

NATIONAL ASSOCIATION FOR HOME CARE & HOSPICE 2016 LEGISLATIVE BLUEPRINT FOR ACTION

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ABOUT THE BLUEPRINT

The 2016 Legislative Blueprint for Action represents the legislative agenda for the National Association for Home Care & Hospice (NAHC). This document contains a discussion of the Association's priorities and other important issues and recommendations concerning home care and hospice. It was prepared through a series of meetings with home care and hospice professionals, state association representatives, and a survey of the NAHC members. It has been reviewed and approved by the NAHC Board of Directors at its 2016 meeting.

The Blueprint is organized by issue area. All items in the Blueprint contain a discussion of the issues and the Association's recommendations as the issue relates to home care and hospice. The Blueprint reflects NAHC's continued dedication to ensuring that high quality home care and hospice services are fully available to all individuals in need.

The central goal of NAHC's legislative agenda is the humane, cost-effective provision of high-quality home care to all who require it, whether they are needy, infirm, elderly, children, or disabled. NAHC believes that quality home care and hospice are the right of all Americans. NAHC believes that home care and hospice are both a humane and cost-effective alternative to institutionalization. Home care and hospice reinforce and supplement the care provided by family members and friends and encourage maximum independence of thought and functioning, as well as preservation of human dignity.

This document has been produced by the National Association for Home Care & Hospice, a trade association that represents the interests of the nation's home health agencies, home care aide organizations and hospices, as well as the caregivers who every year provide services to millions of Americans and their families. It is hoped that this document will be helpful to the Congress in its deliberations and that it will result in the enactment of legislation to improve the quality of life for millions of Americans.

I. ENSURE ENACTMENT OF A COMPREHENSIVE, HOME-BASED NATIONAL HEALTH CARE POLICY

A. HEALTH CARE COVERAGE/LONG TERM CARE DELIVERY AND FINANCING

ENSURE HOME CARE AND HOSPICE PARTICIPATION IN TRANSITIONS IN CARE, ACCOUNTABLE CARE ORGANIZATIONS, CHRONIC CARE MANAGEMENT, HEALTH INFORMATION EXCHANGES, AND OTHER HEALTH CARE DELIVERY REFORMS

ISSUE: The Patient Protection and Affordable Care Act of 2010 (PPACA) includes significant health care delivery system reforms in addition to expansion of Medicaid eligibility, health insurance reforms, and Medicare payment changes. These health care delivery reforms have the potential to radically alter how and where patients receive care. Overall, these reforms shift the focus of care from inpatient services and institutional care to the community setting. Further, these reforms provide a combination of incentives to clinically maintain patients in their own homes and penalties for excessive re-hospitalizations of patients. Importantly, these reforms also focus on individuals with chronic illnesses, providing support for health care that prevents acute exacerbations of their conditions and avoids both initial and repeat hospitalizations.

PPACA includes, among other health care reforms, new benefits, payment changes, pilot programs and demonstration projects such as Accountable Care Organizations, Transitions in Care penalties for re-hospitalizations, a Community Care Management benefit, and trials of integrated and bundled payment for post-acute care.

Home care and hospice services offer an opportunity for these new programs to work at their highest potential for efficiency and effectiveness of care. Home care and hospice bring decades of experience in managing chronically ill individuals with a community-based care approach, limiting the need for inpatient care and creating a comprehensive alternative to most institutional care.

If these health care delivery reforms are to fully succeed, the Centers for Medicare and Medicaid Services (CMS) must recognize the value of home care and hospice as part of the solution to out-of-control health care spending, particularly for patients with chronic illnesses. CMS should take all possible steps to ensure that any pilot programs or demonstration projects include home care and hospice as active participants and, where appropriate, as the qualified, controlling entity to manage post-acute care and patients with chronic illnesses.

In 2015 Senators Johnny Isakson (R-GA), Mark Warner (D-VA), Orrin Hatch (R-UT) and Ron Wyden (D-OR) formed the Finance Committee chronic care working group. The working group is soliciting and evaluating chronic care proposals and plans to introduce legislation in 2016 to better address the management of chronic illness.

RECOMMENDATION: Congressional reforms of the health care delivery system recognize home care and hospice as key partners in securing high quality care in an efficient and efficacious manner. Congress should monitor closely CMS's implementation of the health care delivery reform provisions in PPACA to ensure that the intended goals are fully met.

Congress should encourage CMS to look to home care and hospice as part of the solution to rising health care spending in Medicare and Medicaid, including through community based chronic care management. Congress should investigate and remove any existing laws and regulations that create barriers to the inclusion of home care and hospice entities as integrated partners or participants with other health care organizations in transitions in care actions, bundling of payments, or other delivery of care innovations.

RATIONALE: Community-based care is a valuable, but under-utilized health care asset with respect to efforts to reduce hospitalizations and re-hospitalizations. Further, community-based chronic care management has long been provided effectively by home health agencies and hospices. However, the antiquated structure of Medicare benefits has prevented its application at full capacity. The reforms in PPACA present the opportunity to build a new care delivery model that is not handicapped by this out-of-date structure and to overcome longstanding weaknesses in health care delivery.

ENACT A COMPREHENSIVE, HIGH QUALITY HOME- AND COMMUNITY-BASED LONG-TERM CARE PROGRAM

ISSUE: Millions of Americans of all ages are victims of disability and chronic or terminal illnesses of long-term duration. The bulk of the care needed by such people is practical and supportive assistance, often described as “custodial”; the costs associated with providing this care can be staggering. Most chronically ill and disabled people have few resources to cover these costs.

Current public programs and private insurance are inadequate to meet the country’s growing need for long-term care services. The already significant need will grow substantially with the aging of the baby boom population and the emergence of new technologies that enable people with disabilities to live longer.

The lack of coordinated and comprehensive long-term home- and community- based care often results in premature or unnecessary institutionalization, destruction of the family unit, and reduction of family resources to the point of destitution. The supportive, familiar environment of the home setting for care delivery, however, can provide a cost-effective option that may also enable stabilization of the individual’s chronic conditions.

As part of comprehensive health care reform, Congress included the Community Living Assistance Services and Supports (CLASS) Act, which was intended to create a long-term care insurance program for adults who become functionally disabled. Financed by voluntary payroll deductions, the CLASS program was expected to provide a cash benefit in the form of a debit card to help obtain nonmedical support services that enable beneficiaries to remain in their homes and communities. Private long term care insurance would still be an option for those in the CLASS program who seek to purchase additional supplemental coverage.

At the end of 2011, however, the Secretary of Health and Human Services (HHS) announced that the agency was unable to find a strategy to make the program financially viable and implementation of the CLASS Act was suspended. Since the announcement, Congress repealed the CLASS Act and created a 15 member long term care commission appointed by Congressional leaders and the President that reported back to Congress with long term care policy recommendations. The commission could not agree on a funding mechanism for long term care, but did agree on incremental measures such as eliminating the homebound restriction on access to Medicare home health services and rebalancing Medicaid in favor of home and community-based care.

The health care reform legislation also included enhanced federal Medicaid matching funds to encourage state Medicaid programs to increase diversion of Medicaid patients from costly institutional long term care to more cost-effective home and community-based care. It also extends to spouses of individuals receiving Medicaid home and community-based care the same protections against impoverishment that are currently provided to spouses of nursing home residents.

RECOMMENDATION: The federal government must take the lead in providing adequate coverage of long-term care needs for the physically disabled, chronically and terminally ill, and cognitively impaired. The foundation of this initiative should be home and community-based care and hospice.

The following provisions should be included in a federal long term care plan:

- Congress should clearly define Medicare and Medicaid responsibilities and coverage standards for chronic and long-term care conditions.
- Long-term and chronic care coverage must be coupled with clear and dedicated financing.
- Any new benefit must be distinguishable from the Medicare and Medicaid home health benefits to eliminate confusion regarding the programs' respective responsibilities.
- Disabled and chronically ill Americans who are under 65 should be permitted to qualify for home- and community-based services on the same basis as the elderly.
- Home care agencies and hospices should be allowed to perform case management functions instead of using costly external case management procedures that duplicate standard caregiver activities.
- The distinction between acute care benefits and long-term care benefits should not be so rigid as to inhibit the smooth coordination of in-home services.
- Eligibility for benefits should not be based on income. It should be a social insurance program, not a means-tested welfare program. It should ensure that the spouses of those who need long-term care are not impoverished.
- A long-term care program should be a comprehensive federal insurance plan, not a block grant to the states that is adequately and realistically funded. Funding for a long-term care program should be broad-based and progressive, and reliable for many years to come.
- All individuals who need assistance with one or more activities of daily living (ADLs) or instrumental activities of daily living (IADLs) and all those with cognitive or mental impairments should be covered. Another factor to consider should be whether there are family caregivers in the home.
- The full range of home- and community-based services should be offered to all eligible individuals at a level appropriate to meet their needs. These services should include nursing care; home care aide services; medical social services; personal care services; chore services; physical, occupational, speech, and respiratory therapy and rehabilitative services; hospice services; respite care; adult day services; medical supplies and durable medical equipment; minor home adaptations that, among other benefits, enable beneficiaries to receive services at home; transportation services; nutritional services; and patient and family education and training.
- Quality of care must be ensured. Quality assurance standards, including minimal standards of training, testing, and supervision, should be applied to the delivery of services in the home, regardless of the source of payment for those services.
- For paraprofessional service providers, the Joint Commission on Accreditation of Healthcare Organizations, the Community Health Accreditation Program and the Home Care Aide Association of America have developed suitable standards for the training, testing, and supervision of paraprofessional workers. State certification of these workers should be required to ensure that all home care aides are appropriately trained, tested, and supervised; payment should be sufficient to allow for coverage of basic employee benefits and other support.
- Cash and counseling or voucher programs to purchase home care services should include standards to ensure quality of care; protect vulnerable patients from physical, emotional, or financial abuse or exploitation; guarantee adequate training and supervision of home care personnel; and ensure the provision of any required

employee benefits. Such programs should ensure compliance with applicable state and federal labor, health and safety laws and regulations.

RATIONALE: Any long-term care plan adopted by the Congress should cause a paradigm shift toward much-needed federal coverage for care in the home and community setting rather than in institutions. Currently, the great majority of Medicaid and public funds spent on long-term care are devoted to institutional care.

The adoption of these recommendations in a long-term care plan would ensure that people with disabilities and chronically and terminally ill Americans receive the comprehensive, high quality home- and community-based care they need in the least restrictive environment.

MODIFY EMPLOYER RESPONSIBILITIES IN HEALTH CARE REFORM TO ADDRESS HOME CARE SPECIFIC NEEDS

ISSUE: The Patient Protection and Affordable Care Act of 2010 (PPACA) expands the availability of health insurance to an estimated 32 million of the current uninsured population. It does so through Medicare spending reductions, certain tax increases, fees payable by insurance companies and others, a penalty on uninsured individuals, and a penalty on businesses with more than 50 employees that do not provide health insurance to their employees. This legislation imposes a \$2000 penalty for each full time employee that does not get health insurance from the employer where the business employs 50 or more full time equivalent employees and at least one of the employees qualifies for a federal subsidy to purchase health insurance. The definition of “full-time employee” in the calculation of target employers is based upon the total of the number of employees working at least 30 hours a week.

While the employer responsibility provisions in PPACA were scheduled to take effect on January 1, 2014, the Obama administration delayed the effective date to January 1, 2015. During 2013, numerous legislative proposals were introduced that would repeal or alter the employer responsibilities provisions. One such reform measure would redefine “full-time” to mean 40 hours a week or more.

In 2015, the Administration delayed the mandate until 2016 for businesses with 99 or fewer FTEs. The mandate takes effect in 2015 for businesses with 100 or more FTEs, but with penalties imposed only after the first 80 full-time workers and a compliance rate reduced to 70% for 2015 only.

Home care businesses with more than 50 FTEs have three problems that are fairly unique for employers impacted by the health care reform change. First, home care is most often paid either by government programs such as Medicaid and Medicare. These programs do not normally raise payment rates adequately or at all to cover increased costs. Second, the consumer of private pay home care is most often an elderly or disabled individual on a fixed or low income that cannot afford to absorb any price increase that would be needed to cover the cost of employee health insurance or the alternative penalty. Third, the home care workforce is employed often with widely varying weekly work hours because of changing clientele and changing client needs. The model defining FTE in the legislation does not accommodate these variations.

The Paraprofessional Healthcare Institute (January 2006) found that 40 percent of home care workers lack health insurance coverage (compared to the Bureau of Labor Statistics estimate of 16 percent for all workers). The estimate for home care workers does not include privately paid workers and those who work part time, so the overall percentage of home care workers without health insurance is likely well over 50 percent. A 2014 survey by the National Association for Home Care & Hospice indicates that 35% of Medicare home health agencies do not offer a health insurance to their employees while 75% of Medicaid home care companies and private pay home care companies do not offer health insurance.

On June 19, 2013, Senators Susan Collins and Joe Donnelly introduced the “Forty Hours Is Full Time Act”, which would modify the definition of full time from 30 hours per week to 40 hours per week. The reasoning behind the bill is to prevent employers from having

to limit workers' hours to only 29 hours per week, which would be damaging for the employee, the employer and, most importantly, people receiving care from home care workers who became limited to only 29 hours of work per week. The bill was reintroduced in 2015 as S. 30.

The House of Representatives had comparable bills in 2013 and 2015, entitled "Save the American Workers Act." That bill, HR 30, passed the House in January 2015.

Additional legislation with similar intent has been before Congress. In 2014, The House also had HR 5098, a bill which would have delayed the employer mandate for 2 years for health care businesses primarily providing Medicare or Medicaid Services.

In January 2016, the House and Senate passed a bill that would repeal many parts of the Affordable Care Act. It was the first such measure to pass both houses of Congress. The employer mandate and penalty provisions were part of that bill. However, on January 8, 2016, President Obama vetoed the bill. There was insufficient support for the bill to override the veto.

The absence of health insurance in for home care workers will lead to significant monetary assessments against the home care companies. Current reimbursement levels in Medicare and Medicaid along with the barriers to price increases in private pay home care put continued access to care in severe jeopardy. The only business option available to home care companies in these circumstances is to limit the working hours of caregiving staff to less than 30 per week. While early studies do not show any significant shift to part-time workers in the economy at large, reports from home care employers continue to indicate that limiting working hours to avoid the ACA employer mandate is the primary strategy in use. There is no indication that Medicaid programs have adjusted payment rates to accommodate the cost of health insurance or the employer penalties.

RECOMMENDATION: Congress should amend the Patient Protection and Affordable Care Act (PPACA) to fund the cost of health insurance for full-time workers. Alternatively, PPACA should be amended to exempt home care providers from the employer responsibilities. Congress should also consider amending the definition of full-time to 40 hours a week or repealing the mandate altogether. Funding of worker health insurance can occur through a subsidy to all home care providers to supply health insurance, and/or provide a subsidy or tax credits to home care clients to cover the increased cost of care triggered by the employer responsibility provisions. Congress should help the states ensure that low wage home care workers have health insurance through Medicaid or otherwise. Congress should amend also PPACA to allow for a definition of a full time employee that evaluates the individual's working hours over a 180 day period rather than the current monthly calculation. Finally, Congress should amend PPACA to require that all government health programs adjust provider rates to meet the additional costs that will be incurred by health care providers to make health insurance available to all their employees.

RATIONALE: Home care employers do not have the ability to control service pricing like most other employers that are affected by the employer responsibility provisions in the health care reform legislation. It is counter to the philosophy of health care reform that consumers of private pay home care services would need to pay higher rates for care. Further, most have limited incomes that might force them to choose Medicaid-funded nursing home care if home services are beyond their reach. In addition, Medicaid programs historically do not increase

provider payment rates sufficiently to cover the increases in provider costs. Finally, the work hour flexibility is one of its attractions to employees. The application of employer responsibilities should accommodate the varied work schedules of home care workers in a way that does not disadvantage the employers.

ESTABLISH FEDERAL SUPPORT FOR SMALL BUSINESS EMPLOYEE HEALTH INSURANCE

ISSUE: Employer-based health insurance is on the decline nationally primarily due to growing costs. According to the Kaiser Family Foundation, in 2002, 58 percent of our nation's smallest businesses, those with less than 10 employees, offered health insurance as a workplace benefit. Today, just 48 percent of the smallest businesses are able to offer health insurance. With the economic crisis that surfaced in 2008 and continues, small businesses are challenged to offer health insurance to employees. Small businesses are particularly challenged by rising costs because they are unable to obtain health insurance at rates that are available to larger groups. Home care and hospice is primarily a "small business" enterprise.

The Patient Protection and Affordable Care Act of 2010 (PPACA) establishes an employer financial responsibility to help fund health insurance where the entity employs 50 or more full time equivalents (FTEs). The reforms exempt small companies with less than 50 FTEs and offer tax credits to companies with 25 or fewer employees to encourage them to provide health insurance. The credit varies depending on the size of the company and the average worker wages. The highest credit goes up to 50 percent of premium costs where wages are less than \$25,000 average.

Legislation was introduced in the 111th and 112th Congresses and again in the 113th Congress to repeal any federal requirement for financial responsibility of an employer for health insurance. Expanded tax credits are a viable alternative to encourage employers to help employees with the cost of health insurance.

RECOMMENDATION: Congress should increase tax credit support for health insurance for employees of small businesses and raise the definition of a "small employer" to allow expanded eligibility for the credits. Further, there should be a standard benefit package that includes home care and hospice.

RATIONALE: Home health agencies, home care companies, and hospices have limited access to affordable health insurance for their employees. The solutions to this growing problem may surface with the health care insurance exchanges developed as part of the health care reform legislation. However, even with 50 percent tax credits (the highest available), small home care businesses will face a daunting task securing health insurance for their employees because the increased cost of such is not likely to be addressed with higher service payment rates from government home care benefit programs or through the ability to increase charges to private pay disabled and elderly clients living on limited fixed incomes.

B. MEDICARE

ESTABLISH A CHRONIC CARE MANAGEMENT BENEFIT UNDER MEDICARE

ISSUE: As issues related to acute illnesses are addressed and resolved by the health care system, chronic illness has become the key health care concern of the Medicare population. This chronically ill population requires different services and supports than are currently covered under the traditional acute care benefit structure of Medicare. The absence of coverage for supportive, preventative, and care management services for the chronically ill leads to hospitalizations, emergent care, and serious exacerbations of underlying illness. Care management of this population can save significant expenditures in Medicare and greatly add to the quality of life these citizens enjoy in their final years.

Medicare initiated a pilot “Chronic Care Improvement Program” that does not provide the direct, face-to-face support that is necessary for productive care management. Relying on statistical analyses, broad-based educational efforts, and very limited direct intervention, the pilot program falls short of the care management that can be provided by home care nurse.

Additional concepts of chronic care management are emerging. These include a medical/health home model. A medical/health home model is a physician –centered approach wherein physicians are reimbursed to focus on managing the medical needs of individuals with one or more chronic illness diagnoses. However, there are serious weaknesses in the medical home model. Specifically, there is a severe shortage of physicians with training in managing chronically ill individuals in the community setting. In addition, physicians lack the infrastructure necessary to extend services outside their office practices using modern technologies, data driven actions, and home visitations of patients. Finally, a medical home model does not integrate the wide variety of non-medical services and supports that are needed to achieve the comprehensive goals of effective chronic care management.

In the Patient Protection and Affordable Care Act of 2010 (PPACA), Congress authorized the establishment of several pilot programs and demonstration projects designed to test new models of chronic care management. One model, to be tested in the new Centers for Medicare and Medicaid Services (CMS) Center for Innovation program, uses home health agencies as a base to be provided by an interdisciplinary team approach that includes physicians and other health care professionals along with high tech remote monitoring systems. This project would include in home face to face support of the chronic care patient. This program is recommended by Congress, but not required.

Another program in the reform legislation is a required pilot program known as Independence at Home (IAH), a physician-centered model that incorporates a team approach along with technology supports. This model focuses on certain high risk categories of chronic care patients and uses a reimbursement method that shares the Medicare spending savings from the care between Medicare and the providers. In 2015, Congress extended the lifespan of the IAH program as it has shown success in reducing overall Medicare spending for the patient population involved in the pilot.

In late 2013, CMS modified the physician Medicare reimbursement model to include procedure codes on management of chronically ill beneficiaries. This is a step in the right direction but it still falls short in that it does not recognize the value and importance of non-

physician services in the management of a chronic care population.

The Senate Finance Committee (SFC) has taken up the issues presented in caring for Medicare beneficiaries with chronic illnesses. In 2015, the SFC initiated a public study of the problems and concerns with the current Medicare design as it relates to efficiently and effectively caring for beneficiaries afflicted with one or more chronic diseases. In December 2015, the SFC issued a preliminary report with a set of recommendations on Medicare reforms to address chronic care patients. Among the proposed reforms is the expansion of the Independence at Home Program.

RECOMMENDATION: Congress should monitor the development and implementation of the demonstration programs and pilot projects on chronic care management to ensure CMS compliance with its mandates and recommendations. Congress should establish a separate care management benefit under Medicare that is available for designated categories of chronically ill individuals such as COPD, CHF, diabetic, and certain neurological disorder-afflicted patients based on the outcomes of the various demonstration projects and pilot programs. The service should be provided by professional nurses and others within home health agencies to ensure a discipline- integrated, community care-based approach to care management. The patient care should be under the guidance and supervision of the patient's attending physician who should be included as a member of the care team. The services should include:

1. An interdisciplinary team approach to care management that includes physicians, nurses, therapists, medical social workers, and pharmacists;
2. Evidence-based care plan development;
3. Direct patient care services in the home setting;
4. The application of telehealth services for appropriate remote monitoring as needed by the individual patient;
5. Care counseling, care coordination, medication management, and oversight of services related to activities of daily living;
6. The use of interoperable electronic health care records and efficient electronic-based communication tools;
7. Patient education and support; and
8. Integration and support of informal caregivers such as family members.

In addition, Congress should:

1. Permit nonphysician practitioners to authorize Medicare home health services as NPPS are becoming the primary care practitioner for millions of Medicare beneficiaries;
2. Expand availability of patient remote monitoring services (telehealth) by allowing home health agency professionals to provide telehealth in patient homes;
3. Waive the Medicare home health services "homebound" requirement in program innovations; and
4. Support application of the "management and evaluation of the care plan" skilled nursing service in the existing home health benefit to create a nationwide care management system for individuals with chronic diseases.

RATIONALE: The existing Medicare benefit structure encourages individuals to await condition deterioration before attending to ongoing health-related needs. Higher-cost care for

acute episodes results from the absence of direct care management of the chronic care population. A care management benefit can help avoid these complications and costs.

A chronic care management delivery system is already available through existing home health agencies that possess the skill and experience in managing chronically ill individuals in the community. Through the existing infrastructure of home health agencies, an effective chronic care management system can be created with minor refinements and minimal re-engineering of the delivery system to achieve nearly immediate cost savings and improved patient care. However, Congress needs to modify some elements of current law to secure a full range of home-based solutions in the care of individuals with chronic illnesses.

ESTABLISH A HOME AND COMMUNITY-BASED DEMONSTRATION PROGRAM UNDER MEDICARE

ISSUE: Advances in technology allow more and more services to be provided in the home or community setting. Further, care often times can be provided more cost- effectively, and most elderly and disabled individuals would prefer to be cared for in the comfort of their homes. As the baby boom generation reaches the age of Medicare eligibility, there is growing concern over chronic disease and the toll it will exact from federally-financed health care programs. Home care services, provided on a timely basis, could help to alleviate the need for more complex care at an institution. However, existing requirements under the home health benefit (part-time and intermittent care) deny access to more timely home-based interventions. The result can mean admission to a skilled nursing facility (SNF) or hospital, at a much higher cost to Medicare. The average cost of a home health care stay (60-day episode) is around \$2,700, while the average Medicare SNF stay costs about \$8,500.

In the Patient Protection and Affordable Care Act (H.R. 3590; P.L. 111-148), Congress authorized the creation of a Center for Medicare and Medicaid Innovation (CMS Center on Innovation). In Section 3021 (xiv) of the Act, it calls for the Center to conduct a demonstration project that would fund “home health providers who offer chronic care management services to applicable individuals in cooperation with interdisciplinary teams.”

RECOMMENDATION: The Congress should authorize a home and community-based demonstration program under Medicare that waives the part-time and intermittent care standards, allows greater flexibility relative to services provided than currently under the home health benefit, and covers services in the home for patients that otherwise would be cared for under the Medicare SNF benefit or in a hospital if it can be shown that the cost to Medicare of caring for the individual in the home would be less than the cost of placement in a SNF or hospital. Congress should ensure that the CMS Center on Innovation promptly implements demonstration projects pursuant to Section 3021 (xiv) that meets these guidelines.

RATIONALE: Under the Medicaid program, states may apply for a waiver to provide a wide variety of home and community-based services (section 1915 waivers) to individuals who would otherwise be placed in institutions. Prior to the passage of this legislation, Medicaid long-term care benefits were limited to home health and personal care services in the home, and to hospitals and nursing facilities. The section 1915 waiver program provides a vehicle for states to offer additional services not otherwise available through their Medicaid programs to serve people in their own homes and communities. The program recognizes that many individuals at risk of being placed in institutions can be cared for in their homes and communities, preserving their independence and ties to family and friends at a cost no higher or less than that of institutional care. Providing services in the home can be far more cost-effective than in an institution and can help to speed recovery and foster greater independence, and avenues for expanding access to this service under the Medicare program should be pursued.

CREATE A PHARMACEUTICAL SERVICE HOME HEALTH BENEFIT

ISSUE: Many home care patients are “poly-pharmacy” patients, requiring six or more medications. These patients frequently need additional services as a result, including nursing visits, to ensure compliance with drug regimens. Allowing a pharmacist to review at-risk patients could save the Medicare program money on rehospitalizations and nursing visits that result as the consequence of complications from the use of multiple medications.

RECOMMENDATION: Pharmaceutical services are an essential part of the overall care of the elderly and disabled persons and should be reimbursable under the Medicare home health benefit, as long as they are included in the physician-certified plan of treatment. Pharmaceutical home care services should be delivered by or under the supervision of a registered pharmacist, and payments should be adjusted accordingly.

RATIONALE: The current Medicare home health benefit allows some pharmaceutical services to be billed through the administrative services portion of the cost report. This option is rarely utilized due to cost constraints facing home health agencies under the current cost reporting and payment methodology. Coverage of pharmaceutical services would make the home health benefit more responsive to beneficiaries’ needs and would constitute a better utilization of resources under Medicare. Given concerns about the high cost of health care, Medicare should incorporate sufficient flexibility and appropriate reimbursement to allow for use of non-traditional services in home care that contribute to improved outcomes, safety and cost efficiencies.

C. MEDICAID

REQUIRE TRANSPARENCY IN THE STATE PLAN AMENDMENT PROCESS

ISSUE: In order to make changes to the Medicaid benefits that a state can offer, the state must file a State Plan Amendment (SPA) with CMS. When the SPAs are filed the details and rationale of the SPA are typically unknown to stakeholders. Once a state receives an approval, providers are notified of the changes and are required to comply, often with little notice and little knowledge of the reasoning behind the change. Unfortunately these SPAs can often be damaging to the provider and the patient, requiring more limited services or reduction in payment rates both of which hinder access to care.

RECOMMENDATION: CMS should require states to conduct a transparent State Plan Amendment Process. The SPA should be announced, made public, and offer a comment period prior to submission to CMS. States should also be required to maintain a SPA repository so that stakeholders can review the SPAs in their entirety at any time, including the SPA as approved by CMS. The repository should include the language of each SPA as well as any data that the SPA has been based on so that stakeholders can get a full view of the rationale behind the SPA. In addition, CMS should provide a formal comment process prior to any SPA determination.

RATIONALE: When states make a decision to modify the Medicaid program, it is essential to allow input from the stakeholders who will ultimately be responsible for implementing the changes. Currently, the SPA process is a mystery for most stakeholders and they are left scrambling to find ways to implement the amendments and often discover that the amendments will be damaging to patients and providers after the amendment has already been approved by CMS. Stakeholders are also in the best position to offer insight to the practicality of a particular SPA but can only do so when presented with the information and offered an opportunity to comment. In many cases stakeholders may be able to offer a different solution that does not require the state to submit a SPA. Creating a more transparent SPA process benefits stakeholders, the states, and CMS by allowing the involved parties to participate in the process and avoid unnecessary work on ineffective amendments.

REQUIRE MEDICAID HOME CARE PROGRAMS TO MEET QUALITY OF CARE STANDARDS AND OFFER A FULL RANGE OF DELIVERY MODELS

ISSUE: Some states contract directly with individuals to provide paraprofessional services ranging from social support to “hands-on” personal care rather than using home care organizations for the provision of such services. In some cases, the services provided by these individual providers require highly-trained health care workers, such as in cases where insulin injections, catheter care, nasogastric tube insertion and feeding, and other services are needed. These services are financed through a variety of programs at the federal, state and county levels. Many states have determined these workers to be employees of the client, thereby delegating the traditional duties of the employer (such as hiring, educating, supervising, firing, securing backup workers when the primary care provider is not available, performing background checks, and, in some cases, transmitting payment for services and making employer tax contributions) to the client.

Advocates for people with disabilities are strongly supportive of consumer direction of personal care and have worked diligently to make the option more widely available. Clearly, it provides recipients more choice and greater independence. However, states’ decisions to use this model may be driven by financial considerations rather than patient needs.

The National Association for Home Care & Hospice (NAHC) recognizes and fully supports the rights of individuals to direct their own care. However, NAHC has serious concerns about state or federal imposition of the consumer-directed model of care upon individuals who are incapable of directing their own care, fearful of assuming the responsibilities of an employer, or unaware of the responsibilities associated with consumer-directed care. NAHC is also concerned that, in the absence of minimum quality standards, it is possible that neither clients nor workers may be protected by important Occupational Safety and Health Administration (OSHA) safeguards, such as the blood borne pathogen standard, because the workers are not considered to be employees of organizations which are bound to follow OSHA rules.

In 2012, the Centers for Medicare and Medicaid Services (CMS) issued a final rule regarding the Community First Choice optional benefit. In this rule, CMS suggested that states offer a self-directed care model and an agency model for the delivery of services. However, the rule is not sufficiently clear that states must offer full freedom of choice to Medicaid beneficiaries on the model of care delivery. It is possible that different levels of care may be available under the different models.

RECOMMENDATION: Congress should require all states contracting with individuals to provide paraprofessional home care services through federally-funded programs to provide adequate assurances that consumers receiving care from such individuals are assessed to be capable (for example, a person receiving highly skilled services such as catheter care must be capable of directing the caregiver in the performance of that task) and willing to assume the required employer responsibilities. Consumers should also be given the full option to choose among service models (consumer-directed, home care agency, etc.) to ensure individual freedom of choice, and should have access to the same frequency and type of care regardless of the chosen delivery model. States should also provide a mechanism for resolving any

problems that arise between a consumer and providers, and should devise a method for ensuring that backup workers are available. Consumers directing their own care and their caregivers should be afforded the same important protections that are required when care is provided through an agency. The same needs should be met under each model for the same level of care. Caregivers should be trained, tested, and competent to provide services.

RATIONALE: A goal of home care is to foster independence in the least restrictive environment while safely meeting the consumer's needs. Consumers have the right to choose the model of care that best suits those needs. Individuals who are capable and choose to should be permitted to self-direct care. However, those who are unwilling or unable to assume the many responsibilities associated with this model should be able to select other options. For the safety of consumers and caregivers, the education, testing, and quality standards to which agencies are held should apply to all models of care. All models of care should require compliance with applicable state and federal labor laws and health and safety regulations.

ENSURE ACCESS TO HOME CARE IN MEDICAID MANAGED LONG TERM SERVICES AND SUPPORTS

ISSUE: In the early stages of Medicaid care delivery reforms, most states that tested the use of managed care in Medicaid excluded long term services and supports (LTSS) from the program and continued coverage of those services under traditional Medicaid fee-for-service. In response to Olmstead and the increasing financial pressures of the cost of institutional care, states have begun efforts to rebalance long term services and supports expenditures in favor of home care. At the same time, with the growth of long term care spending, states have begun implementing managed care for LTSS services as well. It is expected that many states will partly or fully move to mandatory managed care enrollment in the next few years.

While states are provided great flexibility in Medicaid, it is crucial that any transition to managed LTSS not lose the valuable benefits of community-based care that have been achieved in Medicaid over the last several years. Foremost is the effort to avoid institutionalization of the elderly and disabled spurred on by the landmark Supreme Court decision in Olmstead v. L.C. A key element of Olmstead compliance is the extensive use of home and community-based care waiver programs. These programs, often targeted to specific disabled groups, provide essential access to care at home. A Medicaid LTSS managed program is at high risk of losing these options as the business of managed care may shift patients to institutional care believing it is less expensive.

Because of the high level of flexibility afforded by the federal government to states in the Medicaid program, managed care plans receive in the management of Medicaid benefits. On the clinical side of care, care that managed care plans have vast experience in providing, many Medicaid beneficiaries have had positive experiences. There is a high risk, though, that due to the states' flexibility in Medicaid, managed care plans' inexperience, and lack of federal oversight, the long term services and supports now being managed by managed care plans will suffer. Payment rates, network adequacy, continuity of care and patient access to care can all be easily jeopardized by a lack of guidance and oversight.

In addition, managed LTSS should conform with the quality of care standards applicable to fee-for-service home care under Medicaid. Finally, managed LTSS home care under Medicaid should afford enrollees with reasonable choices among providers in order to encourage quality and efficiency. Limiting Medicaid eligible patients to a single provider is not effective choice.

State Medicaid programs, with the support of CMS, are rapidly moving to managed LTSS delivery models. In 2014, nearly two dozen states had proposed to adopt some form of managed LTSS, either partially or as the complete delivery model. It is apparent that this trend will continue to expand. Early indications are that Medicaid beneficiaries face limited choices of home care providers and enrollment standards that steer individuals away from the traditional program into a managed care provider model. In addition, access to care appears to be restricted through a combination of payment rate reductions and restrictive care authorizations.

RECOMMENDATION: Congress should require that any LTSS Medicaid managed care program develop an Olmstead compliance plan, establish parity or a "maintenance of effort" requirement for any home care benefits provided by the state in an existing fee- for-service

program, comply with the fee-for-service quality of care standards, and ensure enrollees choice among home care providers. These requirements should apply to both skilled and personal care services. Additionally, CMS should create a program of federal oversight to monitor the compliance of managed long term services and supports programs with respect to payment, network and care adequacy as currently done for Medicare Advantage plans.

RATIONALE: A transition to managed care should not result in a change in the scope of the Medicaid home care benefits or any jeopardy to home care providers or patients. Likewise, the goals of Olmstead and managed care are common: access to community-based care in a clinically and economically appropriate direction for health care.

ESTABLISH FEDERAL STANDARDS FOR MEDICAID PERSONAL CARE SERVICES

ISSUE: In the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993), Congress established a Medicaid optional benefit for personal care services that modified existing regulatory standards for such care. Under OBRA 1993, care can be planned at a state's discretion by non-physicians and provided by any caregiver considered qualified by the state Medicaid program. There are no federal quality of care standards for the services. Some states have implemented personal care programs that require no training or testing of the competency of the caregiver and no quality of care oversight. The result can be poor quality of care and a system that leaves the client open to fraudulent billing and abuse by caregivers.

In the Patient Protection and Affordable Care Act of 2010 (PPACA), Congress added nearly \$13 billion in support for Medicaid home care services. It is expected that Medicaid personal care services will correspondingly grow in future years. However, the legislation did not include a requirement for mandatory minimum quality of care standards or benefit accountability.

RECOMMENDATION: In any Medicaid reform efforts, Congress should establish minimum federal standards for delivery of personal care services, including standards for quality of care and competencies, education, and supervision of caregivers.

RATIONALE: Personal care and support services are significantly growing in home care. Within Medicaid, both the population served and the caregivers providing the service vary widely from state to state and location to location. Strict standards of quality are established for Medicaid and Medicare home health agencies, yet it is left to the states' discretion to establish any quality of care standards for Medicaid personal care services. With that discretion, some states have allowed personal care workers without education or competency testing to provide invasive and complex services such as catheter insertion and tracheal suctioning of ventilator-dependent patients. Some states have allowed untrained individuals who are not home care workers, such as community health workers and paramedics to provide care to patients even though those workers are not subject to quality of care standards equal or comparable to regulated home care agency such as nurse supervisors. For the protection of consumers and caregivers, the same quality standards that apply to agencies should apply to personal care workers, and individuals performing some of the tasks of personal care workers, who are not employed by agencies.

REFORM MEDICAID HOME HEALTH FACE-TO-FACE ENCOUNTER REQUIREMENT

ISSUE: Section 6407 of the Patient Protection and Affordable Care Act of 2010 (PPACA) establishes as a condition of payment for home health services coverage under Medicare that a patient have a face-to-face encounter with the physician who certifies the need for home health services. Subpart (d) of section 6407 applies the face-to-face requirement to Medicaid home health services but does not provide any guidance on how the requirement is to be managed by the individual Medicaid programs. Absent standards from CMS as to how the face-to-face requirement should function and how the requirement will be monitored, states cannot effectively implement the PPACA provision.

Even without guidance from CMS, some states have moved forward with the face-to-face requirement. While the intention behind section 6407 was to gain greater physician involvement in ordering home health services, early indications are that the lack of standards or guidance are causing new problems. Providers and physicians alike are unclear as to what is required of them and states are unclear as to how to make the Medicaid face-to-face requirement any different from the Medicare face-to-face requirement. This lack of clarity is resulting in duplicative work for home care providers and physicians as well as frustrating access to care.

CMS has yet to implement a formal regulation on the Medicaid face-to-face encounter requirements. However, federal Medicaid has permitted states to implement the requirement on their own, creating confusion because of standards that vary from the Medicare requirements. As a result, the requirement is, in some cases, creating a barrier to access to care and in other cases being completely ignored.

The experiences with the Medicare face-to-face physician encounter requirements demonstrate that little or no positive program integrity outcomes occur. Instead, the requirements simply block access to care.

RECOMMENDATION:

1. Congress should repeal the Medicaid face-to-face physician encounter requirements. If such does not occur, the following should be mandated by Congress:
2. CMS should establish standards for the Medicaid face-to-face encounter requirement. Those standards should be specific to the Medicaid home health benefit and not merely an extension of the requirements for Medicare patients.
3. Any future standards from CMS for the Medicaid face-to-face encounter should include the use of a uniform certification statement and not physician narratives. The standards should make no reference to a homebound requirement.
4. Congress should monitor the impact of the face-to-face encounter requirements and, if necessary, repeal the provision and devise more constructive ways to secure physician involvement in home health care.
5. Revise PPACA section 6407 to remove the reference to section 1834(m) of the Social Security Act and substitute a definition of telehealth services that allows an individual to meet the face-to-face encounter requirements through modern technologies available in their home. These technologies should include two-way audio and video communications.

6. Establish exceptions to the requirements for patients who have been recently discharged from an inpatient setting, individuals in frontier areas where access to a physician or non-physician practitioner is limited, and individuals where a physician attests to the inability of the patient to leave the home for a physician encounter and is unable to have a physician perform a home visit.
7. Provide financial protection to a home health agency that admits a patient in good faith with the reasonable expectation that a qualified face-to-face encounter has or will occur on a timely basis with appropriate documentation that is compliant with Medicare standards in the event that compliance is not met without the fault of the home health agency.
8. Allow a non-physician practitioner to perform the encounter, certify that the encounter occurred, and compose all necessary documentation of the findings from the encounter.

RATIONALE: The purpose of the face to face requirement was to enhance physician involvement in home health care, not to discourage physicians referring patients to care in their own homes. There is no evidence that pre-existing methods of physician involvement and communication negatively impacted the quality of patient care. Further, any evidence of overutilization of Medicaid coverage cannot be tied to a lack of physician involvement or the nature of physician/patient/home health agency communications. The benefits of the face-to-face requirement serving as a measure of program integrity are far outweighed by the harm the requirement causes relative to patient access to care.

ESTABLISH MEDICAID HOME CARE AS A MANDATORY BENEFIT AND SUPPORT REBALANCING OF LONG TERM SERVICES AND SUPPORTS EXPENDITURES IN STATE MEDICAID PROGRAMS IN FAVOR OF HOME CARE

ISSUE: In 1999, the United States Supreme Court held, in *Olmstead v. L.C.*, that state Medicaid programs were required under the Americans with Disabilities Act (ADA) to undertake steps to support access to community-based health care options as an alternative to institutional care. Subsequently, the Bush Administration established its New Freedom Initiative, which has provided guidance to the states in developing Olmstead/ADA compliance plans. In addition, both the Bush and Obama administrations have voiced support for increased federal payments to assist states in transitioning Medicaid nursing facility patients into home care services. In some states, Medicaid has moved with reasonable and deliberate speed. In others, action seems nonexistent. One problem is the limits on valuable federal support for the administrative actions needed. Another problem is the pressure from institutional care providers to slow any progress towards home care alternatives.

The Deficit Reduction Act of 2005 (DRA), (Public Law 109-171) contains several provisions that rebalance Medicaid long term services and supports coverage toward home care. These initiatives include a "Money Follows the Person Rebalancing Demonstration" through which individuals who are residing in institutions can be provided an opportunity to receive alternative home and community-based care. The provision makes grants and enhanced federal Medicaid payments available to incentivize states to compete for an award of the demonstration program. The enhanced federal payments can range as high as 100 percent of the cost of the home care for the first 12 months. The bill provided \$1.75 billion in new federal payments to support the project.

DRA also included an optional benefit for Home and Community-Based Services for the Elderly and Disabled that allowed states to bypass the "waiver" process that includes requirements for proving the cost effectiveness of services. This benefit required that states establish more stringent standards for Medicaid payment of institutional care as one means of shifting patients to home care settings.

The DRA provisions, while evidencing the federal preference for rebalancing Medicaid long term care expenditures in favor of home care, also highlight support for self-directed care. Both provisions allow for, and even encourage, the availability of services through consumer-directed care models. However, these models are designed with quality assurance requirements, a patient need assessment requirement, and authority for the use of multiple delivery model types. The degree to which states are establishing and enforcing effective quality standards is less clear.

The Patient Protection and Affordable Care Act of 2010 (PPACA) incorporated several provisions that encourage greater utilization of home and community-based services under Medicare, including, under sections 2401-2406:

- Establishment of the Community First Choice Option, which allows for enhanced federal matching for community-based attendant supports and services to disabled individuals up to 150 percent of federal poverty level who require an institutional level of care;

- Extension of the Money follows the Person Rebalancing Demonstration program;
- Protections against spousal impoverishment in Medicaid home and community- based services;
- Enhanced federal matching through the State Balancing Incentive Program for select states to increase the proportion of non-institutionally-based long-term services and supports; and
- New options for states to offer home and community-based services through the state plan for individuals with incomes up to 300 percent of the maximum supplemental security income payment who have a higher level of need and to extend full Medicaid benefits to individuals receiving home and community-based services under a state plan.

In recent years, as financial strains have beset federal and state governments alike, providers of home care services have raised concerns that while rebalancing efforts continue, payment levels fall far short of the cost of providing services. In addition, these financial strains have led a number of states to shift Medicaid beneficiaries into managed care plans for acute care services as well as long term care supports. The experiences with long term managed care create concern that the rebalancing of care away from an institutional setting and towards home and community-based care will be set back.

RECOMMENDATION: Congress should ensure that CMS properly implements the Medicaid home care expansion in PPACA and encourage states to embrace broader coverage of home and community-based services under Medicaid.

Congress should establish firm deadlines for Olmstead/ADA compliance with the penalty of lost federal financial matching payments for failure to meet the deadlines. Further, Congress should authorize an increase in the federal matching payment for expanded Olmstead/ADA-compliant home and community-based services, and 100 percent federal reimbursement for state Medicaid compliance costs in transitioning to improve home care alternatives. The rebalancing of long term care expenditures in favor of home care should be accomplished consistent with principles that: 1) establish Medicaid home care as a mandatory benefit in state Medicaid programs; 2) authorize care based on need; 3) assure quality of care through enforcement of comprehensive delivery standards; 4) provide the Medicaid client with a choice of care delivery models; and 5) ensure adequate reimbursement levels.

Congress should monitor carefully any shift of Medicaid beneficiaries into long term managed care and ensure that the patients' rights to home care under the ADA and the Olmstead decision are fully secured.

RATIONALE: After several years, it is necessary for the Congress to intervene and secure the systemic reforms guaranteed by the ADA. However, states need financial support in these efforts since the transition will have start-up costs. The rebalancing must be accomplished with federal minimum standards of care and access whether the state maintains a traditional fee-for-service care model or a managed care approach.

SUPPORT AN INCREASE IN THE FEDERAL MEDICAID MATCH (FMAP) AND OPPOSE CAPS ON FEDERAL PAYMENTS

ISSUE: The National Governors Association reports that the states are suffering severe shortfalls in their budgets and have begun, or are planning, to cutback their Medicaid programs. This will likely result in cuts in home and community based care and impede efforts to implement the Olmstead decision, which requires states to offer home care as an alternative to institutionalization.

As part of his FY 2004 budget, President Bush proposed sweeping financing and programmatic changes for Medicaid. Under the proposal, states would have two options: they could continue to run Medicaid under existing rules and receive the normal federal Medicaid matching payments, or they could opt to turn their Medicaid program into a block grant with broad flexibility to change program rules. The capped federal payments would be front-loaded over the 10-year life of the block grant to provide states some additional funds in the first few years, but these funds would be offset through reductions in federal payments to states in the later years. The National Governors Association did not endorse the proposal.

In 2003 Congress rejected President Bush's approach and instead provided a \$10 billion increase in Medicaid payments to the states for the period April 1, 2003 – June 30, 2004. Each state received a 2.95 percentage point increase in its federal Medicaid matching rate for this period. An additional \$10 billion was allocated to state governments for health care and other social services.

Instead of proposing a cap on federal Medicaid spending, in 2006 the President proposed to cut Medicaid spending by \$25 billion over five years through certain "reforms," including restricting the ability of states to enhance federal matching payments and tightening restrictions on individuals transferring away assets to qualify for Medicaid.

In 2008 Medicaid advocates and governors campaigned for a temporary increase in the Federal Medicaid matching rate as part of a stimulus package to revive the economy. Congress took up a stimulus package early in 2009 that included a substantial increase in the Federal contribution to Medicaid over two years. Congress has extended the enhanced FMAP several times. However, with the expiration of the enhancement in 2011, Medicaid programs across the country are in financial jeopardy. The resulting actions include elimination or restrictions of home care programs, restricted eligibility criteria for home care programs, payment rate reductions, and a shift of fee-for-service program models to managed care where experiences indicate that home care will be difficult to secure for Medicaid patients. Congress should support further federal matching payment assistance to the states as the country's economic difficulties have taken a great toll on state Medicaid budgets.

During deficit reduction discussions in 2011 and 2012, proposals surfaced to establish per beneficiary caps on Medicaid spending or, alternatively, to block grant all Medicaid spending to control the federal share of Medicaid costs.

RECOMMENDATION: Congress should reject any consideration of placing caps on Medicaid spending and increase the federal match for state Medicaid programs, thereby bolstering efforts to bring states into compliance with the Olmstead decision. Proposals for

per beneficiary caps or full program federal spending caps such as block grants should be rejected by Congress.

RATIONALE: Many states have begun efforts to expand home and community-based alternatives to institutionalization in their Medicaid programs. The federal government, through such programs as the New Freedom Initiative, has sought to facilitate this development. Medicaid is one of the biggest items in state budgets, so it will certainly be a focus of state efforts to save money. States are required to balance their budgets, so federal assistance is essential to preserve and expand home and community-based care within the Medicaid program.

ENSURE APPROPRIATE MEDICAID RATES FOR HOME CARE AND HOSPICE

ISSUE: Medicaid has taken on an increasing role in providing coverage of home care and hospice services to children, the disabled, and the elderly. In addition, the Patient Protection and Affordable Care Act of 2010 (PPACA) expands Medicaid funding for home care services by nearly \$13 billion through 2019. Data already indicates that Medicaid expenditures for home care and hospice services now exceed Medicare expenditures. A significant part of the reason behind the Medicaid growth is the flexibility allowed states in the structuring of Medicaid coverage and the recognition that home care is a viable, cost-effective alternative to institutional care. However, as Medicaid expenditures for home care and hospice have increased along with general strains on state Medicaid budgets, reimbursement rates have failed to keep pace with increasing costs of care and, in some cases, they have been subject to reduction for purely budgetary savings purposes.

Federal Medicaid law establishes a broad and somewhat ambiguous standard for rate setting that merely requires the states to set rates at a level sufficient to enlist enough providers so that care and services are available at least to the extent that such care and services are available to the general population in the geographic area. The “sufficient access” standard for rate setting operates in a manner that requires a demonstration that individuals in need of care cannot find it solely because of inadequate rates. This method fails to prevent the loss of services and only reacts when inaccessibility to services reaches a high enough level to gain political attention. In 2011, the Centers for Medicare and Medicaid Services proposed a new federal regulation that would establish rate setting standards. The proposed standards are not perfect, but go a long way to setting out a sensible framework that state must follow in rate setting. However, the proposed standards did not progress to a Final Rule. With the passage of more than 3 years, the proposed standards are now considered abandoned under the Administrative Procedures Act.

With the initiation of the Medicaid Access and Payment Advisory Council (MACPAC) it was expected that Congress will be better advised on the shortcomings of existing Medicaid payment rates throughout the states. However, MAPAC has not addressed rate setting concerns in Medicaid generally nor has it addressed rate concerns in Medicaid home care.

Inadequate reimbursement for home care and hospice services has affected all populations served in the home and in all of the various home care programs available under Medicaid. Technology intensive home care services, personal care services, private duty nursing services, and basic home health services are often reimbursed at levels of payment equal to 60 to 75 percent of the cost of the provision of care. Transportation and mileage costs, along with staff travel time, are often not a reimbursable expense even though travel to and between patient’s homes is a necessary piece of providing home care and often hospice. The result is a very fragile Medicaid home care benefit structure that relies on payment subsidization by non-Medicaid sources, thereby jeopardizing continued access to care.

RECOMMENDATION: Congress should enact legislation that requires that states continually assess Medicaid home care and hospice rates of payment and the methodology utilized for establishing rates. The legislation should further require that rates be reasonable and adequate so as to:

- Assure access to care comparable to the non-Medicaid patient population;
- Ensure reimbursement sufficient for providers to conform with quality and safety standards; and
- Guarantee payments sufficiently adequate to incentivize providers of care to operate efficiently while meeting the cost of care provision.

RATIONALE: Virtually all Medicaid home care reimbursement systems pay insufficient attention to the effect of payment rates on patients' access to care or the cost of efficiently delivering services. Inadequate rates also severely impact the ability of the provider to meet quality and safety standards. Requiring states to engage in an annual analysis of the rate setting methodology and the adequacy of payment rates combined with federally mandated goals for a rate setting process will ensure that Medicaid recipients receive high quality care.

REQUIRE MEDICAID MANAGED CARE ORGANIZATIONS TO RECEIVE STATE APPROVAL BEFORE LOWERING PAYMENT RATES FOR HOME CARE SERVICES

ISSUE: Medicaid managed care has been growing in popularity over the last decade. More than half of Medicaid beneficiaries are enrolled in a managed care organization. Traditionally, home care services have been carved out of managed care and instead services are managed through a fee-for-service approach with providers of care. In recent years, however, states have begun moving home care services into managed care. This move into managed care has presented challenges for providers as managed care plans have unilaterally cut payment rates, negatively impacting a provider's ability to stay in business and continue to provide much needed care.

RECOMMENDATION: CMS should require states to require a payment rate review process and state approval before Medicaid managed care organizations are permitted to cut rates paid to providers. As part of the process, managed care organizations would submit the proposed payment rate to the state, along with a rationale for the cut. The state would then allow at least 30 days for public comment before allowing any new rate to be implemented.

RATIONALE: Medicaid managed care organizations' unfettered ability to reduce payment rates is creating an unstable home care industry. Providers are finding themselves unable to operate with rates that are often less than the cost of care. Fair and reasonable payment rates are needed to maintain a viable home care delivery infrastructure to meet the needs of a growing home care-dependent population. To achieve that end, payment rate reductions by Medicaid managed care entities should be monitored and approved prior to implementation.

REJECT MEDICAID WAIVERS THAT REDUCE BENEFITS FOR CURRENT BENEFICIARIES

ISSUE: The CMS waiver policy known as the Health Insurance Flexibility and Accountability Initiative (HIFA), first instituted in the Bush Administration, was touted as a way for states to expand Medicaid and State Children's Health Insurance Program (SCHIP) coverage. However, it included no new funds and gave states new tools to pay for those expansions by curbing Medicaid spending for current low-income beneficiaries, including children and their parents, disabled people, and seniors.

The policy gives states expanded power to charge current and future low-income beneficiaries fees for health care services they cannot afford and to cut many (now mandatory) critical health services for some groups of beneficiaries and not for others. It also allows states to cap the number of people who can enroll.

Nothing in the policy ensures that all dollars raised from fees or saved from cutting services will be reinvested in Medicaid or SCHIP expansions. Alternatively, it is possible that a small expansion could be used to justify significant increases in fees charged to low-income beneficiaries and significant cuts in covered health benefits.

While those in mandatory groups would continue to be entitled to mandatory services and limited cost-sharing, states would have new discretion -- and incentive -- to cut benefits and increase cost-sharing, both for optional groups and for people eligible under any new expansions. Under this scheme, low-income seniors on Medicaid are particularly at risk because the majority of them -- 56 percent -- are optional beneficiaries. Forty-four states set Medicaid eligibility for optional beneficiaries at or below the federal poverty level.

RECOMMENDATION: Congress should closely monitor use of the HIFA option. At a minimum, state officials should be required to provide full disclosure of waiver proposals and ample opportunity for all advocates and stakeholders to have real input in the design of waivers. Unfortunately, rather than promoting public participation, the HIFA waiver policy includes an expedited federal review process that is likely to diminish public participation.

RATIONALE: Under the HIFA initiative, states that want to expand their programs are encouraged to cut services for currently eligible people. The HIFA waiver puts these states in a catch-22: To help new people, the state must hurt current enrollees.

Under the HIFA waivers, states could charge premiums, deductibles, copayments, and coinsurance to optional Medicaid seniors with no limits on the out-of-pocket costs. For low-income seniors, who generally use more health care services, the burden of meeting repeated out-of-pocket copayments and coinsurance may prevent them from receiving needed care.

States that request waivers could eliminate skilled nursing care provided in the home for optional beneficiaries. For both mandatory and optional beneficiaries, the states could eliminate home and community-based care (other than skilled nursing services), prosthetic devices and medical equipment, rehabilitative and physical therapy services, hospice, and personal care services.

By allowing states to cap enrollment, the HIFA waiver policy converts Medicaid from an entitlement program, in which all eligible applicants can enroll and receive services, to a block grant that stops enrollment when a finite expenditure is reached.

EXEMPT HOME CARE AND HOSPICE FROM COST-SHARING BY MEDICAID BENEFICIARIES

ISSUE: Expenditures for Medicaid, the \$330 billion federal-state safety net program that provides health care services to 58 million Americans, have grown from about 11 percent of the average state budget in 1988 to 22 percent in 2006 (National Governors Association, 2006). According to state governments, in testimony before Congress and the Medicaid Commission on Medicaid Reform, this growth is unsustainable from both the state and the federal standpoint. To address this spending growth many states are looking for ways to increase revenues and cut program costs. Potential budget reductions in some states may lead to decrease Medicaid spending resulting in limiting benefits and imposing premiums and cost sharing for beneficiaries. This raises concerns that states may look increasingly more to the imposition of cost sharing for home care services to help fund the program. At the same time, many states are shifting Medicaid program to managed care systems. This shift creates further risks that the managed care plans will restructure Medicaid benefits to include some forms of cost sharing for enrollees.

On November 25, 2008, a new federal rule was promulgated that allows states to charge premiums and higher co-payments to Medicaid participants. On January 9, 2013, CMS issued another proposed rule that would authorize states to impose higher co-payments. However, the proposal also allows states to exempt home care from any beneficiary cost sharing on the rationale that cost sharing is prohibited under the Medicaid nursing facility benefits.

RECOMMENDATION: Congress and state legislatures should support an exemption of home care and hospice services from any Medicaid beneficiary cost sharing.

RATIONALE: Most states do not cover all individuals under the poverty line. In fact, in 1998, less than 25 percent of non-elderly, low-income Americans with incomes below 200 percent of poverty were covered by Medicaid (Kaiser Family Foundation, The Medicaid Program at a Glance, 01/01). The 1996 welfare reform bill, the Personal Responsibility & Work Opportunity Reconciliation Act of 1996 (P.L. 104-193), made Medicaid eligibility even more problematic by eliminating automatic Medicaid coverage for individuals and families eligible for welfare.

If, in an effort to keep Medicaid payments in check, the states impose even a nominal cost-sharing requirement on Medicaid home health services, many low-income individuals would be forced to go without needed care. As a result, beneficiaries may incur unnecessary hospitalizations as they forgo needed home care because they cannot afford the copays. In addition, far from saving program costs, requiring home care agencies to collect copayments can also result in increased administrative costs that exceed the amounts collected.

Finally, federal Medicaid regulations on cost sharing prohibit providers from denying access to services based on a beneficiary's inability to pay the cost sharing amounts. With already inadequate payment rates, providers would be forced to assume significant bad debt.

ESTABLISH MINIMUM FEDERAL STANDARDS FOR HOME HEALTH COVERAGE UNDER MEDICAID

ISSUE: Medicaid is a joint federal and state program of health care for low-income individuals. The federal government shares the cost of the program with the states and establishes certain requirements for the operation of the program. However, each state administers its Medicaid program and establishes eligibility, coverage, and payment levels within broad federal guidelines.

Currently, Medicaid home health benefits are generally more limited in coverage and reimbursement than the Medicare home health benefit. Federal regulations allow states to limit home health benefits to intermittent nursing care, home care aide services, and medical supplies and equipment. In some states, such as California, provision of medical supplies often goes unreimbursed. Physical therapy, occupational therapy and speech pathology services are optional and are frequently not available to Medicaid recipients in the home. In addition, there are no federal standards regarding the minimum frequency and duration of any of these services.

RECOMMENDATION: Congress should expand the mandatory Medicaid home health benefit to include speech, occupational and physical therapy, and medical social work, as well as hospice care. Congress should also set minimum standards regarding the frequency and duration of care. Block grants and other proposals which would grant states full authority to determine the scope, amount, and duration of home care benefits should be rejected.

RATIONALE: The varying levels of home care coverage available under Medicaid create inequities in access to home care services for low income individuals. Institutional care should be the last resort, not one inadvertently encouraged by limitations on Medicaid coverage of home health services. State demonstration programs have shown that reasonable expansions of the Medicaid home health program can be cost-effective, while maintaining patients in their homes and keeping families intact.

REQUIRE COVERAGE OF HOME CARE, HOSPICE AND PERSONAL CARE SERVICES IN ANY MEDICAID REFORM

ISSUE: Title XIX of the Social Security Act (Medicaid) requires that, in order to receive federal matching funds, certain basic services must be offered in any state's program. These are:

- Inpatient and outpatient hospital services;
- Prenatal care;
- Physician services;
- Skilled nursing facility services for individuals age 21 and older;
- Home health care for persons eligible for nursing facility care;
- Family planning services and supplies;
- Rural health clinic services;
- Laboratory and x-ray services;
- Pediatric and family nurse practitioners services;
- Certain ambulatory and health center services;
- Nurse midwife services; and
- Early and periodic screening, diagnosis, and treatment (EPSDT) services for children.

Home health services covered by Medicaid include three mandatory services: part-time nursing, home health aide, and medical supplies and equipment; and one optional service category: physical therapy, occupational therapy, or speech pathology and audiology services.

States may also receive federal funding for 32 optional services, including personal care services and hospice care.

RECOMMENDATION: Congress should require mandatory coverage of comprehensive home care, hospice, and personal care services and home care medical supplies to all populations receiving Medicaid coverage. These services should include all therapies and medical social work services. All home and community-based care services should be mandatory benefits, including those offered under current optional programs and through waiver authority.

RATIONALE: Home care and hospice services are basic to any individual's well-being and are critical to the health of this nation's poor. Home health is already greatly underutilized even as part of the basic Medicaid benefit package. This problem is only exacerbated as more managed care entities provide Medicaid services. Historically, managed care plans provide less home care services than traditional Medicaid.

Home care and hospice services are cost-effective and should be available to all those in need. The Medicaid program could realize substantial cost savings by caring for people in their homes.

In addition, the US Supreme Court held in *L.C. v. Olmstead* that the Americans with Disabilities Act (ADA) requires state Medicaid programs to meet health care needs in the least restrictive environment. However, so long as home care services are optional benefits the promise of the ADA will not be realized.

EXTEND SPOUSAL IMPOVERISHMENT PROTECTIONS TO HOME CARE

ISSUE: Before 1989, when an elderly woman was forced to place her husband in a Medicaid nursing home, she was forced to live in poverty herself. The Medicaid program required that, in order for the husband to qualify for Medicaid nursing home care, nearly all of the couple's assets and income had to be spent-down, leaving the spouse at home with, in many states, less than \$400 per month to pay for housing, food, and other expenses. In 1989, Congress created the Medicaid "spousal impoverishment" protections to end this unfair treatment. In 2016, under these provisions, the spouse at home will be able to retain assets, in addition to the home, of up to \$ 119,220 and income of up to \$2,980.50 a month.

Unfortunately, the spousal impoverishment protections were only required in the case of nursing home care. States with home- and community-based waivers could elect to extend these protections to couples that are able to care for their loved ones at home, but most states had not chosen this option. In these cases, the wife who enrolls her infirm husband in the Medicaid home care waiver program to enable him to continue to live at home was still faced with having to impoverish herself. As a result, the institutional bias of the Medicaid program was stronger than ever.

The Patient Protection and Affordable Care Act (H.R. 3590; Public Law No. 111-148), extends these spousal impoverishment protections to all home and community based Medicaid services beginning January 1, 2014 and ending December 31, 2019.

RECOMMENDATION: Congress should ensure that CMS implements the PPACA spousal impoverishment provision properly and enact legislation to make the protections permanent.

RATIONALE: A spouse should not be penalized when his or her loved one becomes infirm and needs long-term care at home. Current law makes a husband or wife choose between having enough money to live on by putting his or her spouse in a nursing home, and keeping the loved one home and living in poverty. Passage of legislation to extend the spousal impoverishment protections would enable couples to remain together at home.

ESTABLISH REASONABLE STANDARDS FOR CONSOLIDATION OF MEDICARE FEE-FOR-SERVICE PAYMENTS WITH MEDICAID FOR DUAL-ELIGIBLE BENEFICIAIRES

ISSUE: Nearly 30 percent of home health services patients receiving Medicare coverage are also eligible for state Medicaid benefits. In most instances, these patients do not receive Medicaid home care concurrent with Medicare coverage. However, on occasion dual-eligible beneficiaries receive both Medicare and Medicaid covered home care at the same time as these programs cover different services under different conditions.

The Centers for Medicare and Medicaid Services (CMS) has approved “demonstration programs” that combined Medicare and Medicaid benefits and financial support for dual-eligible beneficiaries. These consolidated shift control over both programs to state Medicaid programs. This consolidation will shift control of Medicare fee-for-service from the beneficiaries to Medicaid. Under Medicare, beneficiaries control the decisions as to what care best meets their needs and which provider they wish to supply that care. Under Medicaid, states are permitted to restrict patient choices involuntarily. Further, the availability of providers under Medicaid is often limited because of low reimbursement rates that can be lower than a provider’s cost of care.

The various demonstration programs that have emerged are not true “demonstrations” in that all state Medicaid beneficiaries with the project design are assigned to program. As such, there is no control group for comparison purposes to determine the actual impact on care access, quality, spending, and all the other concerns in a health care program. Further, beneficiaries are passively enrolled in a combined managed care plan requiring and affirmative action by the beneficiary to dis-enroll with regard to Medicare benefits. These plans have also restricted rights of access to qualified providers by limiting benefits to approved in-network providers. Finally, the demonstration programs are approved in the absence of sufficiently detailed structure regarding benefit administration, quality of care, adequate access to care, and provider participation.

RECOMMENDATION: Congress should order the suspension of CMS approval of dual-eligible demonstration programs until adequate safeguards can be devised with regard to standards for benefit administration, quality of care, adequacy of access to care, and provider participation. The standards should prohibit passive or mandatory enrollment of beneficiaries into such programs.

RATIONALE: Medicare is the primary payer over Medicaid. Medicare beneficiaries have greater freedoms to choose care and providers under Medicare than under Medicaid. These beneficiary rights should not be lost or subordinated through consolidation of Medicare and Medicaid programs for dual-eligibles. Medicaid beneficiaries also should have rights to choose their provider of care rather than to be mandatorily enrolled in a managed care plan. At a minimum, Medicaid beneficiaries should have a full and transparent understanding of their home care benefits.

D. PROTECTING CONSUMERS/QUALITY OF CARE

OPPOSE PUBLIC AUTHORITIES OR OTHER MEASURES THAT RESTRICT CONSUMER CHOICE OF PROVIDER IN THE PROVISION OF LONG TERM CARE SERVICES

ISSUE: California and other states have implemented a state-sponsored public authority system that requires that home care aides providing services under the Medicaid program be employed by the public authority. This arrangement was sought by employee unions to facilitate the organization of home care aides. Consumers in these states are required to obtain home care aide services from the public authority.

Similarly, legislation was introduced in New Jersey to establish such a system for that state, but was rejected. Washington State has established a public authority that permits home care agencies to compete with the public authority, but discourages agency participation in the provision of Medicaid home care services by paying more for services provided by the public authority. There is a growing effort by unions to expand the public authority model of delivering home care aide services and to mandate its adoption in any new federal long term care program.

The public authority model of care delivery often is promoted as a means to give consumers greater control in caregiver selection and supervision. However, this model does not fit for all the disabled or elderly in need of home care as it is a model that can deter individuals from seeking care, limit options for continuity of care, and weaken quality of care standards. By providing consumers with a public authority model, choice is limited to the public authority as the provider.

The public authority model raises additional concerns related to accountability and quality of services. Some of these programs operate without appropriate standards for client eligibility, service verification, and the employee's entitlement to wages earned. They fail to provide workers with basic protections related to workers compensation, collective bargaining choices, and other rights afforded most other workers. Finally, the programs operate without quality of service standards that are comparable to an agency model of care delivery.

The Patient Protection and Affordable Care Act (PPACA), P.L. 111-148, contains numerous improvements in federal Medicaid support for home and community-based care. Fortunately, Congress resisted calls for the expanded use of a public authority model in the expansion of Medicaid home care and the states have the full authority to devise any suitable delivery model that secures accessible, high quality home care.

RECOMMENDATION: The Congress should continue to reject legislation under which the federal government or the states are encouraged or required to restrict or discourage home care aides from working for home care agencies or consumers from obtaining home care aide services through agencies. In any new long term care program, the federal government should ensure that consumers have the right to choose to receive home care aide services according to the delivery model that they are most comfortable with. In addition, home care aides should have the opportunity to choose their employer instead of being relegated to a "one-employer" model that can restrict their employment rights.

RATIONALE: Workers are not well served by mandating participation in a public authority, which is at heart a monopoly composed of a union combined with an employer with the authority of government. There is no compelling evidence that imposing a public authority is the best way to achieve increased wages and benefits for employees; there are other means for attaining this goal.

Under the public authority system home care aides are stripped of their right to choose their employer and the protection of working under professional supervision. Home care agencies are better equipped than public authorities to provide worker training and oversight of the home care aide. Many agencies also provide career ladders. Home care agencies assume liability for services and can be held accountable, unlike large government-sponsored monopolies.

The quality of care and service accountability concerns have been exposed in the California model where patients have lost care, workers have received wages for care undelivered, and payments are made on behalf of ineligible clients.

The public authority model either eliminates or makes it difficult for patients to choose to receive home care aide services from an agency, limiting free enterprise and in some cases causing agencies to close their doors. It stifles private sector competition that can lead to improvements in quality and price. A California District Attorney recently said their program is so “riddled with fraud it’s approaching state-subsidized elder and dependent-adult abuse.” A California State analysis for 2003-04 said the council system is so out of control that the state proposed pulling state funding out of the public authority home care system.

Given the myriad problems that have arisen where the public authority model has been tried, it would be particularly inappropriate for the federal government to impose this model on any federal long term care program. A federal mandate imposing this model on state programs such as Medicaid would run counter to ongoing efforts by the federal government to give the states greater flexibility in how they run their programs.

REQUIRE NON-DISCRIMINATION IN MEDICAID HOME CARE ELIGIBILITY

ISSUE: As states have expanded and modified home and community based care through waivers, rebalancing, and the movement to managed care some patients have experienced eligibility discrimination. As a result of transitions in some states, patients have found the scope of services for which they qualify to change dramatically. This change is often related to the care model used by the patient (agency vs. consumer directed care) or on the location of the services being provided (private home vs. assisted living facility). For example, a patient receiving care at his own direction and in his own home receives eight hours of care per day. That same patient chooses to make a change and receive his care through an agency. While all other factors, as far as the patient's required care level, remain the same, his hours of care are cut to four hours per day under the new model of care. The point of offering various care models and service locations is to increase the patient's home care options by creating greater access to high quality, in-home care. Reducing a patient's eligibility based on cost of care is unsafe and results in poor patient outcomes.

RECOMMENDATION: CMS should require states to utilize a uniform standardized assessment to establish patient eligibility and need for services appropriate to the scope of benefits for Medicaid home care services without influence of the cost for the care model or location of services chosen by the patient. CMS should also require states to provide the level of care necessary for the patient instead of capping hours for a patient choosing an agency model of care.

RATIONALE: The Patient Protection and Affordable Care Act gave great weight to rebalancing efforts, demonstrating a value for patient choice and quality care, often at a lower cost than nursing home care. An unintended consequence of those efforts has been a race to the bottom where states are looking not only for lower cost options but the lowest cost by allowing patients access to fewer services and fewer hours of care depending on the cost of the care chosen by the patient. Patient eligibility is being assessed based on the cost of the care (and therefore the opportunity to save money) instead of the need for care. The point of rebalancing is to allow patients access to quality care in the location of their choosing; however, this intent is being thwarted when states offer reduced hours of care and services to patients choosing to receive their care through a home care agency or in an assisted living facility. The patient's need for care does not change if the patient changes provider or location and the patient's access to care should not change either.

REQUIRE CONTRACTORS OF HOME CARE SERVICES AND/OR CONSUMER-DIRECTED HOME CARE SERVICES TO ENSURE QUALITY AND SUPERVISION OF SUCH SERVICES

ISSUE: Some states, through their Medicaid Waiver programs, contract directly with individuals to provide paraprofessional services such as attendant care, chore services and in-home support services instead of obtaining these services through an established home care provider. The approach of using individuals as home care aides has created problems where there has been insufficient education or supervision of the caregivers. The result can be poor quality of care and a system that leaves the client open to fraudulent billing and abuse by caregivers.

The Internal Revenue Service appropriately views these “individual providers” as employees of the state. Under present law, the states and counties are required to pay FICA, unemployment insurance and workers’ compensation, as well as have the burden of withholding federal income tax on behalf of these individuals.

States have found other ways in which to use such unlicensed independent providers, however, such as providing patients with a list of individuals who are available for work, without any screening of those individuals.

In addition, some states and subcontractors for federal and state programs are currently hiring case managers who, while they are not providing direct patient care, are brokering the provision of home care and supportive services. Some case managers are hiring or contracting with individuals directly to provide services instead of using agencies meeting nationally recognized standards in the home care field, such as those established by Medicare, the National Association for Home Care & Hospice (NAHC), the Community Health Accreditation Program or the Joint Commission on Accreditation of Healthcare Organizations. In many cases, the result has been a lack of education, limited (if any) supervision, and instances of poor care and abuse. The Omnibus Budget Reconciliation Act of 1990, P.L. 101-508, established an optional state program to provide home- and community-based long-term care services for the elderly. The legislation does require that persons providing the care be competent to do so. It is unclear, however, what specific standards must be met by individuals providing care. It is NAHC’s position that all care should be supervised and meet nationally-recognized standards. Finally, there appears to be increasing bipartisan interest in and support for consumer-directed home care services in Congress.

RECOMMENDATION: Congress should require that states or subcontractors of home care services and/or consumer-directed home care services using federal funds ensure appropriate education, testing, and supervision of paid caregivers and provide basic employee benefits, OSHA protections, and other support for these workers.

RATIONALE: Basic standards of care, including training, testing, and supervision must be met to assure minimum levels of safety for care recipients and caregivers. A clear line of accountability for the quality and consistency of care provided is essential. Caregivers should have FICA withheld and paid, worker’s compensation paid, and appropriate state, local and federal taxes withheld and paid. These concerns are particularly important in light of increased

bipartisan interest and support in the U.S. Congress for consumer- directed home care services.

ENHANCE CONSUMER PROTECTIONS FOR HOME CARE RECIPIENTS

ISSUE: The overwhelming majority of home care workers are honest and perform their duties with compassion and integrity. Likewise, the vast majority of home care agencies provide reputable, legitimate, quality care. Cases of consumer abuse in home care are rare. Home care providers are often in a position of identifying abuse committed by others. In fact, Congressional testimony by the Government Accountability Office regarding elder abuse indicates “in-home services were considered the most effective factor for both prevention and treatment of elder abuse.”

However, as in any industry, there are a few unscrupulous individuals who defraud and abuse the system and its patients. It is critical that all services are delivered with care and compassion by ethical providers. Fraud and abuse, in any form, cannot be tolerated.

Reduced reimbursement for home care has resulted in an increase in the number of independent providers, workers who provide care independent of agencies. Rarely are these independent providers subject to any education, competency testing, or professional supervision. This trend is fueled by two factors: the desire among people with disabilities to exercise greater control over their own care and states seeking cost-savings measures. The influx of workers into home care who are subject to no standards or screening has necessarily heightened concerns about consumer safety.

Although federal regulations should never be so cumbersome as to pose a barrier to care, basic standards of care must be established to ensure minimum levels of quality and safety for the consumer, the caregiver and the community. A 1995 report by the National Long Term Care Resource Center states: “Federal and state governments have continuing responsibilities for establishing and enforcing the conditions under which programs can be innovative, responsive to consumer preferences, and encouraged to exceed minimum standards.”

The Patient Protection and Affordable Care Act (PPACA) (H.R. 3590; Public Law No. 111-148), provides for a nationwide expansion of background check pilot projects for long term care workers employed by nursing homes and home care agencies providing services under Medicare and Medicaid. It does not require that the pilot projects include background checks for independent providers. In addition, while PPACA expands federal support for Medicaid home care services, the legislation fails to establish any competency, training, or supervision standards for care provided by individual care providers. The Long Term Care Commission, in its September 18, 2013 report to Congress, included consumer protection provisions, including criminal background checks.

