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

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

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

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

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

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

RECOMMENDATION: Congressional reforms of the health care delivery system recognize home care and hospice as key partners in securing high quality care in an efficient and efficacious manner. Congress should monitor closely CMS’s implementation of the health care delivery reform provisions in PPACA to ensure that the intended goals are fully met. Congress should encourage CMS to look to home care and hospice as part of the solution to rising health care spending in Medicare and Medicaid, including through community based chronic care management. Congress should investigate and remove any existing laws and regulations that create barriers to the inclusion of home care and hospice entities as integrated
partners or participants with other health care organizations in transitions in care actions, bundling of payments, or other delivery of care innovations.

**RATIONALE:** Community-based care is a valuable, but under-utilized health care asset with respect to efforts to reduce hospitalizations and re-hospitalizations. Further, community-based chronic care management has long been provided effectively by home health agencies and hospices. However, the antiquated structure of Medicare benefits has prevented its application at full capacity. The reforms in PPACA present the opportunity to build a new care delivery model that is not handicapped by this out-of-date structure and to overcome longstanding weaknesses in health care delivery.
ALLOW NURSE PRACTITIONERS, CLINICAL NURSE SPECIALISTS, CERTIFIED NURSE MIDWIVES AND PHYSICIANS’ ASSISTANTS TO CERTIFY MEDICARE HOME HEALTH PLANS OF CARE

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

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

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

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

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

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

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

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

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

Over the past few years, Congress has taken integral steps to expand the access of technology into the delivery of home health care. Most notably, telehomecare champions Senator John Thune (R-SD) and Amy Klobuchar (D-MN) have taken up the cause and introduced the “Fostering Independence Through Technology (FITT) Act” to mandate that the Secretary of Health and Human Services (HHS) establish pilot projects under the Medicare
program to provide monetary incentives for HHAs to utilize home monitoring and communications technologies. The FITT Act was included as an amendment to the Sustainable Growth Rate “Doc Fix” bill that will be considered by the 113th Congress. In 2008, and again in 2009, Representative Mike Thompson (D-CA) introduced “The Medicare Telehealth Enhancement Act” which provided a number of provisions that addressed the need for enhanced telehealth services including, for Medicare’s purposes, reimbursement for home health telehomecare visits by home health agencies, coverage of remote patient management services including home health remote monitoring, and establishment of a demonstration project to evaluate the impact and benefits of including remote patient management services for certain chronic health conditions. In 2012, Thompson introduced “The Telehealth Promotion Act of 2012” which removes arbitrary coverage restrictions on telehealth from federal health care programs and also increases the Medicare prospective payment rates to home health agencies to include remote monitoring services for three years. In 2013 the “The Telehealth Promotion Act of 2013” was introduced to encourage the use of telehealth technologies in the certification of home care services and enable the home to be a telehealth site. Lastly, in 2014 the Telehealth Enhancement Act of 2013 and the Medicare Telehealth Parity Act of 2014 included phased in expansion of telehealth coverage, the definition of a “home telehealth site” and telehealth services for the remote delivery of home care and hospice services. In 2015, Congress will again be considering an approach to reimbursement of telehealth in Medicare.

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

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

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

Studies indicate that over half of all activities performed by a home health nurse could
be done remotely through telehomecare. Evidence from these studies has shown that the total cost of providing service electronically is less than half the cost of on-site nursing visits. Given the financial constraints on agencies under the prospective payment system (PPS), providers of care should be granted maximum flexibility to utilize cost-effective means for providing care, including non-traditional services such as telehomecare that have been proven to result in high-quality outcomes and patient satisfaction.
ENACT A COMPREHENSIVE, HIGH QUALITY HOME- AND COMMUNITY-BASED LONG-TERM CARE PROGRAM

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

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

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

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

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

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

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

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

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

The adoption of these recommendations in a long-term care plan would ensure that people with disabilities and chronically and terminally ill Americans receive the comprehensive, high quality home- and community-based care they need in the least restrictive environment.
ENSURE AVAILABILITY OF HOME CARE AND HOSPICE PERSONNEL TO MEET THE GROWING NEEDS OF THE BABY BOOM GENERATION, PARTICULARLY IN RURAL AND OTHER UNDERSERVED AREAS

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

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

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

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

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

Congress took legislative action in the 107th Congress to help alleviate the nurse shortage. Specifically, the Nurse Reinvestment Act (H.R. 3487, P.L. 107-205) would establish a National Nurse Service Corps to provide scholarships and loans to nursing students who agree to serve in a public or private non-profit health facility, including home care.
agencies and hospices, determined to have a critical shortage of nurses. The legislation also establishes nurse retention and patient safety enhancement grants to assist health care facilities to retain nurses and improve patient care delivery by encouraging more collaboration between nurses and other health care professionals and more involvement by nurses in the decision-making process.

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

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

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

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

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

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

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

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

RECOMMENDATION: Congress should require the coverage of home care services by qualified home health agencies for all veterans who would prefer to stay in the home as opposed to a VA hospital or nursing home. Moreover, use of existing home care providers should be encouraged by the government to avoid increasing taxpayer costs by creating new VA provider entities. Further, Congress should ensure that the VA has the resources necessary to implement the long term care demonstrations of P.L. 108-422. Congress should also monitor the implementation of the CHOICE program to ensure that care access is improved, prohibit unreasonable waits for home care, and institute transparency and efficiency.
into the CHOICE program operations.

**RATIONALE:** Congress should continue to improve upon the scope of home health services available to veterans. Alternative levels of care should be available to our nation’s veterans. Institutionalization should not be the only method for providing care to chronically ill or rehabilitating veterans. Since Congress saw fit to provide home care services to veterans, this care should include the full range of services and be provided by qualified home health agencies.
II. ENSURE APPROPRIATE AND ADEQUATE REIMBURSEMENT FOR AND ACCESS TO MEDICARE HOME HEALTH SERVICES
REPEAL OR REFORM MEDICARE HOME HEALTH FACE-TO-FACE ENCOUNTER REQUIREMENT

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

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

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

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

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

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

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

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

**RECOMMENDATION:** Congress should:

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

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

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

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

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

Recent data indicates that Medicare margins for home health agencies are quickly declining as the numerous years of rate cuts take their toll. In addition, new regulatory-driven costs are being incurred by home health agencies with more expected in future years. On November 23, 2013, CMS issued a Final Rule that sets Medicare home health payment rates based on a formula that ostensibly relates to the average cost of care. With this approach, CMS reduces base episode payment rates by the full 14% allowed under PPACA through a 4-year phase in of the rate changes. In addition, CMS limits the increases in per visit payment rates to 3.5% despite a finding that average costs of these visits is as much as 133% of the rates. 78 Fed. Reg. 72256 (December 2, 2013).

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

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

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

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

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

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

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

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

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


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

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

MedPAC’s recommendations are predicated on findings of “excessive” Medicare profit margins for freestanding agencies. More comprehensive study of agency margins...
performed by the National Association for Home Care & Hospice has found significantly lower Medicare profit margins that virtually disappear when all payers are taken into account. Further, when agency profit margins are considered on an individual basis, they reflect dramatic ranges.

