NATIONAL ASSOCIATION FOR HOME CARE & HOSPICE

2006 LEGISLATIVE BLUEPRINT FOR ACTION

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# TABLE OF CONTENTS

Table of Contents ............................................................................................................................. i  
About the Blueprint ............................................................................................................................ x  
2006 Legislative Priorities Summary ................................................................................................ xi  

## 1. ENSURE THE ENACTMENT OF A COMPREHENSIVE, HOME-BASED NATIONAL POLICY ON LONG TERM CARE

- Protect Consumer Choice of Provider in the Provision of Long Term Care Services .................................................................................................................. 2  
- Establish Frail Elderly Care Management Benefit Under Medicare ........................................................................................................................... 3  
- Require Medicaid Home Care Programs to Offer a Comprehensive and Full Range of Care Delivery Models ........................................................................ 4  
- Ensure Access to Home Care In Medicaid Managed Long Term Care ........................................................................................................ 5  
- Enact a Comprehensive, High Quality Home- and Community-Based Long Term Care Program ..................................................................................... 6  
- Support Proposals That Will Supply a Stable, Quality Direct Care Workforce Providing Quality Care for Long-Term Care Consumers ......................................................................................... 8  
- Establish Federal Medicaid Standards for Personal Care Services .................................................................................................................. 9  
- Require Contractors of Home Care Services and/or Consumer-Directed Home Care Services to Ensure Quality and Supervision of Such Services ................................................................. 10  
- Require Medicaid Home Care Programs to Offer a Full Range of Delivery Models and to Meet Quality of Care Standards ........................................................................................................ 11  
- Enhance Consumer Protections for Home Care Recipients ............................................................................................................................... 12  
- Eliminate Elder Abuse ................................................................................................................................................................. 14  
- Support Rebalancing of Long Term Care Expenditures in State Medicaid Programs in Favor of Home Care ................................................................................................................................. 15
Support an Increase in the Federal Medicaid Match (FMAP) and Oppose Caps on Federal Payments ................................................................. 16

Ensure Appropriate Medicaid Rates for Home Care and Hospice................................. 17

Reject Medicaid Waivers That Reduce Benefits for Current Beneficiaries...................... 18

Oppose Cost-Sharing by Medicaid Beneficiaries ............................................................... 19

Promote Respite Care for Family Caregivers .................................................................. 20

Support Medicare Coverage of Drug Therapies in the Home ......................................... 21

Establish a Home and Community-Based Waiver-Type Program under Medicare .......... 23

Create a Pharmaceutical Service Home Health Benefit ................................................. 24


Require Coverage of Home Care, Hospice and Personal Care Service in Any Medicaid Reform .................................................................................. 26

Extend Spousal Impoverishment Protections to Home Care ........................................... 27

Support Tax Incentives for Family Caregivers ............................................................... 28

Improve Home Care Services for Veterans .................................................................... 29

Oversee the Implementation of a Comprehensive Home Care Benefit in the Military Health Services System ................................................................. 30

Establish Meaningful Standards for Long-Term Care Insurance ..................................... 31

Monitor States’ Compliance with IDEA Obligations ....................................................... 33

Improve Reimbursement Requirements for Pediatric Home Care under Medicaid .......... 34

Encourage States to Adopt Licensure Laws and Regulations for Home Care Agencies .... 35

Provide Access to Home Care Services for Pediatric Patients with More Intensive Care Needs .................................................................................. 36

Require Medical Residents and Interns to Have Home Care and Hospice Experience as Part of Their Graduate Medical Education ........................................... 37
II. PROMOTE EFFICIENT USE AND ENSURE ADEQUATE SUPPLY OF QUALIFIED HOME CARE AND HOSPICE PERSONNEL .................................................. 38

Establish Federal Authority for Association Health Plans.................................................. 39

Support Health Reform Proposals that Provide Affordable Health Insurance
To Uninsured Low-Wage Workers ...................................................................................... 40

Provide Sufficient Home Care and Hospice Payments so that Agencies Can
Provide Appropriate Wages and Benefits to Clinical Staff .................................................. 42

Ensure Adequate Home Care and Hospice Personnel, Particularly in Rural and
Other Underserved Areas ..................................................................................................... 43

Coordinate Home Care Aide and Nursing Home Aide Training Requirements .............. 45

Strengthen the Home Health Aide Training Requirements Contained in OBRA-87
and Appropriately Reimburse Agencies for Training Costs ................................................. 46

Allow LPNs/LVNs to Supervise Home Care Aides ............................................................ 47

Prevent Violence against Home Care Workers .................................................................... 48

Require Federally Funded Criminal Background Checks and Establish a National
Registry System ..................................................................................................................... 50

Establish Stability and Equity Among Medicare Health Care Providers in
Application of the Wage Index ............................................................................................ 52

III. ENSURE THE APPROPRIATE USE OF TECHNOLOGY IN HOME CARE ...... 53

Recognize Home Telehealth Interactions as a Bona Fide Medicare Service ..................... 54

Provide Financial Assistance to Home Care Agencies to Expand and Use of Information
Technologies and Implement Electronic Health Records ......................................................... 56

Allow Payment for Home Health Services for Center-Based Care for
Technology-Dependent Children ............................................................................................ 57

Cover Appropriate Self-Care Technologies ........................................................................ 58

Finance a Resource Guide to Home Telehealth Technologies ............................................. 59

IV. RECOGNIZE THE APPROPRIATE ROLE OF HOME CARE AS PART OF
ANY DISASTER PREPAREDNESS AND RESPONSE STRATEGY ................... 60

Develop a System that Includes the National Home Care Network to Promote Effective
Preparedness for and Response to Natural and Manmade Disasters ................................... 61
V. ENSURE APPROPRIATE PAYMENT POLICY AND REGULATION OF HOME CARE AND HOSPICE WHILE EASING THE PAPERWORK BURDEN AND DUPLICATIVE STATE AND FEDERAL REQUIREMENTS

Conduct In-Depth Study of Variation in Home Health Service Use and Outcomes in Medicare Managed Care as Compared to the Fee-for-Service Sector

Ensure Appropriate Development of Performance-Based Payment for Medicare Home Health Services

Expand Study of Quality, Cost Effectiveness of Post-Acute Providers

Reform Annual Medicare Inflation Update Calculation Method

Prohibit Suspension of Payment in Suspected Overpayment Cases

Evaluate Use and Accuracy of Home Care Compare

Ensure Appropriate Development of Performance-based Payment for Medicare Home Health Services

Limit Retroactive Recoveries Related to the Implementation of Medicare PPS

Enact Home Care Specific Anti-Fraud Measures

Reform Standards for Health Care Services Liability

Refine Medicare Home Health PPS Outlier Payment

Eliminate Inequities in Partial Episode Payments

Reform PPS Coverage and Reimbursement for Medical Supplies under PPS

Revise Current Significant Change in Condition (SCIC) Payment Policy to Ensure Appropriate Payment for Increased Services

Establish Standards for Modification of PPS Payment Rates and Case-Mix Adjustments

Reject Risk-Sharing Under Home Health PPS

Ensure an Equitable PPS with an Adequate Case Mix Adjustor

Ensure Care Access for Rural and Underserved Patients
Establish Expedited Payment Schedules for Medicare Home Health Services Under PPS ............................................................................................................................ 87

Ensure Full Market Basket Updates for Home Health Payments ................................................................. 88

Oppose Proposals to “Bundle” Home Health and Hospice Benefit Payments With Payments to Other Providers....................................................................................................................... 89

Oppose Copayments for Medicare Home Health Services ........................................................................ 90

Require Multi-State Reciprocity in Medicare Survey Contracts ......................................................................... 93

Allow Flexibility in the Delivery of Home Health Services Under the Medicare PPS ................................................................. 94

Clarify the Definition of Separate Entity ............................................................................................................. 95

Maintain Coverage for Individuals with Ongoing Home Care Needs .................................................................... 96

Preserve the Public Nature of the Medicare Program ....................................................................................... 97

Fully Reimburse OASIS Costs, Streamline OASIS Requirements, and Conduct Research on OASIS Validity ................................................................................................................................. 99

Increase Flexibility in the Application of the Home Health Conditions of Participation .................................. 101

Evaluate Use and Accuracy of Home Care Compare .............................................................................................. 102

Allow Federal Judicial Review of State Medicaid Program Compliance with Federal Medicaid Law .............................. 103

Encourage Appropriate, Collaborative Role of Physicians in Home Care ............................................................. 104

Ensure Access to Home Care and Full Federal Funding in any Proposals to Require Medical Directors in Home Health Agencies ................................................................................................................ 105

Modernize Medicare Home Health Agency Qualification Standards .................................................................................. 106

Limit Administrative Burdens on Home Health Agencies ...................................................................................... 107

Strengthen Requirements for Publication of Policy Changes by CMS ................................................................ 108

Coordinate Government Reviews of Home Health Agencies to Reduce Paperwork Burden ................................................................. 109

Allow Provider Appeals Prior to Sanctioning for Survey and Certification Deficiencies ................................................................. 110
Enact a Homebound Definition that Ensures Access and Eligibility for Needed Home Health Services .......................................................... 112

Allow Payment for Home Health Services for Those Receiving Adult Day Care .......... 113

Make Occupational Therapy and Social Work Services Qualifying Services for Medicare Home Health ............................................. 114

Allow Physicians’ Assistants and Nurse Practitioners to Certify Medicare Home Health Plans of Care ...................................................... 115

Provide Access to Medicare HMO/PPO Enrollment Information .................................. 116

Provide Access to Medicaid Enrollment Information ..................................................... 117

Oppose User Fees for Medicare and Medicaid Administrative Activities .................... 118

Reinstate the Presumptive Status for Home Health Waiver of Liability ......................... 119

Prohibit Use of Sampling Audits ................................................................................... 120

Prohibit States from Using Costly Individual Claims Review in Third-Party Payer Recovery Efforts ................................................................. 122

Limit Retroactivity of Fiscal Intermediary Determinations .............................................. 123

Permit Suits and Authorize Punitive Damages against Medicare Contractors for Bad Faith Medicare Decisions ........................................... 124

Reinforce Beneficiary Due Process Rights ..................................................................... 125

Preserve Independence of Administrative Law Judges .................................................. 126

Improve Access to Judicial Review for Medicare Claims ............................................... 127

Allow Appropriate and Expedited Judicial Review of Medicare Reimbursement Policy Disputes ............................................................................. 128

Ensure and Enforce Beneficiary Choice in all Federal Health Care Programs ............... 129

Establish Safe Harbors and De Minimus Thresholds under the False Claims Act .......... 130

Ensure Patients’ Rights in Managed Care Plans ............................................................. 132

Protect Consumers from Erroneous Service and Coverage Determinations ................. 134

Protect Patients’ Freedom to Choose .............................................................................. 135

Preserve Rights of Home Care Patients in Federally-Qualified HMOs ............................. 136
Prohibit Gag Rules in Managed Care Contracts ................................................................. 137
Modify Preemption Provision of the Employee Retirement Income Security Act ....... 138
Amend the Employee Retirement Income Security Act to Require Direct Provider
Appeal Rights .................................................................................................................... 139
Authorize Punitive Damages Lawsuits for Bad Faith Insurance Decisions ................. 140
Enact Insurance Market Reforms ..................................................................................... 141

VI. ENSURE A CENTRAL ROLE FOR HOME CARE RELATIVE TO WELLNESS
   AND PREVENTION OF DISEASE .............................................................................. 142

   Allow Home Care Agencies to Serve as Case Managers in
   Federally-funded Programs ......................................................................................... 143
   Create a Nutritional Services Home Health Benefit .................................................... 144
   Require Inclusion of Home Care Coverage for Early Maternity Discharge .............. 146

VII. ENSURE THE AVAILABILITY OF HOSPICE AND PALLIATIVE CARE FOR ALL
     AMERICANS NEAR THE END OF LIFE ................................................................ 147

   Preserve the Full Market Basket Update for The Medicare Hospice Benefit .......... 148
   Modernize the Medicare Hospice Benefit .................................................................. 149
   Ensure Access to Medications Necessary for Pain Control ........................................ 150
   Assure SNF/NF Medicare Beneficiary Residents’ Right to Choose a Hospice
   Provider ....................................................................................................................... 151
   Support Quality Assessment/Performance Improvement Program for Hospice ......... 152
   Require CMS to Base Survey Frequency on Performance of Medicare
   Hospice Benefit Providers ............................................................................................ 153
   Require Hospital Discharge Planners to Supply Listing of Qualified Hospices .......... 154
   Oppose Decreasing Hospice Reimbursement for Dually Eligible
   Patients Residing in Nursing Facilities ....................................................................... 155
   Ensure the Portability of Advance Directives .............................................................. 156
   Protect Hospice Agencies from the Impact of Sequential Billing ............................. 157
   Include In-Home Respite Care in the Medicare Hospice Benefit ............................... 158
Require Demonstration Projects to Study Special Services and Financing of End-of-Life Care .......................................................... 159

Oppose Implementation of Penalties for Erroneous Certification of Terminal Illness ................................................................. 160

Mandate Hospice Coverage under Medicaid ................................................................. 161

Eliminate Medicare Provision Requiring Hospice Social Workers to Practice Under the Direction of a Physician ................................................. 162

VIII. HOME MEDICAL EQUIPMENT ................................................................. 163

Monitor Development of Quality Standards, Clinical Conditions of Coverage, and Mandatory Accreditation for HME Suppliers ........................................... 164

Oppose Recertification Rule for Oxygen Patients ......................................................... 166

Support Efforts to Adequately Reimburse HME Suppliers for Costs Associated With In-Home Drug Therapies ................................................................. 168

Revise Application of the “In-Home” Restriction for Medicare Part B Reimbursement of HME Supplies ................................................................. 170

Oversee CMS’ Use of Inherent Reasonableness Authority ........................................ 171

Rescind Competitive Bidding for Home Medical Equipment ........................................ 173

Ensure Adequate Reimbursement for Home Medical Equipment, Parenteral and Enteral Nutrition, and Oxygen Supplies ................................................................. 174

IX. FACT SHEETS ON HOME CARE ................................................................. 175

What is Home Care? ................................................................................................. 176

Who Provides Home Care? ..................................................................................... 178

How Is Home Care Paid For? .................................................................................. 182

Home Health Legislation 2005 .............................................................................. 185

Home Health Legislation 2003 .............................................................................. 195

Home Health Legislation 2002 ............................................................................. 208

Home Health Legislation 2001 ............................................................................. 209

Home Health Legislation 2000 ............................................................................. 210
<table>
<thead>
<tr>
<th>Year</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999</td>
<td>214</td>
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<tr>
<td>1998</td>
<td>217</td>
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ABOUT THE BLUEPRINT

The 2006 Legislative Blueprint for Action represents our legislative agenda for the National Association for Home Care & Hospice (NAHC). This book contains a discussion of the Association’s priorities and other important issues and recommendations concerning home care and hospice. It was prepared through a series of meetings with home care and hospice professionals, state association representatives, and a survey of the NAHC members. It has been reviewed by the Government Affairs Committee and was approved by the NAHC Board of Directors at its January meeting.

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

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

This document has been produced by the National Association for Home Care & Hospice, a trade association that represents the interests of nearly 17,700 home health agencies, home care aide organizations and hospices, as well as the caregivers who every year provide services to more than seven million Americans. 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.
Over the last decade the home care and hospice industries have undergone dramatic change.

The Medicare home health program underwent two major payment system changes, one in 1997 and the next, to a fully prospective payment system (PPS), in late 2000. Home care agencies are no longer paid more to provide more visits; successful agencies’ care plans are carefully crafted to ensure maximum efficiency. At the same time, major advances in wound care treatment, the use of new information technologies, and other improvements have helped agencies adapt to these new incentives. Unfortunately, some agencies lack sufficient access to capital to invest in the technologies that would enable them to incorporate the latest efficiencies in their operations. Along with PPS, Medicare has imposed new regulatory requirements, including significant Outcome and Assessment Information Set (OASIS) data collection and reporting requirements. In 1999, home health agencies began collecting and reporting OASIS data, and in 2003 the Centers for Medicare & Medicaid Services (CMS) began making publicly available data on quality of care provided under the Medicare home health benefit.

Despite change in virtually every aspect of home health in recent years, the Medicare Payment Advisory Commission (MedPAC) has found that agencies continue to provide the high level of care that has made home care the preferred mode of service throughout the United States for decades.\(^i\) Recent study by MedPAC indicates that under the home health benefit certain post-acute care patients not only have outcomes that are as good or better than their peers convalescing in institutions, but that high quality home care is available at a fraction of the cost.\(^ii\)

In recent years, Medicaid has become an even larger financier of home care services than Medicare; Medicaid’s potential for further growth in this area is excellent. The nation’s governors have identified the country’s long term care system as in urgent need of reform; increased availability of home- and community-based care must be part of the solution. In addition, the Bush Administration’s aggressive pursuit of expanded availability of home and community-based services for the disabled as the result of the US Supreme Court decision in Olmstead underscores the vital role of hospice and home care in our nation’s health care system. In a number of states and localities, these home and community-based services are available through several care models, including patient- or consumer-directed care. Ensuring quality of care and legitimate consumer choice under these varied models must remain a high priority.

Hospice as a formalized concept was first brought to the United States during the 1960s, and the first hospice was formed in 1974. Medicare began coverage of hospice services in 1982 to care for terminally ill cancer patients. The average length of stay was 70 days. The patient population served by the nation’s hospices under Medicare has changed dramatically since this most compassionate program first began. Cancer patients now represent less than half of the hospice population and the average length of stay has decreased to 52.5 days, with a median stay of 21 days. Costs for pharmaceuticals and pharmacotherapy for symptom control and pain management have increased dramatically as a percentage of average daily costs. Advancements in technology have resulted in increased outpatient services such as palliative radiation therapy and chemotherapy with accompanying diagnostic procedures required to monitor responses and side effects resulting in increased outpatient service costs. Hospices are caring for patients with more complex diagnoses but for shorter periods of time. As the percentage of the nation’s population moving into
retirement and final years continues to grow, a reassessment of payment and coverage under Medicare’s hospice benefit is long overdue.

The challenges facing home care and hospice in the early 21st century are many. Members of the National Association for Home Care & Hospice (NAHC) have chosen the following issues as the focus of NAHC’s legislative efforts during the year 2006. Central to NAHC’s mission is to preserve and expand access to hospice and home- and community-based care; to ensure an adequate supply of skilled workers to provide that care; and to protect the rights of both patients and providers.

Following are the legislative priorities for 2006 as voted on by the membership of the National Association for Home Care & Hospice. They can be divided into three major areas of concern:

I. MAINTAIN FINANCIAL STABILITY UNDER FEDERALLY-FINANCED HOME CARE AND HOSPICE PROGRAMS.
   -- Ensure full market basket updates for Medicare home health and hospice payments.
   -- Ensure care access for rural and underserved patients.
   -- Ensure patients’ rights in managed care plans.
   -- Provide access to Medicare HMO/PPO enrollment information.
   -- Rescind competitive bidding for home medical equipment.
   -- Oppose copayments for Medicare home health services.
   -- Oppose proposals to “bundle” home health and hospice benefit payments with payments to other providers.

II. REFORM FEDERALLY-FINANCED HOME CARE AND HOSPICE PROGRAMS TO ENSURE EQUITY AND PROMOTE CARE QUALITY AND EFFICIENCY.
   -- Establish a frail elderly care management benefit under Medicare.
   -- Establish stability and equity among Medicare health care providers in application of the wage index.
   -- Allow physicians’ assistants and nurse practitioners to certify Medicare home health plans of care.
   -- Recognize home telehealth interactions as bona fide Medicare services.
   -- Provide financial assistance to home care agencies to expand use of information technologies and implement electronic health records.
   -- Restructure the Medicare hospice benefit.

III. ADDRESS THE IMPENDING LONG-TERM CHRONIC HEALTH CARE CRISIS.
   -- Support rebalancing of long term care expenditures in state Medicaid programs in favor of home care over institutional care.
   -- Require Medicaid home care programs to offer a full range of delivery models and to meet quality of care standards.
   -- Establish meaningful standards for long term care insurance.
   -- Promote respite care for family caregivers.
   -- Enact a comprehensive, high quality home- and community-based long term care program for all age groups.
I. ENSURE THE ENACTMENT OF A COMPREHENSIVE, HOME-BASED NATIONAL POLICY ON LONG TERM CARE
PROTECT CONSUMER CHOICE OF PROVIDER IN THE PROVISION OF LONG TERM CARE SERVICES

ISSUE: California has implemented a state-sponsored public authority system that in most counties in the state requires that home care aides providing services under the Medicaid program be employed by the public authority. This arrangement was sought by public employee unions to facilitate the organization of home care aides. Consumers in these counties 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.

RECOMMENDATION: The Congress should resist approval of 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.

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 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 runs counter to ongoing efforts by the federal government to give the states greater flexibility in how they run their programs.
ESTABLISH FRAIL ELDERLY CARE MANAGEMENT BENEFIT UNDER MEDICARE

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

RECOMMENDATION: Congress should establish a separate care management benefit under Medicare that is available for designated categories of chronically ill individuals such as COPD, CHF, diabetic, and certain neurological disorder-afflicted patients. The service should be provided by professional nurses within home health agencies to ensure a discipline-integrated, community care-based approach to care management. The services should include care counseling, care coordination, medication management, and oversight of services related to activities of daily living.

RATIONALE: The existing Medicare benefit structure encourages individuals to await condition deterioration before attending to ongoing health-related needs. Higher-cost care for acute episodes results. A care management benefit can help avoid these complications and costs.
REQUIRE MEDICAID HOME CARE PROGRAMS TO OFFER A COMPREHENSIVE AND FULL RANGE OF CARE DELIVERY MODELS

ISSUE: State Medicaid programs increasingly are creating new opportunities for community-based care as alternatives to institutional long term care for the elderly and disabled. However, these new opportunities are not always designed to consider the range of needs, competencies, and choices that the consumers of services have and prefer. In some instances, a state will provide only a single delivery model, thereby either leaving population segments outside of the benefit or forcing them into a care delivery model that is a poor fit. The range in current models include: consumer directed care, cash and counseling, provider directed, employer/agent, among others.

These models do not operate under any consistent quality of care or utilization standard. If a state chooses a single model approach, it may not fit the full population that it is intended to serve. For example, if the only model offered is a provide model, individuals who prefer a consumer directed care model may be left out. Similarly, if a consumer directed care model is the only choice, individuals that are not capable of or interested in managing their own care, taking on the role and responsibilities of an employer, or capable of making good choices may be left outside of a community care option.

RECOMMENDATION: Congress should establish that federal standards for home care services under Medicaid must make a full range of service models available with the patient’s needs the determinative element.

RATIONALE: The increasing use of home care under Medicaid has lead to the recognition that “one size does not fit all” in the design and operation of the care delivery method. To gain the full benefit of home care as an alternative to costlier institutional care, states should offer multiple delivery models with consistent quality of care standards and service entitlement driven by an individual’s need for care.
ENSURE ACCESS TO HOME CARE IN MEDICAID MANAGED LONG TERM CARE

ISSUE: Most states that tested the use of managed care in Medicaid excluded long term care (LTC) services 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 care expenditures in favor of home care. Recently, states have begun implementing managed care for LTC services as well.

While states are provided great flexibility in Medicaid, it is crucial that any transition to managed LTC 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. In addition, managed LTC should conform with the quality of care standards applicable to fee-for-service home care under Medicaid. Finally, managed LTC home care under Medicaid should afford enrollees with reasonable choices among providers in order to encourage quality and efficiency.

RECOMMENDATION: Congress should require that any LTC 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.

RATIONALE: A transition to managed care should not result in a change in the scope of the Medicaid home care benefits. 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.
ENACT A COMPREHENSIVE, HIGH QUALITY HOME- AND COMMUNITY-BASED LONG-TERM CARE PROGRAM

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

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

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

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

♦ Congress should clearly define Medicare and Medicaid responsibilities and coverage standards for chronic and long-term care conditions.

♦ Long-term and chronic care coverage must be coupled with clear and dedicated financing.

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

♦ Disabled and chronically ill Americans who are under 65 should be permitted to qualify for home- and community-based services on the same basis as the elderly.

♦ Home care agencies and hospices should be allowed to perform case management functions instead of using costly external case management procedures that duplicate standard caregiver activities.

♦ The distinction between acute care benefits and long-term care benefits should not be so rigid as to inhibit the smooth coordination of in-home services.

♦ Eligibility for benefits should not be based on income. It should be a social insurance program, not a means-tested welfare program. It should ensure that the spouses of those who need long-term care are not impoverished.

♦ A long-term care program should be a comprehensive federal insurance plan, not a block grant to the states, that is adequately and realistically funded. Funding for a long-term care program should be broad-based and progressive, and reliable for many years to come.

♦ All individuals who need assistance with one or more activities of daily living (ADLs) or
instrumental activities of daily living (IADLs) and all those with cognitive or mental impairments should be covered. Another factor to consider should be whether there are family caregivers in the home.

♦ The full range of home- and community-based services should be offered to all eligible individuals at a level appropriate to meet their needs. These services should include nursing care; home care aide services; medical social services; personal care services; chore services; physical, occupational, speech, and respiratory therapy and rehabilitative services; hospice services; respite care; and adult day services; medical supplies and durable medical equipment; minor home adaptations that, among other benefits, enable beneficiaries to receive services at home; transportation services; nutritional services; and patient and family education and training.

♦ Quality of care must be ensured. Quality assurance standards, including minimal standards of training, testing, and supervision, should be applied to the delivery of services in the home, regardless of the source of payment for those services. The requirements contained in the Medicare Conditions of Participation for home health and hospice should be applied to the delivery of in-home skilled services.

♦ For paraprofessional service providers, the Joint Commission on Accreditation of Healthcare Organizations, the Community Health Accreditation Program and the Home Care Aide Association of America have developed suitable standards for the training, testing, and supervision of paraprofessional workers. State certification of these workers should be required to ensure that all home care aides are appropriately trained, tested, and supervised as well as provided with basic employee benefits and other support.

♦ Cash and counseling or voucher programs to purchase home care services should include standards to ensure quality of care; protect vulnerable patients from physical, emotional, or financial abuse or exploitation; guarantee adequate training, and supervision of home care personnel; and ensure the provision of any required employee benefits. Such programs should ensure compliance with applicable state and federal labor, health and safety laws and regulations.

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

The adoption of these recommendations in a long-term care plan would ensure that people with disabilities and chronically and terminally ill Americans receive the comprehensive, high quality home- and community-based care they need in the least restrictive environment.
SUPPORT PROPOSALS THAT WILL SUPPLY A STABLE, DIRECT CARE WORKFORCE PROVIDING QUALITY CARE FOR LONG-TERM CARE CONSUMERS

ISSUE: According to the U.S. Department of Labor Bureau of Labor Statistics about 2.0 million individuals work as direct care workers in long-term care. The Bureau of Labor Statistics recently estimated that nursing aides held the most jobs–approximately 1.4 million. Home health aides held roughly 580,000 jobs and psychiatric aides held 59,000 jobs. Overall employment of nursing, psychiatric, and home health aides is projected to grow faster than the average for all occupations through the year 2012, although individual occupational growth rates will vary. For example, employment of home health aides is expected to grow the fastest, as a result of both growing demand for home healthcare services from an aging population and efforts to contain healthcare costs by moving patients out to hospitals and nursing care facilities as quickly as possible (U.S. Dept. of Labor, Occupational Outlook Handbook, 2004-2005).

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

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

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

ISSUE: In OBRA 1993, Congress established a Medicaid optional benefit of personal care services which 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. As a result, states have implemented personal care programs that require no training or testing of the competency of the caregiver and no quality of care oversight.

