

**NATIONAL ASSOCIATION FOR HOME CARE & HOSPICE  
LEGISLATIVE PRIORITIES FOR 2005**

**TABLE OF CONTENTS**

Key Legislative Priorities January 2005 .....	1
Enact A Comprehensive, High Quality Home- and Community-Based Long-Term Care Program .....	5
Establish Meaningful Standards for Long-Term Care Insurance .....	7
Establish a Home- and Community-Based Waiver-Type Program Under Medicare.....	9
Develop Quality of Care Standards for Consumer-Directed Care .....	10
Ensure Patients’ Rights in Managed Care Plans .....	12
Promote Respite Care for Family Caregivers .....	14
Support an Increase in the Federal Medicaid Match (FMAP) and Oppose Caps on Federal Payments.....	16
Ensure Appropriate Medicaid Rates for Home Care and Hospice .....	17
Support Timely Implementation of ADA Compliance Measures in State Medicaid Programs.....	19
Closely Monitor Efforts to Develop Performance-Based Payment for Medicare Home Health Services .....	20
Oppose Copayments for Medicare Home Health Services.....	21
Oppose Cost-Sharing by Medicaid Beneficiaries .....	24
Reject Medicaid Waivers that Reduce Benefits for Current Beneficiaries .....	25
Reject Risk-Sharing Under Home Health PPS.....	27
Oppose Proposals to “Bundle” Home Health and Hospice Benefit Payments with Payments to Other Providers .....	28
Rescind Competitive Bidding for Home Medical Equipment .....	29

Restore the Full Market Basket Updates for Home Health Payments .....	30
Ensure Continued Care Access for Rural Patients and for Patients in Medically-Underserved Areas Under PPS .....	31
Fully Reimburse Home Health Agencies for Costs of Implementing OASIS; Streamline OASIS Collection and Reporting Requirements .....	32
Allow Flexibility in the Delivery of Home Health Services Under the Medicare Prospective Payment System .....	34
Limit Retroactive Recoveries Related to the Implementation of Medicare PPS .....	35
Ensure an Equitable PPS with an Adequate Case-Mix Adjustor .....	36
Provide Sufficient Home Care and Hospice Payments so that Agencies can Provide Appropriate Wages and Benefits to Clinical Staff.....	37
Improve Application of Wage Index for Medicare Home Health and Hospice .....	38
Support Health Reform Proposals That Provide Affordable Health Insurance to Uninsured Low-Wage Workers .....	39
Allow Physicians' Assistants and Nurse Practitioners to Certify Medicare Home Health Plans of Care .....	41
Recognize Telehomecare as a Bona Fide Medicare Service .....	42
Cover Appropriate Self-Care Technologies.....	44
Provide Financial Assistance to Home Care Agencies to Implement Electronic Capabilities ....	45
Enact Home Care Specific Anti-Fraud Measures .....	46



# **NATIONAL ASSOCIATION FOR HOME CARE & HOSPICE (NAHC)**

## **Key Legislative Issues for Today and Tomorrow**

**January 2005**

As the US approaches the beginning of the baby boom generation's movement into retirement, all demographics point to an overwhelming demand for health care services. The combined need for continued acute care services with an expanding need for care of chronic illnesses will tax an already stressed system. Home care and hospice present themselves as viable means to efficiently and effectively meet these needs.

The nation's governors have identified the country's long term care system as in urgent need of reform; increased availability of home- and community-based care must be part of the solution. In addition, the Administration's aggressive pursuit of expanded availability of home and community-based services for the disabled as the result of the US Supreme Court decision in *Olmstead* underscores the vital role of hospice and home care in our nation's health care system.

Despite the apparent future, the Medicare home health benefit has been seriously eroded and access to care has become a concern, particularly for patients with care-intensive needs. Data from the Centers for Medicare & Medicaid Services (CMS) indicate that in the three years following implementation of the Balanced Budget Act of 1997 (BBA), the number of Medicare beneficiaries receiving home health services annually dropped by about 1 million, or nearly 30 percent. The Medicare Payment Advisory Commission (MedPAC) estimates that in the first calendar year (2001) following implementation of the prospective payment system (PPS), an additional 300,000 beneficiaries lost home health services annually. Starting in October 1997, the number of Medicare-participating home health agencies dropped by more than one-third. While most recently there has been some very limited growth in Medicare beneficiary utilization and the number of home health agencies, both remain far short of the levels of a decade ago.

In recent years MedPAC has reported to Congress double-digit profit margins for Medicare home health agencies. However, broader study conducted by the National Association for Home Care & Hospice indicates that the average Medicare profit margin is 1.53 percent. In its March 2005 Report to Congress, MedPAC found the home health prospective payment system deficient in a number of areas, including the fact that there is wide variation in costs within payment groups and that certain patient characteristics not used to determine payment amounts may have a great impact on agency care costs. It is clear that the upheaval that began with the BBA has continued into the new payment system, and that the stability that the industry has sought over the last few years has not materialized. At the same time, agencies are experiencing record difficulty in recruiting and retaining staff needed to adequately serve the growing population of disabled and elderly patients. Hospices and home health agencies are hard pressed to compete with other health care employers that offer better wages, better benefits, lighter workloads, and better hours.

To meet increasing regulatory demands, incorporate necessary efficiencies, and provide the highest possible quality of care, agencies must avail themselves of the latest technological advances to streamline operations and incorporate cutting-edge care techniques. However, agencies continue to experience difficulties in gaining access to necessary capital.