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

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

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

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

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

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

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

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

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

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

Crude measures such as across-the-board reductions or freezes will only exacerbate inequities in the system, and contribute further to access concerns. Access to care continues to be a serious problem in home health, and it is anticipated that these concerns will only increase with further cuts to home health payments. Home health care is efficient and effective in providing vital services to patients in the comfort of their homes. Use and provision of these services should be encouraged, not discouraged.
OPPOSE A “SICK TAX”—BLOCK EFFORTS TO IMPOSE A FEE TO BE PAID BY PATIENTS TO ACCESS MEDICARE HOME HEALTH SERVICES

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

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

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

RATIONALE:

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

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1 Congressional Record, October 5, 1972, p. 33939.
care and hospitalizations would likely result from the imposition of a home health copayment. The National Association of Insurance Commissioners concluded that beneficiaries, in response to increased cost sharing, “may avoid necessary services in the short term that may result in worsening health and a need for more intensive care and higher costs for Medicare in the long term.” According to an analysis by Avalere, a home health copayment could increase Medicare hospital inpatient spending by $6-13 billion over ten years.5

- **Copayments are an inefficient and regressive “sick tax” that would fall most heavily on the most vulnerable—the oldest, sickest, and poorest Medicare beneficiaries.** About 86 percent of home health users are age 65 or older, 63 percent 75 or older, and nearly 30 percent 85 or older. Sixty-three percent are women.6 Home health users are poorer on average than the Medicare population as a whole. Home health users have more limitations in one or more activities of daily living than beneficiaries in general.7 The Commonwealth Fund cautioned that “cost-sharing proposals, such as a copayment on Medicare home health services, could leave vulnerable beneficiaries at risk and place an inordinate burden on those who already face very high out-of-pocket costs.”8

- **Most people with Medicare cannot afford to pay more.** In 2013, half of Medicare beneficiaries—more than 25 million seniors and people with disabilities—lived on incomes below $23,500.9 On average, Medicare households already spend 14 percent of their income on health care costs, about three times as much as non-Medicare households.10

- **Low-income beneficiaries are not protected against Medicare cost sharing.** Eligibility for assistance with Medicare cost sharing under the Qualified Medicare Beneficiary (QMB) program is limited to those with incomes below 100% of poverty ($11,412 for singles, $15,372 for couples) and non-housing assets below just $6,940 for singles and $10,410 for couples. Even among Medicare beneficiaries eligible for QMB protection, only about one-third are actually enrolled in the program.11

- **Individuals receiving home care and their families already contribute to the cost of their home care.** With hospital and skilled nursing facility care, Medicare pays for room and board, as well as for extensive custodial services. At home, these services

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are provided by family members or paid out-of-pocket by individuals without family support. Family members are frequently trained to render semi-skilled support services for home health care patients. Family caregivers already have enormous physical, mental and financial burdens, providing an estimated $470 billion a year in unpaid care to their loved ones, and too frequently having to cut their work hours or quit their jobs.  

- **Copayments as a means of reducing utilization would be particularly inappropriate for home health care.** Beneficiaries do not “order” home health care for themselves. Services are ordered by a physician who must certify that services are medically necessary, that beneficiaries are homebound and meet other stringent standards. There is scant evidence of overutilization. Adjusted for inflation, home health spending on a per patient basis and overall Medicare spending on home health is less today than in 1997. The Medicare home health benefit has dropped from 9.5 percent of Medicare spending in 1997 to 5.9 percent and serves a smaller proportion of Medicare beneficiaries today than in 1997.  

- **Home health copayments would shift costs on to states.** About 15 percent of Medicare beneficiaries receive Medicaid. Studies have shown that an even larger proportion (estimated to be about 25 percent by MedPAC) of Medicare home health beneficiaries are eligible for Medicaid. A home health copayment would shift significant costs to states that are struggling to pay for their existing Medicaid programs. In addition, states would have to pick up their Medicaid share of new QMB assistance obligations.  

- **Medicare supplemental insurance cannot be relied upon to cover home health copays.** There is no requirement that all Medigap policies cover a home health copay and only 23 percent of Medicare beneficiaries have Medigap coverage. For the 26 percent of Medicare beneficiaries who have supplemental coverage from an employer sponsored plan, there is no assurance that these plans will be expanded to cover a home health copay or remain a viable option for beneficiaries, given the current trend of employers dropping or reducing retiree coverage. The 30 percent of beneficiaries enrolled in Medicare Advantage (MA) plans would not be protected from a home health copay, as many MA plans have imposed home health copays even in the absence of a copay requirement under traditional Medicare.  

- **Copayments would impose costly administrative burdens and increase Medicare costs.** Home health agencies would need to develop new accounting and billing procedures, create new software packages, and hire staff to send bills, post accounts receivable, and re-bill.

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

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

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

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

RECOMMENDATION: Congress should monitor the progress of the ongoing value-based purchasing demonstrations or proposals and use the findings to guide its consideration of value-based payment for Medicare home health services. Any action in this area must: 1) be
developed in conjunction with provider stakeholders; 2) be tested as a pilot program prior to full-fledged implementation; 3) be fair in its assessment of the quality of care provided to home health patients and incorporate pending OASIS changes, as well as a mix of multiple process and outcome measures; 4) refrain from negatively affecting patient access to care; 5) be consistent with the home health PPS and appropriately risk-adjusted; 6) limit any expansion of data collection requirements and fully reimburse agencies for the costs of any additional data collection requirements that are imposed; 7) only reward or penalize agencies for care elements over which they have some control; 8) reward high scoring agencies as well as those that demonstrate improvement for the dynamic value of home health services to the entire Medicare program; 9) not pose cash flow difficulties for agencies, with the incentive pool not to exceed 2 percent of home health payments; and 10) allow the Secretary of Health & Human Services sufficient discretion to delay application of value-based purchasing if implementation concerns arise.

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

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

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

The Medicare Center for Innovation initiated a four-model Bundled Payments for Care Improvement (BPCI) initiative in 2013. Models 2 and 3 included post-acute care services. Model 2 BPCI includes a patient’s hospitalization, physician services, and post-acute care for 30, 60, or 90 days. CMS selected 48 proposals for the Phase 1 preparation period. On October 1, 2013, 9 participants began the risk bearing Phase 2. The participants are primarily hospitals and health systems some of which directly provide home health services. As of February, 2016, there are 628 participants in Model 2.

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

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

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

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

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

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

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

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

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

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

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

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

RECOMMENDATION: Congress should permanently extend the payment differential (“add-on”) for care delivered in rural areas. Congress must also closely monitor the home
health PPS to ensure that individual case payments are sufficient to maintain access to care. Finally, Congress should monitor adequacy of PPS payments so that agencies in underserved areas (rural, inner city, medical shortage areas) can continue to provide care to Medicare beneficiaries.

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

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

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

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

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

The 2016 HHPPS rate rulemaking included a new case mix weight change adjustment that relied partially on previous methods of evaluating “real” and “nominal” case mix weight changes that perpetuated the problems seen with earlier adjustments. However, CMS employed a new methodology for determining the proportion of change that is considered to be “nominal” or unrelated to changes in patients. That method took the average proportion of nominal changes in case mix weights for the period of 2001 to 2010 and applied it to the case mix weight change level in 2012 to 2014. All earlier analyses evaluated the level of “nominal” change consistent with the period of weight change under review. By using a full
decade of past change review on a later period of time, CMS failed to consider time-specific changes in health care that affect the nature of patients served in home health care. Further, in doing so, CMS ignored its past findings that showed material differences in the proportion of nominal and real case mix change that can occur in different years.