RECOMMENDATION: In any Medicaid reform efforts, Congress should require federal standards for quality of care for personal care services, including minimum standards of caregiver education, competency, nursing supervision, and overall caregiver qualifications with quality of care oversight.

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, states have allowed personal care workers without education or competency testing to provide invasive services such as catheter insertion and tracheal suctioning of ventilator-dependent patients. For the protection of consumers and caregivers, the same quality standards that apply to agencies should apply to personal care workers who are not employed by agencies.
REQUIRE CONTRACTORS OF HOME CARE SERVICES AND/OR CONSUMER-DIRECTED HOME CARE SERVICES TO ENSURE QUALITY AND SUPERVISION OF SUCH SERVICES

ISSUE: Some states 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 which 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, poor, 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 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 for consumer-directed home care services.
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 are too often driven by cost savings considerations rather than patient needs.

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

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

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

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 federal standards for home care aide training, competency testing, and supervision are critical components of quality care. Paraprofessionals who work in nursing homes and in home care should be required to meet the same level of training and testing. The job responsibilities, not the care setting, should determine the requirements a caregiver must meet. All patients deserve the same high standard of care.
ELIMINATE ELDER ABUSE

ISSUE: The 1998 National Elder Abuse Incidence Study, prepared by the Administration on Aging, estimated that 450,000 older persons in domestic settings were abused and/or neglected in 1996. This number does not include self-neglect, which was experienced by an additional 100,000 older persons. As the population continues to age, it becomes increasingly important to protect older persons from physical and emotional abuse, neglect, intimidation, and financial exploitation by their families and institutions. Although statistics indicate that most elder abuse is actually carried out by family members, there are still too many reports of abuse carried out by unrelated caregivers.

Stimulated by Congressional attention, many states passed elder abuse protection statutes between 1978 and 1985. Congress, in 1988, passed legislation to assist the states in this effort. In fiscal year 1991, the Congress, for the first time, provided for separate, distinct funding for elder abuse and nursing home ombudsman activities under the Older Americans Act. This separate funding has been continued in subsequent years.

Section 705 of the Older Americans Act Amendments of 2000 (P.L. 106-5d) authorizes a “Prevention of Elder Abuse, Neglect, and Exploitation” study. Under this section, “The Secretary in consultation with the Department of the Treasury and the Attorney General shall conduct a study of the nature and extent of financial exploitation of older individuals.” The purpose of this study would be to define and describe the scope of the problem of financial exploitation of the elderly and to provide an estimate of the number and type of financial transactions considered to constitute exploitation faced by older individuals.

RECOMMENDATION: A coordinated national effort should continue to confront the issue of elder abuse. The federal government should take the lead in assisting the states in this effort. Congress should continue and increase funding for adult protection programs, and should initiate legislation supporting elder abuse reporting laws and providing protection from prosecution for persons reporting incidences of abuse.

RATIONALE: Elder abuse is a hidden problem. Out of fear or dependence, many victims never report the abuse. It is clear that adequate state and federal resources must be allocated to address this national disgrace.
SUPPORT REBALANCING OF LONG TERM CARE 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, the administration has voiced support for increased federal payments to assist states in transitioning Medicaid nursing facility patients into home care services. In some states, Medicaid has moved with reasonable and deliberate speed. In others, action seems nonexistent. One problem is the limits on valuable federal support for the administrative actions needed. Another problem is the pressure from institutional care providers to slow any progress towards home care alternatives.

The Deficit Reduction Act of 2995 (DRA), still pending as of January 31, 2006, contains several provisions that rebalance Medicaid long term care coverage towards 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 provides $1.75 billion in new federal payments to support the project.

DRA also includes an optional benefit for Home and Community-Based Services for the Elderly and Disabled that allows states to bypass the burdensome "waiver" process that includes requirements for proving the cost effectiveness of services. This new benefit would require 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.

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

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

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

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

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

Instead of proposing a cap on federal Medicaid spending, in 2005 the President proposed to cut Medicaid spending by a net of $45 billion over ten 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 2006 Medicaid advocates and governors are expected to oppose proposals to cut federal assistance for state Medicaid programs, while the President likely will continue to promote reductions in federal Medicaid spending.

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

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

ISSUE: Medicaid has taken on an increasing role in providing coverage of home care and hospice services to children, the disabled, and the elderly. Early data indicates that Medicaid expenditures for home care and hospice services now exceed Medicare expenditures. A significant part of the reason behind the Medicaid growth is the flexibility allowed states in the structuring of Medicaid coverage and the recognition that home care is a viable, cost-effective alternative to institutional care. However, as Medicaid expenditures for home care and hospice have increased along with general strains on state Medicaid budgets, reimbursement rates have failed to keep pace with increasing costs of care and, in some cases, they have been subject to reduction for purely budgetary savings purposes. Forty-seven states have reported Medicaid-related budget problems.

Federal Medicaid law establishes a broad and somewhat ambiguous standard for rate setting that merely requires the states to set rates at a level sufficient to enlist enough providers so that care and services are available at least to the extent that such care and services are available to the general population in the geographic area. The "sufficient access" standard for rate setting operates in a manner that requires a demonstration that individuals in need of care cannot find it solely because of inadequate rates. This method fails to prevent the loss of services and only reacts when the inaccessibility to services reaches a high enough level to gain political attention.

Inadequate reimbursement for home care and hospice services has affected all populations served in the home and in all of the various home care programs available under Medicaid. Technology intensive home care services, personal care services, private duty nursing services, and basic home health services are often reimbursed at levels of payment equal to 60 to 75 percent of the cost of the provision of care. The result is a very fragile Medicaid home care benefit structure that relies on payment subsidization by non-Medicaid sources, thereby jeopardizing continued access to care.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

During the 106th Congress, the Older American Act Amendments (OAA) of 2000 (P.L. 106-501), established a National Family Caregiver Support Program for state area agencies on aging to develop respite care programs to enable caregivers to be temporarily relieved from their caregiving responsibilities. In February 2001, Secretary Tommy G. Thompson announced the release of $113 million in grants to states to begin implementing this program. During 2004, the fiscal year 2005 Omnibus Appropriations bill included $157 million for family caregivers, an increase of $4.3 million above the previous year’s appropriation (HR 4818, Conference Report 108-345). During the first session of the 109th Congress, HR 3248 and S. 1283, the “Lifespan Respite Care Act of 2005” was introduced. The legislation amends the Public Health Service Act to establish a program to assist family caregivers in accessing affordable and high-quality respite care.

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

RATIONALE: Friends and family caregivers provide the bulk of long-term care services to their elders with little support from public programs. Instead of public policies that create disincentives for families to provide care for their disabled relatives, policies should be developed that promote caregiving by supporting the development of services designed to provide relief to family members and other unpaid helpers. Available data indicates that families tend to purchase services only when the responsibility of care becomes too great for them to handle or when they become exhausted. Furthermore, researchers have found little evidence that policies aimed at providing formal services to caregivers and care recipients encouraged caregivers to substitute paid care for care by friends and family. Respite care is especially important for individuals residing in rural areas where fewer community resources are available.

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

ISSUE: Medicare rules regarding coverage of drug therapies in the home are outdated and inefficient. Currently, Medicare will cover the cost of drugs in the home only if the drug is administered using home medical equipment (HME), like an infusion pump. Patients who need drugs that can be administered through a gravity-drip, for example, can only receive drug coverage if they remain in a hospital or other institutional setting.

Generally, patients with serious infections are hospitalized for an initial period and, once stabilized, could continue treatment at home if Medicare covered their ongoing drug therapy. Some patients could receive their entire course of IV therapy safely and effectively at home.

Medicare’s outdated rules have resulted in over-prescribing of the drug vancomycin, a powerful antibiotic. Since vancomycin was thought to be safely administrable only through an infusion pump, it was one of the few drugs Medicare would cover at home.

Because many patients preferred to receive drug therapy at home, physicians often prescribed this antibiotic even when milder varieties would have been as effective. Overprescribing led the Centers for Disease Control to warn against the possibility of a serious public health danger due to a major increase in infections by vancomycin-resistant bacteria.

Rather than develop a more sensible approach to determining Medicare coverage rules for drug coverage in the home, the Centers for Medicare and Medicaid Services (CMS) decided to end home health coverage of vancomycin after September 1996 on the grounds that the drug can be administered without an infusion pump.

In this way, patients in need of continuing treatment have gone from over prescription of one of the most powerful antibiotics on the market to no coverage for intravenous antibiotic therapy in the home at all.

Although the rising costs of prescription drugs, particularly for the elderly, have received increased attention by Congress and others, no legislation has passed that covers home care antibiotics or other parenteral drugs in the home.

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Public Law 108-173) does allow the inclusion of intravenous immune globulin (IVIG) for the treatment in the home of primary immune deficiency diseases as a covered medical service under Medicare, however, it only pays 80 percent of the drug (IVIG). The benefit will not pay for items or services related to the administration of the IVIG drug. This provision will be in effect on or after January 1, 2004.

During the 108th Congress, a bill was introduced but not passed that supports medical coverage of drug therapies in the home. H.R. 2476, the Medicare Home Infusion Therapy Act of 2003, would remove coverage of home infusion therapy from the Medicare Part B medical equipment benefit and establish a new infusion drug benefit that more accurately reflects the cost of both the drugs and the services needed to administer such drugs.

RECOMMENDATION: Congress should provide Medicare coverage for all antibiotics administered intravenously in the home.

RATIONALE: Patients who are able to receive drug therapy in their own homes should be allowed to do so. Restrictive Medicare coverage rules which force patients to remain in hospitals in order to receive drug treatment are outdated and wasteful. Keeping individuals with infectious conditions at home will reduce the chances of spreading diseases in hospitals. In addition, the cost of treating an infectious condition at home can be far less costly than the cost of treating the
condition in a hospital admission.

Medicare coverage of drugs should be based on patient need and the appropriateness of the treatment setting, not on the type of equipment needed to administer the drugs. Given concerns about the high cost of health care, Medicare should incorporate sufficient flexibility to allow for use of non-traditional services in home care that contribute to improved outcomes and cost efficiencies.
ESTABLISH A HOME AND COMMUNITY-BASED WAIVER-TYPE PROGRAM UNDER MEDICARE

ISSUE: Advances in technology allow more and more services to be provided in the home or community setting. Further, care often times can be provided more cost-effectively, and most elderly and disabled individuals would prefer to be cared for in the comfort of their homes. Despite these facts, use of the home health benefit under Medicare has dropped precipitously in recent years. In June 2003 the Medicare Payment Advisory Commission (MedPAC) reported that many patients that previously would have been cared for in the home under Medicare are now being served in skilled nursing facilities (SNF). The average cost of a home health care stay is currently around $4,000, while the average Medicare SNF stay costs about $8,500.

RECOMMENDATION: The Congress should authorize a home and community-based waiver-type demonstration program under Medicare which waives the part-time and intermittent care standards, allows greater flexibility relative to services provided than currently under the home health benefit, and covers services in the home for patients that otherwise would be cared for under the Medicare SNF benefit or in a hospital if it can be shown that the cost to Medicare of caring for the individual in the home would be less than the cost of placement in a SNF or hospital.

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

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

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

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

ISSUE: Medicaid is a joint federal and state program of health care for low-income individuals. The federal government shares the cost of the program with the states and establishes certain requirements for the operation of the program. However, each state administers its Medicaid program and establishes eligibility, coverage, and payment levels within broad federal guidelines. Currently, Medicaid home health benefits are generally more limited in coverage and reimbursement than the Medicare home health benefit. Federal regulations allow states to limit home health benefits to intermittent nursing care, home care aide services, and medical supplies and equipment. In some states, such as California, provision of medical supplies often goes unreimbursed. Physical therapy, occupational therapy and speech pathology services are optional and are frequently not available to Medicaid recipients in the home. In addition, there are no federal standards regarding the minimum frequency and duration of any of these services.

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

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

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

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

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

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

RECOMMENDATION: Congress should require mandatory coverage of home care, hospice, and personal care services and home care medical supplies to all populations receiving Medicaid coverage.

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.
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 2005 under these provisions, the spouse at home is able to retain assets, in addition to the home, of up to $95,100 and income of up to $2,377.50 a month.

Unfortunately, the spousal impoverishment protections are only required in the case of nursing home care. States with home- and community-based waivers may elect to extend these protections to couples that are able to care for their loved ones at home, but most states have 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 is still faced with having to impoverish herself. In 2005 the federal Supplemental Security Income (SSI) limits for individuals are $599 in countable monthly income and $2,000 in liquid assets. As a result, the institutional bias of the Medicaid program is stronger than ever.

RECOMMENDATION: Congress should reject any efforts to repeal the spousal impoverishment protections and should enact legislation to extend these provisions to the home care setting.

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.
**SUPPORT TAX INCENTIVES FOR FAMILY CAREGIVERS**

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

Several bills have been introduced that would provide various tax incentives for family caregivers who care for sick or disabled family members, including the Long Term Care and Retirement Security Act of 2005 (S 1244/HR 2682) sponsored by Senator Charles Grassley and Representative Nancy Johnson. Although these bills have attracted much support, the prospect for enactment of caregiver tax incentives is uncertain because CBO has scored these provisions as costly.

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

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

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

Section 102 of the “Veterans Millennium Health Care and Benefits Act” directs the VA to carry out three long-term care pilot programs over a three-year period. The goal of these pilot programs is to determine the effectiveness of different models of providing all-inclusive care on reducing the use of hospital and nursing home care. S. 1572 was introduced in 2003 to add three additional pilot programs. In 2004, Congress enacted Public Law 108-422 (Veterans Health Programs Improvement Act of 2004) which extends through December 31, 2005, the VA’s authority to provide care to veterans participating in certain long-term care demonstrations projects previously authorized in the Veterans Millennium Health Care and Benefits Act. Public Law 108-422 also eliminates copayments for hospice services furnished by the Veterans Administration.

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

RATIONALE: Congress should continue to improve upon the scope of home health services available to veterans. Alternative levels of care should be available to our nation’s veterans. Institutionalization should not be the only method for providing care to chronically ill or rehabilititating veterans. Since Congress saw fit to provide home care services to veterans, this care should include the full range of services and be provided by qualified home health agencies.
OVERSEE THE IMPLEMENTATION OF A COMPREHENSIVE HOME CARE BENEFIT IN THE MILITARY HEALTH SERVICES SYSTEM

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

The 2002 legislation marks the first time that Congress had authorized a specific, structured home care benefit in the military health program for retirees and military dependents. The effort now shifts to proper implementation. In June 2002, the Department of Defense (DoD) published an Interim Final Rule regarding the TRICARE home health benefit. The new TRICARE home health services benefit has been phased in across the country during 2004. The extended benefit program is currently under implementation with the Final Rule published by the DoD on July 28, 2004. However, it has not been administratively implemented as of the end of 2005.

RECOMMENDATION: Congress should monitor DoD’s implementation of the home health benefit and the extended benefit program to ensure compliance with congressional intent.

RATIONALE: DoD contractors have limited experience in administering comprehensive home care benefits. The contractors have experienced difficulties in the implementation of the home health benefit. Oversight is needed to satisfy congressional intent.
ESTABLISH MEANINGFUL STANDARDS
FOR LONG-TERM CARE INSURANCE

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

As public policy makers grapple with a better way to finance the nation’s long-term care bill, the private long-term care insurance market has begun to offer an increasing number of Americans a solution. According to the American Health Insurance Plans (AHIP) latest survey, about 9.16 million long-term care insurance policies had been sold by 2002. About 18 percent were sold through employer-sponsored group plans.

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

At the same time, inadequate state regulation of the private long-term care insurance market has led to development of ineffective policies and abusive sales practices. Additionally, high lapse rates -- the rates at which policy holders drop coverage before they need long-term care -- have significantly reduced the impact long-term care insurance policies could have on defraying long-term care costs.

The “Health Insurance Portability and Accountability Act of 1996” (P.L. 104-191) included tax incentives for the purchase of long-term care insurance. In order to qualify for the special tax treatment, long-term care insurance policies are required by the Act to meet the standards set out in the 1993 National Association of Insurance Commissioners (NAIC) model act. The 1993 NAIC model act was specified in the legislation despite the fact that it is not the most current version, which has stronger consumer protections such as mandatory nonforfeiture of benefits. Favorable tax treatment under the legislation was limited to plans that require that beneficiaries either need assistance with at least two activities of daily living or have cognitive impairment that requires substantial supervision in order to receive home care benefits. This has meant that some plans with the most extensive home care coverage do not qualify for favorable tax treatment.

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

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

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

ISSUE: During the Second Session of the 108th Congress, the Individuals with Disabilities Education Act – H.R. 1350 - (IDEA) was reauthorized by Congress and signed into law on December 3, 2004. IDEA allows for skilled care to be given to pre-school and school children to assure their access to a free, appropriate public education. This care includes one-on-one nursing, if needed. The provider of the care is considered the school district, which must then bill Medicaid and private pay for reimbursement. As originally written in 1975, the federal government made a commitment to pay up to 40 percent of the additional cost of educating children with disabilities. Although this goal has not been met it appears that H.R. 1350 has put the federal government on a six year “glide path” to reach the original funding goal of 40 percent. IDEA needs full and proper funding to help school districts provide the care.

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

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

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

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.

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.
ENCOURAGE STATES TO ADOPT LICENSURE LAWS AND REGULATIONS FOR HOME CARE AGENCIES

ISSUE: As of January 2003, 39 states and the District of Columbia required Medicare-certified agencies to obtain licensure; 35 states required non-Medicare-certified agencies to obtain licensure. For home care aides, 14 states and the District of Columbia required licensure. For hospice, 43 states and the District of Columbia required Medicare-certified hospices to obtain licensure; 36 states 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 law for certification and licensure of home care agencies and encourage states to adopt and implement the model laws. A NAHC task force developed a proposed model licensure law to assist states in adopting a licensure law or strengthening their current law.

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.
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.

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 publicly-financed home health services must be recognized.

RECOMMENDATION: Congress must provide access to the home health benefit for pediatric patients with more intensive care needs and assure adequate reimbursement for the cost of these services.

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

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

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

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

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

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

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

PROMOTE EFFICIENT USE AND ENSURE ADEQUATE SUPPLY OF QUALIFIED HOME CARE AND HOSPICE PERSONNEL
ESTABLISH FEDERAL AUTHORITY FOR ASSOCIATION HEALTH PLANS

ISSUE: Employer-based health insurance is on the decline nationally primarily due to growing costs. However, small businesses are particularly challenged by rising costs because they are unable to obtain health insurance at rates that are available to larger groups. One potential solution is to allow small businesses to combine their insured employees into a pool of other small businesses to create a larger group for insurance rating purposes.

Legislation has been proposed that would provide federal authority for the creation of “Association Health Plans” that would provide the mechanism for small businesses from any of the states to combine into a single healthy plan. Currently, states may allow for association health plans, but generally are limited to businesses within a single state.

RECOMMENDATION: Congress should enact legislative authority for the creation of association health plans with a standard benefit package that includes home care and hospice, to allow small businesses such as home care to combine nationally to secure lower insurance rates.

RATIONALE: Home health agencies and hospices have limited access to affordable health insurance for their employees. An association health plan will improve the opportunities to secure affordable health insurance.
SUPPORT HEALTH REFORM PROPOSALS THAT PROVIDE AFFORDABLE HEALTH INSURANCE TO UNINSURED LOW-WAGE WORKERS

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

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

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

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

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

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

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

RATIONALE: The success of the health care system is dependent on qualified personnel. Access to care, quality of care, and costs of care are all affected by the availability of properly educated and trained workers. In formulating policies, plans, and programs, health policymakers should carefully
consider the supply, demand, distribution, education and use of the low-wage workers needed to deliver essential services to the nation’s children, seniors, and the disabled. The availability of health care benefits for these workers and their families could assist in stemming the national shortages.
PROVIDE SUFFICIENT HOME CARE AND HOSPICE PAYMENTS SO THAT AGENCIES CAN PROVIDE APPROPRIATE WAGES AND BENEFITS TO CLINICAL STAFF

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

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

RATIONALE: Studies indicate that low wages affect an agency’s ability to recruit and retain direct care workers. Agencies throughout the nation have begun to experience severe hardships in recruiting and retaining clinical staff. Because of low wages and benefits, home care aides are often cited in Congressional testimony and policy studies as an example of a work force which would benefit from an increase in the minimum wage. And, increasingly, efforts are being made to document the relationship between wages and quality of care. In 1996, the Older Women’s League’s report, “Faces of Care: An Analysis of Paid Caregivers and Their Impact on Quality Long Term Care,” linked paraprofessional wage and benefit issues directly to quality of care issues. The Government Accountability Office testified before the Congress in May 2001 that low wages and few benefits contribute substantially to employers’ difficulties in recruiting and retaining quality employees.

Without sufficient reimbursement, financially strapped home care and hospice agencies are finding it extremely difficult to provide quality care, pay competitive wages, and foster job satisfaction.
ENSURE ADEQUATE HOME CARE AND HOSPICE PERSONNEL, PARTICULARLY IN RURAL AND OTHER UNDERSERVED AREAS

ISSUE: There is an increasing need for home care and hospice services as a result of the aging of the population, clarification of Medicare coverage policies, continued earlier hospital discharges, and patient preferences for home care and hospice. During the mid-1990s, home care visits and hospice services under the Medicare program increased substantially. While this trend has leveled off, home care and hospice providers continue to report shortages of nurses, home care aides, therapists and social workers, especially in rural areas. The cuts in Medicare home health reimbursements have made it increasingly difficult for agencies to offer competitive wages and benefits. Increased regulatory burdens on home visiting staff have also discouraged workers from continuing in home care.

Home health agencies generally require that newly-hired staff have one year of prior work experience because they cannot afford to provide the level of supervision new nurses and therapists need in the home setting. Reductions in the workforce in inpatient settings have greatly reduced the opportunities for nursing and physical and occupational therapy graduates to obtain on-the-job experience.

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

In 2004, the Office of Occupational Statistics and Employment Projections at the Bureau of Labor Statistics, within the U.S. Department of Labor, released new employment projections for the American workforce for 2002-2012. Health services sectors are projected to grow substantially during this 10-year period. In fact, 12 of the 30 fastest growing occupations are related to health care. The projected job growth in the health care occupational sector includes increases in the following occupations: home health aides, an increase of 48 percent; physical therapist aides, an increase of 46 percent; physical therapist assistants, an increase of 45 percent; occupational therapist aides, an increase of 43 percent; personal and home care aides, an increase of 40 percent; occupational therapist assistants, an increase of 39 percent; and physical therapists, occupational therapists, and respiratory therapists, each with an increase of 35 percent.

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

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

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

**RECOMMENDATIONS:** Congress should fund grant programs for educating therapists, medical social workers, nurses, home care aides, and other home care and hospice personnel with a focus on home- and community-based practice in areas where shortages exist. The number of schools providing therapy programs must be increased and the number of slots available in these schools should be expanded. Special incentives such as loan-forgiveness programs to fund schooling and education should be developed to recruit students for practice in geographic areas with staff shortages, such as rural and inner city areas. Grants to educational facilities should be made available for innovative approaches to recruitment and education of home health care personnel, including consideration of job “ladders” and “classrooms without walls.”

Congress should fund home care internship demonstration projects for nurses and physical and occupational therapists to provide a year of on-the-job education for new graduates.

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

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

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

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

RECOMMENDATION: Congress should require the coordination of aide training and testing programs for home health agencies and nursing facilities by establishing a core training curriculum that applies to both aide training areas, with additional, site-specific training and/or competency testing. The program should provide sufficient flexibility so that experienced aides may move from one care site to the other with relative ease.

RATIONALE: A 2001 Department of Labor report revealed a 47.3 percent employment growth rate projection (2000-2010) for home health aides and 62.5 percent for personal care assistants. The Bureau of Labor Statistics (BLS) (2001) projects that, by 2010, direct care jobs in long-term care will require 780,000 new paraprofessional positions. The BLS further predicts the total number of new job openings (growth plus replacement) will require 1,048,000 new paraprofessional long-term care workers in the coming decade. These figures underscore the need to create additional incentives for individuals to enter the field. The coordination of the two training/testing programs will make the position of home care aide more attractive for individuals given the expanded areas of employment opportunities. Further, the coordination of the programs will allow providers of services greater access to properly trained paraprofessional care. Ultimately, coordination of the two programs will improve access to services and reduce the costs of meeting the training and testing requirements. In its 1998 report, the President’s Advisory Commission on Consumer Protection and Quality in the Health Care Industry called for minimum standards for education, training and supervision of unlicensed paraprofessionals in home care, nursing home and hospital settings.

Finally, the requirement for training should apply to home care aides as well as nursing home aides. All patients deserve the same high standard of care.
STRENGTHEN THE HOME HEALTH AIDE TRAINING REQUIREMENTS CONTAINED IN OBRA-87 AND APPROPRIATELY REIMBURSE AGENCIES FOR TRAINING COSTS

ISSUE: The Omnibus Budget Reconciliation Act of 1987 (OBRA-87, P.L. 100-203), requires Medicare-certified home health agencies to meet requirements relating to the training and testing of home health aides. Section 4021 of OBRA-87 provides that Medicare-certified home health agencies may not use home care aides unless they have completed a training and competency evaluation program, or a competency evaluation program, that meets the minimum standards established by the Secretary of Health and Human Services (HHS).

The legislative language does not REQUIRE training AND competency testing. There is a list of recommended training topics IF training is to be done prior to competency testing. Competency testing may or may not be preceded by training. The use of a competency evaluation-only system that ignores the need for training may place the recipient of service at risk of substandard care.

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

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

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

Development of a “core curriculum” which could be used for basic training of both nursing home and home health aides could help to facilitate training efforts and create greater job flexibility for paraprofessional workers.
ALLOW LPNs /LVNs TO SUPERVISE HOME CARE AIDES

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

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

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

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

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

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

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

♦ Make physical violence directed toward home care workers providing federally-funded care through programs such as Medicare, Medicaid, CHAMPUS, and veterans health programs, a federal-level felony with appropriate classification of the felony dependent upon the degree of violence.

♦ Establish a grant program to provide for the development of educational programs for local and state police regarding the role that they can play in protecting home care workers.

♦ Ensure reimbursement for home care services to allow for pass-through financing for any reasonable and necessary security measures required to protect home care workers and to maintain continued access to services for home care beneficiaries.

♦ Direct the U.S. Department of Health and Human Services and the Civil Rights Division of the U.S. Department of Justice to establish a model standard for suspension of services in geographic areas which may be temporarily subject to increased risk of violence and strengthen the rights of agencies to pull off cases that pose a threat to workers. This standard would allow for suspension of services without risk of allegations of noncompliance with various civil rights laws.

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

Since workplace violence presents a health and safety concern, OSHA is properly positioned to develop model standards for risk management. The benefit of OSHA-based standards is the likely consistency and uniformity in implementation. However, efforts directed toward increased protection of home care workers will increase the cost of the delivery of services. The various federal programs which finance home care services must adjust their rates of reimbursement to meet this cost for these efforts to be effective.
Finally, the occurrence of violence against home care workers may result in discriminatory treatment of geographic areas by home care providers attempting to avoid danger. It is not unusual for a home care provider to suspend services temporarily in geographic areas when violence arises. This suspension may affect a home, apartment building, housing complex, or an entire neighborhood. In order to avoid allegations of discrimination, Congress should require the appropriate federal authorities to establish standards to which home care providers can refer in making determinations on suspension of service as a last resort to protect home care workers.
REQUIRE FEDERALLY FUNDED CRIMINAL BACKGROUND CHECKS AND ESTABLISH A NATIONAL REGISTRY SYSTEM

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

In March 1997, the then-Health Care Financing Administration published proposed rules governing the conditions of participation 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.

