

NATIONAL ASSOCIATION FOR HOME CARE & HOSPICE 2015 LEGISLATIVE PRIORITIES

Table of Contents

1. SECURE THE STRATEGIC ROLE CONGRESS INTENDS FOR HOME CARE AND HOSPICE IN ADDRESSING THE NATION’S ACUTE, CHRONIC, AND LONG TERM CARE NEEDS.....	4
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	5
ALLOW NURSE PRACTITIONERS, CLINICAL NURSE SPECIALISTS, CERTIFIED NURSE MIDWIVES AND PHYSICIANS’ ASSISTANTS TO CERTIFY MEDICARE HOME HEALTH PLANS OF CARE	7
RECOGNIZE TELEHOMECARE INTERACTIONS AS BONA FIDE MEDICARE AND MEDICAID SERVICES	8
ENACT A COMPREHENSIVE, HIGH QUALITY HOME- AND COMMUNITY-BASED LONG-TERM CARE PROGRAM	11
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	14
2. ENSURE APPROPRIATE AND ADEQUATE REIMBURSEMENT FOR AND ACCESS TO MEDICARE HOME HEALTH SERVICES.....	16
OPPOSE A “SICK TAX”—BLOCK EFFORTS TO IMPOSE A FEE TO BE PAID BY PATIENTS TO ACCESS MEDICARE HOME HEALTH SERVICES.....	17
ESTABLISH REASONABLE STANDARDS FOR REBASING MEDICARE HOME HEALTH SERVICES PAYMENT RATES	20
REPEAL OR REFORM MEDICARE HOME HEALTH FACE-TO-FACE ENCOUNTER REQUIREMENT	22
ENSURE THE FULL MARKET BASKET UPDATE FOR HOME HEALTH PAYMENTS.....	25
ENACT MEDICARE HOME HEALTH AND HOSPICE PROGRAM INTEGRITY MEASURES.....	28

ESTABLISH TRANSPARENT AND ACCURATE PROCESSES FOR MODIFICATION OF PPS PAYMENT RATES AND CASE-MIX ADJUSTMENTS	30
ENSURE THAT PROPOSALS TO “BUNDLE” POST-ACUTE BENEFIT PAYMENTS OFFER OPPORTUNITIES FOR HOME HEALTH AGENCY PARTICIPATION	32
MAKE PERMANENT THE ADD-ON FOR SERVICES TO RURAL PATIENTS; ENSURE CARE ACCESS FOR RURAL AND UNDERSERVED PATIENTS	34
ENSURE APPROPRIATE DEVELOPMENT OF PERFORMANCE-BASED PAYMENT FOR MEDICARE HOME HEALTH SERVICES	36
3. MAINTAIN THE INTEGRITY AND ENSURE THE AVAILABILITY OF HOSPICE AND PALLIATIVE CARE FOR ALL NEAR THE END OF LIFE.....	38
OVERSEE HOSPICE PAYMENT REFORM; REJECT REBASING AND SITE-OF- SERVICE ADJUSTMENT FOR NF RESIDENTS	39
REJECT PROPOSALS TO INCLUDE HOSPICE AS PART OF MEDICARE ADVANTAGE BENEFIT PACKAGE	41
ENSURE THE FULL MARKET BASKET UPDATE FOR THE MEDICARE HOSPICE BENEFIT	43
ENSURE ACCESS TO CARE FOR RURAL HOSPICE PATIENTS; ESTABLISH ROLE FOR PAs IN HOSPICE CARE	45
SUPPORT THE PORTABILITY OF ADVANCE DIRECTIVES; SUPPORT ADVANCE CARE PLANNING CONSULTATIONS	47
REVISE REQUIREMENTS TO HOSPICE FACE-TO-FACE ENCOUNTERS	49
4. PROTECT AND EXPAND ACCESS TO HOME AND COMMUNITY-BASED SERVICES UNDER MEDICAID.....	51
REQUIRE MEDICAID MANAGED CARE ORGANIZATIONS TO RECEIVE STATE APPROVAL BEFORE LOWERING PAYMENT RATES FOR HOME CARE SERVICES	52
ENSURE ACCESS TO HOME CARE IN MEDICAID MANAGED LONG TERM SERVICES AND SUPPORTS	53
REQUIRE MEDICAID MANAGED CARE ORGANIZATIONS TO CONTRACT WITH ANY WILLING AND QUALIFIED PROVIDER.....	55
ESTABLISH REASONABLE STANDARDS FOR CONSOLIDATION OF MEDICARE FEE-FOR-SERVICE PAYMENTS WITH MEDICAID FOR DUAL- ELIGIBLE BENEFICIAIRES	56