RECOMMENDATION:

- Federal requirements for worker screening should be strengthened to include federally-funded criminal background checks for all home visiting staff. An organized system for criminal background checks should be developed which is reasonable in cost and will provide up-to-date information in a timely manner. Such a system should be voluntary until an efficient and accessible background check is in place and agencies are adequately reimbursed for the cost of background checks.
- A national registry listing home care workers who have been deemed qualified to

provide home care services or those who have been found in violation of the law or safety standards should be established.

- Quality assurance standards should be required in all federal and state funded long-term care programs. Such standards should include minimum standards of training, testing, supervision, and practice in the delivery of in-home services. Quality and safety standards should apply regardless of consumer, provider or payer.
- Education programs should be approved by the state or by state or federally- approved accrediting organizations.
- Congress should require states to establish mechanisms for resolving problems that arise between consumers and independent providers.
- Congress should increase funding for adult protection programs and mandate that state elder abuse reporting laws include immunity from prosecution for persons reporting incidence of abuse.
- Congress should establish a commission to investigate elder abuse and make recommendations for increasing penalties.

RATIONALE: The care environment must be safe for both patients and caregivers and free of abuse, fear of abuse, neglect, exploitation and inappropriate care. Quality assurance standards are vital for home care. Consistent national standards for home care aide training, competency testing, and supervision are critical components of quality care. Paraprofessionals who work in nursing homes and in home care should be required to meet the same level of training and testing. The job responsibilities, not the care setting, should determine the requirements a caregiver must meet. All patients deserve the same high standard of care.

ELIMINATE ELDER ABUSE

ISSUE: The 2004 Survey of State Adult Protective Services (APS), the most rigorous national study of state-level APS data conducted to date, offers important new insights into the troubling elder abuse problem. The findings show a 19.7 percent increase in the combined total of reports of elder and vulnerable adult abuse and neglect and a 15.6 percent increase in substantiated cases in the four years since the last survey was conducted in 2000. The study, which analyzed the latest data from the states, found that overall, in 2003, APS agencies received 565,747 reports of suspected elder and vulnerable adult abuse, as compared to 482,913 reports four years previously.

According to research funded by the National Institute of Justice, almost 11 percent of people age 60 and older, or 5.7 million individuals, suffered from some form of abuse in 2009 alone.

As the population continues to age, it becomes increasingly important to protect older persons from physical and emotional abuse, neglect, intimidation, and financial exploitation by their families and institutions. Although statistics indicate that most elder abuse is actually carried out by family members, there are still too many reports of abuse carried out by unrelated caregivers.

Stimulated by Congressional attention, many states passed elder abuse protection statutes between 1978 and 1985. Congress, in 1988, passed legislation to assist the states in this effort. In fiscal year 1991, the Congress, for the first time, provided for separate, distinct funding for elder abuse and nursing home ombudsman activities under the Older Americans Act. This separate funding has been continued in subsequent years. Section 705 of the Older Americans Act Amendments of 2000 (P.L. 106-5d) authorized a “Prevention of Elder Abuse, Neglect, and Exploitation” study of financial exploitation of older individuals.

The Patient Protection and Affordable Care Act (PPACA) (H.R. 3590; Pub.Law111-148) incorporated the provisions of the Elder Justice Act, a bill authorizing a coordinated national effort to confront the issue of elder abuse. This includes the collection of accurate and uniform data and education and training in the identification and reporting of abuse. Under this program the federal government takes the lead in assisting the states in this effort. It authorizes increased funding for adult protection programs, requires reporting of elder abuse, and protects from prosecution persons reporting incidences of abuse. PPACA authorizes \$777 million over 4 years for these programs.

RECOMMENDATION: Congress should fully fund the Elder Abuse Act provisions by appropriating the authorized amounts.

RATIONALE: Elder abuse is a hidden problem. Out of fear or dependence, many victims never report the abuse. It is clear that adequate state and federal resources must be allocated to address this national disgrace.

ENCOURAGE STATES TO ADOPT HOME CARE QUALITY OF CARE STANDARDS THROUGH VOLUNTARY ACCREDITATION OR LICENSURE LAWS

ISSUE: As of 2011, 42 states and the District of Columbia required Medicare-certified agencies to obtain licensure; 39 states and the District of Columbia required non-Medicare-certified agencies to obtain licensure. For personal care services, 26 states and the District of Columbia required licensure. For hospice, 45 states and the District of Columbia required Medicare-certified hospices to obtain licensure; 37 states and the District of Columbia required non-Medicare-certified hospices to obtain licensure. There is no uniformity among these laws (and their implementing regulations) and no model licensure law and regulations to look to for guidance. Thus, in the states without a licensure law and in many states with a licensure law, there is inadequate state regulation to ensure that home care agencies are fiscally stable and staffed and organized so as to ensure quality care. Certificate of Need (CON) laws generally do not provide a regulatory solution to assure quality and fiscal stability in lieu of licensure.

In addition, only a few states have laws requiring certification of all persons providing home care aide or other personal care services. The lack of state minimum mandatory training and supervision requirements presents significant problems in assuring quality of care for consumers.

There are several models of voluntary accreditation that address one or more sectors of home care services. The primary focus of these standards is skilled care home health agencies. However, some standards also are applicable to personal care services providers.

RECOMMENDATION: Congress should mandate development of a uniform model accreditation or licensure standards for home care agencies and encourage states to adopt and implement the model laws. A NAHC task force previously developed a proposed model licensure law to assist states in adopting a licensure law or strengthening their current law that Congress could use as a starting point. These model laws should encompass all types of home care providers including skilled, intermittent care, personal care, infusion therapy, private duty nursing, staff registries and hospices. However, private, voluntary accreditation can be a viable alternative to licensure laws.

RATIONALE: Such model standards are needed to ensure appropriate consumer protection and to ensure that quality home care is being delivered by home care agencies and individual home care providers. States would be encouraged, but not required to adopt these model laws.

REQUIRE COMMUNITY PARAMEDICS THAT PROVIDE NON-EMERGENCY SERVICES IN THE HOME TO MEET REGULATORY AND LICENSING HOME CARE STANDARDS

ISSUE: The need to maintain a well-qualified and reliable home care workforce is a well known fact. However, in some states, instead of focusing on the development and maintenance of the home care workforce, states are allowing home care services to be provided by individuals who are not working within a regulated home care agency. More specifically, some states are allowing community paramedics to provide home care on a variety of skill levels—services such as wound care, preventive checks, medication administration, and in some cases even hospice, are being provided by paramedics. The reasoning for relying on paramedics has quite simply been that they are available to do the work. Initially communities were relying on grants and the salaries already paid to paramedics to fund the care being provided; however, now paramedics are looking to Medicaid to compensate for the services provided by the paramedics. This model is flawed for many reasons, including creating a further strain on already stretched Medicaid dollars.

RECOMMENDATION: Require community paramedics and similar parties to comply with the same regulations and licensing standards that home care agencies operate under in order to provide services and to receive payment for services from Medicaid or other governmental programs. In addition, community paramedics should only provide services that are not a duplication of what home care providers already provide in the community.

RATIONALE: Agencies providing home care employ individuals who are specifically trained to provide home care services. The agencies also provide supervision, oversight, liability coverage for the workers and work with the patient's care team to create the most appropriate plan of care for the individual patient. Agencies provide a direct care worker, or workers if necessary, to the patient whereas a paramedic's first priority is to the emergency situations he or she is employed to attend to. Community paramedics cannot offer any continuity of care provider to a patient which could potentially leave the patient with a different provider for each care occurrence, they cannot be certain to arrive at a patient's home at the same time every day and stay for the allotted time. A paramedic can be called away to an emergency situation, which could leave a vulnerable patient without the care that he or she needs. Additionally, home care agencies spend considerable sums to comply with regulations. By using community paramedics, home care agencies are forced to compete with unregulated home care providers which create a financial strain for agencies. When paramedics are inevitably called away to provide emergent care, agencies will likely be called in to help the home care patient, which would create further resource strain for the agencies.

A well-trained and reliable work force is critical to successful patient care. A home care worker consistently providing care and building a relationship with a patient is an essential piece of successful home care. Community paramedics will not always be available to spend the time developing those relationships or have the availability to consistently provide high quality care. Paramedics are employed to provide medical care in emergency situations and it is unreasonable to put patients in danger of waiting for emergency care or

waiting to receive home care. It is even more unreasonable to bill Medicaid for services provided when the services are being provided outside of home care requirements mandated by Medicaid.

REQUIRE MEDICAID MANAGED CARE ORGANIZATIONS TO CONTRACT WITH ANY WILLING AND QUALIFIED PROVIDER

ISSUE: Between the Centers for Medicare and Medicaid Services (CMS) Financial Alignment Initiatives for Dual Eligible Beneficiaries (better known as the Duals Demonstrations) and the movement, in many states, away from fee for service Medicaid and into Medicaid managed care organizations, home care providers are experiencing a seismic shift in the industry. The move to Medicaid managed care has been happening in many states over the last two decades but, traditionally, long term services and supports were carved out of managed care and remained in the fee for service system. Remaining in fee for service allowed providers to have some level of stability and predictability in conducting business. However, as states strive for budgetary certainty, more states are moving all Medicaid services into managed care, including long term services and supports. In those states participating in the Duals Demonstrations, it is almost certain that all services provided through Medicare and Medicaid will be moved into managed care for the affected populations.

The issue that arises from this shift is that, unlike under fee for service Medicaid, providers will now need to be included in a managed care organization's provider network in order to be compensated for providing services. Managed care networks generally have limited the number of provider participants, creating significant issues for providers and for patients.

RECOMMENDATION: Require managed care organizations to contract with any willing provider when building the provider network.

RATIONALE: Many home care patients have been receiving their care through the same agency, and often the same agency employee, for many years. The move to managed care, through a duals demonstration or through a state choosing to carve long term services and supports into managed care, can be very confusing for a patient. Moving to a new benefits system and having to change providers is simply daunting for most home care patients.

It is also important to include any willing provider in the network in order to prevent any access to care issues for patients. If a managed care organization contracts with only a few home care providers then not only will confused patients need to find new providers, there is also a high risk that the in-network providers will not have the capacity to care for all of the patients in need. Allowing any willing provider to participate in a managed care organization's provider network means better care continuity, better access and higher quality care for vulnerable patients.

DEVELOP STANDARD QUALITY METRICS AND MINIMUM MANDATORY UNIFORM DATA SETS

ISSUE: Each year, every state spends a significant portion of its annual budget on providing Medicaid benefits to state residents. The state contribution to Medicaid funding is at least doubled by the federal government by way of the Federal Medical Assistance Percentage (FMAP) and, in many states, the federal government pays for more than half of the Medicaid benefit. Of the Medicaid budget, the greatest portion of dollars is spent on long term services and supports. Despite the vast amount of state and federal resources committed to Medicaid, and more specifically, long term services and supports covered by Medicaid, quality measures and data relating to long term services and supports are lacking.

For many years, the cost effectiveness of in-home long term services and supports has been praised as a strong alternative to institution-based care. The value of home-based care was re-emphasized in the 2010 Patient Protection and Affordable Care Act where great weight was given to rebalancing in favor of home based care instead of institutional care. While the value of home care has been long recognized, little has been done to develop standards on quality of care being provided to patients in their home and even less of a focus has been given to developing data sets that would allow for measuring the quality and value of the care provided.

RECOMMENDATION: CMS should work with stakeholders to devise appropriate quality standards for long term services and supports as well as minimum mandatory uniform data sets that would be required of state Medicaid programs to measure the care and cost effectiveness of long term services and supports.

RATIONALE: A majority of available Medicaid dollars are already committed to long term services with little to show by way of quality outcomes or measurable data. As reliance on long term services and supports continues to grow with the aging of the baby boom generation, it is critical to be sure that scarce Medicaid dollars are being spent on high quality care that can be tracked and measured effectively. The population that relies on Medicaid long term services and supports is expected to grow exponentially in the next decade, making high quality care and effective use of available dollars top priorities.

E. CAREGIVER SUPPORT

PROMOTE RESPITE CARE FOR FAMILY CAREGIVERS

ISSUE: The bulk of long-term care is provided by friends and family caregivers. According to the National Family Caregivers Association (NFCA), more than 65 million Americans provide care for a chronically ill, disabled or aged family member or friend. The value of the services family caregivers provide for “free” is estimated to be worth an estimated \$460 billion per year; more than twice that spent on formal home health care and nursing home services combined.

Persons are burdened by many responsibilities and demands associated with providing long-term care services to a disabled relative or friend. Such problems include limitations on one’s personal life, the competing demands of financial obligations and work conflicts, meeting the care recipient’s emotional and physical demands, and emotional, financial and family strains. According to a study by the American Council of Life Insurers, family caregivers who provide care 36 or more hours a week are more likely than non-caregivers to experience symptoms of depression or anxiety; for those caring for a parent the rate is twice as high; for spouses the rate is six times higher. According to the American Council of Life Insurers, a typical working family caregiver lost \$109 per day in wages and health benefits due to the need to provide full time care at home.

NFCA and AARP have concluded that many caregivers incur direct out-of-pocket expenses to help support a family member or friend with a disability. The average caregiver spent an average of \$200 per month (\$2,400 per year) in out-of-pocket costs on household goods, food and meals, medical equipment and supplies, travel and transportation, medical co-pays and pharmaceuticals. Caregivers who had the greatest level of a caregiving burden reported spending \$324 per month (\$3,888 per year) out of pocket. Furthermore, the loss in productivity to employers related to informal caregiving has been estimated to be as high as \$33.6 billion for full-time employed caregivers according to the MetLife Mature Market Institute’s study on the cost of caregiving in 2006.

Late in 2006, President Bush signed into law the Lifespan Respite Care Act (P.L. 109-442). The bill amends the Public Health Service Act and authorizes the Secretary of Health and Human Services (HHS) to award grants or enter into cooperative agreements with state agencies to develop lifespan respite care at the state and local levels. The term “Lifespan” respite care is defined as a coordinated system of accessible, community- based respite care services for family caregivers. Eligible states will be required to fund at least 25 percent of the program costs. The legislation will empower states to provide respite care services for family caregivers, training and recruitment of workers and volunteers, as well as training and education for family caregivers. The bill also creates a National Resource Center that will be tasked with maintaining a national database on lifespan respite care. Congress authorized appropriations of \$94.8 million for FY 2011, rising to 94.8 million by 2011; however; only \$2 million was appropriated for the Lifespan Respite Care Act for FY 2011.

During the 106th Congress, the Older American Act Amendments (OAA) of 2000 (P.L. 106-501), established a National Family Caregiver Support Program for state area agencies on aging to develop respite care programs to enable caregivers to be temporarily relieved of their caregiving responsibilities. However, the National Family Caregiver Support

Program has received annual appropriations of only \$154 million in the last few years.

Several legislative proposals have surfaced recently in the 114th Congress that recognize the value of family caregivers and offer increased support. These include S. 1719 and HR 3099, RAISE Family Caregivers Act; H.R.1969, Military and Veteran Caregiver Services Improvement Act of 2015; H.R.3989 Support Our Military Caregivers Act; and S.879 Americans Giving Care to Elders (AGE) Act of 2015. These are just a few of the legislative proposals in the 114th Congress indicating that caregivers are a priority.

RECOMMENDATION: Congress should enact legislation that expands support for family caregivers, particularly through respite care.

RATIONALE: Family members cannot continue to carry the burden and responsibility for care without getting a chance to have a break and recharge. Respite care is in the best interest of public programs that finance long term care, the patients receiving the care, and the system of family caregiving.

SUPPORT TAX INCENTIVES FOR FAMILY CAREGIVERS

ISSUE: Currently federal and state programs offer limited assistance to informal unpaid caregivers. Federal law allows a caregiver, under specific circumstances, to classify the older person receiving care as a dependent and claim a personal exemption on their taxes. Those circumstances stipulate that the caregiver and recipient must live in the same home, the caregiver must provide 50 percent of the senior's support for the year, and the older person's income must not exceed the personal exemption amount. Few caregivers can claim the exemption because many older persons receive a Social Security benefit or pension income that exceeds the amount. A limited form of caregiver assistance included in the Health Insurance Portability and Accountability Act allows taxpayers who itemize their tax deductions to deduct long-term care (LTC) expenses if combined medical and LTC expenses exceed 7.5 percent of the taxpayer's adjusted gross income.

Several bills have been introduced that would provide various tax incentives for family caregivers who care for sick or disabled family members. One such approach is H.R. 3377 in the 114th Congress (2015-2016) Social Security Caregiver Credit Act of 2015, which recognizes certain levels of unpaid caregiving as a credit to an individual's Social security account. Although these bills have attracted much support, the prospect for enactment of caregiver tax incentives is uncertain because the Congressional Budget Office (CBO) has scored these provisions as costly.

RECOMMENDATION: Congress, through the tax code, should provide incentives for family members who help shoulder the burden of providing care for a mentally-impaired or disabled parent, grandparent, or child. Such incentives will encourage the utilization of cost-effective home care services for those in need. Moreover, the credit will help keep families intact by providing a financial incentive to those who provide care in the home rather than send the parent, grandparent, or child to a more costly institution for care. A family caregiver tax credit, however, should not be viewed as a substitute for a national, comprehensive long-term care program.

RATIONALE: The tax code has often been used as a tool to encourage or discourage certain behaviors. A tax credit for family caregivers will enable families to stay together by encouraging the use of home care services.

F. VETERANS/MILITARY

IMPROVE HOME CARE SERVICES FOR VETERANS

ISSUE: In passing the “Veterans Millennium Health Care and Benefits Act” (P.L. 106-117), Congress made substantial progress in improving the access of veterans to home- and community-based care. This Act created a four-year plan requiring the Department of Veterans Affairs (VA) to provide extended care services to veterans needing it for a service-connected disability and to any veteran who is 70 percent disabled by service-related injuries. There are two sections of this law that have applicability to home health care services. Section 101 amends the definition, in Chapter 17 of title 38, United States Code, of the term “medical services” to include the term “noninstitutional extended care services.” This legislation requires the VA to provide community-based primary care, adult day health care, respite care, palliative and end-of-life care and home health aide visits to enrolled veterans. Respite care was provided for in the patient’s home or in a VA facility. In 2003, Congress enacted Public Law 108-170 (Veterans Health Care Capital Asset and Business Improvement Act of 2003) which extended the home and community-based care provisions of the “Veterans Millennium Health Care and Benefits Act” to 2008.

Section 102 of the “Veterans Millennium Health Care and Benefits Act” directs the VA to carry out three long-term care pilot programs over a three-year period. The goal of these pilot programs is to determine the effectiveness of different models of providing all-inclusive care on reducing the use of hospital and nursing home care. In 2004, Congress enacted Public Law 108-422 (Veterans Health Programs Improvement Act of 2004) which extends through December 31, 2005, the VA’s authority to provide care to veterans participating in certain long-term care demonstrations projects previously authorized in the Veterans Millennium Health Care and Benefits Act. Public Law 108-422 also eliminates copayments for hospice services furnished by the Veterans Administration.

In many ways, the VA has been a leader in innovation in home care with telehealth services being a particular success. In addition, VA programs that integrate physicians with professional home health personnel have helped with improved care coordination.

2015 was a seminal year in VA health care as concerns surfaced regarding access to care and the quality of services in the VA health care program. As a result, Congress authorized increased funding and created the CHOICE program that permits veterans to obtain care from outside suppliers rather than directly through the VA. The VA home care program has been affected by these changes with the home health benefit shifting to the CHOICE program. However, complaints have been made that veterans have been placed on waitlists for over a year to obtain authorized home care, services have been abruptly terminated, and providers and veterans have been subject to miscommunications regarding the shift to managed care vendors under the CHOICE program.

RECOMMENDATION: Congress should require the coverage of home care services by qualified home health agencies for all veterans who would prefer to stay in the home as opposed to a VA hospital or nursing home. Moreover, use of existing home care providers should be encouraged by the government to avoid increasing taxpayer costs by creating new VA provider entities. Further, Congress should ensure that the VA has the resources necessary to implement the long term care demonstrations of P.L. 108-422. Congress should

also monitor the implementation of the CHOICE program to ensure that care access is improved, prohibit unreasonable waits for home care, and institute transparency and efficiency into the CHOICE program operations.

RATIONALE: Congress should continue to improve upon the scope of home health services available to veterans. Alternative levels of care should be available to our nation's veterans. Institutionalization should not be the only method for providing care to chronically ill or rehabilitating veterans. Since Congress saw fit to provide home care services to veterans, this care should include the full range of services and be provided by qualified home health agencies.

EVALUATE THE IMPLEMENTATION OF THE HOME CARE BENEFIT IN THE MILITARY HEALTH SERVICES SYSTEM

ISSUE: In the National Defense Authorization Act for fiscal year 2002, Congress required the establishment of an effective, efficient, and integrated sub-acute care benefits program with home health care benefits modeled after Medicare. Congress also mandated the creation of a new program of extended benefits for disabled family members while continuing the Case Management Program for certain beneficiaries. Finally, the legislation narrowed statutory exclusions of custodial and domiciliary care with new definitions of those terms.

The 2002 legislation marked the first time that Congress had authorized a specific, structured home care benefit in the military health program for retirees and military dependents. The effort now shifts to proper implementation. In June 2002, the Department of Defense (DoD) published an Interim Final Rule regarding the TRICARE home health benefit. The new TRICARE home health services benefit was phased in across the country during 2004. An extended benefit program also has been implemented with the Final Rule published by the DoD on July 28, 2004.

The implementation of these two new benefits has been saddled with administrative difficulties as DoD contractors struggle to understand and manage the intricacies of a Medicare-like home health benefit and a Medicaid-like home and community based service extended benefit. From 2005 to 2008, complaints surfaced regarding the “mysteries” of TRICARE home care, particularly regarding service authorization, claims processing, and payments. Home care providers indicated that significant confusion continued to exist at the DoD contractors. The primary response from home care providers appears to be resignation, leading to a near abandonment of participation in the program.

While the DOD has greatly improved its home care programs in TRICARE, concerns continue to surface regarding inadequate guidance, delayed program updates, and insufficient integration of home care with other TRICARE programs.

RECOMMENDATION: Congress should legislate that DoD conduct a comprehensive study of its implementation of the home health benefit and the extended benefit program to ensure that military families receive the benefits of home care that Congress intended. A congressional hearing should be scheduled with the assistance of TRICARE consumers and home care providers to attempt to develop a plan to eliminate the program’s confusion and complexities.

RATIONALE: DoD contractors have limited experience in administering comprehensive home care benefits. The contractors have experienced difficulties in the implementation of the home health benefit. In the five years since the implementation of the home health benefit, the contractors appear to have gained only a limited understanding of the benefit structure. The new Medicare payment model that was implemented on January 1, 2008, was not adopted on a timely and consistent basis. Oversight is needed to satisfy congressional intent.

G. LONG TERM CARE INSURANCE

ESTABLISH MEANINGFUL STANDARDS FOR LONG-TERM CARE INSURANCE

ISSUE: Very few individuals can afford to pay the full cost of long-term care at home or in a nursing home out of their own pockets, yet neither Medicare nor private insurance cover those services to any great degree.

As public policy makers grapple with a better way to finance the nation's long-term care bill, the private long-term care insurance market has begun to offer an increasing number of Americans a solution. Currently, there are 7-9 million long term care insurance policies in force. Thirty-five percent were sold through employer sponsored plans, including group plans and individual policies sold at the worksite.

While private insurance won't meet most individuals' long-term care needs, it may be appropriate for those who can afford to pay the premiums for many years and who have assets to protect.

At the same time, inadequate state regulation of the private long-term care insurance market has led to development of ineffective policies and abusive sales practices. Additionally, high lapse rates—the rates at which policy holders drop coverage before they need long-term care—have significantly reduced the impact long-term care insurance policies could have on defraying long-term care costs. The “Health Insurance Portability and Accountability Act of 1996” (P.L. 104-191) included tax incentives for the purchase of long-term care insurance. In order to qualify for the special tax treatment, long-term care insurance policies are required by the Act to meet the standards set out in the 1993 National Association of Insurance Commissioners (NAIC) model act. The 1993 NAIC model act was specified in the legislation despite the fact that it is not the most current version, which has stronger consumer protections such as mandatory nonforfeiture of benefits. Favorable tax treatment under the legislation was limited to plans that require that beneficiaries either need assistance with at least two activities of daily living or have cognitive impairment that requires substantial supervision in order to receive home care benefits. This has meant that some plans with the most extensive home care coverage do not qualify for favorable tax treatment.

The Deficit Reduction Act of 2005 allows for the expansion of the Long Term Care Insurance Partnership Program to all states. Under this program, purchasers of Partnership policies who exhaust their policy benefits may qualify for Medicaid while retaining a greater amount of their assets than would have been possible under the usual state Medicaid rules. Partnership policies must comply with most of the consumer protection standards of the October 2000 NAIC model act, along with some additional protections such as requiring plans for those 60 or younger to have automatic inflation protection.

RECOMMENDATION: Congress should amend the “Health Insurance Portability and Accountability Act” and the “Deficit Reduction Act” to require that all long-term care insurance policies meet the most up-to-date federal minimum standards. The federal minimum standards should include the most current NAIC model and should require that all long-term care policies cover a full range of home care and hospice services. Home care and hospice services should be reimbursed at levels at least equal to that of nursing home care.

Favorable tax treatment should be extended to more generous plans which provide home care benefits for those who need assistance with one activity of daily living (ADL) or one instrumental activity of daily living (IADL), or when home care is otherwise deemed medically necessary by a physician. Congress should continue to look for ways to encourage creative use of the private long-term care insurance market to strengthen the Medicaid program.

RATIONALE: Although private long-term care insurance will not be a total solution for financing long-term care, it can help protect some people against large out-of-pocket expenses. It gives some individuals the opportunity to retain choices and develop a flexible, planned response to a potentially ruinous financial event that will confront many people over 65 as well as many disabled people under 65.

However, state attempts to regulate the private long-term care insurance market have had only limited success. In the absence of federal regulation, consumers are left to carefully sort through the myriad policies, riders and features to find an affordable and reliable plan. The choices are complex and the figures easily manipulated. By mandating that federal requirements for all private long-term care insurance reflect the most currently accepted minimum standards, consumers will be assured adequate protections and special federal tax treatment of long-term care insurance policies will be justified. This is the same principle which was applied in a 1990 law with respect to Medigap insurance. Regulation of the market will foster confidence among consumers that private long-term care insurance constitutes a viable option for their protection from large out-of-pocket expenses in the event that they need long-term care services.

H. CHILDREN'S SERVICES

MONITOR STATES' COMPLIANCE WITH IDEA OBLIGATIONS

ISSUE: The Individuals with Disabilities Education Act (IDEA) was reauthorized by the 108th Congress and signed into law on December 3, 2004 (H.R.1350; P.L.108-446). IDEA Part C provides early intervention services for infants and toddlers and Part B allows for skilled care to be given to school children ages 3-21 to assure their access to a free, appropriate public education. This care includes one-on-one nursing, if needed. Under Part B, the provider of the care is considered the school district, which must then bill Medicaid and private pay for reimbursement.

As originally written in 1975, the federal government made a commitment to pay up to 40 percent of the additional cost of educating children with disabilities. Even though the 2004 reauthorization bill was intended to put the federal government on a six year "glide path" to reach the original funding goal of 40 percent, this goal has not been met. IDEA needs full and proper funding to help school districts provide the care.

Two Senate bills were introduced in the 112th Congress, S.103 introduced by Senator David Vitter (R-LA) and S.1403 introduced by Senator Tom Harkin (D-IA), that would amend the Individuals with Disabilities Education Act to reauthorize and make appropriations for the grant program to assist states and outlying areas to provide special education and related services to children with disabilities. Similar legislation was introduced in the 109th, 110th, and 111th Congresses.

RECOMMENDATION: Congress should monitor states' compliance with their IDEA obligations and fully fund the services.

RATIONALE: IDEA can be a valuable alternative payer source for disabled children. It is misunderstood and misapplied by school districts that do not understand their obligations. The lack of interagency agreements creates needless school liability that would otherwise be borne by Medicaid. Schools also need guidance on billing because they often fail to understand that their expenditures might be reimbursable by private insurance.

IMPROVE REIMBURSEMENT REQUIREMENTS FOR PEDIATRIC HOME CARE UNDER MEDICAID

ISSUE: Current federal Medicaid law requires states to set home care agency payment rates at levels that “are sufficient to enlist enough providers so that care and services are available at least to the extent that such care and services are available to the general population in the geographic area.” Access is the test of the adequacy of a state’s home care rates. In addition, home care rates are often not adjusted on a timely basis to keep pace with inflation. As a result, the rates paid to agencies are often below the actual cost of providing care. Pediatric home care can be more expensive than home care for adults, particularly in situations where more sub-specialized staff is needed and there are fewer pediatric patients in the patient census, limiting economies of scale.

The Centers for Medicare and Medicaid Services (CMS) issued a proposed regulation in 2011 that set standards for states to establish provider payment rates. This rulemaking proceeding is ongoing and offers some promise of improving state rate setting processes. The rule was finalized in 2015, creating new standards for determining the adequacy of payment rates along with revised processes for review of state rate setting. However, with severe limitations on judicial review of state rate setting, CMS has become the only viable overseer of state actions that have significant impact on care access.

Inadequate reimbursement for home care services may cause access problems by discouraging providers from participating in the program and forcing some agencies to limit acceptance of Medicaid patients. This creates a second-class health care system for Medicaid patients, who are often forced into institutional settings, and contributes to the Medicaid program’s strong institutional bias.

In 2015, a federal court in Florida held that the states pediatric home care program was severely flawed and non-compliant with multiple federal laws relating to payment rates, eligibility determinations, and care authorizations. The end result of the non-compliance is a compromised access to care for pediatric patients in need of home care.

RECOMMENDATION: Congress should ensure that home care service rates for pediatric services are reasonable and adequate to meet the costs of providing pediatric care efficiently, in conformity with quality and safety standards, and in a way that assures access to care for the pediatric Medicaid population. Congress should reject proposals to allow states to set provider rates without these guarantees. Congress should monitor CMS’s application of the new rules on Medicaid rate setting to ensure that the rate setting protocols are consistent with achieving ongoing access to care. Congress should prohibit the states from using systems that only react to poor payment rates after Medicaid beneficiaries lose access to care.

RATIONALE: No state has yet designed a home care reimbursement system under Medicaid that achieves the standard of access established under federal law. Virtually all Medicaid home care reimbursement systems are driven by state budgetary concerns with little concern for the patients’ access to care or the costs of delivering services. Adequate, national Medicaid reimbursement rates will ensure access to appropriate pediatric home care services.

PROVIDE ACCESS TO HOME CARE SERVICES FOR PEDIATRIC PATIENTS WITH MORE INTENSIVE CARE NEEDS

ISSUE: Technological advances in recent years have vastly expanded the scope of services that can be provided to pediatric patients in their homes. Services such as parenteral and enteral nutrition, chemotherapy and care of ventilator/trache-dependent patients, which used to be provided only on an inpatient basis, can now be provided in the home, thus reducing the need for more costly hospitalization. Under the Medicaid EPSDT benefit, children are entitled to coverage of home health services and private duty nursing services to the fullest extent allowable under federal law. However, this entitlement cannot be realized unless the state Medicaid programs sufficiently implement these programs and provide adequate reimbursement that recognizes the complex nature of the services to pediatric patients.

These services are costly for the home health agency to provide; however, these services often require nursing staff that have had additional education in administration of drugs and procedures, as well as patient monitoring. In addition, such services require prolonged visits in the patients' homes, as well as high standby costs, extensive case management, transition discharge planning and other activities that add further to the cost per visit.

The higher cost of serving certain patients who qualify for Medicaid home health services must be recognized.

RECOMMENDATION: Congress must provide access to the Medicaid home health benefit for pediatric patients with more intensive care needs and assure adequate reimbursement for the cost of these services. Congress should direct the new Medicaid Access and Payment Advisory Council (MACPAC) to evaluate existing state plans for pediatric patients with extensive home care needs relative to provider qualifications, coverage standards, and provider payment rates and report to Congress on its findings and any recommendations for changes to ensure access to comprehensive care.

RATIONALE: Certain pediatric patients are best cared for in the home, where they can remain with their families. Because home care agencies have fewer pediatric patients and because more specialized staff is needed, services for pediatric patients with more intensive care needs are far more costly.

**II. PROMOTE EFFICIENT USE AND ENSURE
ADEQUATE SUPPLY OF QUALIFIED HOME CARE AND
HOSPICE PERSONNEL**

SUPPORT PROPOSALS THAT WILL SUPPLY A STABLE, DIRECT CARE WORKFORCE PROVIDING QUALITY CARE FOR LONG-TERM CARE CONSUMERS

ISSUE: According to the U.S. Department of Labor Bureau of Labor Statistics about 2.1 million individuals work as direct care workers in long-term care. The Bureau of Labor Statistics recently estimated that nursing aides held the most jobs—approximately 1.5 million. The Bureau of Labor Statistics, Home Health Care Services 2008 Employment data revealed that 513,500 aides were employed within the home setting. Of the 513,500, the employment data reported that 285,100 are employed as home health aides, 228,000 as personal and home care aides, and 400 as personal care and service workers. Overall employment of nursing and home health aides is projected to grow faster than the average for all occupations through the year 2016, although individual occupational growth rates will vary. For example, employment of home health aides is expected to grow the fastest, as a result of both growing demand for home health care services by an aging population and efforts to contain health care costs by moving patients out of hospitals and nursing care facilities as quickly as possible (U.S. Dept. of Labor, Occupational Projections and Training Data, 2006-2007).

Many direct care workers earn very low wages and too few receive health insurance and other benefits. This, combined with difficult working conditions and inadequate training and support, leads to high turnover rates and vacancies. A looming “care gap” is exacerbated by an inadequate supply of workers to meet future consumer demand. There must be innovations to create a stable, well-trained and highly valued direct care workforce.

RECOMMENDATION: Congress should enact legislation to support the proliferation of wage pass-through initiatives, publicly supported health insurance coverage, career ladder and training initiatives and new worker pools to address current and future recruitment and retention problems.

RATIONALE: The use of direct care workers in long-term care settings forms the centerpiece of the formal long-term care system. Policymakers at the federal and state levels should fund and pass legislation, such as wage pass-through initiatives, state-funded health insurance coverage, career ladder and training initiatives and new worker pools to address current and future recruitment and retention problems. Improving the availability and quality of the direct care workforce for long-term care support and services requires a long-term financial commitment and the support of partnerships among various stakeholders, including providers, consumers and their families, labor representatives and public education institutions, as well as various agencies within the state and federal government.

REQUIRE MEDICAL RESIDENTS AND INTERNS TO HAVE HOME CARE AND HOSPICE EXPERIENCE AS PART OF THEIR GRADUATE MEDICAL EDUCATION

ISSUE: Medicare pays for the education of medical residents and interns at virtually all hospitals in the United States. Much of the education is biased toward care provided in the hospital setting. However, a great deal of medical care is moving out of hospitals into the community. Several factors precipitated this shift. Advances in medical technology allow for treatments such as infusion therapy to be provided in the home setting. Existing financial incentives for hospitals to discharge patients quickly means that services such as rehabilitation are now being provided in the home rather than the acute care setting and special arrangements for intensive home therapy prior to hospitalization in the case of chemotherapy, for example, are increasingly commonplace.

In addition, the marked increase in lifespan has resulted in an increasingly elderly population with chronic illnesses which, while they limit functioning, are not life-threatening, and therefore are managed in non-acute settings, primarily the home. Medicare requires physicians to sign a plan of care for beneficiaries to receive home care services, but many physicians may have never practiced outside of a hospital. Often, doctors discharge patients to their home without considering the home environment, support system, and resources.

Physicians must learn to function effectively in “non-traditional” care sites, particularly the home setting. As few medical schools provide their students with comprehensive home care experiences, such education must take place at the residency level. A 1994 survey of US medical schools showed that only half of all medical schools afford the opportunity for home health and hospice education before graduation.

RECOMMENDATION: Congress should mandate that all residents and interns have home care and hospice experience included in their curriculum.

RATIONALE: Medicare pays for the direct costs of graduate medical education. The mandate that residents and interns spend time in the community does not add costs. Currently, Medicare will reimburse a hospital for residents’ time spent in education outside of the hospital as long as the resident spends his or her time in patient care activities.

In the community, residents will learn about the services available and will be better able to coordinate care between the hospital and the home setting. The importance of this increases as hospitals continue efforts to shorten lengths of stay. Indeed, it is now essential to prevent unnecessary hospitalization and long-term institutional care. Moreover, increased understanding of home health services will aid physicians in later determining appropriate levels of Medicare home health utilization for individual beneficiaries. At a minimum, education should include pain and symptom control and a requirement to make home visits.

PRESERVE WORKERS' RIGHTS AND PRIVACY PROTECTIONS IN THE FORMATION OF UNIONS

ISSUE: The National Association for Home Care & Hospice supports the enforcement of laws that allow for the organization of labor free of undue outside influence. The Employee Free Choice Act (EFCA), H.R. 800/S. 1041, which was passed by the House of Representatives during 2007, would amend the National Labor Relations Act to change the requirements for the formation of a union in a way that eliminates workers' right to a private vote. This legislation was reintroduced in the 111th Congress (H.R. 1409/S. 560). Under present labor law employers and workers have the right to demand a secret ballot vote to certify a union. EFCA would eliminate the right to a secret ballot and permit the formation of a union by simply getting a majority of the workers to sign a card authorizing a union. It would also impose some mandatory arbitration requirements and increased penalties on employers for certain practices.

RECOMMENDATION: Congress should preserve worker privacy rights in the formation and certification of unions and reject the EFCA.

RATIONALE: The EFCA would be harmful to home health and hospice workers and their employers by removing the right of the employees to a federally-supervised, private ballot when deciding whether or not to certify a union. Under this system, paid union organizers – not the federal government – oversee the process, and the workers' choice is ultimately made public to the employer, the union organizers and co-workers.

EFCA is fundamentally incompatible with protecting the interests of individual liberty and the principles of a sound democracy. If Congress passes this proposal, it will be stripping away federally-protected private ballots from the hands of American workers. The only way to guarantee worker protection is through the continued use of a federally-supervised private ballot so that personal decisions about whether to join a union remain private and free of undue influence.

EFCA also includes language that would force binding arbitration on both the employer and the collective bargaining unit. This creates uncertainty for business planning and diminishes the control employers have over their operations and property.

RESTORE THE COMPANIONSHIP SERVICES EXEMPTION TO THE FAIR LABOR STANDARDS ACT

ISSUE: In 1974, Congress established an exemption for companionship services from the Minimum Wage and Overtime Requirements of the Fair Labor Standards Act. Congress made a societal choice in balancing the interests of the worker relative to the needs for care to the elderly and the infirm. Current law provides the Secretary of the U.S. Department of Labor (DOL) the authority to define and determine the scope of the companionship exemption.

In June 2007, the US Supreme Court ruled that the DOL companionship services exemption regulation was valid thereby reversing the Court of Appeals in a final decision.

Since the Supreme Court ruling, there has been a re-focusing of efforts by some opposed to the DOL rule. Currently, they are attempting to get Congress to change the law while also seeking legislative and/or regulatory remedies at the state level. Legislative efforts in the 110th, 111th and 112th Congresses intended to eliminate the current companionship services exemption for home care aide workers are opposed by the National Association for Home Care & Hospice (NAHC) because they do not go far enough to protect workers.

Some states already have passed laws that eliminated the companionship services exemption. In others, there are efforts to interpret the regulations in a manner different than the federal rules.

Advocates for changing the exemption have expanded their efforts with the Obama administration to encourage DOL to change the regulation. These efforts include enlisting the aid of 15 Senators to send a letter to the Secretary of Labor requesting that the exemption be modified through regulation to exclude home care aides employed by agencies or family of the client. DOL issued a proposed rule on December 27, 2011 that would significantly restrict the exemption and make it inapplicable to workers employed by home care companies. The proposed rule was made final on October 1, 2013 with an effective date delayed until January 1, 2015, 78 Fed. Reg. 60453 (October 1, 2013). In the absence of a mandate that government payment programs increase payment rates to cover the added cost of wages that would result from these efforts, home care aide employers are expected to restrict working hours to avoid overtime pay. Further, these efforts do nothing to create career opportunities for home care aides or to address their need for health insurance. This isolated action related to a single element of the home care aide working conditions will have a reverse negative impact on those workers.

Legislation has been introduced in the 112th Congress that is intended to codify the current definition of companionship services. NAHC supported of the “Companionship Exemption Protection Act” (H.R.3066) because it creates certainty for home care providers and patients rather than leaving the definition open to changes through the regulatory process.

In 2014, NAHC and other organizations filed a lawsuit against DOL, challenging the validity of the October 2013 regulations. The federal District Court for the District of Columbia held that the regulations that eliminated the application of the exemptions to third-party employed workers and the restricted redefinition of “companionship services” violated the Fair Labor Standards Act. On August 21, 2015, the U.S. Court of Appeals for the DC Circuit reversed the District Court rulings concluding that the FLSA exemptions were ambiguous and permitted the DOL to establish limiting standards through rulemaking. NAHC

and its co-plaintiff sought a stay of the appeal court's ruling with the U.S. Supreme Court. Chief Justice Roberts denied the stay request and the challenged rules went into affect on October 13, 2015. The Court of Appeals ruling has been appealed to the U. S. Supreme Court. A determination as to whether the Supreme Court will hear the appeal is expected in the Spring, 2016.

With the rules going into affect, few states have adjusted Medicaid rates to accommodate new overtime costs. As a result, access to appropriate care scheduling has been compromised as home care employers rely on work hour limitations to avoid overtime. With respect to private pay services, charges have been increased for clients wishing to retain caregivers who provide overtime hours. Otherwise, employers have restricted working hours to limit overtime costs.

Legislation has been introduced in the 114th Congress that would return the FLSA standards to the pre-rule change standards, S.2221 and H.R. 3860, Ensuring Access to Affordable and Quality Home Care for Seniors and People with Disabilities Act.

RECOMMENDATION: A companionship services exemption under wage and hour laws should be restored/maintained at the state and federal level until a comprehensive plan can be implemented that addresses service funding, worker health insurance, and career development. Congress should reverse the Department of Labor rule change that effectively eliminated the application of the companionship services exemption to home care. Alternatively, Congress should ensure that government-funded home care programs adequately reimburse employers for the added costs of overtime compensation and provide financial protection to consumers of private pay services through tax credits or other subsidies. Finally, Congress should enact reforms to the FLSA that establish a reasonable compensation structure for home care that respects the uniqueness of that employment setting where the patient/client is the primary focus of responsibility. That reformed structure should also properly address the unique aspects of "live-in" care where employees reside in the home of the client, receive room and board, and take on caregiving responsibilities throughout a 24 hour day.

RATIONALE: Most home care providers are small business with limited resources. The companionship exemption result would be to reduce the availability of care to the elderly and the infirm and to increase the costs of service delivery with no corresponding increase from third party payers, such as Medicaid. A comprehensive rather than a piecemeal approach to worker compensation and working conditions is necessary if access to high quality of care and continuity of services is to be achieved. Also, the unique employment nature of home care warrants a tailored approach to wage and hour requirements that takes into account that the focus of the employment is a population of vulnerable and infirm elderly a persons with disabilities in their own homes.

PROVIDE SUFFICIENT HOME CARE AND HOSPICE PAYMENTS SO THAT AGENCIES CAN PROVIDE APPROPRIATE WAGES AND BENEFITS TO CLINICAL STAFF

ISSUE: The severe limitations on reimbursement under Medicare and Medicaid make it extremely difficult for agencies to comply with any requirements to increase wages, much less provide wages and benefits that reflect the worth of the care provided by nurses, paraprofessionals, and other caregiving staff. In fact, despite the public push to raise minimum wage to a rate that would allow for a “living wage”, current economic restrictions have resulted in many agencies cutting staff or seeking ways to save on patient care costs by limiting workers’ hours or reducing wages or benefits. Payment under Medicaid and under the prospective payment system for home health and payment rates for hospice care services must be adequate to allow for increased wages and benefits for nurses and home care aides.

RECOMMENDATION: Congress should provide that federal programs (Medicare/Medicaid) that finance home care and hospice services adjust reimbursement to allow for appropriate living wage and benefit levels, including health care and paid sick leave, for all clinical staff. Additionally, Congress should consider implementing a wage pass through for home care and hospice workers under Medicare and Medicaid.

RATIONALE: The U.S. Census estimates that nearly 20 percent of home care paraprofessionals and their families live in poverty, and 30 to 35 percent of those who are single parents receive food stamp assistance. Studies indicate that low wages affect an agency’s ability to recruit and retain direct care workers. Agencies throughout the nation have begun to experience severe hardships in recruiting and retaining clinical staff.

Increasingly, efforts are being made to document the relationship between wages and quality of care. Without sufficient reimbursement, financially strapped home care and hospice agencies are finding it extremely difficult to provide quality care, pay competitive wages, and foster job satisfaction.

ENSURE AVAILABILITY OF HOME CARE AND HOSPICE PERSONNEL TO MEET THE GROWING NEEDS OF THE BABY BOOM GENERATION, PARTICULARLY IN RURAL AND OTHER UNDERSERVED AREAS

ISSUE: There is an increasing need for home care and hospice services as a result of the aging of the population, clarification of Medicare coverage policies, continued earlier hospital discharges, and patient preferences for home care and hospice. While this trend has leveled off, home care and hospice providers continue to report shortages of nurses, home care aides, therapists and social workers, especially in rural areas. Periodic reductions or freezes in agencies' market basket inflation updates, in addition to other cuts, have made it increasingly difficult for agencies to offer competitive wages and benefits. Increased regulatory burdens on home visiting staff have also discouraged workers from continuing in home care.

Home health agencies generally require that newly-hired staff have one year of prior work experience because home caregiving requires that professionals take on substantial responsibility; agencies also have financial difficulty providing the level of supervision new nurses and therapists need in the home setting. Reductions in the workforce in inpatient settings have greatly reduced the opportunities for nursing and physical and occupational therapy graduates to obtain on-the-job experience.

Recruitment and retention of home care and hospice personnel, including nurses and home care aides, is especially difficult in rural and other underserved areas. Providing health care in these areas requires special knowledge, education, and commitment on behalf of health care providers. Continuing education and training often are not readily available. Health care services can be particularly interdependent in rural communities: when a rural hospital closes, many affiliated health care personnel and services leave the area as well.

In 2009, the Office of Occupational Statistics and Employment Projections at the Bureau of Labor Statistics, within the U.S. Department of Labor, released employment projections for the American workforce for 2008-2018. The health care and social assistance sector is projected to grow substantially during this 10 year period. In fact, 17 of the 30 fastest growing occupations are related to health care and medical research. The projected job growth in the health care sector includes increases in the following occupations: home health aides, an increase of 50 percent; personal and home care aides, an increase of 46 percent; physical therapists aides, an increase of 36.3 percent; physical therapist assistants, an increase of 33.3 percent; occupational therapists aides, an increase of 30.7 percent; physical therapists, an increase of 30.3 percent; and occupational therapists assistants, an increase of 29.8 percent.

It is critically important to both increase the supply of qualified health care staff to maintain patient care access and to assure that these staff have the skills needed to provide high quality treatment and rehabilitation services in the home setting. Federal and state regulations should promote the use of nurse practitioners, physician assistants, and other qualified home health personnel.

Congress took legislative action in the 107th Congress to help alleviate the nurse shortage. Specifically, the Nurse Reinvestment Act (H.R. 3487, P.L. 107-205) would establish a National Nurse Service Corps to provide scholarships and loans to nursing students who agree to serve in a public or private non-profit health facility, including home care

agencies and hospices, determined to have a critical shortage of nurses. The legislation also establishes nurse retention and patient safety enhancement grants to assist health care facilities to retain nurses and improve patient care delivery by encouraging more collaboration between nurses and other health care professionals and more involvement by nurses in the decision-making process.

In addition, the bill establishes grants for comprehensive geriatric nurse training, establishes a faculty loan cancellation program, establishes a career ladder program that will assist individuals in the nursing workforce to obtain more education, and establishes partnerships between health care providers like home care agencies and schools of nursing for advanced training. Lastly, the bill establishes a fund for public service announcements that will advertise and promote the nursing profession and educate the public about the rewards of nursing.

RECOMMENDATION: Congress should fund grant programs for educating therapists, medical social workers, nurses, home care aides, and other home care and hospice personnel with a focus on home- and community-based practice in areas where shortages exist. The number of schools providing therapy programs must be increased and the number of slots available in these schools should be expanded. Special incentives such as loan-forgiveness programs to fund schooling and education should be developed to recruit students for practice in geographic areas with staff shortages, such as rural and inner city areas. Grants to educational facilities should be made available for innovative approaches to recruitment and education of home health care personnel, including consideration of job “ladders” and “classrooms without walls,” and for faculty development. Congress should fund home care internship demonstration projects for nurses and physical and occupational therapists to provide a year of on-the-job education for new graduates. Finally, Congress should provide incentives to ensure that a sufficient number of qualified faculty members are available to train the nation’s future health care workforce.

Congress should request Government Accountability Office and Medicare Payment Advisory Commission (MedPAC) studies on the shortage of personnel in the home care and hospice settings, with special attention to rural and inner-city areas, and with recommendations on what can be done to overcome this problem.

RATIONALE: The demand for home care and hospice services will continue to increase as the elderly and disabled population grows. More qualified personnel are necessary to meet the increased needs. These personnel should have skills that enable them to apply their services to home- and community-based care situations. Further, these qualified home care and hospice personnel should be encouraged to practice in rural and underserved areas. When professionals are scarce, the cost of providing care increases. Putting funds into education and other incentive programs will ultimately lower costs to consumers.

COORDINATE HOME HEALTH AIDE AND NURSING HOME AIDE TRAINING REQUIREMENTS

ISSUE: The Omnibus Budget Reconciliation Act of 1987 (OBRA-87, P.L. 100-203) requires Medicare-certified home health agencies to meet requirements related to the training and testing of home health aides. Similarly, OBRA-87 provides that Medicare-certified nursing facilities must also meet requirements relating to training and testing of nurses' aides within their facilities. While the differences in services provided by home care aides and nurses' aides require different training, there are areas that are comparable for both care providers. Neither OBRA-87 nor the regulations promulgated by the Centers for Medicare & Medicaid Services coordinate the two programs in a way that maximizes the availability of personnel to provide health care. The result is duplicative and costly certification programs for aides.

Additionally, the Medicare program requires supervision and competency testing of home health aides. However, there is NO REQUIREMENT for training as is imposed on nurse aides in skilled nursing facilities.

RECOMMENDATION: Congress should require the Secretary of Health and Human Services to thoroughly explore the potential for coordinating aide training and testing programs for home health agencies and nursing facilities by establishing a core training curriculum that applies to both aide training areas, with additional, site-specific training and/or competency testing. If feasible, the Secretary should develop such a program, and ensure that it provides sufficient flexibility so that experienced aides may move from one care site to the other with relative ease.

RATIONALE: A 2010 Bureau of Labor Statistics (BLS) report revealed a 63.15 percent employment growth rate projection (2008-2018) for home health aides and 54.4 percent for personal care aides. The BLS further predicts the total number of new job openings (growth plus replacement) will require 2,327,000 new paraprofessional long-term care workers in the coming decade. These figures underscore the need to create additional incentives for individuals to enter the field. The coordination of the two training/testing programs will make the position of home care aide more attractive for individuals given the expanded areas of employment opportunities. Further, the coordination of the programs will allow providers of services greater access to properly trained paraprofessional care. Ultimately, coordination of the two programs will improve access to services and reduce the costs of meeting the training and testing requirements. In its 1998 report, the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry called for minimum standards for education, training and supervision of unlicensed paraprofessionals in home care, nursing home and hospital settings.

STRENGTHEN THE HOME HEALTH AIDE TRAINING REQUIREMENTS CONTAINED IN OBRA-87 AND APPROPRIATELY REIMBURSE AGENCIES FOR TRAINING COSTS

ISSUE: The Omnibus Budget Reconciliation Act of 1987 (OBRA-87, P.L. 100-203), requires Medicare-certified home health agencies to meet training and testing requirements for a home health aide who works under a medically supervised plan of care assisting the client and/or family with household management and personal care, also categorized as a home health aide III. Section 4021 of OBRA-87 states that home health aides in Medicare-certified agencies must complete training or a competency evaluation program that meets the minimum standards established by the Secretary of Health and Human Services (HHS). The legislative language does NOT REQUIRE training AND competency testing. There is a list of recommended training topics IF training is performed prior to competency testing. Competency testing may or may not be preceded by training. The use of a competency evaluation-only system that ignores the need for training may place the recipient of service at risk of substandard care.

RECOMMENDATION: Congress should pass legislation requiring a home health aide III hired or contracted by Medicare-certified home health agencies to complete and pass an HHS-approved training program and competency test. Congress should mandate inclusion of the Home Care Aide Code of Ethics (developed by the Home Care Aide Association of America in 1999), which focuses on the basic principles of quality care and contains guidelines for client's and home care aide's rights. The legislation should ensure that costs of training, including "opportunity" costs (revenues lost while employees are training rather than delivering service) be reflected in prospective payment rates for agencies. Completion of the training and testing program should be accomplished within six months of employment. Home health agencies should be permitted to use home health aides in direct patient care while participating in a training program under the following circumstances: 1) the aides only provide services they have been trained to perform; 2) the aides have completed a 16-hour basic skills course; 3) the aides are proven competent by direct skills observation; and 4) the aides finish the training program and competency testing within six months from date of hire or beginning of the training program. Further, Congress should directly, or through the Centers for Medicare & Medicaid Services (CMS), appoint an accrediting body to approve programs and require that the cost of these programs be estimated in advance and be reimbursed by the Medicare program. CMS should also determine whether development of a "core curriculum" for nurse and home health aides is appropriate, advisable, and possible.

RATIONALE: With the current requirements, it is now possible that an inadequately trained aide (or one who has received no training) could pass the competency test without actually being qualified to perform home health aide services.

Without question, there will be a cost to agencies to comply with this requirement, and indeed CMS may be trying to minimize this cost by virtually eliminating the requirement for training. However, leaving the door open for the delivery of services by inadequately trained

paraprofessionals puts consumers at risk.

ALLOW LPNs /LVNs TO SUPERVISE HOME CARE AIDES

ISSUE: Medicare permits licensed practical nurses (LPNs) or licensed vocational nurses (LVNs) that are under the general supervision of registered nurses (RN), to perform nursing services in the home, including such complex care as changing dressings on wounds and inserting Foley catheters. However, the Medicare Conditions of Participation do not authorize LPNs/LVNs to supervise home care aides. Many home health agencies and hospices have found that it is not cost-effective to hire LPNs/LVNs to carry out only direct patient-care activities. In a survey conducted by NAHC, a strong majority of home care agencies (82 percent) believe LPNs/LVNs should be allowed to supervise home health aides.

RECOMMENDATION: Congress should enact legislation to allow LPNs/LVNs to supervise home health aides under the general supervision of an RN where permitted by state nurse practice acts. RNs would continue to be responsible for the overall development and management of the patient care plan. In a time of nursing shortages, home health agencies should be given the flexibility to determine whether an RN or LPN/LVN is the most appropriate staff for home health aide supervision.

RATIONALE: LPNs/LVNs are required to conform to established practice standards established by state licensing boards. Their formal education includes basic nursing and personal care skills. Home health aides also provide personal care to patients. Therefore, it is appropriate for LPNs/LVNs to supervise the tasks performed by home health aides.

Allowing LPNs/LVNs to supervise the personal care tasks performed by home health aides would allow RNs more time for care management as they provide complex and highly-skilled nursing services and coordinate the patient plan of care with other disciplines and the physician.

PREVENT VIOLENCE AGAINST HOME CARE WORKERS

ISSUE: Home care workers are facing an increasing risk of violence directed at them by their patients, patients' families and friends and others in the neighborhood of the home. In 1996, that violence reached a dramatic point with the murders of two home care nurses by their patients.

While home care workers deliver health care services outside of controlled environments, only limited protections have been created to guard these workers. As more home care providers initiate risk management efforts to protect their workers, governmental resources should be made available to assist in this important effort.

RECOMMENDATION: As part of an overall federal effort to stem workplace violence affecting home care, Congress should enact legislation to:

- Make physical violence directed toward home care workers providing federally-funded care through programs such as Medicare, Medicaid, TRICARE, and veterans health programs, a federal-level felony with appropriate classification of the felony dependent upon the degree of violence.
- Establish a grant program to provide for the development of educational programs for local and state police regarding the role that they can play in protecting home care workers.
- Ensure reimbursement for home care services to allow for pass-through financing for any reasonable and necessary security measures required to protect home care workers and to maintain continued access to services for home care beneficiaries.
- Direct the U.S. Department of Health and Human Services and the Civil Rights Division of the U.S. Department of Justice to establish a model standard for suspension of services in geographic areas which may be temporarily subject to increased risk of violence and strengthen the rights of agencies to discontinue cases that pose a threat to workers. This standard would allow for suspension of services without risk of allegations of noncompliance with various civil rights laws.

RATIONALE: With federal financing of a significant portion of the home care currently received by the nation's homebound and infirm, Congress plays an important role in protecting the delivery of high quality services to those in need. If home care workers are at risk of violence in the delivery of services, the health and safety of the patient is also at risk and quality of care suffers. Making violence directed at federally-financed home care workers a federal felony may act as a deterrent to future violence. Furthermore, in many communities, local law enforcement has become important partners in the delivery of home care services. Their knowledge and experience should be harnessed to benefit the home care population nationwide. Federal grants can be the springboard to the development and dissemination of successful models of integrated involvement between home care and local law enforcement.

Since workplace violence presents a health and safety concern, the Occupational Safety and Health Administration (OSHA) is properly positioned to develop model standards for risk management. OSHA-based standards are likely to ensure consistency and uniformity in implementation. However, efforts directed toward increased protection of home care

workers will increase the cost of the delivery of services. The various federal programs that finance home care services must adjust their rates of reimbursement to cover this cost for these efforts to be effective.

Finally, the occurrence of violence against home care workers may result in discriminatory treatment of geographic areas by home care providers attempting to avoid danger. It is not unusual for a home care provider to suspend services temporarily in geographic areas when violence arises. This suspension may affect a home, apartment building, housing complex, or an entire neighborhood. In order to avoid allegations of discrimination, Congress should require the appropriate federal authorities to establish standards to which home care providers can refer in making determinations on suspension of service as a last resort to protect home care workers.

REQUIRE FEDERALLY FUNDED CRIMINAL BACKGROUND CHECKS AND ESTABLISH A NATIONAL REGISTRY SYSTEM

ISSUE: At times, media attention has focused on the unacceptable, but few, cases of abuse of home care clients, fueling consumer anxiety and industry concern about the need for better consumer protections. Although any fraud and abuse is unacceptable, it's important to note that cases of consumer abuse in home care are rare, certainly the exception rather than the rule. The overwhelming majority of home care workers perform their duties with compassion and integrity; likewise, the vast majority of home care agencies provide reputable, legitimate, quality care. However, as in any industry, there are a few unscrupulous individuals who defraud and abuse the system and its patients.

In March 1997, the then-Health Care Financing Administration published proposed rules governing the conditions of participation (CoP) in the Medicare program which included a provision to require home health agencies to conduct a criminal background check of home health aides as a condition of employment. The new Hospice CoP require hospices to conduct a criminal background check on all hospice employees and contracted workers providing direct patient care or with access to patient records. Criminal background checks cannot be relied on as the sole method of keeping consumers safe. No matter how effective, the criminal background check should not substitute for the most basic and prudent personnel practices that any responsible employer would undertake to establish the appropriateness, safety and suitability of an applicant.

Under a provision in the fiscal year 1999 Omnibus Appropriations legislation, a home care agency or a nursing facility is permitted but not required to submit a request to the Attorney General (through the appropriate state agency) to conduct a criminal background check on applicants who would be involved in direct patient care. This provision, which does not mandate criminal background checks, is an important step toward making criminal history information more accessible. It is very likely that Congress will continue to consider mandatory criminal background check provisions as the capacity of federal systems to process such requests is improved.

In the 106th Congress, Senator Herb Kohl (D-WI) and Representative Pete Stark (D-CA) introduced "The Patient Abuse Prevention Act" (PAPA) to require criminal background checks for long term care workers. Senator Kohl renewed the effort by reintroducing the bill in the 107th and 108th Congresses, the latest version of which was S.958. Provisions of the bill were included as an amendment to S.1, the Senate version of the Medicare Prescription Drug, Improvement, and Modernization Act. The amendment was dropped in conference with the House and replaced by a pilot program before final passage of the legislation (Public Law 108-173).

Section 307 of P.L. 108-173 required the Secretary of HHS to establish pilot projects in no more than 10 states for the purpose of expanding background checks for workers with direct patient access who are employed by Medicare and Medicaid long term care providers. CMS selected seven states to participate in the Background Check Pilot Program: Alaska, Idaho, Illinois, Michigan, Nevada, New Mexico, and Wisconsin. Long term care facilities or providers include nursing homes, home health agencies, hospices, long term care hospitals,

and other entities that provide long term care services (except for those paid through a self-directed care arrangement). Separate funds were earmarked to conduct an independent evaluation of the background check pilot which has now been completed.

Senator Kohl introduced legislation in the 110th and 111th Congress to expand the pilot projects to make the program available to every state. His legislation was included in the Patient Protection and Affordable Care Act (H.R. 3590; Public Law 111-148) in March 2010.

RECOMMENDATION: Congress should support efforts to establish a national registry and background check system administered by the states for all health and long term care workers, including independent providers, who provide direct care to patients. Such a system should be voluntary until an efficient and accessible background check system is in place. Federal and state background check requirements should not be duplicative. Any new requirement should not impose burdensome supervisory requirements on home care agencies while a background check is pending and must protect providers from liability during a provisional period of employment. Further, it should mandate that agencies be adequately reimbursed for the cost of the background checks. A standard definition of abuse, neglect, or misappropriation of patient property should be used for purposes of establishing a national registry.

RATIONALE: As the demand for high quality home care and hospice increases, it is critical that all services are delivered with care and compassion by ethical providers. Fraud and abuse cannot be tolerated in any form. The care environment must be safe for patients and caregivers and free of abuse, exploitation and inappropriate care. Criminal background checks and a national registry are important components of ensuring consumer safety.

In state laws the trend is toward background check requirements for nursing and home care aides only; however, there is currently no consistent systematic mechanism through which other direct care staff is checked. It is in the best interest of consumers of home care and other health services for all direct care staff to be screened.

ESTABLISH STABILITY AND EQUITY AMONG MEDICARE HEALTH CARE PROVIDERS IN APPLICATION OF THE WAGE INDEX

ISSUE: Since the inception of the Medicare per visit cost limits, home health payment rates have been adjusted to reflect varying wage levels across the nation through the application of a wage index. This payment rate adjustment continues under the Medicare home health prospective payment system (PPS), which was implemented October 1, 2000. However, the wage index that has been utilized by the Centers for Medicare & Medicaid Services (CMS) has been based upon wages within hospitals across the nation. This index is derived from data that explicitly excludes any home health services costs. An attempt some years back to create and utilize a home health-specific wage index failed due to the unavailability of reliable wage data. The hospice wage index also is based upon hospital wage data.

While the home health payment rates are based upon the application of a hospital wage, the index utilized and its manner of application is significantly distinct from that utilized relative to hospital services payment rates. Of particular concern is the fact that a hospital may secure a geographic reclassification for application of the wage index by establishing that the hospital draws on an employment pool different from the geographical area to which it would otherwise be assigned for its wage index level. Home health agencies and hospices are not authorized to secure a wage index reclassification. As a result, a hospital may compete for the same health care employees as a hospice or home health agency but be approved for a relatively higher payment rate through the wage index reclassification. Additionally, Congress has established specific wage index criteria for certain geographic locations. However, these criteria apply only to hospitals. Hospitals also are provided extra protection against losses due to dramatic drops in their wage indices by a provision imposing a “rural floor” under which no hospital’s wage index can fall below the state-specific rural wage index.

Finally, home health agencies and hospices are not afforded any type of stop-loss protections. As a result, changes in area wage indices from year to year are sometimes dramatic, and always difficult to plan for. For example, in recent years one area of Texas underwent a 12 percent drop in its wage index value one year, and a 14 percent increase the next year.

On a related note, concerns are on the rise that the home health PPS case-mix adjuster has proven difficult to refine sufficiently so that agencies are appropriately reimbursed for care. Refinement to the home health wage index calculation method could help in this regard.

During 2007 the Medicare Payment Advisory Commission (MedPAC) recommended to Congress that it give authority to the Secretary of the Department of Health & Human Services to fashion a new system for calculating the wage index for hospitals as well as several other providers, including home health. MedPAC’s recommendation would base the wage indices for all providers on a different data set than the one currently in use by Medicare. In doing so, it also would eliminate any need for geographic reclassifications and the rural floor. MedPAC continues to support a new wage index model for all Medicare providers.

The Patient Protection and Affordable Care Act provides for comprehensive reform of

the Medicare hospital wage index system that takes into account MedPAC's 2007 recommendations (PPACA Section 3137). This provision requires that CMS submit a report to Congress by December 31, 2011, setting out a plan to reform the wage index consistent with the 2007 MedPAC recommendations.

CMS issued the report to Congress on April 11, 2012. The report recommends the use of Commuting Based Wage Index (CBWI) that sets wage index values using the commuting patterns of hospital workers. The consulting group on the report expressed that the CBWI could be adapted for non-hospital providers including home health agencies. It stated: "Medicare could implement one of three options to adapt the index for use in these settings. First, Medicare could adapt the CBWI methodology to develop wage indices specifically for each one of the providers that use the Medicare wage index to adjust their payments. The administrative burden and resource requirements associated with this approach might be considerable. Second, as long as a hospital is located in close proximity to one of these other providers, Medicare could use the hospital's CBWI as the basis for the other healthcare provider's wage index. Using hospital wages assumes that the relative wage differences between areas are similar for hospital workers and for other healthcare provider workers. Third, Medicare could base providers' values on those of nearby hospitals using the nearest-neighbor method. For each healthcare provider, this method would approximate wage index values based on a weighted average of the wage index values for nearby hospitals."

The report did recognize the complexities of using a CBWI in home health and hospice "given that the Hospice and Home Health payment methods use the beneficiary residence or place of service to adjust payments, the relevant commuting patterns would be from the employee residence to the beneficiary residence. This would add a new level of complexity to the collection of commuting data and is unlikely to be feasible." As of January 2014, CMS has not moved forward with any wage index reforms.

RECOMMENDATION: Congress should authorize Medicare to implement and apply a wage index model in line with the system recommended by MedPAC no later than 2015. The CMS proposed CBWI model fails to provide home health agencies and hospices with a level playing field with other health care entities that employ comparable workers, including hospitals and nursing facilities. Otherwise, Congress should allow hospices and home health agencies to obtain a geographic reclassification for wage index purposes in a manner comparable to that available to the hospitals or to allow reclassifications automatically when a hospital in the geographic locale of the hospice or home health agency receives a reclassification. Additionally, Congress should enact legislation that limits a home health agency's loss of income due to a dramatic shift in the agency's wage index (for example, limit the drop in any agency's wage index from one year to the next to 2 percent). Finally, Congress should extend to all providers protections that ensure that no entity's wage index falls below the rural wage index value in that state.

RATIONALE: In today's health care environment, health care providers of all types compete for employment of the same personnel. The adjustment of Medicare payment rates intended to reflect variations in wages across the nation should be consistent across all provider types. With increasing shortages of health care personnel, unequal wage index adjustments for health care providers in the same geographic region results in an uneven and discriminatory distribution of the employment pool of personnel. Further, in recent years some agencies have

experienced dramatic increases and drops in their wage indices. This degree of “swing” in reimbursement can have a significant impact on an agency’s financial viability.

III. ENSURE THE APPROPRIATE USE OF TECHNOLOGY IN HOME CARE

RECOGNIZE TELEHOMECARE INTERACTIONS AS BONA FIDE MEDICARE AND MEDICAID SERVICES

ISSUE: Telehomecare is the use of technologies for the collection and exchange of clinical information from a home residence to a home health agency, a secure monitoring site or another health care provider via electronic means. The scope of telehomecare includes, but is not limited to, the remote electronic monitoring of a patient's health status and the capturing of clinical data using wireless technology and sensors to track and report the patient's daily routines and irregularities to a healthcare professional; electronic medication supervision that monitors compliance with medication therapy; and two-way interactive audio/video communications between the provider and patient allowing for face-to-face patient assessment and self-care education.

With increasing expectations for quality care delivery, the use of technology to deliver home health and hospice care is increasingly being recognized as an invaluable tool for an industry challenged by diminished reimbursement formulas. For example, the Veterans Administration (VA) continues to expand their now ten-year-old Care Coordination/Home Telehealth (CCHT) program. In fiscal year 2012, 119,535 veterans were enrolled in home telehealth services and home monitoring of their conditions enabled 42,699 of these patients to live independently in their own homes, rather than going into nursing homes. In 2012, the VA also eliminated copayments for veterans receiving in-home care via telehealth technology. Home care agencies have also been readily adopting remote monitoring technologies. There has been measured growth in telehealth use by HHAs from 17.1% in 2007, to 22.9% in 2009, and to 31.2% in 2013. (2007 and 2009 data is from independent studies conducted by Fazzi Associates; Philips National Study on the Future of Technology and Telehealth in Home Care (2008); The BlackBerry Report: National State of the Homecare Industry Study (2009); and National State of the Homecare Industry Study (2013)).

Despite significant progress that has been made in the development and use of advanced telehomecare technologies, the absence of a uniform federal Medicaid and Medicare telehomecare guideline that provides for comprehensive reimbursement mechanisms and a uniform certification process for certifying telehealth providers, is creating barriers to more widespread adoption of telehomecare and the establishment of services employing telehomecare. Currently, the Centers for Medicare & Medicaid Services (CMS) does not recognize telehomecare as a distinctly covered benefit under Medicaid, nor does it allow for telehomecare technology costs to be reimbursed by Medicare.

Small inroads have been made under Medicaid as at least 18 state Medicaid programs have passed waivers that include the reimbursement of telehomecare services. Unfortunately, CMS maintains that telehealth visits do not meet the Social Security Act definition of home health services "provided on a visiting basis in a place of residence" under the Medicare program. CMS regulations (42 CFR 484.48(c)) defines a home health "visit" as "an episode of personal contact with the beneficiary by staff of the HHA [home health agency]."

Over the past few years, Congress has taken integral steps to expand the access of technology into the delivery of home health care. Most notably, telehomecare champions Senator John Thune (R-SD) and Amy Klobuchar (D-MN) have taken up the cause and introduced the "Fostering Independence Through Technology (FIT) Act" to mandate that the Secretary of Health and Human Services (HHS) establish pilot projects under the Medicare program to provide monetary incentives for HHAs to utilize home monitoring and

communications technologies. The FITT Act was included as an amendment to the Sustainable Growth Rate “Doc Fix” bill that will be considered by the 113th Congress. In 2008, and again in 2009, Representative Mike Thompson (D-CA) introduced “The Medicare Telehealth Enhancement Act” which provided a number of provisions that addressed the need for enhanced telehealth services including, for Medicare’s purposes, reimbursement for home health telehomecare visits by home health agencies, coverage of remote patient management services including home health remote monitoring, and establishment of a demonstration project to evaluate the impact and benefits of including remote patient management services for certain chronic health conditions. In 2012, Thompson introduced “The Telehealth Promotion Act of 2012” which removes arbitrary coverage restrictions on telehealth from federal health care programs and also increases the Medicare prospective payment rates to home health agencies to include remote monitoring services for three years. In 2013 the “The Telehealth Promotion Act of 2013” was introduced to encourage the use of telehealth technologies in the certification of home care services and enable the home to be a telehealth site. Lastly, in 2014 the Telehealth Enhancement Act of 2013 and the Medicare Telehealth Parity Act of 2014 included phased in expansion of telehealth coverage, the definition of a “home telehealth site” and telehealth services for the remote delivery of home care and hospice services. In 2015, Congress will again be considering an approach to reimbursement of telehealth in Medicare.

In 2013, Congressional allies from both the Senate and the House also sent a letter to CMS conveying their support for the Center for Medicare & Medicaid Innovation (CMMI) created by The Affordable Care Act and recommending the FITT remote monitoring model as one of the pilot projects the CMMI should adopt to effectively test in both rural and underserved urban areas by home health care providers.

RECOMMENDATION: Congress should: 1) establish telehomecare services as distinct benefits within the scope of Medicare and federal Medicaid coverage guided by the concepts embodied in the Fostering Independence Through Technology (FITT) Act; these benefits should include all present forms of telehealth services and allow for sufficient flexibility to include emerging technologies; 2) clarify that telehomecare qualifies as a covered service under the Medicare home health services and hospice benefits and provide appropriate reimbursement for technology costs; 3) eliminate the list of authorized originating sites for telehealth services by physicians under section §1834(m)(3)(C) so that the home residence would be a covered telehealth site; 4) ensure that all health care providers, including HHAs and hospices, have access to appropriate bandwidth so that they can take full advantage of advances in technology appropriate for care of homebound patients and 5) include telehealth equipment and service delivery as allowable costs in home health and hospice.

RATIONALE: Telehomecare is a proven and important component of health care today and vital to reducing acute care episodes and the need for hospitalizations for a growing chronic care population. Establishing a basic federal structure for Medicare and Medicaid reimbursement and coverage of telehomecare services will permit states to more easily add this important service to the scope of Medicaid coverage and benefit the entire Medicare program.

Studies indicate that over half of all activities performed by a home health nurse could be done remotely through telehomecare. Evidence from these studies has shown that the total

cost of providing service electronically is less than half the cost of on-site nursing visits. Given the financial constraints on agencies under the prospective payment system (PPS), providers of care should be granted maximum flexibility to utilize cost-effective means for providing care, including non-traditional services such as telehomecare that have been proven to result in high-quality outcomes and patient satisfaction.

PROVIDE FINANCIAL ASSISTANCE TO HOME CARE AND HOSPICE PROVIDERS TO EXPAND USE OF INFORMATION TECHNOLOGIES AND IMPLEMENT ELECTRONIC HEALTH RECORDS

ISSUE: Administrative costs and paperwork represent significant expenses in health care. The home care industry has been especially paper intensive. Medicare billing, OASIS assessment, patient charting compliance with the Health Insurance Portability and Accountability Act (HIPAA), and many other activities greatly increase administrative costs. The implementation of the Medicare home health prospective payment system has required a wholesale revision in agencies' billing, documentation, data collection and data utilization.

While 80 percent of HHAs currently use an electronic fiscal, billing, and backroom system, changes in documentation responsibilities and advancements in technology will continue to challenge the ability of HHAs to maintain up-to-date systems. The purchase of multi-purpose, integrated clinical and financial systems with multiple electronic capabilities requires a significant capital investment. Traditionally, small business loans have not been readily available to most HHAs because agencies are not viewed as a good credit risk. Many are dependent on Medicare for most of their revenues. Keeping pace with these new technology needs has been beyond the financial capabilities of many HHAs.

