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ABOUT THE BLUEPRINT

The 2014 Medicaid Blueprint for Action represents the legislative agenda for the National Council on Medicaid Home Care. This document contains a discussion of priorities and other important issues and recommendations concerning home care and hospice. It was prepared through a series of meetings with home care and hospice professionals, state association representatives, and a survey of the National Association for Home Care & Hospice (NAHC) members. It has been reviewed by the Government Affairs Committee and was approved by the NAHC Board of Directors at its 2014 meeting.

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

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

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


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

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

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

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

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

If these health care delivery reforms are to fully succeed, the Centers for Medicare and Medicaid Services (CMS) and all participants in the delivery models 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.

**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.
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 Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADL); 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. 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.

After some delays, the Long Term Care Commission came together in June of 2013 and issued its final report, as required by statute, on September 18, 2013. In the final report, the Commissioners adopted 28 public policy recommendations in a 9-6 vote. The policy recommendations centered around service delivery, workforce and financing with a eye toward person and family-centered care, integration of LTSS and medical care, access to information, and caregiver training and involvement, among other concepts. The Commissioners were unable to create a full financing recommendation due to time constraints and limited resources. The full report was delivered to President Barack Obama as well as the leaders of the Senate and House of Representatives on September 18, 2013.

The health care reform legislation also includes 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 health care aide services; medical social services; personal care services; chore services; physical, occupational, speech, and respiratory therapy and rehabilitative services; hospice services; respite care; and adult day services; medical supplies and durable medical equipment; minor home adaptations that, among other benefits, enable beneficiaries to receive services at home; transportation services; nutritional services; and patient and family education and training.
- Quality of care must be ensured. Quality assurance standards, including minimal standards of training, testing, and supervision, should be applied to the
delivery of services in the home, regardless of the source of payment for those services.

- 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 is devoted to institutional care.

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

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 2013 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 65% of Medicaid home care companies and private pay home care companies do not offer health insurance.

On June 19, 2013, Senator Susan Collins 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 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 exempt home care providers from the employer responsibilities, provide 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. Alternatively, Congress should pass the “Forty Hours Is Full Time Act” and allow employees to continue to work 40 hours per week without penalty to their employer. 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.
REQUIRE TRANSPARENCY IN THE STATE PLAN AMENDMENT PROCESS

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

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

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

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

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

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

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

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

**RECOMMENDATION:** Congress should require all states contracting with individuals to provide paraprofessional home care services through federally-funded programs to provide
adequate assurances that consumers receiving care from such individuals are assessed to be capable (for example, a person receiving highly skilled services such as catheter care must be capable of directing the caregiver in the performance of that task) and willing to assume the required employer responsibilities. Consumers should also be given the full option to choose among service models (consumer-directed, home care agency, etc.) to ensure individual freedom of choice, and should have access to the same frequency and type of care regardless of the chosen delivery model. States should also provide a mechanism for resolving any problems that arise between a consumer and providers, and should devise a method for ensuring that backup workers are available. Consumers directing their own care and their caregivers should be afforded the same important protections that are required when care is provided through an agency. The same needs should be met under each model for the same level of care. Caregivers should be trained, tested, and competent to provide services.

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

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

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

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

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

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

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

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

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

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

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

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

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

The lack of implementation of the face-to-face encounter in Medicaid has led to great confusion among physicians, home health agencies, and other parties involved. CMS has yet to proffer any guidance or standards, leaving the states in limbo. Some states have created their own face to face rules, that are often confusing and impractical, while others await information from CMS. As a result, the requirement is, in some cases, creating a barrier to access to care and in other cases being completely ignored.

RECOMMENDATION:

1. CMS should establish standards for the Medicaid face-to-face encounter requirement. Those standards should be specific to the Medicaid home health benefit and not merely an extension of the requirements for Medicare patients.
2. Any future standards from CMS for the Medicaid face-to-face encounter should include the use of a uniform certification statement and not physician narratives. The standards should make no reference to a homebound requirement.
3. Congress should monitor the impact of the face-to-face encounter requirements and, if necessary, repeal the provision and devise more constructive ways to secure physician involvement in home health care.
4. 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.
5. 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.