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.....	58
ESTABLISH MINIMUM FEDERAL STANDARDS FOR HOME HEALTH COVERAGE UNDER MEDICAID.....	60
ENACT MEDICAID HOME CARE AND HOSPICE PROGRAM INTEGRITY MEASURES.....	61
DEVELOP STANDARD QUALITY METRICS AND MINIMUM MANDATORY UNIFORM DATA SETS	64
SUPPORT AN INCREASE IN THE FEDERAL MEDICAID MATCH (FMAP) AND OPPOSE CAPS ON FEDERAL PAYMENTS	65
ENSURE APPROPRIATE MEDICAID RATES FOR HOME CARE AND HOSPICE	67
5. PROTECT ACCESS TO HOME CARE AND HOSPICE SERVICES, INCLUDING FOR CARE PAID BY COMMERCIAL INSURERS, PUBLIC PAYERS, AND INDIVIDUALS	69
MODIFY EMPLOYER RESPONSIBILITIES IN HEALTH CARE REFORM TO ADDRESS HOME CARE SPECIFIC NEEDS.....	70
OPPOSE CHANGES TO THE COMPANIONSHIP SERVICES EXEMPTION TO THE FAIR LABOR STANDARDS ACT	73
REQUIRE COVERAGE OF HOME HEALTH CARE AND HOSPICE AS ESSENTIAL HEALTH INSURANCE BENEFITS.....	75
ESTABLISH MEANINGFUL STANDARDS FOR LONG-TERM CARE INSURANCE	76
ENCOURAGE STATES TO ADOPT HOME CARE QUALITY OF CARE STANDARDS THROUGH VOLUNTARY ACCREDITATION OR LICENSURE LAWS.....	78

1. SECURE THE STRATEGIC ROLE CONGRESS INTENDS FOR HOME CARE AND HOSPICE IN ADDRESSING THE NATION'S ACUTE, CHRONIC, AND LONG TERM CARE NEEDS

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 2014 Senators Ron Wyden (D-OR) and Johnny Isakson (R-GA) and Congressmen Eric Paulson (R-MN) and Peter Welch (D-OR) introduced the Better Care, Lower Cost Act (S.1932/H.R.3890) that would encourage fully-integrated medical care through new “Better Care Plans” (BCPs) for people with chronic disease. The BCPs would include home care and hospice as critically important components in managing chronic illness and preventing institutionalization.

RECOMMENDATIONS: 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 113th Congress, the bill numbers were S.1332/H.R.2504.

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 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.

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

The following provisions should be included in 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.

RECOMMENDATIONS: 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.

**2. ENSURE APPROPRIATE AND ADEQUATE
REIMBURSEMENT FOR AND ACCESS TO MEDICARE
HOME HEALTH SERVICES**

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

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

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

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

RATIONALE:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

mental and financial burdens, providing an estimated \$450 billion a year in unpaid care to their loved ones, and too frequently having to cut their work hours or quit their jobs.^{xii}

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

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

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

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

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

ESTABLISH REASONABLE STANDARDS FOR REBASING MEDICARE HOME HEALTH SERVICES PAYMENT RATES

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

The 2013 and 2014 congressional recommendations from the Medicare Payment Advisory Commission (MedPAC) advises 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; establish home health value based purchasing program in 2019.

RECOMMENDATION: Congress should postpone or suspend the implementation of the

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

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.

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.

In place of the narrative, CMS 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.

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.

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.

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.

ENSURE THE FULL MARKET BASKET UPDATE FOR HOME HEALTH PAYMENTS

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

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

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

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

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

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

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

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

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

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

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

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

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

In its 2015 recommendations to Congress, MedPAC once again suggest 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.

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.

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

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

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

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

In response to the regulatory rate reductions, beginning in 2007 legislation (The Home Health Care Access Protection Act) has been introduced annually in both houses of Congress that would require CMS to utilize a rational and transparent process for adjusting rates under the BIPA authority. That legislation proposes detailed standards such as the use of a Technical Advisory Group, consideration of service utilization through service reviews rather than statistical assumptions, and a full public display of the data and analysis prior to the finalization of rate adjustments. The legislation was refilled in the 112th Congress (S. 659). Unfortunately, the proposed legislation has not advanced. 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.