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

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

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

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

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

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

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

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

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

The Patient Protection and Affordable Care Act (PPACA), P.L. 111-148, contains a number of program integrity measures supported by NAHC that are home care and hospice specific. However, the home care and hospice communities believe that more can be done. Program integrity measures should be targeted as much as possible on program vulnerabilities and high risk providers.

RECOMMENDATION: Congress should continue its work in combating waste, fraud, and abuse in our nation’s health care system by passing additional measures that include:

- The institution of mandatory corporate compliance plans by all home health agencies and hospices to ensure adherence to all federal and state laws with proper funding support.
- Strengthened admission standards for new Medicare home health agencies, including standards for capitalization, claims review, and experience.
- Expanded use of targeted, temporary moratoria on new Home Health Agencies where the number of providers exceeds the level appropriate to ensure access, quality and choice.
- Mandatory screening and federally-funded background checks on all individuals wishing to open a Medicare home health agency or hospice as well as all employees of home health agencies and establishment of a national registry of home care workers consistent with existing state laws.
- Strengthened program participation standards to include experience credentialing and competency testing of home health agency or hospice personnel responsible for maintaining compliance with Medicare standards; such as the Certified Home Care Executive (CHCE), credentialing available through the National Association for Home Care & Hospice (NAHC).
- The investment of sufficient government and industry resources to expedite refinements to the Medicare payment systems so that providers are appropriately reimbursed for the costs of providing services.
- Providing consumers and prospective consumers of Medicare home health services and hospice care with a summary of program coverage requirements. The consumer reporting hotline for suspected fraud, waste, and abuse also should be enhanced and made more accessible.
- Implementation and development of credentialing and competency testing standards for government contractors and federal regulators responsible for issuing Medicare determinations. A hotline should be developed for beneficiaries and providers to report inadequate enforcement action by those charged with protecting Medicare and Medicaid.
• Supplying adequate administrative financing to Medicare/Medicaid to enforce existing laws and regulations such as survey and certification standards, provider education, and claims reviews.

• Requiring federal enforcement authorities to prioritize oversight and enforcement on matters that have high dollar impact while establishing sensible corrective measures to address providers with minor errors and omissions.

• Enhancement of education and training of home health agency and hospice staff through joint efforts with regulators.

• Implementation of outcome-based compliance standards that provide operational flexibility and also eliminate structural requirements that are unrelated to the provision of high quality Medicare home health services or hospice care.

• Development and implementation of Medicare coverage and reimbursement standards in language that is understandable and accessible to providers and consumers through various means; for example, through the Internet, federal depository libraries, and fiscal intermediaries.

• The establishment of a Joint Program Integrity Advisory Council that works in partnership with federal and state programs to prevent and resolve systemic programmatic weaknesses that waste health care resources.

• Development and authorization of an industry-directed enforcement entity working in conjunction with federal and state authorities.

• Establishment of targeted payment safeguards that utilize modern techniques and tools, directed towards abusive utilization of services and payment as necessary and appropriate.

**RATIONALE:** It is particularly important to ensure that limited health care dollars go to the provision of patient care rather than being diverted into the pockets of unscrupulous providers. A comprehensive fraud and abuse package that includes home health and hospice specific provisions and provides adequate enforcement tools to punish those who willfully and knowingly defraud the system is needed. Moreover, any anti-fraud legislation must make a distinction between willful fraudulent activity and unintentional failure to comply with Medicare regulations. For example, the Office of the Inspector General often characterizes as fraud technical errors on claims or billing for services that the need for which is not documented sufficiently to demonstrate that it meets Medicare reimbursement requirements related to medical necessity. In such cases, provider education may be a more appropriate response than more punitive measures.
III. MAINTAIN THE INTEGRITY AND ENSURE THE AVAILABILITY OF HOSPICE AND PALLIATIVE CARE FOR ALL NEAR THE END OF LIFE
REJECT EFFORTS TO INCLUDE HOSPICE AS PART OF MEDICARE ADVANTAGE BENEFIT PACKAGE

ISSUE: Since its inception, the Medicare hospice benefit has been excluded from the Medicare private plan (currently Medicare Advantage --MA) benefit package. In late 2013, the Medicare Payment Advisory Commission (MedPAC) initiated discussion on the advisability of incorporating hospice as part of the MA benefit package; MedPAC has since voted to recommend that legislation be enacted that would incorporate hospice coverage under MA. MedPAC’s rationale is based on the following:

- Concerns about the complexity of current coverage rules for MA patients that elect hospice;
- The desire for greater symmetry in Medicare coverage regardless of whether a beneficiary receives Medicare under fee-for-service, through an accountable care organization (ACO) or through a MA plan;
- The belief that MA plans should have full responsibility for coverage of Medicare benefits, including responsibility for coverage of all care delivered at the end of life; and
- The possibility that MA plans may be willing to offer additional services to patients who elect hospice – such as concurrent care – that is not available under standard Medicare coverage.

On December 18, 2015, the Bipartisan Chronic Care Working Group of the Senate Finance Committee issued a Policy Options Document that indicates the group is considering requiring MA plans to offer the hospice benefit as part of their package of services. The options paper indicates that if legislative action is taken to mandate this change, the MA five-star quality measurement system would need to be updated to include measures associated with hospice care. The working group’s rationale for considering this change is that the current structure for MA enrollees electing hospice care leads to either a disruption in care or fragmented care delivery.

This proposal by MedPAC and the Bipartisan Chronic Care Working Group raises significant concerns for hospice providers and beneficiary advocates; among them are the following:

- Medicare beneficiaries enrolled in MA that elect hospice will no longer have a choice of the hospice provider that will care for them in their final days of life;
- It is anticipated that in most cases MA plans will contract with Medicare certified providers to supply hospice services. In an effort to keep contracted rates low, MA plans may be incentivized to limit the services they contract with the hospices to provide, or may attempt to contract for hospice care on different terms and/or at significantly reduced rates. As a result, beneficiaries may not receive a hospice benefit equivalent to that which they would receive under fee-for-service;
- Many hospices provide additional services beyond the scope of the hospice benefit (such as massage, music, and other therapies) because they have proven value in improving the quality of life for many patients on hospice. Continuing availability of these services may be at risk if hospice services are provided by way of MA plans;
Medicare hospice eligibility rules require that a patient be determined to be terminally ill with a prognosis of six months or less if the disease follows its normal course. Tensions could arise between the MA plans and a contracted hospice relative to whether a patient does or does not meet Medicare’s eligibility requirements;

Additionally, the hospice per diem payment rate is intended to cover all care determined to be reasonable and necessary for the comfort and palliation of the terminal illness and related conditions. Financial incentives may lead MA plans to shift responsibility for unrelated services to a contracted hospice provider;

There is no deductible applicable to Medicare hospice care, and strict limitations on beneficiary coinsurance that may be charged. MA plans, however, are permitted to charge different out-of-pocket costs than under fee-for-service which could result in increased costs to patients and their families at a particularly vulnerable time;

Hospice is currently undergoing significant change. Starting on January 1, 2016, hospices are paid one of two payment rates for RHC depending on how long the patient has been on hospice care. It is uncertain how these and any future changes will impact delivery of hospice care. These uncertainties will impact hospices’ willingness to enter into contracts with MA plans, particularly if the contracts do not, at a minimum, cover costs; and

The terms under which MA plans enter into contracts with hospice organizations could run counter to the current payment reform goal of ensuring that hospice payments better reflect actual costs of care over the course of a patient’s stay on hospice.