HHAs are also readily adopting and using new electronic health records (EHRs) to respond to the Obama Administration's call on health care providers to adopt EHRs by the year 2014. As compared to physicians and hospital discharge planners, HHAs are incorporating EHRs in their practices. According to the latest figures, it's estimated that more than 78.1 percent of HHAs presently use electronic medical records. Therefore, while HHAs are responding to the need to implement EHRs, the great challenge to HHAs is to maintain interoperability with other health care providers.

RECOMMENDATION: Congress needs to continue to work with the Obama administration to provide financial support for HHAs to encourage the adoption of electronic health records by home care providers. The Office of the National Coordinator for Health Information Technology (ONC), should lend assistance to all health care sectors to support for the transition to interoperable EHRs across the continuum of care. This support to currently non-incentivized providers in post acute care settings should include monetary incentives such as small business loans, tax incentives, grants from the Medicare and Medicaid programs, partnerships with hospitals and physician practices, grants for the development of HIT standards for the Home Health Plan of Care (HHPoC) and Care Transition data standards. Lastly, ONC should also develop voluntary EHR certification guidelines for home care EHR products.

RATIONALE: Although not mandated by the HITECH Act to do so, in order to participate in the industry wide goal of EHRs, HHAs and hospices will require financial assistance to purchase the necessary systems and adopt new certified electronic health information technologies. Current reimbursement standards under Medicare, Medicaid, and other payers do not provide the capital foundation for such purchases. As the opportunities for health

information exchange increase home health agencies need to be able to meet these demands function as a key component of longitudinal care coordination and patient centered care.

ALLOW PAYMENT FOR HOME HEALTH SERVICES FOR CENTER- BASED CARE FOR TECHNOLOGY-DEPENDENT CHILDREN

ISSUE: Medicaid waiver programs that provide funds for providing home and community-based services for technology-dependent children have not been sufficient to meet the demand for the delivery of care in non-institutional health care settings. According to a 2005 study it is estimated that 20 percent – 1 in 5 – of all the children discharged from the hospital were dependent upon technology in some way, and 1 percent needed a ventilator. The 2176 waiver program, often called the Katie Beckett Waiver program that gained popularity in the 1980s, enables severely disabled children to be cared for at home and receive ongoing long-term care that is financed by Medicaid. However, even with the addition of Medicaid waiver services to provide home health and personal care benefits at home, additional resources are required to provide families means to care for technology-dependent children.

At the same time, center-based care for technology-dependent children has developed in the United States as a means to provide relief to family caregivers; an opportunity for the technology-dependent child to avoid “institutionalization” at home; and as a means of meeting the medical and rehabilitative needs of the child. Center-based care provides a supplement to direct family services, allowing caregiving of technologically dependent children to receive care in a community-based location while still residing in their own home. However, Medicaid does not cover center-based care consistently across the nation.

RECOMMENDATION: Congress should pass legislation requiring mandatory Medicaid coverage of center-based care for technology-dependent children at day care centers. Medicaid administrators should also recognize the health and economic advantages of serving technology-dependent children in center-based care programs. In addition, more trained caregivers, better coordination of services, and improvements in the design of home-medical devices would all help to improve the lives of families with technology dependent children.

RATIONALE: Center-based care for technology-dependent children is a crucial care option which allows these children to be safely cared for and receive their medical and rehabilitative services in one central location. This coordination of care for technology- dependent children is also cost effective and optimizes outcomes. Further, it relieves families of their burden of 24-hour care.

COVER APPROPRIATE SELF-CARE TECHNOLOGIES UNDER MEDICARE

ISSUE: Internet-based self-care technologies—tools used by consumers and their nonprofessional caregivers to manage health issues either outside of formal medical settings or in collaboration with their health care providers—allow the disabled and infirm to gain increased access to health care professionals and self care management techniques while coping with acute and chronic illnesses. Individuals with diabetes, hypertension, COPD, and other chronic illnesses are their own primary care managers, at no cost to the health care system except when self-monitoring falls short of its capabilities. Applications that combine high-quality information with interactive components for self-assessment, decision support, or behavior change have the potential to reduce cost while maintaining the same or achieving better quality of care. Providing patients and their caregiver’s easy access to self-care technologies that make them less dependent on the health care system could reduce health care costs dramatically. Self-care technologies promise to improve quality of life for people with chronic health conditions and their caregivers, promote healthy communities by providing continuous personal health monitoring and individualized feedback and assure awareness of and access to continuous health data collected in nonclinical settings. Currently, Personal Health Records (PHRs) and Web-based monitoring technologies have interactive components, such as an “ask the doctor service” (via secure email consolation), wearable technologies for fitness, aging-in-place technologies, real-time monitoring, self-tests, online forms, and mobile health applications are evolving rapidly. Through the use of these technologies, individuals are able to self-monitor and obtain necessary insights as to when to contact professional health care providers. However, much of this technology is not covered under the Medicare benefit since it does not neatly fit within the benefit structure as “durable medical equipment” or otherwise.

RECOMMENDATION: Congress should provide Medicare coverage for medically-appropriate self-care technologies, support the availability and development of mobile health applications for use in the home and encourage the development and access to Personal Health Records and other technologies that will enable seniors to age-in-place.

RATIONALE: Self-care monitoring technologies can engage consumers to make better health care decisions, serve as a supplementary educational resource and help to prevent acute exacerbations of an individual’s condition thereby preventing or delaying costlier health care measures.

FINANCE A RESOURCE CENTER FOR HOME TELEHEALTH TECHNOLOGIES

ISSUE: Home telehealth technologies are quickly emerging in the marketplace. However, a comprehensive understanding of these technology options is not readily available to home health care and hospice providers. Therefore, NAHC through its affiliate Home Care Technology Association of America (HCTAA) has sought opportunities to increase resources available to home health care and hospice providers who are interested in health information technologies. HCTAA has sought funding increases for the Office of the Advancement of Telehealth (OAT) which provides funding for telehealth, telehomecare, home health grants, licensure, and home health demonstration projects. While congressionally-mandated projects have increased dramatically from 13 projects totaling \$16 million in FY 2000 to 114 projects totaling \$65 million in FY 2005, OAT's programmatic budget has been inadequate to fund the demand for telehealth and telehomecare projects. The inadequate programmatic budget has prevented OAT from comprehensively funding either the Telehealth Network (THGP) or the Telehealth Resource Center Cooperative Agreement Programs (TRCCP), which would systematically collect best telehealth practices and serve as a repository for information on things such as licensure, reimbursement, malpractice, etc. Supporting programmatic budget increases for OAT would help provide grants to fund a Resources Center for Home Telehealth Technologies.

RECOMMENDATION: Congress should fund the development and maintenance of a national resource center for home telehealth technologies that is available on the Internet and otherwise to home care providers. The center could provide guidance on the availability of technology, the status of any relevant Food and Drug Administration approvals, links to product evaluations, and funding availability.

RATIONALE: The use of technologies in home care has the potential of creating cost saving benefits to Medicare, Medicaid, and other federal health programs. A resource center will help facilitate acquisition and supplementation of appropriate technologies by home health care and hospice providers.

IV. RECOGNIZE THE APPROPRIATE ROLE OF HOME CARE AND HOSPICE AS PART OF ANY DISASTER PREPAREDNESS AND RESPONSE STRATEGY

DEVELOP A SYSTEM THAT INCLUDES THE NATIONAL HOME CARE AND HOSPICE NETWORK TO PROMOTE EFFECTIVE PREPAREDNESS FOR ANY RESPONSE TO NATURAL AND MANMADE DISASTERS

ISSUE: The terrorist attacks on New York City and Washington, DC, on September 11, 2001, and subsequent release through the U.S. Postal Service of active anthrax spores have dramatically underscored the vital role of all aspects of the health care delivery system, including home care and hospice, in addressing emergency situations. While the response to these unprecedented occurrences was exemplary, had there been large numbers of injured survivors, the entire health care system would have been taxed beyond capacity. Home care and hospice agencies can be a fundamental foundation that can support the traditional hospital health care system during a time of disaster, since hospitals have very little surge capacity.

Immediately following the terrorist attacks on New York City, home care agencies and home care clinicians provided services to 5000 patients at ground zero. They rode bicycles to access their patients and paid for needed food, medicine, supplies and water out of their own funds. Home care's role and inclusion in emergency preparedness is crucial, especially in an environment of syndromic surveillance, home isolation and home quarantine.

The hurricanes that struck the Gulf States in 2005, along with preparations for an impending influenza pandemic, have brought to light that meeting the health care needs of individuals in times of crisis will require more efficient use of our nation's health care resources than currently exists. Home care is just beginning to be included in planning proposals for handling large scale disasters. During hurricanes Katrina and Rita home care professionals were instrumental in caring for patients housed in shelters and non-traditional health care facilities. Their ability to deliver health services to individuals in non-structured environments without additional training makes them ideal as key responders in times of crisis. Home care providers can play a vital role in implementing pandemic influenza plans. Home care agencies already help hospitals manage surge capacity, administer vaccines and antiviral medications, and are in a position to participate in community outreach programs to disseminate necessary information to the public during an emergency. Yet, there is much that needs to be done to improve and ensure the readiness of home care professionals in the event of a national emergency.

On November 25, 2002, President Bush signed into law the "Homeland Security Act of 2002" (Public Law 107-296). The Department of Homeland Security's primary mission is to help prevent, protect against, and respond to acts of terrorism within our nation's communities. Title V of the law -- Emergency Preparedness and Response, directs the Secretary of Homeland Security to carry out and fund public health-related activities to establish preparedness and response programs. The Secretary is directed to assist state and local government personnel, agencies, or authorities, non-federal public and private health care facilities and providers, and public and non-profit health and educational facilities, to plan, prepare for, prevent, identify, and respond to biological, chemical, radiological, nuclear event and public health emergencies. Since September 11, 2001, tens of billions of dollars have been provided for first responders, including terrorism prevention and preparedness, general law enforcement, firefighter assistance, airport security, seaport security and public

health preparedness. As such, Medicare home care providers should be included in the Secretary's emergency and preparedness response programs since they can be found within the private as well as public and non-profit health care centers. Unfortunately, home health agencies and hospices have not been the recipients of federal funds nor have they been designated as first responders. The Department of Health and Human Services' Health Resources and Services Administration awarded \$4 million to health organizations in six states affected by the 2005 hurricanes to support development of communications networks. These grant recipients have not included home care and hospice in these communications networks.

Home care has its foundation in and continues to act as an important element in our nation's public health system. In fact, as federal funding for an effective public health infrastructure has failed to keep pace with need, the nationwide network of home care agencies and hospices frequently have performed important functions that protect and serve communities.

Today, home care and hospice care are the only "systems" that are oriented to the community in a broad enough way to provide a massive infrastructure. Furthermore, should in-home isolation be needed, the patient's home could be an option that could afford protection of the community at large.

Because of medical advances in recent years, we often focus on hospitals. We have made significant investments in inpatient facilities and technologies, sometimes at the expense of our public health system. Today, we find ourselves facing the need to put back in place a network of providers that is trained and able to serve the public in a mobile flexible manner. We need the health care equivalent of the armed forces reserves, and we have that in home care and hospice. Integrating and connecting home health and hospice providers to health care systems as well as to state and local governments can go a long way toward establishing and securing a preparedness and response program for the nation.

RECOMMENDATION: The Congress must provide the leadership and resources to ensure fail-safe communication, collaboration, and coordination between the Department of Homeland Security and state and local entities involved in protection of the public's health. This effort must include the home care and hospice infrastructure. Congress must act to ensure that home care agencies throughout the country have a better prepared workforce to deal with biological, chemical, and radiological events as well as mass admissions and public health emergencies. The following steps should be taken:

- Federal resources should be made available to home care and hospice providers for disaster planning, practice, and training.
- Federal funds should be made available to home care and hospice providers to educate and prepare them for nuclear, chemical and/or biological terrorism or a pandemic influenza outbreak.
- Federal appropriations from the Department of Health and Human Services Health Resources and Services Administration (HRSA) should be made available to home care agencies and hospices to spur the development of communications networks for use in emergency situations. Communication systems are needed to enable clinicians to communicate with other providers, as well as from patients' homes and from areas without power or phone availability. HRSA grants should be initiated that would allow agencies and hospices to buy and maintain satellites phones that would connect

to existing state and/or local emergency communications networks.

- Federal financing to develop home care and hospice electronic medical records should be considered a national security priority. Paperless documentation software and hardware would expand clinicians' ability to access patients' medical records.
- Federal resources should be made available to ensure coordinated disaster planning between hospitals and the home care and hospice systems, as easing pressure on hospitals is dependent on the ability of home care and hospice to provide services to those discharged, as well as to keep patients out of hospitals altogether where possible.
- Home care agencies and hospices should be included as vital participants in efforts to develop state emergency preparedness plans.

RATIONALE: With respect to preparedness and response to disasters affecting the public health, it is critical that home care agencies' and hospices' infrastructure be strengthened, and that the special qualities and abilities of health care providers of all types are utilized. As a discipline performed primarily in individual homes and the community, home care and hospice is essential to disaster preparedness and response efforts.

**V. ENSURE APPROPRIATE PAYMENT POLICY AND
REGULATION OF HOME CARE AND HOSPICE WHILE
EASING THE PAPERWORK BURDEN AND DUPLICATIVE
STATE AND FEDERAL REQUIRMENTS**

A. MEDICARE COVERAGE, ACCESS AND ELIGIBILITY

PRESERVE THE PUBLIC NATURE OF THE MEDICARE PROGRAM

ISSUE: The Medicare Prescription Drug, Modernization, and Improvement Act of 2003 (P.L.108- 173) intensified the trend of recent years to encourage greater participation by Medicare beneficiaries in private insurance plans. Many members of Congress have considered proposals that reduce federal responsibilities and further encourage private plan participation. During the 112th and 113th Congresses, efforts were made to transition Medicare from a public insurance program to a premium support model or “voucher” program where beneficiaries receive capped assistance to use towards a private insurance plan of their choice. Other proposals to reform Medicare include creating a Medicare exchange comprised of approved private insurance plans and the traditional Medicare plan serving as choices beneficiaries may select from. Beneficiaries would then receive “premium support” determined by income levels to use towards the exchange plan of their choice.

RECOMMENDATION: In any reform efforts, Congress should preserve the public nature of Medicare, as well as the social insurance model for financing Medicare, and oppose any efforts to income-relate beneficiary payments. While preparing the Medicare program for the changing coverage needs and demographics of the 21st century, Congress should ensure that Medicare continues to provide dependable, affordable, quality health care to older and disabled Americans.

As Congress considers Medicare reform proposals, it should be guided by the following principles:

Defined Benefits

- Medicare should continue to be a guarantee of specified benefits;
- Medicare payments must keep pace with the increase in the cost of these benefits and not be tied to budgetary targets;
- Medicare’s benefit package should provide access to the most current and effective medical treatments, technologies, and prescription drugs; and
- Medicare benefits should include health promotion and preventive care for all beneficiaries, including those with chronic illness.

Coverage

- Medicare should be a guarantee of coverage for all older Americans and persons with disabilities, regardless of income or health status, and include appropriate outreach;
- Medicare reforms must not reduce access to health care by raising the age of eligibility or by basing eligibility on income; and
- Medicare beneficiaries should continue to have access to a choice of providers and health plan options, including traditional Medicare, and supplemental coverage, as needed. Congress should reject Medicare voucher or premium support proposals.

Affordability

- Changes in Medicare financing and benefits should protect all beneficiaries from

burdensome out-of-pocket expenses, such as home health copayments, and should expand and improve programs for low-income beneficiaries.

Program Administration

- The Medicare program should be administered fairly, adequately, and efficiently, and appropriate funds must be provided for program administration;
- Medicare must attack waste, fraud, and abuse to ensure value for the program and for the beneficiaries; and
- The Medicare program should support competition and avoid fostering monopolistic markets through such means as competitive bidding, which reduces the number of Medicare providers and restricts beneficiary choice.

Quality Assurance

- All health options offered to Medicare beneficiaries must meet rigorous standards for consumer protections and quality of care, including a full and fair appeals system;
- Medicare beneficiary education should be strengthened and adequately funded;
- Medicare should find new ways to prevent the overuse, underuse, and misuse of health care services; and
- Medicare should monitor and extend the scope of service and treatment options for minorities and women and address the special needs of these populations.

RATIONALE: The Medicare program is a successful and popular program that provides vital health care to millions of elderly and disabled individuals. It has played a significant role through the years in improving the health and financial stability of senior citizens throughout the nation. Changing the program's financing from social insurance to income relating, or privatizing the program through vouchers, premium support or some other mechanism, would place many seniors at risk, seriously erode support for the program, and set a dangerous precedent for other programs.

ABOLISH THE INDEPENDENT MEDICARE PAYMENT ADVISORY BOARD

ISSUE: The Patient Protection and Affordable Care Act of 2010 (PPACA) establishes an Independent Payment Advisory Board (IPAB) that would make potentially binding recommendations to Congress regarding Medicare payment policy. The IPAB would have jurisdiction over home health services payment policy as early as 2015 and hospice payment policy after 2019. Under section 3403 of PPACA, the IPAB is directed to make recommendations to Congress that must be acted on within a designated time frame or the recommendations become law. Congress would only have authority to reject the recommendations without modification.

The IPAB is an unprecedented shift of power from Congress to a presidential appointed commission of private citizens. It usurps the long-standing power of Congress to enact laws that it deems in the public interest. Further, it virtually eliminates the power of citizens to petition Congress for redress of any grievances and to participate meaningfully in the process of making laws. The Protecting Seniors Access to Medicare Act (S.141/H.R.1190) would repeal this provision

RECOMMENDATION:

1. Congress should repeal section 3403 of PPACA.
2. Alternatively, Congress should amend section 3403 to return authority to Congress to determine what Medicare payment policy should be and limit the IPAB authority to an advisory role.
3. In the event Congress chooses to maintain IPAB, Congress should amend the authority of IPAB with respect to home health services to provide the IPAB with jurisdiction no earlier than 2018 following completion of the scheduled rate rebasing.

RATIONALE: Medicare is a public program and should be governed by the body elected by the citizens who are its beneficiaries. Transferring legislative power to a commission is a slippery slope that sets a dangerous precedent for future actions related to the balance of power in U.S. governance.

In the event that the IPAB is constituted unchanged from current law, it should not have the power to interfere with the payment system reforms already underway in Medicare home health services.

ESTABLISH REASONABLE STANDARDS FOR REBASING MEDICARE HOME HEALTH SERVICES PAYMENT RATES

ISSUE: The Patient Protection and Affordable Care Act of 2010 (PPACA) includes a requirement that Medicare payment rates for home health services be rebased with a four year phase-in beginning in 2014. PPACA provides limited guidance as to the standards that should be applied by Medicare in the rate rebasing. Specifically, rebasing must “reflect such factors as changes in the number of visits in an episode, the level of intensity of services in an episode, the average cost of providing care per episode, and other factors that the Secretary considers to be relevant.” This guidance falls short of the direction needed by Medicare to assure that rates are set a level that does not compromise access or quality of care.

The 2013 and 2014 congressional recommendations from the Medicare Payment Advisory Commission (MedPAC) advise Congress to accelerate rebasing with a two rather than four year phase-in. In a public meeting, a commission staff member suggested rates should be based on average costs although previous MedPAC commissioners (and staff) specifically indicated that cost is just one consideration.

Recent data indicates that Medicare margins for home health agencies are quickly declining as the numerous years of rate cuts take their toll. In addition, new regulatory-driven costs are being incurred by home health agencies with more expected in future years.

On November 23, 2013, CMS issued a Final Rule that sets Medicare home health payment rates based on a formula that ostensibly relates to the average cost of care. With this approach, CMS reduces base episode payment rates by the full 14% allowed under PPACA through a 4-year phase in of the rate changes. In addition, CMS limits the increases in per visit payment rates to 3.5% despite a finding that average costs of these visits is as much as 133% of the rates. 78 Fed. Reg. 72256 (December 2, 2013).

The rebased payment rates are founded in old data and based on a formula that ensures that aggregate payments to home health agencies is less than the cost of care. Forecasts of the impact of the new rates show that nearly 60% of all agencies will be paid less than their costs of care by 2017, the final year of the rate phase-in. In addition to the flawed data and rebasing formula, CMS failed to take into account all the costs of home care, the need for business capital by non-profit and proprietary agencies alike, and the wide variation in financial outcomes due to the unique aspects of delivery of care in individual’s homes rather than a single site institution.

Legislation was introduced in the 113th Congress to address the concerns with rate rebasing. The Medicare Home Health Rebasing Relief and Reassessment Act, HR 4625, would suspend the rebasing rule for 12 months and require that CMS reassess the rule and submit a report to Congress on alternative rebasing methods, including methods offered by stakeholders. The SAVE Medicare Home Health Act of 2014, HR 5110, would repeal 2015-2017 Medicare home health rebasing payment cuts, but offset the cost of repeal by requiring an equivalent level of home health payment cuts in 2019-2024 and establish home health value based purchasing program in 2019 that would put 17-28% of a home health agency’s Medicare payments at risk. These bills were not reintroduced in the 114th Congress.

The Medicare Payment Advisory Commission (MedPAC) is recommending to Congress that a second round of rate rebasing begin in 2018 as it is MedPAC’s position that payment rates are excessive. However, data indicates that by 2018, payment rates will lead to nearly 50% of all HHAs being paid less than the cost of care and providers subject to an average Medicare margin

just above zero percent.

RECOMMENDATION: Congress should postpone or suspend the implementation of the rate rebasing by the Centers for Medicare and Medicaid Services (CMS) until CMS provides a detailed report to Congress on the full impact of the changes on access to care. . Congress should ensure that CMS properly considers cost trends in home health agencies and the imposition of new costs not included in cost report databases. All types of home health agencies should be included in any CMS analysis of costs. Further, Congress should ensure that the rate rebasing include all usual and customary business costs consistent with standards under the Internal Revenue Code, including telehealth services, all disciplines of caregivers, and usual business operating expenses along with needs for operating capital and operating margins. Finally, Congress should reject MedPAC's recommendation for further rate rebasing.

RATIONALE: CMS's rate rebasing will effectively eliminate access to home health services in many parts of the country and trigger a high risk that quality of care will be compromised due to inadequate payment rates. While PPACA requires CMS to establish rebased payment rates, it also requires CMS to consider all relevant factors that will lead to continued access to care. CMS has undertaken no evaluation of its rebasing approach on care access and quality.

ENACT A MEDICARE OPERATED PRESCRIPTION DRUG BENEFIT UNDER TRADITIONAL MEDICARE WITH AUTHORITY TO NEGOTIATE PRESCRIPTION DRUG PRICES

ISSUE: The Medicare Modernization Act of 2003 established a prescription drug benefit under Part D of Medicare that allows only private companies to participate. The law prohibits traditional Medicare from providing a government-administered prescription drug plan and from negotiating drug prices with pharmaceutical companies. Under Part D, seniors must comparison shop among many unfamiliar private plans that have varying formularies, deductibles, premiums, co-pays, and coverage gaps. Plans may increase their prices or drop coverage of drugs needed by the enrollee.

RECOMMENDATION: Seniors should have the option of receiving drug coverage through the traditional Medicare program. A Medicare administered prescription drug benefit should be established with the authority to negotiate price discounts on prescription drugs and provide a more comprehensive formulary at lower uniform prices.

RATIONALE: Currently Medicare Part D has high administrative costs because over 3,000 private plans are competing to attract Medicare's 47 million beneficiaries. The Congressional Budget Office found that marketing costs and insurance industry profits will add \$38 billion to the cost of the drug benefit over the first eight years of the program. A study by the New England Journal of Medicine found that private insurance companies in the U.S. spend 11.7 cents of every health care dollar on administrative costs, compared with 3.6 cents for Medicare. (The New England Journal of Medicine, "Costs of Health Care Administration in the United States and Canada," Volume 349: 768-775, August 21, 2003.)

The Veterans Administration and Medicaid health care programs have negotiated significant price discounts on prescription drugs for veterans and Medicaid beneficiaries. A study by the minority staff at the House of Representatives Government Reform Committee found that the average drug prices offered by the ten leading part D plans were 84 percent higher than federally negotiated prices. ("New Medicare Plans Fail to Provide Meaningful Drug Price Discounts," prepared for Rep. Henry A. Waxman, Washington, DC: November 2005.)

The Medicare Modernization Act eroded the social insurance nature of the Medicare program by fracturing the "risk pool" with an overwhelming number of private Part D plans. The private plans that offer the most comprehensive drug benefits often come at a cost that many of America's oldest and frailest Medicare beneficiaries cannot afford. A Part D benefit operated by the traditional Medicare program could harness the purchasing power of millions of Medicare beneficiaries to deliver lower prescription drug prices.

MAKE PERMANENT THE ADD-ON FOR SERVICES TO RURAL PATIENTS; ENSURE CARE ACCESS FOR RURAL AND UNDERSERVED PATIENTS

ISSUE: The Balanced Budget Act of 1997 (BBA) made a number of dramatic changes in the Medicare home health benefit, including requiring that home health move to a prospective payment system (PPS) and imposition of an interim payment system (IPS) until PPS could be put in place. The stringent payment limits under IPS, which were in place from October 1997 through September 2000, reduced home health outlays far more than expected, resulting in widespread home health agency closures and problems for beneficiaries in obtaining access to care. While the Congress made some modifications to the changes to home health made by BBA, and implementation of the PPS in October 2000 has provided some stability to the industry, many agencies have remained financially strained. This is particularly the case in rural areas, evidenced by a continuing shortage of agencies.

Historically Medicaid payments for home health and home care have failed to reimburse agencies for the cost of delivering that care; as an increasing number of states struggle with financial concerns, the situation has become even more severe. Additionally, agencies are incurring significant unreimbursed costs to recruit and retain home care professionals and paraprofessionals, and better integrate the use of technologies in agency operations. As a result, agencies may be forced to refuse admission to patients whose care costs would place an agency at financial risk; further, insufficient payments could create perverse incentives to place limits on care, affecting the overall health care outcomes of patients.

In late 2000, as part of the Benefits Improvement and Protection Act (BIPA), Congress enacted a 10 percent add-on for care delivered in rural areas between April 2001 and April 2003. As part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Congress restored the rural add-on at a 5 percent rate for the April 2004 through March 2005 period. In early 2006, Congress approved legislation (S. 1932, Public Law 109-362) to provide a reinstatement of the 5 percent payment differential for calendar year 2006. During 2007 legislation was introduced that would reinstate the 5 percent rural add-on, and, as part of H.R. 3162, the full House of Representatives approved a two-year extension of the 5 percent rural add-on for 2008 and 2009, but no further action was taken. The 5 percent payment differential expired at the end of 2006. During 2008 there were serious attempts by the Senate Finance Committee to reinstate the add-on that failed due to lack of a funding source.

The health reform legislation passed in 2010, the Patient Protection and Affordable Care Act (H.R. 3590; P.L. 111-148), reinstated a 3 percent differential payment for home health services delivered to residents of rural areas. Under the legislation the “add-on” payment became effective for visits ending on or after April 1, 2010, and before January 1, 2016. The rural add-on was extended to the end of 2017 in the Medicare Access and CHIP Reauthorization Act of 2015 (H.R.2/Pub Law No: 114-10). The Preserve Access to Rural Home Health Services Act of 2015 (S. 2389) would extend the rural add-on to the end of 2022.

RECOMMENDATION: Congress should permanently extend the payment differential (“add-on”) for care delivered in rural areas. Congress must also closely monitor the home health PPS to ensure that individual case payments are sufficient to maintain access to care. Finally,

Congress should monitor adequacy of PPS payments so that agencies in underserved areas (rural, inner city, medical shortage areas) can continue to provide care to Medicare beneficiaries.

RATIONALE: Under current policies, there is no guarantee that the individual Medicare payment rates will be sufficient to cover the costs of care, particularly for higher-cost patients. The system also provides very limited allowance for agency costs that exceed the national rates. However, some agencies have much higher costs due to higher case mix, travel time, the need to provide escort services, and the like. In order for the home health PPS to be successful, it must be sensitive to variations in the health care marketplace that contribute to extraordinary care delivery costs. Finally, in cases where sufficient justification is available, case mix adjusters should be increased to ensure adequate reimbursement for care.

OPPOSE A “SICK TAX”—BLOCK EFFORTS TO IMPOSE A FEE TO BE PAID BY PATIENTS TO ACCESS MEDICARE HOME HEALTH SERVICES

ISSUE: Congress eliminated the home health copayment in 1972 for the very reasons that it should not be resurrected now. The home health copayment in the 1960s and 1970s deterred Medicare beneficiaries from accessing home health care and instead created an incentive for more expensive institutional care.ⁱ However, some policymakers have suggested adding copayments for Medicare home health services as a means of both reducing the deficit and limiting the growth of Medicare home health expenditures. Some Medicare Advantage (MA) plans have imposed home health copays.

The National Commission on Fiscal Responsibility and Reform (2010) (the “Bowles-Simpson plan”) recommended a uniform 20 percent copay for all Medicare services, including home health care. This would amount to a \$600 copay to access an episode of home health care. The Congressional Budget Office (CBO) put forth a 10 percent home health copay (\$300 per episode) as one of its budget options for deficit reduction, a proposal that received support from the Republican Study Committee. The Medicare Payment Advisory Commission (MedPAC) recommended a home health copay (as much as \$150 per episode) for episodes not preceded by a hospital or nursing home stay. Since 2011, the President’s budget proposals have included a \$100 home health copay for episodes not preceded by a hospital or nursing home stay, beginning in 2019 for newly eligible Medicare beneficiaries.

RECOMMENDATION: Congress should oppose any copay proposal for Medicare home health services and prohibit Medicare Advantage plans from charging a home health copay. Reinstating the copay today would directly conflict with the goal of Congress to modernize the Medicare program.

RATIONALE:

- **Home health copayments would create a significant barrier for those in need of home care, lead to increased use of more costly institutional care, and increase Medicare spending overall.** The Urban Institute’s Health Policy Center found that home health copays “...would fall on the home health users with the highest Medicare expenses and the worst health status, who appear to be using home health in lieu of more expensive nursing facility stays.”ⁱⁱ Similarly, a study in the *New England Journal of Medicine* found that increasing copays on ambulatory care decreased outpatient visits, leading to increased acute care and hospitalizations, worse outcomes, and greater expense.ⁱⁱⁱ The same adverse health consequences and more costly acute care and

ⁱ Congressional Record, October 5, 1972, p. 33939.

ⁱⁱ Urban Institute Health Policy Center, “A Preliminary Examination of Key Differences in Medicare Savings Bills,” July 13, 1997.

ⁱⁱⁱ Trivedi, Amal N., Husein Moloo and Vincent Mor, “Increased Ambulatory Copayments and Hospitalizations among the Elderly,” *New England Journal of Medicine*, January 2010.

hospitalizations would likely result from the imposition of a home health copayment. The National Association of Insurance Commissioners concluded that beneficiaries, in response to increased cost sharing, “may avoid necessary services in the short term that may result in worsening health and a need for more intensive care and higher costs for Medicare in the long term.”^{iv} According to an analysis by Avalere, a home health copayment could increase Medicare hospital inpatient spending by \$6-13 billion over ten years.^v

- **Copayments are an inefficient and regressive “sick tax” that would fall most heavily on the most vulnerable—the oldest, sickest, and poorest Medicare beneficiaries.** About 86 percent of home health users are age 65 or older, 63 percent 75 or older, and nearly 30 percent 85 or older. Sixty-three percent are women.^{vi} Home health users are poorer on average than the Medicare population as a whole. Home health users have more limitations in one or more activities of daily living than beneficiaries in general.^{vii} The Commonwealth Fund cautioned that “cost-sharing proposals, such as a copayment on Medicare home health services, could leave vulnerable beneficiaries at risk and place an inordinate burden on those who already face very high out-of-pocket costs.”^{viii}
- **Most people with Medicare cannot afford to pay more.** In 2013, half of Medicare beneficiaries—more than 25 million seniors and people with disabilities—lived on incomes below \$23,500.^{ix} On average, Medicare households already spend 14 percent of their income on health care costs, about three times as much as non-Medicare households.^x
- **Low-income beneficiaries are not protected against Medicare cost sharing.** Eligibility for assistance with Medicare cost sharing under the Qualified Medicare Beneficiary (QMB) program is limited to those with incomes below 100% of poverty (\$11,412 for singles, \$15,372 for couples) and non-housing assets below just \$6,940 for singles and \$10,410 for couples. Even among Medicare beneficiaries eligible for QMB protection, only about one-third are actually enrolled in the program.^{xi}
- **Individuals receiving home care and their families already contribute to the cost of their home care.** With hospital and skilled nursing facility care, Medicare pays for room and board, as well as for extensive custodial services. At home, these services are provided by family members or paid out-of-pocket by individuals without family support. Family members are frequently trained to render semi-skilled support services for home

^{iv} National Association of Insurance Commissioners, Senior Issues Task Force, Medigap PPACA Subgroup, “Medicare Supplemental Insurance First Dollar Coverage and Cost Shares Discussion Paper” (October 2011).

^v Avalere Health LLC, “Potential Impact of a Home Health Co-Payment on Other Medicare Spending,” July 12, 2011.

^{vi} CMS Office of Information Services, Medicare & Medicaid Research Review/2011 Supplement, Table 7.2.

^{vii} Avalere Health LLC, “A Home Health Copayment: Affected Beneficiaries and Potential Impacts,” July 13, 2011.

^{viii} The Commonwealth fund, “One-Third At Risk: The Special Circumstances of Medicare Beneficiaries with Health Problems,” September 2001.

^{ix} <http://kff.org/medicare/issue-brief/income-and-assets-of-medicare-beneficiaries-2013-2030/>

^x <http://kff.org/medicare/issue-brief/health-care-on-a-budget-the-financial-burden-of-health-spending-by-medicare-households/>

^{xi} Government Accountability Office, “Medicare Savings Programs: Implementation of Requirements Aimed at Increasing Enrollment,” GAO-12-871 (September 2012)

health care patients. Family caregivers already have enormous physical, mental and financial burdens, providing an estimated \$470 billion a year in unpaid care to their loved ones, and too frequently having to cut their work hours or quit their jobs.^{xii}

- **Copayments as a means of reducing utilization would be particularly inappropriate for home health care.** Beneficiaries do not “order” home health care for themselves. Services are ordered by a physician who must certify that services are medically necessary, that beneficiaries are homebound and meet other stringent standards. There is scant evidence of overutilization. Adjusted for inflation, home health spending on a per patient basis and overall Medicare spending on home health is less today than in 1997. The Medicare home health benefit has dropped from 9.5 percent of Medicare spending in 1997 to 5.9 percent and serves a smaller proportion of Medicare beneficiaries today than in 1997.^{xiii}
- **Home health copayments would shift costs on to states.** About 15 percent of Medicare beneficiaries receive Medicaid. Studies have shown that an even larger proportion (estimated to be about 25 percent by MedPAC) of Medicare home health beneficiaries are eligible for Medicaid. A home health copayment would shift significant costs to states that are struggling to pay for their existing Medicaid programs. In addition, states would have to pick up their Medicaid share of new QMB assistance obligations.
- **Medicare supplemental insurance cannot be relied upon to cover home health copays.** There is no requirement that all Medigap policies cover a home health copay and only 23 percent of Medicare beneficiaries have Medigap coverage. For the 26 percent of Medicare beneficiaries who have supplemental coverage from an employer sponsored plan, there is no assurance that these plans will be expanded to cover a home health copay or remain a viable option for beneficiaries, given the current trend of employers dropping or reducing retiree coverage.^{xiv} The 30 percent of beneficiaries enrolled in Medicare Advantage (MA) plans would not be protected from a home health copay, as many MA plans have imposed home health copays even in the absence of a copay requirement under traditional Medicare.^{xv}
- **Copayments would impose costly administrative burdens and increase Medicare costs.** Home health agencies would need to develop new accounting and billing procedures, create new software packages, and hire staff to send bills, post accounts receivable, and re-bill.

^{xii} L. Feinberg, S.C. Reinhard, A. Houser, and R. Choula, “Valuing the Invaluable: 2011 Update, the Growing Contributions and Costs of Family Caregiving,” AARP Public Policy Institute Insight on the Issues 51 (Washington, DC: AARP, June 2011).

^{xiii} CMS Research, Statistics, Data, and Systems/Statistics, Trends and Reports, Medicare Medicaid Stat Supp/2011 (Tables 3.1 and 7.1).

^{xiv} <http://kff.org/medicare/issue-brief/medigap-reform-setting-the-context/>

^{xv} <http://kff.org/medicare/issue-brief/medicare-advantage-2015-data-spotlight-overview-of-plan-changes/>

ANY RESTRUCTURING OF MEDICARE COST SHARING SHOULD NOT LEAD TO BARRIERS TO HOME HEALTH SERVICES OR HOSPICE CARE

ISSUE: Proposals have been raised that would change the beneficiary cost-sharing structure of Medicare from its current system of premiums and deductibles, coinsurance, and copayments targeted to certain care. Among the proposals is one from President Obama's National Commission on Fiscal Responsibility and Reform 2010 report that would essentially blend much of the service-specific cost sharing into a non-specific global deductible and copayment. If such a change is enacted, Medicare beneficiaries who now receive home health services and hospice care without cost sharing would face significant financial obligations to access this care.

The proposals also include limitations on coverage of cost sharing obligations by so-called Medigap supplemental insurance policies, prohibiting first dollar coverage

The use of global cost sharing may have surface appeal, but it can act as a barrier to care that is less costly and clinically better than care in other settings. Over the years, Congress intentionally excluded home health services from cost sharing and allowed only very limited hospice cost sharing because it wanted to encourage the use of these services as better alternatives than costly institutional care or curative care at the end-of-life.

RECOMMENDATION: Congress should preserve the principle operative in Medicare that encourages the use of cost effective care alternatives such as home health services and hospice care in any restructuring of beneficiary cost sharing. Any proposals to revise the current cost sharing approaches through global deductibles and copayments (or their equivalents) should be rejected. Cost sharing standards should be designed to bring financial stability to Medicare through incentives to use high value services such as home health and hospice. Medicare beneficiaries should be able to purchase supplemental insurance to cover co-pays and deductibles without any limitation. Congress should reject any legislative proposals that establish limits on Medigap insurance.

RATIONALE: Studies have shown that Medicare beneficiaries will avoid lower cost, but clinically sufficient, services if it means also avoiding increased cost sharing. Any restructuring of Medicare beneficiary cost sharing should come about only with recognition of this fact. Medigap insurance should not be restricted as beneficiaries should have the right to protect themselves against the cost of health care.

ENACT A HOMEBOUND DEFINITION THAT ENSURES ACCESS AND ELIGIBILITY FOR NEEDED HOME HEALTH SERVICES

ISSUE: Under existing Medicare policy an individual receiving home health care services must be “homebound.” Homebound is defined as having “a condition due to an illness or injury that restricts their ability to leave their place of residence except with the aid of: supportive devices...or the assistance of another person.” According to the longstanding Medicare policy, if a person leaves their home, “absences must be infrequent or for periods of relatively short duration,” unless for medical purposes. Congress and the Administration have expressed an interest in redefining the eligibility criteria needed to be considered homebound under the Medicare home health benefit. The President, in his fiscal year 1998 budget package, put forward a proposal that would have severely restricted access to the home health benefit for many seniors and disabled individuals who are in need of this care, and would have made home care providers responsible for knowing the whereabouts of their patients at all times.

Congress rejected this proposal. Instead, under the Balanced Budget Act of 1997, the Secretary of Health and Human Services was required to study the criteria for determining an individual’s homebound status. The study, in essence, recommended no changes to the current definition of homebound.

There are special considerations for pediatric home care patients. Pediatric home care patients benefit from being able to attend school and play outdoors to the extent that they are able to do so. CMS has clarified that, under the Medicaid program, the homebound requirement is inappropriate in such cases.

Section 702 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173) required the Secretary of Health and Human Services to conduct a two-year demonstration project where beneficiaries enrolled in Medicare Part B with specified chronic conditions would be deemed to be homebound in order to receive home health services under Medicare. The Secretary was required to select three states – one state in each of the northeast, Midwest, and western regions of the United States in which to conduct the demonstration. The states chosen were Massachusetts, Missouri, and Colorado.

After completion of the demonstration, the Secretary reported that participation in the program was very low because of the agencies’ fear of losing money on costlier patients; agency difficulties enrolling Medicaid-eligible beneficiaries who did not wish to switch services; agency estimates that they would be paid less for care under the Medicare benefit; agencies’ concerns that potential enrollees would not benefit from the program; and unduly restrictive eligibility requirements. The demonstration failed to produce sufficient data to make recommendations regarding changes to the homebound definition. In 2013 the Long Term Care Commission recommended eliminating the homebound restriction.

RECOMMENDATION: Congress should enact a homebound definition that ensures access and eligibility to the home health benefit based upon the beneficiary’s functional limitations and clinical condition, rather than an arbitrary number of absences from the home. The definition should guarantee that reasonable absences from the home for medical and nonmedical purposes would not disqualify an individual from home health eligibility. The definition should not put

additional administrative burdens on home care providers beyond documentation of the beneficiary's functional and clinical status.

RATIONALE: The homebound criteria should be redefined in a way that does not require individuals to be bedbound or confined to their homes in order to receive the care they need. Many homebound people are able to go for short walks, although only with substantial assistance. Pediatric patients in need of care should not risk losing their care because they have stepped outside of their homes. Home care services are best provided within the context of the child's own environment. This is also safer from a medical standpoint, since outpatient facilities can expose a child to secondary infections.

ALLOW PAYMENT FOR HOME HEALTH SERVICES FOR THOSE RECEIVING ADULT DAY CARE

ISSUE: Home care, along with other health care services, has evolved in response to technological and economic changes. With these advances has come the opportunity for deinstitutionalization of many patients who would otherwise require hospital or nursing home care. At the same time, adult day care has developed in this country as a means to provide respite to family caregivers, an opportunity for the elderly patient to avoid “institutionalization” at home, and as a means of meeting social and health-related needs of the patient.

During 2000, as part of its legislation to address some of the unintended consequences of the Balanced Budget Act of 1997, the 106th Congress provided clarification of the homebound definition under the Medicare home health benefit. This clarification allows Medicare home health patients regular absences from the home for the purpose of participating in therapeutic, psychosocial, or medical treatment in an adult day-care program. An evaluation of this amendment and its effect on the cost and access to Medicare home health services was conducted by the General Accounting Office (GAO), which found that the recent changes to the homebound definition will have “little effect on costs and access” to home health services (“Medicare Home Health: Clarifying the Homebound Definition is Likely to Have Little Effect on Costs and Access,” GAO-01-555R, 4/26/2002).

Section 703 of the Medicare Prescription Drug, Improvement, and Modernization Act (H.R.1; Public Law 108-173), passed by Congress in 2003, required the Secretary of HHS to establish a three-year demonstration project in not more than five states, under which a home health agency, directly or under arrangement with a medical adult day care facility, provides medical adult day care services as a substitute for a portion of home health services otherwise provided in a beneficiary’s home. The agencies chosen to participate are Aurora Visiting Nurse Association, Milwaukee, Wisconsin; Doctor’s Care Home Health, McAllen, Texas; Landmark Home Health Care Services, Allison Park, Pennsylvania; Metropolitan Jewish Health System, Brooklyn, New York; and Neighborly Care Network, St. Petersburg, Florida.

Phase I included case studies to assess the implementation, interviews with beneficiaries and home health agencies, and an analysis of beneficiary characteristics and services provided by selected demonstration sites to enrolled beneficiaries. Phase II, which ran through September 2009, focused on selection and matching of control patients and an analysis of the use and cost of home health services among both demonstration site beneficiaries and the control patients. An evaluation and report on the demonstration project by CMS failed to show savings or improvements in quality of care, but did show high rates of satisfaction among beneficiaries participating in the demonstration project.

Legislation, the Medicare Adult Day Care Services Act, was introduced in the 109th, 111th, 112th, and 113th Congresses which would permit Medicare home health services to be provided at adult day centers if the center becomes Medicare- certified.

RECOMMENDATION: Congress should pass legislation amending the Medicare home health services benefit to allow for coverage of “home health services” provided to “homebound” patients at adult day centers. Reimbursement for services provided at adult day centers should be set at levels sufficient to achieve access. Congress should require that adult day centers offering home health services meet national standards established by Medicare for adult day facilities. In

cases where these centers provide home health services, they should be required to meet the Medicare home health Conditions of Participation and be a Medicare-certified home health agency. Medicare payments for home health services should be disbursed to certified home health agencies, not to adult day facilities. Home health agencies should be allowed to provide adult day facility services either by meeting Medicare's adult day facility standards or by contract with a Medicare-certified adult day center.

RATIONALE: The Medicare program could better serve the interests of beneficiaries by allowing coverage of home health services provided by home health agencies at adult day centers. This would enable patients to socialize outside the home, which would improve their mental health.

MAKE OCCUPATIONAL THERAPY AND SOCIAL WORK SERVICES QUALIFYING SERVICES FOR MEDICARE HOME HEALTH

ISSUE: The Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35) eliminated occupational therapy as a basis for initial entitlement to home health benefits (although physical or speech therapy alone continue as a basis for entitlement). Once eligible for home health services, patients may, however, continue to receive occupational therapy even if other skilled services are no longer required. Additionally, medical social work services can only be provided after the opening of a case by a qualifying service and must be terminated prior to the closing of the qualifying service. This results in fractured services to patients due to social work's delayed entrance into a case and premature or unplanned termination.

In 2009, Rep. John Lewis (D-GA) introduced H.R. 1094, the Medicare Home Health Flexibility Act of 2009, which would permit a home health agency to determine the most appropriate skilled service to make the initial assessment visit for an individual who: (1) is eligible for Medicare home health services; but (2) does not require skilled nursing care, as long as that skilled service is included as part of the plan of care for such services. The legislation specifically permits an occupational therapist to make the initial assessment visit in such a case if occupational therapy is included in such plan in the initial physician referral in conjunction with physical therapy or speech language pathology services. The provisions of H.R. 1094 were included in the House-passed version of health reform legislation (H.R. 3962) but were not part of the final legislation signed into law in early 2010 as Public Law 111-148. In 2015 Senators Ben Cardin (D-MD) and Dean Heller (R-NV) reintroduced the Medicare Home Health Flexibility Act (S.2364).

RECOMMENDATION: Congress should restore occupational therapy as a skilled service qualifying for the Medicare home health benefit and allow home health agencies to use occupational therapists for the conduct of the initial home health visit in appropriate instances. Medical social services should also be deemed as a qualifying service for purposes of establishing home health eligibility.

RATIONALE: Occupational therapy and medical social services should be accorded full qualifying service status to assure beneficiary access to the most appropriate skilled service. This action would also allow flexibility within home health agencies to streamline beneficiary care planning by maximizing patient recovery and functional performance within the prospective payment system.

A small number of Medicare patients need only occupational therapy or medical social work and no other skilled service. Occupational therapy enables a patient to learn or relearn activities of daily living and decreases the need for other forms of assistance, such as personal care. Occupational therapy promotes independence and self-sufficiency and has great potential for reducing institutionalization.

Medical social work can prevent institutionalization by decreasing the social and economic problems that have a negative impact on a patient's response to treatment and increase the patient's ability to remain at home. Medical social work can also reduce the number of visits

for other home care services by strengthening the family and other support systems. In addition, medical social work services can reduce crises that lead to rehospitalization through long-term planning and crisis management.

B. MEDICARE PAYMENT METHODOLOGY

REFINE MEDICARE HOME HEALTH PPS OUTLIER PAYMENT

ISSUE: The Balanced Budget Act of 1997 (BBA) required implementation of a home health prospective payment system (PPS), including designation of 5 percent of anticipated expenditures for “outlier” patients – those patients whose care is particularly costly to agencies. In implementing this mandate, the Centers for Medicare & Medicaid Services (CMS) created an outlier payment methodology that includes shared losses with the provider of services through the use of an eligibility threshold and percentage payment on costs above that eligibility threshold. CMS could alter the “fixed dollar loss ratio (FDL)” for any future year based on the level of spending for outlier payments in the previous year to keep overall outlier spending in check. If spending for outlier cases was high in a given year, CMS could increase the FDL ratio so that fewer outlier payments would be issued in the following year.

In the first few years of PPS, only a portion of the outlier budget (between 2 and 3 percent) was actually being spent. At the same time, there was strong evidence that certain long term and high-cost home health patients were no longer being served in the home care setting, but instead were receiving care in skilled nursing facilities.

In more recent years, overall outlier spending increased significantly, due primarily to anomalous claim practices in the Miami-Dade, Florida area, where outlier spending jumped to over \$300 million in 2005. In the rest of the nation, outlier spending totaled approximately \$350 million overall in the same year. This anomaly was ignored initially by CMS, despite its awareness of the matter and the instigation of enforcement activities to put a stop to abusive outlier claims.

As part of health reform legislation approved in 2009, the House of Representatives included a series of swift, deep, across-the-board cuts to home health; if enacted, these cuts would have threatened the financial viability of numerous home health agencies throughout the nation and, in turn, access to vital services for elderly and infirm Medicare beneficiaries. As an alternative to these deep cuts, the home health industry recommended that Congress address outlier abuses through reduction of the overall annual home health outlier budget to 2.5 percent of program outlays and imposition of an agency-specific outlier limit of 10 percent of Medicare payments. The industry proposal was included in the final health reform legislation approved by the Senate and ultimately signed into law (Public Law 111-148) by President Obama on March 23, 2010. The outlier provisions became effective January 1, 2011.

RECOMMENDATION: Congress should monitor implementation of the new outlier limitations to ensure that past abuses of the payment system are eliminated, while ensuring that beneficiaries who are legitimate “outliers” continue to have access to needed services, and the agencies that serve them are appropriately compensated.

RATIONALE: The original outlier payment methodology was established based upon speculation and assumptions that have not proven accurate. Actions taken by the Congress as part of P.L. 111-148, if implemented appropriately, should help to ensure that outlier payments are targeted appropriately. However, close monitoring of these significant changes to the outlier

policies must be monitored to ensure that beneficiaries – and the agencies that serve them – are protected.

ENSURE APPROPRIATE DEVELOPMENT OF PERFORMANCE-BASED PAYMENT FOR MEDICARE HOME HEALTH SERVICES

ISSUE: The latest trend in health care payment policy revolves around paying providers based on the quality of care they provide and the success of their treatment patterns. “Pay for performance” (P4P) systems acknowledge financial remuneration as one of the strongest incentives available; they can be designed to reward providers based on use of certain processes of care, outcomes of care, or patient satisfaction. Incentive payments can be designed in a variety of ways – for example, payers could impose a “withhold” of a certain amount on each patient until such time as performance can be assessed or payers could receive an additional payment if it is found that they have relatively high performance standing. While P4P has been used by private payers and on a limited basis in Medicare, it is now gaining the attention of federal policymakers. The Medicare Payment Advisory Commission (MedPAC) has recommended application of a “pay for performance” system for home health and other Medicare provider payments. At the close of 2005, legislation was pending in the Congress that would make a first step toward P4P for home health agencies by requiring, beginning in 2007, reporting of quality data. Agencies that failed to report the data would lose a percentage of their Medicare payments.

Starting in 2008, Medicare began a two-year P4P demonstration project operating in seven states. Under that demo, home health agencies qualify for incentive payments based on high quality of care performance or improvement in performance from the previous year. The incentive payments are based upon the impact that the performance has had on reducing Medicare costs in other health care sectors, including hospital care. This approach recognizes the dynamic value that high quality home health services can have in overall health care spending. Data on savings during 2008 was analyzed during 2009, and 2009 data was analyzed in 2010. CMS announced that it shared more than \$15 million in savings with 166 home health agencies based on their performance during the first year of the Medicare Home Health Pay for Performance demonstration. Another \$15 million in savings was shared with the agencies in 2010.

In the 2015 HHPPS rate rulemaking, CMS initiated a value-based purchasing pilot program in 9 states on a mandatory basis which will withhold 3-8% of payments to fund an incentive pool. NAHC raised concerns about the size of the incentive pool, which contrasts with the 2% withhold that is the maximum allowed for hospitals and skilled nursing facilities under their VBP efforts. NAHC also expressed concerns with the absence of information on the VBP measures that would be employed along with the incentive distribution model. The Chairman of the House Ways and Means Committee, Kevin Brady (R-TX), introduced the Medicare Post-Acute Care Value-Based Purchasing Act of 2015 (H.R.3298) which would replace the separate VBP programs put forth by CMS with a single VBP program for all post-acute providers. It would also withhold 3-8 percent to fund an incentive pool and rely on a single performance measure based on average spending per patient.

RECOMMENDATION: Congress should monitor the progress of the ongoing value-based purchasing demonstrations or proposals and use the findings to guide its consideration of value-

based payment for Medicare home health services. Any action in this area must:

1. Be developed in conjunction with provider stakeholders;
2. Be tested as a pilot program prior to full-fledged implementation;
3. Be fair in its assessment of the quality of care provided to home health patients and incorporate pending OASIS changes, as well as a mix of multiple process and outcome measures;
4. Refrain from negatively affecting patient access to care;
5. Be consistent with the home health PPS and appropriately risk-adjusted;
6. Limit any expansion of data collection requirements and fully reimburses agencies for the costs of any additional data collection requirements that are imposed;
7. Only reward agencies for care elements over which they have some control;
8. Reward high scoring agencies as well as those that demonstrate improvement for the dynamic value of home health services to the entire Medicare program;
9. Not pose cash flow difficulties for agencies, with the incentive pool not to exceed 2 percent of home health payments; and
10. Allow the Secretary of Health & Human Services sufficient discretion to delay application of value-based purchasing if implementation concerns arise.

RATIONALE: When the home health PPS system was implemented in October 2000 it was virtually untested. Since that time a number of problems have been identified in the system. CMS has developed refinements to the existing PPS for home health; it may be another year or two before the impact of these refinements are known. It takes time for providers to adapt to changes in payment and treatment methods. Further, a number of factors beyond a home health agency's control can affect patient outcomes – including patient compliance with self-care regimens or the absence or presence of a responsible caregiver in the home. Development and application of any value-based purchasing model must be approached very cautiously to ensure that incentives are properly and fairly crafted.

REFORM ANNUAL MEDICARE INFLATION UPDATE CALCULATION METHOD

ISSUE: Home health and hospice service payment rates under Medicare are annually updated by a market basket index (MBI). The MBI is intended to reflect changes in the cost of the delivery of services from the previous year. However, the MBI relies on cost input proxies and a weighting of the inputs that reflects cost report experiences from several years in the past. On an irregular basis, Medicare reexamines the inputs, proxies, and respective weights assigned to the inputs. In the 2008 rate regulation, Medicare updated the base year for determining the MBI to 2003 using filed, but not audited cost reports. In that rulemaking, Medicare noted the call from home health care to reweight the MBI on a more frequent basis, but made no commitment to do so.

The current formulas for calculating the MBI for home health and hospice have resulted in inflation updates that are lower than the updates calculated for hospital and outpatient services despite the similarities in cost factors in providing the services. In 2014, the hospital update is 2.7 percent in comparison to a 2.3 percent update for home health services. It is believed that the current MBIs do not adequately take into account transportation, clinical professional, technology, and drug-related costs (among others) that make up the changing costs in home health services and hospice. Part of the problem is explained in Medicare's use of unaudited cost report data that is notoriously unreliable.

Further, the forecasting system employed by Medicare to trend cost changes into succeeding years has often underestimated the increase in costs. For example, the 2005 and 2006 forecast for transportation costs showed a minimal increase that fell far short of reality when gas prices soared. Similarly, the 2009 forecast on staff salaries shows that hospital and nursing home staff salaries will increase at a significantly higher rate than in home health services despite the fact that similar staff are employed by these providers.

Another flaw in the MBI calculation is that it does not address new regulatory costs that occur as a result of legislative and regulatory change. For example, in 2012 home health agencies can expect higher administrative costs due to the physician face-to-face encounter rule as well as new rules requiring compliance plans, intensified provider screening, and PECOS enrollment for physicians ordering home health services.

CMS rebased and re-weighted the Market Basket Index formula for CY2013. That action showed that significant changes had occurred since the last time a similar change occurred.

RECOMMENDATION: Congress should require the Centers for Medicare & Medicaid Services to rebase and re-weight the MBI at least every three years, along with an analysis as to the appropriateness of the price inputs used in the MBI calculation. In addition, Congress should require that Medicare utilize audited cost report data and more than a single forecasting system in estimating succeeding year costs. Finally, Congress should require CMS to incorporate a forecasting model for new regulatory costs into the MBI updates.

RATIONALE: Home care and hospice is changing rapidly in terms of the patients served and the elements of service to the patients. Pharmaceuticals have become a central part of hospice. Technology-based care has grown in use as part of home health services. At the same time, normal costs such as transportation have increased much beyond the projections by the Medicare

program. Finally, the various providers all compete in the same labor marketplace for nurses, therapists, and aides. As such the variation in the inflation updates should never be significant. The MBI is the mechanism by which the changes in costs and prices are reflected in payment rates; every effort should be made to ensure that it reflects those costs and prices.

ESTABLISH TRANSPARENT AND ACCURATE PROCESSES FOR MODIFICATION OF PPS PAYMENT RATES AND CASE-MIX ADJUSTMENTS

ISSUE: Under the Balanced Budget Act of 1997, Congress mandated the creation of a Medicare home health prospective payment system (PPS). That system of PPS was implemented by the Centers for Medicare & Medicaid Services (CMS) on October 1, 2000. At that time, CMS was authorized to annually adjust payment rates solely through the use of a market basket index, which is intended to reflect cost inflation in the delivery of home health services. In addition, CMS is required to include a case-mix adjustment component to PPS to set payment rates in a manner which reflects the varying use of clinical resources among the population of patients receiving Medicare home health services.

Under the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), CMS is authorized to make adjustments in the standard prospective payment amount if it is determined that the changes in the overall case mix result in a change in aggregate payments, whether the result of “upcoding” or classification in different units of service that do not reflect real changes in case-mix. In addition to this payment rate adjustment authority, CMS intends to regularly adjust the case-mix weights with system refinements based upon an expanded database.

CMS revised PPS, including a modified case mix adjustment model, with implementation in January 2008. The changes included an 11.75% rate reduction phased in over four years triggered by a finding that coding weights had increased beyond levels justified by changes in patient characteristics. Additional rate reductions related to changes in the average case mix weights of 3.79% occurred in 2011 and 2012.

In response to the regulatory rate reductions, beginning in 2007 legislation (The Home Health Care Access Protection Act) has been introduced annually in both houses of Congress that would require CMS to utilize a rational and transparent process for adjusting rates under the BIPA authority. That legislation proposes detailed standards such as the use of a Technical Advisory Group, consideration of service utilization through service reviews rather than statistical assumptions, and a full public display of the data and analysis prior to the finalization of rate adjustments. The legislation was refilled in the 112th Congress (S. 659). Unfortunately, the proposed legislation did not advance. In its 2011 rulemaking, CMS promised to revisit its process for evaluating changes in case mix weights. However, CMS did not agree to voluntarily utilize the process prescribed in the bills. In its 2012 and 2015 HHPPS rate rulemaking, CMS recalibrated the case mix adjustment model, but failed to provide comprehensive information regarding that recalibration. As such, affected parties were unable to assess the validity or reliability of the recalibration.

The 2016 HHPPS rate rulemaking included a new case mix weight change adjustment that relied partially on previous methods of evaluating “real” and “nominal” case mix weight changes that perpetuated the problems seen with earlier adjustments. However, CMS employed a new methodology for determining the proportion of change that is considered to be “nominal” or unrelated to changes in patients. That method took the average proportion of nominal changes in case mix weights for the period of 2001 to 2010 and applied it to the case mix weight change level in 2012 to 2014. All earlier analyses evaluated the level of “nominal” change consistent with the period of weight change under review. By using a full decade of past change review on

a later period of time, CMS failed to consider time-specific changes in health care that affect the nature of patients served in home health care. Further, in doing so, CMS ignored its past findings that showed material differences in the proportion of nominal and real case mix change that can occur in different years.

The payment rate adjustment authority weakens the financial security of the home health benefit since the stability of the payment rates is uncertain and subject to vague or ambiguous standards left to the discretion of CMS.

RECOMMENDATION: Congress should restrict the ability of CMS to modify payment rates and revise the case-mix adjustment system. These restrictions should require that no adjustments occur without adequate advance notice of at least 12 months and that CMS develop criteria for application of the BIPA case-mix adjustment correction authority through public rulemaking. The procedural standards set out in S. 659 should be enacted immediately and applied prospectively to any further coding weight adjustments.

RATIONALE: An intended consequence from the transition of cost reimbursement to prospective payment is stability and reasonable certainty regarding Medicare home health service payment rates. With cost reimbursement principles allowing for retroactive payment adjustments, home health agencies suffered through an environment of financial instability. PPS should operate with at least a modicum of stability of payment rates and CMS should not be allowed to arbitrarily adjust payment rates through the application of vague and ambiguous standards.

REJECT RISK-SHARING UNDER HOME HEALTH PPS

ISSUE: A prospective payment system (PPS) for Medicare home health services was implemented on October 1, 2000. Under the system, certified home health agencies are given a single payment for delivery of needed home health services during a 60-day episode of care. The episode payment is adjusted to account for the patient's care needs (case-mix) and for labor costs in the particular geographical area. During the first year of the PPS, payments were further adjusted for "budget neutrality" so that total annual projected outlays would not exceed what would have been spent if the pre-PPS payment methodology remained in place.

The PPS episode payment is adjusted in cases where the patient transfers to another agency for care, the beneficiary experiences a significant change in condition during the episode, or the patient is discharged with goals met but then is readmitted to the home health agency during the initial episode time period. Care provided for four or fewer visits is paid on a per-visit basis.

In a September 2000 report (GAO/HEHS-00-176) reviewing the decline in home health service use in recent years and implications for payment policy, the then-General Accounting Office (GAO) commented that home health PPS will "need to be evaluated and refined periodically and that utilization monitoring and medical review of claims will be critical to ensuring that HHAs [home health agencies] do not stint on care or provide unnecessary services..." and that "PPS should be modified to incorporate a risk-sharing arrangement, which would limit aggregate HHA Medicare gains or losses."

In a February 2004 report to Congress on home health payments, GAO expressed the belief that payments for home health services under Medicare exceed agencies' costs, and reiterated its recommendation for a risk sharing payment system for home health.

In more recent reports and discussions, the Medicare Payment Advisory Commission (MedPAC) has also examined risk-sharing as a potential element for consideration as part of the home health PPS. At the same time, MedPAC, Congress, and CMS have indicated a keen interest in imposing some type of value-based payment system for Medicare providers under which higher quality care would be rewarded with bonus payments, and lower quality care would result in lower reimbursements.

In January 2010, MedPAC Commissioners approved a recommendation that Congress should direct the Secretary of Health and Human Services (HHS) to modify home health payment to protect beneficiaries from "stinting" on care and included risk corridors and blended cost/PPS payments among the approaches that HHS should consider.

RECOMMENDATION: Congress should reject any proposals to establish risk sharing under the home health PPS. Congress should, as an alternative, press CMS to refine PPS to ensure the most appropriate distribution of payments.

RATIONALE: The home health PPS case-mix adjustment system has limited ability to account for variation in agency resource use. Despite the fact that overall average Medicare financial margins calculated by MedPAC appear to be relatively high, there are dramatic ranges among agencies and various areas of the country. Reductions in market basket inflation updates in recent years have further strained agencies financially. Most recently, CMS has finalized regulatory cuts in the home health base payment rate every year since 2008. As a result there is

widespread concern that existing payment levels will fall short of many agencies' actual expenditures in serving patients. There is no type of risk sharing under either the hospital or skilled nursing facility PPS. Such an adjustment would help to perpetuate the complexities and incentives of cost-based reimbursement. Finally, the potential imposition of performance-based payment under Medicare and the myriad of changes such a system will require would advise against further complication of the home health PPS with risk-adjusted payment. Consideration of any type of risk-sharing system at this time, most particularly if it is based on an individual case basis, could cause great harm to agencies and the patients they serve.

ENSURE AN EQUITABLE PPS WITH AN ADEQUATE CASE-MIX ADJUSTOR

ISSUE: The Balanced Budget Act of 1997 (BBA) mandated the implementation of a prospective payment system (PPS) for Medicare home health services; the home health PPS was finally implemented on October 1, 2000. In order to ensure a fair PPS, an adequate case-mix adjustor is needed to avoid penalizing agencies that serve patients who require more care than the average and to avoid rewarding agencies that seek to serve only low-cost patients. At its implementation, CMS estimated the PPS case mix adjustor to have a predictive factor of about 30 percent, meaning that it is able to accurately project costs in about 30 percent of all home health cases. With the 2008 revised version of the case mix adjustor, the predictive ability of the system is increased to nearly 40 percent. Revisions in 2012 led CMS to calculate the predictive ability of the case mix adjustor to be nearly 45%. However, the current model is still handicapped by its significant reliance on therapy visit volume to determine the assigned case mix category. This increases the predictive ability, but incentivizes the delivery of therapy services through higher payments.

Case-mix considerations should and do include such objective variables as health status, age, and socio-economic factors of the patients served. Clinical considerations also are part of a case mix adjustor model. However, since PPS was implemented many concerns have surfaced regarding the reliability and accuracy of the case-mix adjustor.

Recent attention has been given in the media and by Congress to the longstanding industry concerns regarding the inclusion of a therapy utilization component to the case mix adjustment model. While CMS continues to evaluate the case mix adjustment model for potential refinements, little effort has been placed on elimination or mitigation of the impact of the therapy utilization element. In 2011, the Medicare Payment Advisory Council (MedPAC) recommended that a new case mix adjustment model be developed and implemented that would eliminate the use of therapy thresholds to determine payment rates. The MedPAC model relies on existing OASIS-based data inputs instead. At the same time, it is understood that CMS is working on a new case mix adjustment model that may minimize the application of therapy thresholds for payment determinations.

In 2011, the Senate Finance Committee issued a report on its investigation of the use of therapy in home health services. The Committee concluded that the use of therapy visit thresholds to determine payment amounts can corrupt the payment model by incentivizing overutilization of therapy. The Committee suggested that Medicare develop a better alternative than continued use of these therapy thresholds.

The Patient Protection and Affordable Care Act (PPACA), P.L. 111-148, section 3131, includes a number of payment rate changes and reforms for Medicare home health services. Many of the changes are across-the-board rate reductions. In addition, beginning in 2014, rates are subject to a four-year phased-in rebasing. PPACA also requires the completion of two studies that are intended to examine the payment model and to issue recommendations for any needed reforms.

CMS revised the weights given to HHPPS episodes that include therapy services in CY2012 and CY2015 revisions. The changes reduced the case mix weights, resulting in lower reimbursement, for episodes with more than 14 therapy visits. Correspondingly, case mix weights for episodes with less than 14 visits were increased. These changes were, in part, due to

concerns about overutilization of therapy and overpaying for care with high volumes of therapy visits.

MedPAC recommends the elimination of the therapy utilization domain in the HHPPS case mix adjustment model in its 2017 report to Congress.

RECOMMENDATION: Congress should require that the CMS do continuing in-depth study on the adequacy of the new case mix adjustor, and make adjustments as necessary. CMS should be required to seek out the input of providers and case-mix study contractors in this effort. Specifically, Congress should require CMS to eliminate or limit the use of any service utilization components in a case mix adjustment model.

While the continued use of the therapy thresholds is a concern, no new case mix adjustment model should discourage the provision of therapy services and incent the provision of care that makes patients dependent on continued care-giving. No new model should be implemented without advance testing of its impact on care access, care planning, and financial incentives.

In evaluating any new payment models, Congress should also encourage that CMS adjust payment rates for costs agencies incur in complying with regulatory and legislative requirements that were not included in the initial calculation of rates. In addition, Congress should resist imposition of any further across-the-board cuts to home health payments until a comprehensive understanding of the new case mix system is known. Congress also should encourage CMS to consider additional payment model reforms to achieve equitable payment distribution, including consideration of mechanisms to address cost differentials in frontier and rural areas, security costs in metropolitan areas, and wage differentials. Finally, any new model should conform to the following standards:

1. A new model should not substitute disincentives to provide therapy services or behavioral incentives to stint on care or favor one type of patient over another for existing perceived incentives to provide therapy.
2. Congress should also require that any new case mix adjustment model be thoroughly tested before permitting its use with all stakeholders involved in the testing and evaluation.
3. Any new case-mix adjustment model should be based on objective clinical factors rather than the level of service utilization. The current therapy visit volume payment level determinant should be dropped from the case mix adjustment model.
4. Home health agencies should be informed on significant case mix adjustment model revisions at least 6 months before application in order to adjust clinical and operational systems.

RATIONALE: PPS represented a dramatic shift in the manner in which home health care is administered and delivered. Close monitoring and legislative modifications may be needed throughout the process to ensure that a workable PPS results. A payment model should only contain clinical behavioral incentives that are proven necessary and appropriate. In addition, any revised model should account for behavioral changes rather than perpetuate improper clinical actions that may have been financially driven rather than in a patient's best interest.

ENSURE THE FULL MARKET BASKET UPDATE FOR HOME HEALTH PAYMENTS

ISSUE: The Medicare home health benefit has undergone a series of cuts since legislation was enacted to move it toward a prospective payment system (PPS). Through a combination of legislated and regulatory cuts since 2000, payment rates are over 14 percent less than they would have been otherwise.

Under the fiscal year (FY) 1999 omnibus appropriations legislation, the Medicare home health market basket index – used to adjust payments for inflation – was reduced 1.1 percentage points from the projected 3 percent update in each of (FY) 2000-2003. During 2000, Congress restored the full market basket update for FY 2001. In October 2002, a major cut to home health payments of more than 7 percent that was enacted as part of the Balanced Budget Act of 1997 (BBA) was allowed to go forward.

As part of H.R.1, The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Congress enacted reductions of 0.8 percent off the market basket update from April 2004 through December 31, 2006. In early 2006, Congress approved legislation (S. 1932) that eliminated a scheduled 2.8 percent market basket inflation update for 2006.

In 2007 and 2008, the Bush Administration proposed deep cuts to the home health program as part of its budget, including recommendations that home health rates be frozen for five consecutive years. During 2007, Medicare enacted regulatory cuts of 2.75 percent in each of 2008, 2009, and 2010. In 2011 and 2012, additional regulatory cuts of 3.79% were imposed.

Congress' legislative action to reduce market basket inflation updates in recent years was taken, in large part, as the result of recommendations by the Medicare Payment Advisory Commission (MedPAC). During 2003 MedPAC recommended that Congress freeze home health payment rates at the FY 2003 level for FY 2004. MedPAC renewed its market basket freeze recommendation for 2005, 2006, 2007, and 2008.

In March 2009, MedPAC recommended elimination of the home health market basket update for 2010. MedPAC also recommended advancing a scheduled regulatory “case-mix creep” cut from 2011 to 2010. The combined impact of the MedPAC proposals, on top of an already-scheduled 2010 case mix cut, would result in payment rates during 2010 that are a full 5.5 percent below payments being made in 2009.

In March 2010, MedPAC again recommended elimination of the home health market basket update for 2011, as well as rebasing of rates to “reflect the average cost of providing care.” Additionally, MedPAC suggested that Congress direct the Secretary of Health and Human Services (the Secretary) to modify the home health payment system (through possible use of risk corridors and blended payments) to protect beneficiaries from “stinging or lower quality of care” in response to rebasing. MedPAC also recommended that the Secretary identify categories of patients likely to receive greatest clinical benefit from home health and develop quality outcome measures for each category of patient. Finally, MedPAC recommended that Congress direct the Secretary to review agencies that exhibit unusual patterns or claims for payment and provide authority to the Secretary to implement safeguards (including a moratorium, preauthorization requirements or suspension of prompt payment requirements) to address high risk areas.

MedPAC's recommendations are predicated on findings of “excessive” Medicare profit margins for freestanding agencies. More comprehensive study of agency margins performed by

the National Association for Home Care & Hospice has found significantly lower Medicare profit margins that virtually disappear when all payers are taken into account. Further, when agency profit margins are considered on an individual basis, they reflect dramatic ranges.

MedPAC had also expressed interest in imposition of a “productivity adjustment” which would reduce payments to Medicare providers to reflect gains in productivity.

To help finance a portion of health reform legislation, Congress set a reduction in the Market Basket Index of 1 point in 2011, 2012, and 2013. In addition, PPACA institutes rebasing of payment rates in 2014 with a 4-year phase-in approach and rate reductions capped annually during the phase-in at 3.5%. A productivity adjustment reduction to the Market Basket Index begins annually in 2015 at an estimated 0.5 to 1 point reduction per year.

The 2011 MedPAC recommendations include a zero Market Basket Index update in 2012, accelerating the rebasing to 2012 with no more than a 2-year phase-in, and applying the productivity adjustment starting in 2012. MedPAC also recommends a new case mix adjustment model and the use of some form of limits on provider profits. Finally, MedPAC suggests imposing cost-sharing on Medicare beneficiaries use of home health services. In 2013 and 2014, MedPAC continued these recommendations with some updating that included a rate freeze in 2013.

The Patient Protection and Affordable Care Act of 2010 included three consecutive years (2011-2013) of 1 point reductions in the Market Basket Index updates. In addition, the ACA includes the imposition of Market Basket Index reductions annually beginning in 2015 in the form of a “productivity adjustment.”

Beginning in 2014, home health agencies face nearly a 14% reduction in payment rates due to CMS rate rebasing. In addition, it is likely that the Medicare 2% payment sequestration will continue indefinitely. The combination of rate rebasing, reduction in full inflation updates, the 2015 initiation of a productivity adjustment, and payment sequestration has already begun to take its toll on care access. Any further payment reductions through limits or freezes on inflation updates will be devastating to Medicare beneficiary care access and quality.

In its 2015-2017 recommendations to Congress, MedPAC again suggests a zero Market Basket Index update for cost inflation along with an acceleration of rate rebasing. MedPAC posits that HHAs will adjust their costs to offset any rate reductions.

RECOMMENDATION: Congress should reject any proposals to reduce the market basket inflation update or impose additional rate reductions for home health agencies. Congress should maintain its carefully crafted schedule of payment rate changes and enact reforms to rate rebasing as contained in PPACA in order to secure access to continued care.

RATIONALE: Since legislative changes instituted in 1997 and subsequent imposition of a PPS for home health, reimbursement levels have failed to adequately cover the rising costs of providing care, including increased labor costs for home health agencies. Thousands of home health agencies closed following implementation of the 1997 Balanced Budget Act (BBA). In calendar year 2000, one million fewer beneficiaries received home health services than in calendar year (CY) 1997 and, in the first year of PPS (CY 2001), an additional 300,000 fewer beneficiaries received home health services than in CY 2000. In CY 2001, 5.5 percent of Medicare beneficiaries received home health services, compared to 6.5 percent in 1991. Recent study by MedPAC and CMS indicate that a major problem with the PPS is that the case mix adjustor in most cases does not accurately predict the costs of providing care.