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.

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

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

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

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

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 wish to continue in Model 3 move to Phase 2 in January, 2014. Among the participants are several home health agency-related organizations.

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.

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.

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.

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 put forward a value-based purchasing concept that would initiate VBP in 5-8 states on a mandatory basis and withhold 5-8% 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 SAVE Medicare Home Health Act of 2014, HR 5110, included a VBP program as an alternative to rate rebasing. However, HR 5110 leaves nearly all decisions on the structure of VBP to HHS/CMS and appears to require an annual rate cut that is greater than the rebasing cut because of the need for budget neutrality over 6 years to accommodate a repeal of rebasing cuts over 9 years. Further, the SAVE Act would require that the withhold amount be the equivalent of 50-70% of the annual rate cuts.

RECOMMENDATION: Congress should monitor the progress of the ongoing value-based purchasing demonstrations or proposals and use the findings to guide its consideration of a full-fledged value-based payment system for Medicare home health services. Any legislative 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 process and outcome measures;
4. Refrain from negatively affecting patient access to care;
5. Be consistent with the home health PPS and appropriately risk-adjusted;
6. Limit any expansion of data collection requirements and fully reimburses agencies for the costs of any additional data collection requirements that are imposed;
7. Only reward agencies for care elements over which they have some control;
8. Reward high scoring agencies as well as those that demonstrate improvement for the dynamic value of home health services to the entire Medicare program;
9. Not pose cash flow difficulties for agencies; and
10. Allow the Secretary of Health & Human Services sufficient discretion to delay application of P4P 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 P4P model must be approached very cautiously to ensure that incentives are properly and fairly crafted.

3. MAINTAIN THE INTEGRITY AND ENSURE THE AVAILABILITY OF HOSPICE AND PALLIATIVE CARE FOR ALL NEAR THE END OF LIFE.

OVERSEE HOSPICE PAYMENT REFORM; REJECT REBASING AND SITE-OF-SERVICE ADJUSTMENT FOR NF RESIDENTS

ISSUE: The Medicare hospice benefit (MHB) was created in 1982 to care for terminally ill cancer patients. 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, nonspecific debility and congestive heart failure have made up the majority of Medicare's hospice patients in recent years. Although the average length of stay (LoS) has been increasing, 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 (96 percent of the care given) by analyzing data collected during the 1980-1982 Medicare Hospice Benefit Demonstration Project. Despite significant technological, pharmaceutical, and medical care delivery advances over the past 30 years, there has been no reimbursement adjustment to reflect the changes. The shorter LoS increases per diem costs for each patient.

In the intervening years, advances in technology have resulted in increased outpatient services such as palliative radiation therapy and chemotherapy with accompanying diagnostic procedures required to monitor responses and side effects; these have added to patient care costs.

MedPAC issued recommendations to the Congress for revising the hospice reimbursement system in its March 2009 Report to the Congress. MedPAC continues to recommend such changes, which include expansion of data collection and the creation of a new payment model that reflects the variation in costs over the patient's length of hospice care.

The Centers for Medicare & Medicaid Services (CMS) expanded collection of data related to visits and costs in 2008 and 2010, and further expanded collection requirements in April 2014. In-depth analysis of these and other data are essential to establishing an appropriate method for reforming payments for Medicare hospice services, but the expanded collection will significantly increase burdens on providers. During 2014, CMS made significant modifications to the hospice cost reporting requirements, which will be time-consuming and costly to implement.

The final 2010 health care reform legislation (Public Law 111-148) requires the development of payment system reforms and includes among the potential options a system designed along the lines of the MedPAC recommendations (Section 3132(a)). Payment system reforms authorized by P.L. 111-148 were prohibited from being put into place any earlier than October 1, 2013. While CMS has undertaken considerable analysis of hospice and, in April 2013 provided a glimpse of some options that it has under consideration for payment reform, a final payment reform proposal has not been made public. Of particular concern is CMS' indication that, in addition to considering a tiered approach that would supply higher payment at the beginning of hospice care and just prior

to a beneficiary's death, it is also considering action to "rebase" routine home care rates (RHC) (which would reduce them by approximately 10 percent) and cut payments for hospice care provided to nursing facility residents.

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.

During 2013, Sen. Ron Wyden (D-OR) and Rep. Tom Reed (R-NY) introduced companion legislation (S. 1053/H.R. 2302) that includes a provision requiring that changes to the hospice payment system be studied through a 15-site demonstration project prior to nationwide implementation.