These are the challenges facing home care and hospice in the early 21st century, and the context within which the National Association for Home Care & Hospice (NAHC) has chosen the following issues as the focus of its legislative activities during the year 2005. Central to NAHC's mission is to preserve and expand access to home- and community-based care; to ensure an adequate supply of skilled workers to provide that care; and to protect the rights of both patients and providers.

## **PRESERVE AND EXPAND ACCESS TO HOME- AND COMMUNITY-BASED SERVICES.**

### **A. Enact a comprehensive long-term care system and expand access to home- and community-based services by:**

- Enacting a comprehensive home- and community-based long term care program;
- Establishing meaningful long-term care insurance standards;
- Establishing a home- and community-based waiver program under Medicare;
- Developing quality of care standards for self-directed care;
- Ensuring patient choice in Medicare managed care plans;
- Promoting respite for family caregivers;
- Increasing federal Medicaid payment to states and requiring Medicaid coverage of and reasonable reimbursement for home care, hospice, and personal care services; and
- Establishing increased federal matching to states for programs to encourage home care.

### **B. Reject reform proposals that threaten existing access to care by:**

- Closely monitoring efforts to develop performance-based payment for Medicare home health services;
- Opposing cost-sharing for home health or hospice services;
- Rejecting Medicaid waivers that reduce benefits for current beneficiaries;
- Rejecting any proposed profit or loss (risk) sharing under the home health PPS;
- Opposing proposals to bundle home health and hospice payments with payments to other providers; and
- Rescinding home medical equipment (HME) competitive bidding.

### **C. Address inequities in the Medicare home health PPS by:**

- Restoring the full market-basket update and extending the rural add-on;
- Fully reimbursing home health agencies for costs of implementing OASIS; streamlining OASIS collection and reporting requirements;
- Allowing flexibility in the delivery of home health services under the Medicare prospective payment system;
- Limiting retroactive recoveries related to the implementation of Medicare home health PPS; and
- Ensuring an equitable PPS with an adequate case-mix adjustor.

### **ENSURE AN ADEQUATE SUPPLY OF QUALIFIED HOME CARE AND HOSPICE CAREGIVERS BY:**

Providing sufficient home care and hospice payments so clinical staff get appropriate wages and benefits and enacting a wage-related pass-through under Medicare and Medicaid;

- Improving the application of the wage index for Medicare home health and hospice services;
- Supporting proposals that provide affordable health insurance for uninsured, low-wage workers; and
- Allowing nurse practitioners and physicians' assistants to sign home health plans of care.

### **ENCOURAGE THE USE OF ADVANCES IN TECHNOLOGY TO STREAMLINE OPERATIONS AND IMPROVE PATIENT CARE BY:**

- Recognizing telehomecare as a bona fide Medicare service and instituting a pass-through for improvements in computerization of patient care;
- Covering appropriate self-care technologies; and
- Providing investment support for technological advances that are instrumental in delivery of the highest quality of care.

## **FIGHT FRAUD UNDER FEDERAL HOME CARE AND HOSPICE PROGRAMS BY:**

- Establishing minimum qualifications for home health agency and hospice administrators;
- Expanding guidance from the OIG regarding “best practices”; and
- Creating “peer group” councils of health care providers to advise HHS, CMS, and the OIG on noncompliant practices and to establish enforcement action priorities.

## 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.

**RECOMMENDATIONS:** 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 any recommendations:

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.

Home care providers should not be held responsible for providing long-term and chronic care to individuals unless there are clear federal coverage standards and financing.

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; and 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. The requirements contained in the Medicare Conditions of Participation for home health and hospice should be applied to the delivery of in-home skilled 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 as well as provided with 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 is 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.

## 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. According to the American Health Insurance Plans (AHIP) latest survey, about 9.16 million long-term care insurance policies had been sold by 2002. About 18 percent were sold through employer-sponsored group plans.

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.

**RECOMMENDATION:** Congress should amend the “Health Insurance Portability and Accountability 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 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.

## **ESTABLISH A HOME AND COMMUNITY-BASED WAIVER-TYPE 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 in the home, and most elderly and disabled individuals would prefer to be cared for in the comfort of their homes. Despite these facts, use of the home health benefit under Medicare has dropped precipitously in recent years. In June 2003 the Medicare Payment Advisory Commission (MedPAC) reported that many patients that previously would have been cared for in the home under Medicare are now being served in skilled nursing facilities (SNF). The average cost of a home health care stay is currently around \$4,000, while the average Medicare SNF stay costs about \$8,300.

**RECOMMENDATION:** The Congress should authorize a home and community-based waiver-type demonstration program under Medicare which 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.

**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 legislation provided 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.

## **DEVELOP QUALITY OF CARE STANDARDS FOR CONSUMER-DIRECTED CARE**

**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 are too often driven by cost savings considerations rather than patient needs.

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 bloodborne pathogen standard, because the workers are not considered to be employees of organizations which are bound to follow OSHA rules.

**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 option to choose among service models (consumer-directed, home care agency, etc.) to ensure individual freedom of choice. States should also provide a mechanism for resolving any problems which 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. 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 PATIENTS' RIGHTS 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. In the first session of the 107th Congress, the House passed patients' rights legislation to address managed care abuses. The Senate did not pass patient rights legislation during 2002. No action was taken by either the House or Senate in the 108th Congress. 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 payors 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; and
- In the long run, managed care can reduce quality of care by curbing the development and use of new medical technology.

**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. Consumer education should include a clear understanding of any cost sharing requirements or other limitations on services under the managed care plan. To secure many of these goals, a national patient bill of rights should be enacted.

