nursing
 - Physical Therapy
 - Occupational Therapy
 - Speech Therapy
 - Medical Social Workers
 - Home Health Aides
 - Nutritionists
 - Hospice at Home

- ❖ Clinical excellence enhanced with full time dedicated staff focusing on specialties: Director of Health Information and Quality Management, Director of Hospice Services, Director of Rehabilitation Services, Clinical Education Manager, Education Coordinator, Home Health Aide Program/Staff Education Manager, Hospice Medical Director, Hospice Team Physician, Hospice Bereavement Coordinator, Hospice Clinical Supervisor, Hospice Program Manager, Inpatient/Palliative Care Coordinator, IV Manager, IV Coordinator, Managed Care Coordinator, Nurse Liaison, Weekend/On-Call/After Hours Clinical Manager, Performance Improvement Manager, Performance Improvement Coordinator, Registered Dietician, Rehabilitation Manager, Weekend/Holiday Clinical Manager, Wound Care/Ostomy Coordinator, TeleHealth Coordinator, Intake/Patient Customer Services Manager.

CORPORATE GOVERNANCE.

❖ VNS is a voluntary, not-for-profit, 501(c)(3), non-stock Corporation organized under the laws of the State of Connecticut, acting through its voluntary, uncompensated Board of Directors. The Board of Directors consists of members of diverse backgrounds and talents. Standing Board Committees include:

- Audit Committee
- Corporate Compliance Committee
- Ethics Committee
- Executive Committee
- Finance & Investment Committee
- Planning, Program & Human Resources Committee
- Professional Advisory Committee



MISSION STATEMENT

Visiting Nurse Services of Connecticut, Inc (VNS) a non-profit health care provider finds its Mission in the provision of quality home health and hospice services to individuals, families, and the communities it serves.

VNS is committed to the development of a partnership with the patient in the delivery of comprehensive compassionate care. Our highly competent and caring staff is driven to help patients reach their highest attainable health care outcomes.

The VNS approach to care is guided by:

- A respect for the dignity and value of life.
- Patient centered satisfaction.
- Effective use of available resources.
- Responsive advocacy to develop innovative services.
- Dedicated leadership, which helps shape health care policies and services.

VNS is committed to the promotion of health and the provision of quality care within a changing Health care environment. Our corporate core *HEART* values of *Humor, Excellence, Attitude, Respect* and *Teamwork* are visible in all that we do.



VISION STATEMENT

To be the premier home care provider in Connecticut.

We define premier by fostering an uncompromised commitment to:

- Being the agency of choice for patients and referral sources, with an ability to effectively serve all referrals.
- Being the employer of choice with the highest quality staff.
- Consistently achieving excellent clinical outcomes.
- Being the leader in the development of innovative and comprehensive breadth of services that address the changing needs of our patient population.
- Being recognized as a valued community resource with strong affiliations.
- Maintaining financial stability.
- Relentlessly demonstrating our commitment and dedication to our Mission and Core Values.

CHALLENGES SERVING THE MEDICAID PATIENT

The complexities and acuity level of the Medicaid patient population continues to escalate. In addition, access to care issues clearly surface from home care providers unwillingness to accept Medicaid patients, limitations placed on the number of Medicaid patients they will admit, and those providers not having the abilities and/or resources to care for the Medicaid patient effectively. The problem is further compounded in large urban settings like Bridgeport and Norwalk, which has a significantly greater Medicaid population, and more specifically, an unequaled Hispanic population with language barriers and a unique culture. The ethnic diversity also includes significant patients of Jamaican, Portuguese and Asian cultures. The cost of delivering home health care to the Medicaid patient population is greater than for other payor sources due to:

- **Acuity Level ---** With the complexities and level of acuity continuing to increase, the cost of providing services parallels into rising costs. This not only requires a higher skilled professional to perform the visit but also:
 - Increases in-home direct patient care time.
 - Increases pre and post visit time.
 - Increases time for coordination of services.
 - Increases communication with physician and family members (when available and willing) as well as ancillary health providers for Durable Medical Equipment, Pharmacies etc.
 - Increases time needed for patient care conferences.
 - Increases staff in-service education.

- **Payor Mix ----** Payor mix has significant cost implications. A Medicaid patient is a high cost patient to the provider. A disproportionate share of Medicaid patients will notably increase costs due to the unfortunate reality of:
 - Higher level of patient deficits in daily living skills.
 - Higher instances of lack of patient support.
 - Need to address multitude of health, social, and economic issues.
 - Decreased access to preventative care interventions leading to higher co-morbidities resulting in more complex diagnosis.
 - Higher level of utilization.
 - Longer episode of care.
 - Higher rate of "Not Home Not Found" visits – resulting in uncompensated visits and requiring additional visits being made to deliver needed care.

- Bridgeport specific ---
 - Largest city in State of Connecticut.
 - Poorest city in the State of Connecticut.
 - Identified as one of the top ten (10) poorest urban cities nationally.
 - Disproportionate Medicaid population.
 - Unequalled share of Hispanic speaking citizens requiring:
 - Language specific (Spanish) speaking staff.
 - Language specific (Spanish) teaching tools.
 - Cultural differences.
 - Need to maintain a staff of escorts to serve as translators and provide security.
 - Increased difficulty recruiting, hiring, and maintaining staff willing to perform visits in an inner city setting; further exasperated by clinical work force shortages and the availability of a wealth of clinical opportunities in a less demanding and stressful environment.

Due to the factors aforementioned, the Medicaid patient requires more attention and effective care administration, as they are more vulnerable for subsequent hospital admissions, emergency room occurrences, and nursing home placements. VNS has a disproportionate case mix of Medicaid patients, significantly impacting our financial resources, and jeopardizing the delivery of care to the balance of the patient care population we serve. The cost of delivering home health care is greater for the Medicaid patient than other payor mixes. However, despite the rising cost of home health care, and the added cost of serving the Medicaid patient, it is still significantly far less costly to the State than the alternative of institutional care.



HISTORY OF MEDICAID FUNDING

The uniform statewide "Median Rate" system was adopted July 1, 1994, based on 1990 cost data. Prior to 1994 the rate was based on customary and reasonable cost, as established by Medicare cost reporting guidelines, and adjusted for the annual inflation factor. The adopted rates established in 1994 gave no consideration to the 11.6% average National CPI increases which occurred between 1990 through 1994, thus the initial base rates were flawed with an antiquated cost base.

From July 1, 1994 through July 1, 2008, the cumulative State Medicaid base rate increases totaled 15.75%, (1.05% annual average increase) compared to the National average CPI cumulative increase of 38.9% (2.59% annual average increase), and the National average Medical Price Index of 59.8% (3.99% annual average increase)(*Please refer to Section III-2*). The Northeast experienced even greater increases. If the 1990 - 1993 CPI increases were factored in, the disparity between the cumulative Medicaid rate increases and the CPI cumulative increases is staggering (34.75%). If the Medical Price Index was considered, the cumulative disparity is even more substantially pronounced (55.65%).

Home Health Care has received significantly less Medicaid rate relief as compared to Hospitals and Long Term Care Facilities over the past fifteen (15) years despite the significant cost advantages to the State by partnering with Home Health Care. Both have averaged a sizeable greater annual base rate increase; in addition to a number of other financial enhancements not provided to home care which added even greater substantial dollars to care for the Medicaid patient who were institutionalized.