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 are 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 demonstration project before final passage of the legislation (Public Law 108-173).

Section 307 of P.L. 108-173 requires 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 have been earmarked to conduct an independent evaluation of the background check pilot.

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

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

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

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

RECOMMENDATION: Congress should allow hospices and home health agencies to obtain a geographic reclassification for wage index purposes in a manner comparable to that available to the hospitals or to allow reclassifications automatically when a hospital in the geographic locale of the hospice or home health agency receives a reclassification. Additionally, Congress should enact legislation that limits a home health agency’s loss of income due to a dramatic shift in the agency’s wage index (for example, limit the drop in any agency’s wage index from one year to the next to 2 percent). Finally, Congress should extend to all providers protections that ensure that no entity’s wage index falls below the rural wage index value in that state.

RATIONALE: In today’s health care environment, health care providers of all types compete for employment of the same personnel. The adjustment of Medicare payment rates intended to reflect variations in wages across the nation should be consistent across all provider types. With increasing shortages of health care personnel, unequal wage index adjustments for health care providers in the same geographic region results in an uneven and discriminatory distribution of the employment pool of personnel. Further, in recent years some agencies have experienced dramatic increases and drops in their wage indices. This degree of “swing” in reimbursement can have a significant impact on an agency’s financial viability.
III.

ENSURE THE APPROPRIATE USE OF TECHNOLOGY IN HOME CARE
RECOGNIZE HOME TELEHEALTH INTERACTIONS AS BONA FIDE MEDICARE SERVICES

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

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

Unfortunately, the Centers for Medicare and Medicaid Services (CMS) does not recognize telehomecare technology and visit costs as reimbursable by the Medicare program. CMS maintains that telehealth visits do not meet the Social Security Act definition of home health services “provided on a visiting basis in a place of residence.” CMS regulations at 42 CFR 484.48(c) define a home health “visit” as “an episode of personal contact with the beneficiary by staff of the HHA [home health agency].”

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

During 2000, the Congress provided further clarification on the use of telehealth services within the context of Medicare home health. Public Law 106-554 states that nothing prevents a home care agency from delivering services via telehealth, but specifies the services “do not substitute for in-person health services ordered as part of a plan of care certified by a physician and are not considered a home health visit for purposes of eligibility or payment.” This means that a telehealth visit cannot be used to count toward the number of visits that would qualify as a full episode of care. Nor can a telehealth encounter be considered a “visit” for purposes of a low utilization payment adjustment visit (LUPA), which is imposed for episodes comprised of four visits or less. During 2003, P.L. 108-173, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), contained one provision which may open the door for expanded coverage of telemedicine across all provider settings. A provision within MMA Section 721—Voluntary Chronic Care Improvement Under Traditional Fee for Service stipulates that certain elements of the “Care Management Plans” within the Chronic Care Improvement Programs chosen “shall to the extent appropriate include the use of monitoring technologies that enable patient guidance through the exchange of pertinent clinical information, such as vital signs, symptomatic information, and health assessment.” During the first session of the 109th Congress, Rep. Jim Ramstad (R-MN) introduced HR 3588, the “Medicare Home Health Telehealth Access Act of 2005”, which amends Title XVIII of the Social Security Act to allow certain home telehealth
interactions to count as visits under Medicare and establishes a pilot program with coverage for
cost-effective home telehealth interventions that result in savings to the Medicare program.

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

RATIONALE: Use of technology that results in more efficient and effective delivery of health
care services should be encouraged and recognized as covered Medicare expenditures. Studies
indicate that over half of all activities performed by a home health nurse could be done remotely
through telehomecare. Evidence from these studies has shown that the total cost of providing
service electronically is less than half the cost of on-site nursing visits. Furthermore, quality of care
and patient satisfaction has been maintained. Given the financial constraints on agencies under the
prospective payment system (PPS), providers of care should be granted maximum flexibility to
utilize cost-effective means for providing care, including non-traditional services such as
telehomecare that have been proven to result in high-quality outcomes and patient satisfaction.
These innovative approaches to care are of benefit to the entire Medicare program, frequently
helping to reduce acute care episodes and the need for hospitalizations.

Currently, some health maintenance organizations and some state Medicaid programs
reimburse for telehomecare services. The Medicare program must keep pace with these programs.
PROVIDE FINANCIAL ASSISTANCE TO HOME CARE AGENCIES TO EXPAND USE OF INFORMATION TECHNOLOGIES AND IMPLEMENT ELECTRONIC HEALTH RECORDS

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

The purchase of multi-purpose integrated clinical and financial systems with multiple electronic capabilities requires a significant capital investment. Traditionally, small business loans have not been readily available to most home health agencies because agencies are not viewed as a good credit risk. Many are dependent on Medicare for most of their revenue. Keeping pace with these new technology needs has been beyond the financial capabilities of many home care agencies.

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

RATIONALE: With the significant savings that electronic capabilities can provide, it is time to fully support a movement to an electronic environment for health care transactions. Home health agencies will require financial assistance to purchase the necessary systems. Current reimbursement standards under Medicare, Medicaid and other payors do not provide the capital foundation for such purchases.
ALLOW PAYMENT FOR HOME HEALTH SERVICES FOR CENTER-BASED CARE FOR TECHNOLOGY-DEPENDENT CHILDREN

ISSUE: Home care, along with all other health care services, has evolved in response to technological and economic changes. With these advances has come the opportunity for deinstitutionalization of many patients who would otherwise require hospital care. At the same time, center-based care for technology-dependent children has developed in this country as a means to provide relief to family caregivers, an opportunity for the technology-dependent child to avoid “institutionalization” at home, and as a means of meeting the medical and rehabilitative needs of the child. Center-based care provides a supplement to direct family services, allowing caregiving of technologically dependent children to receive care in a community-based location while still residing in their own home.

Medicaid does not cover this care consistently across the nation. Medicaid should recognize the health and economic advantages of serving technology-dependent children in center-based care as an option to extensive home care services.

RECOMMENDATION: Congress should pass legislation requiring mandatory Medicaid coverage of center-based care for technology-dependent children at day care centers.

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

ISSUE: New self-care technologies are emerging that allow the disabled and infirm to remain safely in their homes while coping with acute and chronic illnesses. Through the use of these technologies, individuals are able to self-monitor their conditions and obtain necessary insights as to when to link to professional health care providers. However, much of this technology is not covered under the Medicare benefit since it does not neatly fit within the benefit structure as “durable medical equipment” or otherwise.

RECOMMENDATION: Congress should provide Medicare coverage for medically-appropriate self-care technology that is designed to keep individuals safe in their own homes.

RATIONALE: Self-care monitoring technologies can prevent acute exacerbations of an individual’s condition thereby preventing costlier health care measures.
FINANCE A RESOURCE GUIDE TO HOME TELEHEALTH TECHNOLOGIES

ISSUE: Home telehealth technologies are quickly emerging in the marketplace. However, a comprehensive understanding of these technology options is not readily available to home care and hospice providers.

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

RATIONALE: The use of technologies in home care has the potential of creating cost saving benefits to Medicare, Medicaid, and other federal health program. A resource guide can help facilitate acquisition and supplementation of appropriate technologies.
IV.

RECOGNIZE THE APPROPRIATE ROLE OF HOME CARE AS PART OF ANY DISASTER PREPAREDNESS AND RESPONSE STRATEGY
DEVELOP A SYSTEM THAT INCLUDES THE NATIONAL HOME CARE NETWORK TO PROMOTE EFFECTIVE PREPAREDNESS FOR AND RESPONSE TO NATURAL AND MANMADE DISASTERS

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

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

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

On November 25, 2002, President Bush signed into law the “Homeland Security Act of 2002” (Public Law 107-296). The Department of Homeland Security’s primary mission is to help prevent, protect against, and respond to acts of terrorism within our nation’s communities. Title V of the law -- Emergency Preparedness and Response, directs the Secretary of Homeland Security (Secretary) to carry out and fund public health-related activities to establish preparedness and response programs. The Secretary is directed to assist state and local government personnel, agencies, or authorities, non-federal public and private health care facilities and providers, and public and non-profit health and educational facilities, to plan, prepare for, prevent, identify, and respond to biological, chemical, radiological, nuclear event and public health emergencies. Since September 11, 2001, $26.6 billion has been provided for first responders, including terrorism prevention and preparedness, general law enforcement, firefighter assistance, airport security, seaport security and public health preparedness. As such, Medicare home care providers should be included in the Secretary’s emergency and preparedness response programs since they can be found within the private as well as public and non-profit health care centers.

Home care has its foundation in and continues to act as an important element in our nation’s public health system. In fact, as federal funding for an effective public health infrastructure has failed to keep pace with need, the nationwide network of home care agencies frequently has performed important functions that protect and serve communities.
Those that provide home care services in this country are often invisible. In part this is because they are nurses, therapists and aides who travel to patients’ homes. In America’s past, however, they were very visible as they traveled on foot in traditional uniforms with their medical bags. The organizations known as Visiting Nurses date back to the late 19th century and made visits to the thousands who were suffering from flu in the pandemic of 1918.

Today, home care is the only “system” that is oriented to the community in a broad enough way to provide a massive infrastructure. Through the home care agencies in this country, it is possible to put a nurse in every zip code. In fact, in many counties in this nation, the public home care agency is the sole community provider. The home care clinicians are well acquainted with their communities to the point that they can be quickly deployed. They already form the system for flu immunization, and since the average age of the nurse is now 47, many still are current in their knowledge of how to inoculate for smallpox and other deadly diseases. Epidemics occur in communities and should be treated in the community; this is what home care nurses have done for over 100 years. Furthermore, should quarantine be needed, the patient’s home could be an option which could afford protection of the community at large.

The home care clinician of today is trained in public health service. They are able to assess the patient’s symptoms as well as the environment in which they reside. They conduct patient and safety assessments, skilled care and treatment, educate patient and family, and assist with medical and social supports that are critical to the process of healing the sick and protecting the well. Today, these skills are essential to serve and protect our communities’ health.

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

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

- Federal resources should be made available to Medicare-certified home care providers for disaster planning, practice, and training.
- Federal funds should be made available to home care providers to educate and prepare them for nuclear, chemical and/or biological terrorism or a pandemic influenza outbreak...
- Federal resources should be made available to support the development of public health outreach as well as fund a technology pass-through for needed technology infrastructure within Medicare home health agencies, e.g. communications systems and paperless documentation software and hardware. Communication systems are needed to enable clinicians to communicate from patients’ homes and from areas without power or phone availability. Paperless documentation software and hardware would enable clinicians to have access to a patient’s medical record.
• Federal resources should be made available to ensure coordinated disaster planning between hospitals and the home care system, as the maximization of surge capacity in hospitals is dependent on the surge capacity of home care to provide services to those discharged.
• Home care agencies should be included as vital participants in efforts to develop state emergency preparedness plans.

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

ENSURE APPROPRIATE PAYMENT POLICY AND REGULATION OF HOME CARE AND HOSPICE WHILE EASING THE PAPERWORK BURDEN AND DUPLICATIVE STATE AND FEDERAL REQUIREMENTS
CONDUCT IN-DEPTH STUDY OF VARIATION IN HOME HEALTH SERVICE USE AND OUTCOMES IN MEDICARE MANAGED CARE AS COMPARED TO THE FEE-FOR-SERVICE SECTOR

ISSUE: Nearly five-and-a-half of the more than 43 million Medicare beneficiaries were enrolled in Medicare Advantage (health maintenance organization -- HMO) plans in 2005. While this does not represent a significant increase over the number of Medicare managed care-enrolled beneficiaries in recent years, home health agencies in areas of the country are experiencing significant change in terms of the proportion of their Medicare clients that have chosen to enroll in Advantage plans. Many agencies cannot afford to provide their managed care patients the same level of care as they provide their fee-for-service clients.

RECOMMENDATION: Congress should authorize and fund study of variations in the use of services and outcomes between Medicare Advantage and fee-for-service clients. The beneficiary groups studied should be risk adjusted in order that a true comparison of treatments and outcomes can be made.

RATIONALE: During the 1990s studies concluded that Medicare HMO-participating home health patients received less visits and had less positive outcomes than their fee-for-service counterparts. Since that time there have been a number of changes that have affected the provision of care. First, the imposition of the home health prospective payment system has dramatically changed incentives for patient care; now that agencies receive a rate set in advance for providing an episode of care under fee-for-service Medicare, they no longer are incentivized to provide increasing numbers of visits. Additionally, the Congress has made changes over the years to attempt to encourage Medicare beneficiaries into managed care plans. Data from old studies is no longer applicable to the Medicare home health benefit. It is vital that the Congress, the Administration, and the public know if there are significant differences in the amount and quality of care provided to home health patients under fee-for-service and Medicare Advantage in order to ensure that all beneficiaries receive comparable services under this important federal health insurance program.
ENSURE APPROPRIATE DEVELOPMENT OF PERFORMANCE-BASED PAYMENT FOR MEDICARE HOME HEALTH SERVICES

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

RECOMMENDATION: Congress should ensure that any P4P system for Medicare home health services:

1. Is developed in conjunction with provider stakeholders;
2. Be tested as a pilot program prior to full-fledged implementation;
3. Fairly assesses the quality of care provided to home health patients and incorporates pending OASIS changes, as well as a mix of process and outcome measures;
4. Does not negatively affect patient access to care;
5. Is consistent with the home health PPS and appropriately risk-adjusted;
6. Limits any expansion of data collection requirements and full reimburses agencies for the costs of any additional data collection requirements that are imposed;
7. Only rewards agencies for care elements over which they have some control; and
8. Does not pose cash flow difficulties for agencies.
9. Allows the Secretary of Health and Human Services sufficient discretion to delay application of P4P if implementation concerns arise.

RATIONALE: When the home health PPS system was implemented in October 2000 it was virtually untested. Since that time a number of problems have been identified in the system. CMS is in the process of developing refinements to the existing PPS for home health; it may be another year or two before these refinements are completed and applied. It takes time for providers to adapt to changes in payment and treatment methods. Further, a number of factors beyond a home health agency’s control can affect patient outcomes – including patient compliance with self-care regimens or the absence or presence of a responsible caregiver in the home. Development and application of any P4P model must be approached very cautiously to ensure that incentives are properly and fairly crafted.
EXPAND STUDY OF QUALITY, COST EFFECTIVENESS OF POST-ACUTE PROVIDERS

ISSUE: In recent years, health policy discussions have focused increasingly on ways in which to provide high-quality, cost-effective, site-appropriate care, particularly in federally-funded programs. In the post-acute care arena, some of the most thorough analysis of care quality and cost-effectiveness has been conducted on behalf of the Medicare Payment Advisory Commission (MedPAC). In 2005, MedPAC reported that a study conducted by RAND Corp. on MedPAC’s behalf concluded that the home health benefit ranks highest regarding outcomes and cost-effectiveness for patients who have undergone knee or hip replacement surgery. The study compares care delivered in the home health setting with skilled nursing facility (SNF) and inpatient rehabilitation facility (IRF) care.

RAND considered post-acute care payments and also total episode payments -- including the cost of the initial hospitalization for joint replacement -- in its examination of cost-effectiveness of post-joint replacement care. SNF episode costs were found to be more than $3,500 higher than care for patients discharged to home, and an IRF episode of care was determined to cost about $8,000 more than care provided to patients at home.

RECOMMENDATION: Congress should authorize and fund further study on the cost-effectiveness of federally-financed care in different post-acute settings, and create incentives to encourage the provision of care in the most appropriate, cost-effective setting.

RATIONALE: As the number of citizens achieving Medicare eligibility continues to expand, it is vital that precious financial resources be directed to the most effective and efficient settings of care. Home health has been shown to be not only the preferred care setting, but also to be the most effective in particular cases relative to outcomes and cost-efficiency. Further study is warranted.
REFORM ANNUAL MEDICARE INFLATION UPDATE CALCULATION METHOD

ISSUE: Home health and hospice service payment rates under Medicare are annually updated by a market basket index (MBI). The MBI is intended to reflect changes in the cost of the delivery of services from the previous year. However, the MBI relies on cost input proxies and a weighting of the inputs that reflects cost experiences from several years in the past. On an irregular basis, Medicare reexamines the inputs, proxies, and respective weights assigned to the inputs.

The current formulas for calculating the MBI for home health and hospice have resulted in inflation updates that are lower than the updates calculated for hospital and outpatient services despite the similarities in cost factors in providing the services. It is believed that the current MBIs do not adequately take into account transportation, clinical professional, technology, and drug-related costs (among others) that make up the changing costs in home health services and hospice.

RECOMMENDATION: Congress should require the Centers for Medicare & Medicaid Services to rebase and re-weight the MBI at least every three years, along with an analysis as to the appropriateness of the price inputs used in the MBI calculation.

RATIONALE: Home care and hospice is changing rapidly in terms of the patients served and the elements of service to the patients. Pharmaceuticals have become a central part of hospice. Technology-based care has grown in use as part of home health services. At the same time, normal costs such as transportation have increased much beyond the projections by the Medicare program. The MBI is the mechanism by which the changes in costs and prices are reflected in payment rates; every effort should be made to ensure that it reflects those costs and prices.
PROHIBIT SUSPENSION OF PAYMENT IN SUSPECTED OVERPAYMENT CASES

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

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

RECOMMENDATION: Congress should amend the law to include suspected overpayments that are the basis for payment suspension within the protections afforded under Section 935 of MMA. The amendment should extend to the provider of services the right to pursue a “reconsideration” of the preliminary decision that the claims may not be covered under Medicare prior to the suspension of payment. Alternatively, Medicare should be prohibited from suspending payment at an amount greater than the claims involved in the preliminary review.

RATIONALE: The suspension of payment usually represents the end of the provider’s opportunity to stay in business. It is unfair to provide less protection against wrongful governmental action in situations of suspected overpayments than where Medicare has issued a formal determination that a provider has been overpaid.
EVALUATE USE AND ACCURACY OF HOME CARE COMPARE

ISSUE: The Centers for Medicare & Medicaid Services established a web-based information tool for consumers to aid in their selection of a home health agency for themselves or a loved one. This tool also can be used by health care professionals such as hospital discharge planners and managed care organizations. “Home Care Compare” provides a listing of Medicare-participating home health agencies and the geographic area that they serve. It also offers information regarding the performance of the agencies in terms of certain patient outcomes. However, it is unknown as to how much this tool is actually used to guide parties in the recommendation or selection of a home health agency. Further, there have been some questions raised regarding the accuracy and relevance of the information contained in Home Care Compare.

RECOMMENDATION: Congress should fund a study into the use and accuracy of Home Care Compare. The study should focus primarily on the validity of Home Care Compare and then on whether and how Home Care Compare is used to select a home health agency, guide hospital discharge planners, and influence Medicare Advantage plans in their contracting for services.

RATIONALE: Conceptually, Home Care Compare is a valuable tool for consumers and health care professionals. However, no tool is of value unless it is effectively used. The proposed study will help gain understanding as to how Home Care Compare can be used and improved for maximum beneficial use.
ENSURE APPROPRIATE DEVELOPMENT OF PERFORMANCE-BASED PAYMENT FOR MEDICARE HOME HEALTH SERVICES

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

RECOMMENDATION:

Congress should ensure that any P4P system for Medicare home health services:

1. Is developed in conjunction with provider stakeholders;
2. Be tested as a pilot program prior to full-fledged implementation;
3. Fairly assesses the quality of care provided to home health patients and incorporates pending OASIS changes, as well as a mix of process and outcome measures;
4. Does not negatively affect patient access to care;
5. Is consistent with the home health PPS and appropriately risk-adjusted;
6. Limits any expansion of data collection requirements and full reimburses agencies for the costs of any additional data collection requirements that are imposed;
7. Only rewards agencies for care elements over which they have some control; and
8. Does not pose cash flow difficulties for agencies.
9. Allows the Secretary of Health and Human Services sufficient discretion to delay application of P4P if implementation concerns arise.

RATIONALE: When the home health PPS system was implemented in October 2000 it was virtually untested. Since that time a number of problems have been identified in the system. CMS is in the process of developing refinements to the existing PPS for home health; it may be another year or two before these refinements are completed and applied. It takes time for providers to adapt to changes in payment and treatment methods. Further, a number of factors beyond a home health agency’s control can affect patient outcomes – including patient compliance with self-care regimens or the absence or presence of a responsible caregiver in the home. Development and application of any P4P model must be approached very cautiously to ensure that incentives are properly and fairly crafted.
LIMIT RETROACTIVE RECOVERIES RELATED TO THE IMPLEMENTATION OF MEDICARE PPS

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

A prime example is the ongoing recovery related to “inaccurate” reporting of a patient’s pre-home health care settings. The original instructions with the OASIS patient assessment provided no guidance as to the appropriate classification of a stay in a long term care hospital (LTCH). Beginning in October 2003, Medicare instructed that a LTCH stay should be classified as a general hospital stay. However, home health agencies that classified a LTCH stay as a rehabilitation hospital stay have been determined to have been overpaid back to October 2000.

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

RATIONALE: PPS was implemented without any advance trial. Consequently, not all implementation issues were addressed or resolved in advance. Subjecting providers to retroactive payment adjustments in such circumstances penalizes the providers for systemic shortcomings created by the Centers for Medicare & Medicaid Services (CMS), not the provider.
ENACT HOME CARE SPECIFIC ANTI-FRAUD MEASURES

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

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

- The institution of corporate compliance plans by all home health agencies to ensure adherence to all federal and state laws.
- Mandatory screening and federally-funded background checks on all individuals wishing to open a Medicare home health agency as well as all employees of home health agencies and establishment of a national registry of home care workers consistent with existing state laws.
- Strengthening of program participation standards to include experience credentialing and competency testing of home health agency personnel responsible for maintaining compliance with Medicare standards; such as the Certified Home Care Executive (CHCE), credentialing available through the National Association for Home Care & Hospice (NAHC).
- The investment of sufficient government and industry resources to expedite refinements to the prospective payment system so that agencies are appropriately reimbursed for the costs of providing home health services.
- Providing consumers and prospective consumers of Medicare home health services with a summary of program coverage requirements. The consumer reporting hotline for suspected fraud, waste, and abuse also should be enhanced and made more accessible.
- Implementation and development of credentialing and competency testing standards for government contractors and federal regulators responsible for issuing Medicare determinations.
- Enhancement of education and training of home health agency staff through joint efforts with regulators.
- Implementation of outcome-based compliance standards that provide operational flexibility and also eliminate structural requirements that are unrelated to the provision of high quality Medicare home health services.
- Development and implementation of Medicare coverage and reimbursement standards in language that is understandable and accessible to providers and consumers through various means; for example, through the Internet, federal depository libraries, and fiscal intermediaries.

RATIONALE: It is particularly important to ensure that limited health care dollars go to the provision of patient care rather than being diverted into the pockets of unscrupulous providers. A comprehensive fraud and abuse package that includes home health-specific provisions and provides
adequate enforcement tools to punish those who willfully and knowingly defraud the system is needed.

Moreover, any anti-fraud legislation must make a distinction between willful fraudulent activity and unintentional failure to comply with Medicare regulations. For example, the Office of the Inspector General often characterizes as fraud technical errors on claims or billing for services that the need for which is not documented sufficiently to demonstrate that it meets Medicare reimbursement requirements related to medical necessity. In such cases, provider education may be a more appropriate response than more punitive measures.
REFORM STANDARDS FOR HEALTH CARE SERVICES LIABILITY

ISSUE: Professional liability insurance has become too expensive and too difficult to acquire. In the absence of adequate insurance, access to affordable health care services is at risk. In addition, with rising insurance costs and limited payment rates, home care providers and hospices are forced to cut other expenses that may also jeopardize continued access to care.

RECOMMENDATION: Congress should enact reforms that bring about economies and stabilization in professional liability insurance. Reforms that should be considered to include, but are not limited to, limits on provider liability.

RATIONALE: While professional liability insurance reforms, such as limitations on liability, may cause a victim of health care negligence or malpractice to feel further victimized, the community good is served by having continued access to health care services that might otherwise be lost due to the cost of liability insurance. Individual states have enacted a hodgepodge of liability insurance reforms resulting in inconsistent availability and widely varying costs of liability insurance across the nation. A federal approach to liability insurance reform will aid in supporting access to services across the country.
REFINE MEDICARE HOME HEALTH PPS
OUTLIER PAYMENT

ISSUE: Medicare law requires that the home health prospective payment system (PPS) include a component for outlier payments with 5 percent of the anticipated expenditures allocated to an outlier budget. In implementing this mandate, the Centers for Medicare & Medicaid Services (CMS) created an outlier payment methodology that includes shared losses with the provider of services through the use of an eligibility threshold and percentage payment on costs above that eligibility threshold. In the first few years of PPS, there were indications that only a portion of the outlier budget (between 2 and 3 percent) was actually being spent. At the same time, there was strong evidence that certain long term and high cost home health patients were no longer being served in the home care setting, but instead were receiving care in skilled nursing facilities. In a recent regulatory change, CMS lowered the fixed dollar loss ratio for outlier cases during 2006 to 0.65.

RECOMMENDATION: Congress should mandate that CMS revise the outlier payment methodology in the following manner:

1. The shared loss ratio for costs in excess of the threshold should be eliminated;
2. The cost of medical supplies should be included as an eligibility element for outlier payment;
3. A cost-based outlier methodology should be included along with the present “number of visit” based outlier methodology;
4. In the event that the full outlier budget is not expended, CMS should issue retrospective adjustments to the outlier payments in order to fully expend the five percent budget; and
5. CMS should conduct continuing monitoring of the impact of the lowered outlier threshold on payment for high-cost episodes.

RATIONALE: The original outlier payment methodology was established based upon speculation and assumptions that have not proven accurate. While CMS has taken steps to bring outlier spending more in line with the legislative mandate, there are additional steps that can be taken to ease the considerable financial burden of caring for high cost patients. The loss of access to Medicare home health services for chronically ill individuals or patients requiring acute care over the long term, and individuals with uniquely high-cost needs strongly demonstrates that the outlier payment methodology has failed to achieve its intended goal.
ELIMINATE INEQUITIES IN PARTIAL EPISODE PAYMENTS

ISSUE: The home health prospective payment system (PPS), as implemented by the Centers for Medicare & Medicaid Services (CMS), includes the provision of partial payment in circumstances where the patient is discharged and readmitted or elects to transfer to another home health agency during an episode. This adjustment was established to provide a disincentive to premature discharge from care. The partial episode payment (PEP) adjustment prorates the PPS episodic payment based on the number of days a patient is served between the first and last billable visit in relation to the 60-day episode. As a result of this interpretation, there are payment gaps that inequitably reduce the level of payment.

Further, CMS failed to implement the PEP adjustments concurrent with the beginning of PPS in cases where a patient is discharged from one agency and admitted to another within the original 60 day episode. This failure to implement the adjustment created substantial overpayment liabilities to Medicare from a far back as October 2000. CMS began a two year PEP overpayment recovery effort in the summer of 2003. Providers were assured that recovery would be spread out over the full two years. However, some home health agencies have reported having significant portions of their total overpayments recovered, indicating that CMS’ contractors are failing to use a phased payment approach.

Finally, current CMS policy and intermediary actions in cases where two agencies bill for services provided within a 60-day period of time are confusing. CMS policy identifies the home health agency of records as the “primary agency.” The primary agency is responsible for provision of all bundled services to the home health patient. However, in cases where a second agency bills for home health services, CMS has instructed its contractors to assume that this constitutes a “beneficiary-elected transfer”, resulting in a PEP of the first agency’s episode.