**RATIONALE:** The rapid growth in health costs and the nation's economic woes have led both public and private payors 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. 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.

## 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, there are approximately 22.4 million Americans who care for a loved one, over 50 years of age, who is chronically ill or disabled. When caring for persons of all ages, the National Family Caregivers Association published a report in 2000 that stated that 54 million people had been involved in some level of caregiving. Nearly two-thirds of all home care services are provided by family caregivers, with an estimated market value of over \$190 billion a year.

Persons providing such caregiving are burdened by many responsibilities and demands associated with providing long-term care to a disabled relative or friend. Such problems include limitations on one's personal life, the competing demands of financial obligations and work conflicts, the care recipient's emotional and physical demands, as well as emotional, financial and family strains.

A provision included in the Medicare Catastrophic Coverage Act of 1988 provided for a limited respite care benefit under the Medicare home health benefit. That provision, however, was lost when the law was repealed.

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 from their caregiving responsibilities. In February 2001, Secretary Tommy G. Thompson announced the release of \$113 million in grants to states to begin implementing this program. During the 108th Congress S. 538, "Lifespan Respite Care Act of 2003" was introduced but not enacted. The bill defines lifespan respite care service. During the 108th Congress, the Omnibus Appropriation's bill included \$157 million for family caregivers, an increase of \$4.3 million above last year's appropriation (HR 4818, Conference Report 108-345).

**RECOMMENDATION:** Congress should include in-home respite care in the Medicare home health benefit. Legislation should be enacted that would expand the respite care provision by allowing for more hours and less restrictive eligibility criteria. The persons providing this care should be adequately trained and supervised. In addition, Congress should enact legislation that would provide respite care outside the Medicare program.

**RATIONALE:** Friends and family caregivers provide the bulk of long-term care services to their elders with little support from public programs. Instead of public policies that create disincentives for families to provide care for their disabled relatives, policies should be developed that promote caregiving by supporting the development of services designed to provide relief to family members and other unpaid helpers. Available data indicates that families tend to purchase services only when the responsibility of care becomes too great for them to handle or when they become exhausted.

Furthermore, researchers have found little evidence that policies aimed at providing formal services to caregivers and care recipients encouraged caregivers to substitute paid care for care by friends and family. Respite care is especially important for individuals residing in rural areas where fewer community resources are available.

The availability of respite care can mean the difference between continuation of in-home care and institutionalization. Experience with the implementation of even a small-scale respite benefit can provide critical information about issues such as administration, appropriate eligibility criteria and quality assurance. This information will be essential to the future development of a more comprehensive long-term care benefit.

## **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, the President 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 the President'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.

In 2005 Medicaid advocates and governors are expected to oppose proposals to cut federal assistance for state Medicaid programs, while the President likely will be promoting his Medicaid proposal to impose federal caps again.

**RECOMMENDATION:** Congress should increase the federal match for state Medicaid programs and thus bolster efforts to bring states into compliance with the Olmstead decision.

**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. Early data 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. Forty-seven states have reported Medicaid-related budget problems.

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 the inaccessibility to services reaches a high enough level to gain political attention.

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. 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.

## **SUPPORT TIMELY IMPLEMENTATION OF ADA COMPLIANCE MEASURES IN STATE MEDICAID PROGRAMS**

**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, the administration has 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 alternative.

**RECOMMENDATION:** 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.

**RATIONALE:** After five 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.

## **CLOSELY MONITOR EFFORTS TO DEVELOP 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’s now gaining the attention of federal policymakers. The Medicare Payment Advisory Commission (MedPAC) is examining options for devising a “pay for performance” system that could be applied to home health payments.

**RECOMMENDATION:** Congress should closely monitor efforts to develop P4P for Medicare home health services and ensure that any system developed in this area:

1. Be tested as a pilot program prior to full-fledged implementation;
2. Fairly assesses the quality of care provided to home health patients and incorporate pending OASIS changes;
3. Does not negatively affect patient access to care;
4. Is consistent with the home health PPS and appropriately risk-adjusted;
5. Limits any expansion of data collection requirements and full reimburses agencies for the costs of any additional data collection requirements that are imposed;
6. Only rewards agencies for care elements over which they have some control; and
7. Makes use of new financing to create an incentive pool rather than withholding a portion of existing payments.

**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 is in the process of developing refinements to the existing PPS for home health; it may be another year or two before these refinements are completed and applied. 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. Application of any P4P model must be approached very cautiously to ensure that incentives are properly and fairly crafted.

## OPPOSE COPAYMENTS FOR MEDICARE HOME HEALTH SERVICES

**ISSUE:** Copayments for Medicare home health services have been advanced in Congress as a means of deficit reduction as well as a means of limiting the growth of Medicare home health expenditures. Some Medicare Advantage plans have imposed home health copays. Copays are regressive, inefficient and fall most heavily on the poorest and oldest Medicare beneficiaries.

**RECOMMENDATION:** Congress should oppose any copay proposal for Medicare home health services and should prohibit Medicare Advantage plans from charging a home health copay.

**RATIONALE:** A copayment would create a significant barrier for those in need of home care and lead to increased use of more costly institutional care.

Congress modernized the home health benefit by eliminating copays in 1972 and a home health care deductible in 1980 to encourage use of less costly, noninstitutional services. The Urban Institute's Health Policy Center concluded that 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." ("A Preliminary Examination of Key Differences in the Medicare Savings Bills," 7/13/97.)