RECOMMENDATION: Congress must closely oversee CMS' activities related to hospice payment reform 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. In particular, Congress must ensure that CMS does not overstep its charge to refine the hospice payment system by including 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. Congress should support changes along the lines of those recommended by Sen. Wyden and Rep. Reed to ensure that any revisions to hospice payment are tested in the "real world" to avoid unintended consequences.

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 coverage and payment for hospice services 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 have a dramatic impact on the population served may result. The impact of too many changes at one time could result in greater harm than what might come from failure to act altogether. These consequences frequently only come to light when the system is actually tested. For this reason, most payment reforms under Medicare have undergone a "demonstration" phase. S. 1053/H.R. 2302 would incorporate a "demonstration phase" into the hospice payment reform process to ensure that the new payment system will not have a negative impact on the delivery of high quality care in the hospice program. While CMS has indicated that implementation of rebasing of RHC would, at least in its first year, be done in a budget neutral manner, hospices have warranted concerns that any increase in payment for services that are contracted (such as General Inpatient Care) will likely be accompanied by increased charges from the facilities with which they have contracted. This will take money out of the hospice system rather than reallocating it. Congress must ensure this most humane service for America's terminally ill patients and their families remains a benefit available at the hour of greatest need – the final stage of life.

REJECT PROPOSALS 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 beginning in 2016. 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.

MedPAC's proposal has raised significant concerns among hospice providers and 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;
- Hospices currently provide a wide array of services to patients and their loved ones – a number of which are not reimbursed by Medicare. 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;
- Similarly, 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; and
- The Medicare Hospice Benefit is currently undergoing significant change. Hospices anticipate a major overhaul of the hospice payment system over the near term but are currently uncertain about the impact these changes will have on their financial viability; these uncertainties will impact hospices' willingness to enter into contracts with MA plans, particularly if the contracts do not, at a minimum, cover costs.

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, thorough analysis of the impact of such a change should first be conducted. 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;
- The hospice inter-disciplinary group (IDG) should be the ultimate authority on hospice eligibility, the hospice plan of care, and determinations of which conditions are related to the terminal diagnosis. Likewise, the IDG should determine the conditions that are not related to the terminal and related conditions that should be covered by the MA plan; and
- The quality and coordination of care as patient's transition to end-of-life care should be 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.

ENSURE THE FULL MARKET BASKET UPDATE FOR THE MEDICARE HOSPICE BENEFIT

ISSUE: Section 3132(a) of the Patient Protection and Affordable Care Act (PPACA), enacted in March 2010 as Public Law 111-148, requires that the Centers for Medicare & Medicaid Services (CMS) develop Medicare hospice payment system reforms along the lines first recommended by the Medicare Payment Advisory Commission (MedPAC) in 2009. Under the law, system reforms may be implemented no earlier than October 1, 2013. P.L. 111-148 also includes interim hospice 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 for FY2013 through 2019, but conditions the 0.3 point market basket reductions in each of FY2014 – 2019 on growth in the health insurance-covered population exceeding 5 percent in the previous year. As the result of the PPACA reductions and a regulatorily-imposed cut, hospice payments for FY2013 increased by only 0.9 percent over FY2012 levels. Effective in May 2013 payments were further reduced (by 2 percentage points) to comply with the automatic sequester enacted under the Budget Control Act. For FY2014 and 2015, hospice payments were scheduled to increase on average by 1 and 1.4 percent, respectively; however, due to the sequester (which is currently scheduled to run until 2024), actual payments will be 2 percent less in each year.

RECOMMENDATION: Congress should restore the market basket and productivity reductions authorized under P.L. 111-148, cancel the 2 percent across-the-board sequester, and reject any further cuts to the hospice market basket update. Congress should oppose any reductions in the annual updates until such time as all payment reforms are instituted and then only after the issues are fully examined.