The average daily cost for Skilled Nursing Facilities in Connecticut is \$311 or \$9,330 monthly (source: OPM report, September 2007), compared to the average daily hospital stay of \$ 7,200 (source: American Hospital Directory). The average cost per home care day at VNS is \$47.13, clearly illustrating a material cost advantage to the State Medicaid Program. Financially, quality home health care makes sense. Accessibility and delivery of home health care is also compatible to the State's long term health care strategic goals and initiatives which unmistakably identify home care as a solution, and the direction of choice. Additionally, the residents of this State widely and vigorously support and demand greater accessibility to home health care versus costly and depressing institutional care

The Connecticut Home Care Program for Elders alone, according to DSS, has reported savings for the state's long-term care budget of over \$115,000,000. in 2006 by preventing or delaying admission to a nursing home. This program enables frail seniors to stay in their homes rather than being admitted to a nursing home. The financial benefits and medical successes realized have prompted a State initiative to move 5,000 patients over the next four years out of nursing homes and transfer their care to home health care providers. This provides one example of the cost effectiveness and positive clinical outcomes of home care and the solution home care provides in saving Medicaid dollars.



MEDICAID FINANCIAL IMPLICATIONS ON VNS

The inadequate Medicaid reimbursement rates to serve the intense complexities and high acuity level of the Medicaid patient population have created a material financial hardship on VNS. The VNS financial crisis is the direct result of insufficient Medicaid funding which has accumulated deficits totaling \$7,674,967. over the past five (5) fiscal years (2003 - 2007). The current fiscal year (June 30, 2008) projects a deficit from the Medicaid Program to equal \$2,617,901, bringing the six (6) year accumulated Medicaid deficit to \$10,292,868 (*Please refer to Section III-1*). Continued participation in the Medicaid program, without adequate rate relief, threatens the survival of VNS, which has provided services since 1909, nearly 100 years.

VNS projects nearly 100,200 visits to approximately 2,000 Medicaid patients during the current fiscal year ending June 30, 2008. The total number of visits administered to the Medicaid population continues to increase and now represents 38% of our total patient visits, yet accounts for only 24% of patient revenue. This dramatic increase in Medicaid patients is the direct result of fewer providers willing to consistently serve the urban communities by restricting or refusal of Medicaid patients, fewer providers available due to business closures, and the significant deficiency of Medicaid reimbursement rates. Additionally, on July 1, 2005 VNS purchased the assets of United VNA, whose financial solvency was in jeopardy, and was a significant player in serving the Medicaid population in the Greater Bridgeport area. VNS inherited their volume of Medicaid business which further diminished our resources.

VNS serves a disproportionate share of the Medicaid population in the communities we serve, and the level of unbalance continues to widen. The 38% of VNS Medicaid case mix is in stark contrast to the national average of 9%. The majority of the Medicaid population served by VNS is within a distressed municipality. Additionally, our unequalled share of Hispanic speaking citizens increases costs by requiring language specific speaking staff and language specific teaching/educational tools (*Please refer to Section IV for examples*).

VNS has experienced successes in recruiting clinical staff, but has had increased difficulty hiring, and maintaining staff willing to perform visits in an inner city setting; further exasperated by clinical work force shortages (nurses and therapists), the availability of a wealth of clinical opportunities in a less demanding and stressful environment, and more financially rewarding alternatives. The inadequate Medicaid funding rates, creating the significant deficits, has restricted VNS from elevating clinical wages to a level acceptable to the applicants. The wage differentials could be reconciled with adequate rate funding. Compensation for Home Health Aides also witnessed steady increases, as competition for the paraprofessional has been evident. Minimum wage increases, and the offering of a basic benefit package to compete in Fairfield County for the labor force have added to the cost. Recent escalations in energy costs have created further financial implications as staff utilize their personal automobiles to deliver care and are reimbursed at the IRS mileage rate which has raised the allowance materially over the past couple of years and we expect another significant increase momentarily.

Prior to the Balanced Budget Act of 1997, and most recently the enactment of the Medicare PPS refinement legislation combined with the mandated legislated 2.75% rate reduction, VNS had the ability to revenue shift, which afforded the opportunity to utilize surplus funds of other payor sources to support the deficits of the inadequate Medicaid reimbursement. With the implementation of the PPS refinement legislation, mandated annual rate reduction, and the shrinking of other revenue sources (i.e. United Way, donations etc.) VNS no longer has the luxury of excess revenue resources to fully support the Medicaid deficit.

VNS had secured an equity line of credit in the amount of \$4,400,000. As of June 30, 1997 there were no borrowings against the credit line. As Medicaid deficits exhausted our cash position, annual borrowings have been made against the credit line since 1998 to support the Medicaid shortfalls. As of May 31, 2008, \$3,756,760. has been borrowed and remains outstanding (*Please refer to II-4-ii*). The lending institution recently refinanced our equity line of credit and rejected any increase in the equity line.

VNS has demonstrated an exemplary level of patient care, quality of services, and program excellence. VNS has distinguished itself with superior patient satisfaction and successful patient outcomes. Results have been accomplished with appropriate visit utilization employed for the Medicaid patient, which is well below the national average. Operationally, VNS has confirmed its effectiveness and efficiency when compared to National Benchmarks; favorable results witnessed with key benchmark indicators such as productivity, average daily nursing case load, RN time in the home per visit, home health aide productivity, administrative support FTE's per 100 average daily census, and overall cost per visit as well as direct cost per visit (*Please refer to III-8*).

Commendable clinical outcomes have also been enjoyed by VNS. Outcome excellence has directly resulted in significant cost savings to the State Medicaid Program. Critical benchmarks that measure effective and successful clinical outcomes reveal that VNS standards and results are superior to State benchmarks. Only 27% of VNS patients are admitted to a hospital compared to the State benchmark of 34%. Patients who require urgent unplanned medical care is also a distinguished result at VNS as 25% of patients require emergent care compared to the State measurement of 28%. Three other high profile clinical measurements are exemplary at VNS and worth noting: % of patients who stay at home after an episode of home care ends (VNS=70%, compared to State=64%), % of patients who's wounds improved or healed after surgery (VNS=84%, compared to State=77%), and % of patients who get better at taking their medicines correctly (VNS=48%, compared to State=40%). Impressive clinical outcome results as aforementioned support why VNS was selected as a "HomeCare Elite" provider signifying VNS as a one of the top 25% of home health care providers in the country.

Inadequate Medicaid rates compromise the ongoing business of VNS, and further, jeopardizes patient care to the Medicaid population. VNS needs immediate financial relief in order to continue to be a viable solution in meeting the needs of the Medicaid patient population, and to save the State significant increases they will be obligated to honor from hospitals and skilled nursing facilities if our financial crisis is not remedied.

Although the Medicaid Program has given some recognition to the added costs of providing home health care services to the Medicaid population through "Add-Ons" for four (4) specific extraordinary cost items (AIDS, maternal and child health, escort, and extended hours service), it has failed to recognize the increased costs in the base rate by providing annual adjustments, or changing conditions of providing care. Additionally, the rate setting methodology fails to:

- Recognize regional differences of costs (Medicare does apply different rates by County).
- Recognize disproportionate share of Medicaid patients.
- Recognize distressed municipalities (similar to the methodology available to Hospitals for additional funding).
- Workforce availability (SNF's have received enhancement programs).
- Recognize cultural issues within a community.
- Recognize specialty programs, which are more costly to provide, but greatly reduce hospitalization and nursing home placement.
- Recognize rates implemented in 1994 were based on antiquated 1990 cost data, which did not account for the 16.7% accumulated CPI increases from 1990 – 1994.

As previously stated, from July 1, 1994 through July 1, 2008, the cumulative Medicaid base rate increases totaled 15.75% (1.05% annual average increase), compared to the CPI cumulative increase of 38.9% (2.59% annual average increase), and the Medical Price Index of 59.8% (3.99% annual average increase) (*Please refer to Section III-2*). The failure to provide annual base rate adjustments to minimally maintain a level with the CPI has created the insufficient revenue.