Since implementation of the home health care prospective payment system, there have been substantial declines in use of home health care, increases in use of more expensive skilled nursing facilities (SNFs) and other post acute providers, and some substitution of SNFs for home health services following hospital discharges. MedPAC Report, June 2003.) A home health copay would worsen this trend.

Copayments are an inefficient and regressive "sick tax" that would fall most heavily on the poorest and oldest Medicare beneficiaries.

About 70 percent of home health users are age 75 or older. More than half of all users are women and more than half have family incomes of \$15,000 a year or less. About 43% of home health users have limitations in one or more activities of daily living, compared with 9% of beneficiaries in general. (AARP, "Home Health Copayment Would Have Negative Consequences for Medicare Beneficiaries," 8/7/98.)

The Commonwealth Fund cautioned lawmakers 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. ("One-Third At Risk: The Special Circumstances of Medicare Beneficiaries with Health Problems," 9/01). The elderly already spend 22 percent of their income on health care; those in poor health spend 44 percent and those who are low-income women over 85 spend 52 percent. ("Medicare's Future: Current Picture, Trends and Prescription Drug Policy Debate," Updated Charts, Commonwealth Fund, 7/1/03.)

Seniors spend nearly twice as much of their income on their health care now than they did before Medicare began. (AARP, "Out of Pocket Health Spending by Medicare Beneficiaries Ages 65 and Older: 1997 Projection," 12/1/97.)

Even if Medicaid recipients with low incomes were exempted from the home health copay, a large percentage of them would be ineligible for protection from the home health copay because of the restrictive asset limitation, which has not been adjusted since 1989 and serves as a major barrier. (The Commonwealth Fund, "The Role of the Asset Test in Targeting Benefits for Medicare Savings Programs," October 2002.)

Home care patients and their families already contribute to the cost of their home care.

Elderly Medicare patients receiving the home health benefit pay about one-fourth of their home health care expenses out-of-pocket. Those over 85 pay 33 percent out of pocket. ("Personal Health Care Spending by Type of Service, Age Group, and Source of Payment Distribution," CMS, 1999.) Most elderly Medicare patients in need of home health services must also pay out of pocket for additional custodial home care in order to remain in their homes. ("Doing Without: The Sacrifices Families Make to Provide Home Care," Families USA, 7/94.)

Patients going on service for home health must pay 20 percent copay and the Part B deductible to retain the services of a physician who can order the home health plan of care and provide care plan oversight. They must pay a copay for home medical equipment. Many home health patients will also incur the hospital deductible and copays and the skilled nursing facility copays before becoming eligible for the home health benefit. The Commonwealth Fund estimated that the average Medicare beneficiary in 2000 spent \$1,470 for Medicare premiums and cost sharing exclusive of home health.

With hospital and nursing home 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 patients without family support. Family members are frequently trained to render semi-skilled support services for home care patients, which Medicare would have to pay for in the hospital or nursing home setting.

Copayments as a means of reducing utilization would be particularly inappropriate for home health care.

The number of Medicare beneficiaries receiving home health care annually dropped by 1.3 million between 1997 and 2002, resulting in a cumulative total of over 5 million fewer beneficiaries receiving home health services during this period. For 2005 it is expected that about 1.1 million fewer beneficiaries will receive home health care than in 1997. The average number of visits provided over a 60-day episode has dropped from 36 to 18. Since 1997 the home health benefit has dropped from about 9 percent of the Medicare program to 4 percent, and CMS projects that it will remain at 4 percent for the next ten years.

According to MedPAC, in the first full year of PPS, 300,000 fewer Medicare beneficiaries received home health services than in the previous year. This represents a 12 percent decline in the number of Medicare home health users in just one year.

Imposition of home health copayments should not be used for deficit reduction or to pay for other initiatives.

The Balanced Budget Act of 1997 intended to reduce projected spending on home health services by \$16 billion over five years. Instead, home health outlays were reduced by more than \$74 billion over the same time period.

Since 1997, home health spending has dropped by nearly half and CMS estimates of future growth have dropped dramatically.

Medigap coverage would not necessarily cover home health copays and would be too costly for most home care recipients.

Thirty-seven percent of Medicare recipients have no private supplemental insurance. (Congressional Research Service, "Medicare: The Role of Supplemental Health Insurance," 10/10/96, p.2). The law governing Medigap policies does not require that all models cover copays.

Copayments would impose an unfunded mandate on the states.

About 24 percent of all home care users, and 45 percent of long stay home care users (over 200 visits), are Medicaid-eligible. (Mauser and Miller, "A Profile of Home Care Users in 1992," Health Care Financing Review, Vol 160, Fall 1994, p. 20.)

Even if Medicaid recipients with low incomes were exempted, a home health copay would cause more Medicare recipients to "spend down" to become eligible for Medicaid under the "medically needy" program.

Copayments would be another federal administrative burden on providers and would 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 rebill. Also, unlike hospitals, there is no provision for bad debt from uncollected copays currently built into the base payment for home health care.

Nurses and home care aides might be placed in the position of having to collect copays, a task for which they are unsuited. They would have to carry large sums of money, increasing their exposure to robbery and muggings. Collecting copays in a person's home is not like a hospital or physician's office where clerical staff can handle billing and collection.

## **OPPOSE COST-SHARING BY MEDICAID BENEFICIARIES**

**ISSUE:** Over the past 20 years, Medicaid costs have skyrocketed, forcing many states to look for ways to increase revenues and cut program costs. In 1980, about 9 percent of each state's budget went to fund its portion of Medicaid, which accounts for the majority of state spending on health care. Health care spending now accounts for about 30 percent of total state budgets, with Medicaid costs alone accounting for 20 percent of total state expenditures (National Governors Association, Health Care Cost Containment, 2003).