RECOMMENDATION: Congress should reject current efforts to incorporate hospice as part of the MA benefit package. If inclusion of hospice under MA is to be considered, it should first be studied through a demonstration program that examines inclusion of hospice services under different types of MA plans, and thoroughly analyzes the impact of the model on hospice patients and their families. If and when Congress contemplates inclusion of hospice under the MA benefit package, it should include the following safeguards:

- MA beneficiaries that are determined to be terminally ill and eligible for the hospice benefit should be given the option of immediately disenrolling from MA so that they may elect hospice from the provider of their choice;
- MA plans should be required to contract with Medicare-certified hospices based on fee-for-service benefit and payment terms and levels, including beneficiary cost-sharing limitations;
- The hospice IDG should be the ultimate authority on hospice eligibility, the hospice plan of care, and determinations of which conditions are related to the terminal diagnosis. Likewise, the IDG should determine the conditions that are not related to the terminal and related conditions that should be covered by the MA plan; and
- The quality and coordination of care as patient’s transition to end-of-life care should be closely assessed as part of the MA plan satisfaction ratings.

RATIONALE: Beneficiaries entering MA are, as a general rule, anticipating their needs for curative care rather than end-of-life care. Decisions about end-of-life care are deeply personal and of great significance to patients and their families. When a beneficiary is diagnosed with a terminal illness, he or she should retain the right to determine what level of care to pursue and under what provider’s care.
OVERSEE THE IMPACT OF HOSPICE PAYMENT REFORM; REJECT REBASING AND SITE-OF-SERVICE ADJUSTMENT FOR NF RESIDENTS

ISSUE: The Medicare hospice benefit (MHB) was created in 1982 to provide palliation and management of care to terminally ill beneficiaries with a prognosis of six months or less if the disease runs its normal course. The Medicare Payment Advisory Commission’s (MedPAC) June 2008 Report to the Congress stated that, although the benefit was created to care for terminally ill cancer patients, they are now a minority of MHB participants. Patients with diagnoses such as Alzheimer’s disease, debility and congestive heart failure have made up the majority of Medicare’s hospice patients in recent years.

Over the years, the average length of stay (LoS) has increased to about 88 days, but the more important median LoS remains at about 18 days, according to MedPAC. In 1983, 20 percent of patients received hospice services for seven days; this has increased to about 30 percent. Additionally, 25 percent of hospice patients are on care for five days or less before expiring. The current reimbursement structure was created by estimating the original cost of delivering routine home care (RHC) -- 96 percent of hospice days of care -- by analyzing data collected during the 1980-1982 Medicare Hospice Benefit Demonstration Project.

Despite the changes noted by MedPAC and significant technological, pharmaceutical, and medical care delivery advances over the first 33 years of the hospice program, there had been no associated reimbursement adjustment to reflect the changes.

In March 2009, MedPAC recommended that Congress mandate revision of the hospice reimbursement system to better reflect variation in costs over a patient’s length of stay and expansion of data collection efforts.

The final 2010 health care reform legislation (Public Law 111-148) authorized payment system reforms to be enacted no earlier than October 1, 2013.

The Centers for Medicare & Medicaid Services (CMS) expanded collection of data related to visits and costs in 2008, 2010, and then again in April 2014. While analyzing data for its payment reform efforts, CMS “floated” a seven-tiered payment system for RHC and also suggested that it may be appropriate to “rebase” hospice payments and reduce reimbursement for RHC provided to patients in nursing facilities.

During 2015, CMS promulgated and finalized modifications to payments for RHC under hospice that sets out two payment rates -- a higher rate ($186.84 in 2016) for days one through 60 of hospice care and a lower rate ($146.83) for days 61 and over. Despite a break in service, unless a patient is off hospice care for more than 60 days, the “count of days” for purposes of determining the appropriate RHC rate includes previous hospice service days. CMS also created a Service Intensity Add-on (SIA) applicable to in-person RN and Social Worker visits that are provided during the final seven days of life. The SIA is payable at the hourly rate for Continuous Home Care (CHC, paid at $39.37 in FY2016) for up to four hours per day. CMS was required to make the payment system changes budget neutral in the first year of application. However, given that provision of RN and Social Worker visits in the payment changes, CMS has indicated that in future years it will apply budget neutrality to account for changes in SIA utilization.

Public Law 111-148, the final health reform bill, also includes some interim payment changes, including the institution of a productivity adjustment to the annual market basket
inflation update beginning in FY2013. In addition, the final reform bill reduces the market basket index by 0.3 points in FY2013 through 2019, but makes provision to eliminate the market basket cut in each of FY2014 – 2019 if growth in the health insurance-covered population does not exceed 5 percent in the previous year.

**RECOMMENDATION:** Congress must closely monitor the impact of the payment reform changes implemented by CMS and any future activities related to hospice payment to ensure that changes to the reimbursement system do not affect access to quality hospice services for terminally ill Medicare beneficiaries during the final stages of life. Congress must also monitor the impact of payment changes to ensure that CMS has achieved a proper balance between the costs of providing hospice care and payment levels, particularly for short-stay patients. Congress must ensure that CMS does not overstep its charge to refine the hospice payment system by implementing changes like rebasing of RHC or reduced payments for care provided to NF residents that could go far beyond the payment refinement sought by the health reform law.

In the meantime, Congress should oppose any reductions in the annual hospice updates until all payment reforms are instituted and then only after all issues related to the impact of these changes are fully examined. Any system reforms must assure preservation of access to care, quality of care, and sufficient reimbursement rates to maintain a viable and stable delivery system.

**RATIONALE:** Regardless of the level of care taken when developing a new payment system, unintended consequences that could have a dramatic impact on the population served may result. It appears that the payment reforms implemented by CMS will have a modest impact on the distribution of payments within the hospice program. Additional changes may be necessary to ensure that the balance between costs and payments is appropriate. However, care must be taken to ensure that changes do not disrupt the availability or quality of this most humane service for America’s terminally ill patients and their families, and that hospice remains a benefit available to all at the hour of greatest need – the final stage of life.
ENSURE THE FULL MARKET BASKET UPDATE FOR THE
MEDICARE HOSPICE BENEFIT

ISSUE: Section 3132(a) of the Patient Protection and Affordable Care Act (PPACA -- Public
Law 111-148), enacted in March 2010, requires that the Centers for Medicare & Medicaid
Services (CMS) develop Medicare hospice payment system reforms, and contains hospice
payment cuts -- including the institution of a productivity adjustment to the annual market
basket inflation update beginning in FY2013 and a 0.3 percentage point reduction to the
annual market basket update for FY2013 through FY2019. In addition to the PPACA
reductions, CMS has, over seven years, phased out the Budget Neutrality Adjustment Factor
(BNAF) to the hospice wage index. As the result of these cuts and imposition of the Budget
Control Act’s 2 percent across-the-board sequester, hospice payments for FY2016 are 12
percent LESS than they would otherwise have been. The PPACA cuts and the sequester are
scheduled to continue into future years, which will further reduce the ability of hospices to
provide comprehensive end-of-life care to patients and their loved ones.