VNS has demonstrated cost conscientious and prudent and responsible fiscal management. It has however become financially impossible to deliver home health care to the Medicaid population when receiving approximately \$.72 of reimbursement for every \$1.00 of reasonable and customary cost expended to deliver the care. VNS's inability to compete in the market as a result of insufficient reimbursement will not only result in severely jeopardizing our viability, but will also add to a growing patient access issue, and ultimately a higher cost borne by the State for extended and needless increased hospital length of stays and amplified nursing home placements.



REQUEST FOR MEDICAID RATE RELIEF

Visiting Nurse Services of Connecticut, Inc (VNS) respectfully requests immediate consideration for modifications to existing reimbursement rates paid on behalf of Medicaid eligible patients by the Department of Social Services.

VNS has been aggrieved significantly, having experienced material financial hardships, which have now transcended to immediate potential implications on patient access and our ability to continue the level of patient care services, due to the existing inadequate reimbursement rates paid by the Department of Social Services. Since the passing of the Balanced Budget Act of 1997, recent Medicare legislated policy effective January 1, 2008 mandating a 2.75 annual rate reduction over the next four years, the enactment of the PPS refinement legislation effective January 1, 2008, and the simultaneous shrinking of other non-patient revenue sources (i.e. United Way Funding, Contributions etc.), funding excesses from other payors has not been adequate to continue to fund the deficits realized by servicing the Medicaid patient. Currently, VNS is reimbursed at the rate of \$.72 on each \$1.00 of reasonable and customary cost expended to deliver care to the Medicaid patient.

VNS serves a disproportionate share of the Medicaid population in the communities we serve, thereby creating additional financial hardships.

Responsible planning and actions have occurred at VNS in an effort to avoid program and service reductions, disruptions, and/or terminations. However, the following significant financial factors cannot be overcome without immediate rate relief, that without, will potentially threaten the risk of patient care access due to insufficient Medicaid reimbursement rates.

❖ VNS Financial Statements since Fiscal Year Ended 2005

➤ Fiscal Year 2005 VNS Total Operating Deficit	(\$ 66,183.)
➤ Fiscal Year 2005 Medicaid Operating Deficit	(\$ 1,290,706.)
➤ Fiscal Year 2006 VNS Total Operating Deficit	(\$ 475,810.)
➤ Fiscal Year 2006 Medicaid Operating Deficit	(\$ 1,726,312.)
➤ Fiscal Year 2007 VNS Total Operating Deficit	(\$ 715,363.)
➤ Fiscal Year 2007 Medicaid Operating Deficit	(\$ 2,145,780.)
➤ Fiscal Year 2008 projected VNS Operating Deficit	(\$ 1,401,805.)
➤ Fiscal Year 2008 projected Medicaid Operating Deficit	(\$ 2,617,901.)

❖ Financial Resources.

	<u>Current Year Borrowing</u>	<u>Accumulated Borrowing</u>
➤ Equity Line of Credit as of June 30, 1997	0.	0.
➤ Equity Line of Credit as of June 30, 1998	\$ 420,000.	\$ 420,000.
➤ Equity Line of Credit as of June 30, 1999	\$ 1,590,000.	\$ 2,010,000.
➤ Equity Line of Credit as of June 30, 2000	\$ 1,000,000.	\$ 3,010,000.
➤ Equity Line of Credit as of June 30, 2001	(\$ 723,000.)	\$ 2,287,000.
➤ Equity Line of Credit as of June 30, 2002	\$ 720,000.	\$ 3,007,000.
➤ Equity Line of Credit as of June 30, 2003	\$ 559,760.	\$ 3,566,760.
➤ Equity Line of Credit as of June 30, 2004	(\$ 1,035,000.)	\$ 2,531,760.
➤ Equity Line of Credit as of June 30, 2005	(\$ 950,000.)	\$ 1,581,760.
➤ Equity Line of Credit as of June 30, 2006	\$ 700,000.	\$ 2,281,760.
➤ Equity Line of Credit as of June 30, 2007	\$ 875,000.	\$ 3,156,760.
➤ Equity Line of Credit projected - June 30, 2008	\$ 750,000.	\$ 3,906,760.

VNS had secured an Equity Line of Credit, which has been utilized to support operations due to the significant deficits recognized from Fiscal Year 1998 through Fiscal Year 2008, clearly as a result of the inadequate funding of the Medicaid Program.

The maximum available Line of Credit is \$ 4,400,000. The lending institution prior to January 1, 2003 expressed concerns of the ability of VNS to repay the loan and indicated they were examining the conditions of the loan. They suggested to VNS to seek an alternative lending institution.

With the assistance of the Board of Directors, VNS was able to transfer the debt service to another lending institution, and avoid the potential loan calling, for the equivalent maximum Line of Credit. Monthly reporting is required and the Bank continues to measure the risk factor of the loan. Recently, the equity line of credit was refinanced, and VNS was unable to increase the maximum borrowing amount.

❖ Significant cost influences contributing to financial crisis (*Please refer to Section III-9 for specific details*).

- Medicaid Program deficit for Fiscal Year 2008 project to be \$ 2,617,901.
- Medicaid reimbursement equates to \$.72 on the \$1.00 of reasonable and customary cost.
- The future financial forecast for the next fiscal year, and beyond, is further imperiled as a result of recent actions by the federal government which legislatively lowered Medicare rates by 2.75% as of January 1, 2008, with equivalent amounts over the next three years.
- PPS refinement legislation dramatically reduced Medicare revenue effective January 1, 2008. The impact of the PPS refinement measure resulted in a reduction of an average of \$437 per episode over the four months since inception. The result translates to a Medicare revenue reduction of \$2,202,480 per annum (\$437 x 420 average monthly episodes x 12 months).

- The profit margin previously enjoyed from Medicare was utilized to offset a substantial amount of the Medicaid deficit. Previous Medicare profit margins no longer achieve the relief once witnessed as VNS will report an operating deficit of approximately \$ 1,400,000 for the fiscal year ending June 30, 2008.
- Equity line of credit is nearing maximum borrowing limits.
- On July 1, 2005 VNS purchased the assets of United VNA, whose financial solvency was in jeopardy. United VNA was the only other significant player in serving the Medicaid population in the Greater Bridgeport area. VNS inherited their total volume of Medicaid business which further diminished our financial resources.
- Clinical salary costs averaging 4% to 4.5%.
- Health insurance costs rose 15.4% on May 1, 2008.
- Transportation costs continue to rise. Current IRS rate is \$.505 per mile representing a 13.5% increase over the past two years. It is anticipated that another sizeable increase will be forthcoming momentarily.

VNS SURVIVAL OPTIONS

The Mission of VNS has consistently been uncompromised, as we have faithfully and consistently delivered home care at a level of excellence, and without consideration of reimbursement factors. The culture of VNS for 98+ years has been to provide needed patient care services to the indigent. The Board of Directors continues its unrelenting support to the Mission of VNS; however, it is now being forced to responsibly address business decisions to secure the sustained existence of the organization that adds tremendous value to the community at large. VNS can no longer continue to afford substantially subsidizing governmental entitlement programs. VNS serves the patient population most providers don't and won't accept. Those being the inner city Medicaid patients with a multitude of complex service and care issues. In addition, sixty-two percent (62%) of the visits administered are non-Medicaid and the Board holds equal responsibility to that patient population.

VNS can successfully survive the current financial crisis by responsibly adopting one of two business strategies currently being debated and further evaluated.