**RECOMMENDATION:** Congress and state legislatures should oppose requiring Medicaid beneficiaries to pay copays for home care services.

**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.

## REJECT MEDICAID WAIVERS THAT REDUCE BENEFITS FOR CURRENT BENEFICIARIES

**ISSUE:** The Administration's new waiver policy, the Health Insurance Flexibility and Accountability Initiative (HIFA), is touted as a way for states to expand Medicaid and State Children's Health Insurance Program (SCHIP) coverage. However, it includes no new funds and gives 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 new 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 new 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 new 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.

**RECOMMENDATIONS:** Congress should pass legislation prohibiting implementation of HIFA. At a minimum, state officials should be required to provide full disclosure of waiver proposals and ample opportunity for all advocates and stakeholder to have real input in the design of waivers. Unfortunately, rather than promoting public participation, the new HIFA waiver policy includes an expedited federal review process that is likely to diminish public participation.

**RATIONALE:** Under the HIFA waiver proposal, 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 new 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.

## 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 new 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 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.

**RECOMMENDATION:** At this stage, Congress should reject any proposals to establish risk sharing under the new home health PPS.

**RATIONALE:** The currently applicable home health PPS case-mix adjustment system accounts for only about 30 percent of the variation in resource use. Additionally, the budget neutrality requirement for the first year of PPS artificially lowered PPS payment levels by requiring that they be based upon outlays for home health under the interim payment system. Finally, imposition of the "15 percent" cut in October 2002 and loss of the 10 percent rural add-on in April 2003 (with only partial replacement) have further strained agencies financially. As a result, there is widespread concern that existing payment levels will fall short of agencies' actual expenditures in serving patients. Further, 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. 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. Congress should, in the alternative, bolster the PPS so that high-cost care is more adequately compensated.

## **OPPOSE PROPOSALS TO “BUNDLE” HOME HEALTH AND HOSPICE BENEFIT PAYMENTS WITH PAYMENTS TO OTHER PROVIDERS**

**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 Prospective Payment Assessment Commission (the precursor to the Medicare Payment Advisory Commission). In recent years, the House and Senate Budget Committees have suggested bundling to authorizing committees as an option to achieve Medicare savings.

**RECOMMENDATIONS:** Congress should reject proposals to bundle home health payments into hospital DRGs or other provider payments because it would cause major disruption to the health care industry, be anti-competitive, increase the federal regulatory burden and erect a new and unnecessary barrier to beneficiaries’ access to quality care.

**RATIONALE:** The proposal would make hospitals or other providers responsible for arranging and financing post-acute home health and would combine home health payments into payments to other providers. This direction is inconsistent with the prospective payment system recently implemented for home health care.

Bundling home care payments into hospital DRGs 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. Only 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 would vastly increase the 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 two-track system will result in uneven Medicare coverage for patients with the same care needs as every hospital interprets and applies coverage rules differently. Many of these same arguments apply to proposals to bundle home health payments in with payments to other post-acute care providers.

## RESCIND COMPETITIVE BIDDING FOR HOME MEDICAL EQUIPMENT

**ISSUE:** The “Medicare Prescription Drug, Improvement and Modernization Act,” (P.L. 108-173) contains a provision that would phase-in the 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.

Specifically, the legislation phases-in implementation of competitive bidding starting 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) will be 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.

To provide some guidance, CMS was instructed to establish a Program Advisory and Oversight Committee (POAC) to help determine financial standards, requirements for data collection, and proposals for efficient interaction between manufacturers and suppliers. The POAC was appointed in September 2004. In addition, the Government Accountability Office (GAO) is required to report to Congress on a study examining competitive bidding by January 1, 2009.

**RECOMMENDATION:** Congress should support real competition and avoid fostering monopolistic markets by rescinding the competitive bidding provisions. At a minimum, Congress should closely monitor CMS’s implementation of the competitive bidding program to guard against unintended negative consequences to Medicare beneficiaries or suppliers.

**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.

## **RESTORE THE FULL MARKET BASKET UPDATES FOR HOME HEALTH PAYMENTS**

**ISSUE:** 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.

In 2000, Congress adjusted home health payments for (FY) 2001 so that agencies would receive the equivalent of a full market basket update.

In January 2003, the Medicare Payment Advisory Commission recommended that Congress freeze home health payment rates at the FY 2003 level for FY 2004. As part of HR1, 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.

**RECOMMENDATION:** Congress should fully restore the reductions in the market basket update for Medicare home health services scheduled in 2005 and 2006.

**RATIONALE:** As the result of the BBA, anticipated Medicare home health outlays were reduced by more than \$74 billion over fiscal years 1998 through 2002. This amount is far in excess of the \$16 billion reduction originally contemplated by the Congress, and has had a profound negative effect upon beneficiary access to care and home health agency viability. 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 have closed since implementation of the BBA. In calendar year 2000, one million fewer beneficiaries received home health services than in 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. Access to care continues to be a serious problem in home health. 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 CONTINUED CARE ACCESS FOR RURAL PATIENTS AND FOR PATIENTS IN MEDICALLY-UNDERSERVED AREAS UNDER PPS**

**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.

Additionally, agencies are incurring significant unreimbursed costs to recruit and retain home care professionals and paraprofessionals. 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. The Congress had sufficient concerns about the impact of PPS on beneficiary access to care that, in late 1999, it requested a study from the Medicare Payment Advisory Commission (MedPAC) on the advisability of excluding rural home care providers from the PPS system altogether. 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 H.R.1, The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the Congress restored the rural add-on at a 5 percent rate for the April 2004 through March 2005 period.