RECOMMENDATION:
Congress should direct that CMS:
1. Eliminate the payment gaps or carve-outs under its current interpretation of PEP payments.
2. Make full episode payment when readmissions or beneficiary elected transfers occur for conditions unrelated to the initial reason for care.
3. In cases of readmission or transfer for the same condition, prorate PEPs based on the total number of days out of 60 from the start of care or first day of the episode through the day prior to the date the patient was readmitted or came under the care of the second home health agency.
4. Establish a time limit of one year on retroactive recovery of overpayments caused by CMS or contractor errors; any recovery should be evenly spread over a reasonable period of time.
5. Establish fair and equitable policies and protocols for providers to follow to avoid PEP episodes and conflicts when determining “primary agency.”

RATIONALE: The use of a PEP adjustment is inconsistent with the manner in which CMS calculated average episode costs. CMS originally envisioned home health PPS as a system under which an agency would be paid prospectively for 60 days of care, regardless of the actual number of visits made during that episode. Under the current interpretation, CMS has chosen to carve out the days in between billable visits when paying for a partial episode. However, if the patient receives a full episode of care, the agency would receive the full episodic payment, without the carve-outs. Providers should not be penalized when patients require treatment for a new condition unrelated to the original reason for care within a 60-day period. Reimbursement in this manner is more characteristic of per-visit payment rather than per-episode.
PPS should not exclude portions of episodic payment where there is a gap between intervening events since the nature of home care is the provision of part time or intermittent care. A patient is under a home health plan of care for the duration of the treatment plan, not only on those days that visits are actually made. CMS has implemented an inconsistent manner of calculating and applying payment rates under its current interpretation of PEP adjustments.

Retroactive recovery of overpayments can cause serious financial harm. Therefore, retroactive recovery of overpayments that were caused by CMS or its contractors should be time limited and conducted in a fair and equitable manner.
REFORM PPS COVERAGE AND REIMBURSEMENT FOR MEDICAL SUPPLIES

ISSUE: Under cost reimbursement, home health agencies were not required to provide any non-routine medical supplies, and covered medical supplies were limited to those that were ordered as part of the plan of care. Under the home health prospective payment system (PPS), agencies are required to supply all routine and non-routine medical supplies within the scope of the home health benefit that are needed by a patient during an episode of care. Each episodic payment contains approximately $50, an amount calculated by the Centers for Medicare & Medicaid Services (CMS) as the average supply cost per episode. CMS was unable to incorporate in its calculations for the bundled supply rate all supply costs for which agencies are responsible under PPS. Further, the payment for medical supplies included in the episodic rate is not case-mix adjusted according to the supply needs of the patient. Since case-mix varies by agency, payments will not necessarily “average out” over time. As a result, there is a disincentive for home health agencies to admit patients with high supply costs since they will not be adequately reimbursed. Conversely, some agencies with case-mixes with low supply needs may inappropriately benefit.

In addition, the requirement that home health agencies provide all supplies to the beneficiary during an episode of care could cause difficulties for patients with prior supply needs that are not germane to the current plan of care. This requirement expands the scope of the home health benefit beyond the patient’s plan of care and beyond what was the case under cost-based reimbursement, which could increase costs to the home health agency and disrupt the relationship between the patient and the prior medical supplier.

Finally, CMS did not build in inflationary considerations for the new, high-cost supplies such as those needed for chest drainage and complex wound care. Complicating the issue of accounting for supplies further, contractors and home health agencies had to delete supply charges from claims for an extended period of time in 2002 and 2003 because of CMS systems problems. As a result, Medicare claims files and PS&R reports do not reflect accurate costs to agencies for supplies.

During 2000, as part of discussions on the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (P.L. 106-554), consideration was given to a provision put forth by the home health community under which non-routine medical supplies would be excluded from the home health PPS rate and paid under a fee schedule. The final legislation agreed to by the Congress did not exclude the payment for supplies from the PPS rates, but rather required a study by the General Accounting Office (GAO) on the variation in prices home health agencies pay for non-routine supplies, the volume of supplies used, and what effect the variations have on the provision of services.

The GAO study, issued in August 2003, concluded that separate reimbursement for certain supplies might help ensure that patients have access to care and that agencies are protected financially. However, GAO also stated that CMS needs to collect patient-specific data on costs and utilization to determine whether payment groups and adjustments properly reflect differences in supply costs.

The Secretary of Health and Human Services is required to make recommendations on whether Medicare payment for non-routine supplies should be made separately from the home health PPS.

CMS has agreed to analyze current supply reimbursement and consider changes in a proposal for updates to the PPS system anticipated some time in 2006.

RECOMMENDATION: Congress should unbundle nonroutine supplies from the episodic
payment rate and establish a fee schedule for targeted reimbursement of supplies. If Congress is unable to take steps to unbundle nonroutine supplies, the following steps should be taken:

1. CMS should be directed to immediately revise the PPS case-mix adjustment system to address varying utilization of supplies;
2. CMS should be directed to develop an outlier payment mechanism for medical supplies;
3. CMS should be directed to modify the PPS standard to require that home health agencies provide only those medical supplies that are directly related to the treatment provided by the home health agency to the patient;
4. CMS should be directed to allow individuals to receive supplies that are not ordered as part of the plan of care from their supplier of choice with appropriate Medicare reimbursement under Medicare Part B; and
5. CMS should be directed to ensure that lost supply costs resulting from CMS systems problems and Part B limitations are accounted for when updating the home health case-mix system.

RATIONALE: The cost of non-routine medical supplies needed during an episode of home health care may vary widely – anywhere from nothing at all to thousands of dollars for a 60-day period. Every effort must be made to ensure that PPS case-mix weights (and payments under the system) adequately reflect the costs of the supplies needed or that agencies are fully reimbursed for their expenses through some other means. Additionally, agencies’ responsibilities for provision of non-routine medical supplies to home health patients under PPS should not reflect an expansion of prior responsibilities under cost-based reimbursement.
REVISE CURRENT SIGNIFICANT CHANGE IN CONDITION (SCIC) PAYMENT POLICY TO ENSURE APPROPRIATE PAYMENT FOR INCREASED SERVICES

ISSUE: The home health prospective payment system (PPS) regulations included a provision for a payment adjustment to an episode of care in which a patient experienced a “significant change in condition” (SCIC) that was not envisioned in the original plan of care. The intent of the SCIC adjustment was to provide home health agencies with the ability to meet the changing resource needs of their patients. The Centers for Medicare & Medicaid Services (CMS) stated in the preamble to the final rule that the SCIC adjustment policy was to provide financial relief to agencies that would otherwise “be locked into a case-mix adjusted payment based on a point in time of the patient’s condition at the beginning of the episode.” However, the current operation of the policy does not meet this intent.

The SCIC payment adjustment is calculated in two parts. The first part of the SCIC payment adjustment, reflecting the level of payment prior to the significant change in the patient’s condition, is determined by taking the span of days prior to the SCIC (first billable visit date through and including the last billable visit date) as a proportion of 60 multiplied by the original home health resource group (HHRG). The second part of the SCIC payment adjustment, reflecting the level of payment after the significant change in the patient’s condition, is calculated based on the span of days between billable visits after the SCIC occurs (first billable visit through and including the last billable visit date), taken as a proportion of 60 and multiplied by the episode amount based on the patient’s new HHRG.

Because the SCIC adjustment is based on the span of billable visit dates, the gaps between billable visits are carved out of the payment to the provider for a given episode. These gaps occur mid-episode, in between the last billable visit under the first HHRG, and the first billable visit under the second HHRG. Additional gaps occur at the end of the episode, if the last billable visit is made prior to the last day (day 60) of the episode. Though the payment rate is increased for that portion of the episode, the gaps in service dates more often result in a lower overall payment to the home health agency.

CMS did attempt to alleviate this burden by offering home health agencies the option of not claiming the SCIC if doing so would result in a lower net payment to the agency. However, this option constrains the agency to payment for a full episode under the patient’s original HHRG, and thus does not adequately compensate the agency for the increased resource needs of the patient who experiences a significant change in condition. Additionally, in cases where the significant change in condition is the result of an unexpected improvement in the patient’s condition, CMS has advised that a SCIC must be claimed. Complicating this issue even further, CMS responded to provider inquiries that, should the therapy threshold be reached unexpectedly during the course of a SCIC episode, the provider is prohibited from claiming therapy case-mix points for the pre-SCIC portion of the episode and for the entire episode if no SCIC is claimed.

Finally, it is difficult to determine if a change in condition is “significant” since the term is not defined by CMS other than to state that determination of SCICs should be done by the clinician and should not be based solely on changes to the HHRG. CMS advised home health providers to claim a SCIC when an unexpected change in a patient’s condition results in a higher HHRG AND new orders are required. However, CMS has not defined “unexpected” change.

RECOMMENDATIONS: Congress should direct CMS to eliminate SCICs from the home health PPS. Absent this action, Congress should direct CMS to amend the current SCIC policy as follows:

1. Eliminate SCICs for situations where there is an unexpected improvement in the patient’s
condition.

2. Define a SCIC as an increase in an HHRG value accompanied by a change in orders that adds additional services or increased frequency of services into the plan of care resulting in increased payment.

3. Pay home health agencies for a full 60-day episode, prorated based on the date(s) within the episode on which the HHRG increased.

4. Pay for hitting the therapy threshold for all episodes in which 10 or more therapy visits are provided.

RATIONALE: The failure to develop a consistent definition of a SCIC results in confusion and inconsistent application of the policy. Home health agencies continue to be financially and administratively burdened by the current SCIC policy. As result of the current SCIC payment policy, an agency is penalized when a patient experiences a SCIC during an episode of care, but when a patient does not experience a SCIC, the agency receives payment for a full episode, regardless of gaps in days between billable visits. Eliminating the gaps in payment that occur under the current SCIC policy will more fully meet CMS’ intent of providing additional payment to agencies that must provide additional resources to meet the changing needs of the patient. Eliminating these gaps is also more consistent with the definition of an episode CMS used to calculate PPS costs and payment rates, which were based on a 60-day period, regardless of whether there were gaps in service due to changes in condition, or patients were discharged and readmitted within that 60 day period.

The option not to bill a SCIC when a patient’s condition deteriorates but the overall payment to the agency would be lower if the SCIC were billed creates an administrative and financial burden on home health agencies. An agency must first determine whether it will receive a lower net payment if the SCIC is billed. In the event it does not claim the SCIC, it will still receive an episode payment that does not adequately represent the increased resource needs of the patient.

It is difficult for agencies to determine if a change in condition is “significant” such that a SCIC adjustment is warranted. CMS has advised agencies to claim a SCIC where an unexpected change in the patient’s condition results in a new OASIS assessment and a higher HHRG and new orders are required but has not defined “unexpected” change.

Finally, CMS interpretation of the SCIC policy as it relates to the therapy threshold is inaccurate. According to the July 3, 2000, Federal Register notice for home health PPS, “In the SCIC situation, the therapy threshold applies to the total therapy visits provided to the beneficiary during the episode both before and after the significant change in condition occurred.”
ESTABLISH STANDARDS FOR MODIFICATION OF PPS PAYMENT RATES AND CASE-MIX ADJUSTMENTS

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

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

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

RECOMMENDATION: Congress should restrict the ability of CMS to modify payment rates and revise the case-mix adjustment system. These restrictions should require that no adjustments occur without adequate advance notice of at least 12 months and that CMS develop criteria for application of the BIPA case-mix adjustment correction authority through public rulemaking.

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

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

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

In a September 2000 report (GAO/HEHS-00-176) reviewing the decline in home health service use in recent years and implications for payment policy, the General Accounting Office (GAO) commented that home health PPS will “need to be evaluated and refined periodically and that utilization monitoring and medical review of claims will be critical to ensuring that HHAs [home health agencies] do not stint on care or provide unnecessary services…” and that “PPS should be modified to incorporate a risk-sharing arrangement, which would limit aggregate HHA Medicare gains or losses.” In a February 2004 report to Congress on home health payments, GAO expressed the belief that payments for home health services under Medicare exceed agencies’ costs, and reiterated its recommendation for a risk sharing payment system for home health. In recent reports, the Medicare Payment Advisory Commission (MedPAC) has also examined risk-sharing as a potential element for consideration as part of the home health PPS. At the same time, MedPAC, Congress, and CMS have indicated a keen interest in imposing some type of value-based payment system for Medicare providers under which higher quality care would be rewarded with bonus payments, and lower quality care would result in lower reimbursements.

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

RATIONALE: The currently applicable home health PPS case-mix adjustment system accounts for far less than 30 percent of the variation in resource use. Additionally, the budget neutrality requirement for the first year of PPS artificially lowered PPS payment levels by requiring that they be based upon outlays for home health under the interim payment system. Further, imposition of the “15 percent” cut in October 2002, elimination of the rural differential (“add-on”), and reductions in market basket inflation updates in recent years have further strained agencies financially. As a result, there is widespread concern that existing payment levels will fall short of agencies’ actual expenditures in serving patients. There is no type of risk sharing under either the hospital or skilled nursing facility PPS. Such an adjustment would help to perpetuate the complexities and incentives of cost-based reimbursement. Finally, the planned imposition of performance-based payment under Medicare and the myriad of changes such a system will require would advise against further complication of the home health PPS with risk-adjusted payment. Consideration of any type of risk-sharing system at this time, most particularly if it is based on an individual case basis, could cause great harm to agencies and the patients they serve.
ENSURE AN EQUITABLE PPS WITH AN ADEQUATE CASE-MIX ADJUSTOR

ISSUE: The Balanced Budget Act of 1997 (BBA) mandated the implementation of a prospective payment system (PPS) for Medicare home health services; the home health PPS was finally implemented on October 1, 2000. In order to ensure a fair PPS, an adequate case-mix adjustor is needed to avoid penalizing agencies that serve patients who require more care than the average and to avoid rewarding agencies that seek to serve only low-cost patients. At its implementation, CMS estimated the PPS case mix adjustor to have a predictive factor of about 30 percent, meaning that it is able to accurately project costs in about 30 percent of all home health cases. More recently study has indicated that the predictive ability of the home health case mix system is far lower than 30 percent. Case-mix considerations include such variables as health status, age, and socio-economic factors of the patients served. Since PPS was implemented many concerns have surfaced regarding the reliability and accuracy of the case-mix adjustor.

RECOMMENDATION: Congress should require that the Centers for Medicare & Medicaid Services (CMS) do continuing in-depth study on the adequacy of the case mix adjustor, and make adjustments as necessary. CMS should be required to seek out the input of providers and case-mix study contractors in this effort. Congress should also require that CMS adjust payment rates for costs agencies incur in complying with regulatory and legislative requirements that were not included in the initial calculation of rates. Finally, Congress should resist imposition of across-the-board cuts to home health payments until a more accurate case-mix system is in place.

RATIONALE: PPS represents a dramatic shift in the manner in which home health care is administered and delivered. Close monitoring and legislative modifications may be needed throughout the process to ensure that a workable PPS results.
ENSURE CARE ACCESS FOR RURAL AND UNDERSERVED PATIENTS

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

Additionally, agencies are incurring significant unreimbursed costs to recruit and retain home care professionals and paraprofessionals, and better integrate the use of technologies in agency operations. As a result, agencies may be forced to refuse admission to patients whose care costs would place an agency at financial risk; further, insufficient payments could create perverse incentives to place limits on care, affecting the overall health care outcomes of patients. The Congress had sufficient concerns about the impact of PPS on beneficiary access to care that, in late 1999, it requested a study from the Medicare Payment Advisory Commission (MedPAC) on the advisability of excluding rural home care providers from the PPS system altogether. In late 2000, as part of the Benefits Improvement and Protection Act (BIPA), Congress enacted a 10 percent add-on for care delivered in rural areas between April 2001 and April 2003. As part of H.R.1, The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the Congress restored the rural add-on at a 5 percent rate for the April 2004 through March 2005 period. In early 2006, Congress approved legislation (S. 1932) to provide a reinstatement of the 5 percent payment differential for one year (calendar year 2006).

RECOMMENDATIONS: Congress must closely monitor the home health PPS to ensure that individual case payments are sufficient to maintain access to care. If the system’s payments are found to be insufficient, Congress should increase the home health base payment. Further, Congress should direct the Centers for Medicare & Medicaid Services (CMS) to develop a more adequate system of “outlier” payments under PPS so that high-cost patients will have continued access to services. Congress should restore and permanently extend the payment differential (“add-on”) for care delivered in rural areas. Finally, Congress should monitor adequacy of PPS payments so that agencies in underserved areas (rural, inner city, medical shortage areas) can continue to provide care to Medicare beneficiaries.

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

ISSUE: On October 1, 2000, Medicare participating home health agencies shifted to a new reimbursement methodology based on prospectively-set payments. Under current law, Medicare is prohibited from issuing payment earlier than 14 days after receipt of a claim from the provider of services. If no payment is issued within 30 days of receipt of a “clean” claim, Medicare must pay interest on the overdue payment to the provider of services. The Medicare, Medicaid, and SCHIP Benefits Improvement Act of 2000 (BIPA) requires that claim determinations be rendered within 45 days effective October 1, 2002. In its home health prospective payment system (PPS) implementation regulation, CMS requires that 60 percent of the PPS payment be issued upon receipt and processing of the initial request from the provider of services. At the conclusion of the 60-day episode period, a home health agency is required to submit a second claim, which will lead to the issuance of the remaining payment due the home health agency for that episode of care. For subsequent episodes, the initial payment is 50 percent.

The existing time structure for payment of home health claims can cause significant cash flow difficulties for home health agencies under PPS. These difficulties are exacerbated by payment of only 60 percent of the episodic PPS payment for the initial request from the home health agency.

RECOMMENDATION: Congress should require that CMS issue an initial episode payment to the home health agency equivalent to 90 percent of the anticipated amount due to that agency for a particular beneficiary claim. Congress also should exempt home health agencies from the 14-day payment floor.

RATIONALE: Most of the costs for care in a 60-day episode occur within the first 30 days of admission to service. Since home health agencies do not have large cash reserves to support delayed payment from Medicare, it is essential that payments be expedited in order to support the financial viability of home health agencies where the predominant financial obligation is staff payroll. With the existing standards for claims processing and payment, it is likely that most home health agencies will not receive the full payment of the episode rate until well after most care is provided. Increased medical review activities planned under PPS will further delay payment.
ENSURE FULL MARKET BASKET UPDATES FOR HOME HEALTH PAYMENTS

ISSUE: Under the fiscal year (FY) 1999 omnibus appropriations legislation, the Medicare home health market basket index – used to adjust payments for inflation – was reduced 1.1 percentage points from the projected 3 percent update in each of (FY) 2000-2003.

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

In January 2003, the Medicare Payment Advisory Commission recommended that Congress freeze home health payment rates at the FY 2003 level for FY 2004. MedPAC renewed its market basket freeze recommendation for 2005, 2006 and 2007. MedPAC bases its recommendation on estimates of Medicare profit margins for freestanding agencies. More comprehensive study of agency margins performed by the National Association for Home Care & Hospice have found significantly lower Medicare profit margins that virtually disappear when margins that take all payers into account are considered. Further, when agency profit margins are considered on an individual basis, they reflect dramatic ranges.

As part of HR1, The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Congress enacted reductions of 0.8 percent off the market basket update from April 2004 through December 31, 2006. In early 2006, Congress approved legislation (S. 1932) was pending in the Congress that would eliminate a scheduled 2.8 percent market basket inflation update for 2006.

RECOMMENDATION: Congress should ensure a full market basket inflation update for 2006.

RATIONALE: As the result of the BBA, anticipated Medicare home health outlays were reduced by more than $74 billion over fiscal years 1998 through 2002. This amount is far in excess of the $16 billion reduction originally contemplated by the Congress, and has had a profound negative effect upon beneficiary access to care and home health agency viability. Reimbursement levels have failed to adequately cover the rising costs of providing care, including increased labor costs for home health agencies. Thousands of home health agencies closed following implementation of the BBA. In calendar year 2000, one million fewer beneficiaries received home health services than in CY 1997 and, in the first year of PPS (CY 2001), an additional 300,000 fewer beneficiaries received home health services than in CY 2000. In CY 2001, 5.5 percent of Medicare beneficiaries received home health services, compared to 6.5 percent in 1991. Recent study by MedPAC and CMS indicate that a major problem with the PPS is that the case mix adjustor in most cases does not accurately predict the costs of providing care. Crude measures such as across-the-board reductions or freezes will only exacerbate inequities in the system, and contribute further to access concerns. Access to care continues to be a serious problem in home health. Home health care is efficient and effective in providing vital services to patients in the comfort of their homes. Use and provision of these services should be encouraged, not discouraged.
OPPOSE PROPOSALS TO “BUNDLE” HOME HEALTH AND HOSPICE BENEFIT PAYMENTS WITH PAYMENTS WITH PAYMENTS TO OTHER PROVIDERS

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

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

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

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

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

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

Bundling would vastly increase the administrative burden on home care providers by requiring multiple payment systems for home health - - one for post-acute patients and one for patients entering home care from the community - - and would require home care agencies to bill any number of hospitals for the care they provide to post-hospital patients, rather than using the current single-billing system. This two-track system will result in uneven Medicare coverage for patients with the same care needs as every hospital interprets and applies coverage rules differently. Many of these same arguments apply to proposals to bundle home health payments in with payments to other post-acute care providers.
OPPOSE COPAYMENTS FOR MEDICARE HOME HEALTH SERVICES

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

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

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

• Congress modernized the home health benefit by eliminating copays in 1972 and a home health care deductible in 1980 to encourage use of less costly, noninstitutional services. The Urban Institute’s Health Policy Center concluded that copays “…would fall on the home health users with the highest Medicare expenses and the worst health status, who appear to be using home health in lieu of more expensive nursing facility stays.” (“A Preliminary Examination of Key Differences in the Medicare Savings Bills,” 7/13/97.)

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

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

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

• The Commonwealth Fund cautioned lawmakers that cost-sharing proposals, such as a copayment on Medicare home health services, could leave vulnerable beneficiaries at risk and place an inordinate burden on those who already face very high out-of-pocket costs. (“One-Third At Risk: The Special Circumstances of Medicare Beneficiaries with Health Problems,” 9/01). The elderly already spend 22 percent of their income on health care; those in poor health spend 44 percent and those who are low-income women over 85 spend 52 percent. (“Medicare’s Future: Current Picture, Trends and Prescription Drug Policy Debate,” Updated Charts, Commonwealth Fund, 7/1/03.) Seniors spend nearly twice as much of their income on their health care now than they did before Medicare began. (AARP, “Out of Pocket Health Spending by Medicare Beneficiaries Ages 65 and Older: 1997 Projection,” 12/1/97.)

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

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

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

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

- With hospital and nursing home care, Medicare pays for room and board, as well as for extensive custodial services. At home, these services are provided by family members or paid out of pocket by patients without family support. Family members are frequently trained to render semi-skilled support services for home care patients, which Medicare would have to pay for in the hospital or nursing home setting.

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

- The number of Medicare beneficiaries receiving home health care annually dropped by 1.3 million between 1997 and 2002, resulting in a cumulative total of over 5 million fewer beneficiaries receiving home health services during this period. For 2006 it is expected that nearly 700,000 fewer beneficiaries will receive home health care than in 1997. The average number of visits provided over a 60-day episode has dropped from 36 to 18. Since 1997 the home health benefit has dropped from 8.7 percent of the Medicare program to 3.8 percent, and CMS projects that it will drop to 2.6 percent over the next 10 years.

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

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

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

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

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

**Copayments would impose an unfunded mandate on the states.**

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

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

**Copayments would be another federal administrative burden on providers and would increase Medicare costs.**
• Home health agencies would need to develop new accounting and billing procedures, create new software packages, and hire staff to send bills, post accounts receivable, and rebill. Also, unlike hospitals, there is no provision for bad debt from uncollected copays currently built into the base payment for home health care.

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

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

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

RATIONALE: Medicare is a national program with uniform conditions of participation throughout all states. The failure to require reciprocity agreements can deprive residents of one state the availability of home health services centered in a neighboring state. These services are often centered in a metropolitan region that borders on another state.
ALLOW FLEXIBILITY IN THE DELIVERY OF HOME HEALTH SERVICES UNDER THE MEDICARE PROSPECTIVE PAYMENT SYSTEM

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

RECOMMENDATION: Congress should authorize home health agencies to utilize PPS payments in a flexible manner in order to achieve quality of care and efficiencies without adverse consequences relative to payment, coverage, and compliance with the conditions of participation.

RATIONALE: Optimal health outcomes should be the main goal of the Medicare program and its supporting reimbursement system. Home health agencies should not be prohibited from taking advantage of new technologies and services, along with alternative care, if equal of better patient outcomes can be achieved with greater economies. Flexibility in the delivery of home health services within PPS does not necessitate any change in the home health benefit qualifications, which require that a patient be confined to the home while in need of skilled nursing care on an intermittent basis or physical or speech therapy. Home health agencies should be authorized to utilize such important disciplines as nutritionists and respiratory therapists, or new technologies that can reduce the cost of providing care to patients at home while maintaining or improving patient outcomes.
CLARIFY THE DEFINITION OF SEPARATE ENTITY

ISSUE: In recent years, home health/hospice organizations have become more complex, multi-functional entities. The appearance of these complex organizations has made it increasingly difficult for surveyors to determine what part of the organization is the certified home health agency or hospice and subject to the Medicare conditions of participation (CoP). As the result, other portions of the organization are being subject to the CoP. Many of the instructions issued in the past are outdated and provide conflicting guidelines. The current CMS guidelines provide inadequate clarity to assure consistent application.

RECOMMENDATION: Congress should clarify that the definitions of “home health agency” and “hospice” allow for limitation of the application of the Medicare regulations to that distinct part of the organization that is the home health agency or hospice.

RATIONALE: Federal law defines a home health agency as a “public or private organization or a subdivision of such an agency or organization.” Hospice is defined as a “public agency or private organization or subdivision of either of these that is primarily engaged in providing care to terminally ill individuals.” “Subdivision” is defined in the State Operations Manual as a “component of a multi-function health agency.” There is no requirement that a “subdivision” be a separate legal entity from other parts of an organization. In order to comply with federal law and the definition of “subdivision” in the State Operations Manual, an organization simply must be able to delineate the home health agency from other “components of a multi-function health agency.” This requirement is met when a home health agency or hospice has distinct admission and care management processes and a program description that differentiates the agency or hospice from other organizational programs.
MAINTAIN COVERAGE FOR INDIVIDUALS WITH ONGOING HOME CARE NEEDS

ISSUE: Some in Congress have expressed the desire to restrict access to the Medicare home health benefit by making it available only to individuals with time-limited needs for acute levels of care at home. However, many home health patients need ongoing home care in order to maintain medical stability and enable them to continue to live at home, rather than enter nursing homes. Ongoing monitoring can reduce the number and/or severity of acute episodes, and allows for more comprehensive and effective patient management. The health care needs of the Medicare-eligible population have shifted to chronic care treatment. The home health benefit provides the flexibility to treat both acute and chronic care patients.

RECOMMENDATION: Congress should retain the current nature of the Medicare home health benefit and should not erode or deny any benefits that are currently provided and needed. Instead, Congress, the President, and the American public should engage in a thoughtful debate on the best way to provide for federal coverage of long term and ongoing home care.