✓ **Strategy 1**

- Evaluate each funding source to determine if their reimbursement structure supports the reasonable and customary costs of VNS to deliver their services. If the payor does not provide adequate reimbursement rates, examine the feasibility of making a business decision to restrict or eliminate admissions, and to potentially discharge all or a portion of the current patient caseload. One influencing factor would be dictated on what is best to secure the integrity of care, and ensure access to the majority of patients served.
- Clearly, Medicaid is the funding source responsible for significant VNS operating deficits; threatening VNS financial solvency and patient care access. The restriction or elimination of the Medicaid patient is NOT the direction of choice

shared by the Board of Directors. The preferred direction would be to collaborate with DSS and design a creative solution to reconcile the financial crisis, caused by inadequate Medicaid funding, and secure sufficient funding and commit to the Medicaid population. VNS has 98+ years of experience serving the urban community, understands the needs and complexities, and has the clinical expertise to best administer care to the patients effectively.

- If VNS were forced to restrict/eliminate care to the Medicaid population, due to funding deficits, there would be recognizable benefits to VNS, yet considerable negative implications to the patients and the State.
 - VNS would eliminate the sizeable deficit caused by Medicaid funding; thereby offering security to patient access for all other patient case mixes.
 - VNS would have the opportunity to target market payor sources such as Medicare, which provide incentives to effectively manage patients and offer a payment methodology to reimburse for reasonable and customary costs.
 - VNS could expand by increasing referrals by caring for the less complex and less demanding of clinical resource time.
 - Higher cost patients would be removed from our patient census, thereby lowering our costs to operate.
 - Dollars would be available to further develop, recruit, and retain staff and expand geographic service base.
 - The Medicaid patient would be severely compromised. Most Medicaid patients in the inner city would lack available home health care services. The growth in home care at VNS demonstrates the unwillingness of other home care providers to deliver services in the inner city for numerous reasons.
 - Lacking the immediate availability for home health care, a discernible increase in hospital emergency room occurrences, re-hospitalization, and increased hospital length of stays will develop added stress to the health care system and significant increases of cost to the State. CMS has acknowledged that access to care is currently an issue and hospital discharge planners have indicated difficulties in placing patients at time of discharge, and the condition has worsened.
 - Added budgetary stress would be witnessed by DSS. Emergency room occurrences, re-hospitalization, and extended hospitalizations would be very costly. In addition, other patients currently receiving, or customarily discharged to home care, would require institutional care at a nursing home.
 - If a conservative estimate of ten percent (10%) of the current VNS Medicaid patient population were to be placed in a nursing home, the State budget would require \$2,456,928 of additional funding to support the patients on an annual basis. (The difference between the monthly nursing home rate of \$9,330 and the monthly home care rate of \$1,414 is $\$7,916 \times 81$ patients (10% of VNS average Medicaid daily patient census) = \$641,196 a month $\times 12 = \$7,694,352$)

- The minimum increase to the State Medicaid Budget of \$7,694,352 would be further exacerbated if more than 10% of patients required nursing home placement (which is highly likely based on the acuity level of our existing case load). In addition, the cost of emergency room visits, re-hospitalization, and extended hospital stays has not been estimated but would be substantially higher.

✓ Strategy 2

- An alternative, which is the strategy of choice of the VNS Board of Directors, would be to secure adequate reimbursement for the Medicaid patient. VNS would prefer to maintain our current philosophy of delivering care and address the medical care requirements of those most in need. The Mission of VNS is not to design business practices to generate excessive profits for any individual's advantage, appreciating our non-profit heritage and the value it offers. The Board of Directors does however recognize their fiduciary responsibility of maintaining the integrity of the financial security of the agency and their responsibility to provide access to care for as many patients as practical.
- The Board of Directors would continue to commit to utilizing surpluses generated from other payor sources to support the Medicaid Program through revenue shifting, provided it did not result in an overall Agency operating deficit.
- A creative remedy to reconcile an adequate funding solution, and to provide rate relief to address the financial hardships and resulting financial crisis would result in a win-win scenario for both the State and VNS. The numerous benefits that would be recognized include:
 - No interruption of patient care services to the Medicaid population currently being served by VNS.
 - Availability to patient care access for future clients.
 - Avoidance of unneeded emergency room visits, re-hospitalizations, and extended hospital lengths of stay.
 - Ability to maintain patients in their home, versus more costly institutional care.
 - Compatible to support the State long term health care initiatives/strategies.
 - An experienced home care provider serving the urban community who understands the needs and complexities, and has the clinical expertise to best administer care to the patients effectively.
 - VNS would be placed in a stable financial position, thereby, committing to the Medicaid and all other patient populations.
 - Dollars would be available to further develop, recruit, and retain staff to expand services available to the Medicaid client.
 - Significant cost savings to the State, despite increasing rates to VNS for home care services.
 - VNS would maintain any rate adjustment in the strictest of confidence.



REQUESTED MEDICAID RATE ADJUSTMENT

	<i>Current DSS Rate As of 07/01/07*</i>	<i>Projected Cost 06/30/08</i>	<i>Requested Rate 07/01/08</i>
Skilled Nursing (visit)	\$ 116.83	\$ 152.77	\$ 127.03
Physical Therapy (visit)	\$ 80.49	\$ 166.93	\$ 96.59
Occupational Therapy (visit)	\$ 82.82	\$ 155.06	\$ 99.38
Speech Therapy (visit)	\$ 82.82	\$ 165.83	\$ 99.38
Home Health Aides (15 min.)	\$ 8.09	\$ 11.05	\$ 10.92

* Includes "Add-Ons"

NOTE: Requested Rate Adjustments would result in an additional \$ 1,544,996 of patient revenue to support the projected \$ 2,617,901 of Fiscal Year End June 30, 2008 Medicaid deficit. The requested rate adjustments would be effective on July 1, 2008, and would be based on actual services delivered.

It should be noted that it is the belief of the VNS Board of Directors that each payor for services, requesting patient care services, should reimburse at a level equal to the reasonable cost of delivering such services.

The VNS Board of Directors further believes that the Department of Social Services should give consideration to provide retroactive dollars to support the prior year's deficits that can be documented with factual and supportable data, and have created the financial disability of VNS. Further, it should be noted that Connecticut General Statutes Section 17b-242 authorizes the Commissioner of the Department of Social Services to establish a rate when a provider can document a material change in circumstances and is aggrieved by a rate determined pursuant to this subsection. As such, VNS respectfully requests a rate modification based on the financial evidence presented and the disproportionate share of Medicaid services provided.

FUNDING OF THE CURRENT FISCAL YEAR MEDICAID DEFICIT

State of Connecticut	\$ 772,498. (50% match of Medicaid Claims)
Federal Government	\$ 772,498. (50% match of Medicaid Claims)
VNS	<u>\$ 1,072,905.</u> (Surplus from other Payor Sources)
	\$ 2,617,901.



MEDICAID FINANCIAL LOSSES

	<i>Medicaid Profit (Loss)</i>
FYE 06/30/03	(\$ 1,403,941.)
FYE 06/30/04	(\$ 1,108,228.)
FYE 06/30/05	(\$ 1,290,706.)
FYE 06/30/06	(\$ 1,726,312.)
FYE 06/30/07	(\$ 2,145,780.)
FYE 06/30/08 (projected)	(\$ 2,617,901.)
TOTAL ACCUMULATED MEDICAID LOSSES (06/30/03-06/30/08)	(\$ 10,292,868.)