6. 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.

7. Allow a non-physician practitioner to perform the encounter, certify that the encounter occurred, and compose all necessary documentation of the findings from the encounter.

RATIONALE: The purpose of the face to face requirement was to enhance physician involvement in home health care, not to discourage physicians referring patients to care in their own homes. There is no evidence that pre-existing methods of physician involvement and communication negatively impacted the quality of patient care. Further, any evidence of overutilization of Medicaid coverage cannot be tied to a lack of physician involvement or the nature of physician/patient/home health agency communications. The benefits of the face-to-face requirement serving as a measure of program integrity are far outweighed by the harm the requirement causes relative to patient access to care.
ESTABLISH MEDICAID HOME CARE AS A MANDATORY BENEFIT AND SUPPORT REBALANCING OF LONG TERM SERVICES AND SUPPORTS EXPENDITURES IN STATE MEDICAID PROGRAMS IN FAVOR OF HOME CARE

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

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

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

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

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

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

- Extension of the Money follows the Person Rebalancing Demonstration program

- Protections against spousal impoverishment in Medicaid home and community-based services;

- Enhanced federal matching through the State Balancing Incentive Program for select states to increase the proportion of non-institutionally-based long-term services and supports; and

- New options for states to offer home and community-based services through the state plan for individuals with incomes up to 300 percent of the maximum supplemental security income payment who have a higher level of need and to extend full Medicaid benefits to individuals receiving home and community-based services under a state plan.

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

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

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

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

**RATIONALE:** After several years, it is necessary for the Congress to intervene and secure the systemic reforms guaranteed by the ADA. However, states need financial support in these efforts since the transition will have start-up costs. The rebalancing must be accomplished with federal minimum standards of care and access whether the state maintains
a traditional fee-for-service care model or a managed care approach.
SUPPORT AN INCREASE IN THE FEDERAL MEDICAID MATCH (FMAP) AND OPPOSE CAPS ON FEDERAL PAYMENTS

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

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

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

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

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

During deficit reduction discussions in 2011 and 2012, proposals surfaced to establish per beneficiary caps on Medicaid spending or, alternatively, to block grant all Medicaid spending to control the federal share of Medicaid costs.
RECOMMENDATION: Congress should reject any consideration of placing caps on Medicaid spending and increase the federal match for state Medicaid programs, thereby bolstering efforts to bring states into compliance with the Olmstead decision.

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. Further, with the initiation of the Medicaid Access and Payment Advisory Council (MACPAC) it is expected that Congress will be better advised on the shortcomings of existing Medicaid payment rates throughout the states. As of January 2014, CMS has not issued a final rule on payment rate standards.

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

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

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

RATIONALE: Virtually all Medicaid home care reimbursement systems pay insufficient attention to the effect of payment rates on patients’ access to care or the cost of efficiently delivering services. Inadequate rates also severely impact the ability of the provider to meet quality and safety standards. Requiring states to engage in an annual analysis of the rate setting methodology and the adequacy of payment rates combined with federally mandated goals for a rate setting process will ensure that Medicaid recipients receive high quality care.
REQUIRE MEDICAID MANAGED CARE ORGANIZATIONS TO RECEIVE STATE APPROVAL BEFORE LOWERING PAYMENT RATES FOR HOME CARE SERVICES

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

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

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

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

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

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

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

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

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

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

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

By allowing states to cap enrollment, the HIFA waiver policy converts Medicaid from an entitlement program, in which all eligible applicants can enroll and receive services, to a block grant that stops enrollment when a finite expenditure is reached.
EXEMPT HOME CARE AND HOSPICE FROM COST-SHARING BY MEDICAID BENEFICIARIES