RATIONALE: Home care is extremely successful in meeting both the acute and chronic care needs of millions of seniors and disabled individuals. As the Nation’s chronic care population grows, a system should be developed and fully implemented to meet these important needs. No steps should be taken to narrow the scope of the current benefit programs before such a system is fully in place.
PRESERVE THE PUBLIC NATURE OF THE MEDICARE PROGRAM

ISSUE: the Medicare Prescription Drug, Modernization, and Improvement Act of 2003 (P.L.108-173) continued the trend of recent years to encourage greater participation by Medicare beneficiaries in private insurance plans. Given that, during the 109th Congress, it is anticipated that it will be necessary to take decisive action to shore up the Medicare program; many members of Congress are looking toward proposals that reduce federal responsibilities and further encourage private plan participation.

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

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

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

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

**Affordability**
- Changes in Medicare financing and benefits should protect all beneficiaries from burdensome out-of-pocket expenses, such as home health copayments, and should expand and improve programs for low-income beneficiaries.

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

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

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

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

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

In early 2001, the General Accounting Office (GAO) conducted a study under which it found that nearly all agencies surveyed estimated that start-of-care visits take approximately 40 minutes longer than before OASIS was implemented. These agencies also reported that additional time is needed to check and edit collected OASIS data, enter and transmit the information electronically, and train new staff. GAO data indicate that these additional steps require approximately 50 minutes per OASIS assessment. Eighty-four percent of survey respondents said they provide, on average, eight hours of education for newly hired staff. The GAO did not provide study of the additional administrative burdens associated with additional assessments instituted with OASIS.

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

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

During 2003, legislation was enacted that would suspend OASIS collection and reporting requirements for non-Medicare and non-Medicaid patients pending a study by CMS. CMS has completed the study but the results have not been made public. CMS continues to require full OASIS data collection for Medicaid patients at recertification even though this information is not used for quality measurement or payment.

Following imposition of the PPS, little research was conducted on the validity and reliability of the OASIS items. Recently, the Center for Home Care Policy & Research of the VNS of New York conducted an in-depth study in this area and found that in real-world application of OASIS, many of the data items scored low in reliability tests. Of particular concern were their findings of low reliability for the instrumental activities of daily living (IADLs), functional status in the 14 days prior to the episode, and prognosis.
RECOMMENDATION: Congress should provide for reimbursement of the full costs agencies incur with respect to OASIS. OASIS data collection and submission requirements should be limited to Medicare patients. The number of OASIS items and frequency of assessment should be limited to only those necessary to determine appropriate reimbursement and patient care outcomes. Congress should direct CMS to conduct in-depth study of the reliability and validity of OASIS items on a timely basis, and refrain from using outcome measures derived from OASIS data for performance-based payment until further study has been completed and necessary changes made to the data set.

RATIONALE: OASIS can be a valuable tool that, over time and with appropriate changes, could greatly enhance the delivery of home care services. However, requiring OASIS data collection and submission for non-Medicare patients constitutes an unfunded mandate. OASIS requirements should impose as few administrative and financial burdens as possible upon already severely strained home health agencies. OASIS items should be used to measure quality and alter payment ONLY after their validity and reliability have been proved.
INCREASE FLEXIBILITY IN THE APPLICATION OF THE HOME HEALTH CONDITIONS OF PARTICIPATION

ISSUE: The Centers for Medicare & Medicaid Services (CMS) requires the application of all of the Medicare Home Health Conditions of Participation (CoP) to all patients served by the Medicare-certified agency regardless of payer source or type of services provided. These requirements increase the cost of services to all payers. Yet, one CoP, supervision of home health aides, has been written to provide flexibility in application based on service needs. Application of another condition, that of the Outcome and Assessment Information Set (OASIS), varies depending on payer and need for skilled care, but CMS plans to apply them to all patients served by certified agencies in the future. The application of OASIS to non-Medicare/Medicaid patients has been temporarily suspended, under the 2003 Medicare reform legislation. The Secretary’s Advisory Committee on Regulatory Reform adopted a recommendation to apply certain other Medicare Home Health CoP to Medicare patients only. The Government Accountability Office (GAO) has been charged with the responsibility to evaluate a more flexible application of the home care CoP.

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

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

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

♦ Advance directives are not indicated for medically stable persons and persons not receiving medical intervention for treatment of diseases, such as maternity and newborn patients.

♦ It is not necessary for physicians to review and sign the plan of care for medically stable persons receiving health promotion and personal care services according to state nurse practice acts.

♦ Physician order requirements were designed for legal authority to provide care and control of utilization. Nursing and therapy practice acts now recognize all but invasive procedures as independent aspects of practice, so orders are not usually required for legal coverage. A physician order with the intent of controlling utilization is a payer issue, not an operations or practice issue. If a payer wants to require this and assume the costs thereof, it should be a condition of payment.

♦ Patients’ medication monitoring should be the responsibility of physicians and pharmacists when home health patients require only therapy, medical social work, or aide services.

♦ OASIS data collection and reporting is not covered by most payers. Medicaid payments do not cover the cost of care in most states before the added burden of OASIS. Further, the Medicaid population can differ significantly from the Medicare population, thereby limiting the usefulness of OASIS for such cases.
EVALUATE USE AND ACCURACY OF HOME CARE COMPARE

ISSUE: The Centers for Medicare & Medicaid Services established a web-based information tool for consumers to aid in their selection of a home health agency for themselves or a loved one. This tool also can be used by health care professionals such as hospital discharge planners and managed care organizations. “Home Care Compare” provides a listing of Medicare-participating home health agencies and the geographic area that they serve. It also offers information regarding the performance of the agencies in terms of certain patient outcomes. However, it is unknown as to how much this tool is actually used to guide parties in the recommendation or selection of a home health agency. Further, there have been some questions raised regarding the accuracy and relevance of the information contained in Home Care Compare.

RECOMMENDATION: Congress should fund a study into the use and accuracy of Home Care Compare. The study should focus primarily on whether and how Home Care Compare is used to select a home health agency, guide hospital discharge planners, and influence Medicare Advantage plans in their contracting for services.

RATIONALE: Conceptually, Home Care Compare is a valuable tool for consumers and health care professionals. However, no tool is of value unless it is effectively used. The proposed study will help gain understanding as to how Home Care Compare can be used and improved for maximum beneficial use.
ALLOW FEDERAL JUDICIAL REVIEW OF STATE MEDICAID PROGRAM COMPLIANCE WITH FEDERAL MEDICAID LAW

ISSUE: In the past few 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. 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 where 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 the Centers for Medicare and Medicaid Services (CMS) to oversee the state programs on its own. CMS has, in the past, failed to properly ensure that the states comply with federal Medicaid law. Medicaid beneficiaries and providers 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.
ENCOURAGE APPROPRIATE, COLLABORATIVE ROLE OF PHYSICIANS IN HOME CARE

ISSUE: Medicare home health benefits require a physician’s authorization for a plan of care before a beneficiary can receive home health services. Many physicians are very knowledgeable regarding a patient’s condition and are able to certify the need for home care based on that knowledge. Other physicians perform a physical examination of a patient in order to establish an appropriate course of treatment. The Department of Health and Human Services (HHS) Office of the Inspector General (OIG), concerned that physicians might certify ineligible patients for home health, has advocated a mandatory physician office visit, combined with follow-ups every 60 days. Due to the medical conditions of many homebound patients, a mandatory office visit may be impossible to comply with, could preclude access to home care services, and could increase costs to the Medicare program. Further, such a requirement could be unnecessary and costly where the physician is familiar with the case.

CMS and Congress must examine the role of physicians in home health and the ability of patients to access care. For example, a mandatory physician office visit prior to home health certification will create numerous difficulties for Medicare beneficiaries. Patients who are eligible for home health services are, by definition, homebound. Requiring these beneficiaries to travel to a physician’s office would constitute a severe hardship to non-ambulatory patients and such travel may further complicate the patient’s condition. Moreover, in some rural areas, a trip to the doctor’s office could exceed one hundred miles and would require an ambulance or special vehicle for transportation, adding tremendous costs to the Medicare program. Alternatively, requiring all home health patients to submit to a physical (without specification of the site where the physical must be performed) could also create problems, as many eligible home health patients may be unable to find a physician who is willing to perform a physical in the patient’s home.

RECOMMENDATION: Congress should study the role of the physician in home care and determine which factors enhance the physician’s ability to conduct oversight activities, ensure appropriateness of care, and work collaboratively with home health agencies without compromising quality or access to home care and without wasting precious program funds.

RATIONALE: For over 30 years, home care providers have been the eyes and ears of physicians, conveying necessary clinical information on a continuous basis. Increased physician involvement will undoubtedly strengthen this communication and consequently improve patient care. Existing requirements already ensure physician participation through ongoing reporting responsibilities and monthly progress reports. In 2001, new codes were added to allow physicians to bill for the services involved in certifying and recertifying home health plans of care. Certification, recertification and care plan oversight activities will help to enhance the role of physicians in home care without the need for mandatory physician office visits and follow-ups every 60 days.
ENSURE ACCESS TO HOME CARE AND FULL FEDERAL FUNDING IN ANY PROPOSALS TO REQUIRE MEDICAL DIRECTORS IN HOME HEALTH AGENCIES

ISSUE: Although the 109th Congress has not proposed or addressed the issue of mandatory medical direction of home health agencies, the 105th Congress discussed this issue as a potential means of ensuring quality of care, regulatory compliance and accountability for patient care. Ideally, medical directors could help bridge communication gaps between a home care agency and a physician’s office, and help implement the most appropriate clinical services while helping to clarify the status of homebound patients. Several concerns must be met, however, before this idea becomes a statutory requirement. First, Medicare home health agencies are already under extraordinary financial strain due to the effects of many regulatory burdens and changes in reimbursement. The additional, and potentially substantial, costs of a medical director simply could not be borne under the current payment system and would need to be fully funded by the Medicare program as a pass-through. Second, many physicians have very limited understanding of home care and the medical regulations. Third, agencies in many rural and underserved areas may find it particularly difficult to recruit any medical director, much less a medical director with adequate knowledge of the Medicare home health benefit. Severe access problems would result if home health agencies were not able to meet this requirement.

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

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

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

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

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

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

ISSUE: Through the years, the Centers for Medicare and Medicaid Services (CMS) and other federal agencies have imposed increasing numbers of regulatory requirements on home health agencies, many of which have significantly increased agency costs and added to agency staffs’ workloads. Among these are requirements associated with OASIS, advance beneficiary notices, 15-minute increment billing, and others. Some of these requirements are ill conceived, unnecessary, duplicative, and burdensome. In analyzing the “paperwork” costs, CMS limits its calculations to the time needed to physically complete the form rather than the full costs involved. Even in cases where requirements are reasonable, they may be ill timed, considering all of the other adjustments and adaptations home health agencies are in the process of making. Currently, CMS is implementing a new patient notice process that, when added to existing notice requirements, requires home health agencies to provide up to six different notices, potentially at multiple points when Medicare coverage or service is to be reduced or terminated. The cost of this process takes valuable resources away from patient care.

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

RATIONALE: Home health agencies are currently instituting an overwhelming number of administrative changes. Many of these changes are costly and significantly increase the workloads of already strained agency staffs, affecting the ability of agencies to retain staff and continue to provide high-quality, appropriate care. Regulatory burdens must be more closely monitored to ensure the continued viability of agencies nationwide.
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 can operate branch offices. However, as with many other policies, this policy was developed and issued outside the regulatory process, placing agencies at risk of noncompliance due to lack of knowledge of these changes. Finally, CMS 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.

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.
COORDINATE GOVERNMENT REVIEWS OF HOME HEALTH AGENCIES TO REDUCE PAPERWORK BURDEN

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

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

RATIONALE: The current survey system is inefficient, excessively costly, disruptive, and unfair. An agency should have to submit patient records and claims information only once. Currently, three or four different Medicare contractors may review the agency’s records and operations information on site, by mail, or a combination thereof.
ALLOW PROVIDER APPEALS PRIOR TO SANCTIONING FOR SURVEY AND CERTIFICATION DEFICIENCIES

ISSUE: The Medicare Conditions of Participation (COP) for home health agencies and hospices (42 CFR 484) establish minimum standards for participation in the Medicare program. Although these conditions are intended to be standardized requirements for all certified agencies, the inherent complexity of the system has led to the issuance of deficiencies that may not actually reflect noncompliance with the COP.

Current appeal procedures do not adequately protect providers from inaccurately issued deficiencies. An agency may receive deficiencies that lead to the agency being terminated from program participation. The agency has a right to appeal this determination through a hearing before an administrative law judge (ALJ) and appeal to the Departmental Appeals Board. However, the appeal of a termination notice does not suspend the termination process. An agency may be subjected to public notice of termination and may be required to transfer all Medicare patients before the ALJ finds that the deficiencies cited are unsupported by statute and regulation. For example, a home health agency successfully appealed its termination only to be reinstated nearly two years later by which time the agency’s operation had virtually ceased and could not be restarted.

More commonly, the agency receives deficiencies that do not result in a recommendation for termination but that the surveyor demands be corrected. No formal appeal mechanism exists for agencies that disagree with the findings or interpretations of a surveyor. Lacking a recommendation for termination, the Centers for Medicare and Medicaid Services (CMS) Regional Office is not involved. The agency’s only recourse is to informally appeal to the state survey agency and/or regional CMS office to discuss the deficiencies in question, even though the state or regional office may not be receptive to resolving the issues. The agency may be subject to significant costs and operational changes in correcting nonexistent deficiencies.

With implementation of the Medicare reforms contained in the Omnibus Budget Reconciliation Act of 1987, P.L. 100-203, the impact of deficiencies became increasingly serious whether or not they lead to program termination recommendations. Agencies with conditional deficiencies are barred from performing home health aide training; surveyor reports of deficiencies are available to the public through inquiries to home health hotlines; and intermediate sanctions, including civil monetary penalties, may be levied against agencies for certain deficiencies.

Finally, the need for a formal provider appeals process is highlighted in the case of CSM Home Health Services. CSM was terminated from the Medicare program after three federal surveys found alleged noncompliance with the COP. The termination took effect in July 1996. CSM appealed to an ALJ who reversed the termination on October 25, 1996. Medicare appealed the ALJ decision. The appellate level agreed with the ALJ and reinstated CSM in an August 1997 decision. Since July 1996, however, CSM had been prohibited from serving Medicare patients. By the time the appeal was resolved, it was too late for CSM’s business to resume as it was bankrupt.

The 2003 Medicare reform legislation allows for expedited judicial review of provider agreement terminations in circumstances where facts are not in dispute. However, this change would be of limited value since it would be usable only in rare circumstances.

In addition, the legislation requires the Secretary to develop a “process to expedite proceedings” in termination cases. This change will not affect the timing of appeal rights that begin only after termination. CMS is currently considering the establishment of an alternative dispute resolution process to address survey deficiencies. Such a process had been previously used with nursing facilities.
RECOMMENDATION: Congress should enact legislation establishing formal appeals procedures for deficiencies issued during Medicare surveys regardless of whether or not the deficiencies lead to a recommendation for termination from program participation. This legislation should allow for suspension of the termination and sanction processes pending appeal of deficiencies and should include provisions that would allow continued operations and protect the agency’s reputation while the deficiencies are under review. For example, agencies should be able to continue to provide services, and public notices of deficiencies and issuance of information regarding deficiencies subject to appeal should be suspended until the issuance of a final ruling.

RATIONALE: Agencies should not be penalized for deficiencies that do not actually exist. The Medicare program does not adequately protect providers through appeals procedures. There already are processes in place that provide expedited termination authority for situations where patients are potentially placed in life-threatening situations. The recommended provision strikes a balance between protecting consumers’ and providers’ rights.
ENACT A HOMEBOUND DEFINITION THAT ENSURES ACCESS AND ELIGIBILITY FOR NEEDED HOME HEALTH SERVICES

ISSUE: Congress and the Administration have expressed an interest in redefining the eligibility criteria needed to be considered homebound under the Medicare home health benefit. The President, in his fiscal year 1998 budget package, put forward a proposal that would have severely restricted access to the home health benefit for many seniors and disabled individuals who are in need of this care, and would have made home care providers responsible for knowing the whereabouts of their patients at all times.

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

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

Section 702 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173) requires the Secretary of Health and Human Services to conduct a two-year demonstration project where beneficiaries enrolled in Medicare Part B with specified chronic conditions would be deemed to be homebound in order to receive home health services under Medicare. The Secretary was required to select three states – one state in each of the northeast, Midwest, and western regions of the United States in which to conduct the demonstration. The states chosen were Massachusetts, Missouri, and Colorado. Up to 15,000 beneficiaries can participate. Participation in the program has been extremely low because of the restrictive eligibility requirements. Upon completing the demonstration, the Secretary is required to report to Congress recommendations and findings regarding the demonstration and its impact on the Medicare program.

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

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

ISSUE: Home care, along with other health care services, has evolved in response to technological and economic changes. With these advances has come the opportunity for deinstitutionalization of many patients who would otherwise require hospital or nursing home care. At the same time, adult day care has developed in this country as a means to provide respite to family caregivers, an opportunity for the elderly patient to avoid “institutionalization” at home, and as a means of meeting social and health-related needs of the patient. During 2000, as part of its legislation to address some of the unintended consequences of the Balanced Budget Act of 1997, the 106th Congress provided clarification of the homebound definition under the Medicare home health benefit. This clarification allows Medicare home health patients regular absences from the home for the purpose of participating in therapeutic, psychosocial, or medical treatment in an adult day-care program. An evaluation of this amendment and its effect on the cost and access to Medicare home health services was conducted by the General Accounting Office (GAO), which found that the recent changes to the homebound definition will have “little effect on costs and access” to home health services (“Medicare Home Health: Clarifying the Homebound Definition is Likely to Have Little Effect on Costs and Access,” GAO-01-555R, 4/26/2002).

In the 108th Congress, Rep. Pete Stark (D-CA) and Rep. Gerold Kleczka (D-WI) introduced legislation, H.R. 2453, the Medicare Substitute Adult Day Care Act, which would permit Medicare home health services to be provided at adult day centers if the center becomes Medicare-certified. A similar bill, S. 1227, the Medicare Adult Day Services Alternative Act, was introduced by Senator Rick Santorum (R-PA).

Section 703 of the Medicare Prescription Drug, Improvement, and Modernization Act (H.R.1; Public Law 108-173), passed by Congress in 2003, requires the Secretary of HHS to establish a three-year demonstration project in not more than five states, under which a home health agency, directly or under arrangement with a medical adult day care facility, provides medical adult day care services as a substitute for a portion of home health services otherwise provided in a beneficiary’s home. CMS is currently evaluating applications for participation in the demonstration project.

RECOMMENDATION: Congress should pass legislation amending the Medicare home health services benefit to allow for coverage of “home health services” provided to “homebound” patients at adult day centers. Reimbursement for services provided at adult day centers should be set at levels sufficient to achieve access. Congress should require that adult day centers offering home health services meet national standards established by Medicare for adult day facilities. In cases where these centers provide home health services directly, they should be required to meet the Medicare home health Conditions of Participation. If home health services are provided under contract, they should be delivered by a Medicare-certified home health agency. Additionally, home health agencies should be allowed to provide adult day facility services either by meeting Medicare’s adult day facility standards or by contract with a Medicare-certified adult day center.

RATIONALE: The Medicare program could better serve the interests of beneficiaries by allowing coverage of home health services provided by home health agencies at adult day centers. This would enable patients to socialize outside the home, which would improve their mental health.
MAKE OCCUPATIONAL THERAPY AND SOCIAL WORK SERVICES QUALIFYING SERVICES FOR MEDICARE HOME HEALTH

ISSUE: The Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35) eliminated occupational therapy as a basis for initial entitlement to home health benefits (although physical or speech therapy alone continue as a basis for entitlement). Once eligible for home health services, patients may, however, continue to receive occupational therapy even if other skilled services are no longer required. Additionally, medical social work services can only be provided after the opening of a case by a qualifying service and must be terminated prior to the closing of the qualifying service. This results in fractured services to patients due to social work’s delayed entrance into a case and premature or unplanned termination. During the 109th Congress, H.R. 3022, The Medicare Occupational Therapy Coverage Eligibility Act of 2005 was introduced to make occupational therapy a qualifying service under Medicare home health. A Senate companion bill has not been introduced.

RECOMMENDATION: Congress should restore occupational therapy as a skilled service qualifying for the Medicare home health benefit. Medical social services should also be deemed as a qualifying service for purposes of establishing home health eligibility.

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

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

Medical social work can prevent institutionalization by decreasing the social and economic problems that have a negative impact on a patient’s response to treatment and increase the patient’s ability to remain at home. Medical social work can also reduce the number of visits for other home care services by strengthening the family and other support systems. In addition, medical social work services can reduce crises that lead to rehospitalization through long-term planning and crisis management.
ALLOW PHYSICIANS’ ASSISTANTS AND NURSE PRACTITIONERS TO CERTIFY MEDICARE HOME HEALTH PLANS OF CARE

ISSUE: Both physicians’ assistants (PAs) and nurse practitioners (NPs) are playing an increasing role in the delivery of our nation’s health care. Moreover, many state laws and regulations authorize PAs and NPs to complete and sign physical exam forms and other types of medical certification documents.

The federal government is also recognizing the growing role of PAs and NPs. The Balanced Budget Act of 1997 (BBA), P.L. 105-35, allows Medicare to reimburse PAs and NPs for providing physician services to Medicare patients. These physician services include surgery, consultation, and home and institutional visits. In addition, the Centers for Medicare & Medicaid Services (CMS) now allows PAs and NPs to sign Certificates of Medical Necessity (CMNs) required to file a claim for home medical equipment under Medicare.

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

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

RATIONALE: PAs and NPs are increasingly providing necessary medical services to Medicare beneficiaries, especially in rural and underserved areas. PAs and NPs in rural or underserved areas are sometimes more familiar with particular cases than the attending physician, so allowing PAs and NPs to sign orders may be most appropriate. In addition, PAs and NPs are sometimes more readily available than physicians to expedite the processing of paperwork, ensuring that home health agencies will be reimbursed in a timely manner and that care to the beneficiary will not be interrupted.
PROVIDE ACCESS TO MEDICARE HMO/PPO ENROLLMENT INFORMATION

ISSUE: Health maintenance organizations (HMOs) and preferred provider organizations (PPOs) have become firmly established as a means for providing health insurance coverage for a significant portion of the U.S. population. The Medicare Prescription Drug, Improvement, and Modernization Act (P.L. 108-173) provides new financial support for Medicare HMOs and PPOs, thereby increasing the likelihood of their playing a significant role in services to Medicare patients. Many newly-enrolled HMO/PPO patients, however, fail to understand that enrollment in an HMO/PPO may prohibit their being cared for by their chosen care providers.

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

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

The Centers for Medicare and Medicaid Services (CMS) has established a nationwide data base, known as the common working file (CWF), which contains information on the enrollment status of Medicare beneficiaries. However, this file is far from up-to-date, making the information unreliable.

RECOMMENDATION: To resolve this issue, Congress should:

♦ Require HMOs to determine any health services enrollees receive from other providers and furnish those providers with immediate notification of the HMO/PPO enrollment;

♦ “Hold harmless” providers who in good faith provide needed care to HMO/PPO members before this notification is received; and

♦ Require CMS to upgrade the information contained in the CWF and to make this information available on a nationwide basis.

RATIONALE: Medicare-certified home health agencies need timely enrollment information to avoid retroactive coverage denials. Despite providers’ best efforts to determine HMO/PPO enrollment, information available from patients and families is frequently inadequate and unreliable. This is particularly a problem with HMO/PPO enrollees who do not fully understand the implications of HMO/PPO enrollment and fail to accurately explain their status to home health agencies.
PROVIDE ACCESS TO MEDICAID ENROLLMENT INFORMATION

ISSUE: Medicaid reform efforts may alter eligibility standards for the Medicaid program. At the same time, changes in state 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 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 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.
OPPOSE USER FEES FOR MEDICARE AND MEDICAID
ADMINISTRATIVE ACTIVITIES

ISSUE:  Presidential budget proposals in recent years 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.

In President Bush’s recent budgets, he called for the Department of Health and Human Services to impose a $1.50 fee for each submitted claim that is duplicative, unprocessable, or not filed electronically. He has also called for a user fee for Medicare appeals.

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 and 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.

RECOMMENDATION:  Congress should continue to 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.
REINSTATE THE PRESUMPTIVE STATUS FOR HOME HEALTH WAIVER OF LIABILITY

ISSUE: The presumptive status of the waiver of liability, which expired at the end of 1995, protected hospices, nursing homes, and home health agencies that, in good faith, provided Medicare services to individuals who were later determined to be ineligible or whose services were later determined to be not covered.

In 1972, the Centers for Medicare and Medicaid Services (CMS) created a presumptive status for providers whereby the providers were presumed to have acted in good faith if they demonstrated a reasonable knowledge of coverage standards in their submission of bills.

On February 21, 1986, CMS issued final regulations eliminating the waiver presumption for home health agencies effective March 24, 1986. In response, Congress enacted, as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 (P.L. 99-272), a policy that preserved the waiver of liability presumption for home health agencies for a year after the 10 new regional intermediaries for home health agencies became operational.

COBRA also created two new, separate waivers for home health coverage denials on or after July 1, 1987, and before October 1, 1989, which would cover “technical denials,” such as “intermittent care” and “homebound” denials. A waiver presumption for these types of denials was also enacted.

The waiver of liability was further preserved by the Medicare Catastrophic Coverage Act (MCCA) of 1988 (P.L. 100-360), and retained even under the MCCA’s subsequent repeal. The Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508) extended the waiver of liability presumptive status as applied to medical and technical denials for home health agencies for five years. The home health waiver was further extended in 1995 in HR 2428, the Balanced Budget Act of 1995, which was vetoed. The home health presumptive status expired December 31, 1995.

RECOMMENDATION: The waiver presumption for both medical and technical denials for home health agencies should be permanently reinstated.

RATIONALE: The waiver presumption acts to protect providers who render services to Medicare beneficiaries in good faith, believing that they will be covered. This cushion for error is crucial in the Medicare home health benefit, which is susceptible to vagaries of interpretation by the fiscal intermediary and retroactive application of policy changes.

In the home health setting, in order for an agency to be compensated under the waiver presumption, its overall denial of claims rate must be less than 2.5 percent of the Medicare services provided. Any agency that exceeds this limit is not reimbursed under waiver regardless of whether it accepted beneficiaries and acted in good faith. This requirement forces agencies to use due diligence in determining eligibility and coverage.

Given the vague and inconsistent application of constantly changing regulations, guidelines, and directives, it is difficult for home health agencies to be 97.5 percent correct in their determinations of eligibility. The high number of claims denials that are reversed (40 percent at the reconsideration stage and 77 percent at the administrative law judge level for home health agencies and hospices combined) shows that coverage decisions are not as clear cut as CMS asserts.

At a time when sicker patients are admitted to home care following earlier hospital discharge, coverage questions are more complex, and the buffer zone of waiver presumption is particularly important.

In the absence of waiver presumption, agencies will have no recourse but to reject clients when coverage is questionable.
PROHIBIT USE OF SAMPLING AUDITS

ISSUE: Medicare intermediaries have used sampling techniques to audit home health agency claims. When utilized, sampling has proven itself a devastating device with a high risk of error. Any errors in the sampling process are multiplied, possibly placing the home health agency at risk of financial collapse. A single claim denial can result in tens of thousands of dollars of payment disallowances. The appeals process is an inadequate protection against erroneous denials since it can take several years to resolve a single claim denial.

During the early and mid-1980s, sample adjudication was utilized against three Medicare participating home health agencies. As a result of erroneous sample determinations, one of the agencies was forced into bankruptcy and is no longer available to provide services to Medicare patients in their community. The other two agencies survived, but only after protracted and expensive administrative appeals which established that, generally, Medicare’s determinations were erroneous.