RATIONALE:

- In FY2010, the Centers for Medicare and Medicaid Services (CMS) began phasing out by regulatory issuance the Budget Neutrality Adjustment Factor (BNAF) to the hospice wage index over seven years. In each year since FY2010 the phase out has reduced the scheduled annual payment increase by 0.6 percent. It is estimated that the phase-out, when completed, will reduce hospice payments by 4 percent overall.
- In addition to the BNAF phase out, the FY2014 payment cycle reflects additional reductions mandated by the PPACA, including a 0.5 percent productivity cut and a 0.3 percent market basket reduction. Further, hospice payments are further reduced by the 2 percent sequester. Rather than a scheduled 2.5 percent inflation update, hospice providers were reimbursed at 1 percent below their scheduled FY2013 rates. For FY2015, hospices will receive a .6 percent reduction over the FY 2013 rates.
- MedPAC has projected that Medicare hospice financial margins for 2015 (without consideration of costs related to volunteer, bereavement, and other nonreimbursable services) will average about 6.6 percent; however, financial margins vary widely in the hospice sector, and many hospices are operating at serious financial risk. Additionally, there is some 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.

- 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 from 6 percent in 2011 to NEGATIVE 10 percent by 2022. Additionally, the study estimated that 66 percent of hospices could have negative Medicare financial margins by 2022.
- In late 2012 CMS announced its intention to change the hospice cost report and to require reporting of additional visit data on claims. While this information is needed, these changes will increase administrative costs to hospices.
- A study by Duke University showed that patients who died under the care of hospice cost the Medicare program an average of about \$2,300 less compared with those who did not.

At its November 2008 and subsequent meetings, MedPAC discussed potential recommended revisions to the Medicare hospice benefit reimbursement system. There is concern about the costs of short stay patients not being fully covered under the current reimbursement system. Financial margins for hospices with shorter stay patients are generally significantly lower than those of hospices serving long-stay patients. Paying accurately for all types of patients is important to ensure access to services for all Medicare beneficiaries who want to elect hospice care and to ensure that the program is paying rates that cover providers' costs for all types of patients.

ENSURE ACCESS TO CARE FOR RURAL HOSPICE PATIENTS; ESTABLISH ROLE FOR PAs IN HOSPICE CARE

ISSUE: Hospices are reimbursed one of four per diem rates based on the level of care provided. Payments for one patient in excess of actual costs are used to help offset higher costs that may be associated with other patients. This works if a hospice has a large enough case load to balance expenses. However, given the low population density in rural areas, rural hospices generally have smaller patient censuses; as a result, if a rural hospice has several high cost patients and a relatively low patient census, there are fewer lower cost patients to help balance expenses and keep the hospice financially stable.

In some areas of the country, a large number of residents receive health care through Rural Health Centers (RHC) or Federally-Qualified Health Centers (FQHC). Medicare law recognizes some of the higher costs associated with delivery of care in these areas and pays on a different basis than under regular fee-for-service reimbursement. However, neither RHCs nor FQHCs are able to bill for visits provided by center physicians for hospice attending physician services. This creates a disincentive for RHCs and FQHCs to provide these services, resulting in a greater burden for rural hospices.

Under hospice law, hospice-employed nurse practitioners (NPs) may continue to serve as a patient's attending physician after a patient enters hospice and may also conduct the required hospice face-to-face encounter. Physician assistants (PAs) have no role in hospice care – they cannot serve as a hospice patient's attending physician, nor may they conduct the hospice face-to-face. Neither NPs nor PAs may serve as the physician head of the hospice team or certify a patient as eligible for hospice services.

RECOMMENDATION: Congress should enact a five percent payment rate add-on for hospices located in and caring for patients in rural areas. Further, Congress should enact legislation that would allow RHCs and FQHCs to bill Medicare for attending physician services provided for hospice patients. Finally, Congress should enact legislation to allow PAs to serve as attending physicians for hospice patients and conduct the hospice face-to-face encounter.

RATIONALE: As is the case with other health care providers, hospices in rural areas have difficulty recruiting and retaining adequate staff to meet the full panoply of services required under the Medicare hospice benefit, as well as the increasing number of regulatory requirements (such as the face-to-face encounter requirement). Due to the generally lower patient census in rural areas, these hospices may run higher financial risk when admitting high need hospice patients. Additionally, hospice caregivers must drive greater distances to patients' residences than in urban areas. There is no consideration of consistently more expensive fuel costs in hospice reimbursement rates. The hospice wage index is updated annually using the most currently available hospital wage data as well as any changes by the Office of Management and Budget in the core-based statistical areas followed by the budget neutrality adjustment. In most states, the rural wage index is lower, resulting in comparatively lower reimbursement rates.

Addressing the disincentives for RHC and FQHC physicians to provide attending physician services to hospice patients, as well as establishing a role for PAs in hospice, would help to support the delivery of high quality, individualized hospice care even in remote areas of the U.S.