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

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

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

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

If, in an effort to keep Medicaid payments in check, the states impose even a nominal cost-sharing requirement on Medicaid home health services, many low-income individuals would be forced to go without needed care. As a result, beneficiaries may incur unnecessary hospitalizations as they forgo needed home care because they cannot afford the copays. In addition, far from saving program costs, requiring home care agencies to collect copayments can also result in increased administrative costs that exceed the amounts collected. Finally, federal Medicaid regulations on cost sharing prohibit providers from denying access to services based on a beneficiary’s inability to pay the cost sharing amounts. With already inadequate payment rates, providers would be forced to assume significant bad debt.
ESTABLISH MINIMUM FEDERAL STANDARDS FOR HOME HEALTH COVERAGE UNDER MEDICAID

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

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

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

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

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

- inpatient and outpatient hospital services;
- prenatal care;
- physician services;
- skilled nursing facility services for individuals age 21 and older;
- home health care for persons eligible for nursing facility care;
- family planning services and supplies;
- rural health clinic services;
- laboratory and x-ray services;
- pediatric and family nurse practitioner services;
- certain ambulatory and health center services;
- nurse midwife services; and
- early and periodic screening, diagnosis, and treatment (EPSDT) services for children.

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

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

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

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

Home care and hospice services are cost-effective and should be available to all those in need. The Medicaid program could realize substantial cost savings by caring for people in their homes.
In addition, the US Supreme Court held in *L.C. v. Olmstead* that the Americans with Disabilities Act (ADA) requires state Medicaid programs to meet health care needs in the least restrictive environment. However, so long as home care services are optional benefits the promise of the ADA will not be realized.
EXTEND SPOUSAL IMPOVERISHMENT PROTECTIONS TO HOME CARE

ISSUE: Before 1989, when an elderly woman was forced to place her husband in a Medicaid nursing home, she was forced to live in poverty herself. The Medicaid program required that, in order for the husband to qualify for Medicaid nursing home care, nearly all of the couple’s assets and income had to be spent-down, leaving the spouse at home with, in many states, less than $400 per month to pay for housing, food, and other expenses. In 1989, Congress created the Medicaid “spousal impoverishment” protections to end this unfair treatment. In 2014, under these provisions, the spouse at home will be able to retain assets, in addition to the home, of up to $117,240 and income of up to $2,931 a month.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

RATIONALE: Basic standards of care, including training, testing, and supervision must be met to assure minimum levels of safety for care recipients and caregivers. A clear line of accountability for the quality and consistency of care provided is essential. Caregivers should
have FICA withheld and paid, worker’s compensation paid, and appropriate state, local and federal taxes withheld and paid. These concerns are particularly important in light of increased bipartisan interest and support in the U.S. Congress for consumer- directed home care services.
**ENHANCE CONSUMER PROTECTIONS FOR HOME CARE RECIPIENTS**

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

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

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

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

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

**RECOMMENDATIONS:**

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

- A national registry listing home care workers who have been deemed qualified to provide home care services or those who have been found in violation of the law or safety standards should be established.

- Quality assurance standards should be required in all federal and state funded long-term care programs. Such standards should include minimum standards of training, testing, supervision, and practice in the delivery of in-home services. Quality and safety standards should apply regardless of consumer, provider or payer.

- Education programs should be approved by the state or by state or federally- approved accrediting organizations.

- Congress should require states to establish mechanisms for resolving problems that arise between consumers and independent providers.

- Congress should increase funding for adult protection programs and mandate that state elder abuse reporting laws include immunity from prosecution for persons reporting incidence of abuse.

- Congress should establish a commission to investigate elder abuse and make recommendations for increasing penalties.

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

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.

RECOMMENDATION: Congress should mandate development of a uniform model law for certification and licensure of 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.

RATIONALE: Such model laws are needed to ensure appropriate consumer protection and to ensure that quality home care is being delivered by home care agencies and individual home care providers. States would be encouraged, but not required to adopt these model laws.
REQUIRE COMMUNITY PARAMEDICS THAT PROVIDE NON-EMERGENCY SERVICES IN THE HOME TO MEET REGULATORY AND LICENSING HOME CARE STANDARDS

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

RECOMMENDATION: Require community paramedics and similar to comply with the same regulations and licensing standards that home care agencies operate under in order to receive payment for services from Medicaid.