Under PPS refinement regulations promulgated during 2007-2010, CMS included four years of reductions to the home health base payment rate – 2.75 percent in each of 2008, 2009, and 2010, and 3.79 percent in 2011 and 2012, for a total of over \$20 billion in cuts over a ten year period. In 2013, an additional regulatory cut of 1.32% will be imposed. These cuts could well send the home health network into severe financial difficulties similar to those experienced after passage of the BBA. This would ill serve beneficiaries, agencies, and the Medicare program.

It is estimated that with the MedPAC proposals, well in excess of 50% of all home health agencies will be paid less than the cost of care in 2017 and there are no revenue sources to offset these losses. That means that access to care will be lost to a significant number of Medicare beneficiaries. A similar arbitrary rate-cutting effort in 1998 led to the loss of care to nearly 1.5 million home health patients, forced the closure of over 4000 home health agencies, and increased overall Medicare spending because of the expanded use of more expensive care.

Crude measures such as across-the-board reductions or freezes will only exacerbate inequities in the system, and contribute further to access concerns. Access to care continues to be a serious problem in home health, and it is anticipated that these concerns will only increase with further cuts to home health payments. Home health care is efficient and effective in providing vital services to patients in the comfort of their homes. Use and provision of these services should be encouraged, not discouraged.

ENSURE THAT PROPOSALS TO “BUNDLE” POST-ACUTE BENEFIT PAYMENTS OFFER OPPORTUNITIES FOR HOME HEALTH AGENCY PARTICIPATION

ISSUE: The idea of bundling post-acute care services into hospitals’ diagnosis-related groups (DRG) payments or into other combined payments has been advanced by some Members of Congress and the Medicare Payment Advisory Commission (MedPAC). In recent years, the House and Senate Budget Committees, as well as the Congressional committees with jurisdiction over Medicare, have suggested bundling as an option to achieve Medicare savings.

The Patient Protection and Affordable Care Act (PPACA) (H.R. 3590; P.L. 111-148) calls for launching a post-acute care bundling pilot program by 2013. Among the bundling options that may be tested is one where the bundled payments for post-acute services would be held by home health agencies. The PPACA bundling project authorization does not limit which provider types can participate in or control the bundled payment.

The Medicare Center for Innovation initiated a four-model Bundled Payments for Care Improvement (BPCI) initiative in 2013. Models 2 and 3 included post-acute care services. Model 2 BPCI includes a patient’s hospitalization, physician services, and post-acute care for c30, 60, or 90 days. CMS selected 48 proposals for the Phase 1 preparation period. On October 1, 2013, 9 participants began the risk bearing Phase 2. The participants are primarily hospitals and health systems some of which directly provide home health services. As of February, 2016, there are 628 participants in Model 2.

Model 3 BPCI is focused on post-acute care services provided 30, 60, or 90 days following an inpatient stay, but does not include the inpatient stay in the bundled payment. CMS selected 17 participants for Phase 1. As of October 1, 2013, 6 participants have moved on to Phase 2. All participants that wished to continue in Model 3 moved to Phase 2 in January, 2014. Among the participants are several home health agency-related organizations. CMS reopened the BPCI initiative and there are now 859 participants at various phases.

CMS has also initiated a lower joint replacement bundling pilot program that starts on April 1, 2016. It includes a risk sharing payment model involving all post-acute services, physician services, re-hospitalizations, and other ancillary services provided to patients discharged from an inpatient setting over a 60-day post hospital period of time. This pilot will operate in 67 hospital service areas that comprise nearly 25% of all lower joint replacement surgeries. Hospitals face a gradually increasing risk of bearing financial losses for spending in excess of targets, while also having the opportunity to share in Medicare savings when spending is less than the targets. Home health agencies and hospices can participate in the gainsharing and risk of loss.

Congress is also active in bundling initiatives. The Bundling and Coordinating Post-Acute Care (BACPAC) Act of 2015 (H.R.1458) would bundle all post-acute care services. The 2017 White House budget once again includes significant Medicare spending reductions through post-acute care bundling.

RECOMMENDATION: Congress should monitor the bundling pilot program authorized by PPACA to ensure a reasonable and fair opportunity for home health agencies to participate in and/or manage the payment bundle for post acute care. Such an approach would deter

unnecessary re-hospitalizations, thus reducing administrative burden and cost, as well as increase the quality and availability of home health care. This approach is comparable to the tried and tested Medicare hospice program where payment is bundled to a community-based hospice program where hospitalization is the exception rather than standard practice. Congress should oppose any legislative proposals, such as the BACPAC Act, that do not ensure reasonable and fair opportunities for home health agencies to manage the payment bundle. Full scale bundling should not be considered until the demonstration and pilot programs have concluded. Further, bundling initiatives should proceed cautiously and integrate any uniform patient assessment tool developed as part of the IMPACT Act.

RATIONALE: Bundling home care payments into hospital payments would severely compromise both the quality and availability of home health care for Medicare beneficiaries. Many hospitals have limited experience with the provision of non-hospital, post-acute care. Less than 30 percent of all home care agencies are currently affiliated with hospitals. Requiring hospitals to be responsible for determining post-hospital patient care needs, quality of care, and the appropriateness of care is beyond the scope of many hospitals.

Basing post-hospital payments on DRGs is also completely inappropriate. DRGs are not designed to predict the need for or cost of home health care after a hospitalization. The post-acute care needs of a patient can be completely different from the reason for hospital admission. Home health payments based on DRG rates would not match patient needs.

In addition, the trend away from inpatient hospital care and toward promoting increased use of home care as a means of reducing length of stay means that more high- tech care and more heavy care will be provided in the home setting, making DRGs even less appropriate. In fact, many patients are now able to receive care and treatment at home from the onset of their illness, thus avoiding hospitalization altogether.

Bundling innovations should be evaluated in terms of any change in administrative burden on home care providers by requiring multiple payment systems for home health — one for post-acute patients and one for patients entering home care from the community — and would require home care agencies to bill any number of hospitals for the care they provide to post-hospital patients, rather than using the current single-billing system. This multiple-track system could result in uneven Medicare coverage for patients with the same care needs. Many of these same arguments apply to proposals to bundle home health payments in with payments to other post-acute care providers. While bundled payments may be a promising innovation, it must be carefully monitored to ensure no adverse unintended impact on care access and care quality along with health care spending.

OPPOSE THE INSTITUTION OF UNTARGETED MEDICARE HOME HEALTH PRIOR AUTHORIZATION

ISSUE: The Centers for Medicare and Medicaid Services (CMS) has proposed to institute a system of prior authorization in Medicare home health services. <http://federalregister.gov/a/2016-02277>. This proposal would apply a prior authorization requirement in Florida, Illinois, Michigan, Texas, and Massachusetts. CMS attempts to justify this action by claiming that those states have high incidence of fraud and abuse in Medicare home health services.

CMS has not released details on the prior authorization plan other than to reference the targeted model in use relative to power mobility vehicles in the Durable Medical Equipment benefit.

In addition, the FY 2017 federal budget proposed by the White House includes the allowance of the unspecified use of prior authorization systems in Medicare for a ten year reduction in Medicare spending of \$75 million.

RECOMMENDATION: Congress should reject any effort to institute prior authorization requirements in the administration of the Medicare home health services benefit. Alternatively, prior authorization should be limited to highly targeted elements of the benefit such as application to individually designated providers that demonstrate a high risk of program abuse based on past claims history or new providers of services in high risk geographic areas. In the event that prior authorization is permitted, the system must include adequate due process to reduce the risk of wrongful denials of service authorization along with a simple and efficient process for completing the authorizations.

RATIONALE: Prior authorization is an extraordinary action that triggers significant costs for all parties and establishes barriers to the timely and effective use of home health services. Past trials of prior authorization in Medicare home health services have shown that it has negligible impact on program abuse.

C. MEDICARE ADVANTAGE

ESTABLISH PROVIDER APPEAL RIGHTS IN MEDICARE ADVANTAGE

ISSUE: Under the rules governing Medicare Advantage (MA), plan enrollees have detailed and extensive rights of appeal regarding any adverse decision related to the coverage of an item or service by the MA plan. These rights essentially mirror the rights afforded Medicare fee-for-service beneficiaries. However, neither network nor non-network providers of service have stated appeal rights. In some instances, an aggrieved provider may have grievance and appeal rights under a contract with the MA plan. In other instances, a dissatisfied provider may be able to pursue a complaint under state law authority. The absence of an administrative appeal system for providers in MA plans is in stark contrast to the system of appeals available under the Medicare fee-for-service program, where providers have full appeal rights comparable to Medicare beneficiaries. The absence of provider appeal authority in MA plans results in lost revenues to providers who deliver care to MA enrollees in good faith and later receive claim denials.

RECOMMENDATION: Congress should amend the Medicare law relating to MA plans to provider network and non-network providers of services with administrative appeals rights comparable to those existing under the Medicare fee-for-service program. Congress should also prohibit any retribution by Medicare Advantage plans against providers of services that utilize these administrative appeals rights.

RATIONALE: MA plans have expanded enrollment in recent years thereby taking a more significant role in the business of home health services. Home health agencies complain that the MA plans tend to deny authorization for necessary services and to prematurely terminate coverage. The providers may continue care because of their concern for patient safety and clinical outcomes without MA plan coverage. Providers of services under MA plans are impacted by these claim denials and reimbursement disputes. The most efficient system to address these disputes is the administrative appeals process available under the Medicare fee-for-service program. Medicare beneficiaries under the MA program and beneficiaries and providers under the fee-for-service program can access that appeal system.

LIMIT MEDICARE ADVANTAGE PLAN REIMBURSEMENT TO THE COST OF CARE UNDER TRADITIONAL MEDICARE

ISSUE: At various times since the early 1980s Congress has legislated changes designed to provide financial incentives for private insurers to create plans to replace the Medicare fee-for-service (FFS) benefit package. Most frequently these changes were made in hopes that private coverage under Medicare or “privatization” would result in savings for the program.

Numerous studies in recent years have raised concerns that the Medicare program is paying substantially more – about 14 percent on average -- for care for Medicare Advantage (MA) enrollees than for “traditional” fee-for-service (FFS) Medicare beneficiaries. The findings contrast sharply with the stated goals of creating incentives for private plans to enroll Medicare beneficiaries -- to save money by privatizing what was established as a health care entitlement program for seniors and disabled individuals.

Studies by the Medicare Payment Advisory Commission and the Congressional Budget Office support the Commonwealth findings, and indicate that significant gaps between average care costs for traditional FFS Medicare and MA beneficiaries exist, resulting in tens of billions of dollars in additional expenditures to private plans. Further, a late 2008 study by the Government Accountability Office found that, due to higher calculations on the part of plans relative to their 2006 costs, MA plans earned higher profits.

As part of health reform legislation, the Patient Protection and Affordable Care Act (H.R. 3590; P.L. 111-148) phased down payments to plans over four years to the average plan bid in the bid area; it also begins a program of quality bonus payments for MA plans.

RECOMMENDATION: Congress should limit reimbursement to private plans for Medicare to a level consistent with the costs borne by the program for comparable traditional FFS beneficiaries. Congress should also require stronger oversight of plans’ estimates of costs to ensure that Medicare is not inadvertently overpaying plans.

RATIONALE: Study findings clearly indicate that privatizing the Medicare benefit is not an effective way to save money and, given the poor financial state of the Medicare trust funds, Congress should take steps to ensure that the Medicare program is not spending more than it needs to for care.

RESTRICT EXORBITANT COST-SHARING IN MEDICARE PRIVATE FEE-FOR-SERVICE PLANS

ISSUE: Medicare Part C, otherwise known as Medicare Advantage (MA), includes an option for a “Private Fee-for-Service” (PFFS) plan that is intended to mirror the original Medicare program. These plans are provided through private health insurance companies in many parts of the country. In the last two years, enrollment in this type of Advantage plan has grown to nearly one million Medicare beneficiaries.

Generally, these plans allow enrollees to choose any provider of services, supplies, or equipment that is qualified under the original Medicare program. However, the “Medicare Prescription Drug, Improvement and Modernization Act” (P.L. 108-173) contains a provision that allows Medicare Advantage PFFS plans to establish provider/supplier networks as an alternative to open access that was previously available to enrollees. While this provision requires that the plans allow enrollees to receive benefits through any qualified Medicare provider/supplier, it allows the plans to establish a higher cost-sharing obligation to select non-network providers/suppliers.

The Centers for Medicare & Medicaid Services (CMS) has approved PFFS plans that require enrollees to pay as much as a 50 percent copayment for out-of-network services/supplies. In doing so, a central feature of the PFFS plans -- open access-- is virtually eliminated. However, CMS also has undertaken an analysis of PFFS and other MA plan beneficiary cost sharing with a particular focus on home health services coinsurance. While the outcome of the CMS effort is not yet known, the study may indicate a new hesitancy to allowing nearly unfettered plan activity in restructuring beneficiary cost sharing in comparison to traditional Medicare.

The Patient Protection and Affordable Care Act (PPACA), P.L. 111-148, section 3202, provides limitations on the variation in beneficiary cost-sharing in comparison to traditional Medicare. However, the limitation directly applies only to certain services that include chemotherapy, renal dialysis, and skilled nursing care. Home health is not specifically included in the restriction, but the Secretary of Health and Human Services (HHS) is authorized to expand the scope of the limitation.

In 2010, CMS proposed restricting MA plans from charging any cost sharing on home health services. While CMS recognized that the PPACA provision does not directly authorize a home health cost sharing ban, CMS believes it has broad-based discretionary authority to promulgate such restriction. CMS withdrew this proposed rule.

RECOMMENDATION: Congress should either rescind the MMA provision that allows for PFFS plans to restrict access to services/supplies through selected networks, or establish reasonable limits on cost-sharing obligations for non-network services. Congress also should prohibit a Medicare Advantage PFFS plan from imposing any level of coinsurance on home health services. Alternatively, Congress should support the Secretary of HHS in proposing to ban home health services copayments/coinsurance in MA plans. Congress should also specifically expand the restriction in section 3202 of PPACA to include a ban on home health services cost-sharing.

RATIONALE: If the Medicare Advantage private fee-for-service plan is to be a true alternative to the original Medicare program, it must not be allowed to impose significant financial barriers to open access to qualified providers/suppliers. Such limitations already exist in other Medicare Advantage plans such as health maintenance organizations and preferred provider organizations. To allow the private fee-for-service plans to operate in a comparable manner effectively eliminates an intended option under Medicare Advantage.

REQUIRE MEDICARE ADVANTAGE PLANS TO PROVIDE A HOME HEALTH BENEFIT FULLY EQUIVALENT TO ORIGINAL MEDICARE

ISSUE: With the Balanced Budget Act of 1997 (BBA 97), Congress required that the original Medicare home health benefit be transformed from a per-visit, cost-based reimbursement benefit to an episodic service benefit, with payment based upon a prospective payment rate. With its initiation in October 2000, this reformed benefit dramatically altered the delivery of home health services to Medicare beneficiaries. Home health agencies were transformed from entities that delivered procedure-oriented visits of services to care managers and providers of services with the responsibility to achieve positive patient outcomes. In managing the individual's care in the home for 60- day episodes, home health agencies use both traditional disciplines of care along with new telehealth technologies, preventive services, and wellness services to manage the whole patient. Accordingly, the transition to a prospective payment system is much more than changing the reimbursement methodology.

Most Medicare Advantage plans have not adopted the reformed home health benefit. Instead, plans continue to deliver a visit-based home health services benefit, failing to provide the episodic care management service that is now provided to enrollees in the original Medicare plan. Those plans that have adopted the Medicare episodic reimbursement model have done so only through intense negotiations with network providers. For enrollees of plans that do not provide an episodic home health benefit, the result is restricted access to home health services and, more importantly, barriers to clinical stability, rehabilitation, and care coordination.

RECOMMENDATION: Congress should specifically mandate that all Medicare Advantage plans provide an episodic, care management home health services benefit and prohibit continuation of the antiquated home health benefit currently provided by most Medicare Advantage plans.

RATIONALE: Significant clinical gains have been afforded to Medicare beneficiaries receiving home health services under original Medicare that do not occur in Medicare Advantage plans because of the continued focus on a per-visit benefit structure.

RESTRICT PASSIVE ENROLLMENT OF DUAL ELIGIBLES IN MEDICARE ADVANTAGE PLANS

ISSUE: With the onset of the Medicare Part D drug benefit, the Centers for Medicare & Medicaid Services (CMS) effectively authorized the wholesale transfer of Medicare- Medicaid dual eligibles into a designated Medicare Advantage plan for both health care services and drug benefits. On January 1, 2006, hundreds of thousands of Medicare beneficiaries suddenly found themselves enrolled in a Medicare Advantage plan without a full understanding of the consequences. This wholesale transition of Medicare- Medicaid dual eligibles into Medicare Advantage is known as “passive enrollment.”

CMS designed the passive enrollment process as one that provided limited explanation to the affected individuals prior to the January 1 Medicare Advantage enrollment. The process allowed individuals to opt out of the enrollment, rather than to affirmatively choose a Medicare Advantage plan.

Two problems resulted from this process. First, Medicare beneficiaries were enrolled in Medicare Advantage plans without a full understanding of the consequences of that enrollment. Second, providers of services under the Medicare fee-for-service plan admitted patients or continued to serve patients without knowledge of the Medicare Advantage enrollment that disqualifies the patient from original Medicare coverage.

RECOMMENDATION: Congress should prohibit the passive enrollment of Medicare-Medicaid dual eligibles in a Medicare Advantage plan. Alternatively, Congress should require full disclosure of the passive enrollment process to any affected individuals, providing sufficient time for individuals to opt out. In addition, Congress should require that the effective date of any passive enrollment be no earlier than the date when Medicare beneficiaries’ enrollment status is listed in the common working file.

RATIONALE: Medicare beneficiaries who are also eligible for Medicaid should not be treated differently from all other Medicare beneficiaries. Passive enrollment of these individuals into a Medicare Advantage plan is nearly the equivalent of forced enrollment. At a minimum, full disclosure and reasonable opt-out authority should exist.

With respect to providers of services, passive enrollment increases the risk that they will be ambushed in providing services to Medicare Advantage enrollees without knowledge of that enrollment or the availability of information to uncover that enrollment.

PROVIDE ACCESS TO MEDICARE ADVANTAGE ENROLLMENT INFORMATION/ESTABLISH A PROVIDER “HOLD HARMLESS”

ISSUE: Health maintenance organizations (HMOs) and preferred provider organizations (PPOs) have become firmly established as a means for providing health insurance coverage for a significant portion of the U.S. population. The Medicare Prescription Drug, Improvement, and Modernization Act (P.L. 108-173) provided new financial support for Medicare HMOs, PPOs, and other private plans under the Medicare Advantage (MA) program; as the result, in 2011, about 25 percent of Medicare beneficiaries were enrolled in private plans under Medicare. Many newly-enrolled patients, however, fail to understand that enrollment in an HMO/PPO or other private plan may prohibit their being cared for by their chosen care providers, and may result in copayments in excess of those assessed under traditional Medicare.

Home health agencies are not informed when a Medicare patient enrolls in a MA plan. Often, an agency will continue to provide needed care, only finding out later that neither fee-for-service Medicare nor the MA plan will pay for that care. Home health agencies and patients should not be required to absorb these costs.

This is a serious problem in areas of the country where MA enrollment has made significant inroads. As increasing numbers of Medicare beneficiaries move into and out of MA, this problem will only worsen.

The Centers for Medicare & Medicaid Services (CMS) has established a nationwide data base, known as the Common Working File (CWF), which contains information on the enrollment status of Medicare beneficiaries. CWF contains MA enrollment information only after data is transferred periodically from the separate MA enrollment database. As a result, the CWF is far from up-to-date, making the information unreliable.

RECOMMENDATION: To resolve this issue, Congress should:

- Require MA plans to determine any health services enrollees receive from other providers and furnish those providers with immediate notification of the MA enrollment;
- “Hold harmless” providers who in good faith provide needed care to MA enrollees before this notification is received through direct Medicare payment and concomitant reductions in MA payments; and
- Require CMS to upgrade the timeliness of information contained in the CWF and to make this information available on a nationwide basis.

RATIONALE: Medicare-certified home health agencies need timely enrollment information to avoid retroactive coverage denials. Despite providers’ best efforts to determine MA plan enrollment, information available from patients and families is frequently inadequate and unreliable. This is particularly a problem with MA enrollees who do not fully understand the implications of MA enrollment and fail to accurately explain their status to home health agencies. Since the cost of care provided to an MA plan enrollee by a “fee-for-service” home health agency is the enrollee’s liability, protections are necessary for both the enrollee and the provider.

D. MEDICAID AND MEDICARE ADMINISTRATION

ENSURE TIMELY HEARINGS AND DECISIONS BY MEDICARE ADMINISTRATIVE LAW JUDGES

ISSUE: Medicare law requires that providers and beneficiaries have a right to a hearing before and decision from an Administrative Law Judge (ALJ) within 90 days of request. If the decision is not rendered consistent with that standard, the appellant can accelerate the appeal to the next level. The right of an accelerated appeal has value, but it falls short of the right of a face-to-face hearing before an ALJ.

ALJ appeals are significantly backlogged with an expected delay of 2-3 years before matters are scheduled and heard. Efforts by the Office of Medicare Hearings and Appeals have been useful, but only a small part of the backlogged cases has been resolved with thousands of additional appeals filed each week.

Legislation has been proposed that would add resources to the ALJ hearing budget, provide alternative resolution processes, and permit Medicare to establish parameters for settlement of pending appeals. S.2368 Audit & Appeals Fairness, Integrity, and Reforms in Medicare Act of 2015 has bipartisan support.

RECOMMENDATION: Congress should enact reforms to the audit and appeals process that:

1. Limits audits to circumstances where there is reliable evidence to believe that a provider has submitted ineligible, noncovered claims.
2. Reforms the appeals process that precedes the ALJ level in order to make it more productive and worthwhile as ALJ reversals indicate a high level of erroneous claim denials and inaccurate administrative appeal decisions.
3. Establishes alternative dispute resolution processes to expedite final decisions on appeals.
4. Establishes criteria for the application of class settlements in situations where similar or identical claim denials have been issued to one or more providers.
5. Adds sufficient ALJ staff resources to process all backlogged appeals.
6. Suspends any recovery of alleged overpayments until the conclusion of all appeal rights with no accrual of interest. Interest should be limited to matters where the appeal is frivolous.

RATIONALE: Justice delayed is justice denied. AS of the end of 2015, nearly 900,000 appeals remain backlogged awaiting ALJ review with only 60 ALJs available with a capacity of 1000 appeals per year each.

PROVIDE ACCESS TO MEDICAID ENROLLMENT INFORMATION

ISSUE: Medicaid reform efforts may alter eligibility standards for the Medicaid program. With the 2010 health care reforms, Medicaid enrollment is expected to dramatically increase beginning in 2014. At the same time, standards for determining Medicaid eligibility create a high potential for individuals to be frequently enrolled, terminated, and re-enrolled. This fluctuation in beneficiary status makes it difficult for Medicaid home health and hospice providers to accurately determine a beneficiary's eligibility status.

RECOMMENDATION: Congress should require states to establish systems, electronic or otherwise, which would enable providers to confirm a patient's enrollment status in Medicaid. Further, Congress should establish a "hold harmless" provision under Medicaid to protect providers who, in good faith, provide care to individuals whose enrollment in the Medicaid program terminates without notice to the provider of service.

RATIONALE: Medicaid home health agencies and hospices need timely enrollment status information to avoid retroactive coverage denials. Information from patients and their families is not always reliable, thereby subjecting home health agencies to significant financial losses. Moreover, the risk of uncompensated care discourages providers from accepting Medicaid patients as clients.

ALLOW FEDERAL JUDICIAL REVIEW OF STATE MEDICAID PROGRAM COMPLIANCE WITH FEDERAL MEDICAID LAW

ISSUE: In past years, there have been several federal court decisions that have rejected the efforts of Medicaid providers and patients to challenge state Medicaid programs over their compliance with federal Medicaid law in federal court. The courts have held that either the provider and/or patient does not have a right to determine whether the Medicaid program has adhered to federal law requirements or that the provider and/or patient has no right of action in any forum to enforce the federal Medicaid law. Leaving enforcement authority to the US Department of Health and Human Services (HHS) is an inadequate approach given the longstanding reluctance of HHS to challenge a state's administration of Medicaid.

Some inroads into federal judicial review of state Medicaid actions have been made through litigation in California and other districts. This litigation relies on the Supremacy Clause of the US Constitution arguing that state law is preempted by federal law and all conflicts must be resolved under the federal law. On appeal to the US Supreme Court, the Court remanded the matter back to the lower courts for evaluation of the impact of CMS's partial acceptance and rejection of the State plan amendment on rates. That left some uncertainty regarding how and when a federal court can review Medicaid rate determinations. While a favorable Supreme Court outcome in the California rate case would have been very helpful on some types of claims, there still remain some significant roadblocks to judicial review of matters such as benefit changes, reimbursement policy modifications, and administrative processes on timeliness of eligibility determinations, among other matters.

In 2015, the US Supreme Court issued a ruling in another case involving the jurisdiction of federal courts to adjudicate challenges to state Medicaid rate setting. This matter involved the Idaho Medicaid program that is subject to the same Court of Appeals rulings as California Medicaid. The Supreme Court reversed the Court of Appeals. As a result, there does not appear to be any route to a federal judicial challenge to a state's Medicaid rate setting by providers of services or Medicaid beneficiary.

While states have significant discretionary authority in the implementation and operation of the Medicaid program, federal standards establish certain minimum requirements. If these parties cannot secure judicial review of the state's compliance with federal law, the likelihood of abused discretion increases. The types of claims that might be blocked might include lawsuits to challenge Medicaid rate setting, changes in the scope of Medicaid home care and hospice benefits, and the establishment of quality of care standards.

RECOMMENDATION: Congress should enact legislation which specifically authorizes Medicaid providers and Medicaid recipients to sue state Medicaid programs in federal and state courts whenever the claim is based upon an allegation of non-compliance with federal Medicaid law.

RATIONALE: The vast majority of financing for Medicaid services comes through the federal government. If states are immune from lawsuits by beneficiaries and providers of services in circumstances where there is an allegation that federal law has not been followed by the state, it is left to HHS and the Centers for Medicare and Medicaid Services (CMS) to oversee the state programs on its own. CMS is improving its enforcement of federal Medicaid law. However,

Medicaid beneficiaries and providers also have a vested interest in securing those benefits which are available under federal law and should not be constrained in their efforts to secure such.

STRENGTHEN REQUIREMENTS FOR PUBLICATION OF POLICY CHANGES BY CMS

ISSUE: Over the past few years, the Centers for Medicare and Medicaid Services (CMS) has issued numerous changes in policy through program memoranda, interpretive guidelines, and manual provisions which affect the day-to-day administration of the Medicare home health and hospice benefits. For example, CMS changed the standards regarding whether a home health agency (HHA) can operate branch offices. Similarly, CMS has changed billing requirements for hospices, mandated the billing on a discipline specific per visit basis with per visit charges while continuing to pay on a per diem basis. Most recently, CMS ignited a firestorm when it issued a policy position significantly different than a rule promulgated to limit the transfer of Medicare provider agreements when an HHA changes ownership within 36 months of its initial Medicare enrollment.

These policies, and others, were developed and issued outside the regulatory process, placing agencies at risk of noncompliance due to lack of knowledge of these changes. CMS also has regularly bypassed obligations under the Regulatory Flexibility Act which requires administrative agencies to promulgate rules only after analyzing the impact of the action and providing notice to Congress before the rule is effective. In regulatory reform measures that were enacted in 2003, Congress focused on the timing of regulatory issuances, the use of “interim final” rules, and the reliance of providers on guidance from Medicare. Congress did not address the issues existing in determining which policy positions are subject to formal rulemaking.

RECOMMENDATION: Congress should strengthen Section 1871 of the Social Security Act, 42 U.S.C. § 1395hh, to require that any statement of policy that changes the standards governing program operation, whether as a rule of law or an interpretative guideline, be promulgated only by regulation and only prospectively. Finally, Congress should engage in an audit of CMS rulemaking activity to determine the extent to which CMS has complied with the Regulatory Flexibility Act. Specifically, Congress should evaluate whether CMS conducts the comprehensive impact analyses required under the RFA including the full term impact of proposed rule changes and the actual business viability impact of a rule.

RATIONALE: CMS has ignored rulemaking procedures in all but limited circumstances. However, the day-to-day administration of the Medicare program is governed by these guidelines and providers of services should not be obligated to challenge policy changes which are implemented often without their knowledge and with retroactive effect. Likewise, providers should not be forced to endure the harm caused by the misguided rulemaking that occurs when prior public notice and opportunity to comment is avoided by CMS.

OPPOSE USER FEES FOR MEDICARE AND MEDICAID ADMINISTRATIVE ACTIVITIES

ISSUE: Presidential budget proposals have included a recommendation that would require all health facilities, including home health agencies and hospices, to pay a user fee sufficient to cover the costs associated with administrative activities under the Medicare and Medicaid programs.

The Congress has repeatedly rejected user fee proposals. In the Omnibus Budget Reconciliation Act of 1990 (OBRA-90, P.L. 101-508, § 4207 (h)), Congress specifically prohibited the Department of Health and Human Services (HHS) from imposing or requiring states to impose on home health agencies, hospices, hospitals or other entities (excluding those required by the Clinical Laboratory Improvements Amendments of 1988) a fee to offset the costs of surveys to certify compliance with the Conditions of Participation under Medicare Part A or B.

The fiscal year 1996 (FY96) budget (P.L. 104-134), rather than imposing user fees, increased the time between home health recertification's from once every 12 months to once every 36 months and expanded the Centers for Medicare & Medicaid Services' (CMS) authority to deem agencies as certified if the agencies are accredited by certain private accrediting bodies. These provisions were designed to provide CMS the budget flexibility to begin to alleviate the backlog of initial certifications resulting from insufficient funding levels to cover the number of new providers' initial surveys.

During 2007 Congress authorized CMS to establish a revisit user fee to health facilities, including home health agencies, cited for deficiencies during certification surveys. These fees are assessed when survey revisits are made to address "deficient practice" during initial, recertification, and substantiated complaint surveys. This authority expired in late December 2007; it is unclear whether Congress will approve further authorization for such revisit fees.

Despite growing demand for home health services, CMS has not sought sufficient funding to supply all the needed support services such as survey and certification activities. As a result, parties interested in establishing home health agencies and hospices have been forced to purchase private accreditation services from companies with "deemed status" accreditation.

RECOMMENDATION: Congress should reject user fee proposals, and ensure that funding is sufficient to cover the costs of administrative activities under the Medicare and Medicaid programs.

RATIONALE: User fees are in essence a tax on health care providers for participating in Medicare and Medicaid. These programs currently do not fully compensate providers for their cost of caring for program beneficiaries even without the tax. The user fee proposal also exaggerates the true federal cost savings. A portion of payment for user fees and administrative costs will be rolled into cost reports. In some states, these costs will be partially reimbursed by Medicare and Medicaid. However, providers would still be responsible for costs over and above the limited amount which Medicare and Medicaid provide as reimbursement. Asking health care providers to provide quality care, while at the same time asking them to shoulder both government costs and their own expenses related to the Medicare and Medicaid programs, is unfair.

ESTABLISH PROVIDER, CAREGIVER, AND CONSUMER BILLS OF RIGHTS IN ALL FEDERALLY-FINANCED HOME CARE AND HOSPICE PROGRAMS

ISSUE: The various home care programs that operate with full or partial federal financing have a variety of provider, caregiver, and consumer rights that are established in one form or another. However, none of the federally financed home care programs contain a comprehensive bill of rights for providers, caregivers, and consumers. For example, the Medicare home health services benefit contains a patient's bill of rights, while a provider and caregiver bill of rights is missing.

A comprehensive bill of rights should contain minimum standards that each of the diverse home care programs can use as a starting point while constructing program-specific rights. For example, providers, caregivers, and consumers should have basic rights relative to advance notice of program standards, the right to voice grievances, and the right to address contested matters to an independent adjudicator.

In its proposed rule changes of the Medicare Conditions for Participation for Home Health Agencies, CMS includes an expanded requirement on patient rights in relation to care providers. However, the proposal does not include a patient or provider Bill of Rights in relation to Medicare operations.

RECOMMENDATION: Congress should require that all federally-financed home care programs include a basic bill of rights directed toward providers, caregivers, and consumers.

RATIONALE: The delivery of home care services is a life-affecting endeavor that impacts consumers, caregivers, and providers of that care. Actions taken by all parties involved in the delivery of home care services, including the federal government, should be guided by a set of principles that acts to protect basic rights of those parties. A bill of rights can provide that structure and guidance to ensure that appropriate actions are planned and taken.

ENACT MEDICAID HOME CARE AND HOSPICE PROGRAM INTEGRITY MEASURES

ISSUE: Home care and hospice, like all industries, is not immune to the presence of participants who engage in improper and illegal schemes for the sake of profit. At the same time, health care providers that operate well within the law are unable to effectively compete in the market when faced with competitors that offer kickbacks for patient referrals, bill for services not provided, or charge costs that are not part of the delivery of services.

The Patient Protection and Affordable Care Act (PPACA), P.L. 111-148, contains a number of program integrity measures supported by NAHC that are home care and hospice specific. Unfortunately, many of these measures are confined to the Medicare home health and hospice benefits. Medicaid home care and hospice can benefit from similar measures, particularly those that address provider qualifications and standards for participation in Medicaid.

Medicaid home care program integrity issues share similarities with Medicare, but also present unique circumstances necessitating tailored and targeted action. States are often allowed to design their own program integrity measures. While this permits states to develop the approaches to program integrity that best fit their Medicaid program, it also leaves open a level of risk that could be addressed through model, federally-recommended processes. Medicaid home care is very diverse with services ranging from personal care assistance to high-tech private duty nursing. In addition, providers of Medicaid home care include unlicensed individual home care aides, unlicensed home care agencies along with skilled health care professionals such as nurses and therapists and licensed and accredited home health agencies. Program integrity weaknesses that have been alleged to date include billings for unqualified beneficiaries, inadequate documentation to validate the provision of covered services, unqualified caregivers, billings for unauthorized services, and false billings for care not rendered. As such a broad construct of program integrity measures are needed.

RECOMMENDATION: Congress and CMS should continue its work in combating waste, fraud, and abuse in our nation's health care system by promulgating model minimum standards for compliance and program integrity, with adequate financial support for all parties that include:

- The institution of state Medicaid compliance plans directed to Medicaid home care and hospice programs to ensure adherence to all federal and state laws with proper funding support.
- Standards for "return on investment" so that program integrity efforts are priorities based on impact and corrective measures targeted to the most economic and productive approaches.
- Strengthened admission and program participation standards for individual and agency-model home care providers, including standards for competency, early-stage pre-pay claims review, and experience.
- Mandatory screening and federally-funded background checks on all individuals wishing to provide Medicaid home care or open/operate a Medicaid home care agency or hospice.
- Mandatory background checks on all employees of home care agencies and establishment of a national registry of home care workers consistent with existing state laws.

- Providing consumers and prospective consumers of Medicaid home care services and hospice care with a summary of program coverage requirements. The consumer reporting hotline for suspected fraud, waste, and abuse also should be enhanced and made more accessible.
- Standards for service validation systems that allow for the maintenance of electronic documentation of service delivery consistent with the services approved for payment.
- Standards for pre-payment and post-payment claims review, including the appropriate use of sampling extrapolation.
- Credentialing and competency testing standards for government contractors and federal regulators responsible for issuing Medicaid determinations. A hotline should be developed for beneficiaries and providers to report inadequate enforcement action by those charged with protecting Medicaid.
- Supplying adequate and enhanced administrative financing to Medicaid to enforce existing laws and regulations such as survey and certification standards, provider education, and claims reviews.
- Enhancement of education and training of home health agency and hospice staff through joint efforts with regulators.
- Implementation of outcome-based compliance standards for quality of care that provide operational flexibility and also eliminate structural requirements that is unrelated to the provision of high quality care.
- The establishment of a Joint Program Integrity Advisory Council that includes representatives from state Medicaid programs, CMS, home care providers and Medicaid recipients. The Advisory Council is intended to help increase awareness of program integrity weaknesses and to recommend solutions.
- Establishment of targeted payment safeguards directed towards abusive utilization of services and payment as necessary and appropriate.

RATIONALE: It is particularly important to ensure that limited Medicaid dollars go to the provision of patient care rather than being diverted into the pockets of unscrupulous providers or be wasted on unnecessary or noncovered care. A comprehensive fraud and abuse package that includes Medicaid home care and hospice specific provisions and provides adequate enforcement tools to punish those who willfully and knowingly defraud the system is needed. Moreover, any program integrity legislation or regulation must make a distinction between willful fraudulent activity and unintentional failure to comply with Medicaid policies that set out technical paperwork standards that do not truly affect core elements of claim coverage. For example, audit reports often characterize as fraud, minor technical errors on claims or billing for services that the need for which is not documented sufficiently to demonstrate that it meets coverage standards. In such cases, early and comprehensive provider education may be a more appropriate response than more punitive measures.

ESTABLISH REASONABLE STANDARDS FOR ELECTRONIC VISIT VERIFICATION

ISSUE: There are indications that Medicaid personal care services is subject to an abusive practice by some caregivers who fail to provide all the authorized services to clients or bill for hours of care that are in excess of the hours actually worked. Predominately, this abuse appears in consumer-directed care models. However, agency-model personal care services have been affected as well, but to a lesser extent.

The risk of abuse is heightened when the state Medicaid program relies upon self reporting of time and tasks. It is further heightened with the use of paper reporting systems. To counteract these risks, some state Medicaid programs have instituted requirements for the use of Electronic Visit Verification (EVV). Some states have acquired an EVV system to be used directly by all providers of personal care. In other states, EVV is required, but providers are permitted to use their own system or one available from various vendors.

In 2015, two legislative proposals were issued in the House and Senate respectively. H.R. 2446 would require state Medicaid programs to use electronic visit verification for home care services, including “home health services.” The bill does not mandate the use of any particular system, but instead requires the states to take into consideration efficiencies and accuracies in establishing the state-specific requirements. If a state fails to require EVV, the state is financially penalized with a reduction in the federal share of Medicaid costs.

S. 2416 also requires the use of EVV, but differs from the House bill in that the requirements also apply to Medicare home health services.

RECOMMENDATION: Congress should carefully consider proposals for requiring the use of EVV in home care services. In doing so, Congress should recognize that an EVV system increases the cost of care and that reimbursement rates should reflect the added cost. In addition, providers often operate in multiple states. Unique system requirements in each state would bring added costs to the care. Accordingly, uniform specifications adopted by each state would bring efficiencies. Finally, the need for EVV varies based on the nature of the home care program. Medicare and Medicaid “home health services” as distinct from personal care attendant services, has not presented a risk relative to abusive claimed hours of work as providers of the care are the primary parties at risk in this type of service as a set payment level is made to the provider. As an employer, home health agencies have their own financial and operation interests in assuring a proper work hours count.

RATIONALE: EVV can be of great value in protecting the integrity of government reimbursed home care programs. However, not all programs are alike with program-specific risks that are addressed by EVV. Further, flexibility in EVV requirements for providers creates the opportunity for the development of the best EVV system to fit the program-specific needs.

E. REGULATORY BURDENS/PAPERWORK

REPEAL OR REFORM MEDICARE HOME HEALTH FACE-TO-FACE ENCOUNTER REQUIREMENT

ISSUE: Section 6407 of the Patient Protection and Affordable Care Act of 2010 (PPACA) establishes as a condition of payment for home health services coverage under Medicare that a patient have a face-to-face encounter with the physician who certifies the need for home health services. The encounter also can be provided by certain non-physician practitioners, such as physician assistants and nurse practitioners. However, when a non-physician practitioner provides the encounter, the patient's physician must still certify that the encounter occurred and compose documentation detailing the finding from the encounter in addition to any documentation produced by the non-physician practitioner. Also, while section 6407 allows the encounter to occur through the use of telehealth, the law extremely limits that option by referencing Medicare telehealth coverage requirements that rule out services in a patient's home.

While the intention behind section 6407 was to gain greater physician involvement in ordering home health services, early indications are that physicians are hostile to the new requirement, particularly the documentation standards that Medicare included in the implementing rule. Those documentation requirements are not contained within the law passed by Congress. Under the original rule, a physician was required to document clinical findings with respect to the patient's need for home health services and explain how those clinical findings support Medicare coverage for prescribed care, the so-called "physician narrative."

As constructed, the law does not accommodate the realities of medical practice where patients may be seen by multiple physicians in a course of care. Some of these physicians confine their practice to inpatient settings and generally only initiate care to patients discharged home rather than continue involvement with their care at home. As such, the requirements developed under PPACA section 6407 create unnecessary roadblocks to care.

The implementation of the face-to-face encounter rule has led to great confusion among physicians, home health agencies, and other parties involved. Medicare has tried to mitigate the confusion through various communications, but the requirements remain difficult to understand and apply. As a result, the rule is creating a barrier to access to care with practitioners determining that it is easier to care for patients in alternative settings to home health care.

In 2013, Medicare contractors stepped up claims reviews related to the face-to-face encounter requirements. These reviews triggered a high volume of inconsistent claim determinations and claim denials. The vast majority of denials focused on the adequacy of the physician documentation rather than the existence of a timely encounter. These claim determinations indicate that all stakeholders, including CMS, Medicare contractors, physicians, and home health agencies, are very confused as to what is necessary and appropriate documentation. Good faith efforts by physicians and HHAs to comply with the requirements are resulting in retroactive claim denials for necessary care.

NAHC filed a lawsuit in June 2014 challenging the imposition of the "narrative" requirement and its application in claims reviews. Subsequently, CMS rescinded the narrative requirement effective January 1, 2015. However, the narrative requirement remains in place for all claims between April 2011 and December 31, 2014. This leaves HHAs vulnerable to extended claims reviews for years to come under a standard now abandoned by CMS.

The Federal district court issued its decision on November 3, 2015 finding that CMS had the authority to require a physician narrative to comply with the face-to-face encounter requirements. However, the court also concluded that CMS did not have the authority to second guess the physician and reject a narrative as insufficient. In place of the narrative, CMS now requires that physicians have sufficient documentation in their own files to support the certification of a patient's homebound status and skilled care need. Still, CMS has not issued adequate guidance on how HHAs are to comply with this new requirement. CMS instituted a "probe and educate" audit series in January 2016 with all HHAs subject to a review of five claims from 2015 for compliance with the new documentation standards.

Both under the original standard requiring a physician narrative as well as the new standard on documentation, the HHA is not in control of the documentation yet suffers the risk of a payment denial. Further, the subjectively technical requirements on documentation pose the likelihood of claim denials on patients who are, in fact, homebound and in need of skilled care. Legislation has been proposed that would modify the face-to-face physician documentation standards and provide the foundation for settlement of past denied claims (S.1650, Home Health Documentation and Program Improvement Act of 2015). A House counterpart is in development and it is expected that the Senate sponsors will modify their bill to be consistent with the HOUSE measure.

RECOMMENDATION: Congress should:

- Repeal the face-to-face provision and devise more constructive ways to secure physician involvement in home health care.
- Revise the face-to-face requirements to eliminate or significantly modify the physician documentation requirements as set out in the Medicare rule to eliminate the need for a physician to spell out why the patient's clinical condition requires Medicare covered home health services or to maintain sufficient documentation in their own files.
- Revise PPACA section 6407 to remove the reference to section 1834(m) of the Social Security Act and substitute a definition of telehealth services that allows an individual to meet the face-to-face encounter requirements through modern technologies available in their home. These technologies should include two-way audio and video communications.
- Establish exceptions to the requirements for patients who have been recently discharged from an inpatient setting, individuals in frontier areas where access to a physician or non-physician practitioner is limited, and individuals where a physician attests to the inability of the patient to leave the home for a physician encounter and is unable to have a physician perform a home visit.
- Provide financial protection to a home health agency that admits a patient in good faith with the reasonable expectation that a qualified face-to-face encounter has or will occur on a timely basis with appropriate documentation that is compliant with Medicare standards in the event that compliance is not met without the fault of the home health agency.
- Allow a non-physician practitioner to perform the encounter, certify that the encounter occurred, and compose all necessary documentation of the findings from the encounter.
- Provide an efficient and economical process for resolving past-denied claims through settlement or otherwise that takes into consideration appeal reversal rates, the amounts in controversy and the cost of the appeal process.

RATIONALE: The purpose of the face to face requirement was to enhance physician involvement in home health care, not to discourage physicians referring patients to care in their own homes. There is no evidence that pre-existing methods of physician involvement and communication negatively impacted the quality of patient care. Further, any evidence of overutilization of Medicare coverage cannot be tied to a lack of physician involvement or the nature of physician/patient/home health agency communications. The benefits of the face-to-face requirement serving as a measure of program integrity are far outweighed by the harm the requirement causes relative to patient access to care.

The implementation of the rule has highlighted numerous areas where reform is essential. These include the need for clarified and reduced documentation requirements that discourage and dissuade physician from participating in home health services, modification of the authority to use a telehealth-based physician encounter to fit with current telehealth capabilities in the home, and revisions that recognize that some patients do not have direct access to a physician to provide the encounter. Also, the requirements place all responsibility and consequences on the home health agencies while all the necessary actions are under the control of the patient and physicians. With this lack of control over compliance, home health agencies that act in good faith in serving patients should receive Medicare payments when noncompliance is not their fault.

REQUIRE MULTI-STATE RECIPROCITY IN MEDICARE SURVEY CONTRACTS

ISSUE: The Centers for Medicare and Medicaid Services (CMS) contracts with individual state health departments to perform provider surveys to determine compliance with the Medicare conditions of participation. Where a home health agency operates a branch office in a different state than its parent site, Medicare will allow the branch to participate in Medicare along with its parent only if the state survey office in the branch's location has a reciprocal survey contract with the survey office in the parent's state. CMS allows its state survey contractor the discretion as to whether to establish a reciprocity agreement. As a result, home health agencies have been prevented from operating branch offices across state lines because some states have been unwilling to accept reciprocity agreements.

RECOMMENDATION: Congress should require that CMS develop mandatory reciprocity survey agreements between neighboring states where it is consistent with state licensing laws.

RATIONALE: Medicare is a national program with uniform conditions of participation throughout all states. The failure to require reciprocity agreements can deprive residents of one state the availability of home health services centered in a neighboring state. These services are often centered in a metropolitan region that borders on another state.

ALLOW FLEXIBILITY IN THE DELIVERY OF HOME HEALTH SERVICES UNDER THE MEDICARE PROSPECTIVE PAYMENT SYSTEM

ISSUE: The structure of the Medicare home health benefit defines “home health services” to include certain limited disciplines of care such as nursing, physical therapy, speech-language pathology, occupational therapy, home health aide services, and medical social services. However, the modalities for the delivery of home care services continue to evolve with such recent additions as telehealth care along with pre-existing services that could reduce the episodic cost of home care, including nutrition care, pharmacist services, and respiratory services. While not specifically excluded as services that can be provided within the Medicare home health prospective payment system (PPS), there is no direct authorization for the use of services and technology outside the limited definition of “home health services” other than telehealth services.

Potential adverse consequences of this shortcoming in the Medicare home health benefit may surface in 2014 when the Centers for Medicare and Medicaid Services (CMS) issues its rebased payment rates. In Section 3131 of the Patient Protection and Affordable Care Act of 2010 (PPACA), Congress mandated that Medicare home health services payment rates be rebased effective 2014. However, the congressional mandate did not provide detailed, prescribed rebasing standards that ensure fair consideration of the costs of all the services provided to Medicare patients in the course of a covered episode of care.

CMS has allowed home health agencies (HHAs) to utilize the PPS payments to deliver modalities and disciplines of care beyond the items and services listed in the statutory benefit if those items and services are needed by the patient. However, CMS excludes the cost of any of those items and services from any rate analysis. The PPACA does not correct this deficiency. Further, CMS maintains no specific quality assurance standards relative to these items and services.

RECOMMENDATION: Congress should specifically authorize HHAs to utilize PPS payments in a flexible manner in order to achieve quality of care and efficiencies without adverse consequences relative to payment, coverage, and compliance with the conditions of participation. Further, Congress should require that CMS include all items and services provided to patients in the course of a covered episode of care in any quality standards or payment rate analysis. In addition, Congress should direct the Medicare Payment Advisory Commission (MedPAC) to include consideration of the cost of all clinical services when evaluating payment rates for home health services.

RATIONALE: Optimal health outcomes should be the main goal of the Medicare program and its supporting reimbursement system. HHAs should not be prohibited from taking advantage of new technologies and services, along with alternative care, if equal or better patient outcomes can be achieved with greater economies. Flexibility in the delivery of home health services within PPS does not necessitate any change in the home health benefit qualifications, which require that a patient be confined to the home while in need of skilled nursing care on an intermittent basis or physical or speech therapy. HHAs should be authorized to utilize such

important disciplines as nutritionists and respiratory therapists, or new technologies that can reduce the cost of providing care to patients at home while maintaining or improving patient outcomes.

FULLY REIMBURSE OASIS COSTS, STREAMLINE OASIS REQUIREMENTS, AND CONDUCT RESEARCH ON OASIS VALIDITY

ISSUE: The Centers for Medicare & Medicaid Services (CMS) requires home health agencies to submit patient data using the Outcome and Assessment Information Set (OASIS). In addition to the ongoing agency expenses related to telephone, computer hardware, editing and auditing data entry and supplies, these requirements add considerably to the amount of time clinicians must spend on paperwork related to cases.

Subsequent to implementation of the home health PPS, the then-General Accounting Office (GAO) conducted a study under which it found that nearly all agencies surveyed estimated that start-of-care visits take approximately 40 minutes longer than before OASIS was implemented. These agencies also reported that additional time is needed to check and edit collected OASIS data, enter and transmit the information electronically, and train new staff. GAO data indicate that these additional steps require approximately 50 minutes per OASIS assessment. Eighty-four percent of survey respondents said they provide, on average, eight hours of education for newly hired staff. The GAO did not provide study of the additional administrative burdens associated with additional assessments instituted with OASIS.

The OASIS burden has become so great that agency nursing staff cite OASIS requirements as one of the leading reasons for leaving the home care field.

There has been only limited research conducted on the validity and reliability of the OASIS items. Following implementation of OASIS, the Center for Home Care Policy & Research of the VNS of New York conducted an in-depth study in this area and found that in real-world application of OASIS, many of the data items scored low in reliability tests. Of particular concern were their findings of low reliability for the instrumental activities of daily living (IADLs), functional status in the 14 days prior to the episode, and prognosis.

During 2008, CMS published an “OASIS-C” data set packet that included information regarding a revised version of OASIS. The data set was subsequently finalized and implemented in early 2010.

RECOMMENDATION: Congress should provide for reimbursement of the full costs agencies incur with respect to OASIS. OASIS data collection and submission requirements should be limited to Medicare patients. The number of OASIS items and frequency of assessment should be limited to only those necessary to determine appropriate reimbursement and patient care outcomes. Congress should direct CMS to conduct in-depth study of the reliability and validity of OASIS items on a regular basis. The recognition of the full cost of OASIS should occur in all levels of episodic payment, not just the start of care LUPA episodes as under the 2008 PPS model.

RATIONALE: OASIS can be a valuable tool that, over time and with appropriate changes, could greatly enhance the delivery of home care services. However, requiring OASIS data collection and submission for non-Medicare patients constitutes an unfunded mandate. Initial assessment of OASIS requirements have reflected significant increased burden on agencies and staff; the forthcoming OASIS-C instrument will impose further obligations and costs. OASIS

requirements should impose as few administrative and financial burdens as possible upon already severely strained home health agencies. OASIS items should be used to measure quality and alter payment ONLY after their validity and reliability have been proved.

INCREASE FLEXIBILITY IN THE APPLICATION OF THE HOME HEALTH CONDITIONS OF PARTICIPATION

ISSUE: The Centers for Medicare & Medicaid Services (CMS) requires the application of all of the Medicare Home Health Conditions of Participation (CoP) to all patients served by the Medicare-certified agency regardless of payer source or type of services provided. These requirements increase the cost of services to all payers. Yet, only one CoP, supervision of home health aides, has been written to provide flexibility in application based on service needs. Application of another condition, the Outcome and Assessment Information Set (OASIS) requirement, varies depending on payer and need for skilled care, but CMS plans to apply them to all patients served by certified agencies in the future. The application of OASIS to non-Medicare/Medicaid patients has been temporarily suspended, under the 2003 Medicare reform legislation. The Secretary's Advisory Committee on Regulatory Reform adopted a recommendation to apply certain other Medicare Home Health CoP to Medicare patients only. The Government Accountability Office (GAO) has been charged with the responsibility to evaluate a more flexible application of the home care CoP. However, by the end of 2008, CMS has promulgated no changes to the CoP to allow for improved flexibility.

CMS has proposed significant revisions to the Conditions of Participation. These revisions bring some new flexibility, but the structure continues an inflexible architecture for home health agencies in a number of areas, including staffing. No change is made in applying the CoPs to non-Medicare payers.

RECOMMENDATION: Congress should allow home health agencies flexibility in application of the CoP to payers other than Medicare, including limiting application of the OASIS requirements to Medicare patients only.

RATIONALE: Some CoPs in their full application are excessive for the delivery of some services by home health agencies. With the introduction of prospective payment and OASIS, two burdensome regulations that have been instituted since enactment of the Balanced Budget Act of 1997, it has become increasingly difficult for agencies to comply with the CoP for all patients and keep costs manageable. Building additional flexibility into the CoP would contain costs for delivery of services to non-Medicare patients by certified agencies rather than unregulated separate entities, and thus maintain quality.

Following are some examples of regulations that are not necessary for all populations served by certified agencies:

- It is not necessary for physicians to review and sign the plan of care for medically stable persons receiving health promotion and personal care services according to state nurse practice acts.
- Physician order requirements were designed for legal authority to provide care and control of utilization. Nursing and therapy practice acts now recognize all but invasive procedures as independent aspects of practice, so orders are not usually required for legal coverage. A physician order with the intent of controlling utilization is a payer issue, not an operations or practice issue. If a payer wants to require this and assume the costs thereof, it should be a condition of payment.
- Patients' medication monitoring should be the responsibility of physicians and

pharmacists when home health patients require only therapy, medical social work, or aide services.

- OASIS data collection and reporting is not covered by most payers. Medicaid payments do not cover the cost of care in most states before the added burden of OASIS. Further, the Medicaid population can differ significantly from the Medicare population, thereby limiting the usefulness of OASIS for such cases.

ENSURE ACCESS TO HOME CARE AND FULL FEDERAL FUNDING IN ANY PROPOSALS TO REQUIRE MEDICAL DIRECTORS IN HOME HEALTH AGENCIES

ISSUE: Although the 111th Congress did not propose or address the issue of mandatory medical direction of home health agencies in the Patient Protection and Affordable Care Act (PPACA), the 105th Congress discussed this issue as a potential means of ensuring quality of care, regulatory compliance and accountability for patient care. Ideally, medical directors could help bridge communication gaps between a home care agency and a physician's office, and help implement the most appropriate clinical services while helping to clarify the status of homebound patients. Several concerns must be met, however, before this idea becomes a statutory requirement. First, Medicare home health agencies are already under extraordinary financial strain due to the effects of many regulatory burdens and changes in reimbursement. The additional, and potentially substantial, costs of a medical director simply could not be borne under the current payment system and would need to be fully funded by the Medicare program as a pass-through. Second, many physicians have very limited understanding of home care and the medical regulations. Third, agencies in many rural and underserved areas may find it particularly difficult to recruit any medical director, much less a medical director with adequate knowledge of the Medicare home health benefit. Severe access problems would result if home health agencies were not able to meet this requirement.

RECOMMENDATION: In the event that Congress considers mandating a medical director requirement, care access and funding concerns must be satisfactorily resolved.

RATIONALE: Ideally, increased physician involvement could enhance home care delivery. However, home health agencies are already struggling to survive financially. It would be impossible for all agencies to comply with a mandate to have a physician on staff unless full reimbursement is guaranteed and other concerns are fully met.

MODERNIZE MEDICARE HOME HEALTH AGENCY “ONE SERVICE DIRECTLY” STANDARD

ISSUE: Since the inception of the Medicare Conditions of Participation for home health agencies, there has been a requirement that the home health agency provides skilled nursing care and at least one other qualifying service, with at least one service provided exclusively through employees. This core requirement and, specifically, the requirement that one service be provided exclusively through employees, does not fit within the current health care service economy and workforce market. Staff shortages, specialization, and work flexibility have created difficulties for home care providers to continue to meet the conditions of participation. Home care providers need to contract for any discipline of care in order to substitute for absent employees, fill resource gaps in times of expanded demand, and secure appropriately specialized staff to deal with unique patient needs.

Rather than modernize the standard, the Centers for Medicare and Medicaid Services (CMS) has moved backwards. In 2001, CMS reinterpreted existing regulation to limit the disciplines of service that could qualify to meet the requirement that one service be provided directly and exclusively by employees. CMS withdrew its new interpretation after it was established that the policy violated the original intent of rule.

In 2014, CMS proposed revisions to the Conditions of Participation. However, it did not propose any changes to the “one service directly” requirement.

Other Medicare providers have the flexibility to staff services with their choice of employees or contractors provided quality of care systems are in place. No adverse consequences have been reported. Recently, Congress modified the “core services” requirement for hospice care to increase flexibility in service staffing.

RECOMMENDATION: Congress should amend the statutory authority for the Conditions of Participation to allow for a home health agency to use contracted services for any and all disciplines of care, provided adequate safeguards for supervision and oversight are established by the home health agency.

RATIONALE: The existing core services requirements for home health agency participation in Medicare are a proxy for establishing quality assurance in the provision of care. Medicare maintains an outdated and unfounded belief that an employed caregiver is more capable of providing high quality services to patients than a contracted caregiver under appropriate supervision and oversight. Congress has granted such flexibility to hospices in the 2003 Medicare reform legislation, which indicates that quality of care is not compromised through the use of contracted services. Quality of care should not be assured through employment label status but through outcome-oriented operations.

LIMIT ADMINISTRATIVE BURDENS ON HOME HEALTH AGENCIES

ISSUE: Through the years, the Centers for Medicare and Medicaid Services (CMS) and other federal agencies have imposed increasing numbers of regulatory requirements on home health agencies, many of which have significantly increased agency costs and added to agency staffs' workloads. Among these are requirements associated with OASIS, advance beneficiary notices, 15-minute increment billing, and others. Some of these requirements are ill conceived, unnecessary, duplicative, and burdensome. In analyzing the "paperwork" costs, CMS limits its calculations to the time needed to physically complete the form rather than the full costs involved. Additional costs, including those related to the deliberative process of decision-making, patient assessment, notice delivery, and maintenance of records, are not considered in evaluating burdens and considering alternatives.

In cases where requirements are reasonable, they may be ill timed, considering all of the other adjustments and adaptations home health agencies are in the process of making. Recent examples include when CMS implemented a new patient notice process that, when added to existing notice requirements, requires home health agencies to provide up to six different notices, potentially at multiple points when Medicare coverage or service is to be reduced or terminated. The newly proposed CoPs also include extensive changes that will increase paperwork burdens. The cost of this process takes valuable resources away from patient care. The 2010 and 2015 standards for face-to-face encounter requirements and therapy care planning are additional regulatory actions that have significant adverse financial consequences to providers that may outweigh the intended benefits of the rules. Both lead to paperwork burdens for the vast majority of providers that offer no program integrity risks.

RECOMMENDATION: Congress should require accountability by CMS for any changes it contemplates that would increase administrative burdens on home health agencies. Full cost benefit analyses should be conducted within the context of overall burdens already being borne by agencies. Congress should disapprove imposition of any duplicative, unnecessary, or overly burdensome requirements.

RATIONALE: Home health agencies are currently instituting an overwhelming number of administrative changes. Many of these changes are costly and significantly increase the workloads of already strained agency staffs, affecting the ability of agencies to retain staff and continue to provide high-quality, appropriate care. Regulatory burdens must be more closely monitored to ensure the continued viability of agencies nationwide.

COORDINATE GOVERNMENT REVIEWS OF HOME HEALTH AGENCIES TO REDUCE PAPERWORK BURDEN

ISSUE: Currently, home health agencies are subject to a variety of surveys based on both federal and state requirements to ensure quality of care and compliance with the Medicare Conditions of Participation. Regulation of the home health industry is entirely appropriate. However, every effort must be made to ensure minimal disruption and to avoid unnecessary expense. The current survey system is fragmented, uncoordinated, duplicative, and needs to be streamlined. For example, a Medicare surveyor, a medical review post-payment auditor, a quality improvement organization reviewer, a provider enrollment contractor, and a Medicare audit and reimbursement reviewer all look at an agency's patient records and various agency operations to determine whether the agency should be allowed to continue in the Medicare program. On claims reviews, CMS now employs four different home health review contractors all with the power to retroactively review the same claim.

RECOMMENDATION: As government agencies work to update their information systems, Congress should require the Centers for Medicare and Medicaid Services (CMS) to develop an information-sharing system that would reduce the paperwork burden on agencies and provide the reviewers with information necessary to make decisions. This information should be accessible to all appropriate reviewers upon provider notification. The system should also include safeguards to protect the confidentiality of records.

RATIONALE: The current survey system is inefficient, excessively costly, disruptive, and unfair. An agency should have to submit patient records and claims information only once. Currently, three or four different Medicare contractors may review the agency's records and operations information on site, by mail, or a combination thereof.

ALLOW NURSE PRACTITIONERS, CLINICAL NURSE SPECIALISTS, CERTIFIED NURSE MIDWIVES AND PHYSICIANS' ASSISTANTS TO CERTIFY MEDICARE HOME HEALTH PLANS OF CARE

ISSUE: Nurse practitioners (NP), clinical nurse specialists (CNS), certified nurse midwives (CNM) and physicians' assistants (PA) are playing an increasing role in the delivery of our nation's health care. Moreover, many state laws and regulations authorize these non-physician health professionals to complete and sign physical exam forms and other types of medical certification documents.

The federal government is also recognizing the growing role of PAs and NPs. The Balanced Budget Act of 1997 (BBA), P.L. 105-35, allows Medicare to reimburse PAs and NPs for providing physician services to Medicare patients. These physician services include surgery, consultation, and home and institutional visits. NPs and PAs can certify Medicare eligibility for skilled nursing facility services. The Centers for Medicare & Medicaid Services (CMS) now allows PAs and NPs to sign Certificates of Medical Necessity (CMNs) required to file a claim for home medical equipment under Medicare. Since 1988, CNMs have been authorized to provide maternity-related services to the relatively small population of disabled women of child bearing age who are Medicare-eligible. Despite the expanded role of PAs and NPs in the BBA, the Centers for Medicare & Medicaid Services (CMS) continue to prohibit PAs and NPs and other non-physician health professionals from certifying home health services to Medicare beneficiaries. According to CMS, the Medicare statute requires "physician" certification on home health plans of care.

Legislation was introduced in the 110th Congress which would permit NPs, CNSs, CNMs, and PAs to certify Medicare home health plans of care: the "Home Health Care Planning Improvement Act. This legislation was re-introduced in each Congress since then. In the 114th Congress, the bill numbers are S.578/H.R.1342.

RECOMMENDATION: Congress should enact legislation that would allow NPs, CNSs, CNMs, and PAs to certify and make changes to home health plans of treatment.

RATIONALE: NPs, CNSs, CNMs, and PAs are increasingly providing necessary medical services to Medicare beneficiaries, especially in rural and underserved areas. NPs, CNSs, CNMs, and PAs in rural or underserved areas are sometimes more familiar with particular cases than the attending physician, so allowing them to sign orders may be most appropriate. In addition, they are sometimes more readily available than physicians to expedite the processing of paperwork, ensuring that home health agencies will be reimbursed in a timely manner and that care to the beneficiary will not be interrupted. The Institute of Medicine released a study which recommends that NPs and CNSs be allowed to certify eligibility for Medicare home health services (IOM, *The Future of Nursing: Leading Change, Advancing Health*, October 5, 2010).

OPPOSE USER FEES FOR MEDICARE AND MEDICAID ADMINISTRATIVE ACTIVITIES

ISSUE: Presidential budget proposals have included a recommendation that would require all health facilities, including home health agencies and hospices, to pay a user fee sufficient to cover the costs associated with administrative activities under the Medicare and Medicaid programs.

The Congress has repeatedly rejected user fee proposals. In the Omnibus Budget Reconciliation Act of 1990 (OBRA-90, P.L. 101-508, § 4207 (h)), Congress specifically prohibited the Department of Health and Human Services (HHS) from imposing or requiring states to impose on home health agencies, hospices, hospitals or other entities (excluding those required by the Clinical Laboratory Improvements Amendments of 1988) a fee to offset the costs of surveys to certify compliance with the Conditions of Participation under Medicare Part A or B.

The fiscal year 1996 (FY96) budget (P.L. 104-134), rather than imposing user fees, increased the time between home health recertification's from once every 12 months to once every 36 months and expanded the Centers for Medicare & Medicaid Services' (CMS) authority to deem agencies as certified if the agencies are accredited by certain private accrediting bodies. These provisions were designed to provide CMS the budget flexibility to begin to alleviate the backlog of initial certifications resulting from insufficient funding levels to cover the number of new providers' initial surveys.

During 2007 Congress authorized CMS to establish a revisit user fee to health facilities, including home health agencies, cited for deficiencies during certification surveys. These fees are assessed when survey revisits are made to address "deficient practice" during initial, recertification, and substantiated complaint surveys. This authority expired in late December 2007; it is unclear whether Congress will approve further authorization for such revisit fees.

Despite growing demand for home health services, CMS has not sought sufficient funding to supply all the needed support services such as survey and certification activities. As a result, parties interested in establishing home health agencies and hospices have been forced to purchase private accreditation services from companies with "deemed status" accreditation.

RECOMMENDATION: Congress should reject user fee proposals, and ensure that funding is sufficient to cover the costs of administrative activities under the Medicare and Medicaid programs.

RATIONALE: User fees are in essence a tax on health care providers for participating in Medicare and Medicaid. These programs currently do not fully compensate providers for their cost of caring for program beneficiaries even without the tax. The user fee proposal also exaggerates the true federal cost savings. A portion of payment for user fees and administrative costs will be rolled into cost reports. In some states, these costs will be partially reimbursed by Medicare and Medicaid. However, providers would still be responsible for costs over and above the limited amount which Medicare and Medicaid provide as reimbursement. Asking health care providers to provide quality care while, at the same time, asking them to shoulder both government costs and their own expenses related to Medicare and Medicaid programs is unfair.

PROHIBIT USE OF SAMPLING AUDITS

ISSUE: Medicare intermediaries and Program Safeguard Contractors have used sampling techniques to audit home health agency claims. The Recovery Audit Contractors are authorized to join in the use of sampling as part of expanded program integrity efforts. When utilized, sampling has proven itself a devastating device with a high risk of error. Any errors in the sampling process are multiplied, possibly placing the home health agency at risk of financial collapse. A single claim denial can result in tens of thousands of dollars of payment disallowances. In a recent case, the Program Safeguard Contractor reviewed just 32 claims and extrapolated the results of the review to demand over \$14 Million as an overpayment. The appeals process is an inadequate protection against erroneous denials since it can take several years to resolve a single claim denial and recovery of any alleged overpayment begins 30 days after the Reconsideration decision is issued.

As a result of erroneous sample determinations, agencies have been forced into bankruptcy and are no longer available to provide services to Medicare patients in their community. Some agencies survive, but only after protracted and expensive administrative appeals that establish that, generally, Medicare's determinations were erroneous.

The Centers for Medicare and Medicaid Services (CMS) issued guidelines for sampling in 1999. In the Medicare Modernization Act of 2003, Congress restricted the use of claims audits, but did not ban sampling. The application of those guidelines has been rare, but with consistent results—the methods employed are unreliable and inaccurate. Unfortunately, CMS also issued a regulation that bans any right to appeal whether the use of sampling violates the guidelines. As such, Medicare effectively can ignore its own guidelines without any right of the provider to challenge the use of sampling. Sampling causes great harm to Medicare patients and the home care providers who serve them for the following reasons:

- Recoupment before full appeal: Intermediaries using sampling require alleged overpayments to be refunded before the provider can exercise their full appeal rights. These recoupments can be huge and can threaten the very survival of the provider. The section 935 of MMA protections against recovery prior to appeal apply only through the first two stages of appeal.
- Access to care reduced: Historically, the fear of erroneous Medicare coverage denials has led some providers to limit availability of services to certain Medicare patients. Sample adjudication magnifies this “chilling effect” many felt.
- Claims process compromised: The coverage determination process, which requires individualized review of claims, is rendered meaningless through retrospective review of only a sample of claims. With sampling authority, the Medicare program has no incentive to issue accurate and fair determinations in advance of payment.
- Loss of third-party payment: Since the great majority of the claims on which sample adjudication is based cannot be identified, providers of services have no way of securing payment from alternative sources of payment, such as Medigap policies, which may be liable.

The Medicare Modernization Act of 2003 prohibits the recovery of alleged overpayments that have been calculated through sampling or otherwise through the reconsideration step in the appeal process only. In addition, the legislation limits overpayment extrapolation through

sampling unless the Secretary determines that there are sustained or high levels of payment error, or education efforts have failed to correct payment error. The legislation also permits “consent settlement” sampling and full sampling where there are patterns of serious noncompliance. These reforms are helpful, but not sufficient to protect against the devastation caused by inaccurate sampling methodologies and their underlying decisions.

RECOMMENDATION: Congress should prohibit the use of sampling to audit Medicare home health and hospice bills and clarify the current law to require individual coverage determinations. Alternatively, Congress should guarantee that a provider has a right to challenge whether sampling should be applied to it prior to its use or prior to the recovery of any alleged overpayment.

RATIONALE: At the foundation of the coverage determination process is the recognition that individualized decisions are necessary because each home health care patient presents unique health care needs. Sampling is in direct conflict with that principle. In a recent home health services sampling action, the PSC extrapolated the results of 30 claims it reviewed to the entire universe of claims submitted by the provider over a 15 month period leading to a \$14 million demand by Medicare. Such an action, when done incorrectly, leads to the demise of essential health care services in the affected area of that provider.

F. PROTECTIONS FOR CONSUMERS, PROVIDERS AND CAREGIVERS

PROMOTE MEDICARE-MEDICAID COORDINATION

ISSUE: Some patients are dually eligible for Medicare and Medicaid benefits. Their coverage may alternate between Medicare and Medicaid due to a change in their condition and the need for skilled services. Medicare is considered primary to Medicaid, so some Medicaid programs require a Medicare denial before making payment. Current Centers for Medicare & Medicaid Services (CMS) regulations require that third-party liability recovery programs demonstrate cost effectiveness and that liability be established to the third party prior to recovery from the provider.

It is the belief of the state Medicaid programs that Medicaid has incorrectly made payment on behalf of patients who were eligible for Medicare coverage. Medicaid programs across the nation have initiated projects designed to recover payments made for services to patients who are dually enrolled in both the Medicare and Medicaid programs. Others are requiring a formal Medicare claim determination before processing a Medicaid bill. In addition, some states are taking a hard line against Medicaid payment for any services rendered during any part of the 60 day period that includes some Medicare coverage of home health services. This position is taken even when the Medicaid claim concerns services after the close of Medicare coverage or when necessary care is provided beyond Medicare's scope of benefits.

Significant costs to providers, Medicare, and Medicaid are incurred because these projects require retrospective claims review, submission of claims to Medicare, and administrative appeals. Further, the unsupportable position that Medicare covers everything in the home for each day of the 60 day episode leaves providers with unpaid services.

Problems exist with the demand bill process, sometimes taking three to four months when the payer (e.g., Medicaid) requires billing in a shorter time. Agencies have to bill without the Medicare denial, get rejected, and re-bill when the Medicare denial is received. This costs agencies considerable dollars. Some programs have required billing to Medicare for services clearly not covered (e.g., personal care only, housekeeping).

At the end of 2002, CMS and several states established demonstration programs in Connecticut, Massachusetts, and New York utilizing sampling adjudication to address this cross program conflict. Although home health agencies must supply documentation for sampled claims subject to review by state Medicaid programs, any resultant recovery of funds is completed between Medicare and Medicaid. The program had been extended in New York. No other states are allowed to participate at this time. The expiration of the demonstration program has led to significant increases in administrative costs for providers in states where Medicaid engages in wholesale "Medicare maximization."

RECOMMENDATION: In addition to prohibiting individual claims-based "Medicare maximization," Congress should require that state Medicaid programs:

- Utilize the most cost effective method for recovering payment for dually eligible patients.
- Consider the development of a system of claims review that does not require individual claims submissions and appeals. Medicare and Medicaid claims submission should be

combined with initial billing to Medicare and a transfer billing of remaining non-covered care to the respective state Medicaid program.

- Recoup incorrect payments from the Medicare program rather than the provider. No recovery should take place against a provider until after third party (Medicare's) liability is established.
- Work with CMS on implementation of pilot programs that incorporate the above recommendations for dually eligible beneficiaries' coverage decisions on a nationwide basis.
- Establish clear coverage standards for Medicare and Medicaid that differentiate between the Medicare responsibilities in an episode of care and the Medicaid coverage obligations for additional services.

RATIONALE: While home health agencies make the best effort to determine whether a patient is covered under Medicare prior to submission of a claim to Medicaid, incorrect Medicaid payments have occurred. However, the use of an individual appeals system represents a costly, burdensome process for all parties concerned including the provider of care, the Medicaid program, and Medicare. Strengthened rules and better enforcement would allow CMS to maintain improved oversight over state programs and to minimize the overall cost experienced by all parties. If the model demonstration programs are adopted nationwide, most of the burden of states' efforts to maximize Medicare will be eliminated.

SUPPORT ADEQUATE FUNDING OF MEDICARE ADMINISTRATIVE ACTIVITIES

ISSUE: The Centers for Medicare & Medicaid Services (CMS) has restricted or delayed administrative functions based on the claim of funding priorities. For example, CMS has stalled or suspended the processing of changes in provider ownership because of a lack of sufficient funding available for contractor services. In addition, CMS has essentially suspended the certification of new home health agencies in a number of states because of insufficient administrative financing. This has forced prospective home health agencies to purchase Medicare certification by using private accrediting bodies rather than publicly financed survey and certification processes. At a time when home health agencies and hospices are undergoing corporate and ownership changes, consolidating or expanding operations, these administrative barriers can paralyze the business side of a significant health care sector.

The Patient Protection and Affordable Care Act (PPACA), P.L. 111-148, has taxed CMS's ability to implement the extensive changes that the bill requires for implementation over the next few years. That means that pre-existing responsibilities are likely to be met only if absolutely essential unless sufficient administrative funding is provided.