As part of the proposed budget for FY 2017, the President recommended reducing the
hospice market basket update by an additional 1.7 percentage points in each of FY2018, 2019,
and 2020. Further, the proposed FY2017 budget includes plans to create a hospice-specific
market basket (as opposed to the hospital market basket currently in use for hospice services).
These changes are estimated to reduce hospice outlays by nearly $10 billion over nine years
(FY2018 - 2026). The proposed budget also references additional unspecified, budget-neutral
hospice policy changes.

RECOMMENDATION: Congress should reject the President’s FY2017 proposed hospice
market basket cuts and proposed creation of a hospice-specific market basket. The Congress
should also closely examine the President’s unspecified “budget neutral” payment changes,
giving close consideration to their potential impact on access to high quality hospice services.
Further, Congress should make every effort to restore the market basket and productivity
reductions authorized under PPACA, and cancel the 2 percent across-the-board sequester.
Congress should oppose any reductions in the annual hospice updates or other major payment
system changes until such time as the impact of hospice payment reforms (and other changes)
is fully known.

RATIONALE: The Medicare Hospice program has undergone dramatic changes in recent
years, including:

- Significant payment reductions that, in combination, have resulted in FY2016 hospice
  payments that are 12 percent LESS than they would otherwise be:
  - In FY2010, CMS began phasing out by regulatory issuance the BNAF to the
    hospice wage index over seven years. In each year since FY2010 the phase out
    has reduced payments by 0.6 percentage points. Elimination of the BNAF has
    reduced hospice payments by 4 percent overall.
  - The FY2014, 2015, and 2016 payment cycles reflect reductions mandated by
    the PPACA, including productivity cuts and a 0.3 percentage point market
    basket reduction. Hospice payments are further reduced by the 2 percent
    sequester.
A study conducted for the National Hospice and Palliative Care Organization (NHPCO) estimated that the combined impact of scheduled ACA cuts and elimination of the BNAF could result in average margins for hospice providers decreasing to NEGATIVE 10 percent by 2022. Additionally, the study estimated that 66 percent of hospices could have negative Medicare financial margins by 2022.

- A dramatic increase in costly administrative obligations, such as an expansion in cost reporting requirements; increased reporting of visit, drug and diagnosis data on hospice claims; new quality measure collection and reporting responsibilities; timely filing requirements for hospice Notices of Election (NOE) and Notices of Termination/Revocation (NOTR) that have become burdensome and costly as the result of CMS systems inadequacy; and other changes. In the near future it is expected that CMS will impose additional administrative requirements on hospice programs that will further increase costs.

- Hospice financial margins are decreasing -- MedPAC calculated an average Medicare margin of 8.6 percent for 2013; its projected hospice Medicare margin for 2016 is 7.7 percent. These estimates exclude costs related to volunteer, bereavement, and other nonreimbursable services, which would further reduce margin calculations by as much as 1.7 percentage points. Financial margins vary widely in the hospice sector, and many hospices are operating at serious financial risk. Additionally, there is concern that MedPAC’s estimates may not take into full account costs associated with the face-to-face encounter requirements that went into effect Jan. 1, 2011, and other newly imposed regulatory burdens (referenced above).

- While the payment system changes that became effective January 1, 2016, were designed to redistribute payments so that they better reflect the actual costs of providing care over the course of a patient’s election, hospices with relatively short overall lengths of stay are reporting losses under the system. Further, hospices nationwide are reporting later referrals to hospice, which increases overall costs of care.

- Imposition of across-the-board cuts to hospice services run counter to Congress’ intent in requiring reform of the hospice payment system, which was to ensure that payments over the course of care better reflect actual costs incurred and to reapportion payments within the system.

- Across-the-board payment reductions will disproportionately harm those providers whose patients have shorter overall lengths of stay on hospice care. According to MedPAC, the 20 percent of providers with the shortest average lengths of stay in 2012 had average margins of MINUS 6.5 percent, while providers in the next lowest quintile for length of stay had margins averaging 3.6 percent. These providers cannot continue to operate if their rates are further reduced.

- While the President’s budget recommends a change in the market basket used for hospice payment updates, hospices have not received a full market basket update since FY2012. Further, hospices are subject to special regulatory requirements (such as the requirement that they provide core services -- nursing, medical social services, and counseling -- by way of direct employees) that increase costs and would be difficult to incorporate into a hospice-specific market basket index.

- CMS has revised and expanded the cost reporting requirements for freestanding
hospices, and is still finalizing revised hospice cost report requirements for provider-based entities; these cost reports are only beginning to be submitted to CMS. This means that CMS does not currently have enough data in sufficient detail from cost reports to create a hospice-specific market basket.

In recent years hospices have been subjected to numerous changes, the full impact of which are not yet fully known. Until such time as any proposed policy can be fully analyzed for its impact on delivery of care and in the context of all other recent hospice policy changes, Congress should reject proposals that would further diminish hospices’ ability to provide services to patients in their final days of life and support to those patients’ loved ones.
REJECT ADDITIONAL BENEFICIARY COST SHARING FOR HOSPICE SERVICES UNDER MEDICARE REFORM EFFORTS

ISSUE: The Medicare hospice benefit was created under the Tax Equity and Fiscal Responsibility Act of 1982 to expand the availability of compassionate and supportive care to Medicare’s many beneficiaries suffering from terminal illness at the end of life. Eligibility for hospice is based upon a physician’s certification that the patient has a terminal illness with a life expectancy of six months or less if the illness runs its normal course. When a patient elects hospice under Medicare, he or she agrees to forgo other “curative” treatment for the terminal illness. While the cost of most hospice care is covered by Medicare, the patient may be responsible for copayments related to drugs for symptom control or management and facility-based respite care. The patient is also responsible for copayments related to any regular Medicare services unrelated to the terminal diagnosis.

In discussion, some members of the Medicare Payment Advisory Commission (MedPAC) have suggested that it may be advisable to consider imposition of some type of copayment for Medicare hospice services. Additionally, as part of policy discussions on reform of Medicare, some have advocated consolidation of Parts A and B and imposition of uniform beneficiary copayments and deductibles on all Medicare services. Unless hospice is specifically excluded, beneficiary costs for hospice care could increase significantly.

RECOMMENDATION: Congress should reject imposition of additional copayments on beneficiaries for Medicare hospice services and other changes that would discourage use of the hospice benefit.

RATIONALE: Historically copayments have been imposed on health care services to reduce overutilization of services. While use of hospice services has grown significantly through the years, many Medicare beneficiaries are referred to hospice too late to reap its full benefit, and many more lack sufficient knowledge or understanding of hospice to consider it a viable option at the end of their lives. This is particularly the case for minority and low-income Medicare populations – who are the least likely to be able to afford additional cost-sharing burdens.

Beneficiaries who elect Medicare hospice services must agree to forego curative care for their terminal illness. Given that many “curative” interventions for terminal illnesses can involve administration of costly new medications and treatments, it is not surprising that numerous studies have documented that appropriate use of hospice services can actually reduce overall Medicare outlays while at the same time extending length and quality of life for enrolled beneficiaries.