**RECOMMENDATION:** Congress must closely monitor the home health PPS to ensure that individual case payments are sufficient to maintain access to care. If the system's payments are found to be insufficient, Congress should increase the home health base payment. Further, Congress should direct the Centers for Medicare & Medicaid Services (CMS) to develop a more adequate system of "outlier" payments under PPS so that high-cost patients will have continued access to services. Congress should restore and permanently extend the 10 percent add-on for care delivered in rural areas. 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.

## **FULLY REIMBURSE HOME HEALTH AGENCIES FOR COSTS OF IMPLEMENTING OASIS; STREAMLINE OASIS COLLECTION AND REPORTING REQUIREMENTS**

**ISSUE:** The Centers for Medicare & Medicaid Services (CMS) requires home health agencies to submit patient data using the Outcome and Assessment Information Set (OASIS). Under the Medicare home health prospective payment system (PPS), episodic (60-day) payments include a small reimbursement (about \$5) for ongoing agency expenses, including telephone, computer hardware, editing and auditing data entry, and supplies. However, many additional costs which agencies incur with OASIS are not currently reimbursed, such as costs incurred for collecting and reporting OASIS data for non-Medicare clients. CMS has said that it lacks the authority to increase payments so as to help offset costs of the OASIS requirements.

In recent years, home health agencies were under severe financial burdens due to payment cuts; virtually all agencies were being reimbursed less than the actual costs they incurred in providing care to Medicare beneficiaries. Agencies are also under increasing new demands associated with administrative requirements, including increased claims reviews, expanded compliance surveys, and Health Insurance Portability and Accountability Act (HIPAA) compliance.

In early 2001, the 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.

The Secretary of Health and Human Services' Regulatory Reform Committee has developed several recommendations regarding OASIS simplification, as has the home health industry, and CMS has taken steps to implement several of these refinements. Changes include elimination of several OASIS items as well as demographic information from subsequent assessments, streamlining follow-up assessments to 23 items needed for payment, and elimination of Reason for Assessment (RFA) 2 and 10. A technical expert panel of providers and researchers has been appointed to conduct an ongoing three-year project to evaluate the necessity and validity of each of the OASIS data items and requirements.

During 2003, legislation was enacted that would suspend OASIS collection and reporting requirements for non-Medicare and non-Medicaid patients pending a study by CMS.

**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.

**RATIONALE:** OASIS is a valuable tool that, over time, will greatly enhance the delivery of home care services. However, requiring OASIS data collection and submission for non-Medicare patients constitutes an unfunded mandate. OASIS requirements should impose as few administrative and financial burdens as possible upon already severely strained home health agencies.

## **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.

**RECOMMENDATION:** Congress should authorize home health agencies 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.

**RATIONALE:** Optimal health outcomes should be the main goal of the Medicare program and its supporting reimbursement system. Home health agencies 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. Home health agencies 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.

## **LIMIT RETROACTIVE RECOVERIES RELATED TO THE IMPLEMENTATION 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 ongoing 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.

**RECOMMENDATION:** Congress should limit provider liability for overpayments triggered by PPS implementation errors and weakness where the provider acted in good faith.

**RATIONALE:** PPS was implemented without any advance trial. Consequently, not all implementation issues were addressed or resolved in advance. 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.

## **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 for cost reporting periods beginning on or after October 1, 1999. The BBA target date was delayed by one year, and 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. Case-mix considerations include such variables as health status, age, and socio-economic factors of the patients served. Since PPS was implemented many concerns have surfaced regarding the reliability and accuracy of the case-mix adjustor.

**RECOMMENDATION:** Congress should require that the Centers for Medicare & Medicaid Services (CMS) do continuing in-depth study on the adequacy of the 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. Congress should also require 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.

**RATIONALE:** PPS represents 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.

## **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, 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 wage and benefit levels for all clinical staff. Additionally, Congress should consider implementing a wage pass through for home care and hospice workers under Medicare and Medicaid.

**RATIONALE:** Studies indicate that low wages affect an agency's ability to recruit and retain clinical staff. Agencies throughout the nation have begun to experience severe hardships in recruiting and retaining clinical staff.

Because of low wages and benefits, home care aides are often cited in Congressional testimony as an example of a work force which would benefit from an increase in the minimum wage. And, increasingly, efforts are being made to document the relationship between wages and quality of care. In 1996, the Older Women's League's report, "Faces of Care: An Analysis of Paid Caregivers and Their Impact on Quality Long Term Care," linked paraprofessional wage and benefit issues directly to quality of care issues.

Without sufficient reimbursement, financially strapped home care and hospice agencies are finding it extremely difficult to provide quality care and pay competitive wages.

## **IMPROVE APPLICATION OF WAGE INDEX FOR MEDICARE HOME HEALTH AND HOSPICE**

**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 effective October 1, 2000. However, the wage index that has been utilized by the Centers for Medicare & Medicaid Services (CMS), in accordance with Congressional mandate, has been based upon varying 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 care-specific wage index failed due to the unavailability of reliable wage data.

While the home health payment rates are based upon the application of a hospital wage index, 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 hospitals are allowed to secure a geographic reclassification for application of the wage index by establishing that the particular 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. Finally, hospitals 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.