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

A well-trained and reliable workforce are critical to successful patient care. A home care worker consistently providing care and building a relationship with a patient is an essential piece of successful home care. Community paramedics will not always be available to spend the time developing those relationships or have the availability to consistently provide high quality care. Paramedics are employed to provide medical care in emergency situations and it is unreasonable to put patients in danger of waiting for emergency care or waiting to receive home care. It is even more unreasonable to bill Medicaid for services provided when the services are being provided outside of home care requirements mandated by Medicaid.
REQUIRE MEDICAID MANAGED CARE ORGANIZATIONS TO CONTRACT WITH ANY WILLING AND QUALIFIED PROVIDER

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

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

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

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

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

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

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

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

RATIONALE: A majority of available Medicaid dollars are already committed to long term services with little to show by way of quality outcomes or measurable data. As reliance on long term services and supports continues to grow with the aging of the baby 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.
D. CHILDREN’S SERVICES

IMPROVE REIMBURSEMENT REQUIREMENTS FOR PEDIATRIC HOME CARE UNDER MEDICAID

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

The Centers for Medicare and Medicaid Services (CMS) issued a proposed regulation in 2011 that set standards for states to establish provider payment rates. This rulemaking proceeding is ongoing and offers some promise of improving state rate setting processes.

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

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

RATIONALE: No state has yet designed a home care reimbursement system under Medicaid that achieves the standard of access established under federal law. Virtually all Medicaid home care reimbursement systems are driven by state budgetary concerns with little concern for the patients’ access to care or the costs of delivering services. Adequate, national Medicaid reimbursement rates will ensure access to appropriate pediatric home care services.
PROVIDE ACCESS TO HOME CARE SERVICES FOR PEDIATRIC PATIENTS WITH MORE INTENSIVE CARE NEEDS

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

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

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

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

RATIONALE: Certain pediatric patients are best cared for in the home, where they can remain with their families. Because home care agencies have fewer pediatric patients and because more specialized staff is needed, services for pediatric patients with more intensive care needs are far more costly.
II. PROMOTE EFFICIENT USE AND ENSURE ADEQUATE SUPPLY OF QUALIFIED HOME CARE AND HOSPICE PERSONNEL
REVERSE OR FUND 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 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.

RECOMMENDATION: A companionship services exemption under wage and hour laws should be restored 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 an added costs of
overtime compensation and provide financial protection to consumers of private pay services
through tax credits or other subsidies. Finally, Congress should enact reforms to the FLSA that
establish a reasonable compensation structure for home care that respects the uniqueness of
that employment setting where the patient/client is the primary focus of responsibility. That
reformed structure should also properly address the unique aspects of “live-in” care where
employees reside in the home of the client, receive room and board, and take on caregiving
responsibilities throughout a 24 hour day.

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

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

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

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

Increasingly, efforts are being made to document the relationship between wages and quality of care. Without sufficient reimbursement, financially strapped home care and hospice agencies are finding it extremely difficult to provide quality care, pay competitive wages, and foster job satisfaction.
REQUIRE FEDERALLY FUNDED CRIMINAL BACKGROUND CHECKS AND ESTABLISH A NATIONAL REGISTRY SYSTEM

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

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

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

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

Section 307 of P.L. 108-173 required the Secretary of HHS to establish pilot projects in no more than 10 states for the purpose of expanding background checks for workers with direct patient access who are employed by Medicare and Medicaid long term care providers. CMS selected seven states to participate in the Background Check Pilot Program: Alaska, Idaho, Illinois, Michigan, Nevada, New Mexico, and Wisconsin. Long term care facilities or
providers include nursing homes, home health agencies, hospices, long term care hospitals, and other entities that provide long term care services (except for those paid through a self-directed care arrangement). Separate funds were earmarked to conduct an independent evaluation of the background check pilot which has now been completed.