AVERAGE CPI INDEX

	<u>General CPI</u>	<u>% Change</u>	<u>Medical CPI</u>	<u>% Change</u>
1993	142.1		200.9	
1994	145.6	2.5%	210.4	4.7%
1995	149.8	2.9%	219.8	4.5%
1996	154.1	2.9%	227.6	3.5%
1997	157.6	2.3%	234.0	2.8%
1998	159.7	1.3%	241.4	3.2%
1999	163.2	2.2%	249.7	3.4%
2000	168.9	3.5%	259.9	4.1%
2001	173.5	2.7%	271.8	4.6%
2002	175.9	1.4%	284.6	4.7%
2003	179.8	2.2%	296.3	4.1%
2004	184.5	2.6%	309.5	4.5%
2005	191.0	3.5%	322.8	4.3%
2006	197.1	3.2%	335.7	4.0%
2007	202.8	2.9%	350.9	4.5%
thru Apr-08	208.5	2.8%	362.4	2.9%
CUMMULATIVE AVERAGE		38.9% 2.59%		59.8% 3.99%

HOW MEDICAID HOME HEALTH PATIENTS DIFFER

Medicaid Patients Stand out in LOS, high risk factors

Medicaid patients stand out from other home health beneficiaries in many areas, benchmark vendor Outcome Concept Systems found recently when it looked at some 240,000 patients served by 710 home health agencies during the first quarter of 2002.

OASIS question	Medicare	Medicare HMO	Medicaid	Medicaid HMO	Private Insurance	Private HMO
Average Length of Stay	44.1	31.5	64.2	42.5	35.2	28.7
Primary diagnoses (MO230)						
Endocrine Disease	6%	5%	11%	11%	5%	5%
Musculoskeletal	14%	13%	9%	9%	18%	17%
Mental Disorders	1%	1%	3%	2%	1%	1%
Intravenous or Infusion Therapy (MO250)	2%	2%	6%	7%	8%	9%
Poor overall prognosis (MO260)	9%	8%	12%	10%	7%	6%
High risk factors (MO290)						
Heavy Smoking	7%	6%	14%	19%	8%	10%
Obesity	13%	12%	20%	24%	16%	17%
Patient lives with (MO340)						
Alone	29%	25%	29%	22%	21%	17%
Spouse or other family	37%	42%	23%	27%	53%	60%
No one primary caregiver (MO360)	16%	15%	20%	20%	14%	17%
Case outcome (MO100)						
Hospital transfer	26%	17%	37%	29%	20%	17%
Disch. from Agency	69%	74%	58%	64%	74%	76%
Hospitalization	24%	16%	33%	26%	18%	14%
Emergent care (MO830)	13%	12%	19%	17%	11%	11%

Source: Outcome Concept Solutions
Reprint: Home Health Line 08/23/02

CRITICAL CLINICAL BENCHMARKING DATA

	<u>VNS</u>	<u>State Benchmark*</u>
Percentage of patients who had to be admitted to the hospital	27%	34%
Percentage of patients who need urgent, unplanned medical care	25%	28%
<hr/>		
Percentage of patients who stay at home after an episode of home health care ends	70%	64%
Percentage of patients wounds improved or healed after an operation	84%	77%
Percentage of patients who get better at taking their medicines correctly (by mouth)	48%	40%
Percentage of patients who get better at walking or moving around	43%	41%
Percentage of patients who are short of breath less often	61%	60%
Percentage of patients who get better at bathing	66%	62%

SOURCE: Quality Information Evaluation System (QIES) --- Home Health Compare
March 12, 2008



CRITICAL BENCHMARKING DATA

	<u>VNS</u>	<u>National Benchmark*</u>
Medicaid Payor Mix	38.1%	8.6%
Nursing Productivity (average visits per day)	5.52	4.01
Average Daily Nursing Case Load	27.50	26.51
RN time in home per visit (minutes)	44.00	43.88
Home Health Aide Productivity (ave visits per day)	4.53	3.61
Support FTE's per 100 Average Daily Census	4.78	4.56
Administrative FTE's per 100 Average Daily Census	2.63	3.25
Nursing Cost per visit (top 1/3 providers)	\$ 142.48	\$ 140.96
Home Health Aide cost per visit (top 1/3)	\$ 64.35	\$ 69.06
All disciplines cost per discipline (top 1/3)	\$ 121.89	\$ 121.17
Direct Nursing Cost per visit (top 1/3 providers)	\$ 85.71	\$ 87.45
Direct Home Health Aide cost per visit (top 1/3)	\$ 38.71	\$ 42.66
Direct All discipline cost per discipline (top 1/3)	\$ 71.21	\$ 75.73

SOURCE: Data compiled as a participant of Fazzi Associates, National Operational Benchmark Service. September 2007.



VNS PATIENT SERVICE COSTS/COST INFLUENCES

VNS PATIENT SERVICE COSTS

	<i>VNS Projected 06/30/08</i>	<i>Medicare LUPA Rate 01/01/08*</i>
Skilled Nursing (per visit)	\$ 152.77	\$ 127.03
Physical Therapy (per visit)	\$ 166.93	\$ 138.89
Occupational Therapy (per visit)	\$ 155.06	\$ 139.82
Speech Therapy (per visit)	\$ 165.83	\$ 150.93
Home Health Aide (per visit)		\$ 57.53
Home Health Aide (per ¼ hour)	\$ 11.05	\$ 11.51

* The Medicare LUPA rate is the cost cap established by Medicare as the reasonable and customary maximum allowable costs for Fairfield County. The home health aide hourly rate is calculated based on a visit of 1.25 hours. Rates included the legislated 2.75% rate reduction effective January 1, 2008.

COST INFLUENCES

- **Patient Acuity Level** -- The complexities and acuity level of patients continues to increase as supported by the OASIS assessment tool and resulting HHRG case weight mix. Patient needs are greater, and the skill level of the clinician to effectively address the challenging medical needs of the patient is heightened. A competent clinical staff requires experience, advanced credentialing, on-going education, and expertise. Additionally, clinical specialists are required to address the critical complex needs of the patient. VNS employs specialists in the areas of hospice, infusion therapy, maternal and child health, psychiatric, rehabilitation, and wound care. Exemplary patient outcomes at VNS, and exceptional patient care utilization support the successes and talent level of staff.

High-level staff and specialists create a higher cost per visit of care, yet in totality, deliver the care with fewer visits, more efficiently and effectively, and at a lower overall cost for the episode of care. In addition, cost throughout the continuum of care will be lower with fewer re-hospitalizations and emergency room occurrences.

- **Labor Market/Wages** --The labor force shortages create a very competitive recruitment market, as well as attention to retention. Salary costs and benefit enhancements are a necessary staffing strategy. The labor shortages cross all staffing requirements: Nursing, Therapists and Home Health Aides. The Nursing

and Therapist shortages have been well documented. The Home Health Aide situation is unique as the paraprofessional staff also have a wealth of opportunities that are less demanding, do not require a mode of transportation, and offer a benefit package.

The labor force crisis has added costs with salary increases greater than customary merit increases being offered within the business world, enhancements to the benefit package, sign-on and referral bonuses, and significant recruitment costs. Clinical wages have average 4% to 4.5% increases over the past three years.