The Centers for Medicare and Medicaid Services (CMS) issued guidelines for sampling in 1999. The application of those guidelines has been rare, but with consistent results—the methods employed are unreliable and inaccurate. Sampling would cause great harm to Medicare patients and the home care providers who serve them for the following reasons:

1. **Recoupment before full appeal**: Intermediaries using sampling require alleged overpayments to be refunded before the provider can exercise their full appeal rights. These recoupments can be huge and can threaten the very survival of the provider.

2. **Access to care reduced**: Historically, the fear of erroneous Medicare coverage denials has led some providers to limit availability of services to certain Medicare patients. Sample adjudication magnifies this “chilling effect” many felt.

3. **Claims process compromised**: The coverage determination process, which requires individualized review of claims, is rendered meaningless through retrospective review of only a sample of claims. With sampling authority, the Medicare program has no incentive to issue accurate and fair determinations in advance of payment.

4. **Loss of third-party payment**: Since the great majority of the claims on which sample adjudication is based cannot be identified, providers of services have no way of securing payment from alternative sources of payment, such as Medigap policies, which may be liable.

The 2003 Medicare reform legislation prohibits the recovery of alleged overpayments that have been calculated through sampling or otherwise through the reconsideration step in the appeal process only. In addition, the legislation limits overpayment extrapolation through sampling unless the Secretary determines that there are sustained or high levels of payment error, or education efforts have failed to correct payment error. The legislation also permits “consent settlement” sampling and full sampling where there are patterns of serious noncompliance.

**RECOMMENDATION**: Congress should prohibit the use of sampling to audit Medicare home health and hospice bills and clarify the current law to require individual coverage determinations.
RATIONALE: At the foundation of the coverage determination process is the recognition that individualized decisions are necessary because each home health care patient presents unique health care needs. Sampling is in direct conflict with that principle.
PROHIBIT STATES FROM USING COSTLY INDIVIDUAL CLAIMS REVIEW IN THIRD-PARTY PAYER RECOVERY EFFORTS

ISSUE: State Medicaid programs across the nation have put in place projects to maximize Medicare coverage for patients enrolled in both Medicare and Medicaid (so-called dually-eligible individuals). These programs maintain that Medicaid has incorrectly paid for services that should have been paid for by Medicare. In general, this situation arises when a patient has been determined by the care provider to satisfy the standards for payment under the Medicaid program, but not for Medicare. For home health services, the standards of coverage under Medicare and Medicaid can differ significantly.

State Medicaid programs have instituted Medicare maximization projects that not only prospectively seek to minimize Medicaid expenditures, but also retrospectively allege that providers have been overpaid by Medicaid for services provided up to two years earlier. These Medicaid programs demand that home health agencies submit these old claims to Medicare and reimburse the state program for any Medicaid payments received.

In addition, Medicaid programs have pursued high volume appeals on behalf of dual eligible patients, challenging claim determinations through administrative law judge hearings and in federal district courts. These Medicaid programs have also pursued claims on an individual claim basis, in a manner that is costly for all parties concerned: Medicaid, Medicare, and health care providers.

CMS has instituted a demonstration project that would adjudicate coverage disputes between Medicare and Medicaid through a statewide sampling method. This approach would bring about great efficiencies in comparison to the mass claims appeals method otherwise utilized.

RECOMMENDATION: Congress should prohibit states from using mass retrospective, individual claims reviews and appeals in their third party recovery efforts. States should be required to use cost-effective and sensible systems wherein state Medicaid programs can ensure that Medicaid is the payor of last resort without undue burden upon Medicare, Medicaid and health care providers. Medicare operations should also be modified to accommodate any bona fide effort by states that pursue third-party liability in a cost-effective manner. Congress should authorize the use of a retrospective claims sampling settlement process to reconcile disputes between Medicaid and Medicare as exists under the demonstration project. These changes can begin, if necessary, with a demonstration project in select states where Medicaid has engaged in Medicare maximization.

RATIONALE: While home health agencies do their best to determine whether a patient is covered under Medicare prior to a claim submission to the Medicaid program, differing standards of payment can lead to incorrect Medicaid payments. Often, providers have an incentive to bill Medicare over Medicaid since the level of payment from Medicare is higher in most states. However, where errors in claims determinations occur, states should be prohibited from using recovery methods which create unnecessary expenses for all parties involved.
LIMIT RETROACTIVITY OF FISCAL INTERMEDIARY DETERMINATIONS

ISSUE: Medicare regulations (§ 405.1885) give fiscal intermediaries (FIs) a period of three years after final settlement of a cost report to reopen and revise the settlement amount. (There is no time limit where “fraud or similar fault” are involved.) In some cases this three-year period for reopening “settled” cost reports has been used to give retroactive effect to a new policy interpretation. For example, an FI might advise a provider that a certain cost allocation method is proper and accept it for a number of years. Then, years later, the FI can change its mind, reject the allocation method and apply its new policy not only to the current and future cost reports but also to settled cost reports for the previous three years. There is a similar risk of retroactive disallowances when a provider is switched to a new FI that does not agree with some of the reimbursement practices of the previous FI. Such disallowances may be serious enough to force closure of some agencies.

The movement of home health care to a prospective payment system (PPS) does not alleviate concerns for several years since many cost reports are not settled and still others remain subject to reopening. It is expected that the final period of cost reimbursement will remain subject to reopening for several more years.

RECOMMENDATION: Congress should enact legislation that would bar an FI from revising a cost settlement to recoup overpayments on the basis of an interpretation that is different from the FI’s interpretation at the time of the settlement. In addition, legislation should be passed that would change the rules governing the reopening of final determinations (including Provider Reimbursement Review Board [PRRB] decisions) to conform to the Social Security and Medicare regulations that apply to Medicare beneficiaries (§§ 404.988 and 405.750[b]). Specifically, the rules would be changed so that:

A. The period during which a determination could be reopened for any reason would be reduced from three years to one year following the date of the notice of the FI’s (or PRRB’s) decision.
B. Determinations could be reopened during an additional three-year period for “good cause” – that is, where new and material evidence is submitted, a clerical error has been made, or the evidence that was considered in making the determination or decision clearly shows on its face that an error was made. As in the case of the existing regulations applying to beneficiaries, the case would not be subject to reopening during the additional three-year period “if the only reason for reopening is a change of legal interpretation or administrative ruling upon which the determination or ruling was made.”
C. There would be no time limit on the reopening of determinations that had been “procured by fraud or similar fault.”

RATIONALE: The complexity and vagueness of many aspects of provider reimbursement have made it necessary for providers to rely on the advice and direction of FIs in establishing accounting systems and in accounting for and reporting their costs. Providers should be able to rely on this advice until there is a policy change. The Social Security and Medicare regulations that apply to beneficiaries would protect providers against disallowances that go back more than a year while permitting both providers and fiscal intermediaries an additional year in which to introduce new and material evidence and correct obvious errors. As under the policies that now apply to providers, there would be no time limit on claims involving fraud. Finally, the transition to PPS should bring about a clean and expeditious break from cost reimbursement.
PERMIT SUITS AND AUTHORIZE PUNITIVE DAMAGES AGAINST MEDICARE CONTRACTORS FOR BAD FAITH DECISIONS

ISSUE: Under their Medicare agreements with the Secretary of Health and Human Services (HHS), Medicare contractors are immune from “all judgments, settlements and costs” resulting from lawsuits brought against them for actions they carry out in performing duties under the agreement. In effect, HHS is the only interested party in court actions that may challenge an intermediary’s Medicare determination. This immunity against suit has insulated contractors from court scrutiny and claims for damages in cases where they have injured providers by willfully denying payment for covered services without adequate cause, furnishing grossly inaccurate information on Medicare policies that subsequently led to a damaging recoupment of a substantial overpayment, issuing frivolous audit adjustments or taking other actions for which they should be held accountable. In late 2001 and 2002, Congress was considering legislation that would limit contractor immunity to those circumstances where the conduct was negligent, but allows liability where the conduct was reckless and willful. In 2003, Medicare reform legislation was enacted that allows the Secretary to indemnify Medicare contractors for judgments, settlements, awards, and costs except in situations where the contractor’s action’s are determined to be criminal in nature, fraudulent, or grossly negligent. This legislation does not affect the immunity of the contractor.

RECOMMENDATION: Congress should enact legislation that would eliminate the contractors’ immunity from suit in cases of willful and flagrant misconduct and allow for punitive damages.

RATIONALE: Over the years, there have been instances where Medicare contractors have abdicated their responsibility for processing Medicare claims fairly and with reasonable promptness. For example, a contractor with a burgeoning workload dealt with the problem by arbitrarily denying home health benefit claims; only the appealed claims had to be reviewed substantively. (Although the practice continued over a period of several quarters, the contractor was judged by the Health Care Financing Administration [HCFA] [now the Centers for Medicare and Medicaid Services—CMS] to have met the agency’s standards for accurate initial determinations.) Until CMS develops effective means for monitoring the administration of the Medicare program, the threat of suit would discourage such lawless behavior on the part of contractors.
REINFORCE BENEFICIARY DUE PROCESS RIGHTS

ISSUE: The prospective payment system for home health could create incentives for providers to provide less care than they might otherwise in order to secure profit or remain financially viable. The current Medicare appeals process is inadequate to address beneficiary claims regarding appropriate access to care. Beneficiaries must pay for services which are delivered after a patient has been notified of the provider’s determination that the services are not covered. Hearings regarding these determinations are not held in a timely manner, often taking a year or longer. Many beneficiaries choose to go without care rather than become liable for the cost of the services. Further, the appeals process fails to address quality of care concerns.

With the Medicare, Medicaid, and SCHIP Benefits Improvements and Protection Act of 2000 (BIPA), Congress mandated the implementation of an expedited determination and appeal process. The rule issued by the Centers for Medicare & Medicaid Services (CMS) makes that process available beginning July 1, 2005. However, the rule fails to protect providers from financial losses and inadequately protects Medicare beneficiaries where there is no physician order for care.

RECOMMENDATION: Congress should improve the appeals process for Medicare home health beneficiaries by providing protection from financial loss for providers of care. The system should also guide patients who need physician support to secure services.

Congress should alter the Medicare appeals process to allow for an expedited review in the following circumstances: a) where a home health agency has determined that a patient does not meet the conditions for payment of home health service; and b) where a home health agency has determined that a patient no longer requires home health services; and c) where a home health agency has determined that a patient requires a level of care which is inconsistent with the care prescribed by the patient’s physician.

Medicare payments for home health care services should reflect the agencies’ costs in processing these appeals. State Medicaid programs should not be allowed to mandate the use of this expedited appeals process for beneficiaries dually eligible for both Medicare and Medicaid. More efficient systems should be devised for allocating responsibility for payments between Medicare and Medicaid.

RATIONALE: This recommendation reflects the experience of the Medicare program with the establishment of the hospital diagnosis related group (DRG) payment methodology and the expansion of managed care. Subsequent to the implementation of the DRGs it was necessary to protect beneficiaries from premature hospital discharge by establishing reasonable oversight by peer review organizations. Similar concerns regarding the impact of managed care led to the development of an expedited managed care appeals process. In both the DRG and capitated systems beneficiaries are entitled to care pending the outcome of an expedited review.
PRESERVE INDEPENDENCE OF ADMINISTRATIVE LAW JUDGES

ISSUE: Since the beginning of the Medicare program, patients and providers have had access to fair hearings to challenge Medicare coverage denials. The administrative law judge (ALJ) system offered to Medicare claimants has proven a valuable safeguard against administrative errors and arbitrary determinations. Congress intended that ALJ hearings be conducted by independent judges who will ensure fair coverage determinations.

Since 1988, the Health Care Financing Administration (HCFA) (now the Centers for Medicare and Medicaid (CMS)) has repeatedly attempted to create its own ALJ corps that would review only health-related cases Congress has rebuffed each attempt by CMS to compromise the independence of the ALJs by bringing them under CMS control.

The Medicare Modernization Act (MMA) of 2003, required the Secretary of HHS and the Commissioner of Social Security to develop a plan by April 1, 2004, to transfer the Medicare ALJ function from the Social Security Administration to HHS. ALJ functions are required to be transferred no earlier than July 1, 2005, and no later than October 1, 2005. To preserve the independence of the ALJs, the MMA required the Secretary to place the ALJs in an administrative office that is organizationally and functionally separate from CMS. The ALJs will be required to report to, and be under the general supervision of the Secretary, not the Administrator of CMS. As required by the MMA, the Government Accountability Office (GAO) has issued an evaluation of the plan. The GAO concluded that important details were left out of the plan or not adequately developed, threatening the ability of HHS to provide appropriate appeals support by the October 2005 deadline.

RECOMMENDATION: Congress should carefully monitor the implementation of the transfer of the ALJs to HHS to ensure that the independence of the ALJs is maintained. Congress should block any CMS effort to interfere with the independence of the ALJs through oversight, indoctrination, or otherwise.

RATIONALE: Historically, CMS has responded to decisions favorable to beneficiaries in ALJ hearings with efforts to reduce or eliminate the impact of these determinations. For example, CMS has engaged in a stepped-up effort to have favorable ALJ decisions reopened and revised by the Appeals Council. Similarly, CMS has attempted to develop instruction programs for ALJs regarding Medicare coverage criteria. Most recently, CMS attempted to gain control of the ALJs by bringing them under its own roof. Independence of ALJs is crucial to fair decisions on Medicare appeals. This provides the checks and balances upon which our system relies.
IMPROVE ACCESS TO JUDICIAL REVIEW FOR MEDICARE CLAIMS

ISSUE: The Medicare program currently operates an elaborate and extensive administrative appeals system for coverage disputes. At the same time, an administrative appeals process is available for review of cost disallowances that come about through reimbursement audits of home health agencies by fiscal intermediaries (FI). Both these systems ultimately provide for a right of judicial review, but only after exhaustion of administrative remedies. The U.S. Supreme Court, in Illinois Long Term Care Council v. Shalala, ruled that exhaustion of all administrative remedies under Medicare is a prerequisite in almost all instances to jurisdiction in federal court.

Where the controversy involves a widespread practice of a FI, a policy interpretation, or the validity of a regulation, administrative review may not only postpone a global resolution of the issue, but may also prevent such resolution. A favorable administrative ruling cannot be appealed nor does it set a precedent. The Centers for Medicare and Medicaid Services (CMS) has generally followed a policy of nonacquiescence to administrative rulings it does not approve of, thereby leading to multiple administrative appeals on the same issue without any programmatic correction of the controversy. If providers and beneficiaries were allowed to pursue such issues in federal court without needing to resort to administrative remedies, an injunction issued by the court on behalf of a class of providers or beneficiaries would allow for resolution of the issue globally. CMS has proposed to provide for a process whereby parties can secure an expedited route to judicial review where there are no factual issues in dispute and the legal issues cannot be adequately addressed by the administrative review process. This process applies to coverage disputes only.

The 2003 Medicare reform legislation authorizes an expedited right of judicial review where there are no material issues of fact in dispute and the validity of a law or regulation is the only dispute. This right applies to payment and provider agreement determinations, but not reimbursement disputes. Process-related issues are also not addressed.

RECOMMENDATION: Congress should enact legislation to specifically provide for judicial review of claims and controversies involving such matters as widespread practices or processes of FIs, regional policy interpretations, or challenges to the validity of any Medicare regulation without first having to present the claim through the administrative appeals process. This type of judicial review should be available for claims for payment issues related to audit and reimbursement, and survey and certification concerns.

RATIONALE: Where issues involving significant segments of Medicare operation are to be reviewed, the current administrative appeals process presents a costly and unnecessary burden. Requiring exhaustion of administrative remedies for matters of potentially widespread impact could lead to inconsistent operations within the Medicare program. Claimants that are successful within the administrative process are made whole. For those providers who have neither the resources nor ability to access the appeals process, an illegal payment denial or disallowance of cost becomes final. Systemic reform of errors in practice or policy at CMS or its intermediaries can come about only through class action judicial review.
ALLOW APPROPRIATE AND EXPEDITED JUDICIAL REVIEW OF MEDICARE REIMBURSEMENT POLICY DISPUTES

ISSUE: In the administration of the Medicare program, issues arise concerning the validity of policy that has been implemented by the Centers for Medicare and Medicaid Services (CMS) which is intended to carry out a statutory or regulatory obligation. Those policies have significant impact on the rights of home health agencies and beneficiaries if their validity can only be challenged after the provider has incurred costs (which may be disallowed) and has completed the administrative appeals process. Under this system, a challenge to the validity of a CMS policy position, based on the current backlog, may not take place for at least five years following its implementation. Judicial review is generally not available until exhaustion of this process.

In addition, the Balanced Budget Act of 1997 (BBA) prohibited judicial review of any decisions by CMS relative to the creation and implementation of the home health prospective payment system (PPS). This leaves CMS with unfettered discretion and forces Congress to micromanage CMS through ongoing oversight.

RECOMMENDATION: Congress should enact legislation that would create an expedited route to judicial review where the basis of the action is a challenge to the validity of a Medicare reimbursement policy, including the home health PPS. Judicial review should be available where the claim is collateral to a direct claim for payment and the provider of services faces irreparable harm without judicial intervention.

RATIONALE: The current system allows CMS to develop reimbursement policy without subjecting it to public or judicial oversight and in a manner which dissuades home health agencies from incurring costs which may actually be allowable under the Medicare program. Further, it allows CMS to establish PPS policy which is counter to the mandates of Congress. An expedited judicial review under these limited circumstances would allow for program-wide resolution of disputes, thereby reducing the number of individual disputes that have to be resolved through the administrative process.
ENSURE AND ENFORCE BENEFICIARY CHOICE IN ALL FEDERAL HEALTH CARE PROGRAMS

ISSUE: Section 4321 of the Balanced Budget Act of 1997 requires that hospitals, as part of their discharge planning evaluation, identify all home health agencies that serve the area in which the patient resides and who request to be listed by the hospital as available. In addition, the legislation requires hospitals to maintain and disclose information to the Secretary of the Department of Health and Human Services (HHS) on referrals made to entities in which that hospital has a financial interest. This information must include the nature of the hospital’s financial relationship to the entity, the number of individuals discharged from the hospital who required that entity’s type of services, and the percentage of these individuals who received services from the hospital. CMS published a Notice of Proposed Rulemaking in December 2002 to implement this reporting requirement. However, both hospital-based and freestanding home health agencies report concerns that the report limits information collection to numbers of referrals.

In a recent update on the status of the proposed regulation, CMS reported that it is unable to publish the final rule due to the many concerns raised in public comments to the proposed rule and its inability to identify “home health referral” vs. “home admission” information from available data. In light of the problems, CMS intends to request that Congress reconsider the reporting requirement.

The provision requiring identification of all home health agencies that serve the area only applies to hospital referrals to home health agencies. To ensure true freedom of choice of providers, Medicare and Medicaid beneficiaries should be given a list of providers when referred by any health care entity.

Moreover, any beneficiary choice legislation must provide for a private cause of action allowing providers to bring suit against other providers for failing to adhere to the proper discharge planning and referral processes.

RECOMMENDATION: Congress should modify the freedom of choice provision to require that all health care entities in the position to refer patients in federal health programs provide comprehensive information regarding the availability of health services and inform beneficiaries of any financial interest involved in the referral. A private right of action should be established for providers affected or aggrieved by noncompliance with the freedom of choice provision by competing providers. Procedures should be established for reporting referrals by geographic area, by region, by agency, and by month.

RATIONALE: Reinforcing the beneficiary choice language will ensure that beneficiaries are aware of home health and hospice providers in their area and that their freedom in choosing a provider will not be abridged. Moreover, establishment of a private right of action for providers who have been adversely affected by noncompliance with the freedom of choice provisions will make it difficult for providers and others in the position to make referrals, to “steer” patients toward agencies in which they have a financial interest and help eliminate any inappropriate competitive advantages.
ESTABLISH SAFE HARBORS AND DE MINIMUS THRESHOLDS UNDER THE FALSE CLAIMS ACT

ISSUE: Currently, federal prosecutors can use the False Claims Act (FCA) to accuse health care providers of fraud and threaten the imposition of treble damages and fines of $5,000 to $10,000 per claim even if the error was an inadvertent billing mistake. In these instances, most providers are often compelled to settle these claims instead of facing the prospect of an automatic fine or costly legal bills. In response to complaints from health care providers, H.R. 3523, the “Health Care Claims Guidance Act,” introduced in the 105th Congress, would have distinguished claims of fraud from the honest mistakes of innocent providers by establishing de minimus thresholds and safe harbors for an action to be brought under the FCA. In addition, the legislation included incentives for health care providers to maintain compliance plans by establishing a safe harbor for providers that follow model compliance plans.

In response to Congressional inquiries and industry concern, the Department of Health and Human Services Office of the Inspector General (OIG) and the Department of Justice (DoJ) issued guidelines to be used in national enforcement projects. The guidelines establish “minimum monetary thresholds and/or percentage error rates” for each national enforcement project. Calculations of the minimum thresholds are to be based on applicable statutes, regulations, and program guidelines, as well as applicable provider data. These thresholds will then be used for “determining which health care providers the OIG will initially refer to the appropriate contractor for overpayment recoupment and which will be developed for potential referral to the DoJ or other appropriate enforcement agency.”

The General Accounting Office (GAO) issued a report on the guidelines, entitled “Medicare Fraud and Abuse: DoJ’s Implementation of False Claims Guidance in National Initiatives Varies” (GAO/HEHS-99-170), in which it determined that U.S. Attorneys’ Offices varied widely in their application of DoJ’s FCA guidance, undermining the consistency in the way the FCA is utilized in health fraud cases. In its recommendations, the GAO called upon the DoJ to increase its oversight of U.S. Attorneys Offices’ compliance by giving reviewers specific, concrete steps to determine whether an office is following the guidelines. In addition, the GAO recommended that those reviewing DoJ compliance guidelines document all proof of compliance.

A more recent GAO report, entitled “Medicare Fraud and Abuse: DoJ Continues to Promote Compliance with False Claims Act Guidance,” (GAO-02-546) found that the DoJ successfully integrated an assessment of compliance in its evaluations of all U.S. Attorneys’ Offices involved in investigating health care fraud. In addition, the GAO noted that the DoJ appears to be conducting its three national health care fraud initiatives in a manner consistent with the guidance. Lastly, the GAO surveyed representatives from the American Hospital Association and state hospital groups who stated that they were “generally satisfied” that the DoJ was adhering to the False Claims Act guidance.

Recent legislation has codified some of the GAO recommendations. For example, the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (P.L. 106-113) included legislative language requiring GAO to monitor, for three years, the DoJ’s implementation of guidelines on the use of the FCA in civil health matters.

RECOMMENDATION: Congress should enact legislation that establishes de minimus thresholds and safe harbors for an action to be brought under the federal False Claims Act. At a minimum, Congress and the GAO should closely monitor DoJ to ensure compliance with the guidelines.
RATIONALE: Codification of federal FCA enforcement procedures would help to ensure increased consistency of guideline use. Greater balance must be ensured in OIG and DoJ protocols between the rights of health care providers and the need for enforcement of the False Claims Act.
ENSURE PATIENTS’ RIGHTS IN MANAGED CARE PLANS

ISSUE: Managed care can be defined as a system that: integrates the financing and delivery of health care services; employs a variety of techniques to manage utilization and contain costs, including utilization review, case management, and the use of primary care physicians as coordinators and managers of care; and provides significant financial incentives for patients to use low cost providers and procedures. Health maintenance organizations (HMO) and preferred provider organizations (PPO) are the most prominent examples of managed care systems.

Managed care began in the 1930s as prepaid group practices and was promoted on the grounds that they were designed to improve quality and continuity of care and provide preventive health care services including the development of outcome data. However, the purpose of managed care has shifted dramatically since that time. Managed care is now seen mainly as a means of limiting the use of health services, reducing costs or both.

The increased emphasis on managed care as a means of cost containment has caused concerns about quality and access among consumers and providers, who fear that increased reliance on managed care will exacerbate the problems experienced to date. In the first session of the 107th Congress, the House passed patients’ rights legislation to address managed care abuses. The Senate did not pass patient rights legislation during 2002. No action was taken by either the House or Senate in the 108th Congress. There are wide disagreements over the circumstances and extent to which managed care enrollees should be allowed to sue their managed care plans. Patients’ rights legislation is expected to remain a major issue for members of Congress and the Administration.

Foremost among the problems experienced by home care recipients and providers are the following:

♦ The patient’s physician loses control of the patient’s care;
♦ Managed care plans create strong financial incentives to deny services, and some plans have illegally denied home care services to patients who need them;
♦ Patients whose care needs can be both expensive and lengthy are especially vulnerable under managed care plans that seek primarily to control costs;
♦ When plans fail to achieve sustained cost savings, and many payors have found that promised savings were experienced only as a one-time phenomenon, benefits are reduced or eliminated altogether;
♦ Patients are sometimes illegally denied home care services and must sue insurers to get the care they need and deserve;
♦ Managed care organizations have sometimes engaged in unfair competitive practices and heavy-handed bargaining in negotiating referrals to home care agencies;
♦ Consumers resent their lost freedom of choice in what can seem like a third-party bureaucracy designed to deprive them of care;
♦ Unwarranted interference with the caregiving process and excessive paperwork have been continuing problems;
♦ The potential for fraud and abuse increases under managed care when plans pursue cost savings at the expense of quality and access; and
♦ In the long run, managed care can reduce quality of care by curbing the development and use of new medical technology.
♦ Consumers are not told about copay requirements and other limitations on the provision of home health services in the managed care plans.
RECOMMENDATION: Managed care is not a panacea for controlling costs and ensuring access to appropriate services. If utilized, managed care plans should be designed carefully so that the pursuit of least costly care does not jeopardize quality of care or access to necessary services. Managed care plans should include mechanisms to preserve consumer choice, ensure easy access to needed services, require and enforce quality assurance standards for all providers, ensure payment rates that recognize the costs associated with high-quality care, allow individuals to challenge adverse decisions, promote fair marketing practices, and provide appropriate consumer education. Consumer education should include provisions to ensure that consumers understand the cost sharing requirements and other limitations on home health services in managed care plans. To secure many of these goals, a national patient bill of rights should be enacted.

RATIONALE: The rapid growth in health costs and the nation’s economic woes have led both public and private payors to turn increasingly to managed care in an effort to get more services for the money they spend. However, studies of managed care have failed to show that cost increase reductions, where they occur, are more than a one-time-only phenomenon; and even strong supporters of managed care are not sure that it will work to hold down costs. Further, a study conducted by the University of Colorado has found that Medicare home health patients in managed care plans received fewer services and had worse outcomes than other home health patients. Clearly, there is a strong need for safeguards to ensure that cost savings are not achieved by denying needed services. Without these safeguards, managed care will ultimately be rejected by both consumers and providers as an appropriate system of financing and delivery of health care services.
PROTECT CONSUMERS FROM ERRONEOUS SERVICE AND COVERAGE DETERMINATIONS

ISSUE: In recent years, there has been a growing shift in both the public and private sectors to managed health care. Experience indicates that the utilization controls imposed within managed care systems combined with financial incentives existing within a capitated framework create an environment where a health plan may benefit from denial of health care services to the consumer. Health maintenance organizations (HMOs) have been reported to severely restrict patients’ referral to home care services and specialty care. Home care agencies across the country have stated that HMOs erect administrative barriers to approval of care and often refuse to authorize coverage of services needed by patients.

Over the last ten years, Congress has debated an HMO Patients’ Bill of Rights. A crucial component to the Bill of Rights is the right to challenge and appeal HMO decisions. By way of regulation, the U.S. Department of Health and Human Services and the Department of Labor established some level of protection for Medicare managed care enrollees and certain participants in employer-based health plans. However, these protections are not comprehensive in scope or applicability.