While valid concerns have been raised about the length of time some Medicare beneficiaries are on hospice service, the median length of stay under the hospice benefit is about 18 days. About 25 percent of hospice beneficiaries are on service for a total of five days or less and over 95 percent of hospice care is provided in the patient’s residence. In lieu of imposing additional beneficiary cost-sharing that could discourage appropriate, timely and desirable use of the hospice benefit, Congress and other policymakers should explore
additional ways to ensure that hospice services are being ordered for patients that are truly eligible, such as through physician education, and at a time in their disease trajectory when they can reap the full benefit that the hospice benefit has to offer.
SUPPORT THE PORTABILITY OF ADVANCE DIRECTIVES; CREATE AN ADVANCE CARE PLANNING BENEFIT UNDER MEDICARE

ISSUE: Between 20 and 25 percent of Americans above the age of 18 have advance directives but are not assured that this legal document will be honored in any state other than the state in which it was executed. The law honoring advance directives from another state is unclear. An individual is burdened with the responsibility of having the advance directive meet the laws of any state in which he may be spending some time. There should be a nationwide policy on advance directives for individuals receiving items and services under titles XVIII and XIX of the Social Security Act (42 U.S.C. 1395 et seq., 1396 et seq.), assuring that an advance directive validly executed outside of the state in which such advance directive is presented by an adult to a provider of services be given the same effect by that provider as an advance directive executed under the law of the state in which it is presented. This would help assure that an individual’s decisions directing end-of-life care will be followed.

The final health care reform legislation (Public Law 111-148) did not address the need for portability of advance directives or advance care planning services to support individuals in development of their plans for future care needs. However, the original health reform legislation approved by the House (H.R.3962) provided for payment to physicians and other health care professionals to provide a voluntary advance care planning consultation (Section 1233); it also contained a provision regarding the dissemination of advance care planning information (Section 240). In response to steep opposition, the provisions were struck from the legislation prior to final passage.

During 2014, the American Medical Association (AMA) approved the addition of two Common Procedural Terminology (CPT) codes for advance care planning and effective January 1, 2016, the Centers for Medicare & Medicaid Services (CMS) has activated those advance care planning codes under the Medicare Part B physician fee schedule. In conjunction with activation of the codes, CMS has authorized a waiver of beneficiary cost sharing when advanced care planning is requested by a patient and provided at the time of his or her annual wellness visit. CMS’ request for comments on this regulatory change drew overwhelming support from the public.

In the 114th Congress, Senators Mark Warner (D-VA) and Johnny Isakson (R-GA) introduced S. 1549 -- The Care Planning Act of 2015. Among its many provisions, the legislation creates a voluntary Medicare advance care planning and coordination benefit for beneficiaries with serious or life-threatening illnesses that includes team-based discussions of goals of care and values, explanation of disease progression, exploration of a relevant range of treatment options, and a documented care plan that reflects the individual’s goals and preferences; it also requires that facilities ensure that care plans made during the process are appropriately documented prior to discharge and sent to appropriate providers and facilities. Medicare-certified hospice providers and others meeting criteria set out in the legislation would be eligible for payment for the services.

RECOMMENDATION: Congress should support legislation that ensures the portability of an individual’s advance directive between health care facilities as well as between states.
Congress should also enact the Care Planning Act to establish a benefit under which Medicare beneficiaries receive broad-based support from trained professionals to assist them in development of their care planning goals, and assurance that documentation of those goals will be shared with relevant health care providers.

**RATIONALE:** An advance directive belongs to the individual and should not be interfered with or interrupted by the laws of any particular state or health care facility. As an individual travels or relocates to a different state, his stated end-of-life-care choices should be honored based on the choices of the individual, not based on the location of the individual. Establishing a nationwide policy on advance directives that assures the portability of an individual’s end-of-life care choices strengthens patient self-determination efforts and could encourage more individuals to communicate with families, physicians and health care providers about their end-of-life-care choices.

A full-fledged voluntary advance care planning benefit under Medicare, supplied by an appropriately trained team of professionals, will help to educate beneficiaries and their loved ones about their conditions and treatment options. As a result, they will be better informed about disease processes and better prepared to make advance health care decisions if that is their desire; those wishes will be conveyed to appropriate health care providers and facilities. This will substantially increase the likelihood that those life choices will be honored.
REVISE REQUIREMENTS FOR HOSPICE FACE-TO-FACE ENCOUNTERS

ISSUE: Section 3131(b) of the Affordable Care Act of 2010 requires a hospice physician or nurse practitioner (NP) to have a face-to-face encounter with every hospice patient prior to the patient’s 180th-day recertification, and prior to each subsequent recertification. The provision applies to recertifications occurring on and after January 1, 2011.

In the Home Health Prospective Payment System Rate Update for Calendar Year (CY) 2011, the Centers for Medicare & Medicaid Services (CMS) finalized its implementation approach for this hospice provision. The final rule, codified at 42 C.F.R. 418.22(a)(4) (75 Fed. Reg. 70463, November 17, 2010), states that the encounter must occur no more than 30 calendar days prior to the start of the hospice patient’s third or subsequent benefit period. The regulation requires that the hospice physician or NP attest that the encounter occurred, and the recertifying physician must include a narrative describing how the clinical findings of the encounter support the patient’s terminal prognosis of six months or less. Both the narrative and the attestation must be part of, or an addendum to, the recertification.

A number of concerns have arisen relative to the hospice face-to-face requirement:

- Hospices must complete the face-to-face encounter PRIOR TO the beginning of the applicable benefit period. As the result, a patient’s care may be delayed while the hospice identifies an available physician or NP and completes the encounter requirement.
- If a patient is on continuing hospice care but the hospice is not able, due to staffing limitations or other complications, to conduct the face-to-face prior to the benefit period for which the encounter is required, the hospice will not be paid for services provided prior to the date on which the face-to-face has been completed.
- The face-to-face requirement is applicable to a patient’s full time on hospice regardless of when previous hospice service was provided. A patient may have been off hospice service for a lengthy period of time, after which he or she begins rapid deterioration and need immediate admission. In such cases the face-to-face requirement may delay admission.
- CMS data systems are not all available 24 hours, seven days a week to access patient information and most do not have full information related to a patient’s history on hospice care to establish with absolute certainty whether a face-to-face encounter is required. A hospice may take a patient onto service only to discover some time later (once Medicare systems are updated) that a face-to-face encounter was required. These hospices may not bill Medicare for those days of service, which could mean a significant financial loss to the hospice.
- Hospices will not be reimbursed for costs related to the face-to-face requirements, which may be prohibitive -- particularly for small hospices in rural areas.
- Hospices may not utilize telehealth services to meet the face-to-face requirement.

On Dec. 23, 2010, CMS announced a three-month delay in enforcement of the face-to-face requirements to allow time for hospices to establish operational protocols necessary to comply with the new law. In early 2011, CMS modified requirements so that under well-documented “exceptional circumstances” (for example, a hospice is unable to schedule a timely face-to-face prior to beginning needed services for a newly readmitted hospice patient.
or a hospice is not aware that a patient requires a face-to-face encounter because CMS’ data systems do not contain adequate information) hospices are given an additional two days within which to complete the face-to-face.