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

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

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

In state laws the trend is toward background check requirements for nursing and home care aides only; however, there is currently no consistent systematic mechanism through which other direct care staff are checked. It is in the best interest of consumers of home care and other health services for all direct care staff to be screened.
III. ENSURE THE APPROPRIATE USE OF TECHNOLOGY IN HOME CARE
RECOGNIZE TELEHOMECARE INTERACTIONS AS BONA FIDE MEDICARE
AND MEDICAID SERVICES

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

With increasing expectations for quality care delivery, the use of technology to deliver home health and hospice care is increasingly being recognized as an invaluable tool for an industry challenged by diminished reimbursement formulas. For example, through the use of telehomecare, the Veterans Administration realized a 25 percent reduction in the number of bed days of care, a 19 percent reduction in hospital admissions, and an 86 percent satisfaction rate of veterans being seen in their home with their Care Coordination/Home Telehealth (CCHT) program. Home care agencies have also been readily adopting remote monitoring technologies (In a 2009 NAHC-sponsored study [“The Blackberry Report: The National State of the Home Care Industry”, conducted by Fazzi Associates], 23 percent of HHAs report using telehealth systems, up from 17.1 percent in 2006).

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 13 state Medicaid programs have passed Medicaid waivers that include the reimbursement of telehomecare. 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. In 2009, a companion bill was introduced in the House of Representatives by Rep. Tim Walz (D-MN). 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.

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) expand the list of authorized originating sites for telehealth services by physicians under section §1834(m)(3)(C) to include an individual’s home; 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.
IV. DUAL ELIGIBLE BENEFICIARIES
ESTABLISH REASONABLE STANDARDS FOR CONSOLIDATION OF MEDICARE FEE-FOR-SERVICE PAYMENTS WITH MEDICAID FOR DUAL-ELIGIBLE BENEFICIARIES

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 demonstrations 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 disenroll 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.
RESTRICT PASSIVE ENROLLMENT OF DUAL ELIGIBLES IN MEDICARE ADVANTAGE PLANS

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

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

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

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

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

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

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

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

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

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

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

RECOMMENDATION: In addition to prohibiting individual claims-based “Medicare maximization” (a separate Blueprint item), Congress should require that state Medicaid programs:

1. Utilize the most cost effective method for recovering payment for dually eligible
patients.
2. Consider the development of a system of claims review that does not require 
individual claims submissions and appeals. Medicare and Medicaid claims submission 
should be combined with initial billing to Medicare and a transfer billing of remaining 
non-covered care to the respective state Medicaid program.
3. Recoup incorrect payments from the Medicare program rather than the provider. No 
recovery should take place against a provider until after third party (Medicare’s) 
liability is established.
4. Work with CMS on implementation of pilot programs that incorporate the above 
recommendations for dually eligible beneficiaries’ coverage decisions on a nationwide 
basis.
5. Establish clear coverage standards for Medicare and Medicaid that differentiate 
between the Medicare responsibilities in an episode of care and the Medicaid coverage 
obligations for additional services.

RATIONALE: While home health agencies make the best effort to determine whether a 
patient is covered under Medicare prior to submission of a claim to Medicaid, incorrect 
Medicaid payments have occurred. However, the use of an individual appeals system 
represents a costly, burdensome process for all parties concerned including the provider of 
care, the Medicaid program, and Medicare. Strengthened rules and better enforcement 
would allow CMS to maintain improved oversight over state programs and to minimize the 
overall cost experienced by all parties. If the model demonstration programs are adopted 
nationwide, most of the burden of states’ efforts to maximize Medicare will be eliminated.
V. ENSURE APPROPRIATE PAYMENT POLICY AND REGULATION OF HOME CARE AND HOSPICE WHILE EASING PAPERWORK BURDEN AND DUPLICATIVE STATE AND FEDERAL REQUIREMENTS
PROVIDE ACCESS TO MEDICAID ENROLLMENT INFORMATION