RECOMMENDATION: Congress should adequately fund all CMS administrative functions regarding home health services and hospice care and establish performance standards for those functions.

RATIONALE: Medicare is not simply a health insurance payment program. It drives the business structure of many health care providers. Inadequate financing of CMS administrative functions is a problem that leads to higher cost for providers and restricts the improvements that are underway in the business of health care.

PROHIBIT SUSPENSION OF PAYMENT IN SUSPECTED OVERPAYMENT CASES

ISSUE: In 2004-2005, new Medicare contractors, Program Safeguard Contractors (PSCs), began a series of home health services claim reviews. In some cases, less than a dozen claims were subject to the reviews. The PSCs issued preliminary findings to the home health agencies indicating that they had determined that the claims might not meet Medicare coverage standards. In addition, as a result of these preliminary findings, the PSCs suspended all Medicare payments to these providers based on the allegation that the agency may have been overpaid. The PSCs continued this practice through 2008.

Medicare regulations, without specific statutory authority, allow for suspension of payment for up to 360 days based merely on the suspicion of an overpayment. The provider has no rights to challenge or appeal the payment suspension. This is in stark contrast with Section 935 of the Medicare Modernization Act of 2003 (MMA), which prohibits recovery of any determined overpayments until the provider has the opportunity to take two steps in the administrative appeals process. As a result, providers have less protection from wrongful payment actions for suspected overpayments than they have for overpayments that Medicare has actually determined have been made.

The Patient Protection and Affordable Care Act of 2010 (PPACA), Section 6402, permits Medicare and Medicaid to establish standards for the suspension of payments when overpayments/fraud is suspected. CMS issued an interim final rule in early 2011 that implements this provision in a manner that limits any reasonable due process for providers of services allowing unchecked and unappealable determinations to suspend payment based simply on a “reliable evidence” of abusive conduct. 76 F.R. 5862 (February 2, 2011).

CMS also issued a set of “alternative sanctions” that can be imposed on home health agencies that allegedly violate a Medicare Condition of Participation. These sanctions include the power to suspend payments. 42 CFR 488.820.

RECOMMENDATION: Congress should amend the law to include suspected overpayments that are the basis for payment suspension within the protections afforded under Section 935 of MMA. The amendment should extend to the provider of services the right to pursue a “redetermination” and “reconsideration” of the preliminary decision that the claims may not be covered under Medicare prior to the suspension of payment. Alternatively, Medicare should be prohibited from suspending payment at an amount greater than the claims involved in the preliminary review. Finally, Congress should require that Medicare issue formal coverage determinations within 30 days of any finding that a provider is suspected to have been overpaid. Extended suspensions of payment due to suspected, but not established, overpayments should be prohibited in the absence of evidence of fraud.

Any decision of Medicare or its contractors that could trigger a payment suspension should be fully subject to review and appeal before any suspension can take effect. For example, if the suspension is based on an allegation that there is “reliable evidence of an overpayment,” the affected provider should have a right to challenge that allegation in advance of any punitive measure such as payment suspension.

RATIONALE: The suspension of payment usually represents the end of the provider’s opportunity to stay in business. It is unfair to provide less protection against wrongful

governmental action in situations of suspected overpayments than where Medicare has issued a formal determination that a provider has been overpaid.

LIMIT RETROACTIVE RECOVERIES RELATED TO THE IMPLEMENTATION OR MODIFICATION OF MEDICARE PPS

ISSUE: The implementation of the Medicare prospective payment system (PPS) for home health services has been relatively successful. However, there have been a few matters where the implementation has been burdened with incomplete guidance to providers and weakness in the claims systems. As a result, providers acting in good faith and with due diligence have been subjected to overpayment determinations and demands for recovery dating back to the inception of PPS.

A prime example is the MO 175 recovery related to “inaccurate” reporting of a patient’s pre-home health care settings. The original instructions with the OASIS patient assessment provided no guidance as to the appropriate classification of a stay in a long term care hospital (LTCH). Beginning in October 2003, Medicare instructed that a LTCH stay should be classified as a general hospital stay. However, home health agencies that classified a LTCH stay as a rehabilitation hospital stay have been determined to have been overpaid back to October 2000. Fortunately, CMS recently abandoned MO 175 recovery, but only after numerous appeal decisions held that reopening such claims after 4+ years was not valid.

The transition to a new PPS model in 2008 is likely to lead to similar problems with potential overpayments occurring. For example, while the MO 175 problem has been eliminated, it has been replaced with the payment distinction between early and late episodes. Recently, CMS instructed contractors to resolve all payment adjustments that occurred through the error- prone implementation of the new PPS model by March 2009, over 14 months since the PPS implementation.

In 2010, CMS issued two new regulations that can create a risk of retroactive recoveries. In July 2010, CMS began requiring that care orders for Medicare home health services be authorized only through physicians enrolled in the CMS PECOS system. While CMS has postponed claim editing for PECOS enrollment, it has not definitively said that it would not retroactively enforce the rule. Similarly, beginning in 2011, initial episodes of Medicare home health services must include a qualified face-to-face encounter with a physician or certain non-physician practitioners. CMS has postponed enforcement of the rule for 3 months, but not guarantee of retroactive enforcement has been provided.

In early 2013 legislation, Congress extended the opportunities for Medicare to recover overpayments by amending section 1870 of the Social Security Act to extend the collection period to 5 years from the 3 years previously in the law. Under 1870, provider is immunized from an overpayment collection if it is without fault in receiving the overpayment. The provider is presumed without fault after a point in time. The amendment now triggers the protection after 5 years rather than 3.

RECOMMENDATION: Congress should waive provider liability for overpayments triggered by PPS or other rulemaking implementation errors and weaknesses where the provider acted in good faith regardless as to when the error is discovered.

RATIONALE: The original PPS was implemented without any advance trial. Consequently, not all implementation issues were addressed or resolved in advance. However, the revised PPS was touted as operationally accurate by CMS prior to its January 2008 implementation.

Nevertheless, numerous claims processing mistakes occurred. Subjecting providers to retroactive payment adjustments in such circumstances penalizes the providers for systemic shortcomings created by the Centers for Medicare & Medicaid Services (CMS), not the provider. Similarly, CMS has promulgated various rules with dates effective before the CMS system or other parties were ready to comply.

REFORM STANDARDS FOR HEALTH CARE SERVICES LIABILITY

ISSUE: Professional liability insurance has become too expensive and too difficult to acquire. In the absence of adequate insurance, access to affordable health care services is at risk. In addition, with rising insurance costs and limited payment rates, home care providers and hospices are forced to cut other expenses that may also jeopardize continued access to care.

RECOMMENDATION: Congress should enact reforms that bring about economies and stabilization in professional liability insurance. Reforms that should be considered to include, but are not limited to, limits on provider liability.

RATIONALE: While professional liability insurance reforms, such as limitations on liability, may cause a victim of health care negligence or malpractice to feel further victimized, the community good is served by having continued access to health care services that might otherwise be lost due to the cost of liability insurance. Individual states have enacted a hodgepodge of liability insurance reforms resulting in inconsistent availability and widely varying costs of liability insurance across the nation. A federal approach to liability insurance reform will aid in supporting access to services across the country.

ALLOW PROVIDER APPEALS PRIOR TO SANCTIONING FOR SURVEY AND CERTIFICATION DEFICIENCIES

ISSUE: The Medicare Conditions of Participation (COP) for home health agencies and hospices (42 CFR 484) establish minimum standards for participation in the Medicare program. Although these conditions are intended to be standardized requirements for all certified agencies, the inherent complexity of the system has led to the issuance of deficiencies that may not actually reflect noncompliance with the COP.

Current appeal procedures do not adequately protect providers from inaccurately issued deficiencies. An agency may receive deficiencies that lead to the agency being terminated from program participation. The agency has a right to appeal this determination through a hearing before an administrative law judge (ALJ) and appeal to the Departmental Appeals Board. However, the appeal of a termination notice does not suspend the termination process. An agency may be subjected to public notice of termination and may be required to transfer all Medicare patients before the ALJ finds that the deficiencies cited are unsupported by statute and regulation. For example, a home health agency successfully appealed its termination only to be reinstated nearly two years later by which time the agency's operation had virtually ceased and could not be restarted.

More commonly, the agency receives deficiencies that do not result in a recommendation for termination, but instead require changes in the agency's operation. No formal appeal mechanism exists for agencies that disagree with the findings or interpretations of a surveyor. Lacking a recommendation for termination, the Centers for Medicare and Medicaid Services (CMS) Regional Office is not involved. The agency's only recourse is to informally appeal to the state survey agency and/or regional CMS office to discuss the deficiencies in question, even though the state or regional office may not be receptive to resolving the issues. The agency may be subject to significant costs and operational changes in correcting nonexistent deficiencies.

With implementation of the Medicare reforms contained in the Omnibus Budget Reconciliation Act of 1987, P.L. 100-203, the impact of deficiencies became increasingly serious whether or not they lead to program termination recommendations. Agencies with conditional deficiencies are barred from performing home health aide training; surveyor reports of deficiencies are available to the public through inquiries to home health hotlines; and intermediate sanctions, including civil monetary penalties, may be levied against agencies for certain deficiencies.

Finally, the need for a formal provider appeals process is highlighted in the case of CSM Home Health Services. CSM was terminated from the Medicare program after three federal surveys found alleged noncompliance with the COP. The termination took effect in July 1996. CSM appealed to an ALJ who reversed the termination on October 25, 1996. Medicare appealed the ALJ decision. The appellate level agreed with the ALJ and reinstated CSM in an August 1997 decision. Since July 1996, however, CSM had been prohibited from serving Medicare patients. By the time the appeal was resolved, it was too late for CSM's business to resume as it was bankrupt. The CSM travesty has been repeated several times since 1996 with other HHAs desperately attempting to survive the provider participation appeals process with no Medicare revenue for two to three years.

The Medicare Modernization Act of 2003 allows for expedited judicial review of

provider agreement terminations in circumstances where facts are not in dispute. However, this change is of limited value since it would be usable only in rare circumstances.

In addition, the legislation requires the Secretary to develop a “process to expedite proceedings” in termination cases. This change will not affect the timing of appeal rights that begin only after termination. CMS is currently considering the establishment of an alternative dispute resolution process to address survey deficiencies. Such a process had been previously used with nursing facilities.

Beginning on July 1, 2013, the need for pre-sanction appeals rights is heightened as new “intermediate sanctions” take effect under a rule promulgated by CMS in late 2012. While CMS allows the postponement of collecting any civil money penalties under all appeals are exhausted, the penalties continue to accrue with interest. Non-monetary sanctions are not postponed. As of July 1, 2015, CMS also established an “Informal Dispute Resolution” (IDR) process that can be used to resolve deficiency allegations that underlie intermediate sanctions.

RECOMMENDATION: Congress should enact legislation establishing formal appeals procedures for deficiencies issued during Medicare surveys regardless of whether or not the deficiencies lead to a recommendation for a sanction or termination from program participation. This legislation should allow for suspension of the termination and sanction processes pending appeal of deficiencies and should include provisions that would allow continued operations and protect the agency’s reputation while the deficiencies are under review. For example, agencies should be able to continue to provide services and public notices of deficiencies and issuance of information regarding deficiencies subject to appeal should be suspended until the issuance of a final ruling.

RATIONALE: Agencies should not be penalized for deficiencies that do not actually exist. The Medicare program does not adequately protect providers through appeals procedures. There already are processes in place that provide expedited termination authority for situations where patients are potentially placed in life-threatening situations. The recommended provision strikes a balance between protecting consumers’ and providers’ rights.

REINSTATE THE PRESUMPTIVE STATUS FOR HOME HEALTH WAIVER OF LIABILITY

ISSUE: The presumptive status of the waiver of liability, which expired at the end of 1995, protected hospices, nursing homes, and home health agencies that, in good faith, provided Medicare services to individuals who were later determined to be ineligible or whose services were later determined to be not covered.

In 1972, the Centers for Medicare & Medicaid Services (CMS) created a presumptive status for providers whereby the providers were presumed to have acted in good faith if they demonstrated a reasonable knowledge of coverage standards in their submission of bills.

On February 21, 1986, CMS issued final regulations eliminating the waiver presumption for home health agencies effective March 24, 1986. In response, Congress enacted, as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 (P.L. 99-272), a policy that preserved the waiver of liability presumption for home health agencies for a year after the 10 new regional intermediaries for home health agencies became operational.

COBRA also created two new, separate waivers for home health coverage denials on or after July 1, 1987, and before October 1, 1989, which would cover “technical denials,” such as “intermittent care” and “homebound” denials. A waiver presumption for these types of denials was also enacted.

The waiver of liability was further preserved by the Medicare Catastrophic Coverage Act (MCCA) of 1988 (P.L. 100-360), and retained even under the MCCA’s subsequent repeal. The Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508) extended the waiver of liability presumptive status as applied to medical and technical denials for home health agencies for five years. The home health waiver was further extended in 1995 in HR 2428, the Balanced Budget Act of 1995, which was vetoed. The home health presumptive status expired December 31, 1995.

RECOMMENDATION: The waiver presumption for both medical and technical denials for home health agencies should be permanently reinstated.

RATIONALE: The waiver presumption acts to protect providers who render services to Medicare beneficiaries in good faith, believing that they will be covered. This cushion for error is crucial in the Medicare home health benefit, which is susceptible to vagaries of interpretation by the fiscal intermediary and retroactive application of policy changes.

In the home health setting, in order for an agency to be compensated under the waiver presumption, its overall denial of claims rate must be less than 2.5 percent of the Medicare services provided. Any agency that exceeds this limit is not reimbursed under waiver regardless of whether it accepted beneficiaries and acted in good faith. This requirement forces agencies to use due diligence in determining eligibility and coverage.

Given the vague and inconsistent application of constantly changing regulations, guidelines, and directives, it is difficult for home health agencies to be 97.5 percent correct in their determinations of eligibility. The high number of claims denials that are reversed (40 percent at the reconsideration stage and 77 percent at the administrative law judge level for home health agencies and hospices combined) shows that coverage decisions are not as clear cut as CMS asserts.

At a time when sicker patients are admitted to home care following earlier hospital

discharge, coverage questions are more complex, and the buffer zone of waiver presumption is particularly important. In the absence of waiver presumption, agencies will have no recourse but to reject clients when coverage is questionable.

PROHIBIT STATES FROM USING COSTLY INDIVIDUAL CLAIMS REVIEW IN THIRD-PARTY PAYER RECOVERY EFFORTS

ISSUE: Since 1986 State Medicaid programs across the nation have put in place projects to maximize Medicare coverage for patients enrolled in both Medicare and Medicaid (so-called dually-eligible individuals). In 2007, Pennsylvania joined these ranks by requiring HHAs to submit claims retroactively to Medicare and using a private contractor to identify and pursue potential Medicare payment. In 2008, Colorado initiated an effort to identify home health services claims for potential Medicare payment and seek retroactive recovery of Medicaid payment for the services involved. These programs maintain that Medicaid has incorrectly paid for services that should have been paid for by Medicare. In general, this situation arises when a patient has been determined by the care provider to satisfy the standards for payment under the Medicaid program, but not for Medicare. For home health services, the standards of coverage under Medicare and Medicaid can differ significantly.

State Medicaid programs have instituted Medicare maximization projects that not only prospectively seek to minimize Medicaid expenditures, but also retrospectively allege that providers have been overpaid by Medicaid for services provided up to two years earlier. These Medicaid programs demand that home health agencies submit these old claims to Medicare and reimburse the state program for any Medicaid payments received.

In addition, Medicaid programs have pursued high volume appeals on behalf of dual eligible patients, challenging claim determinations through administrative law judge hearings and in federal district courts. These Medicaid programs have also pursued claims on an individual claim basis, in a manner that is costly for all parties concerned: Medicaid, Medicare, and health care providers.

CMS instituted demonstration projects in Connecticut, Massachusetts, and New York that adjudicate coverage disputes between Medicare and Medicaid through a statewide sampling method. This approach brings about great efficiencies in comparison to the mass claims appeals method otherwise utilized. The demonstration projects were time-limited thereby resulting in a return to the inefficient individual claims review method of reconciling payment obligations between Medicare and Medicaid. CMS discontinued the demonstration programs in 2008 thereby forcing the state Medicaid programs to return to the costly individual claims adjudication and appeals method that preceded the demonstration program. Congressional efforts to convince CMS to reinstate the demonstration program have been unsuccessful to date. In addition, several more states have taken steps to institute Medicare recovery projects. These states would not qualify to participate in the demonstration program if it is reinstated.

The demonstration program was temporarily extended in New York state in 2010 while it was discontinued in Connecticut and Massachusetts. As a result, Connecticut and Massachusetts providers now face huge costs to respond to the demands for individualized claim submissions and appeals. In addition, the surge in claim/appeal demands put some providers in a position where compliance was not possible on a timely basis. Those providers then faced a demand for repayment of Medicaid payments on the allegation that the state lost its opportunity to determine Medicare liability.

RECOMMENDATION: Congress should prohibit states from using mass retrospective, individual claims reviews and appeals in their third party recovery efforts. Congress should permit states to utilize a sample adjudication process to evaluate Medicare coverage eligibility for dual-eligible beneficiaries. States should be required to use cost-effective and sensible systems wherein state Medicaid programs can ensure that Medicaid is the payer of last resort without undue burden upon Medicare, Medicaid and health care providers. Medicare operations should also be modified to accommodate any bona fide effort by states that pursue third-party liability in a cost-effective manner. Congress should permanently authorize the use of a retrospective claims sampling settlement process to reconcile disputes between Medicaid and Medicare based on the demonstration projects.

RATIONALE: While home health agencies do their best to determine whether a patient is covered under Medicare prior to a claim submission to the Medicaid program, differing standards of payment can lead to incorrect Medicaid payments. Often, providers have an incentive to bill Medicare over Medicaid since the level of payment from Medicare is higher in most states. However, where errors in claims determinations occur, states should be prohibited from using recovery methods which create unnecessary expenses for all parties involved.

PERMIT SUITS AND AUTHORIZE PUNITIVE DAMAGES AGAINST MEDICARE CONTRACTORS FOR BAD FAITH DECISIONS

ISSUE: Under their Medicare agreements with the Secretary of Health and Human Services (HHS), Medicare contractors are immune from “all judgments, settlements and costs” resulting from lawsuits brought against them for actions they carry out in performing duties under the agreement. In effect, HHS is the only interested party in court actions that may challenge an intermediary’s Medicare determination. This immunity against suit has insulated contractors from court scrutiny and claims for damages in cases where they have injured providers by willfully denying payment for covered services without adequate cause, furnishing grossly inaccurate information on Medicare policies that subsequently led to a damaging recoupment of a substantial overpayment, issuing frivolous audit adjustments or taking other actions for which they should be held accountable. In late 2001 and 2002, Congress was considering legislation that would limit contractor immunity to those circumstances where the conduct was negligent, but allows liability where the conduct was reckless and willful. In 2003, Medicare reform legislation was enacted that allows the Secretary to indemnify Medicare contractors for judgments, settlements, awards, and costs except in situations where the contractor’s action’s are determined to be criminal in nature, fraudulent, or grossly negligent. This legislation does not affect the immunity of the contractor.

RECOMMENDATION: Congress should enact legislation that would eliminate the contractors’ immunity from suit in cases of willful and flagrant misconduct and allow for punitive damages.

RATIONALE: Over the years, there have been instances where Medicare contractors have abdicated their responsibility for processing Medicare claims fairly and with reasonable promptness. For example, a contractor with a burgeoning workload dealt with the problem by arbitrarily denying home health benefit claims; only the appealed claims had to be reviewed substantively. (Although the practice continued over a period of several quarters, the contractor was judged by the Health Care Financing Administration [HCFA] [now the Centers for Medicare and Medicaid Services—CMS] to have met the agency’s standards for accurate initial determinations.) Until CMS develops effective means for monitoring the administration of the Medicare program, the threat of suit would discourage such lawless behavior on the part of contractors.

REINFORCE BENEFICIARY DUE PROCESS RIGHTS

ISSUE: The Medicare home health prospective payment system for home health could create incentives for providers to provide less care than they might otherwise in order to secure profit or remain financially viable. The current Medicare appeals process is inadequate to address beneficiary claims regarding appropriate access to care. Beneficiaries must pay for services which are delivered after a patient has been notified of the provider's determination that the services are not covered. Hearings regarding these determinations are not held in a timely manner, often taking a year or longer. Many beneficiaries choose to go without care rather than become liable for the cost of the services. Further, the appeals process fails to address quality of care concerns.

With the Medicare, Medicaid, and SCHIP Benefits Improvements and Protection Act of 2000 (BIPA), Congress mandated the implementation of an expedited determination and appeal process. The rule issued by the Centers for Medicare & Medicaid Services (CMS) allows for an expedited review in the following circumstances: a) where a home health agency has determined that a patient does not meet the conditions for payment of home health service; and b) where a home health agency has determined that a patient no longer requires home health services; and c) where a home health agency has determined that a patient requires a level of care which is inconsistent with the care prescribed by the patient's physician. However, the rule fails to protect providers from financial losses and inadequately protects Medicare beneficiaries where there is no physician order for care. Further, the process does not have prospective effect, limiting the care under review to that which was provided prior to the appeal.

RECOMMENDATION: Congress should improve the appeals process for Medicare home health beneficiaries by providing assurance of coverage and protection from financial loss for providers of care. The system should also guide patients who need physician support to secure services.

Medicare payments for home health care services should reflect the agencies' costs in processing these appeals. State Medicaid programs should not be allowed to mandate the use of this expedited appeals process for beneficiaries dually eligible for both Medicare and Medicaid. More efficient systems should be devised for allocating responsibility for payments between Medicare and Medicaid.

RATIONALE: This recommendation reflects the experience of the Medicare program in its many prospective payment systems in use with various health care providers. While Congress instituted significant improvements through the mandated expedited determination process, the weaknesses that remain should be addressed.

PRESERVE INDEPENDENCE OF ADMINISTRATIVE LAW JUDGES

ISSUE: Since the beginning of the Medicare program, patients and providers have had access to fair hearings to challenge Medicare coverage denials. The administrative law judge (ALJ) system offered to Medicare claimants has proven a valuable safeguard against administrative errors and arbitrary determinations. Congress intended that ALJ hearings be conducted by independent judges who will ensure fair coverage determinations.

Since 1988, the Health Care Financing Administration (HCFA) (now the Centers for Medicare & Medicaid (CMS)) has repeatedly attempted to create its own ALJ corps that would review only health-related cases Congress has rebuffed each attempt by CMS to compromise the independence of the ALJs by bringing them under CMS control.

The Medicare Modernization Act (MMA) of 2003 required the Secretary of HHS and the Commissioner of Social Security to develop a plan by April 1, 2004, to transfer the Medicare ALJ function from the Social Security Administration to HHS. ALJ functions were transferred to HHS as of October 2005. To preserve the independence of the ALJs, the MMA required the Secretary to place the ALJs in an administrative office that is organizationally and functionally separate from CMS. The ALJs are required to report to, and be under the general supervision of the Secretary, not the Administrator of CMS.

RECOMMENDATION: Congress should block any CMS effort to interfere with the independence of the ALJs through oversight, indoctrination, or otherwise.

RATIONALE: Historically, CMS has responded to decisions favorable to beneficiaries in ALJ hearings with efforts to reduce or eliminate the impact of these determinations. For example, CMS has engaged in a stepped-up effort to have favorable ALJ decisions reopened and revised by the Appeals Council. Similarly, CMS has attempted to develop instruction programs for ALJs regarding Medicare coverage criteria. Most recently, CMS attempted to gain control of the ALJs by bringing them under its own roof. Independence of ALJs is crucial to fair decisions on Medicare appeals. This provides the checks and balances upon which our system relies.

IMPROVE ACCESS TO JUDICIAL REVIEW FOR MEDICARE CLAIMS

ISSUE: The Medicare program currently operates an elaborate and extensive administrative appeals system for coverage disputes. At the same time, an administrative appeals process is available for review of reimbursement disputes that come about through audits of home health agencies by fiscal intermediaries (FI). Recent federal court rulings indicate that providers of services may be required to utilize these administrative appeals to resolve broad-based complaints regarding reimbursement policy actions by Medicare. For example, in *NHPCO v. Leavitt*, the court held that hospices must individually exhaust all administrative appeal remedies before the court can hear a challenge to the Medicare rule eliminating the Budget Neutrality Adjustment Factor for all hospices. The administrative systems ultimately provide for a right of judicial review, but only after exhaustion of administrative remedies. The U.S. Supreme Court, in *Illinois Long Term Care Council v. Shalala*, ruled that exhaustion of all administrative remedies under Medicare is a prerequisite in almost all instances to jurisdiction in federal court.

Where the controversy involves a widespread practice or a policy interpretation, administrative review may not only postpone a global resolution of the issue, but may also prevent such resolution. A favorable administrative ruling cannot be appealed nor does it set a precedent. The Centers for Medicare and Medicaid Services (CMS) has generally followed a policy of nonacquiescence to administrative rulings it does not approve of, thereby leading to multiple administrative appeals on the same issue without any programmatic correction of the controversy. If providers and beneficiaries were allowed to pursue such issues in federal court without needing to resort to administrative remedies, an injunction issued by the court on behalf of a class of providers or beneficiaries would allow for resolution of the issue globally.

Through legislative and regulatory reforms in 2003-2005, including the Medicare Modernization Act of 2003, an expedited right of judicial review where there are no material issues of fact in dispute and the validity of a law or regulation is the only dispute that exists. This right applies to payment and provider agreement determinations, but not reimbursement disputes. Process-related issues are also not addressed.

In 2014, NAHC filed a lawsuit challenging the validity of the Medicare face-to-face physician encounter rule requirement for a physician narrative along with its implementation and oversight by CMS. The federal court permitted the prosecution of the claim regarding the validity of the rule, but dismissed the claims related to its administration, requiring an exhaustion of individual claims' administrative appeals.

RECOMMENDATION: Congress should enact legislation to specifically provide for judicial review of claims and controversies involving such matters as widespread practices or processes of FIs or regional policy interpretations without first having to present the claim through the administrative appeals process. This type of judicial review should be available for claims for payment issues related to audit and reimbursement, and survey and certification concerns.

RATIONALE: Where issues involving significant segments of Medicare operation are to be reviewed, the current administrative appeals process presents a costly and unnecessary burden. Requiring exhaustion of administrative remedies for matters of potentially widespread impact could lead to inconsistent operations within the Medicare program. Claimants that are successful

within the administrative process are made whole.

For those providers who have neither the resources nor ability to access the appeals process, an illegal payment denial or disallowance of cost becomes final. Systemic reform of errors in practice or policy at CMS or its intermediaries can come about only through class action judicial review.

ALLOW APPROPRIATE AND EXPEDITED JUDICIAL REVIEW OF MEDICARE REIMBURSEMENT POLICY DISPUTES

ISSUE: In the administration of the Medicare program, issues arise concerning the validity of policy that has been implemented by the Centers for Medicare and Medicaid Services (CMS) which is intended to carry out a statutory or regulatory obligation. Those policies have significant impact on the rights of home health agencies and beneficiaries if their validity can only be challenged after the provider has incurred costs (which may be disallowed) and has completed the administrative appeals process. Under this system, a challenge to the validity of a CMS policy position, based on the current backlog, may not take place for at least five years following its implementation. Judicial review is generally not available until exhaustion of this process.

In addition, the Balanced Budget Act of 1997 (BBA) prohibited judicial review of any decisions by CMS relative to the creation and implementation of the home health prospective payment system (PPS). This leaves CMS with unfettered discretion and forces Congress to micromanage CMS through ongoing oversight. The recent case mix creep adjustment as part of the PPS reforms is a clear example of arbitrary rulemaking that may go un-reviewed by federal courts. NAHC filed a lawsuit in 2009 challenging CMS's evaluation of changes in case mix coding weights. Among the claims, the lawsuit argued that CMS switch its rationale for the adjustment between the proposed and final rule giving no opportunity for public review. The federal court dismissed the case holding that the individual providers of care had to exhaust administrative review prior to litigation in court. To do so, providers, individually or in small groups, would need to pursue administrative appeals. Such an approach is inefficient and impractical thereby insulating CMS from real review.

The current expedited judicial review authority allows a party to bypass some of the administrative appeal steps, but it still requires a party to wait for a Notice of Program Reimbursement (NPR) before proceeding. In a typical reimbursement dispute the NPR is issued only months after the close of a provider's Medicare cost report year. This means that the impact of a disputed rule will continue for several years before judicial review of its validity is available.

This roadblock to judicial review also impacts hospice. An example is the case, *NHPCO v. Leavitt*, where the court held that hospices must individually exhaust all administrative appeal remedies before the court can hear a challenge to the Medicare rule eliminating the Budget Neutrality Adjustment Factor for all hospices.

RECOMMENDATION: Congress should enact legislation that would create an expedited route to judicial review where the basis of the action is a challenge to the validity of a Medicare reimbursement policy, including the home health PPS and any hospice payment policy. Judicial review should be available where the claim is collateral to a direct claim for payment and the provider of services faces irreparable harm without judicial intervention. The review should allow for nationwide relief rather than a ruling that affects only the named parties to the litigation. Also, that review should be available immediately after Medicare issues a Final Rule rather than needing to wait through the entire cost report year and NPR process.

RATIONALE: The current system allows CMS to develop home health services and hospice reimbursement policy without subjecting it to public or judicial oversight and in a manner which dissuades home health agencies and hospices from incurring costs which may actually be allowable under the Medicare program. Further, it allows CMS to establish PPS and hospice policy which is counter to the mandates of Congress. An expedited judicial review under these limited circumstances would allow for program wide resolution of disputes, thereby reducing the number of individual disputes that have to be resolved through the administrative process.

ENSURE AND ENFORCE BENEFICIARY CHOICE IN ALL FEDERAL HEALTH CARE PROGRAMS

ISSUE: Section 4321 of the Balanced Budget Act of 1997 requires that hospitals, as part of their discharge planning evaluation, identify all home health agencies that serve the area in which the patient resides and who request to be listed by the hospital as available. In addition, the legislation requires hospitals to maintain and disclose information to the Secretary of the Department of Health and Human Services (HHS) on referrals made to entities in which that hospital has a financial interest. This information must include the nature of the hospital's financial relationship to the entity, the number of individuals discharged from the hospital who required that entity's type of services, and the percentage of these individuals who received services from the hospital. CMS published a Notice of Proposed Rulemaking in December 2002 to implement this reporting requirement. However, both hospital-based and freestanding home health agencies report concerns that the report limits information collection to numbers of referrals.

In an update on the status of the proposed regulation, CMS reported that it is unable to publish the final rule due to the many concerns raised in public comments to the proposed rule and its inability to identify "home health referral" vs. "home admission" information from available data. In light of the problems, CMS intends to request that Congress reconsider the reporting requirement.

The provision requiring identification of all home health agencies that serve the area only applies to hospital referrals to home health agencies. To ensure true freedom of choice of providers, Medicare and Medicaid beneficiaries should be given a list of providers when referred by any health care entity.

Moreover, any beneficiary choice legislation must provide for a private cause of action allowing providers to bring suit against other providers for failing to adhere to the proper discharge planning and referral processes.

RECOMMENDATION: Congress should modify the freedom of choice provision to require that all health care entities in the position to refer patients in federal health programs provide comprehensive information regarding the availability of health services and inform beneficiaries of any financial interest involved in the referral. A private right of action should be established for providers affected or aggrieved by noncompliance with the freedom of choice provision by competing providers. Procedures should be established for reporting referrals by geographic area, by region, by agency, and by month.

RATIONALE: Reinforcing the beneficiary choice language will ensure that beneficiaries are aware of home health and hospice providers in their area and that their freedom in choosing a provider will not be abridged. Moreover, establishment of a private right of action for providers who have been adversely affected by noncompliance with the freedom of choice provisions will make it difficult for providers and others in the position to make referrals, to "steer" patients toward agencies in which they have a financial interest and help eliminate any inappropriate competitive advantages.

ENSURE PATIENTS' RIGHTS AND "TRUTH IN COVERAGE" IN MANAGED CARE PLANS

ISSUE: Managed care can be defined as a system that: integrates the financing and delivery of health care services; employs a variety of techniques to manage utilization and contain costs, including utilization review, case management, and the use of primary care physicians as coordinators and managers of care; and provides significant financial incentives for patients to use low cost providers and procedures. Health maintenance organizations (HMO) and preferred provider organizations (PPO) are the most prominent examples of managed care systems.

Managed care began in the 1930s as prepaid group practices and was promoted on the grounds that they were designed to improve quality and continuity of care and provide preventive health care services including the development of outcome data. However, the purpose of managed care has shifted dramatically since that time. Managed care is now seen mainly as a means of limiting the use of health services, reducing costs or both.

The increased emphasis on managed care as a means of cost containment has caused concerns about quality and access among consumers and providers, who fear that increased reliance on managed care will exacerbate the problems experienced to date. Despite significant attention to the need for patients' rights legislation to address managed care abuses beginning in the 107th Congress, Congress has been unable to successfully complete action on such a measure. There are wide disagreements over the circumstances and extent to which managed care enrollees should be allowed to sue their managed care plans. Patients' rights legislation is expected to remain a major issue for members of Congress and the Administration.

Foremost among the problems experienced by home care recipients and providers are the following:

- The patient's physician loses control of the patient's care;
- Managed care plans create strong financial incentives to deny services, and some plans have illegally denied home care services to patients who need them;
- Patients whose care needs can be both expensive and lengthy are especially vulnerable under managed care plans that seek primarily to control costs;
- When plans fail to achieve sustained cost savings, and many payers have found that promised savings were experienced only as a one-time phenomenon, benefits are reduced or eliminated altogether;
- Patients are sometimes illegally denied home care services and must sue insurers to get the care they need and deserve;
- Managed care organizations have sometimes engaged in unfair competitive practices and heavy-handed bargaining in negotiating referrals to home care agencies;
- Consumers resent their lost freedom of choice in what can seem like a third-party bureaucracy designed to deprive them of care;
- Unwarranted interference with the caregiving process and excessive paperwork have been continuing problems;
- The potential for fraud and abuse increases under managed care when plans pursue cost savings at the expense of quality and access;
- In the long run, managed care can reduce quality of care by curbing the development and use of new medical technology; and

- Consumers are not told about copay requirement and other limitations on the provision of home health service in the managed care plans.

During 2007, Rep. Pete Stark (D-Calif.), chair of the House Ways & Means Health Subcommittee, introduced legislation that would address one specific element of concern that relates to the Medicare Advantage program – that of private plans charging more in the way of beneficiary coinsurance for services than are charged under the traditional Medicare program. In 2010 the Patient Protection and Affordable Care Act (H.R. 3590; P.L. 111-148) included a provision forbidding higher copays in Medicare Advantage plans for certain services but did not specify home health care.

RECOMMENDATION: Managed care is not a panacea for controlling costs and ensuring access to appropriate services. If utilized, managed care plans should be designed carefully so that the pursuit of least costly care does not jeopardize quality of care or access to necessary services. Managed care plans should include mechanisms to preserve consumer choice, ensure easy access to needed services, require and enforce quality assurance standards for all providers, ensure payment rates that recognize the costs associated with high-quality care, allow individuals to challenge adverse decisions, promote fair marketing practices, and provide appropriate consumer education. To secure many of these goals, a national patient bill of rights should be enacted.

Congress should pass plan “truth in coverage” requirements that include consumer education provisions to ensure consumers understand the cost-sharing requirements and other limitations on home health services under managed care plans. Medicare Advantage plans should be prohibited from charging beneficiary cost sharing in excess of that charged under the traditional Medicare program, including a prohibition against any home health copayments. Beneficiaries should be given clear explanations of how accessibility of Medicare Advantage home health benefits will differ from under traditional Medicare.

RATIONALE: The rapid growth in health costs and the nation’s economic woes have led both public and private payers to turn increasingly to managed care in an effort to get more services for the money they spend. However, studies of managed care have failed to show that cost increase reductions, where they occur, are more than a one-time-only phenomenon; and even strong supporters of managed care are not sure that it will work to hold down costs. Further, a study conducted by the University of Colorado has found that Medicare home health patients in managed care plans received fewer services and had worse outcomes than other home health patients. Most recently, the Medicare Payment Advisory Commission (MedPAC) has found that, while the number of beneficiaries enrolled in MA has significantly increased, the quality of services received has not. Clearly, there is a strong need for safeguards to ensure that cost savings are not achieved by denying needed services. Without these safeguards, managed care will ultimately be rejected by both consumers and providers as an appropriate system of financing and delivery of health care services.

PROTECT CONSUMERS FROM ERRONEOUS SERVICE AND COVERAGE DETERMINATIONS

ISSUE: In recent years, there has been a growing shift in both the public and private sectors to managed health care. Experience indicates that the utilization controls imposed within managed care systems combined with financial incentives existing within a capitated framework create an environment where a health plan may benefit from denial of health care services to the consumer. Managed Care Organizations (MCOs) have been reported to severely restrict patients' referral to home care services and specialty care. Home care agencies across the country have stated that MCOs erect administrative barriers to approval of care and often refuse to authorize coverage of services needed by patients.

Over the last ten years, Congress has debated an MCO Patients' Bill of Rights. A crucial component to the Bill of Rights is the right to challenge and appeal MCO decisions. By way of regulation, the U.S. Department of Health and Human Services and the Department of Labor established some level of protection for Medicare managed care enrollees and certain participants in employer-based health plans. However, these protections are not comprehensive in scope or applicability.

In order to protect consumers from wrongful denials of health care services and coverage under managed care plans, a detailed appeals process for both consumers and providers of health services must be in place. This appeals process must provide for expedited review of disputes, decision making outside the health plan in order to avoid any bias, and the assistance of health care expertise where appropriate. This process will go a long way toward protecting the interests of consumers enrolled in managed care plans.

RECOMMENDATION: To achieve necessary protection for highly vulnerable consumers of health care services, Congress should enact legislation to implement the following safeguards:

- Allow federal court review of all disputed MCO determinations regardless of payer.
- Establish an office of a health plan ombudsman within each state with responsibility to provide oversight of health plan operations and advocacy on behalf of consumers. This office should resolve disputes informally and refer consumers to necessary advocacy resources when appropriate.
- Require that the Department of Labor consult with the Department of Health and Human Services in establishing the standards of operation for the review offices within states.
- Require that claims review be performed only by personnel with expertise in the area of concern, not limiting such expertise to physician reviewers, but including all disciplines of service.
- Amend the Employee Retirement Income Security Act to provide for rights of action under state law for damages as related to principles of equity, including but not limited to, promissory estoppel, bad faith, and unjust enrichment.

RATIONALE: Safeguards are necessary to ensure that financial incentives designed to minimize the utilization of unnecessary services do not restrict access to necessary care. A comprehensive, unencumbered process to resolve claims disputes is the best means to this end.

PROTECT PATIENTS' FREEDOM TO CHOOSE IN MANAGED CARE PLANS

ISSUE: There has been a growing shift toward use of managed care plans in the Medicaid program and the in spite of recently decreased payment rates for Medicare managed care under the Medicare Advantage program, beneficiary enrollment in Medicare-managed care plans has increased significantly.

An “any qualified provider” provision will allow an enrollee of a managed care organization (MCO) to go to any out-of-network provider as long as the provider is willing to accept the MCO’s operating terms including its schedule of fees, covered expenses and quality standards.

Through an “any qualified provider” provision, individuals would retain the freedom to choose providers, even under a health plan that relies heavily on managed care. This provision is also extremely important to the home care community, since it helps ensure that competition will continue to exist among home care agencies and agencies that are not a formal part of a managed care network will not be frozen out of a client base.

Services utilized by enrollees when they go out of network tend to be low-cost services. Rather than going out of network for hospitalizations, for example, patients are more likely to use an out-of-network service option for less costly services and for services that are closer to home. In this way, the “any qualified provider” provision can become a valuable feature for non-MCO home care agencies.

The Medicare Advantage program known as the Private Fee-for-Service plan allows enrollees to utilize any Medicare participating provider of services and receive the identical benefit available under traditional Medicare. This approach has worked well for Medicare beneficiaries who wish to choose a particular provider of care. However, the Medicare Modernization Act of 2003 allows these plans to limit patient choice through the imposition of copayments where the plan develops a network of providers. Further, the availability of the PFFS plans was reduced dramatically in 2010 when new federal rules took effect requiring the plans to maintain network providers in addition to the allowed freedom of choice.

RECOMMENDATION: Any health care reform plan must assure all individuals, even those enrolled in MCO-type managed care plans, the freedom to choose from among all qualified providers. This provision is critical to maintaining patient choice of home care agencies and ensuring that no single large agency will monopolize a market.

Where the cost of the out-of-network service is no greater than the cost of the service within the managed care plan, managed care plans should be prohibited from charging any additional out-of-pocket costs, including copays and deductibles.

In addition, health plans, when referring patients, should be required to inform all patients of both in-network and out-of-network providers, and to provide assistance to secure care from whichever provider the patient chooses.

Finally, in the event that a managed care plan is authorized to limit participating providers, Congress should require more than one option to the enrollee in order to encourage quality and efficiencies.

RATIONALE: An “any qualified provider” provision helps protect patients from the

increasingly common trend in MCOs of frequently changing contract providers as the MCO bargains for ever-lower provider rates. The "any qualified provider" provision also helps ensure that patients are not forced to choose a new provider with every renegotiation. Restricting a patient's freedom to choose violates the spirit of the Medicare and Medicaid programs and should not be permitted in any health plan.

PROHIBIT GAG RULES IN MANAGED CARE CONTRACTS

ISSUE: There have been problems with some managed care plans that restrict access to home care in violation of the terms of the private insurance policy or federal regulation in the case of Medicare health maintenance organizations (HMOs). In some cases, contracts with managed care plans contain “gag” rules that prohibit providers from communicating with patients about the full range of appropriate treatment options for a patient’s condition or about disagreements providers may have with health plan decisions. Providers are often reluctant to pursue corrective action either by reporting the matter to appropriate government authorities or discussing the matter with the patient for fear of retribution by the health plans, which may terminate or not renew their contracts.

RECOMMENDATION: Congress should enact legislation which would forbid “gag” rules in managed care contracts and prohibit any adverse action by managed care plans against a provider for medical communications between provider and patient, or between provider and state or federal regulators with the responsibility of licensing and oversight of the managed care plan.

RATIONALE: Where inadequate services are provided by managed care plans, patients may suffer adverse health outcomes or face unnecessary costly institutionalization, which often must be financed by state Medicaid programs. Forbidding “gag rules” and retaliatory actions by health plans would enable providers to fulfill their professional obligations to tell their patients what care they should be receiving and act as “whistleblowers” by reporting improper restrictions on home care utilization to appropriate government agencies.

MODIFY PREEMPTION PROVISION OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT

ISSUE: As a result of a series of rulings by the U.S. Supreme Court, employer-based health benefits plans subject to the Employee Retirement Income Security Act (ERISA) are protected from risk of financial penalty that might come from bad faith or arbitrary and capricious claims determinations. In addition, ERISA has been used to block medical malpractice claims against third-party payers who control the delivery of services to patients. Finally, courts have construed ERISA to preempt claims against insurance companies by health care providers who relied upon an insurance company's information that the patient served by the provider was dually enrolled and entitled to insurance payment. Courts have also held that ERISA preempts state "any willing provider" provisions. Moreover, under ERISA, claims for punitive damages, malpractice, and negligent misrepresentation are preempted since they are founded in state rather than federal law. ERISA, therefore, allows claims against insurance companies solely for payment of improperly withheld benefits.

RECOMMENDATION: Congress must amend ERISA to allow aggrieved employer-based health plan enrollees, participants, and providers of services to challenge arbitrary and capricious action, negligent determinations which affect the delivery of health care, and misrepresentations to providers of services related to the insured status of the individual.

RATIONALE: The essential purpose behind ERISA was to allow self-insured plans offered by multi-state employers to maintain a consistent plan for insuring the health care needs of their workers. With varying state law and regulation, collective bargaining and program management have become complex and costly. However, ERISA-based plans have utilized the federal preemption of state law claims to protect insurance companies from having to act fairly, consistently, and accountably. With the ERISA preemption, the plan has no incentive to issue correct determinations since its liability is limited to the cost of care that would have been covered had a proper determination been made. If only one plan participant who is wrongly denied benefit payments fails to challenge the denial, the plan incurs a financial gain.

AMEND THE EMPLOYEE RETIREMENT INCOME SECURITY ACT TO REQUIRE DIRECT PROVIDER APPEAL RIGHTS

ISSUE: The Employee Retirement Income Security Act (ERISA) is designed to protect consumers from arbitrary decisions by health care plans. Providers of health care services are not protected under ERISA. Therefore, there are limited avenues of recourse open to providers who have been improperly denied reimbursement under ERISA- sponsored plans.

Currently, health care providers who deliver care under ERISA plans risk a coverage denial of the claim. Even prior authorization is no guarantee that the provider will be reimbursed for services rendered under the plan.

Providers seeking recourse may take assignment of the claim from the beneficiary. This means that the provider assumes the rights of the beneficiary when bringing a claim against the health plan. This assignment, however, forecloses any claim the provider may have against the beneficiary for payment of the services provided.

Providers should be given direct appeal rights that are concurrent and corresponding with plan enrollees. This would bestow upon both health care providers and enrollees the right of action to pursue claims against a health plan. Because the right would be “concurrent and corresponding,” the provider would not need the beneficiary (and the beneficiary would not need the provider) to subject the plan to arbitration, administrative review, or judicial review.

RECOMMENDATION: Congress should amend ERISA to provide a process through which providers of health care services have the right to appeal health plan determinations for reimbursement of services. Such a right should not be restricted and should allow the provider to pursue claims, both against the plan and the enrollee.

RATIONALE: Providers of health care services under an ERISA plan should be given the right to have third-party review of all disputed claim determinations. The current strategy of assignment of enrollee rights to providers is limited and prevents the provider from pursuing claims against the beneficiary. Moreover, where the enrollee predeceases a plan’s payment of a claim, providers must pursue the estate of the enrollee. If the estate has no assets or is not interested in bringing action against the health plan, there is no recourse available to the provider.

AUTHORIZE PUNITIVE DAMAGES LAWSUITS FOR BAD FAITH INSURANCE DECISIONS

ISSUE: The U.S. Supreme Court has ruled that individuals under employer-based health insurance plans governed by the Employer Retirement Income Security Act (ERISA) can only sue to recover the benefits wrongfully denied by the insurance company. As a result, punitive damages for bad faith administration of the insurance plan are unavailable to the insured. This standard allows insurance companies to knowingly deny insurance coverage for medically necessary care and be held immune from a financial award beyond the costs of the care.

RECOMMENDATION: Congress should amend ERISA to allow beneficiaries to recover punitive damages for erroneous claim determinations issued in bad faith by insurance companies. In addition, Congress should prohibit insurance companies from passing on the costs of punitive damage awards to consumers or to employers that provide health insurance.

RATIONALE: The threat of punitive damages will encourage insurance companies to properly review and pay claims in the first instance. Where these damages are unavailable, the insurance company has no financial incentive to correctly pay claims.

G. PRIVATE INSURANCE

REQUIRE COVERAGE OF HOME HEALTH CARE AND HOSPICE AS ESSENTIAL HEALTH INSURANCE BENEFITS

ISSUE: Among the many different proposals to improve the U.S. health care system, one common set of recommendations has dealt with reforms to the private health insurance market. These have generally addressed questions of preexisting conditions, portability, setting premium rates and increases, guaranteed issue and renewability, and standardized benefit packages.

The Patient Protection and Affordable Care Act (PPACA) (H.R. 3590; Public Law No. 111-148), prohibits premium variations based on one's health status or sex (community rating) and places limits on variations based on age. However, the legislation leaves it up to the Department of Health and Human Services (HHS) to determine if home health care and hospice are covered in standardized benefit packages. HHS has issued a regulation giving wide discretion to the states to make the final determination of what are "essential benefits" in the standardized benefit packages offered in state health insurance exchanges.

RECOMMENDATION: Congress should require that insurance companies provide a standardized benefit package that includes coverage for home health care and hospice. Any listing of "Essential Benefits" in insurance offered through state health insurance exchanges under PPACA should include home health care and hospice.

RATIONALE: All Americans should have access to home care and hospice coverage in their health insurance. According to a recent national study, home health is a benefit in 77 percent of health plans and hospice in 66 percent. Home health has proven to be effective in reducing health care expenditures by reducing hospitalizations, shortening hospital stays, and serving as an alternative to costly post-acute inpatients stays. In addition, cost savings are realized at the end of life through the delivery of hospice services. Failure to include home health and hospice coverage will result in increased costs and fewer options to enrollees. Furthermore, failure to include home health and hospice benefits is inconsistent with the Administration's focus on home and community based services and could be in violation of the American with Disabilities Act (ADA).

H. STUDIES

CONDUCT IN-DEPTH STUDY OF VARIATION IN HOME HEALTH SERVICE USE AND OUTCOMES IN MEDICARE MANAGED CARE AS COMPARED TO THE FEE-FOR-SERVICE SECTOR

ISSUE: Nearly one quarter of Medicare's 45 million beneficiaries were enrolled in Medicare Advantage (MA) health maintenance organizations (HMOs) and other types of private plans during 2008. Home health agencies are experiencing significant change in terms of the proportion of their Medicare clients that have chosen to enroll in Advantage plans. MA plans pay in a variety of ways, including on a per-visit basis; most do not reimburse agencies their full costs of providing care. Many home care agencies experience financial hardship in ensuring that their managed care patients the same level of care as they provide their fee-for-service clients.

Under traditional Medicare, quality of care provided to home health beneficiaries has continued to improve. However, in recent years the Medicare Payment Advisory Commission (MedPAC) has studied Medicare's private plans and found that the care quality MA HMOs that entered the market before 2004 has improved somewhat; however, the quality of care from newer plans has not. Further, even greater concerns surround Medicare Private Fee-for-Service (PFFS) plans, which have been the fastest growing segment of private coverage in recent years, because they do not employ care coordination as part of their coverage.

RECOMMENDATION: Congress should authorize and fund study of variations in the use of services and outcomes between Medicare Advantage and fee-for-service home health clients. The beneficiary groups studied should be risk-adjusted in order that a true comparison of treatments and outcomes can be made.

RATIONALE: During the 1990s studies concluded that Medicare HMO-participating home health patients received less visits and had less positive outcomes than their fee-for-service counterparts. Since that time there have been a number of changes that have affected the provision of care. First, the imposition of the home health prospective payment system has dramatically changed incentives for patient care; now that agencies receive a rate set in advance for providing an episode of care under fee-for-service Medicare, they no longer are incentivized to provide increasing numbers of visits. Additionally, the Congress has made changes over the years to attempt to encourage Medicare beneficiaries into managed care plans. Data from old studies is no longer applicable to the Medicare home health benefit. It is vital that the Congress, the Administration, and the public know if there are significant differences in the amount and quality of care provided to home health patients under fee-for-service and Medicare Advantage in order to ensure that all beneficiaries receive comparable services under this important federal health insurance program.

EXPAND STUDY OF QUALITY, COST EFFECTIVENESS OF POST- ACUTE PROVIDERS

ISSUE: In recent years, health policy discussions have focused increasingly on ways in which to provide high-quality, cost-effective, and site-appropriate care, particularly in federally-funded programs. In the post-acute care arena, some of the most thorough analysis of care quality and cost-effectiveness has been conducted on behalf of the Medicare Payment Advisory Commission (MedPAC). In 2005, MedPAC reported that a study conducted by RAND Corp. on MedPAC's behalf concluded that the home health benefit ranks highest regarding outcomes and cost-effectiveness for patients who have undergone knee or hip replacement surgery. The study compares care delivered in the home health setting with skilled nursing facility (SNF) and inpatient rehabilitation facility (IRF) care.

RAND considered post-acute care payments and also total episode payments -- including the cost of the initial hospitalization for joint replacement -- in its examination of cost-effectiveness of post-joint replacement care. SNF episode costs were found to be more than \$3,500 higher than care for patients discharged to home, and an IRF episode of care was determined to cost about \$8,000 more than care provided to patients at home.

Under the Deficit Reduction Act of 2005, Congress mandated study of Medicare beneficiary health and the care received across different post-acute care settings to determine what programmatic changes, including payment incentives, could be made to ensure that patients receive the highest quality care in the most appropriate setting. In late 2007 the Centers for Medicare & Medicaid Services announced 10 geographic areas in the country in which this Post Acute Care Payment Reform Demonstration (PAC- PRD) would be conducted over three years. In 2008 CMS began to study the effectiveness of a newly-devised combined PAC assessment tool in assessing appropriateness and effectiveness of different PAC sites of care. Unfortunately, home health agencies participating in the study had to conduct patient assessments using not only the PAC assessment instrument but also the Outcome and Assessment Information Set (OASIS) assessment. CMS reported to Congress in 2011 on the findings of the study and recommended that more funds be provided for further study.

RECOMMENDATION: Congress should monitor activities related to the PAC-PRD closely and authorize and fund further study, as needed, on the cost-effectiveness of federally-financed care in different post-acute settings, and create incentives to encourage the provision of care in the most appropriate, cost-effective setting. These incentives should include use of an effective PAC assessment tool that minimizes the burden on agency staff.

RATIONALE: As the number of citizens achieving Medicare eligibility continues to expand, it is vital that precious financial resources be directed to the most effective and efficient settings of care. Home health has been shown to be not only the preferred care setting, but also to be the most effective in particular cases relative to outcomes and cost- efficiency. However, each new regulatory requirement results in increased costs to agencies and reduces staff time that could be otherwise spent delivering care, so every effort must be made to limit regulatory burdens. Continuing study is warranted.

I. QUALITY AND INTEGRITY OF CARE

EVALUATE USE AND ACCURACY OF HOME HEALTH COMPARE

ISSUE: The Centers for Medicare & Medicaid Services established a web-based information tool for consumers to aid in their selection of a home health agency for themselves or a loved one. This tool also can be used by health care professionals such as hospital discharge planners and managed care organizations. “Home Health Compare” provides a listing of Medicare-participating home health agencies and the geographic area that they serve. It also offers information regarding the performance of the agencies in terms of certain patient outcomes. The home care community was an avid supporter of Home Health Compare prior to its inauguration several years ago. However, it is unknown as to how much this tool is actually used to guide parties in the recommendation or selection of a home health agency. Further, there have been some questions raised regarding the accuracy and relevance of the information contained in Home Health Compare. A core problem is a weak risk adjustment model used when comparing agencies serving widely differing patients and the use of a limited data set on adverse patient events such as re-hospitalizations.

The Office of Inspector General indicated in its 2007 and 2008 Work Plans that it would evaluate the accuracy of Home Health Compare data. This study does not have the depth and focus necessary to analyze whether Home Health Compare is meeting its purpose. No study results have yet to be released.

CMS has extended the use of Home Health Care Compare data in its Star rating system for home health agencies. CMS has selected a portion of the Compare data to support the system that presents consumers with a simpler comparison rating model. As such, the reliability of the Compare data is more important than ever. One central weakness in the Star rating system is that it uses measures that focus on improvement in patient function while a large portion of the home health patient population are not candidates for functional improvement. The Star ratings do not evaluate an agency’s performance in maintaining function or slowing the deterioration of function. That weakness is compounded by a design flaw that rates agencies on a bell curve, leading to most agencies rated at a 3 Star. Unlike consumer-known star ratings where objective criteria allow the service or good to be objectively rated, the CMS Star model forces a proportion of agencies into each of the 9 levels of ratings.

In 2016, CMS is expected to add a new, separate Star rating that is focused on patient satisfaction survey data.

RECOMMENDATION: Congress should support and expand the OIG study into the use and accuracy of Home Health Compare. The study should focus primarily on the validity of Home Health Compare and then on whether and how Home Health Compare is used to select a home health agency, guide hospital discharge planners, and influence Medicare Advantage plans in their contracting for services. Further study should be done on the validity and usefulness of the Star rating systems.

RATIONALE: Conceptually, Home Health Compare is a valuable tool for consumers and health care professionals. However, no tool is of value unless it is accurately composed and

effectively used. The proposed study will help gain understanding as to how Home Health Compare can be used and improved for maximum beneficial use.

ENACT MEDICARE HOME HEALTH AND HOSPICE PROGRAM INTEGRITY MEASURES

ISSUE: Home care and hospice, like all industries, is not immune to the presence of participants who engage in improper and illegal schemes for the sake of profit. At the same time, health care providers that operate well within the law are unable to effectively compete in the market when faced with competitors that offer kickbacks for patient referrals, bill for services not provided, or charge costs that are not part of the delivery of services.

The Patient Protection and Affordable Care Act (PPACA), P.L. 111-148, contains a number of program integrity measures supported by NAHC that are home care and hospice specific. However, the home care and hospice communities believe that more can be done. Program integrity measures should be targeted as much as possible on program vulnerabilities and high risk providers.

RECOMMENDATION: Congress should continue its work in combating waste, fraud, and abuse in our nation's health care system by passing additional measures that include:

- The institution of mandatory corporate compliance plans by all home health agencies and hospices to ensure adherence to all federal and state laws with proper funding support.
- Strengthened admission standards for new Medicare home health agencies, including standards for capitalization, claims review, and experience.
- Expanded use of targeted, temporary moratoria on new Home Health Agencies where the number of providers exceeds the level appropriate to ensure access, quality and choice.
- Mandatory screening and federally-funded background checks on all individuals wishing to open a Medicare home health agency or hospice as well as all employees of home health agencies and establishment of a national registry of home care workers consistent with existing state laws.
- Strengthened program participation standards to include experience credentialing and competency testing of home health agency or hospice personnel responsible for maintaining compliance with Medicare standards; such as the Certified Home Care Executive (CHCE), credentialing available through the National Association for Home Care & Hospice (NAHC).
- The investment of sufficient government and industry resources to expedite refinements to the Medicare payment systems so that providers are appropriately reimbursed for the costs of providing services.
- Providing consumers and prospective consumers of Medicare home health services and hospice care with a summary of program coverage requirements. The consumer reporting hotline for suspected fraud, waste, and abuse also should be enhanced and made more accessible.
- Implementation and development of credentialing and competency testing standards for government contractors and federal regulators responsible for issuing Medicare determinations. A hotline should be developed for beneficiaries and providers to report inadequate enforcement action by those charged with protecting Medicare and Medicaid.
- Supplying adequate administrative financing to Medicare/Medicaid to enforce existing laws and regulations such as survey and certification standards, provider education, and

claims reviews.

- Requiring federal enforcement authorities to prioritize oversight and enforcement on matters that have high dollar impact while establishing sensible corrective measures to address providers with minor errors and omissions.
- Enhancement of education and training of home health agency and hospice staff through joint efforts with regulators.
- Implementation of outcome-based compliance standards that provide operational flexibility and also eliminate structural requirements that are unrelated to the provision of high quality Medicare home health services or hospice care.
- Development and implementation of Medicare coverage and reimbursement standards in language that is understandable and accessible to providers and consumers through various means; for example, through the Internet, federal depository libraries, and fiscal intermediaries.
- The establishment of a Joint Program Integrity Advisory Council that works in partnership with federal and state programs to prevent and resolve systemic programmatic weaknesses that waste health care resources.
- Development and authorization of an industry-directed enforcement entity working in conjunction with federal and state authorities.
- Establishment of targeted payment safeguards that utilize modern techniques and tools, directed towards abusive utilization of services and payment as necessary and appropriate.

RATIONALE: It is particularly important to ensure that limited health care dollars go to the provision of patient care rather than being diverted into the pockets of unscrupulous providers. A comprehensive fraud and abuse package that includes home health and hospice specific provisions and provides adequate enforcement tools to punish those who willfully and knowingly defraud the system is needed. Moreover, any anti-fraud legislation must make a distinction between willful fraudulent activity and unintentional failure to comply with Medicare regulations. For example, the Office of the Inspector General often characterizes as fraud technical errors on claims or billing for services that the need for which is not documented sufficiently to demonstrate that it meets Medicare reimbursement requirements related to medical necessity. In such cases, provider education may be a more appropriate response than more punitive measures.

ENACT MEDICAID HOME CARE AND HOSPICE PROGRAM INTEGRITY MEASURES

ISSUE: Home care and hospice, like all industries, is not immune to the presence of participants who engage in improper and illegal schemes for the sake of profit. At the same time, health care providers that operate well within the law are unable to effectively compete in the market when faced with competitors that offer kickbacks for patient referrals, bill for services not provided, or charge costs that are not part of the delivery of services.

The Patient Protection and Affordable Care Act (PPACA), P.L. 111-148, contains a number of program integrity measures supported by NAHC that are home care and hospice specific. Unfortunately, many of these measures are confined to the Medicare home health and hospice benefits. Medicaid home care and hospice can benefit from similar measures, particularly those that address provider qualifications and standards for participation in Medicaid.

Medicaid home care program integrity issues share similarities with Medicare, but also present unique circumstances necessitating tailored and targeted action. States are often allowed to design their own program integrity measures. While this permits states to develop the approaches to program integrity that best fit their Medicaid program, it also leaves open a level of risk that could be addressed through model, federally-recommended processes. Medicaid home care is very diverse with services ranging from personal care assistance to high-tech private duty nursing. In addition, providers of Medicaid home care include unlicensed individual home care aides, unlicensed home care agencies along with skilled health care professionals such as nurses and therapists and licensed and accredited home health agencies. Program integrity weaknesses that have been alleged to date include billings for unqualified beneficiaries, inadequate documentation to validate the provision of covered services, unqualified caregivers, billings for unauthorized services, and false billings for care not rendered. As such a broad construct of program integrity measures are needed.

RECOMMENDATION: Congress and CMS should continue its work in combating waste, fraud, and abuse in our nation's health care system by promulgating model minimum standards for compliance and program integrity, with adequate financial support for all parties, which include:

- The institution of state Medicaid compliance plans directed to Medicaid home care and hospice programs to ensure adherence to all federal and state laws with proper funding support.
- Standards for "return on investment" so that program integrity efforts are priorities based on impact and corrective measures targeted to the most economic and productive approaches.
- Strengthened admission and program participation standards for individual and agency-model home care providers, including standards for competency, early-stage pre-pay claims review, and experience.
- Mandatory screening and federally-funded background checks on all individuals wishing to provide Medicaid home care or open/operate a Medicaid home care agency or hospice.

- Mandatory background checks on all employees of home care agencies and establishment of a national registry of home care workers consistent with existing state laws.
- Providing consumers and prospective consumers of Medicaid home care services and hospice care with a summary of program coverage requirements. The consumer reporting hotline for suspected fraud, waste, and abuse also should be enhanced and made more accessible.
- Standards for service validation systems that allow for the maintenance of electronic documentation of service delivery consistent with the services approved for payment.
- Standards for pre-payment and post-payment claims review, including the appropriate use of sampling extrapolation.
- Credentialing and competency testing standards for government contractors and federal regulators responsible for issuing Medicaid determinations. A hotline should be developed for beneficiaries and providers to report inadequate enforcement action by those charged with protecting Medicaid.
- Supplying adequate and enhanced administrative financing to Medicaid to enforce existing laws and regulations such as survey and certification standards, provider education, and claims reviews.
- Enhancement of education and training of home health agency and hospice staff through joint efforts with regulators.
- Implementation of outcome-based compliance standards for quality of care that provide operational flexibility and also eliminate structural requirements that are unrelated to the provision of high quality care.
- The establishment of a Joint Program Integrity Advisory Council that includes representatives from state Medicaid programs, CMS, home care providers and Medicaid recipients. The Advisory Council is intended to help increase awareness of program integrity weaknesses and to recommend solutions.
- Establishment of targeted payment safeguards directed towards abusive utilization of services and payment as necessary and appropriate.

RATIONALE: It is particularly important to ensure that limited Medicaid dollars go to the provision of patient care rather than being diverted into the pockets of unscrupulous providers or be wasted on unnecessary or noncovered care. A comprehensive fraud and abuse package that includes Medicaid home care and hospice specific provisions and provides adequate enforcement tools to punish those who willfully and knowingly defraud the system is needed. Moreover, any program integrity legislation or regulation must make a distinction between willful fraudulent activity and unintentional failure to comply with Medicaid policies that set out technical paperwork standards that do not truly affect core elements of claim coverage. For example, audit reports often characterize as fraud, minor technical errors on claims or billing for services that the need for which is not documented sufficiently to demonstrate that it meets coverage standards. In such cases, early and comprehensive provider education may be a more appropriate response than more punitive measures.

**VI. ENSURE A CENTRAL ROLE FOR HOME CARE
RELATIVE TO WELLNESS AND PREVENTION OF
DISEASE**

ALLOW HOME CARE AGENCIES TO SERVE AS CASE MANAGERS IN FEDERALLY-FUNDED PROGRAMS

ISSUE: Case management has been a home care agency responsibility for more than a century and is an essential part of the caregiving process. As practiced by home care providers, case management consists of assessment, planning, coordination, organization and staffing, implementing or providing care, and evaluation.

External case managers who are responsible for fiscal management are often inadequately qualified and frequently see too little of clients to deal with their problems on a timely and informed basis. While an external or independent case manager was suggested as a means to contain costs as part of H.R. 2342 and S. 1179, the Medicare Chronic Care Improvement Act of 2003, it can be quite costly to implement and is unnecessary where case management is already available from a home health agency.

The Patient Protection and Affordable Care Act, P.L. 111-148, (PPACA) included numerous components that utilize case management services as part of the overall care benefits of various programs. For example, case management is an integral part of post-partum depression programs (PPACA section 2952), the patient-centered medical home pilot (section 3502), and community-based collaborative care networks (section 10333). Case management is also central to the program establishing incentives for state Medicaid programs to offer home care as an alternative to nursing home care (PPACA section 10202). In that program, the states must provide “conflict-free” case management services. This program has the potential to leave providers of home care services outside of the opportunity to also provide the case management services.

RECOMMENDATION: In any Medicaid, Medicare, Older Americans Act, or long term care legislation, Congress should allow home care agencies to manage all elements of their clients’ care.

RATIONALE: Home care providers have the experience and knowledge to be responsible for the clients’ plans of care, as well as other components of case management. Requiring a separate case management system can impose additional and unnecessary administrative and financial burdens on home care programs.

CREATE A NUTRITIONAL SERVICES HOME HEALTH BENEFIT

ISSUE: Home health agencies (HHAs) are required to have specialized nutrition expertise in order to be Medicare certified. Centers for Medicare & Medicaid Services (CMS) regulations, however, do not specifically include the nutrition professional in the list of mandated participants. There is no provision to pay for these services, other than as administrative costs. Furthermore, the episodic rate within the home care prospective payment system (PPS) does not recognize the services of a nutritional professional nor does Medicare pay for nutritional interventions that are projected to last for less than 90 days. This oversight encourages HHAs to use other untrained professionals or to budget so little for the nutritional professional that adequate services cannot be provided.

Health statistics show that more than 3.4 million Medicare beneficiaries received home care services in 2007 (CMS, HCIS data). Half had chronic diseases that are normally treated with diet (NCHS, 1999). Others report that patients who receive home care services have a high prevalence of malnutrition and need some type of nutrition service (Rebovich et al., 1990). Malnutrition can be a risk for early nonelective hospital readmission.

An estimated 40,000 Medicare patients received parenteral nutrition and 152,000 received enteral nutrition at home (Howard, et al., 1995). The current Medicare benefit pays for some aspects of home parenteral and enteral nutrition; however, in order to obtain Medicare reimbursement, the patient must be unable to meet nutritional requirements using an oral diet for more than 90 days. For parenteral nutrition support, the patient must have a nonfunctional gastrointestinal (GI) tract due to interruption in continuity or impairment in absorptive capacity. For enteral nutrition support, there must be a disruption in the ability to ingest oral foods or impairment of the upper GI tract, which interrupts the transport of food to the small intestine.

Coverage regulations for enteral and parenteral nutrition are under the Prosthetic Devices section of Medicare. This section, which covers such things as pacemakers, braces, and artificial limbs, also defines reimbursement for home nutrition support. The assumption in placing nutrition support in this section is that it is a prosthetic device for a dysfunctional GI tract. For this reason, Medicare does not cover nutrition support if it is provided to a patient who has a functioning GI tract. Nutritional support is also not covered for the patients with significant nutritional needs, but who will be able to eat within the 90-day time period. Medicare covers nutritional solutions and equipment, but not the consultation by a nutrition professional needed for the assessment of energy and nutrient needs, implementation, and monitoring of the effects that treatments have on the patient's nutritional status. Moreover, there is an inequity in Medicare coverage for enteral and parenteral nutrition in the home care or ambulatory setting compared to the hospital or skilled nursing setting. Although a physician, nurse and pharmacist are typically involved in the care of the home care or ambulatory patient receiving nutrition support, the nutritional professional is often absent.

In addition to the lack of consultation by a nutritional professional, many beneficiaries need home enteral or parenteral interventions that are not reimbursed by Medicare. These beneficiaries may require tube feedings or parenteral interventions that are projected to last for less than 90 days. They may also need to take some food by mouth, but not enough to meet nutrient or energy needs. Few individuals are able to pay for this therapy on their own and lack of inclusion of nutrition support within the PPS episodic rate puts these Medicare beneficiaries at

nutritional risk.

During 2000, the National Academy of Sciences Institute of Medicare (IoM) submitted a report to Congress entitled, "The Role of Nutrition in Maintaining Health in the Nation's Elderly: Evaluating Coverage of Nutrition Services for the Medicare Population" (IoM, 2000). This report summarizes conditions that were identified as requiring a nutritional professional within the home setting. The conditions identified are listed below.

- Counseling about altered nutrient needs or dietary modification
- Newly diagnosed diabetes (homebound individuals should have the same benefits for diabetes self-management as those being seen in an ambulatory setting)
- Poorly controlled diabetes related to other conditions that require skilled care
- Heart failure
- Dietary modification following myocardial infarction
- Complications of cancer treatment (i.e., chemotherapy, radiation, and surgical treatment) that result in food aversions, need for consistency modifications, or altered nutrient or energy requirements
- Dysphagia
- Under nutrition -- weight loss in the absence of remedial medical or psychiatric disorders
- Pre-end-stage renal failure with complex dietary modifications
- Osteoporosis or hip fracture
- Wound-healing problems

RECOMMENDATION: Congress should amend the Medicare home care benefit to create a nutritional services benefit and include in the calculation of the PPS episodic rate the services of nutritional professionals. Congress should also amend the home care benefit to include the recommendations of the National Academy of Sciences mentioned above.

RATIONALE: Patients seen in the home care setting are often the most frail, undernourished group of elders within the health care system. Because these patients are homebound, they do not have the ability to use nutrition services that may be available in other ambulatory settings. Beneficiaries who are unable to maintain adequate nutritional status are more likely to experience adverse outcomes, including premature hospital readmission, functional compromise, comorbidities and mortality.

**VII. ENSURE THE AVAILABILITY OF HOSPICE AND
PALLIATIVE CARE FOR ALL AMERICANS NEAR THE END
OF LIFE**

ENACT THE PALLIATIVE CARE AND HOSPICE EDUCATION AND TRAINING ACT

ISSUE: Rapid changes in the health care delivery system -- among them a growing Medicare population, increased interest in and use of hospice care, an expanded number of palliative care programs associated with hospitals and health systems nationwide, and the Centers for Medicare & Medicaid Services' (CMS) activation of advance care planning codes under Medicare Part B - indicate that our nation's need for appropriately trained hospice and palliative care professionals will continue to grow at a fast pace. As an example of this growth, in 1998 only 15 percent of hospitals with more than 50 beds had an inpatient palliative care program; that number has now grown to 67 percent of hospitals with more than 50 beds.

Studies indicate that patients receiving earlier (rather than later) exposure to palliative care had:

- Lower rates of inpatient admissions in the last 30 days of life (33 percent vs. 66 percent)
- Lower rates of ICU use in the last month of life (5 percent vs. 20 percent)
- Fewer emergency department visits in the last month of life (34 percent vs. 39 percent)
- A lower rate of inpatient death (15 percent vs. 34 percent)
- Fewer deaths within three days of hospital discharge (16 percent vs. 39 percent)
- Lower 30-day mortality rates post hospital admission (33 percent vs. 66 percent)

In 2010, the American Academy of Hospice and Palliative Medicine estimated an existing need for 6,000 or more full time physician equivalents to serve current needs in hospice and palliative care programs. However, at maximum capacity, the current system would produce only about 5,300 new hospice and palliative medicine certified physicians over the next 20 years. This falls far short of the projected growing needs of the rapidly aging population and does not address the growing need for similarly trained non-physician professionals, including palliative nurses.

To begin to address the anticipated the growing need for trained palliative care professionals, during 2015 Reps. Elliott Engel (D-NY), Tom Reed (R-NY) and others reintroduced the Palliative Care and Hospice Education and Training Act (PCHETA), H.R. 3119, which would amend the Public Health Service Act to increase the number of permanent faculty in palliative care at accredited allopathic and osteopathic medical schools, nursing schools, social work schools, and other programs (including physician assistant education programs) to promote education and research in palliative care and hospice, and to support the development of faculty careers in academic palliative medicine.

RECOMMENDATION: Congress should enact H.R. 3119, the Palliative Care and Hospice Education and Training Act, and provide appropriations to implement the legislation.

RATIONALE: As knowledge and understanding of the nature of palliative and hospice care become more widespread, many patients and family caregivers are finding these services more appropriate for their needs and more consistent with their desires for treatment of advanced and terminal illnesses. It is anticipated that the demand for the compassionate, supportive care supplied by hospice and palliative care programs will only grow over the coming years. Given the clear benefits associated with such care, our nation must prepare for this growing need.

Enactment of the Palliative Care and Hospice Education and Training Act would make important inroads toward an increased supply of well-trained palliative care practitioners.

REJECT EFFORTS TO INCLUDE HOSPICE AS PART OF MEDICARE ADVANTAGE BENEFIT PACKAGE

ISSUE: Since its inception, the Medicare hospice benefit has been excluded from the Medicare private plan (currently Medicare Advantage --MA) benefit package. In late 2013, the Medicare Payment Advisory Commission (MedPAC) initiated discussion on the advisability of incorporating hospice as part of the MA benefit package; MedPAC has since voted to recommend that legislation be enacted that would incorporate hospice coverage under MA. MedPAC's rationale is based on the following:

- Concerns about the complexity of current coverage rules for MA patients that elect hospice;
- The desire for greater symmetry in Medicare coverage regardless of whether a beneficiary receives Medicare under fee-for-service, through an accountable care organization (ACO) or through a MA plan;
- The belief that MA plans should have full responsibility for coverage of Medicare benefits, including responsibility for coverage of all care delivered at the end of life; and
- The possibility that MA plans may be willing to offer additional services to patients who elect hospice – such as concurrent care – that is not available under standard Medicare coverage.