- Ongoing Education -- With the patient complexities, high acuity levels, medical advances, changing clinical practice methods, and regulatory changes, the need for ongoing staff education is paramount. The hours of staff education have significantly increased and thus added costs at a material level.
- Regulation -- The proliferation of regulations has added significant cost increases. Medicare specifically enacted two major pieces of legislation, both becoming effective on January 1, 2008 that have materially impacted revenue. A 2.75% rate reduction became effective, as well as a major refinement to PPS. The impact of the PPS refinement measure resulted in a reduction of an average of \$437 per episode over the four months since inception. The result translates to a Medicare revenue reduction of \$2,202,480 per annum ($\437×420 average monthly episodes $\times 12$ months). In addition to the financial loss, and beyond the training component of teaching staff, material hours are expended in educating, planning and implementation. Some of the other major impacts on cost as a direct result of regulation compliance include: software modifications, adding staff, development and reprinting of patient information tools (in English and Spanish), development and reprinting of clinical and office forms, supply costs, and legal and accounting fees.
- On July 1, 2005 VNS purchased the assets of United VNA, whose financial solvency was in jeopardy, and was a significant player in serving the Medicaid population in the Greater Bridgeport area. VNS inherited their total volume of Medicaid business which further diminished our financial resources.
- Health Insurance – Health Insurance benefit costs continue to rise at an alarming rate. During 2007 the premium increase was in excess of 20%. The current plan year commencing May 1, 2008 has witnessed a 15.4% increase. VNS changed Plan Broker, insurance carrier, and modified benefits to achieve a lower rate increase.
- Mileage/Transportation Costs -- An essential requirement for employment is reliable transportation. The cost of gasoline continues to escalate impacting the mileage reimbursement paid to staff. On January 1, 2008 the IRS rate rose to \$.505 per mile representing a 13.5% increase over the past two years. We are anticipating another sizeable increase momentarily
- Operating Expenses -- A number of operating costs have been increasing well above inflation rates and are essential to continue to operate. Despite efforts to employ competitive bidding, where appropriate, the costs are escalating at an unprecedented rate. Examples include: Health Insurance, Workers Compensation Insurance, General Liability and Malpractice Insurance, and recruiting expenses.

- Interest Expense -- As a direct result of inadequate Medicaid reimbursement rates, Medicaid deficits have been funded by an equity line of credit. The cost to carry the debt service increases the cost per visit as an indirect cost for the interest expense. This is a material expense VNS could avoid if Medicaid rates were adequate.
- Weekend Admissions/Patient Care -- An increasing number of admissions now occur on weekends or outside of the normal regularly scheduled workday (22%). To accommodate this change in referral pattern, the demands for after hour staff and weekend staff has increased. This has added costs as staff are paid a premium wage rate to work weekends, holidays, and after hours.

As hospitals feel the pressure to lower their Length of Stays, it is expected that greater demands for weekend admissions will occur. The acuity level of the patient has dictated more care being provided on weekends. Many patients require services beyond the traditional regularly scheduled hours, and cannot be left unattended over weekends, especially in the area of IV Therapy, wound care and pediatrics.

- Weather -- The weather has an impact on the cost per visit. Severe weather conditions that prohibit or restrict staff from visiting patients adds to non-visiting time, which becomes an indirect cost and increases the cost per visit as it reduces billable visit time.

COST SAVING MEASURES

The Board of Directors is acuity cognizant of the financial instability and patient care challenges of VNS and has consistently acted in a responsible and vigilant manner. Under the diligent review of the Board Finance & Investment Committee, conscious decisions have been made to effectively manage the available financial resources. Cost containment and reduction programs have been initiated to consider the funding availability over the past ten years.

- Froze wages of Senior Administration.
- Limited wage increases for non-clinical positions.
- Reduced employee benefits for all staff.
 - Reduced vacation, personal and sick day annual accruals.
 - Amended Health Insurance coverage's.
 - ✓ Health Benefit coverage's reduced.
 - ✓ Alternative high deductible plans introduced.
 - ✓ Maximum employer contribution of \$432 per month.
 - ✓ Increased employee out of pocket health insurance costs.
 - Reduced employer paid Pension contribution by 2%.

- Eliminated positions from the staffing population of clinical and business staff.
- Increased productivity of nursing staff.
- Consolidating the Derby and Southbury branches (early summer 2003) to a central location in Oxford.
- Reduced the number of communities VNS serves.
- Additional staff reductions:
 - Consolidation of branch office clinical leadership.
 - Consolidated the positions of Director of Performance Improvement and Director of Medical Records.
 - Realignment of job functions to reduce number of support staff.
 - Realignment of secretarial/clerical positions.
- On a monthly basis, in conjunction with the oversight of the Board Finance & Investment Committee, meet to responsibly examine cost items to determine need and/or necessity. Also examine alternative cost containment and/or reduction possibilities. Promote competitive bidding for appropriate recurring annual expenditures (i.e. Health Insurance, General Insurances, Workers Compensation, employee benefits, auditing fees etc.).
- Extensive modifications to processes, paper work, and realignment of job responsibilities creating a more efficient operation.
- Discontinued needed advanced technology development.
- Discontinued all further technology development.
- Continue to re-evaluate programs/services to determine if VNS will continue specific programs/services.
- Currently re-evaluating any payor source creating financial losses that clearly jeopardize the financial viability of VNS.
 - Examining the Board fiduciary responsibility to ensure the delivery of quality patient care service.
 - Examining the limiting of providing services by means of accepting patient admission by payor source.
 - Examining the complete discontinuation of providing services by payor source.
- Postponed capital improvements.



MEDICARE PROSPECTIVE PAYMENT SYSTEM OVERVIEW

On October 1, 2000, the Federal Medicare Program instituted a new payment system for all home care providers. The Prospective Payment System (PPS) completed the reimbursement methodology transition from a cost based system, to a modified cost based system (Interim Payment System (IPS)), to a series of predetermined rates to be paid over an episode of care (PPS).

The prior Medicare rate methodology reimbursed the home care provider based upon the lower of: the provider's Medicare reimbursable cost, Medicare cost limits, Medicare charges, or the Medicare established per patient beneficiary limit as established under the Interim Payment System (IPS) which was created as a result of the Balanced Budget Act of 1997. Under the new payment system (PPS), the payment rate is determined based upon the completion of a HCFA adopted OASIS (Outcome And Assessment Information Set) patient admission/assessment document and the utilization of therapy services. The OASIS document consists of 218 questions, of which 23 of the answers are graded and scored, which will result in one of eighty different payment rates. The payment rates are based on historical national data with the wage portion adjusted regionally. Established rates will differ between the various regions in Connecticut as a result of differing wage factor adjustments, and urban versus rural regions.

The following is a list of terms used under the prospective payment system:

Prospective Payment System (PPS):

The PPS reimbursement system for Medicare patients began on October 1, 2000.

Episode:

The payment rate will cover an episode of care. Medicare has defined an episode of care as 60 days. If a patient is serviced for a period longer than 60 days, additional episodes will be paid so long as the care is medically necessary. Full episode payments can be adjusted for several reasons including a Significant Change In Condition (SCIC) or Low Utilization Payment Adjustment (LUPA).

The episode will continue if a patient is admitted to the hospital and then referred back to the provider within the 60-day episode period.

Home Health Resource Group (HHRG):

A HHRG is the episodic rate the agency will be paid for the services provided to a patient. There are eighty (80) potential rates dependent upon the score calculated after the completion of the OASIS document. The rate is based upon the answers

established on twenty-three (23) specific questions contained in the OASIS document and the utilization of therapy services. The twenty-three (23) specific questions are categorized into three sections: Clinical, Functional and Service Intensity. Each section is graded and the resulting score in each dictates the rate to be paid for that patient.

The agency will bill for the episodic rate once the OASIS tool is completed, and the physician order is received. Payment will be paid at 60% of the HHRG upon submission of Request for Payment (RAP). Once the episode is completed, the agency will bill for the remaining 40% of the episodic rate, reflect any adjustments in the rate and list all services provided during that episode in 15 minute increments. Subsequent episodes for the patient will be paid at 50% initially and 50% upon conclusion of the 60 day episode period.