Subsequently, the National Association for Home Care & Hospice (NAHC) has heard from hospice providers that have not been permitted an “exceptional circumstances” exception because the circumstances of the late face-to-face did not precisely meet the examples provided in the CMS Benefit Policy Manual.

During the 114th Congress, Rep. Tom Reed (R-NY) introduced H.R. 2208, The Hospice Commitment to Accurate and Relevant Encounters Act (Hospice CARE Act). The legislation would permit hospices to utilize physician assistants (PAs) and other clinicians for completion of the face-to-face encounter. Additionally, under CMS’ “exceptional circumstances” provision, the legislation would give hospices seven days from the beginning of the benefit period within which to complete the encounter.

**RECOMMENDATION:** Congress should enact legislation that would allow hospices to utilize PAs and other appropriate clinicians to perform the required face-to-face encounter, and also provide additional time for hospices to complete the face-to-face encounter when exceptional circumstances occur, as well as provide greater flexibility with respect to the use of exceptional circumstances. Additionally, Congress should revise the face-to-face requirement to allow for reimbursement of costs related to the encounter and allow use of telehealth technologies to assist hospices in meeting the face-to-face requirement. Congress should direct CMS to ensure that its data systems are available and contain adequate information for hospices to be able to determine with certainty whether a potential hospice patient will require a face-to-face encounter; hospices should not be held liable for the cost of services they provide to patients without a face-to-face encounter when Medicare data systems contain out of date information that only after the fact reflects that a face-to-face encounter was required.

**RATIONALE:** The intent of the face-to-face requirement is to ensure adequate and appropriate involvement and accountability of physicians relative to certification of eligibility for hospice care. However, as currently written and interpreted by CMS, it may delay access to care and serve as a deterrent for some hospices to take eligible patients in need of immediate care onto service. This was neither its intent nor an advisable result of the requirement.
IV. PROTECT AND EXPAND ACCESS TO HOME AND COMMUNITY-BASED SERVICES UNDER MEDICAID
ENSURE APPROPRIATE MEDICAID RATES FOR HOME CARE AND HOSPICE

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

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

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

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

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

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

RATIONALE: Virtually all Medicaid home care reimbursement systems pay insufficient attention to the effect of payment rates on patients’ access to care or the cost of efficiently delivering services. Inadequate rates also severely impact the ability of the provider to meet quality and safety standards. Requiring states to engage in an annual analysis of the rate setting methodology and the adequacy of payment rates combined with federally mandated goals for a rate setting process will ensure that Medicaid recipients receive high quality care.
ESTABLISH MEDICAID HOME CARE AS A MANDATORY BENEFIT AND SUPPORT REBALANCING OF LONG TERM SERVICES AND SUPPORTS EXPENDITURES IN STATE MEDICAID PROGRAMS IN FAVOR OF HOME CARE

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

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

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

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

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

- Establishment of the Community First Choice Option, which allows for enhanced federal matching for community-based attendant supports and services to disabled individuals up to 150 percent of federal poverty level who require an institutional level of care;
• Extension of the Money follows the Person Rebalancing Demonstration program;
• Protections against spousal impoverishment in Medicaid home and community-based services;
• Enhanced federal matching through the State Balancing Incentive Program for select states to increase the proportion of non-institutionally-based long-term services and supports; and
• New options for states to offer home and community-based services through the state plan for individuals with incomes up to 300 percent of the maximum supplemental security income payment who have a higher level of need and to extend full Medicaid benefits to individuals receiving home and community-based services under a state plan.

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

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

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

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

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

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

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

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

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

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

RECOMMENDATION: Congress should require that any LTSS Medicaid managed care program develop an Olmstead compliance plan, establish parity or a "maintenance of effort" requirement for any home care benefits provided by the state in an existing fee-for-service program, comply with the fee-for-service quality of care standards, and ensure enrollees
choice among home care providers. These requirements should apply to both skilled and personal care services. Additionally, CMS should create a program of federal oversight to monitor the compliance of managed long term services and supports programs with respect to payment, network and care adequacy as currently done for Medicare Advantage plans.

**RATIONALE:** A transition to managed care should not result in a change in the scope of the Medicaid home care benefits or any jeopardy to home care providers or patients. Likewise, the goals of Olmstead and managed care are common: access to community-based care in a clinically and economically appropriate direction for health care.
REQUIRE MEDICAID MANAGED CARE ORGANIZATIONS TO RECEIVE STATE APPROVAL BEFORE LOWERING PAYMENT RATES FOR HOME CARE SERVICES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

RATIONALE: Medicare is the primary payer over Medicaid. Medicare beneficiaries have greater freedoms to choose care and providers under Medicare than under Medicaid. These beneficiary rights should not be lost or subordinated through consolidation of Medicare and Medicaid programs for dual-eligibles. Medicaid beneficiaries also should have rights to choose their provider of care rather than to be mandatorily enrolled in a managed care plan. At a minimum, Medicaid beneficiaries should have a full and transparent understanding of their home care benefits.
ISSUE: Home care and hospice, like all industries, is not immune to the presence of participants who engage in improper and illegal schemes for the sake of profit. At the same time, health care providers that operate well within the law are unable to effectively compete in the market when faced with competitors that offer kickbacks for patient referrals, bill for services not provided, or charge costs that are not part of the delivery of services.

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

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

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

- The institution of state Medicaid compliance plans directed to Medicaid home care and hospice programs to ensure adherence to all federal and state laws with proper funding support.
- Standards for “return on investment” so that program integrity efforts are priorities based on impact and corrective measures targeted to the most economic and productive approaches.
- Strengthened admission and program participation standards for individual and agency-model home care providers, including standards for competency, early-stage pre-pay claims review, and experience.
- Mandatory screening and federally-funded background checks on all individuals wishing to provide Medicaid home care or open/operate a Medicaid home care agency or hospice.
- Mandatory background checks on all employees of home care agencies and establishment of a national registry of home care workers consistent with existing state laws.
• Providing consumers and prospective consumers of Medicaid home care services and hospice care with a summary of program coverage requirements. The consumer reporting hotline for suspected fraud, waste, and abuse also should be enhanced and made more accessible.

• Standards for service validation systems that allow for the maintenance of electronic documentation of service delivery consistent with the services approved for payment.

• Standards for pre-payment and post-payment claims review, including the appropriate use of sampling extrapolation.

• Credentialing and competency testing standards for government contractors and federal regulators responsible for issuing Medicaid determinations. A hotline should be developed for beneficiaries and providers to report inadequate enforcement action by those charged with protecting Medicaid.

• Supplying adequate and enhanced administrative financing to Medicaid to enforce existing laws and regulations such as survey and certification standards, provider education, and claims reviews.

• Enhancement of education and training of home health agency and hospice staff through joint efforts with regulators.

• Implementation of outcome-based compliance standards for quality of care that provide operational flexibility and also eliminate structural requirements that are unrelated to the provision of high quality care.

• The establishment of a Joint Program Integrity Advisory Council that includes representatives from state Medicaid programs, CMS, home care providers and Medicaid recipients. The Advisory Council is intended to help increase awareness of program integrity weaknesses and to recommend solutions.

• Establishment of targeted payment safeguards directed towards abusive utilization of services and payment as necessary and appropriate.