On December 18, 2015, the Bipartisan Chronic Care Working Group of the Senate Finance Committee issued a Policy Options Document that indicates the group is considering requiring MA plans to offer the hospice benefit as part of their package of services. The options paper indicates that if legislative action is taken to mandate this change, the MA five-star quality measurement system would need to be updated to include measures associated with hospice care. The working group's rationale for considering this change is that the current structure for MA enrollees electing hospice care leads to either a disruption in care or fragmented care delivery.

This proposal by MedPAC and the Bipartisan Chronic Care Working Group raises significant concerns for hospice providers and beneficiary advocates; among them are the following:

- Medicare beneficiaries enrolled in MA that elect hospice will no longer have a choice of the hospice provider that will care for them in their final days of life;
- It is anticipated that in most cases MA plans will contract with Medicare certified providers to supply hospice services. In an effort to keep contracted rates low, MA plans may be incentivized to limit the services they contract with the hospices to provide, or may attempt to contract for hospice care on different terms and/or at significantly reduced rates. As a result, beneficiaries may not receive a hospice benefit equivalent to that which they would receive under fee-for-service;
- Many hospices provide additional services beyond the scope of the hospice benefit (such as massage, music, and other therapies) because they have proven value in improving the quality of life for many patients on hospice. Continuing availability of these services may be at risk if hospice services are provided by way of MA plans;
- Medicare hospice eligibility rules require that a patient be determined to be terminally ill with a prognosis of six months or less if the disease follows its normal course. Tensions

could arise between the MA plans and a contracted hospice relative to whether a patient does or does not meet Medicare's eligibility requirements;

- Additionally, the hospice per diem payment rate is intended to cover all care determined to be reasonable and necessary for the comfort and palliation of the terminal illness and related conditions. Financial incentives may lead MA plans to shift responsibility for unrelated services to a contracted hospice provider;
- There is no deductible applicable to Medicare hospice care, and strict limitations on beneficiary coinsurance that may be charged. MA plans, however, are permitted to charge different out-of-pocket costs than under fee-for-service which could result in increased costs to patients and their families at a particularly vulnerable time;
- The Medicare Hospice Benefit is currently undergoing significant change. Starting on January 1, 2016, hospices are paid one of two payment rates for RHC depending on how long the patient has been on hospice care. There remain uncertainties about the impact of these changes on the delivery of hospice care, as well as about potential additional changes in the hospice program. These uncertainties will impact hospices' willingness to enter into contracts with MA plans, particularly if the contracts do not, at a minimum, cover costs; and
- The terms under which MA plans enter into contracts with hospice organizations could run counter to the current payment reform goal of ensuring that hospice payments better reflect actual costs of care over the course of a patient's stay on hospice.

RECOMMENDATION: Congress should reject current efforts to incorporate hospice as part of the MA benefit package. If inclusion of hospice under MA is to be considered, it should first be studied through a demonstration program that examines inclusion of hospice services under different types of MA plans, and thoroughly analyzes the impact of the model on hospice patients and their families. If and when Congress contemplates inclusion of hospice under the MA benefit package, it should include the following safeguards:

- MA beneficiaries that are determined to be terminally ill and eligible for the hospice benefit should be given the option of immediately disenrolling from MA so that they may elect hospice from the provider of their choice;
- MA plans should be required to contract with Medicare-certified hospices based on fee-for-service benefit and payment terms and levels, including beneficiary cost-sharing limitations;
- The hospice inter-disciplinary group (IDG) should be the ultimate authority on hospice eligibility, the hospice plan of care, and determinations of which conditions are related to the terminal diagnosis. Likewise, the IDG should determine the conditions that are not related to the terminal and related conditions that should be covered by the MA plan; and
- The quality and coordination of care as patient's transition to end-of-life care should be closely assessed as part of the MA plan satisfaction ratings.

RATIONALE: Beneficiaries entering MA are, as a general rule, anticipating their needs for curative care rather than end-of-life care. Decisions about end-of-life care are deeply personal and of great significance to patients and their families. When a beneficiary is diagnosed with a terminal illness, he or she should retain the right to determine what level of care to pursue and under what provider's care.

REVISE REQUIREMENTS FOR HOSPICE FACE-TO-FACE ENCOUNTERS

ISSUE: Section 3131(b) of the Affordable Care Act of 2010 requires a hospice physician or nurse practitioner (NP) to have a face-to-face encounter with every hospice patient prior to the patient's 180th-day recertification, and prior to each subsequent recertification. The provision applies to recertifications occurring on and after January 1, 2011.

In the Home Health Prospective Payment System Rate Update for Calendar Year (CY) 2011, the Centers for Medicare & Medicaid Services (CMS) finalized its implementation approach for this hospice provision. The final rule, codified at 42 C.F.R. 418.22(a)(4) (75 Fed. Reg. 70463, November 17, 2010), states that the encounter must occur no more than 30 calendar days prior to the start of the hospice patient's third or subsequent benefit period. The regulation requires that the hospice physician or NP attest that the encounter occurred, and the recertifying physician must include a narrative describing how the clinical findings of the encounter support the patient's terminal prognosis of six months or less. Both the narrative and the attestation must be part of, or an addendum to, the recertification.

A number of concerns have arisen relative to the hospice face-to-face requirement:

- Hospices must complete the face-to-face encounter **PRIOR TO** the beginning of the applicable benefit period. As the result, a patient's care may be delayed while the hospice identifies an available physician or NP and completes the encounter requirement.
- If a patient is on continuing hospice care but the hospice is not able, due to staffing limitations or other complications, to conduct the face-to-face prior to the benefit period for which the encounter is required, the hospice will not be paid for services provided prior to the date on which the face-to-face has been completed.
- The face-to-face requirement is applicable to a patient's full time on hospice regardless of when previous hospice service was provided. A patient may have been off hospice service for a lengthy period of time, after which he or she begins rapid deterioration and need immediate admission. In such cases the face-to-face requirement may delay admission.
- CMS data systems are not all available 24 hours, seven days a week to access patient information and most do not have full information related to a patient's history on hospice care to establish with absolute certainty whether a face-to-face encounter is required. A hospice may take a patient onto service only to discover some time later (once Medicare systems are updated) that a face-to-face encounter was required. These hospices may not bill Medicare for those days of service, which could mean a significant financial loss to the hospice.
- Hospices will not be reimbursed for costs related to the face-to-face requirements, which may be prohibitive -- particularly for small hospices in rural areas.
- Hospices may not utilize telehealth services to meet the face-to-face requirement.

On Dec. 23, 2010, CMS announced a three-month delay in enforcement of the face-to-face requirements to allow time for hospices to establish operational protocols necessary to comply with the new law. In early 2011, CMS modified requirements so that under well-documented "exceptional circumstances" (for example, a hospice is unable to schedule a timely face-to-face prior to beginning needed services for a newly readmitted hospice patient or a

hospice is not aware that a patient requires a face-to-face encounter because CMS' data systems do not contain adequate information) hospices are given an additional two days within which to complete the face-to-face.

Subsequently, the National Association for Home Care & Hospice (NAHC) has heard from hospice providers that have not been permitted an "exceptional circumstances" exception because the circumstances of the late face-to-face did not precisely meet the examples provided in the CMS Benefit Policy Manual.

During the 114th Congress, Rep. Tom Reed (R-NY) introduced H.R. 2208, The Hospice Commitment to Accurate and Relevant Encounters Act (Hospice CARE Act). The legislation would permit hospices to utilize physician assistants (PAs) and other clinicians for completion of the face-to-face encounter. Additionally, under CMS' "exceptional circumstances" provision, the legislation would give hospices seven days from the beginning of the benefit period within which to complete the encounter.

RECOMMENDATION: Congress should enact legislation that would allow hospices to utilize PAs and other appropriate clinicians to perform the required face-to-face encounter, and also provide additional time for hospices to complete the face-to-face encounter when exceptional circumstances occur, as well as provide greater flexibility with respect to the use of exceptional circumstances. Additionally, Congress should revise the face-to-face requirement to allow for reimbursement of costs related to the encounter and allow use of telehealth technologies to assist hospices in meeting the face-to-face requirement. Congress should direct CMS to ensure that its data systems are available and contain adequate information for hospices to be able to determine with certainty whether a potential hospice patient will require a face-to-face encounter; hospices should not be held liable for the cost of services they provide to patients without a face-to-face encounter when Medicare data systems contain out of date information that only after the fact reflects that a face-to-face encounter was required.

RATIONALE: The intent of the face-to-face requirement is to ensure adequate and appropriate involvement and accountability of physicians relative to certification of eligibility for hospice care. However, as currently written and interpreted by CMS, it may delay access to care and serve as a deterrent for some hospices to take eligible patients in need of immediate care onto service. This was neither its intent nor an advisable result of the requirement.

ENSURE THE FULL MARKET BASKET UPDATE FOR THE MEDICARE HOSPICE BENEFIT

ISSUE: Section 3132(a) of the Patient Protection and Affordable Care Act (PPACA -- Public Law 111-148), enacted in March 2010, requires that the Centers for Medicare & Medicaid Services (CMS) develop Medicare hospice payment system reforms, and contains hospice payment cuts -- including the institution of a productivity adjustment to the annual market basket inflation update beginning in FY2013 and a 0.3 percentage point reduction to the annual market basket update for FY2013 through FY2019. In addition to the PPACA reductions, CMS has, over seven years, phased out the Budget Neutrality Adjustment Factor (BNAF) to the hospice wage index. As the result of these cuts and imposition of the Budget Control Act's 2 percent across-the-board sequester, hospice payments for FY2016 are 12 percent LESS than they would otherwise have been. The PPACA cuts and the sequester are scheduled to continue into future years, which will further reduce the ability of hospices to provide comprehensive end-of-life care to patients and their loved ones.

As part of the proposed budget for FY 2017, the President recommended reducing the hospice market basket update by an additional 1.7 percentage points in each of FY2018, 2019, and 2020. Further, the proposed FY2017 budget includes plans to create a hospice-specific market basket (as opposed to the hospital market basket currently in use for hospice services). These changes are estimated to reduce hospice outlays by nearly \$10 billion over nine years (FY2018 - 2026). The proposed budget also references additional unspecified, budget-neutral hospice policy changes.

RECOMMENDATION: Congress should reject the President's FY2017 proposed hospice market basket cuts and proposed creation of a hospice-specific market basket. The Congress should also closely examine the President's unspecified "budget neutral" payment changes, giving close consideration to their potential impact on access to high quality hospice services. Further, Congress should make every effort to restore the market basket and productivity reductions authorized under PPACA, and cancel the 2 percent across-the-board sequester. Congress should oppose any reductions in the annual hospice updates or other major payment system changes until such time as the impact of hospice payment reforms (and other changes) is fully known.

RATIONALE: The Medicare Hospice program has undergone dramatic changes in recent years, including:

- Significant payment reductions that, in combination, have resulted in FY2016 hospice payments that are 12 percent LESS than they would otherwise be:
 - In FY2010, CMS began phasing out by regulatory issuance the BNAF to the hospice wage index over seven years. In each year since FY2010 the phase out has reduced payments by 0.6 percentage points. Elimination of the BNAF has reduced hospice payments by 4 percent overall.
 - The FY2014, 2015, and 2016 payment cycles reflect reductions mandated by the PPACA, including productivity cuts and a 0.3 percentage point market basket reduction. Hospice payments are further reduced by the 2 percent sequester.
 - A study conducted for the National Hospice and Palliative Care Organization

(NHPCO) estimated that the combined impact of scheduled ACA cuts and elimination of the BNAF could result in average margins for hospice providers decreasing to NEGATIVE 10 percent by 2022. Additionally, the study estimated that 66 percent of hospices could have negative Medicare financial margins by 2022.

- A dramatic increase in costly administrative obligations, such as an expansion in cost reporting requirements; increased reporting of visit, drug and diagnosis data on hospice claims; new quality measure collection and reporting responsibilities; timely filing requirements for hospice Notices of Election (NOE) and Notices of Termination/Revocation (NOTR) that have become burdensome and costly as the result of CMS systems inadequacy; and other changes. In the near future it is expected that CMS will impose additional administrative requirements on hospice programs that will further increase costs.
- Hospice financial margins are decreasing -- MedPAC calculated an average Medicare margin of 8.6 percent for 2013; its projected hospice Medicare margin for 2016 is 7.7 percent. These estimates exclude costs related to volunteer, bereavement, and other nonreimbursable services, which would further reduce margin calculations by as much as 1.7 percentage points. Financial margins vary widely in the hospice sector, and many hospices are operating at serious financial risk. Additionally, there is concern that MedPAC's estimates may not take into full account costs associated with the face-to-face encounter requirements that went into effect Jan. 1, 2011, and other newly imposed regulatory burdens (referenced above).
- While the payment system changes that became effective January 1, 2016, were designed to redistribute payments so that they better reflect the actual costs of providing care over the course of a patient's election, hospices with relatively short overall lengths of stay are reporting losses under the system. Further, hospices nationwide are reporting later referrals to hospice, which increases overall costs of care.
- Imposition of across-the-board cuts to hospice services run counter to Congress' intent in requiring reform of the hospice payment system, which was to ensure that payments over the course of care better reflect actual costs incurred and to reapportion payments within the system.
- Across-the-board payment reductions will disproportionately harm those providers whose patients have shorter overall lengths of stay on hospice care. According to MedPAC, the 20 percent of providers with the shortest average lengths of stay in 2012 had average margins of MINUS 6.5 percent, while providers in the next lowest quintile for length of stay had margins averaging 3.6 percent. These providers cannot continue to operate if their rates are further reduced.
- While the President's budget recommends a change in the market basket used for hospice payment updates, hospices have not received a full market basket update since FY2012. Further, hospices are subject to special regulatory requirements (such as the requirement that they provide core services -- nursing, medical social services, and counseling -- by way of direct employees) that increase costs and would be difficult to incorporate into a hospice-specific market basket index.
- CMS has revised and expanded the cost reporting requirements for freestanding hospices, and is still finalizing revised hospice cost report requirements for provider-based entities; these cost reports are only beginning to be submitted to CMS. This means that CMS

does not currently have enough data in sufficient detail from cost reports to create a hospice-specific market basket.

In recent years hospices have been subjected to numerous changes, the full impact of which is not yet fully known. Until such time as any proposed policy can be fully analyzed for its impact on delivery of care and in the context of all other recent hospice policy changes, Congress should reject proposals that would further diminish hospices' ability to provide services to patients in their final days of life and support to those patients' loved ones.

REJECT ADDITIONAL BENEFICIARY COST SHARING FOR HOSPICE SERVICES UNDER MEDICARE REFORM EFFORTS

ISSUE: The Medicare hospice benefit was created under the Tax Equity and Fiscal Responsibility Act of 1982 to expand the availability of compassionate and supportive care to Medicare’s many beneficiaries suffering from terminal illness at the end of life. Eligibility for hospice is based upon a physician’s certification that the patient has a terminal illness with a life expectancy of six months or less if the illness runs its normal course. When a patient elects hospice under Medicare, he or she agrees to forgo other “curative” treatment for the terminal illness. While the cost of most hospice care is covered by Medicare, the patient may be responsible for copayments related to drugs for symptom control or management and facility-based respite care. The patient is also responsible for copayments related to any regular Medicare services unrelated to the terminal diagnosis.

In discussion, some members of the Medicare Payment Advisory Commission (MedPAC) have suggested that it may be advisable to consider imposition of some type of copayment for Medicare hospice services. Additionally, as part of policy discussions on reform of Medicare, some have advocated consolidation of Parts A and B and imposition of uniform beneficiary copayments and deductibles on all Medicare services. Unless hospice is specifically excluded, beneficiary costs for hospice care could increase significantly.

RECOMMENDATION: Congress should reject imposition of additional copayments on beneficiaries for Medicare hospice services and other changes that would discourage use of the hospice benefit.

RATIONALE: Historically copayments have been imposed on health care services to reduce overutilization of services. While use of hospice services has grown significantly through the years, many Medicare beneficiaries are referred to hospice too late to reap its full benefit, and many more lack sufficient knowledge or understanding of hospice to consider it a viable option at the end of their lives. This is particularly the case for minority and low-income Medicare populations – who are the least likely to be able to afford additional cost-sharing burdens.

Beneficiaries who elect Medicare hospice services must agree to forego curative care for their terminal illness. Given that many “curative” interventions for terminal illnesses can involve administration of costly new medications and treatments, it is not surprising that numerous studies have documented that appropriate use of hospice services can actually reduce overall Medicare outlays while at the same time extending length and quality of life for enrolled beneficiaries.

While valid concerns have been raised about the length of time some Medicare beneficiaries are on hospice service, the median length of stay under the hospice benefit is about 18 days. About 25 percent of hospice beneficiaries are on service for a total of five days or less and over 95 percent of hospice care is provided in the patient’s residence. In lieu of imposing additional beneficiary cost-sharing that could discourage appropriate, timely and desirable use of the hospice benefit, Congress and other policymakers should explore additional ways to ensure that hospice services are being ordered for patients that are truly eligible, such as through physician education, and at a time in their disease trajectory when they can reap the full benefit that the hospice benefit has to offer.

ENSURE ACCESS TO CARE FOR RURAL HOSPICE PATIENTS; ESTABLISH ROLE FOR PAs IN HOSPICE CARE

ISSUE: Hospices are reimbursed one of four per diem rates based on the level of care provided. Payments for one patient in excess of actual costs are used to help offset higher costs that may be associated with other patients. This works if a hospice has a large enough case load to balance expenses. However, given the low population density in rural areas, rural hospices generally have smaller patient censuses; as a result, if a rural hospice has several high cost patients and a relatively low patient census, there are fewer lower cost patients to help balance expenses and keep the hospice financially stable.

In some areas of the country, a large number of residents receive health care through Rural Health Centers (RHC) or Federally-Qualified Health Centers (FQHC). Medicare law recognizes some of the higher costs associated with delivery of care in these areas and pays on a different basis than under regular fee-for-service reimbursement. However, neither RHCs nor FQHCs are able to bill for visits provided by center physicians for hospice attending physician services. This creates a disincentive for RHCs and FQHCs to provide these services, resulting in a greater burden for rural hospices.

Under hospice law, hospice-employed nurse practitioners (NPs) may continue to serve as a patient's attending physician after a patient enters hospice and may also conduct the required hospice face-to-face encounter. Physician assistants (PAs) have no role in hospice care – they cannot serve as a hospice patient's attending physician, nor may they conduct the hospice face-to-face. Neither NPs nor PAs may serve as the physician head of the hospice team or certify a patient as eligible for hospice services.

RECOMMENDATION: Congress should enact a five percent payment rate add-on for hospices located in and caring for patients in rural areas. Further, Congress should enact legislation that would allow RHCs and FQHCs to bill Medicare for attending physician services provided for hospice patients, as permitted under state law. Finally, Congress should enact legislation to allow PAs to serve as attending physicians for hospice patients and conduct the hospice face-to-face encounter if this does not conflict with state statute.

RATIONALE: As is the case with other health care providers, hospices in rural areas have difficulty recruiting and retaining adequate staff to meet the full panoply of services required under the Medicare hospice benefit, as well as the increasing number of regulatory requirements (such as the face-to-face encounter requirement). Due to the generally lower patient census in rural areas, these hospices may run higher financial risk when admitting high need hospice patients. Additionally, hospice caregivers must drive greater distances to patients' residences than in urban areas. There is no consideration of consistently more expensive fuel costs in hospice reimbursement rates. The hospice wage index is updated annually using the most currently available hospital wage data as well as any changes by the Office of Management and Budget in the core-based statistical areas followed by the budget neutrality adjustment. In most states, the rural wage index is lower, resulting in comparatively lower reimbursement rates.

Addressing the disincentives for RHC and FQHC physicians to provide attending physician services to hospice patients, as well as establishing a role for PAs in hospice, would help to support the delivery of high quality, individualized hospice care even in remote areas of

the U.S.

OVERSEE THE IMPACT OF HOSPICE PAYMENT REFORM; REJECT REBASING AND SITE-OF-SERVICE ADJUSTMENT FOR NF RESIDENTS

ISSUE: The Medicare hospice benefit (MHB) was created in 1982 to provide palliation and management of care to terminally ill beneficiaries with a prognosis of six months or less if the disease runs its normal course. The Medicare Payment Advisory Commission's (MedPAC) June 2008 Report to the Congress stated that, although the benefit was created to care for terminally ill cancer patients, they are now a minority of MHB participants. Patients with diagnoses such as Alzheimer's disease, debility and congestive heart failure have made up the majority of Medicare's hospice patients in recent years.

Over the years, the average length of stay (LoS) has increased to about 88 days, but the more important median LoS remains at about 18 days, according to MedPAC. In 1983, 20 percent of patients received hospice services for seven days; this has increased to about 30 percent. Additionally, 25 percent of hospice patients are on care for five days or less before expiring. The current reimbursement structure was created by estimating the original cost of delivering routine home care (RHC) -- 96 percent of hospice days of care -- by analyzing data collected during the 1980-1982 Medicare Hospice Benefit Demonstration Project.

Despite the changes noted by MedPAC and significant technological, pharmaceutical, and medical care delivery advances over the first 33 years of the hospice program, there had been no associated reimbursement adjustment to reflect the changes.

In March 2009, MedPAC recommended that Congress mandate revision of the hospice reimbursement system to better reflect variation in costs over a patient's length of stay and expansion of data collection efforts.

The final 2010 health care reform legislation (Public Law 111-148) authorized payment system reforms to be enacted no earlier than October 1, 2013.

The Centers for Medicare & Medicaid Services (CMS) expanded collection of data related to visits and costs in 2008, 2010, and then again in April 2014. While analyzing data for its payment reform efforts, CMS "floated" a seven-tiered payment system for RHC and also suggested that it may be appropriate to "rebase" hospice payments and reduce reimbursement for RHC provided to patients in nursing facilities.

During 2015, CMS promulgated and finalized modifications to payments for RHC under hospice that sets out two payment rates -- a higher rate (\$186.84 in 2016) for days one through 60 of hospice care and a lower rate (\$146.83) for days 61 and over. Despite a break in service, unless a patient is off hospice care for more than 60 days, the "count of days" for purposes of determining the appropriate RHC rate includes previous hospice service days. CMS also created a Service Intensity Add-on (SIA) applicable to in-person RN and Social Worker visits that are provided during the final seven days of life. The SIA is payable at the hourly rate for Continuous Home Care (CHC, paid at \$39.37 in FY2016) for up to four hours per day. CMS was required to make the payment system changes budget neutral in the first year of application. However, given that provision of RN and Social Worker visits in the payment changes, CMS has indicated that in future years it will apply budget neutrality to account for changes in SIA utilization.

Public Law 111-148, the final health reform bill, also includes some interim payment

changes, including the institution of a productivity adjustment to the annual market basket inflation update beginning in FY2013. In addition, the final reform bill reduces the market basket index by 0.3 points in FY2013 through 2019, but makes provision to eliminate the market basket cut in each of FY2014 – 2019 if growth in the health insurance-covered population does not exceed 5 percent in the previous year.

RECOMMENDATION: Congress must closely monitor the impact of the payment reform changes implemented by CMS and any future activities related to hospice payment to ensure that changes to the reimbursement system do not affect access to quality hospice services for terminally ill Medicare beneficiaries during the final stages of life. Congress must also monitor the impact of payment changes to ensure that CMS has achieved a proper balance between the costs of providing hospice care and payment levels, particularly for short-stay patients. Congress must ensure that CMS does not overstep its charge to refine the hospice payment system by implementing changes like rebasing of RHC or reduced payments for care provided to NF residents that could go far beyond the payment refinement sought by the health reform law.

In the meantime, Congress should oppose any reductions in the annual hospice updates until all payment reforms are instituted and then only after all issues related to the impact of these changes are fully examined. Any system reforms must assure preservation of access to care, quality of care, and sufficient reimbursement rates to maintain a viable and stable delivery system.

RATIONALE: Regardless of the level of care taken when developing a new payment system, unintended consequences that could have a dramatic impact on the population served may result. It appears that the payment reforms implemented by CMS will have a modest impact on the distribution of payments within the hospice program. Additional changes may be necessary to ensure that the balance between costs and payments is appropriate. However, care must be taken to ensure that changes do not disrupt the availability or quality of this most humane service for America's terminally ill patients and their families, and that hospice remains a benefit available to all at the hour of greatest need – the final stage of life.

PROVIDE FULL DISCLOSURE OF HOSPICE AVAILABILITY AND CHOICE OF HOSPICE PROVIDER TO TERMINALLY ILL BENEFICIARIES RESIDING IN SNFs/NFs

ISSUE: In 1989, Public Law 101-239 mandated the ability of terminally ill Medicare beneficiaries residing in skilled nursing facilities/nursing facilities (SNF/NFs) to access services under the Medicare hospice benefit (MHB). As SNF/NF residents become aware of the MHB, more of them are seeking hospice services. However, the SNF/NF is not required to offer hospice services, nor is it required to disclose at admission if residents will be able to access hospice services without the need to transfer to another facility. Further, if the facility does have an arrangement to provide hospice, it is not required to disclose the hospice program with which it has a contract to provide services to residents. Finally, a resident does not have the right to choose the hospice program that he/she will receive hospice services from in the facility.

RECOMMENDATION: Congress should require that SNF/NFs disclose upon admission whether or not hospice services are available at the facility, and the name(s) of the hospice(s) with which the facility has contracted to provide hospice services on site. Additionally, Congress should mandate that eligible Medicare beneficiaries residing in SNF/NFs have the right to receive hospice services from the Medicare-certified hospice of their choice.

RATIONALE: SNF/NFs should provide full disclosure regarding the availability of hospice services through the facility at admission so that potential residents are fully aware of whether or not they will be able to access hospice services at some time during their stay if needed. Such disclosure could help to avoid the significant upheaval and trauma that could result from a resident's transfer to a different facility in order to exercise his/her right to the hospice benefit. Potential residents should also be notified regarding the names of the program(s) through which hospice services would be provided if they elect the hospice benefit while in residence at the facility. Finally, Medicare beneficiaries eligible for the hospice benefit should have the right to choose which hospice will serve them. Currently, a terminally ill SNF/NF resident may only access the Medicare hospice benefit if the SNF/NF has a formal arrangement with a hospice program to provide services in the facility.

ENSURE ACCESS TO MEDICATIONS NECESSARY FOR PAIN CONTROL

ISSUE: Inadequate pain management has been identified by experts in the field as a national health concern. Some legislative proposals in recent years have the potential for compromising palliative care because they could empower drug enforcement officials to prosecute physicians to determine their intent for prescribing medication. This could have the unintended consequence of discouraging or limiting physicians from adequately treating terminally ill patients. This type of legislation would create a negative impact on the basic needs and rights of terminally ill patients as well as their comfort, dignity and freedom from pain.

RECOMMENDATION: Congress should oppose any legislation that would directly or indirectly set limits or prohibit physicians from prescribing adequate and appropriate controlled substances for the management of pain related to terminal illness.

RATIONALE: Terminally ill patients should not suffer due to inadequate pain management and lack of access to appropriate medications. Creating laws and policies that impose arbitrary limitations on physicians who prescribe controlled substances could have the unintended consequences of discouraging or limiting adequate treatment of terminally ill patients.

ALLOW PAs TO SERVE AS HOSPICE ATTENDING PHYSICIANS AND NPs AND PAs TO CERTIFY/RECERTIFY PATIENTS FOR MEDICARE HOSPICE SERVICES

ISSUE: While a nurse practitioner (NP) is allowed to serve as a hospice patient's attending physician, since inception of the hospice benefit the Medicare program has permitted only physicians (medical doctors or doctors of osteopathy) to certify or recertify a patient as terminally ill and eligible for hospice services. The 2010 health reform legislation (The Patient Protection and Affordable Care Act -- Public Law 111-148) allows either a hospice physician or hospice NP to gather clinical findings that support continuing eligibility for Medicare hospice care to satisfy the face-to-face encounter requirement for hospice patients expected to enter a third or later benefit period. Under current law, physician assistants (PAs) are not permitted to serve as a patient's attending physician; nor are they permitted to certify/recertify patients for Medicare hospice services.

NPs are currently permitted under Medicare to order skilled nursing facility care if working in collaboration with a physician.

During the 114th Congress, Senators Michael B. Enzi (R-WY) and Thomas Carper (D-DE) introduced S. 1354, which would permit physician assistants to serve as attending physician to hospice patients. Identical legislation was introduced in the House of Representatives by Reps. Lynn Jenkins (R-KS) and Mike Thompson (D-CA) as H.R. 1202.

RECOMMENDATION: Congress should enact S. 1354/H.R. 1202, which would authorize PAs to serve as attending physicians for hospice purposes under the same circumstances as NPs are permitted; further, Congress should authorize NPs and PAs to certify and recertify eligibility for the Medicare hospice benefit.

RATIONALE: Given current concerns about the growing shortage of primary care health professionals and growing outlays in federal health care programs, full advantage should be taken of the significant clinical skills and capabilities that NPs and PAs could bring to the palliative and hospice care settings. The Institute of Medicine (IoM) of the National Academy of Sciences reported in October 2010 (*The Future of Nursing: Leading Change, Advancing Health*) that care provided by NPs and primary care physicians are similar in terms of their complexity, and advanced practice nurses are trained to provide many of the same services offered by physicians. In many areas NPs are helping to fill a growing gap. The IoM also notes the significant overlap in scope of practice among physicians, physician assistants, and advanced practice nurses. However, IoM noted that a number of regulatory and institutional obstacles still exist that prevent the health system from reaping "the full benefit of nurses' training, skills, and knowledge in patient care." Among these are prohibitions under the Medicare program that prevent NPs from practicing to the full extent of their training and experience, including prohibitions against NPs certifying/recertifying beneficiaries eligible for hospice care. These limitations should be recognized and corrected.

PROTECT AND EXPAND HOSPICE COVERAGE UNDER MEDICAID

ISSUE: In 1986, when Congress enacted legislation making the Medicare hospice benefit permanent, hospice care was made an optional benefit under Medicaid. Hospice care allows terminally ill patients to move out of acute care facilities into less expensive care arrangements, primarily their own homes. There, the hospice team of health care professionals and other specialists provide physical, emotional and spiritual care to make the remainder of a patient's life as comfortable and meaningful as possible. As of 2011, 48 states had chosen to offer the hospice benefit to Medicaid beneficiaries. However, as states experience growing budget concerns, some are considering elimination of hospice coverage under their Medicaid programs or limiting the number of covered days, which would leave some of the country's most vulnerable individuals without appropriate care at the end of life. Alternatively, many states have opted to cover hospice under Medicaid managed care, which has led to some difficulty in securing timely authorization and sufficient payment for hospice services.

The 2010 health care reform measure greatly expanded the populations eligible for Medicaid. Additionally, as the result of a provision in the final health reform legislation, which became Public Law 111-148, states must now cover hospice and curative services concurrently for those children eligible for Medicaid or Medicaid-expansion Children's Health Insurance Program (CHIP) programs. However, hospice remains an optional benefit for adults.

RECOMMENDATION: Congress should mandate Medicaid hospice coverage for all populations served. Congress should also closely monitor Medicaid hospice services covered through managed care contracts to ensure that plan practices (care authorization and payment policies) do not reduce timely access to high quality end of life care.

RATIONALE: States expanded their Medicaid programs to cover hospice care in an effort to provide a more cost-effective and compassionate manner of caring for terminally-ill adults and children, including indigent and disabled individuals. Mandating hospice under Medicaid would speed access to hospice services. Hospice, with its combination of inpatient and outpatient care and case management by an interdisciplinary team composed of doctors, nurses, social workers and counselors, can provide high quality, comprehensive end-of-life care for the terminally ill patient while saving taxpayer funds. But with the current financial strains on Medicaid programs, even some states that currently offer hospice are considering dropping their Medicaid hospice benefit.

PROTECT HOSPICE AGENCIES FROM THE IMPACT OF SEQUENTIAL BILLING

ISSUE: The Centers for Medicare & Medicaid Services (CMS) has imposed the longstanding hospital sequential billing policy on hospice agency claims. The policy prohibits providers from submitting claims for care where previously submitted claims are pending. Claims processing can be delayed for weeks or months for many reasons -- including medical review activities, common working file problems, CMS or Medicare Administrative Contractor (MAC) claims processing issues, and pending claims from other providers. Hospices must continue to serve patients even though Medicare payments have been delayed for months.

RECOMMENDATION: Congress should require CMS to process and pay all clean claims as submitted regardless of whether previous claims have been processed, and pay interest on claims that are not processed in a timely fashion.

RATIONALE: Many hospices are small businesses with little financial reserve, dependent on uninterrupted payment for services delivered. Interruption of payment for weeks or months, while requiring agencies to continue services to hospice patients, can result in severe financial hardships. Further, the significant expansion of regulatory requirements and factors related to outdated CMS systems, in combination with sequential billing policy, have resulted in reimbursement loss for hospice providers despite no fault on the part of the hospice provider.

OPPOSE IMPOSITION OF PENALTIES FOR ERRONEOUS CERTIFICATION OF TERMINAL ILLNESS

ISSUE: Medicare regulation (42CFR §418.22) requires that, in order to be eligible to elect hospice services, an individual's physician and the hospice medical director must certify, in writing, that the individual's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course. About 25 percent of persons use hospice for five days or less, while approximately 12 percent of patients receiving Medicare hospice survive longer than six months. The median length of stay on hospice care is 18 days.

It is often difficult to make the determination that a patient will live no longer than six months because the course of terminal illness is different for each patient. A recently-published study reported that the recommended clinical prediction criteria are not effective in a population with a survival prognosis of six months or less. This information demonstrates what is well known by those in the hospice community: that prognostication is an inexact science. In a letter to all Medicare-certified hospices in the country, the then-Centers for Medicare & Medicaid Services Administrator reiterated that "In no way are hospice beneficiaries restricted to six months of coverage."

In the 2010 health care reform measures no new penalties were proposed for erroneous certification of a terminal illness by a physician. Instead, the final legislation required that continuing eligibility for patients entering their third or later benefit period be contingent upon certification by a hospice physician, but only after a hospice physician or nurse practitioner conducts a face-to-face encounter during which clinical information is gathered that is used to help support a six-month prognosis. The hospice physician or NP who conducts the encounter must also attest that the encounter has taken place. There is no separate payment by Medicare to cover the costs of the face-to-face encounter.

RECOMMENDATION: Congress should oppose imposition of civil monetary penalties upon physicians for erroneous certification of eligibility for hospice care. Congress should also ensure proper reimbursement is provided for visits to confirm continuing eligibility for hospice care.

RATIONALE: Physicians should not be punished for possible underestimation of a terminally ill patient's life expectancy. The only ones to be punished by such a penalty will be those patients in need of hospice services whose physicians will avoid recommending this compassionate, humane, and patient-family-centered care due to fear of penalties for erroneously underestimating their prognosis.

OVERSEE HOSPICE QUALITY REPORTING PROGRAM

ISSUE: The June 2008 hospice conditions of participation (CoP) require hospices to develop, implement, maintain, and evaluate an effective, data-driven quality assessment and performance improvement (QAPI) program. The Centers for Medicare & Medicaid Services (CMS) has directed hospices to either develop their own or use currently available systems of measures to track patient outcomes in such areas as pain management, quality of life, skin integrity, and patient satisfaction. The requirement includes retaining the information in a database that permits analysis over time.

The final 2010 health care reform legislation provides a strong start towards the development and implementation of a quality reporting program (the Hospice Quality Reporting Program – HQRP) by mandating that the Department of Health and Human Services (HHS) publish hospice quality measures covering all dimensions of hospice quality and care efficiency by October 1, 2012, and that hospices begin reporting these measures by FY2014. Failure to submit quality measures by a hospice would result in a 2 percentage point reduction in the annual market basket index update (Section 3004). CMS initiated a voluntary quality measure collection and reporting program in late 2011 and early 2012; mandatory quality measure data collection began October through December 2012, with mandatory data reporting in January and April of 2013. Failure to report data in early 2013 resulted in a 2 percent payment reduction for FY2014. Starting January 2013 hospices were required to collect and report the first full year of data, which must be reported by April 1, 2014, or hospices will have their FY2015 payments reduced by 2 percentage points. Beginning in July 2014, the HQRP entered a new phase with the requirement that hospices collect and submit data for a patient-specific Hospice Item Set (HIS). Subsequently, beginning in Jan. 2015, hospices are required to contract with an outside vendor to collect responses to a hospice experience of care survey (Hospice CAHPS) that will be completed by hospice patient family members.

CMS and others have additional hospice quality measures under development, in addition to plans for public reporting of hospice quality measures and, ultimately, development of a pilot program for hospice value-based purchasing.

RECOMMENDATION: Congress should monitor efforts by CMS to advance the HQRP and ensure the agency works with the hospice industry to select appropriate measures for reporting and establish a reasonable time frame for incorporating new measures. Congress should also ensure that sufficient funds are available to CMS to support these efforts.

The following conditions must be met in implementing any outcome measurement system:

- Reliable and valid indicators.
- Number of outcome measures limited to those that most accurately predict quality.
- Method for risk adjustment.
- Standard assessment limited to items needed for outcomes measurement and risk adjustment.
- A simple system with clinical utility.
- A mechanism enabling CMS to validate agency data.
- Ongoing evaluation of the entire system.

RATIONALE: The ideal hospice quality reporting program would be based on what happens to patients; however, there currently are no standard outcome measures for hospice care. Research and demonstration projects are not factored into the current per diem reimbursement structure. Every effort must be made to keep data collection and the paperwork burden to a minimum to allow concentration of resources on patient care.

SUPPORT THE PORTABILITY OF ADVANCE DIRECTIVES; CREATE AN ADVANCE CARE PLANNING BENEFIT UNDER MEDICARE

ISSUE: Between 20 and 25 percent of Americans above the age of 18 have advance directives but are not assured that this legal document will be honored in any state other than the state in which it was executed. The law honoring advance directives from another state is unclear. An individual is burdened with the responsibility of having the advance directive meet the laws of any state in which he may be spending some time. There should be a nationwide policy on advance directives for individuals receiving items and services under titles XVIII and XIX of the Social Security Act (42 U.S.C. 1395 et seq., 1396 et seq.), assuring that an advance directive validly executed outside of the state in which such advance directive is presented by an adult to a provider of services be given the same effect by that provider as an advance directive executed under the law of the state in which it is presented. This would help assure that an individual's decisions directing end-of-life care will be followed.

The final health care reform legislation (Public Law 111-148) did not address the need for portability of advance directives or advance care planning services to support individuals in development of their plans for future care needs. However, the original health reform legislation approved by the House (H.R.3962) provided for payment to physicians and other health care professionals to provide a voluntary advance care planning consultation (Section 1233); it also contained a provision regarding the dissemination of advance care planning information (Section 240). In response to steep opposition, the provisions were struck from the legislation prior to final passage.

During, 2014, the American Medical Association (AMA) approved the addition of two Common Procedural Terminology (CPT) codes for advance care planning and effective January 1, 2016, the Centers for Medicare & Medicaid Services (CMS) has activated those advance care planning codes under the Medicare Part B physician fee schedule. In conjunction with activation of the codes, CMS has authorized a waiver of beneficiary cost sharing when advanced care planning is requested by a patient and provided at the time of his or her annual wellness visit. CMS' request for comments on this regulatory change drew overwhelming support from the public.

In the 114th Congress, Senators Mark Warner (D-VA) and Johnny Isakson (R-GA) introduced S. 1549 -- The Care Planning Act of 2015. Among its many provisions, the legislation creates a voluntary Medicare advance care planning and coordination benefit for beneficiaries with serious or life-threatening illnesses that includes team-based discussions of goals of care and values, explanation of disease progression, exploration of a relevant range of treatment options, and a documented care plan that reflects the individual's goals and preferences; it also requires that facilities ensure that care plans made during the process are appropriately documented prior to discharge and sent to appropriate providers and facilities. Medicare-certified hospice providers and others meeting criteria set out in the legislation would be eligible for payment for the services.

RECOMMENDATION: Congress should support legislation that ensures the portability of an individual's advance directive between health care facilities as well as between states. Congress

should also enact the Care Planning Act to establish a benefit under which Medicare beneficiaries receive broad-based support from trained professionals to assist them in development of their care planning goals, and assurance that documentation of those goals will be shared with relevant health care providers.

RATIONALE: An advance directive belongs to the individual and should not be interfered with or interrupted by the laws of any particular state or health care facility. As an individual travels or relocates to a different state, his stated end-of-life-care choices should be honored based on the choices of the individual, not based on the location of the individual. Establishing a nationwide policy on advance directives that assures the portability of an individual's end-of-life care choices strengthens patient self-determination efforts and could encourage more individuals to communicate with families, physicians and health care providers about their end-of-life-care choices.

A full-fledged voluntary advance care planning benefit under Medicare, supplied by an appropriately trained team of professionals, will help to educate beneficiaries and their loved ones about their conditions and treatment options. As a result, they will be better informed about disease processes and better prepared to make advance health care decisions if that is their desire; those wishes will be conveyed to appropriate health care providers and facilities. This will substantially increase the likelihood that those life choices will be honored.

ENACT HOSPICE-SPECIFIC COMPLIANCE MEASURES

ISSUE: Hospice, like most other health care segments, is not immune to the presence of participants that engage in improper, unethical and possibly illegal schemes for the sake of profit. At the same time, health care providers that operate well within the law are unable to effectively compete in the market when faced with competitors that offer kickbacks for patient referrals, bill for services not provided, or charge costs that are not part of delivery of services.

The final health reform law (Public Law 111-148) allows the Department of Health and Human Services (HHS) to require compliance plans and background screening of owners and managers, as well as authorizes the Secretary of HHS to impose a moratorium on new providers (Section 6401). The law also extends the criminal background check pilot program at CMS (Section 6201).

RECOMMENDATION: Congress should continue its work to ensure compliance with federal requirements and to combat waste, fraud, and abuse in our nation's health care system by passing a hospice-specific compliance package that would:

- Implement hospice-specific requirements enacted as part of the Patient Protection and Affordable Care Act (PPACA) and take appropriate next steps related to PPACA reforms
- Strengthen admission standards for new Medicare hospice organizations through probationary initial enrollment, prepayment claims review, initial capitalization requirements, and early-intervention oversight by Medicare surveyors
- Require credentialing of hospice agency executives
- Require criminal background checks on hospice agency owners, significant financial investors, and management
- Require all Medicare participating hospice agencies to implement a comprehensive corporate compliance plan
- Enhance education and training of health care provider staff, regulators and their contractors to achieve uniform and consistent understanding and application of hospice program standards
- Implement a targeted, temporary moratorium on new hospice organizations
- Create a joint Hospice Benefit Program Integrity Council to provide a forum for partnering in program integrity improvements with Medicare, Medicaid, providers of services, and beneficiaries
- Require that curricula for residents and interns contain hospice and palliative care-related training and experience.

RATIONALE: A comprehensive compliance package that is specifically focused on hospice is good "preventive medicine" to help maintain compliance and ensure proper expenditures of limited health care dollars for appropriate hospice care. It is in the best interests of compliant hospice organizations to take steps to keep unscrupulous providers from operating within federal and state programs. The health care reform proposals go a long way toward meeting the compliance measures needed to succeed.

VIII. HOME MEDICAL EQUIPMENT

SUPPORT EFFORTS TO ADEQUATELY REIMBURSE HME SUPPLIERS FOR COSTS ASSOCIATED WITH IN-HOME DRUG THERAPIES

ISSUE: Prior to the implementation of the Medicare and Prescription Drug, Improvement and Modernization Act (MMA) (PL 108-173), Medicare Part B paid 95 percent of average wholesale price (AWP) for drugs used in home infusion and home inhalation therapies administered through home medical equipment. A report by the Government Accountability Office (GAO), however, characterized the reimbursement for drugs under Medicare Part B as flawed and called on Congress to explore new ways to pay for drugs under the home medical equipment (HME) benefit.

Partly in response to this report, the MMA reduced payments for most in-home drug therapies. Drug and drug therapies furnished in 2004 were reimbursed at 85 percent of the AWP (determined as of April 1, 2003). Beginning in 2005, drugs and biologicals, except for pneumococcal, influenza, and hepatitis B vaccines and those associated with certain renal dialysis services, were paid using either the average sales price (ASP) methodology or through competitive bidding.

Infusion drugs furnished through covered home medical equipment starting January 1, 2004, were paid 95 percent of the AWP in effect on October 1, 2003; those infusion drugs that may be furnished in a competitive acquisition area starting January 1, 2007, will be paid at the competitive price. HME suppliers do not dispute that, under the old law, Medicare Part B payments for drugs were higher than the costs of the actual drugs. What CMS and GAO failed to take into consideration is that the reimbursement also paid for the high level of service that accompanies the administration of such drugs in the home.

A report developed by consultants at Lewin and Associates demonstrates that actual cost of the drugs represents only a small fraction of the overall costs of caring for patients with inhalation or IV therapy. According to the Lewin report, the cost of the drugs to treat these patients represents only 26 percent of total costs, while direct patient care costs average 46 percent and indirect costs such as accreditation, information systems, and Medicare/Medicaid compliance amount to another 25 percent.

In early 2009, Sens. Blanche Lincoln (D-AR) introduced S. 254, The Medicare Home Infusion Therapy Coverage Act of 2009, which would provide coverage for infusion-related services, supplies and equipment under Medicare Part B, while leaving coverage of the drugs used in infusions under Part D. The bill has 31 Senate cosponsors. Similar legislation (H.R. 574) was introduced in the House by Rep. Eliot Engel (D-NY). The bill was re-introduced in the 112th Congress (S. 1203; H.R. 2195) and in the House in the 113th Congress (H.R. 5435). In the 114th Congress the legislation was re-introduced as the Medicare Home Infusion Site of Care Act of 2015 (H.R.605/S.275).

RECOMMENDATION: Congress should consider reforming reimbursement for home infusion and inhalation therapies to ensure appropriate coverage of services (including patient care costs associated with equipment and supplies), drug and supplies under Medicare.

Congress should reject recommendations to subject the HME drug benefit to competitive bidding. The HME community is concerned that competitive bidding will lead to monopolistic practices by suppliers that would hamper beneficiary choice, increase costs in the long run, and

lower quality.

RATIONALE: Current Medicare reimbursement fails to recognize such services as the need to compound certain drugs in a sterile setting, responding to emergencies and questions concerning therapies, and participating in the training and education of the patient (and often the patient's family). Oftentimes, the therapies require services of a nurse or respiratory therapist to perform a variety of functions. If the patient does not qualify as "homebound," nursing services are not covered by the HME drug benefit.

For these reasons, the HME community supports efforts to enact legislation that accurately reflects the cost of drugs, equipment, and the appropriate services necessary to administer such drug therapies.

REVISE APPLICATION OF THE “IN-HOME” RESTRICTION FOR MEDICARE PART B REIMBURSEMENT OF DME SUPPLIES

ISSUE: Current law (42 U.S.C. § 1861 (n)) requires that durable medical equipment (DME) be used “in the patient’s home,” rather than a hospital or skilled nursing facility, to qualify for Medicare Part B reimbursement. Congressional intent was to exclude Part B coverage of DME in an institutional setting. Congress did not otherwise impose a geographical limit on the use of DME. For example, there is no requirement that the actual use of the DME be confined to within the four walls of a home.

Nevertheless, the Centers for Medicare & Medicaid Services (CMS) and the Durable Medical Equipment Regional Carriers (DMERCs) have interpreted and applied the “in the patient’s home” clause in an overly restrictive manner. Specifically, Medicare DME coverage has been limited to those items an individual demonstrates are needed within the home, rather than the DME needed to allow the individual to meet his or her daily responsibilities. As a result, persons with disabilities, young and old, have been denied Medicare coverage for the types of medical equipment that will enable them to attend school; go to work; meet their obligations as parents and heads of households e.g., to shop, attend meetings and activities at their children’s schools; participate in religious services; and to otherwise be fully involved in their local communities and in American society.

During 2009, the Medicare Independent Living Act was introduced by Sen. Jeff Bingaman (D-NM) and others in the Senate (S. 1186), and by Rep. James R. Langevin (D-RI) and others in the House (H.R. 3184); the legislation would eliminate the “in the home” restriction on reimbursement of medical equipment. In the 113th Congress this legislation was incorporated into the Insuring Access to Quality Complex Rehabilitation Technology Act (H.R.942; S.948), introduced by Rep. Langevin and Senator Charles Schumer. In the 114th Congress the bill numbers of this legislation are S.1013/H.R.1516.

RECOMMENDATION: Congress should direct CMS to make changes to definitions, policies, and practices so as to ensure that HME supplies, along with rehab and assistive technologies, are covered by Medicare even if such supplies or technologies allow the beneficiary to leave the home and might be used outside the home.

RATIONALE: The “New Freedom Initiative” for persons with disabilities includes helping individuals with disabilities by “increasing access to assistive technologies, expanding educational opportunities, increasing the ability of Americans with disabilities to integrate into the workforce, and promoting increased access into daily community life.” Without access to appropriate DME in the community, persons with disabilities will not be able to fulfill their potential in the work place, to get to school to develop new job skills, or to meet their family responsibilities of performing many of activities of daily living.

REFINE COMPETITIVE BIDDING FOR HOME MEDICAL EQUIPMENT

ISSUE: The “Medicare Prescription Drug, Improvement and Modernization Act,” (P.L. 108-173) required phased implementation of a national competitive bidding program for home medical equipment (HME). Upon implementation of competitive bidding, the Medicare program will no longer reimburse HME suppliers through a specified fee schedule, but instead award suppliers who submit the lowest bid with the contract to supply the region with the particular product.

Initially, competitive bidding was set to start with 10 of the largest Metropolitan Statistical Areas (MSAs) in 2007, 80 of the largest MSAs in 2009, and additional areas after 2009. In developing the competitive bidding program, the Centers for Medicare & Medicaid Services (CMS) is allowed to exempt rural areas and areas with low population density.

In addition, CMS is prohibited from awarding a contract unless the supplier meets quality standards and financial standards (with special consideration to small suppliers), and unless there are assurances that real savings will be achieved and that beneficiaries will have a choice of suppliers. To participate in the bidding program, HME suppliers are required to waive their right to administrative or judicial review of the competitive bidding process.

In June 2005 an industry-financed study conducted by Economist Dr. Kenneth Brown of the University of Northern Iowa found that savings estimated to accrue from national competitive bidding will not materialize as most of the savings have already been achieved through imposition of a fee schedule based on reimbursement under the Federal Employees Health Benefits Program.

The first round competitive bidding areas (CBAs) and product categories were announced in April 2007, and bids were due on Sept. 25, 2007. CMS began implementation of the first round of competitive bidding on July 1, 2008. However, in July 2008, Congress enacted legislation (The Medicare Improvements for Patients and Providers Act--MIPPA) that delayed the first round of competitive bidding for 18 months and in its stead imposed an across-the-board cut of 9.5 percent on all items selected for the bidding program. Congress acted because of concerns expressed by medical equipment suppliers that the bidding process use by CMS may have been flawed.

Round one of competitive bidding began on January 1, 2011, in nine MSAs. Under the final health reform legislation signed into law in March 2010 (Public Law 111-148), the number of CBAs in the second round of competitive bidding has been expanded to 100, with inclusion of the remaining areas of the country by 2016.

Members of Congress remain concerned about the impact of the competitive bidding program. During 2009, Rep. Kendrick Meek (D-FL) introduced legislation to repeal the competitive bidding program; more than 200 members of Congress have joined in cosponsoring the legislation. A new approach to competitive bidding was proposed in the 112th Congress (The Medicare DMEPOS Market Pricing Program Act). In 2013 the Small Supplier Fairness in Bidding Competition Act (H.R. 27) was introduced that would repeal competitive bidding. In 2015 another approach was proposed in the Medicare DMEPOS Competitive Bidding Improvement Act (H.R.284).

RECOMMENDATION: Congress should support real competition and avoid fostering

monopolistic markets by refining the competitive bidding program for HME and ensuring its use only in cases where real savings can be achieved. Congress should closely monitor CMS's implementation of the competitive bidding program to guard against unintended negative consequences to Medicare beneficiaries or suppliers. Congress should make certain that CMS has effective processes in place to determine the credentials of bidders and ensure quality compliance and accountability of bidders and their subcontractors.

RATIONALE: Competitive bidding raises significant concerns, including loss of quality and service and the potential negative impact on beneficiary access and choice. Specifically, competitive bidding for HME supplies:

- Reduces beneficiary choice by allowing only those suppliers with winning bids to serve Medicare beneficiaries;
- Reduces quality since, under competitive bidding, price becomes the main buying criteria;
- Raises costs over the long run by promoting supplier monopolies that reduce competition; and
- Creates beneficiary confusion and additional burdens if the beneficiary is already receiving supplies and service from a supplier who can no longer serve in the area as a result of competitive bidding.

ENSURE ADEQUATE REIMBURSEMENT FOR OXYGEN AND OXYGEN SUPPLIES

ISSUE: Oxygen and oxygen supplies help extend life and maintain maximum functioning despite the presence of serious chronic illness. Payments for oxygen and related supplies have been seriously curtailed in recent years, including freezes on the annual inflation updates for the 2004 – 2008 period of time.

In late March 2005 the Centers for Medicare & Medicaid Services (CMS) issued new rates that became effective in April of that year. Payment reductions varied by state; the average reduction for stationary oxygen was 8.6 percent and for portable units the average reduction is 8.1 percent.

In 2006 CMS published a final rule that implemented the Deficit Reduction Act of 2005 (DRA) requirements to further reduce Medicare expenditures and beneficiary coinsurance payments for affected items. Specifically, the rule changed payment methodologies for oxygen and oxygen equipment, imposed capped rental requirements on oxygen equipment, and established new protections for beneficiaries who require these items. In addition CMS established separate payment classes and monthly payments for oxygen generating portable equipment (OGPE). CMS implemented the capped rental of oxygen equipment to beneficiaries after 36 months of continuous rental in January 2009. Additional cuts of 9.5% and 2.53% went into effect on the same date. CMS' plans for imposing the cap have been criticized by members of Congress and the Small Business Administration (SBA). SBA expressed particular concern that CMS failed to fully consider the impact of the cap on small businesses, a requirement of the Regulatory Flexibility Act.

RECOMMENDATION: Congress should conduct review of the combined impact of the payment cuts and capped rental on oxygen equipment that went into effect in 2009 with particular focus on their impact on access to care and the financial stability of small suppliers. Modifications to existing payments should be made to ensure appropriate access to equipment, supplies and services. Congress should mandate a study of the impact of fewer oxygen suppliers and the re-hospitalizations that have resulted from the limitations on oxygen payments.

RATIONALE: Keeping reimbursement rates for oxygen, oxygen equipment and services below CPI threatens patient access to care and the financial stability of small suppliers; these threats could extend to vulnerable Medicare beneficiaries who lack the clinical resources needed to ensure appropriate oxygen administration in the home setting.

IX. FACT SHEETS ON HOME CARE

HOME CARE AND HOSPICE LEGISLATION 2015

The Medicare Access and CHIP Reauthorization Act of 2015 (H.R. 2, P.L. 114-10) replaced the Medicare physician payment formula known as the Sustainable Growth Rate (SGR) with a new payment methodology. The cost of the legislation was partially offset by setting the annual payment rate update for post acute (including home health) and hospice providers at 1 percent in 2018. This represents an estimated 1 percentage point reduction from what would otherwise have been the update.

It included a provision that extended the Medicare rural add-on payment for home health agencies for two years (to the end of 2017). It also contained a modification to home health surety bond requirements, setting the bond minimum at \$50,000 and allowing Medicare to scale the bond value above \$50,000 commensurate with a home health agency's volume of Medicare revenue. CMS has taken no action to implement the bond requirement.

HOME CARE AND HOSPICE LEGISLATION 2013/14

The Consolidated Appropriations Act of 2014 (H.R. 3547; Pub. Law No: 113-76 (1-17-2014)) extended the 2 percent sequester payment cut for all Medicare providers through 2023. The Medicare physician payment formula “fix” was extended to March 31, 2014 to prevent a cut in physician payments. In March 2014, the physician payment fix was extended again to March 31, 2015. Home health and hospice were spared from any payment cuts to help offset the cost of the temporary physician payment fixes.

The Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 (H.R. 4994; P.L.113-185) requires that 1) post-acute providers (PAC) report standardized patient assessment data, data on quality measures, and data on resource use and other measures; 2) the data be interoperable to allow for its exchange among PAC and other providers to give them access to longitudinal information so as to facilitate coordinated care and improve Medicare outcomes; and 3) PAC assessment instruments applicable to PAC providers be modified for the submission of standardized patient assessment data and comparison of assessment data across all such providers.

The IMPACT Act requires CMS to survey hospices at least as frequently as every 36 months for the next 10 years. It also corrects a legislative drafting error that has prevented implementation of the Affordable Care Act provision requiring medical review of hospices with a high proportion of long-stay patients. The legislation also modifies the annual update for the hospice aggregate cap; beginning with the 2016 cap year the aggregate cap will be updated by the net market basket update for that year, rather than by the BLS medical expenditure category of the Consumer Price Index for all Urban Consumers -- the CPI-M(U), as has historically been the case.

HOME CARE LEGISLATION 2012

The American Taxpayer Relief Act (ATRA) of 2012 (H.R. 8; P.L. 112-240) extended the Medicare physician payment formula “fix” to the end of 2013 to prevent a cut in physician payments. Medicare payments to hospitals and some other Medicare providers were cut to help offset the cost of the physician fix. Home health and hospice were again spared.

The sequester cuts scheduled for January 2, 2013 were delayed by the ATRA until March 1, 2013; the 2 percent Medicare payment cut under the sequester was delayed until April 1, 2013.

HOME CARE LEGISLATION 2011

On August 2, 2011, at the conclusion of an intensive effort by Congress and the Administration to negotiate a deficit reduction package and raise the debt ceiling, Congress passed the Budget Control Act of 2011 (S. 365/P.L. 112-25). In the Act Congress mandated certain percentage cuts in federal spending (known as a “sequester”) sufficient to achieve \$1.2 trillion in savings over 10 years. Under Section 302 Medicare provider payments, including payments for home health and hospice, will be cut by 2 percent beginning in 2013 as part of the sequester.

At the conclusion of 2011 and early 2012 Congress worked to extend a payroll tax cut, unemployment insurance, and a Medicare physician payment “fix” through the end of 2012 (Middle Class Tax Relief and Job Creation Act (H.R. 3630/P.L. 112-96)). Medicare hospital and nursing home payments were cut to help offset the costs of these provisions; home health and hospice were spared.

HOSPICE LEGISLATION 2011

Chronological Summary of Health Care Reform Provisions Affecting Hospice Care (Patient Protection and Affordable Care Act (H.R. 3590; Public Law No. 111-148))

2010

Medicaid/CHIP Pediatric Hospice. Medicaid or CHIP-eligible children may receive hospice services without forgoing other services to which they are entitled under Medicaid/CHIP. (Sec. 2302)

2010 or later

Medicare Hospice Concurrent Care Demonstration. Three-year demonstration program would allow hospice patients to concurrently receive all other Medicare-covered services. This demonstration is required to be budget neutral and expected to improve patient care, quality of life and cost-effectiveness. (Sec. 3140)

January 1, 2011

Continued Eligibility for Medicare Hospice Services. The Secretary of HHS must require a hospice physician or advanced practice nurse to determine, through a face-to-face encounter, a patient's continued hospice eligibility prior to the 180th day recertification, and for each certification thereafter, and attest that such a visit took place. In the case of hospice programs for which the number of patient stays in excess of 180 days meet a certain threshold (as determined by the Secretary), stays in excess of 180 days must be reviewed by CMS or its contractors for medical necessity. (Sec. 3132(b))

January 1, 2011

Additional Data Collection from Medicare Hospice Programs. Requires the Secretary of HHS to collect additional data and information to be used for payment system revisions. (Section 3132(a))

October 1, 2012

Medicare Market Basket Update Reductions (applicable for FY 2013 through 2019)/Productivity Adjustments. The Secretary of HHS must, beginning with Fiscal Year 2013, impose annually a productivity adjustment (reduction roughly estimated at 1 percent) to the market basket inflation update. Additionally, for FYs 2013 through 2019, the hospice market basket update would be reduced by an additional 0.3 percentage point. However, for FY2014 through 2019, if growth in the previous year's insured population does not exceed 5 percent, no 0.3 percent reduction is imposed in that year. (Sec. 3401(g); HCERA Sec. 10319(f))

October 1, 2012

Publication of Quality Measures. By October 1, 2012 The Secretary of HHS must publish quality measures for reporting by hospices in FY2014. The measures would cover all dimensions of quality as well as efficiency of care. (Sec. 3004(c))

October 1, 2013

Medicare Payment Revisions. Effective no earlier than October 1, 2013, payment system revisions for hospice services will be implemented on a budget-neutral basis. (Sec. 3132(a))

October 1, 2013

Reporting of Quality Measures. Hospice programs must begin to report quality measures; failure to do so would result in a 2.0 percentage point cut in the annual Medicare market basket update. (Sec. 3004(c))

January 1, 2016

Pilot Testing of Pay-for-Performance. No later than this date, the Secretary of HHS is required to establish a pilot program to test value-based purchasing under hospice. (HCERA Sec. 10326)

Other Provisions of Interest

2010

Criminal Background Check Pilot Program Expansion. Extends existing pilot program for background checks on direct patient access employees of long-term care facilities and providers to a nationwide program (based on individual state choice of participation). Definition of long-term care facility or provider includes providers of hospice care. (Sec. 6201)

2010 or later

Advancing Research and Treatment for Pain Care Management. Pending appropriations, the Secretary of HHS shall convene a Conference on Pain in conjunction with the Institute of Medicine. The Director of NIH is encouraged to engage in an aggressive program of pain research through the Pain Consortium. The Secretary of HHS shall establish no later than one year after enactment an Interagency Pain Research Coordinating Committee. The Secretary may make awards of grants, cooperative agreements, and contracts to hospices and other entities for the development and implementation of programs to provide education and training to health care professionals in pain care. (Sec. 4305)

2010-2012

Grants for Postpartum Depression Services. Allows the Secretary of HHS to establish under the Material and Child Health Services Block Grant projects to provide services to individuals with a postpartum condition and their families. Definition of “eligible entities” to receive grants includes hospices. (Sec. 2952(b))

2010

Compliance and Penalties. Requires background screening and credentialing of provider and supplier owners and managers; requires compliance plans; provides authority to the Secretary of HHS to impose a temporary moratorium on new providers. (Sec. 6401)

2014

Independent Payment Advisory Board. Establishes an Independent Payment Advisory Board (IPAB) to submit legislative proposals containing recommendations to reduce the per capita rate of growth in Medicare spending if spending is expected to exceed a target growth rate.

Beginning January 15, 2014, in years when Medicare costs are projected to be unsustainable, IPAB proposals will take effect unless Congress passes an alternative measure that achieves the same level of savings. IPAB would be prohibited from making proposals that ration care, raise taxes or Part B premiums, or change Medicare benefit, eligibility, or cost-sharing standards. IPAB would be prohibited from recommending payment reductions for providers during a year in which those providers' market basket updates are scheduled for reduction beyond the annual productivity adjustment. (Sec. 3403)

HOME CARE LEGISLATION 2010

Chronological Summary of Health Care Reform Provisions Affecting Home Care (Patient Protection and Affordable Care Act (H.R. 3590; Public Law No. 111-148))

January 1, 2010

(proposed extension to January 1, 2011 by regulation)

Sec. 6407. Face to face encounter with patient required before physicians may certify eligibility for home health services or durable medical equipment under Medicare; Sec. 10605 of Manager's Amendment. Certain other providers permitted to conduct face to face encounter for home health services.

Face-to-face physician encounter requirement (including telehealth encounter) with patients within a reasonable timeframe as determined by the Secretary; nurse practitioners, advanced practice nurses, and physician assistants may substitute for physicians to meet the face-to-face encounter requirement.

January 1, 2010

Sec. 6406. Requirement for Physicians to Provide Documentation on Referrals to Programs at High Risk of Waste and Abuse.

Physician must maintain and provide access to documentation on Medicare home health referrals if requested. Home health agencies must maintain and provide access to documentation of certification of Medicare home health services if requested.

April 1, 2010

Sec. 3131. Payment Adjustment for Home Health Care

Sec. 3131(c). Application of the Medicare Rural Home Health Add-on Policy. 3% rural add-on for episodes and visits ending on or after April 1, 2010 and before January 1, 2016.

July 1, 2010 (regulation out July 6)

Sec. 6405 Physicians who order items or services required to be Medicare enrolled physicians or eligible professionals; Sec. 10604 of Manager's Amendment. Technical Correction to Section 6405.

Medicare enrolled physician requirement regarding care plan certification

September 30, 2010

Sec. 5101. National Health Care Workforce Commission.

Establishes commission to review health care workforce and projected workforce needs.

October 1, 2010

Sec. 2401. Community First Choice Option.

Expanded Medicaid home care through agencies and self-directed care.

October 1, 2010

Sec. 2402. Removal of barriers to Home and Community based Services.

Expanded rebalancing requirements and waiver authority and removal of restrictions on waivers.

October 1, 2010

Sec. 2403. Money Follows the Person Rebalancing Demonstration.

Extension through September 2016.

2010

Sec. 6401. Provider Screening and other enrollment requirements under Medicare, Medicaid, and CHIP.

Require background screening and credentialing of provider and supplier owners and managers, require compliance plans, gives CMS the authority to impose a temporary moratorium on new providers

2010

Sec. 3502. Establish Community Health Teams to Support Patient-Centered Medical Home.

Grants to community-based interdisciplinary, interprofessional teams to support primary care practices; includes chronic care management.

2010

Sec. 6201. Nationwide program for National and State background checks on direct patient access employees of long-term care facilities and providers.

Extends existing pilot program for background checks on direct patient access employees of long-term care facilities and providers to a nationwide program (based on individual state choice of participation). Definition of long-term care facility or provider includes providers of home care.

2010 - 2014

Sec. 4201. Community Transformation Grants

Competitive grants to State and local governmental agencies and community based organizations for the implementation, evaluation and dissemination of evidence-based community preventive health activities in order to reduce chronic disease rates, prevent the development of secondary conditions, address health disparities and develop a stronger evidence-base of effective prevention programming. Authorized appropriations for 2010 – 2014.

2010

Sec. 10501. National Diabetes Prevention Program

Grants to entities determined by the Secretary for community-based diabetes prevention programs.

2010 - 2014

Sec. 4202. Healthy Aging, Living Well; Evaluation of Community-Based Prevention and Wellness Programs for Medicare Beneficiaries

Grants to state or local health departments and Indian tribes to carry out 5-year pilot programs to

provide public health community interventions, screenings, and clinical referrals for individuals between 55 and 64.

2010

Sec. 4204. Demonstration Program to Improve Immunization Coverage.

Demonstration program awarding grants to states to improve the provision of recommended immunizations through the use of evidence-based, population-based interventions for high-risk populations.

2010 - 2015

Sec. 2951. Grants for Early Childhood Home Visitation.

Grants to states to establish quantifiable and measurable 3 and 5 year benchmarks to demonstrate improvements in maternal and newborn health, prevention of child injuries and abuse, improvements in family economic self-sufficiency and school readiness/achievement, and improvements in coordination and referrals between other community resources.

2010 (authorized for five years, with option of additional five years)

Sec. 2601. Medicaid Waiver Demonstration Projects for Dual Eligibles.

Medicaid waivers for coordinating care for dual eligible beneficiaries.

January 1, 2011

Sec. 2703. Health Homes for Chronically Ill Patients

Planning grants to states to develop a new state plan option to permit Medicaid enrollees with at least two chronic conditions, one condition and risk of developing another, or at least a serious and persistent mental health condition to select a designated provider (could include a home health agency), a team of healthcare professionals operating with such a provider, or a health team as the individual's health home for purposes of providing the individual with health home services. States taking up option provided with 90 percent of FMAP for two years for home health related services, including care management, care coordination, and health promotion.

January 1, 2011

Sec. 3021. Establish a Center for Medicare and Medicaid Innovation within CMS.

Opportunities for chronic care and other initiatives includes funding home health providers who offer chronic care management services to applicable individuals in cooperation with interdisciplinary teams (xiv). Telehealth advancement opportunities through new CMS Innovations Center but no guarantee.

January 1, 2011

Sec. 3026. Community Based Transitions Program

Funding for hospitals with high admission rates and community-based organizations that improve care transition services for high risk Medicare beneficiaries. (\$500 million total.)

January 1, 2011

Sec. 3131. Payment Adjustment for Home Health Care

Sec. 3131(b). Program Specific Outlier Cap.

Beginning in 2011, cap total outliers at 2.5%; impose individual agency outlier cap of 10%.

January 1, 2011

Sec. 3401 Revision of certain market basket updates and incorporation of productivity improvements into market basket updates that do not already incorporate such improvements.; Sec. 10319 of Manager’s Amendment. Revisions to market basket adjustments.

Reduce home health market basket update by 1 percentage point in 2011, 2012, and 2013.

October 1, 2011

Sec. 3006. Plans for a Value-Based Purchasing Program for Skilled Nursing Facilities and Home Health Agencies.

Secretary of HHS shall submit plan for value—based purchasing program for home health agencies to Congress by Oct. 1, 2011.

2011 (enroll)

2016 (coverage begins)

Sec. 8001. Community Living Assistance Services and Supports Act (CLASS Act).

Establish voluntary national home and community-based long term care insurance program.

Beneficiaries vest after 5 years paying premiums.

January 1, 2012

Sec. 3024. Independence at Home demonstration program.

Tests a payment incentive and service delivery model that utilizes physician and nurse practitioner directed home-based primary care teams.

January 1, 2012 – December 31, 2016

Sec. 2704. Bundled Payments Medicaid.

Medicaid demonstration project in 8 states to pay bundled payments to hospitals for episodes of care that include hospitalizations.

January 1, 2012

Sec. 3022. Accountable Care Organizations.

Establishes a shared savings program that rewards Accountable Care Organizations (ACO) that take responsibility for the costs and quality of care. ACO’s may include groups of health care providers.

October 1, 2012

Sec. 3025. Hospital Readmissions and Reductions Program.

Reduce hospital payments for readmissions.

January 1, 2013

Sec. 3023. National Pilot Program on Payment Bundling.

Directs HHS Secretary to develop a national, voluntary pilot program encouraging bundled payment models for hospitals, doctors, and post-acute care providers. Entities including a hospital, a physician group, a SNF and a home health agency may apply to participate. Requires the Secretary to establish this program by January 1, 2013 for a period of five years. Before January 1, 2016, the Secretary is also required to submit a plan to Congress to expand the pilot program if doing so will result in improving the quality of patient care and reducing spending.

January 1, 2014

Sec. 3131. Payment Adjustment for Home Health Care; Sec. 10315 of Manager's Amendment. Revisions to Home Health Provisions.

Rebase starting in 2014 phasing in through 2017; rebasing adjustment limited to no more than 3.5% reduction per year.

January 1, 2014 – December 31, 2018

Sec. 2404. Protection for Recipients of Home and Community Based Services Against Spousal Impoverishment.

Spousal impoverishment protection for home care eligibility.

January 1, 2014

Sec. 1513. Shared Responsibility for Employers.

Assess employers with more than 50 employees that do not offer coverage and have at least one full-time employee who receives a premium tax credit a fee of \$2,000 per full-time employee, excluding the first 30 employees from the assessment. (Effective January 1, 2014) Exempt employers with 50 or fewer employees from any of the above penalties.

January 1, 2014

Sec. 10108. Free Choice Vouchers.

Require employers that offer coverage to their employees to provide a free choice voucher to employees with incomes less than 400% FPL who choose to enroll in a plan in the Exchange. The voucher amount is equal to what the employer would have paid to provide coverage to the employee under the employer's plan and will be used to offset the premium costs for the plan in which the employee is enrolled. Employers providing free choice vouchers will not be subject to penalties for employees that receive premium credits in the Exchange. (Effective January 1, 2014)

The term 'full-time employee' means an employee who is employed on average at least 30 hours of service per week.

January 15, 2014

Sec. 3403. Independent Medicare Advisory Board; Sec. 10320 of Manager's Amendment. Expansion of the Scope of, and additional improvements to, the Independent Medicare Advisory Board.

Establish an Independent Payment Advisory Board comprised of 15 members to submit legislative proposals containing recommendations to reduce the per capita rate of growth in Medicare spending if spending exceeds a target growth rate. Beginning January 15, 2014, in years when Medicare costs are projected to be unsustainable, the Board's proposals will take effect unless Congress passes an alternative measure that achieves the same level of savings. The Board would be prohibited from making proposals that ration care, raise taxes or Part B premiums, or change Medicare benefit, eligibility, or cost-sharing standards.

March 1, 2014

Sec. 3131(d). Study and Report on the Developments of the Home Health Payment Reforms In Order to Ensure Access to Care and Quality Services.

By March 1, 2014, HHS Secretary must report on home health rebasing and impact on access and quality.

March 1, 2014

Sec. 10315 (b). Revisions to Home Health Care Provisions.

HHS Study and Report: By March 1, 2014, HHS must report results of a study with recommendations for legislative and administrative action, regarding home health agency costs for care provided to low-income beneficiaries or those in medically underserved areas, and those with varying levels of severity.

2014

Sec. 1302. Essential Health Benefits Requirements

Secretary shall define essential health benefits with respect to any health plan; provides for notice and opportunity for public comment.

January 1, 2015

Sec. 3131(2)(B). MedPAC Study and Report.

MedPAC shall report by Jan. 1, 2015, on impact of rebasing.

January 1, 2015

Sec. 3401. Revision of Certain Market Basket Updates and Incorporation of Productivity Improvements into Market Basket Updates That Do Not Already Incorporate Such Improvements.

Annual productivity adjustment (estimated 1 percentage point reduction) beginning 2015.

January 1, 2015

Sec. 10315 (b) Revisions to Home Health Care Provisions.

Medicare Demonstration Project: HHS Secretary may provide for a four-year (beginning no later than January 1, 2015) \$500M demonstration project to test whether making payment adjustments based on the study substantially improve access to care for patients with high severity levels of illness or for low-income or underserved Medicare beneficiaries.

HOME HEALTH LEGISLATION 2009-2010

Patient Protection and Affordable Care Act (H.R. 3590: Public Law No. 111-148)

MEDICARE HOME HEALTH PAYMENT ADJUSTMENTS

Sec. 3131. Payment Adjustment for Home Health Care

Sec. 3131(b). Program Specific Outlier Cap.

Beginning in 2011, cap total outliers at 2.5%; impose individual agency outlier cap of 10%.

Sec. 3131(c). Application of the Medicare Rural Home Health Add-on Policy.

3% rural add-on for episodes and visits ending on or after April 1, 2010 and before January 1, 2016.

Sec. 3401 Revision of certain market basket updates and incorporation of productivity improvements into market basket updates that do not already incorporate such improvements.; Sec. 10319 of Manager's Amendment. Revisions to market basket adjustments.

Reduce home health market basket update by 1 percentage point in 2011, 2012, and 2013.

Sec. 3131. Payment Adjustment for Home Health Care; Sec. 10315 of Manager's Amendment. Revisions to Home Health Provisions.