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

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

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

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

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

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

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

RATIONALE: The vast majority of financing for Medicaid services comes through the federal government. If states are immune from lawsuits by beneficiaries and providers of services in circumstances where there is an allegation that federal law has not been followed by the state, it is left to HHS and the Centers for Medicare and Medicaid Services (CMS) to oversee the state programs on its own. CMS is improving its enforcement of federal Medicaid law. However, Medicaid beneficiaries and providers also have a vested interest in securing those benefits which are available under federal law and should not be constrained in their efforts to secure such.
STRENGTHEN REQUIREMENTS FOR PUBLICATION OF POLICY CHANGES BY CMS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Medicaid home care program integrity issues share similarities with Medicare, but also present unique circumstances necessitating tailored and targeted action. States are often allowed to design their own program integrity measures. While this permits states to develop the approaches to program integrity that best fit their Medicaid program, it also leaves open a level of risk that could be addressed through model, federally-recommended processes.

Medicaid home care is very diverse with services ranging from personal care assistance to high-tech private duty nursing. In addition, providers of Medicaid home care include unlicensed individual home care aides, unlicensed home care agencies along with skilled health care professionals such as nurses and therapists and licensed and accredited home health agencies. Program integrity weaknesses that have been alleged to date include billings for unqualified beneficiaries, inadequate documentation to validate the provision of covered services, unqualified caregivers, billings for unauthorized services, and false billings for care not rendered. As such a broad construct of program integrity measures are needed.

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

• The institution of state Medicaid compliance plans directed to Medicaid home care and hospice programs to ensure adherence to all federal and state laws with proper funding support.

• Standards for “return on investment” so that program integrity efforts are priorities based on impact and corrective measures targeted to the most economic and productive approaches.
• Strengthened admission and program participation standards for individual and agency-model home care providers, including standards for competency, early-stage pre-pay claims review, and experience.

• Mandatory screening and federally-funded background checks on all individuals wishing to provide Medicaid home care or open/operate a Medicaid home care agency or hospice.

• Mandatory background checks on all employees of home care agencies and establishment of a national registry of home care workers consistent with existing state laws.

• Providing consumers and prospective consumers of Medicaid home care services and hospice care with a summary of program coverage requirements. The consumer reporting hotline for suspected fraud, waste, and abuse also should be enhanced and made more accessible.

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

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

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

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

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

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

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

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

ISSUE: In 1986, when Congress enacted legislation making the Medicare hospice benefit permanent, hospice care was made an optional benefit under Medicaid. Hospice care allows terminally ill patients to move out of acute care facilities into less expensive care arrangements, primarily their own homes. There, the hospice team of health care professionals and other specialists provide physical, emotional and spiritual care to make the remainder of a patient’s life as comfortable and meaningful as possible. As of 2011, 48 states had chosen to offer the hospice benefit to Medicaid beneficiaries. However, as states experience growing budget concerns, some are considering elimination of hospice coverage under their Medicaid programs or limiting the number of covered days, which would leave some of the country’s most vulnerable individuals without appropriate care at the end of life. South Carolina is one of the states that has, unfortunately, already announced its intent to eliminate the hospice benefit from its Medicaid program.

The 2010 health care reform measure greatly expanded the populations eligible for Medicaid. Additionally, as the result of a provision in the final health reform legislation, which became Public Law 111-148, states must now cover hospice and curative services concurrently for those children eligible for Medicaid or Medicaid-expansion Children's Health Insurance Program (CHIP) programs. However, hospice remains an optional benefit for adults.

RECOMMENDATION: Congress should mandate Medicaid hospice coverage for all populations served.

RATIONALE: States expanded their Medicaid programs to cover hospice care in an effort to provide a more cost-effective and compassionate manner of caring for terminally-ill adults and children, including indigent and disabled individuals. Mandating hospice under Medicaid would speed access to hospice services. Hospice, with its combination of inpatient and outpatient care and case management by an interdisciplinary team composed of doctors, nurses, social workers and counselors, can provide high quality, comprehensive end-of-life care for the terminally ill patient while saving taxpayer funds. But with the current financial strains on Medicaid programs, even some states that currently offer hospice are considering dropping their Medicaid hospice benefit.