**RECOMMENDATION:** 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).

**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.

## **SUPPORT HEALTH REFORM PROPOSALS THAT PROVIDE AFFORDABLE HEALTH INSURANCE TO UNINSURED LOW-WAGE WORKERS**

**ISSUE:** Currently over 2 million Americans provide professional care to our nation's children, seniors and the disabled. Many of these important caregivers are low-wage earners who do not have health insurance for themselves or their families. In 1999, the national average hourly wage for nursing aides was \$8.29, home care aides had hourly wages of \$8.67 compared to \$9.22 for service workers and \$15.29 for all workers (GAO-01-750T, 2001).

The nursing home industry averages a 94 percent turnover rate of nurses' aides. For child care facilities, the annual turnover rate is more than 33 percent. Studies have shown that children attending lower-quality child care facilities and child care facilities with high staff turnover are less competent in language and social development. A study during 2000, by the California Health Care Foundation, found that nearly 72,000 home care workers in Los Angeles County were uninsured. Approximately 90 percent of the uninsured home care workers were found to be living below or near the poverty level. Over 40 percent of uninsured home care workers delayed or did not receive needed medical care because they couldn't afford the care.

A General Accounting Office (GAO) report documented that 18 percent of all nursing home aides and 19 percent of all home care aides each night return home to families who are living in poverty. In May 2001, GAO testimony to the U.S. Senate documented that the median individual income of all nursing home direct care staff was \$13,287 per year while the median income for all home-based direct care staff was just \$12,265 per year. In all, 1.36 million health care workers provide care that they and their children cannot expect to receive.

Low wages and lack of health care benefits force these workers to have second and even third jobs or to continually look for better jobs. High turnover rates in these caregiving jobs can be a disincentive for employers to provide employee education. The net result may be that some of our children, seniors, and disabled are attended by inexperienced, untrained, and tired caregivers.

During the 107th Congress, Senator Richard Durbin (D-IL) developed the Caregiver Access to Health Insurance Act. This legislative proposal would make \$4 billion annually available for states to provide health insurance for caregivers through any of the following four methods: (1) Medicaid expansion; (2) Enrollment in the state and local employees' health insurance program; (3) Federal Employees Health Benefits Plan (FEHBP) for non-federal employees; or (4) Subsidies through private health insurance. States choosing to participate would be required to have some matching funds, but between 80 percent and 85 percent of the costs would be paid for by the federal government. The bill was not reintroduced during the first or second session of the 108th Congress.

In late 2000, the Health Insurance Association of America (HIAA), Families USA, and the American Hospital Association unveiled a plan to insure all low-wage workers by expanding existing federal programs and providing a tax credit to employers to help defray the cost of workers' insurance premiums. The cost of this proposal was estimated at \$259 billion over 10 years.

**RECOMMENDATION:** Congress should provide meaningful health coverage expansions for full and part-time low-wage workers, such as child care workers, nurses' aides, and home care aides, their families, and other low-income populations that are the least capable of obtaining health coverage on their own.

**RATIONALE:** The success of the health care system is dependent on qualified personnel. Access to care, quality of care, and costs of care are all affected by the availability of properly educated and trained workers. In formulating policies, plans, and programs, health policymakers should carefully consider the supply, demand, distribution, education and use of the low-wage workers needed to deliver essential services to the nation's children, seniors, and the disabled. The availability of health care benefits for these workers and their families could assist in stemming the national shortages.

## **ALLOW PHYSICIANS' ASSISTANTS AND NURSE PRACTITIONERS TO CERTIFY MEDICARE HOME HEALTH PLANS OF CARE**

**ISSUE:** Both physicians' assistants (PAs) and nurse practitioners (NPs) are playing an increasing role in the delivery of our nation's health care. Moreover, many state laws and regulations authorize PAs and NPs 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. In addition, 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.

Despite the expanded role of PAs and NPs in the BBA, the Centers for Medicare & Medicaid Services (CMS) continues to prohibit PAs and NPs from certifying home health services to Medicare beneficiaries. According to CMS, the Medicare statute requires "physician" certification on home health plans of care.

**RECOMMENDATION:** Congress should enact legislation that would instruct CMS to allow PAs and NPs to certify and make changes to home health care plans.

**RATIONALE:** PAs and NPs are increasingly providing necessary medical services to Medicare beneficiaries, especially in rural and underserved areas. PAs and NPs in rural or underserved areas are sometimes more familiar with particular cases than the attending physician, so allowing PAs and NPs to sign orders may be most appropriate. In addition, PAs and NPs 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.

## RECOGNIZE TELEHOMECARE AS A BONA FIDE MEDICARE SERVICE

**ISSUE:** Over the past decade, great strides have been made in telehealth technology and its use in the home. In 1995, there were only three telehomecare nursing projects. This number increased to about 10 in 1997, with even greater growth in subsequent years. The reason for this growth is the evolution of technology to allow for effective nurse-patient interactions over regular phone lines using equipment that costs less than a personal computer. National standards have been established by the American Telemedicine Association for the delivery of telehomecare services.

Telehealth technology provides a two-way interactive audio-video connection over telephone lines. During an on-line visit, the nurse at her base station and patients in their own homes see and talk with each other. The following activities can be carried out: health status assessment, monitoring vital signs, medication supervision, monitoring heart and lung sounds, and patient education. Additional devices can be added as needed to perform more in-depth patient tests, such as blood coagulation checks, electrocardiograms, scales, and pulse oximetry. These interactive connections can also be used for remote supervision of home care personnel.