Rebase starting in 2014 phasing in through 2017; rebasing adjustment limited to no more than 3.5% reduction per year.

Sec. 3131(2)(B). MedPAC Study and Report.

MedPAC shall report by Jan. 1, 2015, on impact of rebasing.

Sec. 3131(d). Study and Report on the Developments of the Home Health Payment Reforms In Order to Ensure Access to Care and Quality Services.

By March 1, 2014, HHS Secretary must report on home health rebasing and impact on access and quality.

Sec. 3401. Revision of Certain Market Basket Updates and Incorporation of Productivity Improvements into Market Basket Updates That Do Not Already Incorporate Such Improvements.

Annual productivity adjustment (estimated 1 percentage point reduction) beginning 2015.

Sec. 3025. Hospital Readmissions and Reductions Program.

Reduce hospital payments for readmissions.

Sec. 3023. National Pilot Program on Payment Bundling.

Directs HHS Secretary to develop a national, voluntary pilot program encouraging bundled payment models for hospitals, doctors, and post-acute care providers. Entities including a

hospital, a physician group, a SNF and a home health agency may apply to participate. Requires the Secretary to establish this program by January 1, 2013 for a period of five years. Before January 1, 2016, the Secretary is also required to submit a plan to Congress to expand the pilot program if doing so will result in improving the quality of patient care and reducing spending.

Sec. 3006. Plans for a Value-Based Purchasing Program for Skilled Nursing Facilities and Home Health Agencies.

Secretary of HHS shall submit plan for value—based purchasing program for home health agencies to Congress by Oct. 1, 2011.

Sec. 10315 of Manager’s Amendment. Revisions to Home Health Care Provisions.

Sec. 10315(b).

HHS Study and Report: By March 1, 2014, HHS must report results of a study with recommendations for legislative and administrative action, regarding home health agency costs for care provided to low-income beneficiaries or those in medically underserved areas, and those with varying levels of severity.

Medicare Demonstration Project: HHS Secretary may provide for a four-year (beginning no later than January 1, 2015) \$500M demonstration project to test whether making payment adjustments based on the study substantially improve access to care for patients with high severity levels of illness or for low-income or underserved Medicare beneficiaries.

Sec. 3403. Independent Medicare Advisory Board; Sec. 10320 of Manager’s Amendment. Expansion of the Scope of, and additional improvements to, the Independent Medicare Advisory Board.

Establish an Independent Payment Advisory Board comprised of 15 members to submit legislative proposals containing recommendations to reduce the per capita rate of growth in Medicare spending if spending exceeds a target growth rate. Beginning January 15, 2014, in years when Medicare costs are projected to be unsustainable, the Board’s proposals will take effect unless Congress passes an alternative measure that achieves the same level of savings. The Board would be prohibited from making proposals that ration care, raise taxes or Part B premiums, or change Medicare benefit, eligibility, or cost-sharing standards.

INNOVATIONS IN HEALTH CARE/PRIVATE LONG TERM CARE INSURANCE PROGRAM (CLASS)

Sec. 3021. Establish a Center for Medicare and Medicaid Innovation within CMS.

Opportunities for chronic care and other initiatives funding home health providers who offer chronic care management services to applicable individuals in cooperation with interdisciplinary teams (xiv). Telehealth advancement opportunities through new CMS Innovations Center but no guarantee.

Sec. 3024. Independence at Home demonstration program.

Tests a payment incentive and service delivery model that utilizes physician and nurse practitioner directed home-based primary care teams.

Sec. 8001. Community Living Assistance Services and Supports Act (CLASS Act).

Establish voluntary national home and community-based long term care insurance program. Beneficiaries vest after 5 years paying premiums.

PROGRAM INTEGRITY

Sec. 6401. Provider Screening and other enrollment requirements under Medicare, Medicaid, and CHIP.

Require background screening and credentialing of provider and supplier owners and managers, require compliance plans, gives CMS the authority to impose a temporary moratorium on new providers

Sec. 6405 Physicians who order items or services required to be Medicare enrolled physicians or eligible professionals; Sec. 10604 of Manager's Amendment. Technical Correction to Section 6405.

Medicare enrolled physician requirement regarding care plan certification

Sec. 6407. Face to face encounter with patient required before physicians may certify eligibility for home health services or durable medical equipment under Medicare; Sec. 10605 of Manager's Amendment. Certain other providers permitted to conduct face to face encounter for home health services.

Face-to-face physician encounter requirement (including telehealth encounter) with patients within a reasonable timeframe as determined by the Secretary; nurse practitioners, advanced practice nurses, and physician assistants may substitute for physicians to meet the face-to-face encounter requirement.

Sec. 6406. Requirement for Physicians to Provide Documentation on Referrals to Programs at High Risk of Waste and Abuse.

Physician must maintain and provide access to documentation on Medicare home health referrals if requested. Home health agencies must maintain and provide access to documentation of certification of Medicare home health services if requested.

Sec. 6201. Nationwide program for National and State background checks on direct patient access employees of long-term care facilities and providers.

Extends existing pilot program for background checks on direct patient access employees of long-term care facilities and providers to a nationwide program (based on individual state choice of participation). Definition of long-term care facility or provider includes providers of home health care.

MEDICAID HOME AND COMMUNITY-BASED SERVICES EXPANSIONS

Sec. 2401. Community First Choice Option. Expanded Medicaid home care through agencies and self-directed care. (Effective October 1, 2011).

Sec. 2402. Removal of barriers to Home and Community based Services. Expanded rebalancing requirements and waiver authority and removal of restrictions on waivers.

Sec. 2403. Money Follows the Person Rebalancing Demonstration.

Extension through September 2016.

Sec. 2404. Protection for Recipients of Home and Community Based Services Against Spousal Impoverishment.

Spousal impoverishment protection for home care eligibility. (Effective 2014-2019)

EMPLOYER REQUIREMENTS

Sec. 1513. Shared Responsibility for Employers.

Assess employers with more than 50 employees that do not offer coverage and have at least one full-time employee who receives a premium tax credit a fee of \$2,000 per full-time employee, excluding the first 30 employees from the assessment. (Effective January 1, 2014)

Exempt employers with 50 or fewer employees from any of the above penalties.

Sec. 10108 of Manager's Amendment. Free Choice Vouchers.

Require employers that offer coverage to their employees to provide a free choice voucher to employees with incomes less than 400% FPL who choose to enroll in a plan in the Exchange. The voucher amount is equal to what the employer would have paid to provide coverage to the employee under the employer's plan and will be used to offset the premium costs for the plan in which the employee is enrolled. Employers providing free choice vouchers will not be subject to penalties for employees that receive premium credits in the Exchange. (Effective January 1, 2014)

The term 'full-time employee' means an employee who is employed on average at least 30 hours of service per week.

HOSPICE LEGISLATION 2009-2010

Patient Protection and Affordable Care Act (H.R. 3590; P.L. 111-148)

Section 3132(a). Additional Data Collection from Medicare Hospice Programs.

Requires the Secretary of HHS to collect additional data and information to be used for payment system revisions. January 1, 2011

Sec. 3132(b). Continued Eligibility for Medicare Hospice Services.

The Secretary of HHS must require a hospice physician or advanced practice nurse to determine, through a face-to-face encounter, a patient's continued hospice eligibility prior to the 180th day recertification, and for each certification thereafter, and attest that such a visit took place. In the case of hospice programs for which the number of patient stays in excess of 180 days meet a certain threshold (as determined by the Secretary), stays in excess of 180 days must be reviewed by CMS or its contractors for medical necessity. Effective date: January 1, 2011

Sec. 3401(g); HCERA Sec. 10319(f). Medicare Market Basket Update Reductions (applicable for FY 2013 through 2019)/Productivity Adjustments.

The Secretary of HHS must, beginning with Fiscal Year 2013, impose annually a productivity adjustment (reduction roughly estimated at 1 percent) to the market basket inflation update. Additionally, for FYs 2013 through 2019, the hospice market basket update would be reduced by an additional 0.3 percentage point. However, for FY2014 through 2019, if growth in the previous year's insured population does not exceed 5 percent, no 0.3 percent reduction is imposed in that year. Effective date: October 1, 2012

Sec. 3004(c). Publication of Quality Measures.

By October 1, 2012 The Secretary of HHS must publish quality measures for reporting by hospices in FY2014. The measures would cover all dimensions of quality as well as efficiency of care. Effective date: October 1, 2012

Sec. 3132(a). Medicare Payment Revisions.

Effective no earlier than October 1, 2013, payment system revisions for hospice services will be implemented on a budget-neutral basis. Effective date: October 1, 2013

Sec. 3004(c). Reporting of Quality Measures.

Hospice programs must begin to report quality measures; failure to do so would result in a 2.0 percentage point cut in the annual Medicare market basket update. Effective date: October 1, 2013

HCERA Sec. 10326. Pilot Testing of Pay-for-Performance.

The Secretary of HHS is required to establish a pilot program to test value-based purchasing under hospice. Effective date: January 1, 2016

Sec. 2302. Medicaid/CHIP Pediatric Hospice.

Medicaid or CHIP-eligible children may receive hospice services without forgoing other services to which they are entitled under Medicaid/CHIP.

Sec. 3140. Medicare Hospice Concurrent Care Demonstration.

Three-year demonstration program would allow hospice patients to concurrently receive all other Medicare-covered services. This demonstration is required to be budget neutral and expected to improve patient care, quality of life and cost-effectiveness.

Sec. 6201. Criminal Background Check Pilot Program Expansion.

Extends existing pilot program for background checks on direct patient access employees of long-term care facilities and providers to a nationwide program (based on individual state choice of participation). Definition of long-term care facility or provider includes providers of hospice care.

Sec. 3403. Independent Payment Advisory Board.

Establishes an Independent Payment Advisory Board (IPAB) to submit legislative proposals containing recommendations to reduce the per capita rate of growth in Medicare spending if spending is expected to exceed a target growth rate. Beginning January 15, 2014, in years when Medicare costs are projected to be unsustainable, IPAB proposals will take effect unless Congress passes an alternative measure that achieves the same level of savings. IPAB would be prohibited from making proposals that ration care, raise taxes or Part B premiums, or change Medicare benefit, eligibility, or cost-sharing standards. IPAB would be prohibited from recommending payment reductions for providers during a year in which those providers' market basket updates are scheduled for reduction beyond the annual productivity adjustment.

Sec. 4305. Advancing Research and Treatment for Pain Care Management.

Pending appropriations, the Secretary of HHS shall convene a Conference on Pain in conjunction with the Institute of Medicine. The Director of NIH is encouraged to engage in an aggressive program of pain research through the Pain Consortium. The Secretary of HHS shall establish no later than one year after enactment an Interagency Pain Research Coordinating Committee. The Secretary may make awards of grants, cooperative agreements, and contracts to hospices and other entities for the development and implementation of programs to provide education and training to health care professionals in pain care.

Sec. 2952(b). Grants for Postpartum Depression Services.

Allows the Secretary of HHS to establish under the Material and Child Health Services Block Grant projects to provide services to individuals with a postpartum condition and their families. Definition of "eligible entities" to receive grants includes hospices.

Sec. 6401. Compliance and Penalties.

Requires background screening and credentialing of provider and supplier owners and managers; requires compliance plans; provides authority to the Secretary of HHS to impose a temporary moratorium on new providers.

HOME HEALTH LEGISLATION 2008

THE MEDICARE IMPROVEMENTS FOR PATIENTS AND PROVIDERS ACT OF 2008 (H.R. 6331; Public Law No: 110-275)

H.R. 6331 contained a number of provisions of interest to home care and hospice providers. Most importantly, the legislation preserved full inflation updates for home health and hospice by rejecting the President's proposed five year freeze in home health payments and three year freeze in hospice payments. It reduced payments to Medicare Advantage plans to help fund several Medicare provisions, including blocking scheduled physician payment cuts.

Following is a summary of the sections in the bill of most interest to home care and hospice providers.

Sec. 123. Demonstration project on community health integration models. Establishes a demonstration project to allow states to test new ways to better coordinate hospital, nursing home, home health and other critical health care services in rural areas.

Sec. 141. Extension of exceptions process for therapy caps. Extends the exceptions process for therapy limits through December 31, 2009.

Sec. 150. MedPAC study and report on improving chronic care demonstration programs. Requires the MedPAC to examine the possibility of using a standing network of providers to test innovative approaches to care coordination and other chronic care delivered to the Medicare patient population.

Sec. 154. Delay in and reform of Medicare DMEPOS competitive acquisition program. Imposes an 18-month delay to Round 1 of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Acquisition Program (CAP), with a corresponding 18-24 month delay of Round 2 and subsequent applications of the program. Also modifies and improves the CAP to ensure a fair bidding process and to protect beneficiaries. Pays for this delay with a reduction in the payment rates for items included in the CAP.

Sec. 162. Revisions to requirements for Medicare Advantage private fee-for-service plans. Changes requirements for private fee-for-service (PFFS) plans in counties where there are two or more non-PFFS plans (either an HMO or PPO). In these counties, PFFS plans could no longer "deem" providers into the plan. Instead, beginning in 2011, they would have to form provider networks.

Secs. 168-169. MedPAC studies. Directs MedPAC to study how comparable measures of performance and patient experience can be collected and reported in the MA and FFS programs. Also directs MedPAC to study alternative payment formulas for MA plans.

Sec. 187. OIG report on compliance with and enforcement of national standards on culturally and linguistically appropriate services (CLAS) in Medicare. Directs the Office of Inspector General to report, within two years, on the extent to which Medicare providers follow the rules regarding discrimination against beneficiaries with limited English proficiency and the Culturally and Linguistically Appropriate Services Standards, and requires the Secretary to correct and deficiencies.

HOME HEALTH LEGISLATION 2007

On December 19, 2007, as one of the last acts of the first session of the 110th Congress, the House and Senate passed the “Medicare, Medicaid and SCHIP Extension Act of 2007” (S. 2499, P.L. 110-173). Unable to reach agreement on a wide range of Medicare and Medicaid issues, Congressional leaders cobbled together a pared down package of Medicare and Medicaid provisions designed primarily to prevent a 10 percent reduction in physician payments under Medicare through June 30, 2008, and extend some expiring Medicare and Medicaid programs.

The home health and hospice community successfully defeated legislative proposals by the President to freeze home health payments for five years and cut the hospice inflation update. The House passed the “The Children's Health and Medicare Protection Act of 2007” (H.R. 3162) that would have frozen Medicare home health payments for one year and reinstated the 5 percent rural add on for two years. The Senate rejected the House bill.

S. 2499 did not contain any provisions directly impacting home health and hospice. Of interest to some home health providers was Section 105 of the legislation that extended the exceptions process for the caps on outpatient therapy services through June 30, 2008 (cap does not apply to therapy services provided under the Medicare home health benefit).

In the final days of 2007, Congress passed the fiscal year 2008 omnibus appropriations bill (Public Law No: 110-161) that contained more than \$20 billion in funding for telehealth and health information technology (HIT) programs. The spending bill, which contained \$555 billion overall, included approximately \$6 billion for telehealth projects funded through the Office for the Advancement of Telehealth housed in the U.S. Department of Health and Human Services. An additional \$17.7 billion for telehealth and HIT projects was included at the request of individual Members of Congress for special projects within their home states and districts.

HOME HEALTH LEGISLATION 2006

On December 9, 2006, as one of the last acts of the 109th Congress, the House and Senate passed the “Tax Relief and Health Care Act of 2006” (H.R. 6111; Public Law No: 109-432). This legislation includes several provisions affecting the Medicare and Medicaid programs, as well as a number of other health care items that may of interest to home health and hospice providers.

Division B: Medicare and Other Health Provisions - Medicare Improvements and Extension Act of 2006 –

Title I: Medicare Improved Quality and Provider Payments

Section 103: Directs the Comptroller General to report to Congress on the costs for home hemodialysis treatment and patient training for both home hemodialysis and peritoneal dialysis.

Section 111: Deems Medicare provider number 29-1511 to be a multiple location of Medicare provider number 29-1500, for purposes of calculating the hospice aggregate payment cap for 2004, 2005, and 2006 for a hospice program for care provided between November 1, 2003, and December 27, 2005.

Title II: Medicare Beneficiary Protections

Section 201: Amends SSA title XVIII to extend through 2007 the exceptions process for Medicare therapy caps.

Section 204: Directs the Secretary to establish under SSA title XVIII a medical home demonstration project to redesign the health care delivery system to provide targeted, accessible, continuous and coordinated, family-centered care to high-need populations. Requires such project to provide that: (1) care management fees are paid to persons performing services as personal physicians; and (2) incentive payments are paid to physicians participating in practices that provide services as a medical home under subsection (d).

Title III: Medicare Program Integrity Efforts

Section 301: Amends SSA title XVIII to make a total of \$3.5 billion available to the MA Regional Plan Stabilization Fund for expenditures between January 1, 2012, and December 31, 2013.

Section 302: Requires the Secretary, under the Medicare Integrity Program, to enter into contracts with recovery audit contractors to identify underpayments and overpayments and recoup overpayments for all services for which payment is made under Medicare part A (Hospital Insurance) or Medicare part B (Supplementary Medical Insurance).

Requires the Secretary to enter into such contracts in a manner so as to provide for activities in all states under such a contract by January 1, 2010.

Section 303: Makes appropriations to the Health Care Fraud and Abuse Control Account for FY2007-FY2010 and ensuing fiscal years.

Provides funding for the same period for the activities of the Office of the Inspector General of the Department of Health and Human Services with respect to the Medicare and Medicaid programs.

Makes appropriations for the same period for the Federal Bureau of Investigation to cover the costs of the administration and operation of the health care fraud and abuse control program.

Section 304: Directs the Secretary to make certain funds transfers from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund to the Centers for Medicare and Medicaid Services Program Management Account for this title and titles I and II of this division for FY2007-FY2008.

Title IV: Medicaid and Other Health Provisions

Section 403: Amends SSA title XIX (Medicaid) to revise the formula for determining the existence, between January 1, 2008, and October 1, 2001, of an indirect guarantee to hold taxpayers harmless for any portion of the costs of a broad-based health care related tax, which would require reduction in the computation of state Medicaid expenditures when determining the amount of federal payments to be made to the state. (This reduction is a function of a certain limitation on the use of provider-specific taxes to obtain federal financial participation under Medicaid.)

Section 405: Revises requirements for: (1) continued application of regular Medicaid cost-sharing rules for individuals with family income not exceeding 100% of the poverty line; and (2) cost-sharing rules applicable to disabled children provided medical assistance under the eligibility category added by the Family Opportunity Act.

Waives citizenship or nationality documentation requirements for an individual declaring to be a U.S. citizen or national who is receiving disability insurance benefits under SSA title II (Old-Age, Survivors, and Disability Insurance Benefits) (OASDI).

Title IV: Other Provisions

Section 405: Authorized appropriation and directs the Secretary of Health and Human Services to conduct a study on establishing a uniform national database on elder abuse.

HOME HEALTH LEGISLATION 2005

THE DEFICIT REDUCTION ACT OF 2005 (S. 1932; PL 109 -171)

On December 19, 2005, the House agreed to a conference report on S. 1932. However, the Senate amended the report, removing a few provisions as the result of a point of order raised associated with the “Byrd Rule.” The amended agreement passed the Senate on December 21, 2005, and was returned to the House for further action. On February 1, 2005, the House agreed to the Senate amendment by a vote of 216 to 214. S. 1932 was signed into law (Public Law 109-171) on February 8, 2006, by President Bush.

TITLE V -- MEDICARE

Subtitle A – Provisions Relating to Part A

Section 5008. Post Acute Care Payment Reform Demonstration Program.

The Secretary of the Department of Health and Human Services is required to establish a three-year demonstration program to assess the costs and outcomes across different post-acute care sites by January 1, 2008.

Subtitle B – Provisions Relating to Part B

Section 5101. Beneficiary Ownership of Certain Durable Medical Equipment (DME).

Requires the supplier to transfer the title of durable medical equipment in the capped rental category to the beneficiary after a 13-month rental period, but retains a beneficiary option for purchasing power-driven wheelchairs when initially furnished. Automatic payment to the suppliers every six months for maintenance and servicing would be eliminated. Such payments (for parts and labor not covered by the supplier’s or manufacturer’s warranty) would only be made if the Secretary determined them to be reasonable and necessary. This amendment would apply to items for which the first rental month occurred on or after January 1, 2006.

Provides that rental payments for oxygen equipment (including portable oxygen equipment) are converted to ownership at 36 months. The supplier is required to transfer the title of the equipment to the beneficiary after a 36-month rental period. After transfer of the title, monthly payments for oxygen contents (in the case of gaseous and liquid oxygen) will continue to be made, as provided for under current law, for the period of medical need. Payments for maintenance and servicing (for parts and labor not covered by the supplier’s or manufacturer’s warranty) will be made if the Secretary determines them to be reasonable and necessary. This provision takes effect on January 1, 2006. In the case of an individual receiving oxygen equipment as of December 31, 2005, the 36 month period begins January 1, 2006.

Section 5107. Revisions to Payments for Therapy Services.

Does not extend the moratorium, however, the Secretary is required to implement an exceptions process for expenses incurred in 2006. Under the process, a Part B enrollee, or a person acting on

behalf of the enrollee, may request an exception from the physical therapy and occupational therapy caps. The individual may obtain an exception if the provision of services is determined medically necessary. If the Secretary does not make a decision on a request within 10 business days of receipt, the Secretary is deemed to have found the services medically necessary. The Secretary is required to waive such provisions of law and regulations (including those related to the Paperwork Reduction Act) as are necessary to implement these amendments on a timely basis. The amendments may be implemented by program instruction or otherwise. The legislation specifies that there can be no administrative or judicial review of the exceptions process (including establishment of the process). It also requires the Secretary, by July 1, 2006, to implement clinically appropriate code edits for physical therapy services, occupational therapy services, and speech language pathology services. The edits are to identify and eliminate improper payments. The edits are to include edits of clinically illogical combinations of procedure codes and other edits to control inappropriate billings.

Subtitle C – Provisions Relating to Parts A and B

Section 5201. Home Health Payments.

Eliminates the update for home health payments in 2006. It also extends the 5% additional payment for rural home health episodes or visits beginning on or after January 1, 2006 and before January 1, 2007. Starting in 2007, home health agencies will submit to the Secretary health care quality data in a form, manner, and time period specified by the Secretary. In 2007 and subsequent years, a home health agency that does not submit the required quality data will receive an update of the market basket minus two percentage points. This reduction would only apply to the fiscal year in question. Directs the Secretary to design procedures for making the data available to the public. The Medicare Payment Advisory Commission is directed to submit a report to Congress no later than June 1, 2007 on a value-based purchasing program for home health services. The report is to include recommendations on the structure of the program, determining thresholds, the size of value-based payments, sources of funds, and the relationship of payments and improvements in health care quality.

Section 5202. Revision of Period For Providing Payment for Claims that are not Submitted Electronically.

Directs Medicare contractors to delay the payment of claims that are not submitted electronically. The contractors are directed to pay 95% of all “clean” claims within 29-30 days of receipt for paper claims.

Section 5203. Time Frame for Part A and B Payments.

Delays Medicare Part A and B payments by nine days. Claims that would otherwise be paid on September 22, 2006, through September 30, 2006 would be paid on the first business day of October 2006. No interest or late penalty would be paid to an entity or individual for any delay in a payment during the period.

Section 5204. Increase in Medicare Integrity Program Funding.

Increases Medicare Integrity Program funding \$100 million for fiscal year 2006. As part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Congress acted to

increase and stabilize federal funding for anti-fraud activities. As required by Section 1817(k) of the Medicare law, an expenditure account was established within the Federal Hospital Insurance Trust Fund. Certain amounts were appropriated from the Trust Fund for specific activities, including the Medicare Integrity Program (MIP).

TITLE VI – MEDICAID

Chapter 2 – Long-Term Care Under Medicaid

Subchapter A – Reform of Asset Transfer Rules

Section 6011. Lengthening Look-Back Period; Change in Beginning Date for Period of Ineligibility.

Section 6011(a). Amends section 1917(c)(1)(B)(i) of the Social Security Act to lengthen the look-back date to five years, or 60 months, for all income and assets disposed of by the individual after enactment. For income and assets disposed of prior to the enactment date, the look back periods of 36 months for income and assets and 60 months for certain trusts would apply. Therefore states will now be required to delay Medicaid eligibility as specified above for certain Medicaid long-term care services for individuals applying for care in a nursing home, and, at state option, for certain people receiving care in community-based settings, who have transferred assets for less than fair market value on or after a “look-back date.” The beginning date for the period of ineligibility will change from the date of the asset transfer to the date of application for Medicaid. The section identifies hardship exceptions in certain cases.

Section 6012. Disclosure and Treatment of Annuities.

Amends Section 1917 of the Social Security Act and requires individuals applying for Medicaid-covered LTC services, upon Medicaid application and recertification of eligibility, to disclose to the state, a description of any interest the individual or community spouse has in an annuity (or similar financial instrument, as specified by the Secretary), regardless of whether the annuity is irrevocable or is treated as an asset. Also amends Section 1917(c)(1) of the Social Security Act by adding that the purchase of an annuity be treated as a disposal of an asset for less than fair market value unless the state is named as the remainder beneficiary in the first position for at least the total amount of Medicaid expenditures paid on behalf of the annuitant or is named in the second position after the community spouse or minor or disabled child and such spouse or a representative of the such child does not dispose of any such remainder for less than fair market value. Includes annuities purchased by or on behalf of an annuitant who has applied for Medicaid-covered nursing facility or other long-term care services in the definition of annuities that are subject to asset transfer rules.

Section 6014. Disqualification for Long-Term Care Assistance for Individuals with Substantial Home Equity.

Amends Section 1917 of the Social Security Act to exclude from Medicaid eligibility for nursing facility or other long-term care services, certain individuals with an equity interest in their home of greater than \$500,000. A state may elect, without regard to Medicaid’s requirements concerning state wideness and comparability, to substitute an amount that exceed \$500,000 but does not exceed \$750,000. These dollar amounts are increased, beginning in 2011, from year to year based on the percentage increase in the consumer price index for all urban consumers (all items, United States city average), rounded to the nearest \$1,000. The Secretary establishes a

process for waiving this provision in the case of a demonstrated hardship. Individuals whose spouse, child under age 21, or child who is blind or disabled (as defined by the Section 1614 of the Social Security Act) lawfully resides in the individual's home would not be excluded from eligibility. This provision would not prevent an individual from using a reverse mortgage or home equity loan to reduce the individual's total equity interest in the home. The provision applies to individuals who are determined eligible for Medicaid nursing facility or other long-term care services based on an application filed on or after January 1, 2006.

Section 6015. Enforceability of Continuing Care Retirement Communities (CCRC) and Life Care Community Admission Contracts.

Amends Section 1919(c)(5) of the Social Security Act to provide an exception for state-licensed, registered, certified, or equivalent continuing care retirement communities (CCRCs) or a life care community (including nursing facility services provided as part of that community) to allow them to require in their admissions contracts that residents spend their resources (subject to Medicaid's rules concerning the resources allowance for community spouses, described above), declared for the purposes of admission, on their care before they apply for Medicaid. For applicants with community spouses, only that part of the entrance fee that is not protected for by the community spouse's resource allowance would be considered in the computation of the spousal share available to Medicaid. Also amends Section 1917 of the Social Security Act to consider certain entrance fees for CCRCs or life care communities to be countable resources, and thus available to the applicant, for purposes of the Medicaid eligibility determination to the extent that: (A) the individual has the ability to use the entrance fee, or the contract provides that the entrance fee may be used, to pay for care should other resources or income of the individual be insufficient to pay for care; (B) the individual is eligible for a refund of any remaining entrance fee when the individual dies or terminates the CCRC or life care community contracts and leaves the community; and (C) the entrance fee does not confer an ownership interest in the continuing care retirement community or life care community.

Section 6016. Additional Reforms of Medicaid Asset Transfer Rules.

Section 6016(a). Amends Section 1917(c)(1)(E) of the Social Security Act by adding that a state shall not round down, or otherwise disregard any fractional period of ineligibility when determining the ineligibility period with respect to the disposal of assets.

Section 6016(b). Amends Section 1917(c)(1) of the Social Security Act by adding that for an individual or an individual's spouse who disposes of multiple fractional assets in more than one month for less than fair market value on or after the applicable look-back date, states may determine the penalty period by treating the total, cumulative uncompensated value of all assets transferred by the individual (or individual's spouse) during all months as one transfer. States would be allowed to begin such penalty periods on the earliest date which would apply to such transfers.

Section 6016(c). Amends Section 1917(c)(1) of the Social Security Act to make additional assets subject to the look-back period, and thus a penalty, if established or transferred for less than fair market value. Such assets would include funds used to purchase a promissory note, loan or mortgage, unless the repayment terms are actuarially sound, provide for payments to be made in equal amounts during the term of the loan and with no deferral nor balloon

payments, and prohibit the cancellation of the balance upon the death of the lender. In the case of a promissory note, loan, or mortgage that does not satisfy these requirements, their value shall be the outstanding balance due as of the date of the individual's application for certain Medicaid long-term care services.

Section 6016(d). Amends Section 1917(c)(1) of the Social Security Act by adding a provision that would redefine the term 'assets,' with respect to the Medicaid asset transfer rules, to include the purchase of a life estate interest in another individual's home unless the purchaser resides in the home for at least one year after the date of purchase.

Subchapter B – Expanded Access to Certain Benefits –

Section 6021. Expansion of State Long-Term Care Partnership Program.

Amends Section 1917(b)(1)(C)(ii) of the Social Security Act to: (1) require that existing Medicaid long-term care (LTC) insurance partnership programs not allow consumer protection standards to be less stringent (determined by the Secretary) than those applying under the state plan amendment as of December 31, 2005; and (2) allows certain individuals in states with state plan amendments approved after May 14, 1993 to be exempt from estate recovery requirements if the amendment provides for the disregard of any assets or resources in the amount equal to the amount of insurance benefits made to or on behalf of an individual who is a beneficiary under a LTC policy (including a certificate issued under a group insurance contract), if the following requirements are met:

- (I) The policy covers an insured who was a resident of such state when coverage first became effective under the policy. In the case of a LTC insurance policy exchanged for another such policy, this requirement applies based on the coverage of the first such policy that was exchanged;
- (II) The policy is a qualified LTC insurance policy (meeting specifications defined in Section 7702B(b) of the Internal Revenue Code of 1986) issued not earlier than the effective date of the Medicaid state plan amendment;
- (III) The policy meets the following requirements specified in the National Association of Insurance Commissioner's (NAIC) Long-Term Care Insurance Model Regulations and Long-Term Care Insurance Model Act (as adopted as of October 2000);
- (IV) If at the date of purchase the purchaser is younger than age 61, the policy must provide for compound inflation; if the purchaser is at least age 61 but not older than age 76, the policy must provide some level of inflation protection; and if the purchaser is age 76 or older, the policy may, but is not required to, provide some level of inflation protection;
- (V) The state Medicaid agency provides information and technical assistance to the state insurance department on the insurance department's role of assuring that any individual who sells a LTC insurance policy under the partnership receives training or demonstrates evidence of an understanding of such policies and how they relate to other public and private coverage of LTC;
- (VI) The issuer of the policy provides regular reports to the Secretary that include, in accordance with the Secretary's regulations (after consultation with the National Association of Insurance Commissioners, issuers of LTC insurance policies, states with experience with LTC insurance partnership plans, other states, and

representatives of consumers of LTC insurance policies) notification regarding when all benefits and their amounts under the policy have been paid, when the policy otherwise terminates, and other information that the Secretary determines is appropriate to the administration of the partnership programs. These regulations shall specify the type and format of the data and information to be reported, and the frequency with which such reports are to be made. The Secretary, as appropriate, provides copies of the reports to the state involved.

The Secretary develops recommendations for Congress to authorize and fund a uniform minimum data set to be reported electronically by all issuers of LTC insurance policies under qualified state LTC insurance partnerships to a secure, centralized electronic query and report generating mechanism that state, the Secretary, and other federal agencies can access.

Chapter 3 – Eliminating Fraud, Waste, and Abuse in Medicaid

Section 6031. Encouraging the Enactment of State False Claims Acts.

Requires that if a state has in effect a law relating to false or fraudulent claims that meets requirements specified in the bill, the FMAP, with respect to any amounts recovered under a state action brought under such a law, is decreased by 10 percentage points. The provision is effective January 1, 2007, except in the case of a state which the Secretary of HHS determines that state legislation is required for compliance.

Section 6032. Employee Education about False Claims Recovery.

Requires a state to provide that any entity that receives annual Medicaid payments of at least \$5 million, as a condition of receiving such payments, must: (1) establish written policies for all employees (and any contractor or agent) of the entity that provide detailed information on state and federal false claims laws and whistle-blower protections under such laws, (2) include in such written policies detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste, and abuse, and (3) include in any employee handbook for the entity a specific discussion of such laws, the rights of employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste, and abuse. The provision is effective January 1, 2007, except in the case of a state which the Secretary of HHS determines that state legislation is required for compliance.

Section 6034. Medicaid Integrity Program.

Establishes a Medicaid Integrity Program, under which the Secretary of HHS shall enter into contracts with eligible entities to carry out its activities, including review of the actions of individuals or entities, audit of claims for payment, identification of overpayments, and education with respect to payment integrity and quality of care. Appropriations for the program total \$5 million in FY2006, \$50 million in each of FY2007 and FY2008, and \$75 million in each fiscal year thereafter (with a mandated increase of 100 employees whose duties consist solely of protecting the integrity of the Medicaid program). States are required to comply with any requirements determined by the Secretary to be necessary for carrying out the Medicaid Integrity Program. In each of FY2006-2010, \$25 million is appropriated for Medicaid activities of the HHS Office of Inspector General (in addition to any other amounts appropriated or made

available for its Medicaid activities, to remain available until expended). Also establishes a national expansion of the Medicare-Medicaid data match project (referred to as the Medi-Medi Program) as a required activity of the Medicare Integrity Program. The Medi-Medi program data match project analyzes claims data from both programs together to detect aberrant patterns that may not be evident when billings are viewed in isolation. It is primarily supported by “wedge” funds from the Health Care Fraud and Abuse Control Account (HCFAC) within the federal Hospital Insurance (Medicare Part A) trust funds. In addition to HCFAC appropriations for the Medicare Integrity Program, the Medi-Medi Program is appropriated \$12 million in FY2006, \$24 million in FY2007, \$36 million in FY2008, \$48 million in FY2009, and \$60 million in FY2010 and each fiscal year thereafter.

Section 6035. Enhancing Third Party Identification and Payment

Substitutes the term “managed care organization” for “health maintenance organization” and amends the list of third parties named in Section 1902(a)(25) of the Social Security Act for which states must take all reasonable measures to ascertain the legal liability to include self-insured plans, pharmacy benefit managers, and other parties that are legally responsible (by statute, contract, or agreement) for payment of a claim for a health care item or service. It also amends that section to include these entities in the list of health insurers that states must prohibit from taking an individual’s Medicaid status into account when enrolling the individual or making payments for benefits to or on behalf of the individual. Requires a state to provide assurances satisfactory to the Secretary of HHS that it has laws in effect requiring third parties to provide, upon request of the state, information to determine health insurance coverage (in a manner prescribed by the Secretary) and to cooperate with payment and recovery efforts by Medicaid.

The provision is effective January 1, 2006, except in the case of a state which the Secretary of HHS determines that state legislation is required for compliance.

Chapter 4 – Flexibility in Cost Sharing and Benefits

Section 6041. State Option For Alternative Medicaid Premiums and Cost Sharing.

Section 6041(a). Allows the states to impose premiums and cost-sharing for any group of individuals for any type of service (except prescribed drugs which are treated separately), through Medicaid state plan amendments (rather than waivers), subject to specific restrictions. Premiums and cost-sharing imposed under this option are allowed to vary among classes or groups of individuals, or types of service. Premiums and cost-sharing provisions in current law for workers with disabilities are not affected. For individuals in families with income between 100 and 150% Federal Poverty Level (FPL): (1) no premiums may be imposed, (2) cost sharing for any item or service cannot exceed 10% of the cost of the item or service, and (3) the total aggregate amount of all cost-sharing (including cost sharing for prescribed drugs and emergency room copayments for non-emergency care; see below) cannot exceed 5% of family income as applied on a quarterly or monthly basis as specified by the state. For individuals in families with income above 150% FPL: (1) the total aggregate amount of all cost sharing (including cost sharing for prescribed drugs and emergency room copayments for non-emergency care) cannot exceed 5% of family income as applied on a quarterly or monthly basis as specified by the state, and (2) cost-sharing for any item or service cannot exceed 20% of the cost of the item or service.

Exempts premiums for the following groups: (1) mandatory groups of children under 18, including individuals in foster care receiving aid or assistance under Part B of Title IV and persons receiving adoption or foster care assistance under Title IV-E, regardless of age; (2) pregnant women; (3) terminally ill persons receiving Medicaid hospice care; (4) individuals in medical institutions who are required to pay for costs of care all but a minimal amount of their income for personal needs, and (5) women who qualify for Medicaid under the breast and cervical cancer eligibility group. States may exempt additional groups from premiums.

Cost-sharing is not permitted for: (1) services provided to mandatory groups of children under 18, including individuals in foster care receiving aid or assistance under Part B of Title IV and persons receiving adoption or foster care assistance under Title IV-E, regardless of age; (2) preventive services provided to children under 18 regardless of family income; (3) services provided to pregnant women that relate to pregnancy or to other medical conditions that may complicate pregnancy; (4) services provided to terminally ill individuals receiving Medicaid hospice services; (5) services provided to individuals in medical institutions who are required to spend for costs of care all but a minimal amount of their income for personal needs; (6) emergency services; (7) family planning services and supplies, and (8) services to women who qualify for Medicaid under the breast and cervical cancer eligibility group. States may exempt additional individuals or services from service-related cost-sharing.

Section 6041(b). Beginning with 2006, the Secretary is required to increase nominal amounts for service-related cost-sharing by the annual percentage increase in the medical care component of the consumer price index (CPI) for all urban consumers (U.S. city average), as rounded up in an appropriate manner.

Chapter 6 – Other Provisions

Subchapter A – Family Opportunity Act

Section 6063.

Establishes a five year demonstration project in which up to 10 states could provide a broad range of home- and community-based services (HCBS) to children who would otherwise require services in a psychiatric residential treatment facility. The demonstration would test the effectiveness of improving or maintaining the child's functional level, and the cost-effectiveness of providing these types of services as an alternative to psychiatric residential treatment services. The projects must follow the existing requirements of the HCBS waiver, and be budget neutral. \$218 million has been appropriated for FY2007-FY2011 to carry out the demonstration. The funds available for this demonstration total: \$21 million in FY2007; \$37 million in FY2008; \$49 million in FY2009, \$53 million in FY2010; and \$57 million in FY2011.

Section 6071. Money Follows the Person Demonstration

Authorizes the Secretary to conduct a demonstration project in states to (1) increase the use of home and community-based care instead of institutions by relocating individuals from institutions into the community, (2) expand the state's capacity to provide home and community-

based long-term care services for individuals who choose to transition into the community; and (3) to ensure that procedures are in place to provide quality assurance and continuous quality improvement, that is at least comparable to other Medicaid home and community-based services.

States awarded a demonstration would receive additional federal funding for the costs of home and community-based, long-term care services (under a HCBS waiver and/or the state plan) for 12 months following a demonstration participant's transition from an institution into the community. In a given fiscal year, funding would be capped at the amount of a state's grant award. After the 12 months of grant funding, the state would be required to continue providing services through a Medicaid home and community based long-term care program.

Individuals may participate in the demonstration if they meet the following criteria: (1) they are residents of a hospital, nursing facility, ICF-MR, or an institution for mental disease (IMD) (but only to the extent that the IMD benefit is offered as part of the existing state Medicaid plan); (2) they have resided in the facility for no less than six months or for a longer time period specified by the state (up to a maximum of two years); (3) they are receiving Medicaid benefits for the services in this facility; (4) they will continue to require the level of care of the facility but for the provision of HCBS services. After relocating into the community, the individual must reside in one of the following: a home owned or leased by the individual or his/her family; an apartment with an individual lease in which the individual (or family) has domain and control over the space; or a community-based residential setting where no more than four unrelated individuals reside.

\$250 million is appropriated for the portion of FY2007 which begins on January 1, 2007, and ends on September 30, 2007; \$300 million in FY2008; \$350 million in FY2009; \$400 million in FY2010; and \$450 million in FY2011 to carry out the demonstration project. Funds not awarded to states in a given fiscal year would continue to be available in subsequent fiscal years, through September 30, 2011.

Section 6086. Expanded Access to Home and Community-Based Services for the Elderly and Disabled.

Establishes home and community-based services as an optional Medicaid benefit that would not require a waiver and that meets certain other requirements for individuals whose income does not exceed 150% of the federal poverty level. The scope of services may include any services permitted under Section 1915(c)(4)(B) of the Social Security Act which the Secretary has the authority to approve, and would not include an individual's room and board. The state may provide this option to individuals without determining that but for the provision of such services, the person would require the level of care provided in a hospital, nursing home, or ICF-MR. States that offer this new benefit must establish needs based criteria to determine an individual's eligibility for HCBS services, and the specific HCBS the individual will receive. The state must also establish needs-based criteria for determining whether an individual requires the level of care provided in a hospital, nursing home, ICF-MR, or under a waiver of the state plan, that is more stringent than the needs-based criteria for the HCBS option established by this provision. The needs-based criteria must be based on an assessment of an individual's support needs and capabilities, and may take into account the inability of the individual to perform two or more activities of daily living (ADLs) as defined in the Internal Revenue Service (IRS) code (i.e.,

bathing, dressing, transferring, toileting, eating, and continence), or the need for significant assistance to perform these activities, and other risk factors determined to be appropriate by the state.

For this new benefit, a state may allow an individual or the individual's representative to receive self-directed home and community-based services. If the state permits self-direction, there must be an assessment of the needs, capabilities and preferences of the individual. There must also be a service plan developed jointly with the individual that is approved by the state. The service plan must specify the services to be self-directed, identify the method of self-direction, specify the roles of various parties, and, if offered by the state, an individualized budget for the value of the services and supports to be self-directed. The provision of home and community-based services must meet state and federal guidelines for quality assurance. The state must also establish standards for the conduct of the independent evaluation and assessment to safeguard against conflict of interest.

Section 6087. Optional Choice of Self-Directed Personal Assistance Services (Cash and Counseling).

Allows a state to cover, under the Medicaid program, payment for part or all of the cost of self-directed personal assistance services (other than room and board) based on a written plan of care to individuals for whom there has been a determination that, but for the provision of such services, the individuals would require and receive personal care services under Medicaid state plan or home and community-based services under a HCBS waiver. Self directed personal assistance services may not be provided to individuals who reside in a home or property that is owned, operated, or controlled by a provider of services, not related by blood or marriage.

The state must ensure that the necessary safeguards have been taken to protect the health and welfare of individuals receiving these services and to assure financial accountability for funds expended for these services.

A state may provide self-directed personal assistance services under the state plan without regard to the Medicaid requirements for state wideness (under Section 1902(a)(1) of the Social Security Act), and may limit the population eligible to receive these services and the number of persons served without regard to Medicaid requirements regarding comparability (Section 1902(a)(10)(B) of the Social Security Act).

Individuals participating in such services would be permitted, within an approved self-directed services plan and budget, to purchase personal assistance and related services, and hire, fire, supervise, and manage the individuals providing such services. At the election of the state, a participant is be allowed to (1) choose as a paid service provider, any individual capable of providing the assigned tasks including legally liable relatives, and (2) use the individualized budget to acquire items that increase independence or substitute (such as a microwave oven or an accessibility ramp) for human assistance, to the extent that expenditures would otherwise be made for the human assistance.

The approved self-directed services plan developed under option must meet the following requirements: (1) The participant (or his/her guardian or authorized representative if appropriate)

exercises choice and control over the budget, planning, and purchase of self directed personal assistance services, including the amount, duration, scope, provider and location of service provision; (2) There is an assessment of the needs, strengths, and preferences of the participants for such service; (3) An individual's plan for self-directed services and supports, which has been developed and approved by the state, is based on a person-centered assessment process that builds upon the participant's capacity to engage in activities that promote community life; respects the participant's preferences, choices and abilities; and involves families, and professionals in the planning or delivery of services or supports as desired or required by the participant.

In establishing and implementing the self-directed services plan and budget, appropriate quality assurance and risk management techniques must be used which recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and which assure the appropriateness of the plan and the budget, based on the individual's resources and capabilities.

A state may employ a financial management entity to make payments to providers, track costs, and make reports under this program. Payment for the activities of the financial management entity is reimbursed at the same rate as other Medicaid administrative activities (generally federal Medicaid administrative reimbursement is 50 %, though certain activities may be eligible for 75 % reimbursement). This provision becomes effective on January 1, 2007.

Labor, Health and Human Services, and Education

Fiscal Year 2006 Appropriations

Public Law 109-149

On December 30, 2005, President Bush signed into law H.R. 3010, the "Department of Health, Labor, and Human Services, and Education, and Related Agencies Appropriations Act, 2006." H.R. 3010 includes funding for telehealth. Specifically, it provides \$3,000,000 to the Office of the Advancement of Telehealth to carry out programs and activities under the Health Care Safety Net Amendments of 2002 (Public Law 107-251). Of that amount, \$1,500,000 can be used to fund telehealth resource centers that provide assistance with respect to technical, legal, regulatory service delivery or other related barriers to the development of telehealth technologies. The Congress urged the Department of Health and Human Services' Health Resources and Services Administration (HRSA) department to place a high priority on the needs of rural States with populations of less than 1,500,000 individuals in the awarding and geographical placement of the telehealth resource grants. \$750,000 will be used for network grants and demonstration or pilot projects for telehomecare and another \$750,000 will be used for grants to carry out the licensure provisions in Section 102 of Public Law 107-251.

HOME HEALTH LEGISLATION 2003

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (HR 1; PL 108-173)

HOME CARE

Section 421-One-year increase for home health services furnished in a rural area.

Provides a one-year, five percent additional payment for home health services furnished in a rural area. The temporary additional payment begins for episodes and visits ending on or after April 1, 2004, and before April 1, 2005.

Section 701-Update in home health services.

Changes the time frame for the home health inflation update from the federal fiscal year to a calendar year basis beginning with 2004. Home health agency payments are increased by the full market basket percentage for the last quarter of 2003 (October, November, and December) and for the first quarter of 2004 (January, February, and March). The update for the remainder of 2004 and for 2005 and 2006 is the home health market basket percentage increase minus 0.8 percentage points.

Section 702-Demonstration project to clarify the definition of homebound.

The Secretary is required to conduct a two-year demonstration project under which beneficiaries enrolled in Medicare Part B with specified chronic conditions would be deemed to be homebound in order to receive home health services under Medicare.

The Secretary is required to select three states in the northeast, Midwest, and western regions of the United States in which to conduct the demonstration. Up to 15,000 beneficiaries can participate. The demonstration is required to begin within six months of enactment. Within one year of completing the demonstration, the Secretary is required to report to Congress recommendations and findings regarding the demonstration and its impact on the Medicare program. The provision is effective upon enactment.

Section 703-Demonstration project for medical adult day care services.

Requires the Secretary to establish a three-year demonstration project in not more than five states that license or certify providers of medical adult day care services, under which a home health agency, directly or under arrangement with a medical adult day care facility, provides medical adult day care services as a substitute for a portion of home health services otherwise provided in a beneficiary's home. Payment for the episode will equal 95 percent of the amount that would otherwise apply, subject to budget neutrality provisions. The agency or facility is prohibited from charging the beneficiary separately for the medical adult day care services. Participation of up to 15,000 Medicare beneficiaries is on a voluntary basis.

When selecting participants, the Secretary is required to give preference to home health agencies that are currently licensed to furnish medical adult day care services and have furnished such services to Medicare beneficiaries on a continuous basis for a prior two-year period.

The Secretary is required to evaluate the project's clinical and cost effectiveness and submit a report to Congress no later than six months after completion of the demonstration. The provision is effective upon enactment.

Section 704-Temporary suspension of OASIS requirement for collection of data on non-Medicare and non-Medicaid patients.

Suspends the requirement that home health agencies must collect OASIS data on private pay (non-Medicare, non-Medicaid) patients until the Secretary (1) reports to Congress on the benefits of these data, the value of the data compared to the administrative burden of data collection in small agencies, and the use of the OASIS information by both large and small agencies, and then (2) publishes final regulations regarding the collection and use of OASIS. The provision does not prohibit home health agencies from collecting OASIS data on private pay patients for the agencies' own use.

Section 705-Medicare Payment Advisory Commission (MedPAC) study on Medicare margins of home health agencies.

The conference agreement requires MedPAC to study payment margins of home health agencies paid under the Medicare home health prospective payment system, using cost reports filed by agencies. The study is required to examine whether systematic differences in payment margins are related to differences in case mix, as measured by home health resource groups (HHRGs), among agencies. MedPAC is required to submit a report to Congress on the study within two years of enactment.

Section 953-GAO report on flexibility in applying home health Conditions of Participation to patients who are not Medicare beneficiaries.

Requires the GAO to report to Congress on the implications if the Medicare conditions of participation for home health agencies were applied flexibly with respect to groups or types of patients who are not Medicare beneficiaries. The report is due no later than six month after enactment.

Section 307-Pilot program for national and state background checks on direct patient access employees of long-term care facilities and providers.

Requires the Secretary to establish pilot projects in no more than 10 states for the purpose of expanding background checks for workers with direct patient access who are employed by Medicare and Medicaid long-term care providers, including nursing homes, home health agencies, hospices, long-term care hospitals, and other entities (except for those paid through a self-directed arrangement). Funding in each of fiscal years 2005 and 2006 is set at \$25 million.

How Will the Medicare Reform Bill Affect Home Health Payments?		
Episodes Ending Between	National Avg. Episode Rate	National Avg. Rural Rate
_____	_____	_____

Oct 1, 2002-Sept 30, 2003	\$2159.39	\$2159.39 (as of 4/1/03)
Oct 1, 2003-Mar 31, 2004	\$2230.65	\$2230.65
Apr 1, 2004-Dec 31, 2004	\$2213.37	\$2324.04

For episodes ending on or after October 1, 2003, but before April 1, 2004, there is a 3.3% market basket index (inflation) increase. The Medicare reform bill mandates that inflation increases be made on a calendar year basis. Also, for episodes ending on or after April 1, 2004, but before January 1, 2005, the 3.3% market basket index inflation increase will be reduced by 0.8%. Rates for calendar year 2005 and 2006 will be increased by market basket minus 0.8%. The legislation provides a 5% rural add-on for episodes ending between April 1, 2004-March 31, 2005.

HOME HEALTH LEGISLATION 2002

The 2002 legislative session began with passage by the House of legislation that would eliminate the 15% cut in home health payments (implemented on October 1, 2002), extend the 10% rural add on until January 2005, create a new hospice consultation benefit, eliminate the OASIS requirement for non-Medicare/non-Medicaid patients, and provide many regulatory reforms. Similar legislation was introduced by the Chair and Ranking Member of the Senate Finance Committee. However, passage of this legislation fell victim to partisan gridlock over the creation of a prescription drug benefit. The Administration, senior groups, and some in Congress insisted that relief for Medicare providers should not be granted unless Congress first created a prescription drug benefit, but Congress could not agree on the size and structure of such a benefit.

The following legislation that could help alleviate the widespread shortage of home health nurses was signed into law. An effort will be made in 2003 to obtain an appropriation of funds to implement the new law.

Nurse Reinvestment Act (H.R. 3487, P.L. 107-205)

Title I: Nurse Recruitment

Section 101 – Defines “health care facility” to include home health agencies and hospice programs.

Section 102 – Permits the Secretary of HHS to make grants to support State and local advertising campaigns to promote the nursing profession.

Section 103 – Expands eligibility for the nursing loan repayment program to include service at any health care facility with a critical shortage of nurses. Restricts service to nonprofits after FY 2007. Provides nursing scholarships in exchange for two years of nursing services at facilities with a critical shortage of nurses.

Title II: Nurse Retention

Section 201 – Authorizes the Secretary of HHS to award grants or contracts to schools of nursing or health care facilities to expand nursing education and practice opportunities and creation of career ladders.

Section 202 – Directs Secretary to award grants for geriatric care training programs.

Section 203 – Authorizes establishment of student loan program to increase the number of qualified nursing faculty and provides loan forgiveness in exchange for service on nursing faculty.

Section 204 – Requires GAO report on national variations in nursing shortages; differences in nurse hiring practices between profit and nonprofit private entities because of the inclusion of for-profit private entities in the loan repayment program; and whether the scholarship program increases applications to nursing schools.

HOME HEALTH LEGISLATION 2001

The 2001 legislative session got off to a promising start, with early progress on a number of health care and home health priorities. However, the events of September 11, 2001, shifted the congressional focus dramatically. As a result, most pending legislation affecting health care providers took a back seat until the start of the 2002 legislative session. The following pieces of legislation that impact home health and hospice providers were signed into law:

The National Defense Authorization Act for Fiscal Year 2002 (P.L. 107-107)

Title VII: Health Care Provisions - Subtitle A: TRICARE Program Improvements - Amends the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) to direct the Secretary to establish a sub-acute care benefits program for the same types of health care authorized under CHAMPUS. Requires such program to include a uniform skilled nursing facility benefit and a home health care benefit as provided under title XVIII (Medicare) of the Social Security Act.

Administrative Simplification Compliance Act (P.L. 107-105)

SEC. 2. Extension of Deadline for Covered Entities Submitting Compliance Plans -- Extends by one year the deadlines for compliance by health care providers, health plans other than small health plans, and health care clearinghouses with the standards for electronic health care transactions and code sets adopted under part C (Administrative Simplification) of title XI of the Social Security Act (SSA) by the Secretary of Health and Human Services only if, before the current deadline, such entity submits to the Secretary a plan for compliance with such standards.

HOME HEALTH LEGISLATION 2000

MEDICARE, MEDICAID, AND SCHIP BENEFITS IMPROVEMENT AND PROTECTION ACT (H.R. 4577, incorporated into P.L. 106-554)

Title V, Subtitle A – Home Health Services

Section 501 – 1-Year Additional Delay in Application of 15 Percent Reduction on Payment Limits to Home Health Services

The 15 percent reduction in payment rates scheduled for October 1, 2001, is delayed until October 1, 2002.

The Comptroller General of the General Accounting Office (GAO) (rather than the Secretary of Health and Human Services) would be required to submit a report by April 1, 2002, analyzing the need for the 15 percent or other reduction.

Additionally, if the Secretary of HHS determines that updates to the PPS system for a previous fiscal year (or estimates of such adjustments for a future fiscal year) did (or are likely to) result in a change in aggregate payments due to changes in coding or classification of beneficiaries' service needs that do not reflect real changes in case mix, effective for home health episodes concluding on or after October 1, 2001, the Secretary of HHS may adjust PPS amounts to eliminate the effect of such coding or classification changes.

Section 502 – Restoration of Full Home Health Market Basket Update for Home Health Services for Fiscal Year 2001

The provision would modify the home health PPS updates. During the period October 1, 2000, through March 31, 2001, the rates promulgated in the home health PPS regulations on July 3, 2000, would apply for 60-day episodes of care (or visits) ending in that period. For the period April 1, 2001, through September 31, 2001, those rates would be increased by 2.2 percent for 60-day episodes ending in that time period.

Section 503 -- Temporary Two-Month Periodic Interim Payment Extension

The provision would provide for a one-time payment to home health agencies that were receiving periodic interim payments as of September 30, 2000, equal to four times the last two-week payment the agency received before implementation of the home health PPS on October 1, 2000. The amounts would be included in the agency's last settled cost report before implementation of the PPS. This payment will be made by CMS as soon as is "practicable."

Section 504 -- Use of Telehealth in Delivery of Home Health Services

This provision would clarify that the telecommunications provisions should not be construed as preventing a home health agency from providing a service, for which payment is made under the prospective payment system, via a telecommunications system, provided that the services do not substitute for "in-person" home health services ordered by a physician as part of a plan of care or are not considered a home health visit for purposes of eligibility or payment. Moreover, nothing in this provision shall be construed as waiving the physician certification requirement for payment for home health services, whether or not such certification is provided by telephone.

Section 505 -- Study on Costs to Home Health Agencies of Purchasing Nonroutine Medical Supplies

The provision would require that, not later than August 15, 2001, the Comptroller General of the GAO shall submit to Congress a report regarding the variation in prices home health agencies pay for nonroutine supplies, the volume of supplies used, and what effect the variations have on the provision of services. The Secretary of HHS would be required to make recommendations on whether Medicare payment for those supplies should be made separately from the home health PPS.

Section 506 -- Treatment of Branch Offices; GAO Study on Supervision of Home Health Care Provided in Isolated Rural Areas

The provision would clarify that neither time nor distance between a home health agency parent office and a branch office shall be the sole determinant of a home health agency's branch office status. The Secretary would be authorized to include forms of technology in determining "supervision" for purposes of determining a home health agency's branch office status.

Not later than January 1, 2002, the Comptroller General would be required to submit to Congress a report regarding the adequacy of supervision and quality of home health services provided by home health agency branch offices and subunits in isolated rural areas and to make recommendations on whether national standards for supervision would be appropriate in assuring quality.

Section 507 -- Clarification of the Homebound Definition under the Medicare Home Health Benefit

The provision clarifies that the need for adult day care for a patient's plan of treatment does not preclude appropriate coverage for home health care for other medical conditions. The provision also clarifies the ability of homebound beneficiaries to attend religious services without being disqualified from receiving home health benefits.

In addition, the Comptroller General will conduct a study on the effect of the provision "on the cost of and access to home health services" under Medicare. A report on the study will be presented to Congress no later than 1 year after enactment.

Section 508 -- Temporary Increase for Home Health Services Furnished in a Rural Area

For home health services furnished in certain rural areas during the two-year period beginning April 1, 2001, Medicare payments are increased by 10 percent, without regard to budget neutrality for the overall home health prospective payment system. This temporary increase would not be included in determining subsequent payments.

Title V, Subtitle C – Changes in Medicare Coverage and Appeals Process

Section 521 -- Revisions to Medicare Appeals Process

Provides that an expedited determination would be available for a beneficiary who received notice:

1. that a provider plans to terminate services and a physician certifies that failure to continue the provisions of the services is likely place the beneficiary's health at risk; or
2. that the provider plans to discharge the beneficiary.

New steps are instituted in the appeals process by implementing a "redetermination," an expedited in-house review by the regional home health intermediaries. The redetermination would be required to be completed within 30 days of a beneficiary's request.

The Secretary would enter into three-year contracts with at least 12 qualified independent contractors (QICs) to conduct reconsiderations, thereby replacing the current intermediary reviewers with an outside body of reviewers.

Title III, Subtitle C -- Hospice Care

Section 321 -- Five Percent Increase in Payment Base

The provision would increase, effective April 1, 2001, the base Medicare daily payment rates for hospice care for fiscal year (FY) 2001 by 5 percentage points over the rates otherwise in effect. This increase would continue to apply after fiscal year 2001. The temporary increase in payment rates provided in BBRA 99 for FY 2001 and FY 2002 (.5 percent and .75 percent, respectively) would not be affected. In addition, the hospice wage index for Wichita, Kansas' metropolitan statistical area for FY 2000 would be adjusted.

Section 322 -- Clarification of Physician Certification

Effective for certifications of terminal illness made on or after the date of enactment, the provision would modify current law to specify that the physician's or hospice medical director's certification of terminal illness would be based on his/her clinical judgment regarding the normal course of the individual's illness. The Secretary would be required to study and report to Congress within two years of enactment on the appropriateness of certification of terminally ill individuals and the effect of this provision on such certification.

Section 323 -- MedPAC Report on Access to, and Use of, Hospice Benefit

The provision would require MedPAC to examine the factors affecting the use of Medicare hospice benefits, including delay of entry into the hospice program and urban and rural differences in utilization rates. The provision would require a report on the study to be submitted to Congress 18 months after enactment.

Title IV, Subtitle C -- Other Services

Section 425 -- Full Update for Durable Medical Equipment (DME)

The provision would modify updates to payments for durable medical equipment. For 2001, the payments for covered DME would be increased by the full increase in the consumer price index for urban consumers (CPI-U) during the 12-month period ending June 2000. In general, in 2002 and thereafter, the annual update would equal the full increase in the CPI-U for the 12 months the previous June. The provision specifies that, for the period January 1, 2001, through June 30, 2000, the applicable amounts paid for DME are the amounts in effect before enactment of this provision. The amounts in effect for the period July 1, 2001, through December 31, 2001, would be the amounts established under this section increased by a transitional allowance of 3.28 percent.

Older Americans Act Amendments of 2000 (H.R. 782, incorporated into P.L. 106-501)

Title III – Amendments to Title III of the Older Americans Act of 1965

Section 310 – Consumer Contributions and Waivers

Authorizes a state to implement cost sharing by recipients for all services, with specified exceptions, provided for in the Act. Requires cost sharing to be on a sliding scale based solely on individual income and the cost of delivering services.

Provides for waivers of cost sharing requirements upon demonstrations by area agencies that: (1) a significant proportion of recipients in the area have incomes below the threshold established in state policy; or (2) cost sharing would be an unreasonable administrative or financial burden.

Allows solicitations of voluntary contributions for services provided under the Act.

Requires states and area agencies to develop plans to ensure that the participation of low-income older individuals receiving services will not decrease with the implementation of cost sharing.

Directs the Assistant Secretary to take corrective action to assure that services are provided to all older individuals without regard to cost sharing criteria if there is a disparate impact upon low-income or minority older individuals in any state or region regarding provision of services.

Authorizes the Assistant Secretary, subject to certain requirements, to waive any of the following provisions of the Act with respect to a state: (1) specified statewide uniformity requirements under title III; (2) area or state plan requirements; (3) restrictions on the amount that may be transferred between supportive and nutrition services programs; and (4) a requirement that certain amounts of a state allotment be used for the provision of services with respect to states that reduce expenditures under a state plan.

Not later than 1 year after enactment, and annually thereafter, the Assistant Secretary of the Administration on Aging will conduct a comprehensive evaluation of the practices for cost-sharing to determine its impact on participation rates with particular attention to low-income and minority older Americans and older Americans living in rural areas. If the Assistant Secretary finds a disparate impact on any of these groups, the Assistant Secretary shall take “corrective action” to assure that such groups fully participate in OAA programs.

Section 314 – In-home Services and Additional Assistance

Repeals provisions of the Act regarding: (1) in-home services for frail older individuals; (2) additional assistance for special needs of older individuals; and (3) supportive activities for caretakers who provide in-home services to frail older individuals.

Section 316 – National Family Caregiver Support Program

Establishes a three-year grant program for: (1) support services for family caregivers (including grandparents and older relatives) and development and testing of innovative approaches to sustaining the efforts of families and other informal caregivers of older individuals; and (2) activities of national significance to promote quality and continuous improvement in the support provided to family and other informal caregivers of older individuals through program evaluation, training, technical assistance, and research.

The Assistant Secretary of the Administration on Aging shall evaluate the effectiveness of these grant programs and disseminate this report to the states so that useful approaches can be identified and incorporated into the program.

Title VI – Amendments to Title VI of the Older Americans Act of 1965

Section 604 – General Provisions

Establishes a Native American caregiver support program.

Title VII – Amendments to Title VII of the Older Americans Act of 1965

Section 704 – State Long-Term Care Ombudsman Program

Revises the provisions regarding the State Long-Term Care Ombudsman program.

Section 707 – Native Americans Programs

Authorizes appropriations for Native American elder rights and protection program.

HOME HEALTH LEGISLATION 1999

MEDICARE, MEDICAID, AND SCHIPP REFINEMENT ACT OF 1999 (H.R.3426, incorporated into P.L. 106-113)

Title III, Subtitle A -- Home Health Services

Section 301 -- Adjustment to Reflect Administrative Costs Not Included in the Interim Payment System; GAO Report on Costs of Compliance with OASIS Data Collection Requirements.

The bill provides that a home health agency be paid \$10 to defray the costs of OASIS for each beneficiary served by the agency during the agency's cost reporting period beginning in fiscal year 2000.

This provision mandates that Medicare pay the agency 50 percent of the estimated aggregate amount payable to the agency by April 1, 2000. The balance is payable when the cost reports are settled.

The General Accounting Office (GAO) is required to submit a study to Congress no later than 180 days after enactment of the Act which includes an assessment of the costs incurred by agencies in complying with OASIS and an analysis of the effect of OASIS on patient privacy.

Section 302 -- Delay in Application of 15 Percent Reduction in Payment Rates for Home Health Services Until One Year After Implementation of Prospective Payment System.

The 15 percent reduction in payment rates scheduled for October 1, 2000, is delayed for one year after implementation of the prospective payment system.

Not later than six months after the date the Secretary of HHS implements PPS, the Secretary shall submit to Congress a report analyzing the need for the 15 percent reduction or any reduction in PPS payment amounts.

Section 303 -- Increase in Per Beneficiary Limits

The per beneficiary limits under the interim payment system are increased by 2 percent for those agencies with per beneficiary limits below the national median. Effective for cost reporting periods beginning during or after fiscal year 2000.

Section 304 -- Clarification of Surety Bond Requirements.

This provision limits the surety bond requirement to four years, or in the case of a change of ownership or control, an additional period determined by the Secretary but not to exceed four years from the change of ownership or control.

The surety bonds are set at the lesser of \$50,000 or 10 percent of Medicare and Medicaid payments to the agency. One bond shall satisfy the requirement for both Medicare and Medicaid.

Section 305 -- Refinement of Home Health Agency Consolidated Billing.

This provision eliminates the requirement that home health agencies bill for durable medical

equipment.

Section 306 -- Technical Amendment Clarifying Applicable Market Basket Increase for PPS.

This provision makes clear that scheduled reductions in market basket adjustments for home health agencies shall take place in "2002 and 2003," rather than "2002 or 2003."

Title I, Subtitle D – Hospice

Section 131 – Temporary Increase in Payment for Hospice Care

For each of fiscal years 2001 and 2002, hospice payment rates (otherwise in effect for those years) are increased by 0.5 percent and 0.75 percent, respectively.

Section 132 – Study and Report to Congress Regarding Modification of the Payment Rates for Hospice Care

Requires the General Accounting Office to conduct a study on the feasibility and advisability of updating the hospice rates and certain capped payment amounts, including an evaluation of whether the cost factors used to determine the rates should be modified, eliminated, or supplemented with additional cost factors. The report and recommendation are to be submitted to Congress within 1 year of enactment.

Title I, Subtitle C – Other Services

Section 223 – Implementation of the Inherent Reasonableness (IR) Authority

The Secretary is prohibited from using inherent reasonableness authority until after (1) the GAO releases a report regarding the Secretary's recent use of the authority; and (2) the Secretary has published a notice of final rulemaking in the Federal Register that responds to the GAO report and to comments received in response to the Secretary's interim final regulation published January 7, 1998. In promulgating the final regulation, the Secretary is required to (1) reevaluate the appropriateness of the criteria included in the interim regulation for identifying payments which are excessive or deficient; and (2) take appropriate steps to ensure the use of valid and reliable data when exercising the authority.

Section 228 – Temporary Increase in Payment Amount for Durable Medical Equipment (DME) and Oxygen

Provides temporary adjustments to the DME fee schedule payments equaling 0.3 percent in FY 2001 and 0.6 percent in FY 2002. The Secretary is prohibited from including the additional payments for FY 2001 and 2002 in updates for future years.

Section 229 – Studies and Reports

Directs MedPAC to conduct a comprehensive study to review the regulatory burdens placed on all classes of health care providers under Parts A and B of the Medicare program. The purpose of the study is to determine the costs these burdens impose on the nation's health care system and the impact on patients and providers, and their ability to deliver cost-effective quality care to Medicare beneficiaries.

THE VETERANS MILLENNIUM HEALTH CARE AND BENEFITS ACT (P.L. 106-117)

PRIVATE

Section 101 -- Requirement to Provide Extended Care Services

Creates a four-year plan requiring the Department of Veteran Affairs (VA) to provide extended care services to veterans needing it for a service-connected disability and to any veteran who is 70 percent disabled by service-related injuries.

Requires the Secretary to provide community-based primary care, adult day health care, respite care, palliative and end-of-life care, and home health aide visits to enrolled veterans. Respite care would be furnished in the patient's home or in a VA facility.

At the end of four years Congress will determine whether these provisions should be eliminated, expanded or left intact. In the event that these provisions were to expire, veterans would continue to be eligible for such services under existing law. A copayment will be developed and assessed by the VA.

Section 102 -- Pilot Programs Relating to Long-Term Care

Directs VA to carry out three long-term care pilot programs over a three-year period. The goal of these pilot programs is to determine the effectiveness of different models of providing all-inclusive care with the aim of reducing the use of hospital and nursing home care. Each model would be carried out in two VA regions designated by the Secretary. The pilots would provide a comprehensive array of services to include institutional and noninstitutional long-term care services, and appropriate case-management.

Under one pilot model, VA would provide long-term care services directly through VA staff and facilities. A second model would employ a mix of VA provided care and care provided under cooperative arrangements with other service providers (who VA reimburses exclusively by providing in-kind services). Under a third model, VA would serve as a case-manager to ensure that veterans receive needed long-term care services through arrangements with non-VA entities. VA would collect data relevant to such programs and, after the completion of the program, provide Congress a report describing the services provided.

NATIONAL DEFENSE AUTHORIZATION ACT FOR FISCAL YEAR 2000 (P.L. 106-65, SECTION 703); THE DEPARTMENT OF DEFENSE APPROPRIATIONS ACT FOR FISCAL YEAR 2000 (P.L. 106-79, SECTION 8118)

These two provisions reject the Department of Defense policy that limits the duration and scope of home health services provided to disabled individuals. These provisions provide that members and retired members of the military services and their dependents have access to all medically necessary home health services through the health care system of the military services regardless of the health care status of the individual seeking care.

HOME HEALTH LEGISLATION 1998

Making Omnibus Consolidated and Emergency Supplemental Appropriations for Fiscal Year 1999 (P.L. 105-277)

Interim Payment System

Section 5010—Increase in per beneficiary limits (PBL) and per visit payment limits for payment for home health services.

Per Beneficiary Limits (PBLs)

Agencies with a 12-month cost reporting period ending in fiscal year 1994 whose PBLs are below the national median have their PBLs increased by 1/3 of the difference between their PBL and the national median.

Agencies without a 12-month cost reporting period ending in fiscal year 1994, but for which the first cost reporting period begins before fiscal year 1999, have their PBLs increased from 98 percent to 100 percent of the national median.

Agencies whose first cost reporting period begins during or after fiscal year 1999 receive as their PBL 75 percent of the national median.

Per Visit Limits

Per visit limits are increased from 105 percent of the national median to 106 percent of the national median.

15 percent Reduction in Payment Limits

The automatic 15 percent reduction in home health payment limits is delayed until October 1, 2000, for all agencies.

Prospective Payment

Implementation of a prospective payment system is delayed until October 1, 2000, for all agencies.

Periodic Interim Payment (PIP)

PIP is extended until October 1, 2000.

Change in Home Health Market Basket Increase

The home health market basket is reduced by 1.1 percentage points for fiscal year 2000 through FY2003.

Criminal Background Checks

Section 124—A nursing facility or home health care agency may submit a request to the Attorney General to conduct a search and exchange of records regarding an applicant for employment if the employment position is involved in direct patient care.

Centers for Medicare and Medicaid Services—Program Management

\$2,000,000 of the funds available for research, demonstration, and evaluation activities is available to continue demonstration projects on Medicaid coverage of community-based attendant care services for people with disabilities which ensure maximum control by the consumer to select and manage their attendant care services.

HOME HEALTH LEGISLATION 1997

Balanced Budget Act of 1997 (P.L. 105-33)

Commissions

Section 4019 -- Community Nursing Demonstration Projects.

The Community Nursing Organization Demonstration Projects, which test a prepaid, capitated, nurse-managed system of care, are extended for an additional period of two years. Fraud and Abuse Provisions

Section 4021 -- National Bipartisan Commission on the Future of Medicare.

The bill establishes a new Commission to make recommendations to Congress concerning the long-term financial condition of the Medicare program. The Commission, which will begin work in December 1997 and file its recommendations by March 1, 1999, will also examine the impact of chronic care on the Medicare program. This part of the Commission's mandate is expected to include making recommendations related to chronic home care needs of the elderly and disabled populations.

The Commission will be composed of 17 members. Four Commissioners will be appointed by the President. Six will be appointed by the Majority Leader of the Senate, and six by the Speaker of the House. An additional Commissioner will serve as Chair and will be appointed jointly by the President, the Senate Majority Leader, and the Speaker.

This Commission is expected to be composed of Members of Congress and the Administration.

Section 4022 -- Medicare Payment Advisory Commission.

The BBA abolishes the Prospective Payment Assessment Commission (ProPAC) and the Physician Payment Review Commission (PPRC) and consolidates their work into one new group, called the Medicare Payment Advisory Commission.

This Commission will serve as an advisory body to Congress in all areas of Medicare payment and coverage policies, including payment policies under Parts A and B, the Medicare Choice program, and access and quality of care issues.

The Commission will be composed of 15 members, appointed by the Comptroller General of the GAO. A majority of the members must be non-providers.

Fraud and Abuse

Section 4301 -- Permanent Exclusion for Those Convicted of Three Health Care-related Crimes.

The bill establishes a new "three strikes and you're out" policy for providers convicted of three healthcare-related crimes. Under this provision, the penalty for a health care provider found guilty of defrauding any federal health program for a second time would be increased from a five-year exclusion to a 10-year exclusion. A third conviction would trigger a mandatory lifelong exclusion from participation in federal health programs.

Section 4302 -- Authority to Refuse to Enter into Medicare Agreements with Individuals or Entities Convicted of Felonies.

The budget package gives the Secretary of HHS the authority to exclude from participation any health provider convicted of a felony. This section takes effect on date of enactment.

Section 4303 -- Exclusion of Entity Controlled by Family Member of a Sanctioned Individual.

Effective beginning 45 days after date of enactment, the bill authorizes the Secretary of HHS to prohibit an entity owned or controlled by an immediate family member of an excluded individual from participation from any federal healthcare program.

Section 4304 -- Imposition of Civil Monetary Penalties.

Effective on date of enactment, this provision adds a new civil monetary penalty for cases in which a person who contracts with an excluded provider knows or should have known that the provider was excluded from participation in a federal health care program.

Section 4311 -- Improving Information to Medicare Beneficiaries.

This provision requires that each explanation of benefit (EOB) form contain HHS' toll-free number to report fraud and abuse. Moreover, under this provision, a beneficiary will be given 30 days to request an itemized bill for Medicare services from the appropriate carrier or fiscal intermediary.

Section 4312 -- Disclosure of Information and Surety Bonds.