In order to protect consumers from wrongful denials of health care services and coverage under managed care plans, a detailed appeals process for both consumers and providers of health services must be in place. This appeals process must provide for expedited review of disputes, decision making outside the health plan in order to avoid any bias, and the assistance of health care expertise where appropriate. This process will go a long way toward protecting the interests of consumers enrolled in managed care plans.

RECOMMENDATIONS: To achieve necessary protection for highly vulnerable consumers of health care services, Congress should enact legislation to implement the following safeguards:

♦ Allow federal court review of all disputed HMO determinations.

♦ Establish an office of a health plan ombudsman within each state with responsibility to provide oversight of health plan operations and advocacy on behalf of consumers. This office should resolve disputes informally and refer consumers to necessary advocacy resources when appropriate.

♦ Require that the Department of Labor consult with the Department of Health and Human Services in establishing the standards of operation for the review offices within states.

♦ Require that claims review be performed only by personnel with expertise in the area of concern, not limiting such expertise to physician reviewers, but including all disciplines of service.

♦ Amend the Employee Retirement Income Security Act to provide for rights of action under state law for damages as related to principles of equity, including but not limited to, promissory estoppel, bad faith, and unjust enrichment.

RATIONALE: Safeguards are necessary to ensure that financial incentives designed to minimize the utilization of unnecessary services do not restrict access to necessary care. A comprehensive, unencumbered process to resolve claims disputes is the best means to this end.
PROTECT PATIENTS’ FREEDOM TO CHOOSE

ISSUE: There has been a growing shift toward use of managed care plans in the Medicaid program and Congress recently increased payment rates for Medicare managed care in hopes of increasing beneficiary enrollment in Medicare-managed care plans.

An “any qualified provider” provision will allow an enrollee of a health maintenance organization (HMO) to go to any out-of-network provider as long as the provider is willing to accept the HMO’s operating terms including its schedule of fees, covered expenses and quality standards.

Through an “any qualified provider” provision, individuals would retain the freedom to choose providers, even under a health plan that relies heavily on managed care. This provision is also extremely important to the home care community, since it helps ensure that competition will continue to exist among home care agencies and that agencies that are not a formal part of a managed care network will not be frozen out of a client base.

Services utilized by enrollees when they go out of network tend to be low-cost services. Rather than going out of network for hospitalizations, for example, patients are more likely to use an out-of-network service option for less costly services and for services that are closer to home. In this way, the “any qualified provider” provision can become a valuable feature for non-HMO home care agencies.

RECOMMENDATION: Any health care reform plan must assure all individuals, even those enrolled in HMO-type managed care plans, the freedom to choose from among all qualified providers. This provision is critical to maintaining patient choice of home care agencies and ensuring that no single large agency will monopolize a market.

Where the cost of the out-of-network service is no greater than the cost of the service within the managed care plan, managed care plans should be prohibited from charging any additional out-of-pocket costs, including copays and deductibles.

In addition, health plans, when referring patients, should be required to inform all patients of both in-network and out-of-network providers, and to provide assistance to secure care from whichever provider the patient chooses.

Finally, in the event that a managed care plan is authorized to limit participating providers, Congress should require more than one option to the enrollee in order to encourage quality and efficiencies.

RATIONALE: An “any qualified provider” provision helps protect patients from the increasingly common trend in HMOs of frequently changing contract providers as the HMO bargains for ever-lower provider rates. The “any qualified provider” provision also helps ensure that patients are not forced to choose a new provider with every renegotiation. Restricting a patient’s freedom to choose violates the spirit of the Medicare and Medicaid programs and should not be permitted in any health plan.
ISSUE: Federally-qualified health maintenance organizations (HMOs) are required to provide home health services without limit as to time or cost. Many HMOs have neglected this obligation. One major HMO has also taken the position that the required “home health services” are limited to nursing care, thereby excluding therapy and home care aide services. Litigation and administrative actions affirming the requirement of HMOs to provide home health services without limit may result in the HMO industry attempting to obtain an amendment to the federal HMO law to provide limits on home health services coverage. Further, certain provisions of the federal law which make federal status attractive to HMOs, such as the favored position offered regarding employer-based health plans, “sunsetted” in 1995. This favored position entitled federally-qualified HMOs to insist that employers of 50 or more employees offer HMO coverage by federally-qualified HMOs as a health insurance option for the employees. Finally, the HMO law does not provide a right for private enforcement by individuals or providers of care, thereby limiting enforcement to Centers for Medicare and Medicaid Services (CMS).

RECOMMENDATION: Congress should oppose any efforts by the HMO industry to seek an amendment to 42 U.S.C. § 300e-1 (which requires the provision of home health services without limit as to time or cost), oppose any effort by the industry to restrict the disciplines of service required to be provided, enact a private right of action for individuals and providers, and restore those HMO provisions which encourage federal status.

RATIONALE: Many hospitalized patients could receive safe and cost-effective home health services as an acceptable alternative. The imposition of a limit on home health services denies patients access to this option. The HMO obligation would also be shifted to the consumer, Medicaid and other public programs. Private insurers have already recognized the financial value of allowing hospitalized patients to use home care as a cost-effective alternative to hospital benefits. There is no justification for modifying the current federal HMO obligations.

A private right of action is essential to ensure compliance with federal law. Reliance upon CMS for comprehensive enforcement has proven inadequate. Further, an extension of the HMO Act provisions regarding employer-based health plans would encourage HMO participation in the federal qualifications program which mandates unlimited home health services.
PROHIBIT GAG RULES IN MANAGED CARE CONTRACTS

ISSUE: There have been problems with some managed care plans that restrict access to home care in violation of the terms of the private insurance policy or, in the case of federally-qualified health maintenance organizations (HMOs) and Medicare HMOs, federal regulations. In some cases, contracts with managed care plans contain “gag” rules that prohibit providers from communicating with patients about the full range of appropriate treatment options for a patient’s condition or about disagreements providers may have with health plan decisions. Providers are often reluctant to pursue corrective action either by reporting the matter to appropriate government authorities or discussing the matter with the patient for fear of retribution by the health plans, which may terminate or not renew their contracts.

RECOMMENDATION: Congress should enact legislation which would forbid “gag” rules in managed care contracts and prohibit any adverse action by managed care plans against a provider for medical communications between provider and patient, or between provider and state or federal regulators with the responsibility of licensing and oversight of the managed care plan.

RATIONALE: Where inadequate services are provided by managed care plans, patients may suffer adverse health outcomes or face unnecessary costly institutionalization, which often must be financed by state Medicaid programs. Forbidding “gag rules” and retaliatory actions by health plans would enable providers to fulfill their professional obligations to tell their patients what care they should be receiving and act as “whistleblowers” by reporting improper restrictions on home care utilization to appropriate government agencies.
MODIFY PREEMPTION PROVISION OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT

ISSUE: As a result of a series of rulings by the U.S. Supreme Court, employer-based health benefits plans subject to the Employee Retirement Income Security Act (ERISA) are protected from risk of financial penalty that might come from bad faith or arbitrary and capricious claims determinations. In addition, ERISA has been used to block medical malpractice claims against third-party payors who control the delivery of services to patients. Finally, courts have construed ERISA to preempt claims against insurance companies by health care providers who relied upon an insurance company’s information that the patient served by the provider was dually enrolled and entitled to insurance payment. Courts have also held that ERISA preempts state “any willing provider” provisions. Moreover, under ERISA, claims for punitive damages, malpractice, and negligent misrepresentation are preempted since they are founded in state rather than federal law. ERISA, therefore, allows claims against insurance companies solely for payment of improperly withheld benefits.

RECOMMENDATION: Congress must amend ERISA to allow aggrieved employer-based health plan enrollees, participants, and providers of services to challenge arbitrary and capricious action, negligent determinations which affect the delivery of health care, and misrepresentations to providers of services related to the insured status of the individual.

RATIONALE: The essential purpose behind ERISA was to allow self-insured plans offered by multi-state employers to maintain a consistent plan for insuring the health care needs of their workers. With varying state law and regulation, collective bargaining and program management have become complex and costly. However, ERISA-based plans have utilized the federal preemption of state law claims to protect insurance companies from having to act fairly, consistently, and accountably. With the ERISA preemption, the plan has no incentive to issue correct determinations since its liability is limited to the cost of care that would have been covered had a proper determination been made. If only one plan participant who is wrongly denied benefit payments fails to challenge the denial, the plan incurs a financial gain.
AMEND THE EMPLOYEE RETIREMENT INCOME SECURITY ACT TO REQUIRE DIRECT PROVIDER APPEAL RIGHTS

ISSUE: The Employee Retirement Income Security Act (ERISA) is designed to protect consumers from arbitrary decisions by health care plans. Providers of health care services are not protected under ERISA. Therefore, there are limited avenues of recourse open to providers who have been improperly denied reimbursement under ERISA-sponsored plans.

Currently, health care providers who deliver care under ERISA plans risk a coverage denial of the claim. Even prior authorization is no guarantee that the provider will be reimbursed for services rendered under the plan.

Providers seeking recourse may take assignment of the claim from the beneficiary. This means that the provider assumes the rights of the beneficiary when bringing a claim against the health plan. This assignment, however, forecloses any claim the provider may have against the beneficiary for payment of the services provided.

Providers should be given direct appeal rights that are concurrent and corresponding with plan enrollees. This would bestow upon both health care providers and enrollees the right of action to pursue claims against a health plan. Because the right would be “concurrent and corresponding,” the provider would not need the beneficiary (and the beneficiary would not need the provider) to subject the plan to arbitration, administrative review, or judicial review.

RECOMMENDATION: Congress should amend ERISA to provide a process through which providers of health care services have the right to appeal health plan determinations for reimbursement of services. Such a right should not be restricted and should allow the provider to pursue claims, both against the plan and the enrollee.

RATIONALE: Providers of health care services under an ERISA plan should be given the right to have third-party review of all disputed claim determinations. The current strategy of assignment of enrollee rights to providers is limited and prevents the provider from pursuing claims against the beneficiary. Moreover, where the enrollee predeceases a plan’s payment of a claim, providers must pursue the estate of the enrollee. If the estate has no assets or is not interested in bringing action against the health plan, there is no recourse available to the provider.
AUTHORIZE PUNITIVE DAMAGES LAWSUITS FOR BAD FAITH INSURANCE DECISIONS

ISSUE: The U.S. Supreme Court has ruled that individuals under employer-based health insurance plans governed by the Employer Retirement Income Security Act (ERISA) can only sue to recover the benefits wrongfully denied by the insurance company. As a result, punitive damages for bad faith administration of the insurance plan are unavailable to the insured. This standard allows insurance companies to knowingly deny insurance coverage for medically necessary care and be held immune from a financial award beyond the costs of the care.

RECOMMENDATION: Congress should amend ERISA to allow beneficiaries to recover punitive damages for erroneous claim determinations issued in bad faith by insurance companies. In addition, Congress should prohibit insurance companies from passing on the costs of punitive damage awards to consumers or to employers that provide health insurance.

RATIONALE: The threat of punitive damages will encourage insurance companies to properly review and pay claims in the first instance. Where these damages are unavailable, the insurance company has no financial incentive to correctly pay claims.
ENACT INSURANCE MARKET REFORMS

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

“The Health Insurance Portability and Accountability Act of 1996” (P.L. 104-191) addressed the issues of preexisting conditions, portability, and guaranteed issue and renewability. However, a guarantee that someone can purchase insurance is no guarantee that premiums will not be set prohibitively high for those with preexisting conditions or advanced age. Also, insurance companies can choose to limit what conditions they cover for certain groups.

RECOMMENDATION: Congress should require that insurance companies provide a standardized benefit package that includes coverage for home care and hospice, and limit premium variation (i.e. community rating) and year-to-year increases based on one’s health status, age, or sex. Insurers that meet these standards should be exempted from state minimum benefit laws.

RATIONALE: Insurance market reforms are common elements of most health reform plans, be they incremental or more comprehensive. As a result, they comprise a politically “doable” package of reforms that are a first and necessary step to any broader reform effort. Further incremental reforms should not be postponed while Congress debates other aspects of health care reform which have less universal support and which may require more time to resolve.
VI.

ENSURE A CENTRAL ROLE FOR HOME CARE RELATIVE TO WELLNESS AND PREVENTION OF DISEASE
ALLOW HOME CARE AGENCIES TO SERVE AS CASE MANAGERS IN FEDERALLY-FUNDED PROGRAMS

ISSUE: Case management has been a home care agency responsibility for more than a century and is an essential part of the caregiving process. As practiced by home care providers, case management consists of assessment, planning, coordination, organization and staffing, implementing or providing care, and evaluation.

External case managers who are responsible for fiscal management are often inadequately qualified and frequently see too little of clients to deal with their problems on a timely and informed basis. While an external or independent case manager has been offered as a means to better cost-containment, most recently in the 108th Congress, as part of H.R. 2342 and S. 1179, the Medicare Chronic Care Improvement Act of 2003, it can be quite costly to implement and is unnecessary where case management is already available from a home health agency.

RECOMMENDATION: In any Medicaid, Medicare, Older Americans Act, or long term care legislation, Congress should allow home care agencies to manage all elements of their clients’ care.

RATIONALE: Home care providers have the experience and knowledge to be responsible for the clients’ plans of care, as well as other components of case management. Requiring a separate case management system can impose additional administrative and financial burdens on home care programs.
CREATE A NUTRITIONAL SERVICES HOME HEALTH BENEFIT

ISSUE: Home health agencies (HHAs) are required to have specialized nutrition expertise in order to be Medicare certified. Centers for Medicare & Medicaid Services (CMS) regulations, however, do not specifically include the nutrition professional in the list of mandated participants. There is no provision to pay for these services, other than as administrative costs. It is unclear if the costs of the services of a nutrition professional are included in these administrative costs, particularly since CMS does not list the nutritional professional in its regulations. Furthermore, the episodic rate within the home care prospective payment system (PPS) does not recognize the services of a nutritional professional nor does Medicare pay for nutritional interventions that are projected to last for less than 90 days. This oversight encourages HHAs to use other untrained professionals or to budget so little for the nutritional professional that adequate services cannot be provided.

Health statistics show that more than 2.7 million Medicare beneficiaries received home care services in 2002 (CMS, HCIS data). Half had chronic diseases that are normally treated with diet (NCHS, 1999). Others report that patients who receive home care services have a high prevalence of malnutrition and need some type of nutrition service (Rebovich et al., 1990). Malnutrition can be a risk for early nonelective hospital readmission.

An estimated 40,000 Medicare patients received parenteral nutrition and 152,000 received enteral nutrition at home (Howard, et al., 1995). The current Medicare benefit pays for some aspects of home parenteral and enteral nutrition. In order to obtain Medicare reimbursement, the patient must be unable to meet nutritional requirements using an oral diet for more than 90 days. For parenteral nutrition support, the patient must have a nonfunctional gastrointestinal (GI) tract due to interruption in continuity or impairment in absorptive capacity. For enteral nutrition support, there must be a disruption in the ability to ingest oral foods or impairment of the upper GI tract, which interrupts the transport of food to the small intestine.

Coverage regulations for enteral and parenteral nutrition are under the Prosthetic Devices section of Medicare. This section, which covers such things as pacemakers, braces, and artificial limbs, also defines reimbursement for home nutrition support. The assumption in placing nutrition support in this section is that it is a prosthetic device for a dysfunctional GI tract. For this reason, Medicare does not cover nutrition support if it is provided to a patient who has a functioning GI tract. Nutritional support is also not covered for the patients with significant nutritional needs, but who will be able to eat within the 90-day time period. Medicare covers nutritional solutions and equipment, but not the consultation by a nutrition professional needed for the assessment of energy and nutrient needs, implementation, and monitoring of the effects that treatments have on the patient's nutritional status. Moreover, there is an inequity in Medicare coverage for enteral and parenteral nutrition in the home care or ambulatory setting compared to the hospital or skilled nursing setting. Although a physician, nurse and pharmacist are typically involved in the care of the home care or ambulatory patient receiving nutrition support, the nutritional professional is often absent.

In addition to the lack of consultation by a nutritional professional, many beneficiaries need home enteral or parenteral interventions that are not reimbursed by Medicare. These beneficiaries may require tube feedings or parenteral interventions that are projected to last for less than 90 days. They may also need to take some food by mouth, but not enough to meet nutrient or energy needs. Few individuals are able to pay for this therapy on their own and lack of inclusion of nutrition support within the PPS episodic rate puts these Medicare beneficiaries at nutritional risk.

During 2000, the National Academy of Sciences Institute of Medicare (IoM) submitted a report to Congress entitled, "The Role of Nutrition in Maintaining Health in the Nation's Elderly: Evaluating Coverage of Nutrition Services for the Medicare Population" (IoM, 2000). This report
summarizes conditions that were identified as requiring a nutritional professional within the home setting. The conditions identified are listed below.

♦ Counseling about altered nutrient needs or dietary modification
♦ Newly diagnosed diabetes (homebound individuals should have the same benefits for diabetes self-management as those being seen in an ambulatory setting)
♦ Poorly controlled diabetes related to other conditions that require skilled care
♦ Heart failure
♦ Dietary modification following myocardial infarction
♦ Complications of cancer treatment (i.e., chemotherapy, radiation, and surgical treatment) that result in food versions, need for consistency modifications, or altered nutrient or energy requirements
♦ Dysphagia
♦ Undernutrition -- weight loss in the absence or remedial medical or psychiatric disorders
♦ Pre-end-stage renal failure with complex dietary modifications
♦ Osteoporosis or hip fracture
♦ Wound-healing problems

RECOMMENDATION: Congress should amend the Medicare home care benefit to include nutritional professionals within the list of mandated participants. It should also include in the calculation of the PPS episodic rate the services of nutritional professionals. Lastly, Congress should amend the home care benefit to include the recommendations of the National Academy of Sciences mentioned above.

RATIONALE: Patients seen in the home care setting are often the most frail, undernourished group of elders within the health care system, and because they are homebound, have no ability to use nutrition services that may be available in other ambulatory settings. Beneficiaries who are unable to maintain adequate nutritional status are more likely to experience adverse outcomes, including premature hospital readmission, functional compromise, comorbidities and mortality.
REQUIRE INCLUSION OF HOME CARE COVERAGE FOR EARLY MATERNITY DISCHARGE

ISSUE: In an effort to reverse a phenomenon that has become known as “drive-through deliveries,” Congress passed the “Newborns’ and Mothers’ Health Protection Act of 1996.” The legislation required that health plans cover a minimum of 48 hours of in-patient care following a vaginal delivery and 96 hours following a caesarean section, unless the attending provider in consultation with the mother prescribed a shorter stay.

In its original version, however, the bill mandated that home care be provided by health plans in cases where the attending physician prescribes a hospital stay shorter than the required minimum. The insurance industry objected to the home care provision, arguing that it created a new mandate. The conference committee of House and Senate members revised the bill to provide that the attending physician can order an early discharge without a requirement that home care be provided.

In the 105th Congress, Rep. Steven LaTourette (R-OH) introduced legislation that would require insurance plans to provide post-delivery follow-up including home care – for mothers and newborns discharged less than 48 hours after a vaginal delivery or less than 96 hours following delivery by caesarean section. The bill, HR 2854, required that insurers cover timely post-delivery care in a setting selected by the mother. Settings qualifying for coverage include: the mother’s home, a provider’s office, a hospital, a federally qualified health center, a federally qualified rural health clinic, a state health department maternity clinic, or another setting “determined appropriate under regulations promulgated by the Secretary.” The bill was not enacted by the 105th Congress; nor was it reintroduced in the 108th Congress. No similar legislation has been introduced since then.

In October 1998, the Centers for Medicare & Medicaid Services (CMS), at that time the Health Care Financing Administration, issued an interim rule to implement the discharge protection law. The interim rule, which is subject to public comment, noted that a health plan would not violate the law if the plan provides, after discharge, follow-up services – like home care – to a mother and newborn discharged early if those services are not more than the mother and newborn would have received if they had stayed in the hospital for the full 48 or 96 hours. To date, CMS has yet to issue a final rule on this provision.

RECOMMENDATION: Congress should enact legislation that requires insurance plans to cover home health services if the new mother is discharged prior to 48 hours after delivery (or 96 hours following a Cesarean section). Such coverage would ensure that mothers and their newborns receive proper post-natal care even if discharged from the hospital prior to the 48-hour requirement.

RATIONALE: As enacted, the baby discharge legislation allows a physician to release a mother and newborn from the hospital in less than 48-hours if the physician makes this determination “in consultation” with the mother. In such cases, coverage for follow-up care is not mandated. However, a report by the General Accounting Office entitled “Appropriate Follow-up Services Critical with Short Hospital Stays” (GAO/HEHS-96-207) stated that follow-up care, such as home care, can be “a safety net” to protect mothers and newborns who are discharged early. A home care mandate is, therefore, necessary to ensure that mothers and newborns who are released from the hospital within 48 hours receive the proper level of care.
VII.

ENSURE THE AVAILABILITY OF HOSPICE AND PALLIATIVE CARE FOR ALL AMERICANS NEAR THE END OF LIFE
PRESERVE THE FULL MARKET BASKET UPDATE FOR THE MEDICARE HOSPICE BENEFIT

ISSUE: The Administration’s fiscal year 2007 budget proposes to cut Medicare hospice benefit payments by $550 million over five years by cutting 0.4 percent from the market basket inflation updates in 2007, 2008, and 2009. The Centers for Medicare and Medicaid Services (CMS) Administrator stated that the Administration’s proposed Medicare cuts mostly follow along the lines of the Medicare Payment Advisory Commission (MedPAC) recommendations. However, MedPAC did NOT recommend any cuts in the inflation update for hospice.

RECOMMENDATION: Congress should reject any proposals to cut the hospice market basket update. A study of the need for refinements in the Medicare hospice benefit as recommended by GAO and MedPAC should be conducted.

RATIONALE:

- In its June 2004 report on the Medicare Hospice Benefit, the Government Accountability Office (GAO) determined that 34 percent of hospices in 2000 and 32 percent in 2001 had higher costs than reimbursements. A cut in the market basket update would impair the ability of hospices to maintain access to care.

- The GAO recommended that CMS should collect comprehensive, patient-specific data on the utilization and cost of hospice visits and services to determine whether the hospice payment categories and methodology require modification. It did not recommend an across the board cut in hospice payments.

- MedPAC in its June 2004 report to Congress stated that Congress should evaluate payment refinements related to case mix, length of hospice enrollment, care settings, geographic variation and hospice eligibility. MedPAC did not recommend a cut in the hospice market basket update.
MODERNIZE THE MEDICARE HOSPICE BENEFIT

ISSUE: The Medicare Hospice Benefit (MHB) was created in 1982 to care for terminally ill cancer patients. Recent statistics show that cancer patients represented less than half of those now being cared for under the MHB. The balance consisted of conditions for which it is more difficult to determine the terminal stage, such as congestive heart failure, chronic obstructive pulmonary disease, stroke, and dementia. These circumstances have resulted in a growing decline in the length of stay (LoS) on the MHB. The current reimbursement structure was created by estimating the original cost of delivering routine home care (95 percent of the care given) by analyzing data collected during the 1980-1982 Medicare Hospice Demonstration Project. Although there have been significant technological, pharmaceutical, and medical delivery advances made over the past 20 years, there has been no reimbursement adjustment specific to them. The shorter LoS increases per diem costs for each patient. In 1983, 20 percent of patients received hospice services for seven days. In its June 2004 Report to the Congress, the Medicare Payment Advisory Commission (MedPAC) reported that from 1998 to 2002, Medicare hospice data shows that of the patients dying in hospice, 25 percent were on the benefit for less than a week. Based on a survey of hospices conducted in August, 2005 by the Hospital & Healthcare Compensation Service, the average length of stay has decreased 52.48 days. However, the more relevant median length of stay was 21.40 days.

Increased costs for pharmaceuticals and pharmacotherapy for symptom control and pain management have resulted in a dramatic rise in their percentage of average daily costs from 3 percent in 1983 to 13 percent in 1999. The advancement in technology has resulted in increased outpatient services such as palliative radiation therapy and chemotherapy with accompanying diagnostic procedures required to monitor responses and side effects resulting in increased outpatient services costs from 6 percent to 15 percent of daily costs for routine home care.

The combination of decreased LoS and significantly increased costs makes it very difficult for hospices to continue providing much needed services.

RECOMMENDATION: Congress must take action to ensure terminally ill Medicare beneficiaries will be able to access the MHB when they reach the final stage of life. Congress should immediately:
1. Mandate a new hospice demonstration to collect data necessary to restructure the Medicare Hospice Benefit to reflect care currently given.
2. In the interim, mandate creation of:
   a) An outlier payment policy to cover high tech treatments such as renal dialysis, mechanical ventilation, palliative radiation therapy, chemotherapy and high cost specialized drugs, and
   b) A payment floor of the routine home care rate for 14 days to ease the burden of the short LoS.

RATIONALE: Congress asked MedPAC to provide a report on the adequacy of the MHB reimbursement rates by June of 2002. However, there are flaws in the cost report which make the data questionable and, in June 2004, MedPAC recommended that CMS evaluate hospice payments to ensure consistency with costs. The demand for hospice services will continue to increase. We must ensure this most humane service for America’s terminally ill patients and their families remains a benefit to which we can turn in our hour of greatest need – the final stage of life.
ENSURE ACCESS TO MEDICATIONS NECESSARY FOR PAIN CONTROL

ISSUE: Inadequate pain management has been identified by experts in the field as a national health concern. Recently proposed legislation, which states that controlled substances may be used legitimately for treating pain, may inadvertently compromise the quality of palliative care because it empowers drug enforcement officials to prosecute physicians to determine their intent for prescribing medication. This could have the unintended consequence of discouraging or limiting physicians from adequately treating terminally ill patients. This type of legislation would create a negative impact on the basic needs and rights of terminally ill patients as well as their comfort, dignity and freedom from pain.

RECOMMENDATION: Congress should oppose any legislation that would directly or indirectly set limits or prohibit physicians from prescribing adequate and appropriate controlled substances for the management of pain related to terminal illness.

RATIONALE: Terminally ill patients should not suffer due to inadequate pain management and lack of access to appropriate medications. Creating laws and policies that impose arbitrary limitations on physicians who prescribe controlled substances could have the unintended consequences of discouraging or limiting them from adequately treating terminally ill patients.
ISSUE: In 1989, Public Law 101-239 mandated the ability of terminally ill Medicare beneficiaries residing in skilled nursing facilities/nursing facilities (SNF/NFs) to access services under the Medicare Hospice Benefit (MHB). As SNF/NF residents become aware of the MHB, more of them are seeking hospice services. However, the SNF/NF has the right to deny hospice services to their residents or at a minimum choose the hospice the SNF/NF will allow to provide the services.

Currently, a terminally ill SNF/NF resident may only access the Medicare Hospice Benefit if the SNF/NF will allow this to occur. If the facility agrees to permit a hospice to provide services for the SNF/NF resident, the Hospice and SNF/NF must have a written agreement which specifies the coordinated services each provider will perform.

RECOMMENDATION: Congress should mandate that eligible Medicare beneficiaries residing in SNF/NFs have the right to receive hospice services from a Medicare-certified hospice of their choice.