Low Utilization Payment Adjustment (LUPA):

If a home care provider performs four (4) or less visits in an episode, the HHRG rate will not be paid, and the provider will be paid on a per visit rate based on the actual number of visits, and types of services, performed. The per visit rates for agencies in Fairfield County are listed below. The rates are as January 1, 2008 and reflect the 2.75% reduction as legislated.

<u>Service</u>	<u>Fairfield County LUPA Rate</u>
Skilled Nursing	\$ 127.03
Physical Therapy	\$ 138.89
Speech Therapy	\$ 150.93
Occupational Therapy	\$ 139.82
Medical Social Worker	\$ 203.62
Home Health Aide (per visit)	\$ 57.53

NOTE: Federal Medicare Rates are established by County within the State and reflect adjustments for regions.

Significant Change in Condition (SCIC):

There are times when a patient will incur a Significant Change In Condition (SCIC) during treatment. A SCIC may result in a revised scoring for the patient as a result of the change in the patients' medical condition. The original episode HHRG payment rate will then be prorated based on the number of days the agency serviced the patient prior to the SCIC occurring. If the patient is admitted to the hospital or other facility in-between the episodes, the agency will not receive payment for those days the patient is in the hospital. There will be a gap in payment.

Partial Episodic Payment (PEP):

A Partial Episodic Payment (PEP) will result when a patient is not seen for the entire episode and the goals are not met for the patient. For example, if a patient moves and transfers to another home care agency, the agency will receive a prorated portion of the rate based on the number of days the patient was serviced.

PPS Reform Final Rule

In August 2007, CMS released the Home Health Prospective Payment Reform Final Rule with an implementation date of January 1, 2008. Some of the key areas of change included in the legislation are:

- 1 Significant Change in Condition (SCIC) adjustments are eliminated from the PPS reimbursement system. SCICs will remain as an OASIS requirement but will no longer factor into reimbursement.
- 2 The annual rate increase that is slated for each January 1 will be reduced by 2.75% for each of the next 3 years and then 2.71% in the fourth year.
- 3 The therapy threshold of 10 visits will be changed to thresholds at 6, 14 and 20 visits. In addition, there will be declining incremental reimbursement between the 7th and 19th visit. The reimbursement starts at \$42 for visit number 7 and declines to \$23 for visit number 19.
- 4 The single weight case mix model is replaced with a 4 step model:
 - a. Early episodes and <14 therapy visits
 - b. Early episodes and >= 14 therapy visits
 - c. Later episodes and < 14 therapy visits
 - d. Later episodes and >= 14 therapy visits

The definition of an early episode is episodes 1 and 2 and later episodes are the 3rd or more consecutive episodes. This also applies if the patient transfers from one agency to another with continued service. The fifth step is all episodes with therapy visits greater than 20 per episode.

- 5 Supplies are no longer a standard amount included in the case mix weight.
 - a. CMS has created 5 severity levels for supplies ranging from 0 to 4.
 - b. Payment will range from \$14.12 to \$551.00 per episode.
 - c. The amount included in the original base rate for supplies under the current system is \$49.62 per episode.
- 6 The current 80 different case mix groups are expanded to 153 case mix groups and when factoring in the breakdown for the early/late and greater and less than 14 therapy visits, it is actually 612 different case mix weights plus the therapy per visit pay and 5 supply severity levels.
- 7 CMS has expanded the diagnostic categories that will be considered when calculating the payment and will consider some secondary diagnoses for scoring.
 - a. These categories include gastrointestinal, pulmonary, cardiac, hypertension, cancer, blood disorders, and affective and other psychoses.
 - b. The scoring will also include infected surgical wounds, abscesses, chronic ulcers, gangrene, dysphagia, tracheostomy and cystostomy.
- 8 MO175 (Inpatient facility prior to home care), MO530 (incontinence) and MO610 (behavior modifications) are no longer part of the payment calculation. They will remain on the OASIS but not used to calculate the payment rate.

- 9 MO470 (stasis ulcer), MO520 (urinary catheter) and MO800 are added to the payment calculation. MO825 is eliminated and MO826 is added to accommodate the new therapy threshold levels.
 - a. Clinical staff will now be required to project the actual number of visits to be done during the 60 day episode.
- 10 Increase in the LUPA payment for PPS episodes that occur as the only episode, or the first PPS episode during an admission.
- 11 Quality data reporting is increased from 10 to 12 measures of quality. CMS added emergent care for wound infections and improvement in status surgical wounds.
- 12 Transition:
 - a. Episodes beginning prior to 12/31/07 and ending on or after 1/1/08 – Paid under the current system with the final inflationary update included.
 - b. Episodes beginning (new and recertification) on or after 1/1/08 will be paid under the new rules.



FINANCIAL STATEMENTS

Visiting Nurse Services of Connecticut, Inc.

**Statement of Revenues and Expenses
PROJECTED
For the Fiscal Year Ended June 30, 2008**

Reviewed and Approved
Finance & Investment Committee – May 29, 2008
Board of Directors – June 3, 2008



HOME CARE SERVICES

Services constantly change due to the multiple needs and complexities of the individuals who require care at home. Visiting Nurse Services of Connecticut, Inc. consistently evaluates the needs of the communities and people it serves, and responds to the recommendations of the medical community. Introduction of new services, programs, patient care procedures and techniques and medical supplies to accommodate the changing environment are an outcome of these evaluations.

Services are provided on a part-time, intermittent basis addressing the needs of the acute, chronic, and terminally ill patient. The following services are available and provided under a physician's plan of care.

SKILLED NURSING

Registered nurses or licensed practical nurses with diversified clinical backgrounds provide care utilizing the nursing process to systemically assess, plan, implement, and evaluate quality individualized nursing care. The professional nurse/case manager is responsible for the management of patient care and coordination of services of other disciplines. Consideration is given to the total needs of the patient and family.

PHYSICAL THERAPY

Registered physical therapists provide rehabilitative techniques of exercise and gait training, prosthetics, and electrical stimulation in helping to restore the highest functional level of strength, range of motion, and mobility to the patient.

OCCUPATIONAL THERAPY

Registered occupational therapists use rehabilitative techniques such as an exercise regimen, splinting and/or assistive devices to increase the patient's ability to perform normal day-to-day activities, such as feeding, dressing, grooming, and household tasks. The occupational therapist guides the patient through specialized care plans that encourage sensory and muscle return. Exercises or activities are used to increase upper extremity function.

SPEECH/LANGUAGE PATHOLOGY

Licensed speech therapists design and execute treatment programs to regain and maximize the communicative effectiveness of patients. They are concerned with improving the abilities of individuals in the areas of verbal comprehension, verbal expression, reading, writing, and swallowing when oral motor deficit is present. Perceptual and cognitive deficits are addressed in the overall treatment.

MEDICAL SOCIAL SERVICES

Licensed medical social workers provide assessment, information and referral casework, short-term counseling, and consultation services. The medical social worker assists the patient and family when social or economic factors interfere with treatment or health maintenance, or inhibit the patient in coping with disease induced limitations.

HOME HEALTH AIDE

Paraprofessionals, who have successfully completed a training and competency evaluation program approved by the State of Connecticut, Department of Public Health, provide personal care, assist in exercise, plan and prepare meals, and perform light housekeeping and shopping service to patients under the supervision of a professional nurse, physical therapist, or speech therapist. Home health aide services help support and maintain the functioning of individuals in their own home.