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

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

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

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

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

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

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

RECOMMENDATION: Congress should reject any consideration of placing caps on Medicaid spending and increase the federal match for state Medicaid programs, thereby bolstering efforts to bring states into compliance with the Olmstead decision. Proposals for per beneficiary caps or full program federal spending caps such as block grants should be rejected by Congress.
RATIONALE: Many states have begun efforts to expand home and community-based alternatives to institutionalization in their Medicaid programs. The federal government, through such programs as the New Freedom Initiative, has sought to facilitate this development. Medicaid is one of the biggest items in state budgets, so it will certainly be a focus of state efforts to save money. States are required to balance their budgets, so federal assistance is essential to preserve and expand home and community-based care within the Medicaid program.
DEVELOP STANDARD QUALITY METRICS AND MINIMUM MANDATORY UNIFORM DATA SETS

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

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

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

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

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

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

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

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

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

RATIONALE: EVV can be of great value in protecting the integrity of government reimbursed home care programs. However, not all programs are alike with program-specific risks that are addressed by EVV. Further, flexibility in EVV requirements for providers creates the opportunity for the development of the best EVV system to fit the program-specific needs.
V. PROTECT ACCESS TO HOME CARE AND HOSPICE SERVICES, INCLUDING FOR CARE PAID BY COMMERCIAL INSURERS, PUBLIC PAYERS, AND INDIVIDUALS
RESTORE THE COMPANIONSHIP SERVICES EXEMPTION TO THE FAIR LABOR STANDARDS ACT

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

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

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

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

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

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

In 2014, NAHC and other organizations filed a lawsuit against DOL, challenging the validity of the October 2013 regulations. The federal District Court for the District of Columbia held that the regulations that eliminated the application of the exemptions to third-party employed workers and the restricted redefinition of “companionship services” violated the Fair Labor Standards Act. On August 21, 2015, the U.S. Court of Appeals for the DC Circuit reversed the District Court rulings concluding that the FLSA exemptions were ambiguous and permitted the DOL to establish limiting standards through rulemaking. NAHC and its co-plaintiff sought a stay of the appeal court’s ruling with the U.S. Supreme Court. Chief Justice Roberts denied the stay request and the challenged rules went into affect on October 13, 2015. The Court of Appeals ruling has been appealed to the U. S. Supreme Court. A determination as
to whether the Supreme Court will hear the appeal is expected in spring 2016.

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

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

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

**RATIONALE:** Most home care providers are small business with limited resources. The companionship exemption result would be to reduce the availability of care to the elderly and the infirm and to increase the costs of service delivery with no corresponding increase from third party payers, such as Medicaid. A comprehensive rather than a piecemeal approach to worker compensation and working conditions is necessary if access to high quality of care and continuity of services is to be achieved. Also, the unique employment nature of home care warrants a tailored approach to wage and hour requirements that takes into account that the focus of the employment is a population of vulnerable and infirm elderly persons with disabilities in their own homes.
ISSUE: The Patient Protection and Affordable Care Act of 2010 (PPACA) expands the availability of health insurance to an estimated 32 million of the current uninsured population. It does so through Medicare spending reductions, certain tax increases, fees payable by insurance companies and others, a penalty on uninsured individuals, and a penalty on businesses with more than 50 employees that do not provide health insurance to their employees. This legislation imposes a $2000 penalty for each full time employee that does not get health insurance from the employer where the business employs 50 or more full time equivalent employees and at least one of the employees qualifies for a federal subsidy to purchase health insurance. The definition of “full-time employee” in the calculation of target employers is based upon the total of the number of employees working at least 30 hours a week.

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

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

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

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

On June 19, 2013, Senators Susan Collins and Joe Donnelly introduced the “Forty Hours Is Full Time Act”, which would modify the definition of full time from 30 hours per week to 40 hours per week. The reasoning behind the bill is to prevent employers from having to limit workers’ hours to only 29 hours per week, which would be damaging for the employee, the employer and, most importantly, people receiving care from home care workers who became limited to only 29 hours of work per week. The bill was reintroduced in 2015 as S. 30.
The House of Representatives had comparable bills in 2013 and 2015, entitled “Save the American Workers Act.” That bill, HR 30, passed the House in January 2015.

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

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

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

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

**RATIONALE:** Home care employers do not have the ability to control service pricing like most other employers that are affected by the employer responsibility provisions in the health care reform legislation. It is counter to the philosophy of health care reform that consumers of private pay home care services would need to pay higher rates for care. Further, most have limited incomes that might force them to choose Medicaid-funded nursing home care if home services are beyond their reach. In addition, Medicaid programs historically do not increase provider payment rates sufficiently to cover the increases in provider costs. Finally, the work hour flexibility is one of its attractions to employees. The application of employer responsibilities should accommodate the varied work schedules of home care workers in a way that does not disadvantage the employers.
ESTABLISH MEANINGFUL STANDARDS FOR LONG-TERM CARE INSURANCE

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

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

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

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

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

RECOMMENDATION: Congress should amend the “Health Insurance Portability and Accountability Act” and the “Deficit Reduction Act” to require that all long-term care insurance policies meet the most up-to-date federal minimum standards. The federal minimum standards should include the most current NAIC model and should require that all long-term care policies cover a full range of home care and hospice services. Home care and hospice services should be reimbursed at levels at least equal to that of nursing home care. Favorable tax treatment should be extended to more generous plans which provide home care benefits for those who need assistance with one activity of daily living (ADL) or one instrumental activity of daily living (IADL), or when home care is otherwise deemed medically necessary by a physician. Congress
should continue to look for ways to encourage creative use of the private long-term care insurance market to strengthen the Medicaid program.

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

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

ISSUE: Among the many different proposals to improve the U.S. health care system, one common set of recommendations has dealt with reforms to the private health insurance market. These have generally addressed questions of preexisting conditions, portability, setting premium rates and increases, guaranteed issue and renewability, and standardized benefit packages.

The Patient Protection and Affordable Care Act (PPACA) (H.R. 3590; Public Law No. 111-148), prohibits premium variations based on one’s health status or sex (community rating) and places limits on variations based on age. However, the legislation leaves it up to the Department of Health and Human Services (HHS) to determine if home health care and hospice are covered in standardized benefit packages. HHS has issued a regulation giving wide discretion to the states to make the final determination of what are “essential benefits” in the standardized benefit packages offered in state health insurance exchanges.

RECOMMENDATION: Congress should require that insurance companies provide a standardized benefit package that includes coverage for home health care and hospice. Any listing of “Essential Benefits” in insurance offered through state health insurance exchanges under PPACA should include home health care and hospice.

RATIONALE: All Americans should have access to home care and hospice coverage in their health insurance. According to a recent national study, home health is a benefit in 77 percent of health plans and hospice in 66 percent. Home health has proven to be effective in reducing health care expenditures by reducing hospitalizations, shortening hospital stays, and serving as an alternative to costly post-acute inpatients stays. In addition, cost savings are realized at the end of life through the delivery of hospice services. Failure to include home health and hospice coverage will result in increased costs and fewer options to enrollees. Furthermore, failure to include home health and hospice benefits is inconsistent with the Administration’s focus on home and community based services and could be in violation of the American with Disabilities Act (ADA).
ENCOURAGE STATES TO ADOPT HOME CARE QUALITY OF CARE STANDARDS THROUGH VOLUNTARY ACCREDITATION OR LICENSURE LAWS

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

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

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

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

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