Effective January 1, 1998, this provision requires home health agencies to post a \$50,000 bond to participate in the Medicare program. The provision also mandates that home health agencies disclose identification of all officers, directors, physicians, and principal partners owning five percent or more of the agency. Durable medical equipment suppliers are also subject to the disclosure and surety bond requirements.

Section 4313 -- Provision of Certain Identification Numbers.

Under this provision, within 90 days of filing the disclosure report on ownership interest, Medicare providers are required to supply HHS with both the employer identification number and Social Security numbers for each person or entity with an ownership interest. In addition, health care providers who have at least a five-percent ownership interest in a contractor or subcontractor must disclose their employer identification numbers and Social Security numbers. HHS will then forward these numbers to both the Social Security Commission and the Department of the Treasury for verification.

Section 4314 -- Advisory Opinions Regarding Certain Physician Self-referral.

This provision allows providers to request written advisory opinions from HHS concerning whether an arrangement violates the prohibition against physician self-referrals (known as "Stark I and II"). These opinions will be binding on both HHS and the requesting party.

Section 4315 -- Replacement of Reasonable Charge Methodology with Fee Schedules.

Under this provision, the Secretary of HHS is authorized to implement a statewide or other area wide fee schedule for payment of specified items and services paid on a reasonable charge basis. The specified items and services are medical supplies, home dialysis supplies and equipment,

therapeutic shoes, parenteral and enteral nutrients, equipment and supplies, electromyogram devices, salivation devices, blood products, and transfusion medicine.

Section 4316 -- Application of Inherent Reasonableness to all Part B Services Other than Physician Services.

This provision requires the Secretary of HHS to promulgate regulations describing the factors to be used in determining cases in which application of payment rules under Part B result in the determination of an amount that is not inherently reasonable. The regulations, however, cannot increase or decrease payment amounts by more than 15 percent from the preceding year for a particular item or service.

Section 4317 -- Requirement to Furnish Diagnostic Information.

This provision requires health providers to furnish diagnostic information to non-physician practitioners when ordering specified items or services furnished by such providers. This requirement would apply to diagnostic x-rays, diagnostic lab tests, durable medical equipment, prosthetic devices, braces, and artificial limbs.

Section 4318 -- Report by GAO on Operation of Fraud and Abuse Control Program.

This provision requires the General Accounting Office to report on the operation of the new Medicare fraud and abuse control program by no later than June 1, 1998.

Section 4319 -- Competitive Bidding Demonstration Project.

This provision requires the Secretary of HHS to establish competitive acquisition areas for Part B services. The Secretary could establish different competitive acquisition areas for different classes of items and services. The areas would be chosen based on availability and accessibility of entities able to furnish items and services and probable savings to be realized.

Section 4320 -- Prohibiting Unnecessary and Wasteful Medicare Payments for Certain Items.

This provision specifies that reasonable costs do not include costs for entertainment, gifts, costs for fines and penalties under federal or state law, or certain educational expenses for spouses or dependents of providers, their employees or contractors. Moreover, personal use of motor vehicles is specified as a non-reimbursable charge under Medicare.

Section 4321 -- Nondiscrimination in Post-Hospital Referral to Home Health Agencies.

This provision requires that hospitals, as part of their discharge planning process, provide a list of all home health agencies that serve the area in which the patient resides and who request to be listed by the hospital as available. In addition, the legislation requires hospitals to maintain and disclose information to the Secretary of HHS on referrals made to entities in which that hospital has a financial interest. This information must include the nature of the hospital's financial relationship to the provider, the number of individuals discharged from the hospital who required that provider's type of services, and the percentage of these individuals who received services from the hospital-based provider.

Section 4407 -- Hospital Transfers.

Effective for discharges occurring on or after October 1, 1998, the current law that applies to

transfers from one PPS hospital to another PPS hospital would be extended, for patients within a specified group of 10 diagnostic related groups (DRG), to transfers from a PPS hospital to a PPS-exempt hospital or unit, skilled nursing facility, or home health care. Under this policy hospitals will be paid on a per-diem basis, rather than receiving the full DRG payment, for patients in the specified DRGs who are transferred after short hospital stays. The provider receiving the patient would be paid under its own Medicare payment policy.

Hospice Provisions

Section 4441 -- Payments for Hospice Services and Data Collection.

For each of FY 98 through FY 2002, payment updates will be the market-basket percentage increase minus one percentage point. Hospice providers will also be required to submit to the Secretary of HHS such data as the Secretary determines is necessary regarding the costs of providing hospice care for each fiscal year, beginning with FY 99.

Section 4442 -- Payments for Home Hospice Care Based on Location Where Care is Furnished.

Beginning with cost-reporting periods starting on or after October 1, 1997, hospice claims for services furnished in an individual's home must be submitted on the basis of the geographic location at which the service is furnished, rather than the location of the billing office.

Section 4443 -- Hospice Benefit Periods.

The final bill restructures the hospice benefit periods to include two 90-day periods, followed by an unlimited number of subsequent periods of 60 days each. This provision is effective for benefits provided on or after date of enactment.

Section 4444 -- Items and Services Included in Hospice Payment.

The bill amends the current definition of hospice care to include the existing enumerated services as well as any other item or service that is specified in the patient's plan of care and which Medicare may pay for. This provision is effective for benefits provided on or after date of enactment.

Section 4445 -- Contracting with Independent Physicians or Physician Groups for Hospice Care.

The bill deletes physician services from a hospice's core services and allows hospices to employ or contract with physicians for their services. This provision is effective upon date of enactment.

Section 4446 -- Waiver of Certain Staffing Requirements for Hospice Care Programs in Non-urbanized Areas.

The bill allows the Secretary of HHS to waive requirements with regard to hospices having to provide certain services as long as they are not located in urbanized areas and can demonstrate to the satisfaction of the Secretary that they have been unable, despite diligent efforts, to recruit appropriate personnel. For these hospices, the Secretary could waive specifically the provision of physical or occupational therapy or speech language pathology services and dietary counseling. This provision is effective upon date of enactment.

Section 4447 -- Limitation on Liability of Beneficiaries for Certain Hospice Coverage

Denials.

This provision, which is effective for benefits provided on or after the date of enactment, extends the limitation of liability protection to determinations that an individual is not terminally ill.

Home Health Payment Reform**Section 4601 -- Recapturing Savings from Home Health Freeze.**

The budget bill recaptures the savings resulting from the freeze of the home health cost limits included in the 1993 budget by eliminating consideration of any cost increases that occurred between July 1, 1994, and July 1, 1996, when updating future cost limits.

Section 4602 -- Interim Payments for Home Health.

The budget bill establishes a new interim payment plan for home health services for FY 98 and FY 99. Beginning October 1, 1997, home care agencies will be paid the lesser of their actual, allowable costs; the per-visit cost limits reduced to 105 percent of the national median; or a new blended agency-specific per-beneficiary annual limit, applied to the agency's unduplicated census count of Medicare patients.

Section 4602(c) -- Blend.

The blended per-beneficiary limit will be calculated based 75 percent on 98 percent of the agency's own costs per beneficiary and 25 percent on 98 percent of census-region data. These calculations will be made using cost reports for cost-reporting periods ending in FY 94 including non-routine medical supplies, and updated by the home health market-basket index. The per-beneficiary limits for new providers and those providers without a 12-month cost-reporting period ending in FY 94 would be equal to the median of limits for all home health agencies. The Secretary of HHS will establish by April 1, 1998, the per-beneficiary limits that will be effective for FY 98.

Section 4603 -- Home Health Prospective Payment.

A prospective payment system (PPS) for home health must be designed and implemented by October 1, 1999. The reimbursement system is not defined other than stating that it must consider an appropriate unit of service and number of visits with potential changes in the mix of services provided. Certain elements of the system would not be subject to administrative or judicial review. The Secretary of HHS is also required to reduce cost limits and per-beneficiary limits in effect on September 30, 1999, by 15 percent, regardless of whether PPS is ready to be implemented on October 1, 1999. Periodic interim payments (PIP) would also be eliminated on October 1, 1999.

Additional Home Health Provisions**Section 4604 -- Site of Service.**

Effective for cost reporting periods beginning on or after October 1, 1997, home health payments will be based on the location where the home health service is furnished, rather than the location of the billing office. Additional Home Health Related Provisions.

Section 4611 -- A to B Shift.

The bill gradually transfers from Part A to Part B home health visits that are not part of the first

100 visits following a beneficiary's three-day stay in a hospital or skilled nursing facility and during a home health spell of illness. The transfer would be phased in over a period of six years, beginning on January 1, 1998. For 1998, 1/6 of the payments that would have been made under Part A, prior to this change, are transferred into Part B. For 1999, 2/6; for 2000, 3/6; for 2001, 4/6; for 2002, 5/6; and for 2003, 6/6. In addition, the Medicare Part B premium would also be recalculated to reflect the increase attributable to the transfer. This increase would be phased in over a period of seven years, between 1998 and 2004. For 1998, the Part B premium would be increased by one-seventh of the extra costs due to the transfer; for 1999, the Part B premium would be increased by two-sevenths of the extra costs; for 2000, three-sevenths; for 2001 four-sevenths; for 2002, five-sevenths; for 2003, six-sevenths; and for 2004, the total of the extra costs due to the transfer.

Part A, beginning January 1, 1998, will cover only post institutional home health services for up to 100 visits during a home health spell of illness, except for those individuals with Part A coverage only who would be covered for services without regard to the shift.

Post institutional home health services are defined as services furnished to a Medicare beneficiary: (1) after an inpatient hospital or rural primary care hospital stay of at least three days, initiated within 14 days after discharge, or (2) after a stay in a skilled nursing facility, initiated within 14 days after discharge.

A home health spell of illness is defined as a period of consecutive days beginning with the first day that the individual receives post institutional home health services and ending with the close of the first period of 60 consecutive days thereafter on each of which the individual is neither an inpatient of a hospice or rural primary care hospital nor an inpatient of a skilled nursing facility, nor is receiving home health care.

Claims administration for transferred visits would continue to be done by Part A fiscal intermediaries (FIs).

The threshold for hearings before an administrative law judge on disputed claims would be \$100 for home health services under Part B, consistent with the threshold for Part A home health claims. NAHC was successful in gaining the provisions that provide for seamless administration of the home care benefit by fiscal intermediaries, ensure access to home care for individuals with Part A coverage only, and provide consistent appeals protections.

Section 4612 -- Part-time/Intermittent Standard.

This provision clarifies the part-time/intermittent standards for the home care benefit and conforms to current regulatory practice.

Section 4613 -- Homebound Standard.

The budget bill directs the Secretary of HHS to conduct a study of the criteria that should be applied, as well as the method for applying such criteria, in the determination of whether an individual is homebound for the purpose of qualifying for home health services. The bill requires the Secretary of HHS to report back recommendations to Congress by October 1, 1998.

Section 4614 -- Normative Standards.

The Secretary of HHS is authorized to deny the frequency and duration of home health services where that care is "in excess of such normative guidelines that the Secretary shall establish by regulation." This provision allows the Medicare program to utilize norms of care for limiting coverage to individuals.

Section 4615 -- Venipuncture.

The bill revises the definition of skilled home health services, effective six months after the date of enactment, to specifically exclude venipuncture (blood drawing) as a qualifying service for the Medicare home care benefit.

Section 4616 -- Reports to Congress Regarding Home Health Cost Containment.

The bill requires the Secretary of HHS to submit to the appropriate Congressional committees by October 1, 1997, an estimate of projected Medicare expenditures for home health services for each of FY 1998 through FY 2002. Each year, if actual expenditures exceed the estimates, the Secretary of HHS shall make recommendations to Congress regarding beneficiary copayments or other methods to reduce the growth in expenditures.

Section 4743 -- Medicaid Home and Community-based Waivers.

The bill eliminates the requirement of prior institutionalization with respect to habilitation services furnished under a Medicaid waiver for home and community-based services.

HOME HEALTH LEGISLATION 1996

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (P.L. 104-191)

This legislation addresses portability and continuity of coverage issues in private health insurance coverage. It limits the ability of insurers to restrict beneficiaries on the basis of a pre-existing condition, and guarantees renewal of coverage to groups and individuals as long as they have paid their premiums.

Title III, Subtitle C -- Tax-Related Health Provisions; Long-Term Care Services and Contracts

This section makes changes in the tax code establishing certain incentives for the purchase of private long-term care insurance policies. Benefits under long-term care policies will be tax free and eligible long-term care premiums along with qualified long-term care services, including home care, will be treated as medical expenses for the purpose of the itemized medical expenses deduction.

Section 232 -- Penalty for False Certification for Home Health Service

This section establishes a new civil monetary penalty for physicians who falsely certify that a beneficiary meets all of Medicare's requirements to receive home health care. The amount of this penalty will be equal to three times the amount of payments for the home health services provided or \$5,000, which ever is greater.

OMNIBUS APPROPRIATIONS ACT OF 1996 (P.L. 104-134)

Section 516 -- Survey and Certification of Medicare Providers

This section increases the time between home health recertifications from once every 12 months to once every 36 months. The legislation also expands The Centers for Medicare and Medicaid Services' (CMS's) deeming authority. These provisions were designed to provide CMS the budget flexibility to begin to alleviate the backlog of initial certifications and avoid the need to implement user fees as a way to finance traditional CMS functions.

OMNIBUS CONSOLIDATION APPROPRIATIONS ACT OF 1997 (P.L. 104-208)

Title II -- Department of Health and Human Services

This title earmarks \$158 million for survey and certification activities in fiscal year (FY) 1996. This amount represents an additional \$10 million increase for survey and certification activities over fiscal year FY 1996 levels.

HOME HEALTH LEGISLATION 1995

Although Congress passed the Balanced Budget Act of 1995, H.R. 2491, which contained sweeping changes in the structure of Medicare and Medicaid, the legislation was vetoed by the President. H.R. 2491 contained important changes in the home care benefit, the most significant of which was the inclusion of a prospective payment system for home care.

HOME HEALTH LEGISLATION 1994

Congress did not pass any home health legislation in 1994. The primary reason was the absence of a reconciliation bill, which is the usual vehicle for home health amendments. And although there are sometimes significant items in the Labor/HHS appropriations bill, that was not the case in 1994. Much of the legislation that would have affected home health care was focused on the larger issue of health care reform. But the 103rd Congress adjourned without passing any elements of reform legislation.

HOME HEALTH LEGISLATION 1993

OMNIBUS BUDGET RECONCILIATION ACT OF 1993 (P.L. 103-66)

Section 13564 — Reduction in payments for home health services.

This section essentially freezes the home health cost limits for two years. On July 8, 1993, new cost limits were published in the Federal Register that apply to cost report periods beginning from July 1, 1993, through June 30, 1994. The new legislation provides for the continued use of these same limits until the cost caps are updated effective with cost reporting periods beginning on and after July 1, 1996. In addition, the wage index that applies to a home health agency during its July 1993-June 1994 cost reporting period will also be continued for the following two reporting periods. It is intended that the new cost limits will apply over the period of the freeze with as little change as possible (except for reductions necessitated by the elimination of the hospital add-on). The legislation provides that the amount of any cost limits exception that may be granted cannot exceed what would have been allowed if the cost limits had not been frozen.

Section 13564(b) — Elimination of Hospital Add-On.

This section eliminates the hospital add-on effective with reporting periods beginning October 1, 1993. Thus, hospital-based home health agencies will be able to continue to use the add-on for at least the balance of their current reporting period and until they begin a reporting period that begins on or after October 1, 1993.

Section 13504 — Reductions in Payments for Hospice Services.

This section changes the inflation factor that is used to update hospice payments each October. Instead of using the hospital market basket (HMB) as the measure of inflation, this section provides for the use of the following update factors: October 1993, HMB minus 2.0 percent; October 1994, HMB minus 1.5 percent; October 1995, HMB minus 1.5 percent; October 1996, HMB minus 0.5 percent. In October 1997, Medicare would resume using the full HMB in updating the hospice payment rates.

Section 13601 — Medicaid personal care mandate.

This section repeals the mandate requiring personal care services to be covered under states' Medicaid programs. The mandate was to have gone into effect on October 1, 1994.

Section 13567 — Extension of social HMO demonstrations.

This section extends the social health maintenance organizations (SHMO) demonstrations for an additional two years. These demonstrations, which provide health and long-term care on a capitated basis, are presently authorized to continue through 1995.

Section 13552 — Extension of Alzheimer's disease demonstration projects.

This section extends for one more year and \$3 million the Alzheimer's disease demonstrations that had been authorized for \$40 million for three years in OBRA-86 (P.L. 99-509, Section 9342) and extended for two years and \$15 million by OBRA-90 (P.L. 101-508, Section 4164(a)(2)). The demonstration projects were designed to determine the cost and effectiveness of providing

comprehensive services including home- and community-based services to Medicare beneficiaries with Alzheimer's disease or related disorders.

Section 13568 — Timing of claims payments.

This section modified requirements for claims payments by establishing separate payment floors for claims submitted electronically and otherwise, and extended the time limit for processing clean claims before interest must be paid. The change in timing for claims processing conforms to earlier modifications brought about indirectly through the appropriations bill, which became effective in October 1992. Under these standards, no Medicare claim that is submitted on paper can be paid any earlier than the 27th day after submission. For electronic billers, the payment floor is 14 days. This section also gives CMS 30 days to process clean claims or begin making interest payments; the previous standard was 24 days.

Section 13562 — Ban on physician ownership and referral.

This section extends the self-referral ban that exists under Medicare law that prohibits physicians or immediate family members with a financial relationship with clinical laboratories from referring Medicare patients to those entities. The self-referral ban is extended to other designated health services that include home care, clinical laboratory services, physical therapy services, occupational therapy services, radiology or other diagnostic services, radiation therapy, durable medical equipment, parenteral and enteral nutrients, equipment and supplies, outpatient prescription drugs, and inpatient and outpatient hospital services.

The extended ban on self-referrals is subject to numerous exceptions including the in-office ancillary services exemption that applies to all the designated health services except durable medical equipment (excluding infusion pumps) and parenteral and enteral nutrients, equipment, and supplies.

Additionally, exceptions relating to compensation arrangements include rentals of office space and equipment, employment relationships, and personal services arrangements, among others designed in a manner comparable to those set under the current anti-kickback safe harbor regulations.

The bill provides an effective date of January 1, 1995, to allow physicians and their immediate families sufficient time to sever ownership or compensation arrangements. It should be noted that the legislation does not ban ownership and compensation, it only affects the ability of a physician to refer Medicare patients with a prohibited ownership or financial relationship exists.

HOME HEALTH LEGISLATION 1992

Congress did not pass a budget reconciliation bill in 1992 because of the five-year budget agreement reached in 1990. The annual reconciliation bill is the major vehicle for home care legislation as Congress rarely passes stand-alone legislation. Despite the absence of reconciliation, several important home care provisions were included in Labor/HHS Appropriations Act, which was signed into law on October 6, 1992. In addition, Congress reauthorized the Older Americans Act.

LABOR/HEALTH AND HUMAN SERVICES/EDUCATION APPROPRIATIONS (P.L. 102-394)

Prohibit Postpayment Claims Sampling—Language was included in both the Senate and House reports on Labor/HHS Appropriations that denounced the Centers for Medicare and Medicaid Services use of sampling in postpayment review of Medicare claims and directed CMS to stop the practice (S.Rept. 102-397, pp. 164-5; H.Rept. 102-708, p. 110). The appropriations conferees viewed the report language sufficient to condemn the practice.

Rejection of Survey and Certification User Fees—Congress rejected the Administration's proposal to impose a fee on providers to cover the costs of Medicare surveys and certification and approved an appropriation of \$149 million for survey and certification activities.

Encouragement of Electronic Claims Transmissions—In an effort to encourage providers to transmit Medicare claims to contractors electronically, Congress established a payment floor of 14 days for electronically transmitted claims and a payment floor of 27 days for claims submitted on paper.

Ryan White CARE Act—The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act received \$300 million for FY93 appropriations. Of that amount, \$185 million was directed toward emergency assistance grants to high-impact cities.

In-Home Services to Frail Elderly—Congress appropriated \$7 million for in-home services for the frail elderly under the Older Americans Act (Title III-D).

Home Health Demonstration Projects—Congress did not include further funding for the Health Care Services in the Home Demonstration program, which is a demonstration program being conducted under the Health Resources and Services Administration in Hawaii, South Carolina, North Carolina, Mississippi and Utah. Senate report language stated the unobligated FY92 funds were "expected to allow current grantees to complete this demonstration in FY93" (S.Rept. 102-397, p. 42).

OSHA Seat Belt, Driver Safety Regulations—Congress directed the Occupational Safety and Health Administration (OSHA) to reconsider its proposed rules on seat belt use and driver awareness education, which were published July 12, 1990. Congress expressed particular

concern about the impact of the regulations on employers and about the imposition of sanctions against employers who have made a good faith effort to comply with the standards (H.Rept. 102-974, p. 49).

OLDER AMERICANS ACT AMENDMENTS OF 1992 (P.L. 102-375)

Reauthorizes the Older Americans Act through 1995, and requires: that the National Academy of Sciences' Institute of Medicine conduct a study on home care quality; that providers of in-home services promote the rights of the frail elderly individuals who receive such services; that a White House Conference on Aging be held no later than December 31, 1994; that the National Center for Health Statistics conduct studies on demographic information related to paraprofessionals working in the home and nursing home settings; and that the Department of Labor conduct a study on employment conditions of in-home and nursing home paraprofessionals.

The Act also includes provisions related to case management of services funded under the OAA. The bill provides a comprehensive definition of case management services for OAA purposes. It also requires that OAA case management services not duplicate such services provided through other federal and state programs, that they be coordinated with services provided through other federal and state programs, and that such services be provided by a public agency or a nonprofit private agency that does not provide other OAA services under Title III of the Act. An exception to the service-provision limitation is included for nonprofit private agencies located in rural areas that obtain a waiver.

HOME HEALTH LEGISLATION 1991

Congress did not pass a budget reconciliation bill in 1991 because of the five-year budget agreement reached in 1990. The annual reconciliation bill is the major vehicle for home care legislation as Congress rarely passes stand-alone legislation. Despite the absence of reconciliation, several important home care provisions were included in the 1991 Labor/HHS appropriations bill.

LABOR/HEALTH AND HUMAN SERVICES/EDUCATION APPROPRIATIONS (P.L. 102-170)

Prohibit Postpayment Claims Sampling—Language originating in the Senate Report of the Labor/HHS appropriations bill denounced the Centers for Medicare and Medicaid Services' use of sampling in postpayment reviews of Medicare claims (S.Rept. 102-104, p. 172). The appropriations conferees viewed the Senate report language sufficient to condemn the practice.

Rejection of Survey and Certification User Fees—Congress rejected the Administration's proposal to impose a fee on providers to cover the costs of Medicare surveys and certification and approved an appropriation of \$150 million for survey and certification activities.

Ryan White CARE Act—The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act received \$280 million for FY92 appropriations, an increase of \$59.4 million over the previous year.

Home Health Demonstrations Grants—A \$2.9 million appropriation was approved to continue for two years the Health Care in the Home Demonstrations program, under the Health Resources and Services Administration. These demonstrations have been underway for the past three years in Hawaii, South Carolina, North Carolina, Mississippi and Utah.

Home Health Care and Alzheimer's Disease Pilot Grants—A \$4 million appropriation was approved for 10 state pilot projects to provide home care and other services to individual with Alzheimer's disease. The pilots were authorized by P.L. 101-557, § 102.

NATIONAL DEFENSE AUTHORIZATION ACT (P.L. 102-190)

Section 702(a)—Creates a new hospice benefit for active military and their families either in military hospitals or under CHAMPUS. Hospice care may be provided in facilities of the uniformed services to a terminally ill patient who chooses to receive hospice care rather than continuing hospitalization or other health care services for treatment of the patient's terminal illness.

Section 702(b)—Allows hospices to contract with CHAMPUS to provide hospice services. The reimbursement is to be determined by the Secretary of Defense.

HOME HEALTH LEGISLATION 1990

OMNIBUS BUDGET RECONCILIATION ACT OF 1990 (P.L. 101-508)

MEDICARE

Section 4207(d)—Home Health Wage Index: The conference agreement includes a provision which permanently reinstates the use of the hospital wage index for determining home health agency cost limits, with a transition period to the 1988 hospital wage index for cost reporting periods beginning on or after July 1, 1991.

For home health agency reporting periods that begin between July 1, 1991, and June 30, 1992, the wage index would be based two-thirds on the 1982 wage index now in use and one-third on the new index. For the 12-month period beginning July 1, 1992, the blend would be based on one-third of the 1982 index and two-thirds of the 1988 index. For cost reporting periods beginning on or after July 1, 1993, the 1988 wage index, or any later version that may be in effect, would be used.

The Omnibus Budget Reconciliation Act of 1989 (OBRA-89) had included a provision which required the Secretary of Health and Human Services (HHS) to continue to use the hospital wage index until the cost reporting period beginning on or after July 1, 1991.

Sections 4207(b)(3) and 4008(a)(2)—Waiver of Liability: The waiver of liability presumptive status as applied to medical and technical denials will be extended for five years, through December 31, 1995, for home health agencies. The waiver for hospices was also extended for five years.

The waiver for home health and hospice providers was scheduled to expire on November 1, 1990.

Section 4207(h)—Prohibition of User Fees for Survey and Certification: This provision prohibits HHS from imposing, or requiring states to impose, on home health agencies, hospices, hospitals or other entities (excluding those required by the Clinical Laboratory Improvement Amendments of 1988) a fee to offset the costs of surveys to certify compliance with the conditions of participation under Medicare Part A or B.

Sections 4207(j) and 4801(a)—Home Care Aide Requirements: The conference agreement includes an amendment which would make any home care agency ineligible to train and test home care aides if, within the previous two years, the agency: (1) is found to be out of compliance with training and testing standards; (2) has been subjected to a partial or extended survey; (3) has been assessed a monetary penalty of \$5,000 or more for deficiencies relating to quality of care; or (4) has been subject to suspension of payment or temporary management for noncompliance.

The conference agreement also includes an amendment which would permanently bar agencies from training and testing home care aides if, between October 1, 1988, and September 30, 1990, the agency: (1) was terminated from the Medicare program; (2) was assessed a civil monetary

penalty of \$5,000 or more for deficiencies relating to quality of care; (3) was subject to suspension of payment or temporary management for noncompliance; or (4) pursuant to state action was closed or required to transfer patients.

Section 4006—Hospice 210-Day Limit: This amendment eliminates the 210-day cap on the Medicare hospice benefit and allows for unlimited days of coverage. This amendment would be effective for services furnished on or after January 1, 1990.

This amendment will not change the requirement that a patient have a prognosis of six months or less to live, nor does it change the aggregate cap which limits the amount of Medicare reimbursement a hospice can receive each year.

Section 4751—Patient Self-Determination: Effective one year after enactment, Medicare providers, including home health agencies and hospices, will be required to inform patients of their rights under state law to make decisions concerning medical care, including: (1) the right to accept or refuse medical or surgical treatment; and (2) the right to formulate advance directives recognized under state law, such as through appointment of an agent or surrogate to make health care decisions on his/her behalf (durable power of attorney) and written instructions about health care (living will).

As a condition of participation, all providers will (1) inquire whether an adult patient has formulated an advance directive, and (2) document whether an advance directive exists in the medical record. In addition, all providers, including home health agencies and hospices, will be required to provide patients with the provider's written policies concerning the implementation of advance directives.

Civil monetary penalties will be applied for noncompliance.

Section 4207(b)(2)—Prohibition on Payment Cycles: Effective upon enactment, HHS is prohibited from issuing any final regulation, instruction or policy change which is primarily intended to have the effect of slowing down claims processing or delaying the rate at which claims are paid. An existing provision expired September 30, 1990.

Section 4207(g)—Case Management Study: The budget agreement requires HHS to resume three case management demonstration projects authorized by the Medicare Catastrophic Coverage Act (MCCA) of 1988 (P.L. 100-360), but later lost when the Act was repealed. Under the demonstration projects, appropriate entities will provide case management services to Medicare beneficiaries with selected catastrophic illnesses.

Section 4207(c)—Prospective Payment Study: The conference agreement directs the Centers for Medicare and Medicaid Services (CMS) to conduct research and sets deadlines for CMS to report back to Congress on whether to move cost-based providers, including home health agencies, to some form of alternative reimbursement. HHS is to submit a report to Congress that includes a proposal for prospective payment for home health agencies by September 1, 1993. The Prospective Payment Assessment Commission is to analyze HHS' proposal and report to Congress by March 1, 1994.

In developing this proposal, HHS is to:

1. take into account the need to provide for appropriate limits on home care expenditures;

2. provide for changes in patient case mix, severity of illness, volume of cases and the development of new technologies and standards of medical practice;
3. take into consideration the need to increase payment for outlier cases, those cases which exceed the average length or cost of treatment;
4. take into account the varying wage-related costs among agencies; and
5. analyze the feasibility and appropriateness of establishing the episode of illness as the basic unit for making payments.

Section 4007—Delay in Hospice Payment Update: The conference agreement includes an amendment which would delay the update in the daily hospice payment rates from October 21 until January 1, 1991. However, hospices will receive the 5.2 percent increase in daily rates from October 1-20, then drop back to the old rates until January 1, 1991, when the increased rates will again apply.

Section 4158—Part B Payment Reductions: All payments to Medicare Part B providers will be reduced by 2 percent for services furnished on or after November 1, 1990, and on or before December 31, 1990.

Section 4153(d)—Home Health Supplies: Home health agencies who are caring for Medicare home health beneficiaries who need catheters, catheter supplies, ostomy bags and related supplies must offer to furnish these supplies directly to the beneficiary under the home health benefit. Previously, home health agencies were required to furnish ostomy supplies only, as part of OBRA-89 amendments which exempted all of these items from the "Six-Point Plan" reimbursement system.

Section 4156—Coverage of Injectionable Drugs for Osteoporosis: The conference agreement includes an amendment which provides coverage under Part B for drugs, and its administration for osteoporosis. The administration of this and any drug is already covered under the home health benefit. This provision is in effect from January 1, 1991, through December 31, 1995.

MEDICAID

Section 4711—Home and Community Care as an Optional Statewide Service: This amendment would allow states to offer, under a capped program, without demonstrating budget neutrality, home or community-based services to elderly beneficiaries with the inability to perform two out of three activities of daily living. The five-year optional program is capped at \$580 million.

The legislation defines "home and community care" as one or more of the following services furnished, according to an individual community care plan, to an individual who has been determined, after an assessment, to be eligible: home care aide services, chore services, personal care services, nursing care services (provided by or under the supervision of a registered nurse), training for family members, adult day health services, and in the case of individuals with chronic mental illness, day treatment and clinic services, and any other such items as HHS may approve.

Eligibility—An eligible individual is: (1) 65 years or older; (2) determined to be functionally disabled; and (3) eligible for Medicaid including, at the state's option, the "medically needy."

A state may continue to maintain its current waiver programs and choose this new option. Also a

state may substitute the new option for its existing waiver program provided that it grandfathers current-program clients in the new programs. Of course, due to different eligibility rules, new beneficiaries who would have qualified under the terminated waiver program may not qualify under the new program.

Functionally Disabled—Functionally disabled individuals are defined as persons who (1) are unable to perform without substantial assistance at least two of the specified three activities of daily living (toileting, transferring and eating); or (2) have a primary or secondary diagnosis of Alzheimer's disease and are unable to perform without substantial assistance at least two of the five specified activities (bathing, dressing, toileting, transferring, and eating).

Assessments—Assessments will be based on a uniform minimum data set and assessment instrument specified by HHS.

HHS is required by July 1, 1991, to specify a minimum data set of core elements and common definitions for use in conducting the assessments and to establish guidelines for using the data set. Also by July 1, 1991, HHS is to designate one or more instruments for use by the state in conducting comprehensive functional assessments.

Appeals Procedures—Each state which elects to provide this benefit must provide for an appeal procedure for individuals adversely affected by eligibility determinations.

Periodic Review—Individuals' assessments must be reviewed and revised, as may be appropriate, not less often than once every 12 months.

Conduct of Assessments by Interdisciplinary Teams—Assessments and reviews are to be conducted by an interdisciplinary team designated by the state. These must be under contracts with public or nonpublic organizations which do not provide, directly or through an affiliate, home or community care or nursing home care.

Individual Community Care Plans (ICCP)—An ICCP is defined as a written plan which (1) is established and periodically reviewed and revised by a qualified case manager; and (2) specifies the care to be provided and indicates the individual's preference for the types and providers of services.

Qualified Case Management Entity—A qualified case management entity is defined as: (1) a nonprofit or public agency or organization which has experience in establishing, reviewing and revising care plans for the elderly and in providing case management services to the elderly; (2) is responsible for assuring that the care as specified for in the plan is being provided; (3) in the case of nonpublic agency, does not provide home or community services or nursing facility services; (4) has procedures for assuring quality case management services that include a peer review process; (5) completes the ICCP in a timely manner, and meets other standards established by HHS to assure competency.

Appeals Procedures—The legislation requires that the state provide for an appeal procedure for any individual who disagrees with the ICCP.

Minimum Requirements for Home and Community Care—Home and community care providers must meet the following requirements: (1) individuals providing the care must be competent; and (2) specify patient rights to the beneficiary (similar to current Medicare bill of rights). Minimum requirements are established for community care settings as well.

Certification—States will be responsible for certifying compliance of providers of home and community care no less frequently than once every 12 months. Periodic review of provider performance will be conducted.

Investigation of Complaints and Allegations of Abuse—States will be responsible for the investigation of complaints regarding the violation of certification requirements and allegation of individual neglect and abuse.

Disclosure of Results of Inspections and Activities—This section requires the states and HHS to make available to the public information on all surveys, reviews and certifications.

State and Secretarial Authority—Both the state and HHS will be permitted to terminate from the program and impose civil monetary penalties on home and community care providers who no longer meet the requirements.

Payment for Services—States are required to pay for home and community care at rates which are reasonable and adequate to meet the costs of providing care, efficiently and economically, in conformity with applicable state and federal laws, regulations, and quality and safety standards. It further amends the Medicaid law to specify that HHS could not limit the amount of payment that may be made for home and community care.

Effective Date—This new waiver authority is available to states effective with services provided on or after July 1, 1991, without regard to whether or not final regulations have been promulgated by that date.

Section 4705—Hospice Payments: Effective as if included in OBRA-89, the conference agreement includes a retroactive provision which further clarifies that an additional amount should be paid for dual eligible nursing facility residents electing hospice under Medicaid.

Section 4717—Clarifying Effect of Hospice Election: This sections adds to the Medicaid law a clarification that, in electing hospice care, a Medicaid beneficiary waives payment for services for which payment may otherwise be made under Medicare.

Section 4746—New Jersey Respite Care Demonstration: The conference agreement extends the New Jersey respite care demonstration project through September 1992. This project was originally authorized under OBRA-86 and is designed to determine the extent to which respite services will delay or avert the need for institutional care.

Section 4741—Respite Care: The agreement clarifies that HHS has no authority to limit the number of hours of respite care that a state may offer under a budget-neutral "2176" waiver.

Section 4720—Personal Care Services: The agreement provides that, in Minnesota, for fiscal years 1991-1994, federal Medicaid matching funds are available for personal care services prescribed by a physician, provided by a qualified person, supervised by a nurse, and furnished in a home or other location; but does not include such services furnished to an inpatient or resident of a hospital or nursing home. It further requires that in fiscal year 1995 and beyond, Medicaid's definition of home health services is to include personal care services prescribed by a physician, provided by a qualified individual, supervised by a registered nurse, and furnished in a home or other location, not including such services furnished to an inpatient or resident of a nursing facility.

Section 4744—Frail Elderly Demonstration Project Demonstrations: This section expands from 10-15, the number of demonstrations to provide health care on a capitated basis to frail elderly at risk of institutionalization.

RYAN WHITE COMPREHENSIVE AIDS RESOURCES EMERGENCY (CARE) ACT OF 1990 (P.L. 101-381)

Title I—Provides for \$87.8 million in the form of grants for cities hardest hit by the AIDS crisis. The 16 eligible cities, in order of severity of need are: New York, Los Angeles, San Francisco, Houston, Washington, DC, Newark, Miami, Chicago, Philadelphia, Atlanta, San Juan, Dallas, Boston, Fort Lauderdale, San Diego, and Jersey City.

Funding under Title I of the bill, to be administered through the Health Resources Services Administration (HRSA) under the US Public Health Services, is intended to help eligible areas operate programs that enable persons with HIV disease to receive appropriate care on an outpatient and ambulatory basis.

Title I also establishes a HIV Health Services Planning Council in each state. These councils can be an existing entity with demonstrated experience in (1) planning for HIV health care services needs and (2) implementing coordinated delivery of HIV health care services within the eligible geographic area. The councils are to include representatives of other providers, including health care providers. The duties of the planning councils include the development of a comprehensive plan for the organization and delivery of health services to eligible individuals.

Title II—Provides for another \$87.8 million to states in the form of grants to promote HIV-related care through the development of HIV community-care consortia, home- and community-based care, therapeutic drug subsidies and maintenance of health insurance.

Also administered through HRSA, this title provides for direct grants to states for the provision of health care services, including home- and community-based care. Monies under this title also can be used to establish and operate HIV-care consortia in areas most affected by HIV disease. These consortia would consist of public and nonprofit private, health care and support service providers and community-based organizations operating in the areas determined to be most affected by the AIDS disease. They must agree to use the funds for the planning, development and delivery, either through direct service or through contract, of comprehensive outpatient health and support services. These services may include case management services, medical, nursing, dental, home health and hospice care and essential support services such as attendant care, home care aide, personal care, intravenous drug therapy, day or respite care, durable medical equipment, transportation and nutritional services.

The home- and community-based care must be provided pursuant to written plans of care prepared by a case management team. The case management team will include appropriate health care professionals with priority given to entities that participate in the consortia, if one exists, and to entities that provide care to low-income individuals. Co-charges for services provided under the CARE bill will be imposed on individuals according to their income. None will be assessed if the recipient's income is at or below the official poverty line.

Title III—Provides \$130 million to states for HIV testing and counseling services and another \$44.9 million to community health centers for HIV-related care, including early intervention programs.

HOME HEALTH CARE AND ALZHEIMER'S DISEASE AMENDMENTS OF 1990 (P.L. 101-557)

Home Health Care Demonstration Projects—Reauthorizes and expands the home health care demonstration projects first authorized in the 1987 amendments to the Older Americans Act. The grants would continue to provide skilled nursing care, and be expanded to include home care aide services, for low-income individuals who, with the availability of such assistance, can avoid institutionalization or prolonged hospitalization. Expands the number of grants available to 10.

Alzheimer's Demonstrations Projects—Provides grants to states to provide home- and community-based care, including respite care, for individuals with Alzheimer's disease or related disorders.

HOME HEALTH LEGISLATION 1989

OMNIBUS BUDGET RECONCILIATION ACT OF 1989 (P.L. 101-239)

MEDICARE

Sections 6001 & 6101—Gramm-Rudman-Hollings Reduction: Home health agencies were subject to a 2.092 percent reduction in their Part A Medicare payments until December 31, 1989. Medicare Part B providers were subject to the 2.092 percent reduction until March 31, 1990, after which Medicare Part B providers will be subject to 1.42 percent reduction throughout the remainder of the fiscal year, October 1, 1990.

Section 6222—Home Health Wage Index: In determining home health cost limits, the wage index in use prior to July 1, 1989 (hospital wage index), will continue to be utilized until cost-reporting periods beginning on or after July 1, 1991.

Section 6112(e)—Home Health Supplies: This provision continues to include 38 ostomy and catheter supplies as home health supplies. It requires home health agencies to offer to furnish ostomy supplies to individuals who require them as part of the home health service. This is effective with respect to items supplied on or after January 1, 1990.

Section 6005—Increased Payments for Hospice Care: Medicare hospice payments will be increased by 20 percent. Payments in subsequent years will be indexed to the hospital market basket. The provision further provides that written certification for hospice care be obtained no later than eight days after care is initiated, provided a verbal order is given by the physician within two days. The effective date for the increased payments is January 1, 1990. Additionally, the provision provides for the Secretary of Health and Human Services (HHS) to conduct a study of high-cost hospice care provided to Medicare beneficiaries and to evaluate the ability of hospice programs participating in Medicare to provide this care. On the basis of this study, HHS is required to develop methods to compensate hospices for high-cost care provided to Medicare beneficiaries. HHS to report to Congress by April 1, 1991.

Section 6214—Determining Eligibility of Home Health Agencies for Waiver of Liability for Denied Claims: Amends the current policy for purposes of calculating the waiver of liability presumption so that denials would be deemed final if (1) the initial denial is not appealed by the home health agency within the allotted 60-day time period; or (2) upon a reconsideration decision by the fiscal intermediary. The provision further states that HHS is to monitor the proportion of denied claims for which reconsideration is requested and report to Congress if the proportion of denials reversed upon reconsideration increases significantly. This provision is effective with determinations for quarters beginning on January 1, 1990.

Section 6224—Peer Review Organizations: This section requires that Peer Review Organizations (PRO) establish procedures for the involvement of health care practitioners who

are not doctors of medicine in the review of services provided by members of their profession. This is effective with contracts entered into after enactment.

Section 6204—Physician Ownership of, and Referral to, Health Care Entities: This provision will require entities to report to HHS with information concerning the entity's ownership arrangement, including the covered items and services provided by the entity and the names and all of the Medicare provider numbers of all of the physicians who are interested investors or who are immediate relatives of interested investors. HHS is to specify the form and manner of such reporting. It further specifies that such information shall be furnished not later than one year after the date of enactment. Only clinical laboratories will be subject to a general prohibition against the referral of a beneficiary to an entity which the physician, or members of his or her immediate family, are interested investors. HHS must submit to Congress, not later than 90 days after the end of each quarter, a report which provides a statistical profile (by state and type of item and service) comparing utilization of items and services by Medicare beneficiaries served by entities in which the referring physician has a direct or indirect financial interest, and by Medicare beneficiaries serviced by other entities. Additionally, the General Accounting Office (GAO) is to conduct a study of ownership of hospitals and other Medicare providers by referring physicians.

Section 6218—General Accounting Office Study of Administrative Costs of the Medicare Program: GAO will be required to conduct a study of the administrative burden of Medicare regulations and program requirements on providers of services (including home health agencies), fiscal intermediaries and carriers. No later than March 31, 1990, GAO is to submit a report to Congress that includes (1) an assessment of current administrative costs to such entities and of trends in such administrative costs since 1982, and (2) a comparison of the administrative burden to such entities in providing services to individuals who are not Medicare beneficiaries. For purposes of such an assessment, administrative costs shall include personnel costs, training costs, the costs of data and communications systems as affected by changes in requirements of the Medicare program and costs to such entities for noncompliance with such requirements resulting from the failure of HHS to provide entities with adequate notice of changes in program requirements.

Section 6220—Amendments Relating to the Bipartisan Commission on Comprehensive Health Care: This amendment provides that the commission may also be known as the "Claude Pepper Commission," after the late Senator Claude Pepper. It also extends the deadline to March 1, 1990, for the two reports that the commission must submit to Congress.

Section 6112—Durable Medical Equipment: Fees will be frozen in 1990 and there will be no national cap on fee schedules.

MEDICAID

Section 6408(c)—Hospice Payment for Room and Board: When a hospice patient is residing in an intermediate care facility (ICF) and/or a skilled nursing facility (SNF), Medicaid will be required to pay an additional amount to take into account the room and board furnished by the facility equal to at least 95 percent of the rate that the state would have paid under the plan for

facility services in that facility for that person. The effective date is for calendar quarters beginning on or after July 1, 1990.

MEDICAID ELIGIBILITY EXPANSION ITEMS

Section 6401—Phased-In Coverage of Pregnant Women and Infants up to 133 percent of the Federal Poverty Level: This section requires states (including Arizona) to offer Medicaid coverage to pregnant women and infants under one years old up to 133 percent of the federal poverty level.

Section 6401—Phased-In Mandatory Coverage of Children up to 100 percent of the Federal Poverty Level: States will be required to extend Medicaid coverage to all children born after September 30, 1990, up to age six in families with incomes below 133 percent of the federal poverty level.

MEDICARE CATASTROPHIC COVERAGE REPEAL ACT OF 1989 (P.L. 101-234)

P.L. 101-234 repeals all provisions of the Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360), including the home care-related provisions for an IV therapy drug benefit, intermittent care, hospice care and respite care. Retained were minor and technical provisions, including the extension of the home health waiver of liability.

Enacted were several transitional provisions designed to protect some patients and providers from the abrupt termination of repealed benefits. Among those provisions were two relating to home care and hospice providers. The first extends through 1990 the full benefits of catastrophic coverage for enrollees in risk-based health maintenance organizations (HMO). Congress determined this necessary because the 1990 rates already had been adjusted for risk-based HMOs. The second transitional provision indicates that the repeal of the hospice benefit extension "shall not apply to hospice care provided during the subsequent period (described as in effect on December 31) with respect to which an election has been made before January 1, 1990."

HOME HEALTH LEGISLATION 1988

MEDICARE CATASTROPHIC COVERAGE ACT OF 1988 (P.L. 100-360)

Section 426—Waiver of Liability: The favorable presumption under the waiver of liability for home health agencies and hospices is extended through October 1990. The extension applies to medical necessity denials as well as to intermittent care and homebound denials. In addition, the Secretary of Health and Human Services (HHS) is prohibited from modifying the criteria for these waivers.

Section 206—Extending Home Health Benefits: Nursing care and home care aide services may be provided seven days per week (with one or more visits per day) for up to 38 days, after which additional days of care can be provided under exceptional circumstances. There is no prior hospitalization requirement.

Section 202-203—IV Drug Therapy: Under Part B, effective for services provided after January 1, 1990, home IV antibiotic drug therapy services including nursing visits, pharmacy and related items (such as medical supplies, IV fluids, delivery and equipment) will be covered under Medicare. Other IV drugs would be covered only if the HHS Secretary determines that providers can administer them safely and effectively in a home setting. The HHS Secretary is expected to complete a review of the safety and effectiveness of home IV cancer chemotherapy drugs as soon as possible. IV drug therapy services would not be subject to the Part B deductible or coinsurance. Coverage and reimbursement for the drugs used for this service are not included in the definition of home IV drug therapy, but would be reimbursed under the Medicare Catastrophic Drug Benefit. The drug benefit deductible and coinsurance would be waived if the therapy was initiated during a hospital admission.

To be a qualified home IV drug therapy provider, an entity must meet the following standards set by HHS Secretary: (1) is capable of providing or arranging for services and items mentioned above and the drugs; (2) adheres to written protocols with respect to service provisions and (3) can assure that only trained personnel provide covered home IV drugs (and any other services for which training is required to safely provide the service); (4) maintains clinical records on all patients; (5) makes services available on a 24-hour basis; (6) coordinates services with the patient's physician; (7) conducts a quality assessment and assurance program, including drug regimen review and patient care coordination; (8) assumes responsibility for the quality of services provided by others under arrangement; (9) is licensed, or approved as meeting the requirements for licensure, if state or local law provides for licensure for home IV drug providers; (10) meets other requirements the HHS Secretary deems necessary.

There will be limitations on physician referrals to a home IV provider in cases where the doctor receives compensation from, or has an ownership interest in, the provider. The HHS Inspector General will be required to conduct a study of physician ownership of, and compensation by, other suppliers of Medicare-covered services to which they make referrals.

Reimbursement would be calculated based on whichever is the lower charge, the provider's actual charge or the fee schedule amount. The HHS Secretary would be required to establish a fee schedule through regulation before January 1, 1990, that would provide payment on a per-

diem basis. In establishing the fee schedule, the HHS Secretary could consider cost information, charge information and payment rates for similar items and services covered under Medicare. The HHS Secretary would not, however, require routine cost reports. Report language indicates that the HHS Secretary is expected to use broad flexibility in establishing a fee schedule that assures adequate access to services while preventing excessive payment.

A care plan must be developed by the physician prescribing the home IV drug therapy. In addition, through 1992, prior approval by a Peer Review Organization (PRO) would be required as a condition of payment. PROs would be required to complete review determinations within one working day of a request. To assure the validity and uniformity of PRO reviews, the conference agreement requires the HHS Secretary to establish criteria that would be used by PROs in conducting reviews with respect to the appropriateness of home IV drug therapy services.

Section 205—Respite Care: Services covered would include home care aide services (performed by aides who have successfully completed a training program approved by the HHS Secretary), personal care services and nursing services provided by a licensed professional nurse. Eighty hours per year will be covered. Care provided on any one day for less than three hours would be counted as three hours. Services must be provided under the supervision of a registered nurse, home health agency or others under arrangement with the agency.

Those eligible for respite care coverage must meet the following qualifications: (1) Medicare Part B beneficiary who is dependent on a daily basis on a primary caregiver who is living with the beneficiary and is assisting the beneficiary without compensation in performing at least two activities of daily living (ADL); (2) without this assistance could not perform these two ADLs; and (3) the covered expenses must exceed the catastrophic limit (estimated to be \$1,370 in 1990) or the newly created Medicare drug benefit deductible (\$550 in 1990).

Services would then be available to the beneficiary for a 12-month period from the date the beneficiary was determined to have incurred such expenses. If a beneficiary meets a second limit within the 12-month period, he or she would be entitled to a new 12-month period. In no situation could a beneficiary carry over hours not used in a previous 12-month eligibility period, nor could a beneficiary use more than 80 hours of care per year.

The beneficiary would be responsible for a 20 percent coinsurance even if the beneficiary's costs have exceeded the catastrophic limit; however, the 20 percent coinsurance payment would be counted toward the limit. Payment will be made on the basis of hourly rates based on reasonable costs of furnishing care.

A physician is required to certify that the beneficiary is chronically dependent during the immediate preceding three-month period. Payment will not be made unless the care is deemed reasonable and necessary. The HHS Secretary is required to take appropriate efforts to assure high quality and provide for the appropriate utilization of in-home care.

The HHS Secretary is to study and report to Congress within 18 months after enactment on the advisability of providing out-of-home services, such as adult day care centers or nursing facility services, as an alternative to in-home care. The provision applies to services furnished on or after January 1, 1990.

Section 101(1)(4)—Medicare Hospice Extension: Provides for a subsequent extension (time period not specified) beyond the 210-day limit for Medicare-certified hospice providers, if the beneficiary is recertified as terminally ill by the medical director or the physician member of the

interdisciplinary group of the hospice program. This provision is effective for services provided on or after January 1, 1989.

Section 427—Home Health Advisory Commission: Requires the Centers for Medicare and Medicaid Services (CMS) Administrator to appoint an 11-member Advisory Commission on Home Health Claims. The commission is to study and report to Congress within one year after enactment on the reasons for the increase in the denial rate for home health claims in 1986 and 1987, the ramifications of such increase and the need to reform the process involved in such denials. At least five of the commission members must be representatives of home health or visiting nurse agencies. The remaining six must consist of representatives of senior citizens' groups, physicians' groups and fiscal intermediaries, with no more than three of the six representing fiscal intermediaries.

Section 425—Case Management Study: The HHS Secretary must establish four demonstration projects within 12 months after enactment, under which an appropriate entity (one of which must be a PRO) agrees to provide case management services under the Medicare program to Medicare beneficiaries with selected catastrophic illnesses, particularly those with high costs. The demonstration projects are to evaluate the appropriateness of, and determine the most effective approach of, providing case management services for Medicare beneficiaries with high medical bills.

The HHS Secretary is to waive limitations or restrictions on benefits necessary to conduct the demonstration. The demonstrations will be conducted for a two-year period. The HHS Secretary is to make an interim report within a year after the demonstrations begin and a final report upon completion.

Section 207—Research on Long-Term Care Services for Medicare Beneficiaries: The HHS Secretary is required to provide for research relating to the delivery and financing of long-term care services for Medicare beneficiaries. The study is to include at least the following: (1) the financial characteristics of Medicare beneficiaries who receive or need long-term care; (2) how financial and other characteristics of Medicare beneficiaries affect their utilization of institutional and noninstitutional services; (3) how beneficiaries and relatives are affected financially and other ways because the beneficiary requires or received long-term care services; (4) the quality of long-term care services (in community and custodial settings) and how the provision of such services may reduce expenditures for acute care services; and (5) the effectiveness of, and need for, state and federal consumer protections that assure adequate access to and protect the rights of beneficiaries receiving long-term care (other than in a nursing home).

The provision defines long-term care to include nursing home care, home care, community-based services and custodial care. The HHS Secretary would submit interim reports December 1990 and December 1992, with a final report due June 1994. The provision also requires the Secretary of Treasury to conduct a study of federal tax policies to promote the financing of long-term care due to Congress by November 31, 1988.

Section 401-408—U.S. Bipartisan Commission on Comprehensive Health Care: Establishes a commission to examine shortcomings in the health care delivery and financing mechanisms that limit or prevent access to all individuals of comprehensive health care, and make recommendations to Congress on federal programs, policies and financing needed to assure the

availability of comprehensive health care services for all U.S. citizens.

Both the terms "comprehensive health care services" and "comprehensive long-term care services" include home care services. The commission is to submit to Congress no later than six months after enactment a report on its findings regarding comprehensive long-term care services for the elderly and disabled. Within one year, the commission is to report to Congress on its findings regarding comprehensive health care services for the elderly, disabled and for all individuals. Both reports are to include detailed legislative initiatives.

Section 208—Study of Adult Day Care Services: Effective upon enactment, this provision requires the HHS Secretary to survey adult day care services to collect information on (1) the scope of such services; (2) the characteristics of entities providing the services; (3) licensure, certification and other quality standards applied to those providing the services; (4) their cost and financing; and (5) the characteristics of people receiving such services.

The HHS Secretary is to report to Congress within one year on recommendations for appropriate standards for Medicare adult day care services.

CHANGES FROM THE OMNIBUS BUDGET RECONCILIATION ACT OF 1987 (OBRA-87, P.L. 100-203) INCLUDED IN THE MEDICARE CATASTROPHIC PROTECTION ACT OF 1988

Section 411—Data Used to Determine Home Health Agency Cost Limits: Beginning July 1, 1989 (July 1, 1988, in OBRA-87), the HHS Secretary is to utilize, for home health agencies cost limits, a wage index that is based on verified data (audited data in OBRA-87) obtained by home health agencies. The amendment will penalize agencies that refuse to provide data or deliberately provide false data.

Section 411—Home Health Prospective Payment Demonstration: The effective date for the demonstration has been changed to begin on April 1, 1989, rather than July 1, 1988.

Section 411—Training for DME Suppliers: All durable medical equipment (DME), whether provided by a home health agency or a DME supplier, must be furnished by individuals who have met training standards set by HHS. The 1987 budget reconciliation law required only home health agencies providing DME to meet the standard.

HOME HEALTH LEGISLATION 1987

OMNIBUS BUDGET RECONCILIATION ACT OF 1987 (P.L. 100-203)

Section 4001—Gramm-Rudman-Hollings: The reduction to home health agencies under the Gramm-Rudman-Hollings sequestration was in effect only until December 31, 1987. The sequester was continued for inpatient hospital services and physician services until March 31, 1988.

Section 4024—Homebound Requirement: Clarifies that an individual does not have to be bedridden to be homebound. Includes those whose ability to leave home without assistance or supportive device is restricted due to illness. Clarifies that limitations on individuals' absences from home do not apply to absences for the purposes of medical treatment. Absences must be infrequent, of short duration and require considerable effort by the beneficiary.

Section 4032—Denials and Reconsiderations of Claims for Home Health Services: Effective with claims received on or after January 1, 1988, the intermediary must furnish the provider and beneficiary promptly with a written explanation of the denial and of the statutory and regulatory basis for the denial. Effective with claims filed on or after October 1, 1988, the HHS Secretary shall take into account, when evaluating fiscal intermediaries and carriers, whether or not they process 75 percent of reconsiderations within 60 days, and 90 percent of reconsiderations within 90 days, and the extent to which determinations are reversed on appeal.

Section 4035—Publication and Notification of Policies: No rule, requirement or other statement of policy that establishes or changes substantive legal standards governing the scope of benefits; the payment for services; or the eligibility of individuals, entities or organizations to furnish or receive services shall take effect unless it is promulgated by the HHS Secretary by regulation. The HHS Secretary shall publish in the Federal Register, not less frequently than every three months, a list of all manual instructions, interpretative rules, statements of policy and guidelines of general applicability. Effective June 1, 1988, each fiscal intermediary and carrier shall make available to the public all interpretative materials, guidelines and clarifications of policies that relate to payment for such benefits.

Section 4037—Medicare Hearing and Appeals: Hearings will be conducted by administrative law judges (ALJ) under the Social Security Administration until September 1, 1988, or upon receipt by Congress of a report regarding the administrative review hearings by the Secretary, whichever is earlier. This study, to focus on whether telephone hearings allow for a full and fair evidentiary hearing, is due six months after enactment.

Section 4039(e)—Moratorium on Home Health Prior Authorization: Prohibits the HHS Secretary from implementing a national program of voluntary or mandatory prior authorization for home health and post-hospital extended care services claims until six months after Congress receives final results of the Administration's evaluation of studies required by OBRA (1986). The report is due February 1, 1989; therefore implementation could not be prior to July 1, 1989.

Section 4026—Study of Urban/Rural HHA Cost Limits: The HHS Secretary must study and report to Congress by June 1, 1988, whether cost limits for home health agencies (HHA) located in rural and urban areas accurately reflect cost differences and the appropriateness of modifying the limits to take into account the proportions of patients from urban and rural areas.

Section 4026—Data Used to Determine HHA Cost Limits: In determining the cost limits, the HHS Secretary is required to utilize a wage index that is based on audited wage data obtained from HHAs, not hospitals. Such audited data cannot be from cost reporting periods before July 1, 1985.

Section 4027—Home Health Prospective Payment Demonstration: The HHS Secretary will provide for a demonstration project to develop, test and evaluate various methods of paying HHAs on a prospective basis. The project shall be designed in a manner to enable the HHS Secretary to evaluate the effects of various methods of prospective payments (including payments on a per-visit, per-case, and per-episode basis) on program expenditures, as well as beneficiaries' access to quality care. An interim report is due to Congress within one year after enactment. A final report is due four years after enactment. The demonstration is to begin no later than July 1, 1988.

Section 4021—Home Care Quality:

1. Conditions of Participation—Beneficiary Rights

Informed. Beneficiaries have the right to be fully informed in advance about the care and treatment to be provided by the agency. Beneficiaries will have the right to participate in the planning of care and treatment and any changes that might occur. Family members of those judged incompetent would be consulted.

Grievances. Beneficiaries have the right to voice grievances about care without reprisals.

Confidentiality. Clinical records will be confidential to ensure appropriate release or review under federal or state law.

Property. Beneficiaries have the right to have their property treated with respect.

Informed of All Services and Any Other Services Provided by the Federal Government. Beneficiaries must be informed, orally and in writing, about all items and services to be provided, the availability and extent of coverage for those items and the costs for services for which the beneficiary is responsible. This information must be provided prior to the beneficiary's care by the agency.

Informed of Rights and Obligations. HHAs would be required to notify beneficiaries of their rights and obligations under the Medicare statute, in writing and in advance of start of service. This includes the right to be informed about Medicare costs, charges and coverage, as well as their right to appeal any denial.

2. Conditions Relating to Agency Administration

Notification of Changes in Ownership and Management. HHAs will be required to notify the state agency responsible for their licensure of changes in ownership or management of the agency. This information should be considered as part of the licensure process, in particular with regard to those decertified as part of other health care facilities, or those previously convicted of fraud.

Durable Medical Equipment and Supplies. With respect to durable medical equipment furnished to individuals for whom the agency provides items and services, suppliers of such equipment may not use any individual who does not meet minimum training standards established by the HHS Secretary by October 1, 1988, for the demonstration and use of any such equipment.

Inclusion of Plans of Care in Records. Mandates the inclusion of plans of care in beneficiaries' records to ensure the maintenance of the most complete and accurate clinical records possible.

Compliance with Laws and Regulations and Professional Standards. Requires that all HHAs provide services in accordance with all relevant professional standards and principles.

3. Conditions Relating to Provision of Service

As a condition of participation, by January 1, 1990, non-licensed health care professionals (home care aides) will have to (a) have completed or be enrolled in and making progress towards completion of a training program that meets minimum standards and (b) must be competent to provide such services. HHAs would have to provide regular review and in-service education so as to assure competency.

The minimum standards to be established by the HHS Secretary no later than October 1, 1988, would have to include: (a) requirements regarding the content of the training curriculum, (b) minimum hours of training, (c) the qualification of training instructors and (d) the procedures by which competency is to be determined. These standards are not meant to supersede any state requirements.

The above standards may permit recognition of training programs, either within or by other agencies, so long as those agencies have not been out of compliance with all Medicare conditions of participation within the previous two years. Medicare certification—which can be awarded even when an agency has not met all participation requirements—is not sufficient to grant recognition of a program offered by the agency. Those individuals who completed a training program prior to January 1, 1989, may be deemed as completing an HHS program, if the program offered met the standards under this section at that time.

Standards for determining the level of competency should receive careful consideration by the HHS Secretary. The individual must be competent to perform only those tasks for which he or she is responsible, such as turning the patient, or transferring him or her from the bed to a wheelchair. The HHS Secretary is not precluded from allowing HHAs in the establishment of a minimum standard, as part of an HHS-approved training program, to determine on their own decisions regarding competency; however, the HHS Secretary must include specific methods (such as HHS review) for ensuring that competency determinations made by the agencies about their own aides are accurate and in compliance with HHS standards.

Section 4022(a)—Standard Survey: Each HHA shall be subject to a standard survey performed without notice and up to, but not beyond, 15 months after the previous survey. The statewide average may not exceed 12 months. The survey shall be conducted by an individual who meets minimum requirements established by the HHS Secretary not later than July 1, 1989. Survey agencies would be allowed to survey within two months after any change in agency's ownership, management or administration. This is not mandated; however, a survey is required

to be conducted when a significant number of complaints are reported to any appropriate federal, state or local agency.

The content of the survey would be based on protocol that is developed, tested and validated by the HHS Secretary no later than January 1, 1989. The protocol must include visits to a sample number of beneficiaries in their homes. (These visits are to be used to evaluate the qualitative impact of services provided on the functional capacity, as reflected in their plans of care. Agencies do not have to demonstrate that the services provided resulted in a complete recovery of the beneficiary, but that quality care should result in the highest possible functional capacity given the restraints of the beneficiary's illness or injury.)

To ensure that individual assessments are conducted accurately and effectively, the HHS Secretary must provide for the training of federal, state and local surveyors.

Section 4022(b)—Extended Survey: Each HHA that is found, under a survey, to have provided substandard care, shall be subject to an extended survey, not later than two weeks after the completion of the standard survey. The HHS Secretary must develop protocol for an extended survey, including at a minimum, a review of the agency's compliance with all of the Medicare conditions of participation.

Section 4023—Enforcement: Decisions about enforcement would begin with the HHS Secretary's determination about the type of deficiency, based upon findings of standard, extended or partial survey, or an investigation of complaints.

Deficiency jeopardizes the health and safety. If the health and safety of beneficiaries are determined by the HHS Secretary to be immediately jeopardized, the Secretary may: (1) appoint temporary management to oversee the operation of the agency or (2) terminate the agency's certification of participation. Temporary management would remain in place until such time as the HHS Secretary determines that the agency has a management in place to comply with all relevant requirements. Termination would mean denial of all existing and new beneficiary claims.

The HHS Secretary also is authorized to provide for intermediate sanctions, including civil monetary penalties.

Deficiency does not jeopardize the health and safety. When deficiencies are not found to be jeopardizing to health and safety of beneficiaries, the HHS Secretary may impose one or more intermediate sanctions for no longer than six months. If the agency still has not come into compliance in this time, certification will be terminated.

Payments may be made during this six-month period if three conditions are met: (1) the surveying agency finds it more appropriate to take alternative action rather than terminate; (2) the agency submits and the HHS Secretary approves of a plan of corrective action; and (3) the agency agrees to repay any payments received if corrective action is not taken in accordance with the plan.

The HHS Secretary has the authority to develop and implement additional sanctions (civil monetary penalties, suspensions of Medicare payments and temporary management).

Section 4025—Maintenance of Toll-Free Hotline and Investigative Unit: Surveying organizations will be required to establish and maintain a toll-free hotline for complaints and questions. They also will be required to maintain a unit to investigate complaints. Such a unit will possess enforcement authority, including data collection authority. Data collection may

include survey and certification data and patient medical records, but with patient consent only.

Section 4079—Community Nursing and Ambulatory Care on Prepaid, Capitated Basis: Requires the HHS Secretary to conduct demonstrations in at least four sites of community nursing and ambulatory care services furnished on a prepaid, capitated basis. Projects would begin no later than July 1989, and would be conducted for a period of three years. The HHS Secretary is required to report to Congress no later than January 1, 1992.

Section 4009(e)—Waiver of Inpatient Limitations for Connecticut Hospice: Provides that the existing two-year waiver from the 20-80 percent inpatient-home care day requirement is permanently waived.

Section 4039(f)—Delay in Publishing Regulations with Respect to Deeming the Status of Home Health Agencies: The HHS Secretary is prohibited from publishing earlier than six months after publication of proposed regulations, final regulations providing that an entity may be deemed a home health care agency for the purposes of Medicare on the grounds that it has been certified by a private accreditation agency.

Section 4114—Medicaid Waiver for Hospice Care for AIDS Patients: Provides, for Medicaid services only, that a hospice may be allowed to exclude days of inpatient care provided to individuals with AIDS from the days counted towards the 20 percent inpatient day limit. The HHS Secretary is required to establish procedures for making this allowance.

Section 4102—Home- and Community-Based Services for the Elderly: Establishes a new state waiver authority, separate from the existing "2176" waiver authority under the Medicaid program. Payments may be made for part or all of the cost of home- or community-based services (other than room and board), approved by the HHS Secretary, that are provided pursuant to a written plan of care to individuals 65 years or older, with respect to whom there has been a determination that institutionalization would be required in the absence of such services.

OLDER AMERICANS ACT AMENDMENTS OF 1987 (P.L. 100-175)

Section 140—Creates a new Part D of Title III, In-Home Services for Frail Elderly. Services include homemaker and home health aide, visiting and telephone reassurance, chore maintenance, in-home respite care and adult day care as a respite for families, and minor modification of homes. Frail elderly individuals are defined as those having a physical or mental disability, including Alzheimer's disease or a related disorder with neurological or organic brain dysfunction that restricts their ability to perform daily tasks or threatens their capacity to live independently.

Section 141—Creates a new Part E of Title III, Assistance for Special Needs. Activities include transportation, outreach, targeting services to those with the greatest economic or social need, long-term care ombudsman services, and other services where there is unmet need.

Section 143—Creates a new Part F of Title III, Preventive Health Services. The services include: routine health screening; group exercise programs; home injury control services, including screening of high-risk home environments and educational programs on injury

protection in the home environment; nutritional counseling and educational services; screening for the prevention of depression, coordination of community mental health services, educational activities, and referral to psychiatric and psychological services; educational programs on the benefits and limitations of Medicare and various supplemental insurance coverage, including individual policy screening and health insurance-needs counseling; and counseling regarding follow up health services based on any of the services provided for above.

Section 144—Creates a new Part G of Title III, Prevention of Abuse, Neglect and Exploitation of Older Individuals.

Section 602—Establishes a two-part grant program for home care services under the Public Health Service Act. Part I, Health Care Services in the Home, provides in-home health services to help low-income individuals avoid institutionalization or prolonged hospitalization. Part II, establishes grants for in-home services for individuals with Alzheimer's disease or related disorders.

HOME HEALTH LEGISLATION 1985—1986

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (P.L. 99-272)

Section 9123—Increased payment in daily rates for hospice care; eliminated sunset provision of the program.

Section 9205—Extended presumption of waiver of liability for home health agencies.

Section 9502—Modified requirements for waiver provisions for home- and community-based care.

Section 9503—Added hospice care as an optional Medicaid benefit.

Section 9508—Revised requirements for optional targeted case management services.

Section 9520—Required HHS to establish a task force regarding alternatives to institutional care for technology-dependent children.

Section 9601—Required HHS to establish a task force on long-term health care policies.

SIXTH OMNIBUS BUDGET RECONCILIATION ACT OF 1986 (P.L. 99-509)

Section 9315—Required HHS to restore the aggregated method of applying the home health cost limits; also required that cost limits be based on the most recent data available. Cost limits also must take into account costs of current billing and verification procedures, as appropriate. GAO is to study the relative merits of applying the cost limits on a per discipline or an aggregate basis.

Section 9305(g)—Extended presumption of waiver of liability to "technical denials" (i.e., denials because beneficiaries did not meet the homebound requirement or did not have a need for intermittent skilled care). New favorable presumption for technical denials is in addition to the existing favorable presumption for claims that are not medically necessary or are for custodial care.

Section 9305(f)—Presumption of waiver also was extended to hospices for claims denied on the basis of medical necessity.

Section 9353(e)—Extended PRO review to home health agencies. PROs will review home health services and complaints.

Section 9305(h)—HHS must develop a uniform needs assessment to evaluate an individual's

functional capacity and available resources to meet those needs.

Section 9305(k)—HHS must implement four demonstration projects regarding prior and concurrent authorization for home health services.

Section 9305(a)—HHS is required to develop guidelines and standards for hospital discharge planning.

Section 9313(a)—Clarified that providers may represent Medicare beneficiaries in appeals of denied claims.

Section 9311—Maintains periodic interim payment for home health agencies while eliminating it for hospitals under prospective payment. Established deadlines for payment of "clean" Medicare claims, with interest required when deadlines are not met.

Section 9305(i)—HHS is required to include in prospective payment reports information on the adequacy of quality assurance procedures for post-hospital services.

Section 9313(b)—Allows Medicare beneficiaries to appeal denials for home health services that do not meet the homebound and intermittent care requirements.

Section 9337—Extended Part B coverage to occupational therapy services furnished by an independently practicing therapist in the therapist office or beneficiary's home.

Section 9341—Specified that national coverage determinations are not subject to review by an administrative law judge and limited judicial review. Also added carrier and judicial review of a Part B claim.

Section 9342—HHS must conduct between 5 and 10 demonstration projects to determine the cost and effectiveness of providing comprehensive services including case management, respite care and other in-home services to Medicare beneficiaries with Alzheimer's disease or related disorders.

Section 9408—Permits states to provide optional coverage of respiratory care services at home to ventilator-dependent individuals without having to provide the same amount, duration and scope of services to other Medicaid beneficiaries.

Section 9411—Extended eligibility for home- and community-based services under Medicaid waiver authority to all individuals who, but for such services, would require institutional care which could be reimbursed under Medicaid. States may target waived services to groups by illness (e.g., AIDS) or condition (e.g., chronic mental illness, ventilator dependency).

Section 9435—Clarified rules for hospice payment for individuals who are eligible for both Medicare and Medicaid.

HOME HEALTH LEGISLATION 1984

DEFICIT REDUCTION ACT OF 1984 (P.L. 98-369)

Section 2321—Established a 20 percent beneficiary deductible for durable medical equipment provided by a home health agency.

Section 2336—Permitted physicians who have a financial interest in a sole community home health agency to carry out certifications and plan of care functions for patients served by the agency under certain circumstances. Also deleted uncompensated officers or directors from the list of disqualified physicians.

Section 2343—Allowed a waiver of the hospice "core services" requirements if the hospice has shown good faith in trying to hire its own nurses.

Section 2348—Reduced period in which Medicare would pay for services provided to beneficiaries following termination of participation agreements with home health agencies or hospices.

OLDER AMERICANS ACT AMENDMENTS OF 1984 (P.L. 98-459)

Authorized funds to address the increasing demands for in-home services; required the Commissioner on Aging to establish linkages with peer review organizations to strengthen the involvement of the Administration on Aging in the development of policies relating to community-based long-term care.

INDIAN HEALTH CARE IMPROVEMENT ACT (S. 2166)

Expanded Indian Health Service facilities eligible for Medicare reimbursement to include (in addition to hospitals and skilled nursing facilities) health centers, clinics and home health services.

PAYMENT RATE FOR HOSPICE ROUTINE HOME CARE AND OTHER SERVICES (H.R. 5386)

Increased hospice payment rate for routine home care.

PREVENTIVE HEALTH SERVICE AMENDMENTS (P.L. 98-555)

Authorized grants and loans to meet initial costs of establishing and operating home health services in areas in which those services are inadequate, or not readily accessible. Funds also were approved for training programs for paraprofessionals to provide home health services.

HOME HEALTH LEGISLATION 1983

ORPHAN DRUG ACT (P.L. 97-414)

Section 6(b)—Required a report to Congress on the results of studies currently evaluating home- and community-based services.

Section 6(c)—Required analysis of results of studies on alternative reimbursement methodologies for home health services.

Section 6(d)—Required investigation of methods to stem fraud and abuse in Medicare and Medicaid home health programs; also required report to Congress.

Section 6(e)—Required demonstrations to test—(1) methods for identifying patients at risk of institutionalization who could be treated more cost effectively in a home health program, including hospitalized Medicare patients who are candidates for early discharge due to availability of home health services, and persons in the community who could avoid institutionalization if they had access to home health services; and (2) alternative reimbursement methodologies for home health agencies to determine the most cost-effective and efficient way of providing home health services, including fee schedules, prospective reimbursement and capitation payments.

HOME HEALTH LEGISLATION 1982

TAX EQUITY AND FISCAL RESPONSIBILITY ACT OF 1982 (P.L. 97-248)

Section 105—Requires the HHS Secretary to issue regulations establishing a single reimbursement limit for home health agencies, based on the costs of freestanding facilities, and provided for exceptions.

Section 134—Expanded state ability to cover under Medicaid certain disabled children age 18 or under who live at home. Provision applies to children who would have been eligible for SSI and hence Medicaid, if they had been institutionalized.

Section 122—Provided Medicare Part A coverage of hospice services.

HOME HEALTH LEGISLATION 1981

OMNIBUS BUDGET RECONCILIATION ACT OF 1981 (P.L. 97-35)

Section 2122—Eliminated occupational therapy as a basis for initial entitlement to home health benefits.

Section 2144—Reduced Medicare reimbursement limits applied to home health agencies from the 80th to the 75th percentile, or such comparable or lower limit as the HHS Secretary may determine.

Section 2176—Provided for Medicaid waivers to provide home- and community-based services for certain individuals.

HOME HEALTH LEGISLATION 1980

OMNIBUS RECONCILIATION ACT OF 1980 (P.L. 94-499)

Section 930—Provided for coverage under Medicare of unlimited home health visits; eliminates the three-day prior hospitalization requirement for home health services under Part A; eliminates the \$60 deductible for home health services under Part B; includes the need for occupational therapy as qualifying criteria for home health benefits; allows proprietary home health agencies in states without licensure laws to participate in Medicare; eliminates the authority of HHS to establish additional standards solely on the basis of the tax status of an agency; provides authority for HHS to require bonding or the establishing of escrow accounts to the extent necessary; and requires HHS to establish regional intermediaries for home health agencies.