HOSPICE AT HOME™

The Hospice At Home™ Program is dedicated to providing support at home for the physiological, psychological, sociological, and spiritual needs of the terminally ill and their families. Pain and symptom management is addressed under the physician's plan of care by an experienced team of certified Hospice nurses who operate under the direction of a Director of Hospice Services and Hospice Program Manager.

PALLIATIVE CARE PROGRAM

Oncology/Supportive Care is delivered by an inter-disciplinary team of professionals. Oncology and/or Hospice certified nurses offer comprehensive home care services to patients with life-threatening illness who continue to receive aggressive treatment for their diagnosis or who have not selected the Hospice Program of care.

PAIN MANAGEMENT THERAPY

Under the direction of the Hospice At Home™ Program, Oncology and Hospice team members provide ongoing interventions to manage acute and chronic pain experienced by patients with diseases that produce high levels of pain. Consultation is available when patients have difficult pain management problems. Team members strive to enhance the patient's quality of life by keeping patients pain free.

INFUSION THERAPY (IV) PROGRAM

Registered nurses prepared to deliver infusion therapy services are responsible for insertion, access, and maintenance of the infusion therapy line, the delivery of treatments, case management and education of patients and caregivers. A registered nurse certified in infusion therapy (CRNI) supervises the Infusion Therapy Team, coordinates staff education, directs competency training, and coordinates the overall Infusion Therapy Program. Patients can remain at home while receiving high tech treatments.

JOINT REPLACEMENT PROGRAM

The Joint Replacement Team of registered nurses, physical therapists and home health aides under the guidance of the Director of Rehabilitation work with referring hospitals, orthopedic surgeons and skilled nursing facilities to provide a smooth transition through the process of having a hip or knee replaced. The Joint Replacement Program allows patients to return home following hospital or nursing home discharge by making physical therapy and other recovery services available seven (7) days a week.

MATERNAL-CHILD HEALTH PROGRAM

Registered nurses experienced in the provision of Maternal-Child Health (MCH) services provide in home skilled nursing services and education to routine post-partum women and healthy newborn infants.

PSYCHIATRIC NURSING PROGRAM

Psychiatric nurse specialists assist the psychiatrist and other physicians in the home care needs of patients through therapeutic nursing interventions and supportive counseling and reinforcing the therapy prescribed by the psychiatrist for the home environment. By maximizing the patient's strengths, providing education regarding the disease process, prescribed medication, identifying a support system, and assisting the patient to develop skills to manage symptoms and problem behavior, patients have been helped to manage their disease with some independence. An APRN, with specialized psychiatric training, is available on a consultative basis to all staff and meets with the psychiatric team on a monthly basis to provide clinical supervision and oversight.

WOUND CARE/OSTOMY PROGRAM

The Wound Care/Ostomy Team, under the guidance of a Wound Care Specialist, provides assessment, management, treatment and monitoring of existing and potential wound problems. Consultants and enterostomal therapists are available to staff when needed. The Wound Care/Ostomy Program has experienced many successes of wound healing that were tenuous at best.

WOUND VACUUM ASSISTANCE PROGRAM

Agency nursing staff is skilled in the management of Wound VAC equipment in the home setting. Nursing staff coordinate the successful transition of the patient receiving wound VAC therapy from an acute care setting to the home environment, maintaining compliance with treatment protocols and ensuring ongoing wound healing.

TELEHEALTH PROGRAM

Under the direction of a TeleHealth Program Coordinator, VNS electronically monitors the vital signs of patients who can benefit from this service and represent a wide range of diagnoses. Blood pressure, heart rate, oxygen saturation, temperature and weight are recorded for each patient and remotely transmitted to a central computer station at VNS. The daily transmissions are interpreted by a nurse, who responds to the data in a triage fashion. This service enables VNS to more effectively trend changes in patient conditions that may warrant early intervention. By doing so, patients receive appropriate care when needed with the goal of intervening before more costly ER visits become necessary. The telemonitoring process also instills a greater rate of compliance and improves patient understanding of self-care.

NUTRITIONIST SERVICES

A registered dietitian provides educational programs for professional and ancillary staff in basic nutrition and specialized dietary needs. The dietitian consults with staff regarding specific patient problems and makes home visits to those who have very specialized, or complex, nutrition and /or dietary requirements.

MEDICAL/PHARMACEUTICAL SUPPLIES

Supplies needed for treatment, i.e. dressings, wound care, rehabilitation and intravenous therapy are available from VNS contracted providers. Timely delivery of products enabling a prompt start of treatment is assured.

TEACHING TOOLS

VNS has the capability of producing customized, printed teaching tools for patients with over 1,500 specific health needs. Each is also available in Spanish. Our clinicians have the capability of customizing instructions and protocols contained in the teaching tools for individualized patients' plans of care. These tools enable us to improve patient compliance and progress toward meeting their goals.

INTERPRETIVE SERVICES

VNS makes translators available to patient in over 14 languages.



HOME CARE SERVICES

SERVICES	BRIDGEPORT	OXFORD	NORWALK	TORRINGTON	TRUMBULL
Skilled Nursing	√	√	√	√	√
Physical Therapy	√	√	√	√	√
Occupational Therapy	√	√	√	√	√
Speech/Language Pathology	√	√	√	√	√
Medical Social Services	√	√	√	√	√
Home Health Aide	√	√	√	√	√
Hospice At Home™	√	√		√	√
Palliative Care Program	√	√	√	√	√
Pain Management Therapy	√	√	√	√	√
Infusion Therapy (IV) Program	√	√	√	√	√
Joint Replacement Program	√	√	√	√	√
Maternal Child Health Program				√	
Psychiatric Nursing Program	√	√	√	√	√
Wound Care/Ostomy Program	√	√	√	√	√
Wound Vacuum Assistance Prog.	√	√	√	√	√
TeleHealth Program	√	√	√	√	√
Nutritionist Services	√	√	√	√	√
Medical/Pharmaceutical Supplies	√	√	√	√	√
Teaching Tools	√	√	√	√	√
Interpretive Services	√	√	√	√	√
Adult Bereavement Counseling	√	√	√	√	√
Blood Pressure Screening Clinics	√	√	√	√	√
Child Bereavement Support Group				√	
Flu Vaccine Clinics	√	√	√	√	√
Health Fairs	√	√	√	√	√
Home Care Assessments	√	√	√	√	√
Senior Health Walks	√				
Speaker's Bureau	√	√	√	√	√
Walk In Consultations	√	√	√	√	√



SENIOR ADMINISTRATION RESUMES

William F Sullivan Jr
President/Chief Executive Officer

Bachelor of Science -- Financial Accounting
Master of Business Administration

Health Care Managerial Experience:

Visiting Nurse Services of Connecticut, Inc.
28 years

Anthem Blue Cross
Manager, Health Care Provider Audits
9 years

Jeanne M. Bodyk
Executive Vice President/Administrator

Bachelor of Science -- Nursing

Health Care Managerial Experience:

Visiting Nurse Services of Connecticut, Inc.
3 years

United Visiting Nurse Association
Vice President, Patient Care
16 years

Trumbull Public Health Nursing Association
Assistant Nursing Supervisor
3 years

F. Edward Nicolas
Vice President/Chief Financial Officer

Certified Public Accountant
Bachelor of Science -- Financial Accounting
Masters of Business Administration

Health Care Managerial Experience:

Visiting Nurse Services of Connecticut, Inc.
15 years

Laventhol & Horwath, C.P.A.
Health Division
5 years

Scott W. Burrows
Vice President of Human Resources

Bachelor of Science -- Human Resources
Masters of Healthcare Administration

Health Care Managerial Experience:

Visiting Nurse Services of Connecticut
1 year

Danbury Hospital
1 year

Norwalk Hospital
5 years