SUPPORT THE PORTABILITY OF ADVANCE DIRECTIVES; SUPPORT ADVANCE CARE PLANNING CONSULTATIONS

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 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. However, the original 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). Legislation to authorize advance care planning consultations (H.R. 1173) and to support portability of advance directives was introduced by Rep. Earl Blumenauer (D-OR) during 2013. During, 2014, the American Medical Association (AMA) approved the addition of Common Procedural Terminology (CPT) codes for advance care planning; the Centers for Medicare & Medicaid Services (CMS) has indicated that it may consider allowing use of these codes under the Medicare physician payment system at some future time.

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 authorize voluntary advance care planning consultations under Medicare to educate beneficiaries on issues related to end-of-life care and end-of-life care planning.

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.

Voluntary advance care planning consultations under Medicare would help to familiarize beneficiaries with end-of-life care choices and the availability of the Medicare hospice benefit and the services available under it so that a beneficiary is more aware of the options available to them if terminal illness should occur.

REVISE REQUIREMENTS TO 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. Hospice may take a patient onto service only to discover some weeks or months 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.

During the 113th Congress, Sen. Ron Wyden (D-OR) and Rep. Tom Reed (R-NY) introduced S. 1053/H.R. 2302, the Hospice Evaluation and Legitimate Payment (HELP) 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’ “special circumstances”, 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. 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.

4. PROTECT AND EXPAND ACCESS TO HOME AND COMMUNITY-BASED SERVICES UNDER MEDICAID

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.

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

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

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

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

RECOMMENDATIONS: 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.

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.

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.

ENACT MEDICAID HOME CARE AND HOSPICE PROGRAM INTEGRITY MEASURES

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

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

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

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

- The institution of state Medicaid compliance plans directed to Medicaid home care and hospice programs to ensure adherence to all federal and state laws with proper funding support.
- Standards for "return on investment" so that program integrity efforts are priorities based on impact and corrective measures targeted to the most economic and productive approaches.
- Strengthened admission and program participation standards for individual and agency-model home care providers, including standards for competency, early-stage pre-pay claims review, and experience.

- Mandatory screening and federally-funded background checks on all individuals wishing to provide Medicaid home care or open/operate a Medicaid home care agency or hospice.
- Mandatory background checks on all employees of home care agencies and establishment of a national registry of home care workers consistent with existing state laws.
- Providing consumers and prospective consumers of Medicaid home care services and hospice care with a summary of program coverage requirements. The consumer reporting hotline for suspected fraud, waste, and abuse also should be enhanced and made more accessible.
- Standards for service validation systems that allow for the maintenance of electronic documentation of service delivery consistent with the services approved for payment.
- Standards for pre-payment and post-payment claims review, including the appropriate use of sampling extrapolation.
- Credentialing and competency testing standards for government contractors and federal regulators responsible for issuing Medicaid determinations. A hotline should be developed for beneficiaries and providers to report inadequate enforcement action by those charged with protecting Medicaid.
- Supplying adequate and enhanced administrative financing to Medicaid to enforce existing laws and regulations such as survey and certification standards, provider education, and claims reviews.
- Enhancement of education and training of home health agency and hospice staff through joint efforts with regulators.
- Implementation of outcome-based compliance standards for quality of care that provide operational flexibility and also eliminate structural requirements that 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.

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.

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

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

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

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

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

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

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

RECOMMENDATION: Congress should reject any consideration of placing caps on Medicaid spending and increase the federal match for state Medicaid programs, thereby bolstering efforts to bring states into compliance with the Olmstead decision. Proposals for per beneficiary caps or full program federal spending caps such as block grants should be rejected by Congress.

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

ENSURE APPROPRIATE MEDICAID RATES FOR HOME CARE AND HOSPICE

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

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

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

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

RECOMMENDATION: Congress should enact legislation that requires that states

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

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

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

5. PROTECT ACCESS TO HOME CARE AND HOSPICE SERVICES, INCLUDING FOR CARE PAID BY COMMERCIAL INSURERS, PUBLIC PAYERS, AND INDIVIDUALS

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

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

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

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

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

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

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

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

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

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. This will likely lead to increased turnover, lower overall wages, and the weakening of quality of care while still not providing health insurance to the workers.

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.

OPPOSE CHANGES TO 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. It is expected that DOL will appeal.

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 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 govern-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.

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 inpatient 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).

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.

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

ISSUE: As of 2010, 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.