Unfortunately, the Centers for Medicare and Medicaid Services (CMS) does not recognize telehomecare technology and visit costs as reimbursable by the Medicare program. 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.” CMS regulations at 42 CFR 484.48(c) define a home health “visit” as “an episode of personal contact with the beneficiary by staff of the HHA [home health agency].”

During 1999, as part of its legislation to address some of the unintended consequences of the Balanced Budget Act of 1997, the Congress included specific language, in a conference report, directing the Secretary of Health and Human Services to consider new technologies within home health services to improve health outcomes (House Report 106-479). Specifically, the report urges HHS to “consider what changes would be necessary to provide home health care agencies with the flexibility to adopt new market innovations and new technologies that can improve health outcomes while maintaining the goals of quality of care and cost containment.” Telehomecare services is one innovative technology that can assist home health agencies in improving health outcomes while at the same time maintaining quality patient care and containing costs.

During 2000, the Congress provided further clarification on the use of telehealth services within the context of Medicare home health. Public Law 106-554 states that nothing prevents a home care agency from delivering services via telehealth, but specifies the services “do not substitute for in-person home health services ordered as part of a plan of care certified by a physician and are not considered a home health visit for purposes of eligibility or payment.” This means that a telehealth visit cannot be used to count toward the number of visits that would qualify as a full episode of care. Nor can a telehealth encounter be considered a “visit” for purposes of a low utilization payment adjustment visit (LUPA), which is imposed for episodes comprised of four visits or less. During 2003, P.L. 108-173, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), contained one provision which may open the door for expanded coverage of

telemedicine across all provider settings. A provision within MMA Section 721—Voluntary Chronic Care Improvement Under Traditional Fee for Service stipulates that certain elements of the “Care Management Plans” within the Chronic Care Improvement Programs chosen “shall to the extent appropriate include the use of monitoring technologies that enable patient guidance through the exchange of pertinent clinical information, such as vital signs, symptomatic information, and health assessment.”

**RECOMMENDATION:** Congress should clarify legislatively that telehomecare “constitutes a service(s) ... provided on a visiting basis in a place of residence used as an individual’s home” as defined in §1861m of the Social Security Act. Medicare should also provide appropriate reimbursement for technology costs to home care agencies. Finally, Congress should ensure that all health care providers, including home health agencies, have access to appropriate bandwidth so that they can take full advantage of advances in technology appropriate for care of homebound patients.

**RATIONALE:** Use of technology that results in more efficient and effective delivery of health care services should be encouraged and recognized as covered Medicare expenditures. 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. Furthermore, quality of care and patient satisfaction has been maintained. 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. These innovative approaches to care are of benefit to the entire Medicare program, frequently helping to reduce acute care episodes and the need for hospitalizations.

Currently, some health maintenance organizations and some state Medicaid programs reimburse for telehomecare services. The Medicare program must keep pace with these programs.

## **COVER APPROPRIATE SELF-CARE TECHNOLOGIES**

**ISSUE:** New self-care technologies are emerging that allow the disabled and infirm to remain safely in their homes while coping with acute and chronic illnesses. Through the use of these technologies, individuals are able to self-monitor their conditions and obtain necessary insights as to when to link to 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 technology that is designed to keep individuals safe in their own homes.

**RATIONALE:** Self-care monitoring technologies can prevent acute exacerbations of an individual’s condition thereby preventing costlier health care measures.

## **PROVIDE FINANCIAL ASSISTANCE TO HOME CARE AGENCIES TO IMPLEMENT ELECTRONIC CAPABILITIES**

**ISSUE:** Administrative costs and paperwork represent significant expenses in health care. The home care industry has been especially paper intensive. Medicare billing, OASIS assessments, patient charting compliance with the Health Insurance Portability and Accountability Act (HIPAA), and many other activities greatly increase administrative costs. While home health agencies have substantially moved to electronic transactions, continued changes in documentation responsibilities and advancements in technology challenge the ability of home health agencies to maintain up-to-date systems. The implementation of the Medicare home health prospective payment system has required a wholesale revision in agencies' billing, documentation, data needs and data analysis.

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 home health agencies because agencies are not viewed as a good credit risk. Many are dependent on Medicare for most of their revenue. Keeping pace with these new technology needs has been beyond the financial capabilities of many home care agencies.

**RECOMMENDATION:** Congress should provide financial support and incentives such as small business loans, tax incentives, grants from the Medicare program, and other Medicare technology pass-through support to encourage and facilitate the implementation of electronic capabilities.

**RATIONALE:** With the significant savings that electronic capabilities can provide, it is time to fully support a movement to an electronic environment for health care transactions. Home health agencies will require financial assistance to purchase the necessary systems. Current reimbursement standards under Medicare, Medicaid and other payors do not provide the capital foundation for such purchases.

## ENACT HOME CARE SPECIFIC ANTI-FRAUD MEASURES

**ISSUE:** Home care, 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.

**RECOMMENDATION:** Congress should continue its work in combating waste, fraud, and abuse in our nation's health care system by passing a home care specific anti-fraud package that includes:

- The institution of corporate compliance plans by all home health agencies to ensure adherence to all federal and state laws.
- Mandatory screening and federally-funded background checks on all individuals wishing to open a Medicare home health agency as well as all employees of home health agencies and establishment of a national registry of home care workers consistent with existing state laws.
- Strengthening of program participation standards to include experience credentialing and competency testing of home health agency 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 prospective payment system so that agencies are appropriately reimbursed for the costs of providing home health services.
- Providing consumers and prospective consumers of Medicare home health services 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.
- Enhancement of education and training of home health agency 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.
- 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.

**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-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.





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