RATIONALE: Medicare beneficiaries eligible for the Hospice benefit should have the right to choose which hospice will serve them. In March, 2000, the Office of Disability, Aging and Long-Term Care Policy, Department of Health and Human Services, and the Urban Institute released a study, “Outcomes and Utilization for Hospice and Non-Hospice Nursing Facility Decedents.” This study resulted in six reports: 1) Synthesis and Analysis of Medicare’s Hospice Benefit: Executive Summary and Recommendations; 2) Important Questions for Hospice in the Next Century; 3) Medicare’s Hospice Benefit: Use and Expenditures; 4) Use of Medicare’s Hospice Benefit by Nursing Facility Residents; 5) Outcome and Utilization for Hospice and Non-Hospice Nursing Facility Decedents; 6) Hospice Benefits and Utilization in the Large Employer Market.

The study showed that:

- Hospice patients in daily pain are twice as likely to receive level 3 analgesics as are non-hospice patients in daily pain.
- Hospice patients are less likely to be restrained, to receive tube or parenteral/IV feedings and to be given medications via intramuscular or intravenous routes.
- Hospice patients receive less occupational, speech and physical therapy.
- Hospice patients consistently have fewer hospitalizations, with the greatest differences observed 30 days prior to death (9.8 percent vs 31.7 percent).
- A nursing facility’s hospice concentration appears to have a strong influence on the hospitalization patterns of non-hospice patients. Non-hospice patients in a nursing facility with no hospice involvement had a 30 percent probability of dying in a hospital. Where there was a .01 to 5 percent hospice concentration, non-hospice patients had a 24 percent probability of dying in a hospital. Patients of nursing facilities with a 5+ percent hospice concentration had a 21 percent probability of dying in a hospital.
SUPPORT QUALITY ASSESSMENT/PERFORMANCE IMPROVEMENT PROGRAM FOR HOSPICE

ISSUE: The proposed new hospice conditions of participation require hospices to develop, implement, maintain, and evaluate an effective, data driven quality assessment and performance improvement program. The Centers for Medicare & Medicaid Services (CMS) has indicated its intent to require hospices to either develop their own or use currently available systems of measures to track patient outcomes in such areas as pain management, quality of life, skin integrity, and patient satisfaction. The requirement will include retaining the information in a database that permits analysis over time. CMS has also indicated that it will not be initiating any research and demonstration projects to develop systems of measures for the hospice industry, but in the future it may require that hospices report performance data into a national database.

RECOMMENDATION: Congress should direct CMS to establish standards of care for providers of the Medicare Hospice Benefit and authorize necessary funding. Agencies should be responsible for ongoing quality assessment performance improvement (QA/PI) programs based on patient outcomes. There does not yet exist a valid and reliable data set of performance measures for use in hospice care QA/PI programs.

1. Broad parameters of quality improvement requirements should be specific but providers should be allowed to identify, prioritize, and phase in specific systems of measures to capture outcomes they believe are essential to their provision of optimal hospice care.

2. The following conditions must be met in implementing any outcome measurement system for hospices:
   a. Reliable and valid indicators.
   b. Number of outcome measures limited to those that most accurately predict quality.
   c. Method for risk adjustment.
   d. Standard assessment limited to those items needed for outcomes measurement and risk adjustment (agencies may develop their own assessment tool and will use additional assessment items for care planning purposes).
   e. A simple system with clinical utility.
   f. A mechanism enabling CMS to validate agency data.
   g. Ongoing evaluation of the entire system.

RATIONALE: The ideal QA/PI program is based on what happens to the patients. However, currently there are no standard, valid, and reliable outcome measures for hospice. In addition, research and demonstration projects are not factored into the current per diem reimbursement structure. Therefore, hospices should be surveyed for initiating QA/PI programs based on currently available tools until such time as the industry has been able to develop hospice-specific systems of measures. Also, quality assessment should not rely solely on outcome measures; limited structure and process measures are appropriate.

The proposed quality system will have a tendency to involve massive data collection unless purposely controlled. Every effort must be made to keep data collection and the paperwork burden to a minimum so resources can be used for patient care rather than paperwork.
REQUIRE CMS TO BASE SURVEY FREQUENCY ON PERFORMANCE OF MEDICARE HOSPICE BENEFIT PROVIDERS

ISSUE: Only 1% of Medicare hospice providers are surveyed each year. There is no legislative requirement for the frequency of surveys for providers of the Medicare Hospice Benefit (MHB). CMS’ failure to require that hospice providers be surveyed on a regular basis can result in lack of compliance with regulations and poor quality of care. CMS states they recognize the problem but do not have the funds necessary to conduct more frequent surveys. CMS currently has hospice providers on a six-year cycle for surveys but that sometimes extends to 10 years in some parts of the country. CMS’ 2006 work plan will extend the time frame to every eight years.

RECOMMENDATION: Limited resources available for hospice surveys should be used to target quality issues by adopting the following survey frequency guidelines:
1. New Medicare hospice agencies should be surveyed annually for at least the first two years of certification.
2. Agencies with condition level deficiencies should be surveyed at least annually until they are deficiency free.
3. Complaint surveys should be conducted following significant complaints. If deficiencies are found, annual surveys should be conducted until the hospice is deficiency free.
4. All hospices should be surveyed, at a minimum, every three years.

RATIONALE: When the MHB was created by the Congress, in order to assure quality of care and implement the benefit, CMS was given the responsibility of creating regulations to be followed by providers of hospice services. As the next step of this responsibility, there need to be regular surveys to ensure compliance with these regulations. Recipients of the MHB should be afforded the same protections provided to recipients of other Medicare benefits.
REQUIRE HOSPITAL DISCHARGE PLANNERS TO SUPPLY LISTING OF QUALIFIED HOSPICES

ISSUE: In 1994, Congress passed legislation that would require hospital discharge planners to inform appropriate patients about the availability of the Medicare Hospice Benefit. Section 146(b)(5) of the Social Security Act Amendments of 1994 (Public Law 103-432) mandated that “the hospital conditions of participation with respect to discharge planning be modified to require an evaluation of a patient’s likely need for appropriate post-hospitalization services, including hospice services and the availability of those services.”

The Centers for Medicare & Medicaid Services (CMS) has stated they are currently in the process of rewriting the hospital conditions of participation and would look at expanding the discharge planning section to reflect this legislative mandate. However, CMS has concluded that there is no legislative mandate for the hospital to supply a listing of qualified hospices available to provide hospice services.

RECOMMENDATION: Congress should mandate that the hospital conditions of participation require the provision of a list of available, qualified providers.

RATIONALE: CMS has stated it does not believe it has the authority to require hospital discharge planners to provide a listing of qualified hospice providers. If the hospital discharge planner conducts an evaluation of a patient’s likely need for hospice services but does not give a list of available, qualified providers, the patient and their family will then have to search out the hospices in their community. It is less likely the patient will receive needed services in a timely manner. When a patient is at this most critical time of life, every day has added intensity of meaning. Our nation’s health care system should provide appropriate information to ensure the most vulnerable in our society spend their final days in the peace, comfort and dignity they deserve.
OPPOSE DECREASING HOSPICE REIMBURSEMENT FOR DULLY ELIGIBLE PATIENTS RESIDING IN NURSING FACILITIES

ISSUE: Since 1989, terminally ill Medicare patients living in nursing homes could elect the Medicare hospice benefit (P.L. 101-239). When a patient is entitled to both Medicare and Medicaid, the state Medicaid program must pay the hospice at least 95 percent of the nursing home rate for room and board services as set forth by each state’s Medicaid program. The hospice then reimburses the nursing home.

The contractual relationship between hospice programs and nursing homes has been under the scrutiny of the Department of Health and Human Services Office of Inspector General (OIG). In its report, Hospice Patients in Nursing Homes, OIG made recommendations to eliminate or reduce the Medicare or Medicaid payments for hospice patients living in nursing homes. If this action is taken without further data gathering and analysis of the nature and cost of hospice care provided in the nursing home, it could result in the complete lack of, or diminished access to, appropriate hospice services for these individuals.

RECOMMENDATION: Congress should oppose any legislation that would decrease the reimbursement for hospice services for dually eligible patients residing in nursing facilities without appropriate data collection and analysis supporting such a change.

RATIONALE: Legislative changes to the hospice reimbursement and nursing home room and board reimbursement prior to an in-depth study and analysis of the services provided and the cost of those services will, in effect, deny access to a humane and compassionate approach to care for bona fide eligible terminally ill residents of nursing homes. Only after appropriate data collection and analysis is performed should any adjustments to Medicare or Medicaid payments be made.
ENSURE THE PORTABILITY OF ADVANCE DIRECTIVES

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

RECOMMENDATION: Congress should support legislation that ensures the portability of an individual’s advance directive between health care facilities as well as between states.

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

ISSUE: The Centers for Medicare & Medicaid Services (CMS) has imposed the longstanding hospital sequential billing policy on hospice agency claims. The policy prohibits providers from submitting claims for care to beneficiaries where previously submitted claims are pending. Claims processing can be delayed for weeks or months for many reasons, including medical review activities, common working file problems, CMS or fiscal intermediary (FI) claims processing problems, and pending claims from other providers. Hospices have continued to serve patients even though Medicare payments have been delayed for months.

RECOMMENDATION: Congress should require CMS to process and pay all clean claims as submitted regardless of whether previous claims have been processed, and pay interest on claims that are not processed in a timely fashion.

RATIONALE: Hospices are small businesses with little financial reserve, dependent on uninterrupted payment for services delivered. Interruption of payment for weeks or months, while requiring agencies to continue services to hospice patients, can result in severe financial hardships.
INCLUDE IN-HOME RESPITE CARE IN THE MEDICARE HOSPICE BENEFIT

ISSUE: In 1982, when Congress enacted the Medicare hospice benefit, the issue of providing family support during the death and dying of their loved ones was apparent. Nowhere was this more evident than in the legislative provision that allowed for respite care so that families did not “burn out” and become unable to provide informal care to the family member who was dying. As originally intended, respite care was to include both in-home respite and inpatient respite services. However, when the four daily payment rates were established, respite care was identified as being inpatient respite care only. In-home respite care, which makes the most sense as far as home-based hospice care is concerned, is not available or financially feasible for the hospice provider.

A demonstrated need exists for reimbursement of non-skilled respite services in the home. Without this important service, patients who require around-the-clock non-skilled assistance, who may be receiving part of these services from family caregivers and who desire to remain at home, will have to be institutionalized.

RECOMMENDATION: Congress should establish a separate payment category in the Medicare hospice benefit for in-home respite care.

RATIONALE: The Medicare hospice benefit as currently constructed permits inpatient respite care services to be provided in a skilled nursing facility or an intermediate care facility and for 24-hour acute/crisis skilled nursing services in the home. There is nothing in between. Patients who have need of a home care aide on a continuous basis of 8 to 16 hours are unable to obtain that service without considerable out-of-pocket expense.

When some relief is available from the hospice, it rarely is available for the evening or night hours, when caregiver families are most likely to need respite support to prevent “burn out.” Provision of an in-home respite care category would allow many patients to remain in their homes, particularly those terminally ill patients who live alone and/or who have other problems that require support for longer than a routine visit but less than 8 hours of skilled nursing services. It is not only reasonable but humane to permit the patient to die at home with adequate support if this is desired by the patient and the family.
REQUIRE DEMONSTRATION PROJECTS TO STUDY SPECIAL SERVICES AND FINANCING OF END-OF-LIFE CARE

ISSUE: People in the last phase of life need a different care system for many months or sometimes years before death. Eligibility for the Medicare hospice benefit is limited to people who have a terminal illness with a prognosis of six months or less. Most people die slowly of relentless but rather unpredictable chronic illness and disease. Studies show that almost 80 percent of Americans die in institutions where they often receive futile high-tech interventions and are in pain. Currently, the last year of life Medicare beneficiary spending is almost six times more than for those who are not in their final year of life. The last month expands to 20 times as high as average monthly expenditures for those not in their last year of life due to rapid acceleration of inpatient hospital spending. About 28 percent of Medicare funds are now spent on care in the last phase of life, which is comprised, for the most part, of expensive, high-technological interventions and “rescue care.”

Children in the last phase of life need a different care system for many months or sometimes years before death. With children having potentially life-threatening conditions, it is particularly hard to predict how many months or years a child has remaining. Often parents are reluctant to stop aggressive treatment until the very end.

Demonstration projects are needed to study special care needs and financial reimbursement for comprehensive services for end-of-life care for children and for Medicare beneficiaries who are seriously ill or who suffer from a medical condition that is likely to be fatal.

RECOMMENDATION: Congress should enact legislation that would provide for demonstration projects to study special services and financing of end-of-life care in home care and hospice settings. These demonstrations should examine the needs of children as well as adults.

RATIONALE: Demonstration projects that study special care needs and evaluate the practices and procedures that will improve patient outcomes and resource utilization for end-of-life care would contribute valuable information about care needs and costs at the end of life.
OPPOSE IMPLEMENTATION OF PENALTIES FOR ERRONEOUS CERTIFICATION OF TERMINAL ILLNESS

ISSUE: Medicare regulation (42CFR §418.22) requires that, in order to be eligible to elect hospice services, an individual’s physician and the hospice medical director must certify, in writing, that the individual’s prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course. According to Medicare survival data, only 17.3 percent of patients receiving Medicare hospice survive longer than six months and half of Medicare hospice patients receive care for 16 days or less. It is often difficult to make the determination that a patient is terminally ill, because the course of terminal illness is different for each patient. A recently-published study reported that the recommended clinical prediction criteria are not effective in a population with a survival prognosis of six months or less. This information demonstrates what has been well known by those in the hospice community: that the science of prognostication is in its infancy. In a letter to all Medicare-certified hospices in the country, the then-CMS Administrator reiterated that “In no way are hospice beneficiaries restricted to six months of coverage.”

RECOMMENDATION: Congress should oppose imposition of civil monetary penalties upon physicians for false certification of eligibility for hospice care.

RATIONALE: Physicians should not be punished for possible underestimation of a terminally ill patient’s life expectancy. The only ones to be punished will be those patients in need of hospice services whose physicians will avoid recommending this compassionate, humane, and patient-family-centered care due to fear of penalties for erroneously underestimating their prognosis.
MANDATE HOSPICE COVERAGE UNDER MEDICAID

**ISSUE:** In 1986, when Congress enacted legislation making the Medicare hospice benefit permanent, hospice care was made an option 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. Currently, 46 states have chosen to offer the hospice benefit to Medicaid beneficiaries.

**RECOMMENDATION:** Congress should mandate Medicaid hospice coverage.

**RATIONALE:** States are gradually enacting hospice coverage under Medicaid 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 and increasing numbers of AIDS patients. Mandating hospice under Medicaid would speed access to hospice services. Hospice, with its combination of inpatient and outpatient care and case management by the interdisciplinary team composed of doctors, nurses, social workers and counselors, can provide comprehensive care for the terminally ill patient while saving taxpayer funds. But with the current decline in Medicaid dollars, some states are considering dropping their Medicaid hospice benefit.
ELIMINATE MEDICARE PROVISION REQUIRING HOSPICE SOCIAL WORKER TO PRACTICE UNDER THE DIRECTION OF A PHYSICIAN

ISSUE: Under § 1861 (dd) (1) (c) of the Social Security Act, social workers are the only members of the hospice interdisciplinary group required to be under the direction of a physician. Social workers, as members of the interdisciplinary team, work in concert with the members of the team, which is guided by the team coordinator or clinical director. The interdisciplinary team, as defined by the hospice statute, consists of at least a doctor of medicine or osteopathy, a registered nurse, a social worker, and a pastoral or other counselor. The statute also defines the role of the registered nurse as the coordinator of the plan of care for the patient and family.

RECOMMENDATION: Congress should amend Section 1861 (dd) (1) (c) of the Social Security Act to eliminate the requirement that a hospice social worker function under the direction of a physician and require instead that the interdisciplinary team be under the direction of the team coordinator or clinical director and that each discipline should be under the direction of the supervisor of that discipline.

RATIONALE: Placing social workers under the direction of a physician imposes an unnecessary burden on the team and agency and creates needless complexity by requiring convoluted reporting patterns and organizational charts. It also undermines the concept of the team by mandating that one team member report to another team member rather than to the team leader. Social workers should report to their discipline’s supervisor or the team leader, not a physician. Further, all members of the team should be under the direction of the clinical director who is responsible for the delivery of quality services in an appropriate and timely fashion.
VIII.

HOME MEDICAL EQUIPMENT
MONITOR DEVELOPMENT OF QUALITY STANDARDS, CLINICAL CONDITIONS OF COVERAGE, AND MANDATORY ACCREDITATION FOR HME SUPPLIERS

ISSUE: The Medicare Prescription Drug, Improvement and Modernization Act (MMA - P.L. 108-173) requires the Centers for Medicare & Medicaid Services (CMS) to establish and implement quality standards for home medical equipment (HME) suppliers. Standards are to be set out in program memoranda on a prospective basis after consultation with relevant parties. In addition, CMS is to designate one or more independent accreditation organizations no later than one year after the new quality standards are implemented. The legislation also requires CMS to establish clinical conditions, a face-to-face examination, and a written prescription in order to receive payment for a HME claim.

In September 2004, CMS selected 21 individuals to serve on the HME competitive bidding Program Advisory and Oversight Committee (POAC); the group included several “stakeholders” associated with the HME industry. Among other functions, the POAC is to provide input to CMS on development of quality standards for HME.

CMS published proposed DMEPOS Quality Standards and allowed for acceptance of comments through November 28, 2005. These standards mirror requirements found in most recently published provider conditions of participation with an emphasis on data collection and quality assessment performance improvement. However, they also include specific, overly prescriptive requirements related to such topics as personnel issues including criminal background checks, inventory control, physician notification of problems and prescribed services via “visit” frequency recommendations for certain supplies and pieces of equipment. Supplier procurement of proof of manufacturer testing of equipment is implied. Prohibition of all mail order services for initial delivery is required. Several of the standards are contradictory and others fail to reflect the latest in clinical practice in the home.

The MMA also requires CMS to establish clinical conditions, a face-to-face examination, and a written prescription in order to receive payment for a HME claim. The face-to-face examination requirement was immediately effective for motorized wheelchair claims. As part of proposed changes to implement the 2005 updates to the Medicare physician fee schedule, CMS proposed a requirement for a face-to-face examination for Medicare HME patients. CMS held off on implementing the requirement as part of the final physician payment rule, however, due to the expression of widespread opposition.

RECOMMENDATION: Congress should closely monitor CMS’ efforts to establish quality standards and clinical conditions. As stated in the legislation, members of the HME community must be consulted in the development of such standards. Moreover, Congress should ensure that there is flexibility in the clinical conditions so that coverage is based on medical necessity and not linked to any specific diagnosis. CMS must also be urged to consider costs of compliance when establishing final standards and testing procedures. Lastly, exceptions or alternatives to the accreditation process should be provided to very small suppliers who may not have the resources to become accredited.

RATIONALE: Given concerns regarding fraudulent activity in the HME benefit, there should be increased standards and accountability to ensure that HME suppliers are playing by the rules. Such standards, however, must balance the need to curtail fraudulent activities with the HME supplier’s ability to meet accreditation.

These standards may create access problems for patients, especially those in rural areas. Moreover, there is concern that linking particular HME products to specific clinical conditions
could severely restrict access to beneficiaries with legitimate needs who may not fall into a qualified
category. Eligibility for HME must be predicated on medical necessity and functionality and not
linked to any specific condition or diagnosis.

Burdensome personnel and inventory requirements will be costly for all suppliers and will
result in small providers being unable to remain in business. Procurement of manufacturer testing
information is an unnecessary burden to impose on suppliers that are ill-equipped to evaluate the
appropriateness of such documentation. Imposition of “visit” requirements adds the burden of
service delivery for which suppliers are not compensated.

Accreditation will place considerable financial burdens on suppliers at a time when
Medicare reimbursement for equipment is being reduced. Also, accrediting organizations may not
have the surge capacity to accredit the large numbers of suppliers not currently accredited.
OPPOSE RECERTIFICATION RULE FOR OXYGEN PATIENTS

ISSUE: Oxygen coverage is determined by the results of an arterial blood gas or oximetry test. A certificate of medical necessity (CMN) for oxygen equipment must include results of specific testing before coverage can be determined. The policy for home oxygen and oxygen equipment limits the initial coverage period for home oxygen to three months for all Group II patients, regardless of diagnosis, disease severity, and baseline laboratory results. Group II patients are those whose arterial PO2 is 56 to 59 mm Hg or whose arterial blood oxygen saturation is 89%. Since the policy requires that all Group II oxygen patients be recertified, a new arterial blood gas or oxygen saturation study is required for coverage beyond the initial three-month period in a 29-day window between the 61st and 90th days after the start of the home oxygen therapy.

Homebound patients may be unable to get laboratories to come to their homes to draw blood specimens needed for recertification oxygen saturation testing. Medicare has historically prohibited home oxygen suppliers from performing any laboratory testing related to the determination of medical necessity. This policy is based on an administrative requirement designed to prevent a theoretical conflict of interest. Failure, for any reason, to achieve recertification during this brief time frame will result in stopped payment for a patient’s legally prescribed home oxygen on the basis of a “lack of medical necessity.”

CMS contractors also have the discretion to require recertification of Group I patients (those with an arterial PO2 at or below 55 mm Hg, or arterial oxygen saturation at or below 88%), the sickest category of patients who often need access to home oxygen services for their lifetime. Currently, practice is to require Group I patients to be recertified every 12 months.

RECOMMENDATION: Congress should require CMS to:
1. Eliminate the policy requiring regular oxygen saturation testing for individuals with chronic, long-term respiratory conditions;
2. Permit suppliers providing oxygen in areas that are documented to have limited access to home laboratory services to conduct laboratory tests; and
3. Conduct a study to evaluate the need for a change to the current policy to ensure that beneficiary access to necessary oxygen therapy services is not compromised as a result of the limitation and recertification rule.

RATIONALE: The restrictions on oxygen coverage and the recertification mandate is based on limited and conflicting scientific evidence and fails to adequately address the medical complexities and testing logistics associated with retesting those with oxygen needs. While some patients may improve clinically after the start of home oxygen therapy, there is like to be merely false short-term improvement as a result of the reparative effect of oxygen therapy. If left untreated, however, the patient could return to their baseline hypoxemia.

The policy requiring oxygen saturation testing is outdated and not in keeping with current standards of practice. Many private insurance carriers and state Medicaid programs have eliminated the need for retesting. Of those that still require retesting, many authorize home medical equipment (HME) providers to perform the test. Additionally, many state Medicaid programs have no initial or recertification requirements and instead prefer to treat oxygen like other legend drugs, requiring only a valid physician prescription. Moreover, in most states, a prescription for oxygen is valid for
one year. Medicare medical necessity guidelines are designed to control utilization and often conflict with prescription dispensing law and medical practice.
SUPPORT EFFORTS TO ADEQUATELY REIMBURSE HME SUPPLIERS FOR COSTS ASSOCIATED WITH IN–HOME DRUG THERAPIES

ISSUE: Prior to the implementation of the Medicare and Prescription Drug, Improvement and Modernization Act (MMA) (PL 108-173), Medicare Part B paid 95 percent of average wholesale price (AWP) for drugs used in home infusion and home inhalation therapies administered through home medical equipment. A report by the Government Accountability Office (GAO), however, characterized the reimbursement for drugs under Medicare Part B as flawed and called on Congress to explore new ways to pay for drugs under the home medical equipment (HME) benefit.

Partly in response to this report, the MMA reduced payments for most in-home drug therapies. Drug and drug therapies furnished in 2004 were reimbursed at 85 percent of the AWP (determined as of April 1, 2003). Beginning in 2005, drugs and biologicals, except for pneumococcal, influenza, and hepatitis B vaccines and those associated with certain renal dialysis services, were paid using either the average sales price (ASP) methodology or through competitive bidding.

Infusion drugs furnished through covered home medical equipment starting January 1, 2004, were paid 95 percent of the AWP in effect on October 1, 2003; those infusion drugs that may be furnished in a competitive acquisition area starting January 1, 2007, will be paid at the competitive price. Intravenous immune globulin was paid at 95 percent of AWP in 2004 and paid according to the average sales price method beginning in 2005. While the Centers for Medicare & Medicaid Services (CMS) is authorized to substitute a different percent of the April 1, 2003, AWP, this percentage was not to be less than 80 percent. Also, CMS was allowed to adjust the price based on data submitted by the manufacturer of the drug or biological by October 15, 2003.

HME suppliers do not dispute that, under the old law, Medicare Part B payments for drugs were higher than the costs of the actual drugs. What CMS and GAO failed to take into consideration is that the reimbursement also paid for the high level of service that accompanies the administration of such drugs in the home.

A report developed by consultants at Lewin and Associates demonstrates that actual cost of the drugs represents only a small fraction of the overall costs of caring for patients with inhalation or IV therapy. According to the Lewin report, the cost of the drugs to treat these patients represents only 26 percent of total costs, while direct patient care costs average 46 percent and indirect costs such as accreditation, information systems, and Medicare/Medicaid compliance amount to another 25 percent.

Legislation was introduced in the 108th Congress that would establish a fee schedule that reflects all covered components required under home infusion or inhalation therapies. The legislation, HR 2476, the Medicare Home Infusion Therapy Act of 2003, introduced by Representatives Eliot Engel (D-NY), Dave Weldon (R-FL), Michael McNulty (D-NY), Martin Frost (D-TX), Ed Case (D-HI), and Ron Paul (R-TX) would remove coverage of home infusion therapy from the DME benefit and establish a new benefit that more accurately reflects the cost of both the drugs and the services needed to administer such drugs. Congress, however, took no action on this legislation in the 108th Congress, and the bill was not reintroduced during 2005.

RECOMMENDATION: Congress should consider reforming reimbursement for home infusion and inhalation therapies. The HME community supports efforts like HR 2476 that would establish a new home infusion and inhalation benefit that covers the cost of both drugs and services. Congress should reject recommendations to subject the HME drug benefit to competitive bidding. The HME community is concerned that competitive bidding will lead to monopolistic practices by
suppliers that would hamper beneficiary choice, increase costs in the long run, and lower quality.

**RATIONALE:** Current Medicare reimbursement fails to recognize such services as the need to compound certain drugs in a sterile setting, responding to emergencies and questions concerning therapies, and participating in the training and education of the patient (and often the patient’s family). Oftentimes, the therapies require services of a nurse or respiratory therapist to perform a variety of functions. If the patient does not qualify as “homebound,” nursing services are not covered by the HME drug benefit.

For these reasons, the HME community supports efforts to enact legislation that establishes a separate HME infusion and inhalation drug benefit that accurately reflects the cost of both drugs and the appropriate services necessary to administer such drug therapies.
REVISE APPLICATION OF THE “IN-HOME” RESTRICTION FOR MEDICARE PART B REIMBURSEMENT OF HME SUPPLIES

ISSUE: Current law (42 U.S.C. § 1861 (n)) requires that home medical equipment (HME) be used “in the patient’s home,” rather than a hospital or skilled nursing facility, to qualify for Medicare Part B reimbursement. Congressional intent was to exclude Part B coverage of HME in an institutional setting. Congress did not otherwise impose a geographical limit on the use of HME. For example, there is no requirement that the actual use of the HME be confined to within the four walls of a home.

Nevertheless, the Centers for Medicare & Medicaid Services (CMS) and the Durable Medical Equipment Regional Carriers (DMERCs) have interpreted and applied the "in the patient's home" clause in an overly restrictive manner. Specifically, Medicare HME coverage has been limited to those items an individual demonstrates are needed within the home, rather than the HME needed to allow the individual to meet his or her daily responsibilities. As a result, persons with disabilities, young and old, have been denied Medicare coverage of the types of medical equipment that would enable them to attend school; go to work; meet their obligations as parents and heads of households -- e.g., to shop, attend meetings and activities at their children's schools; participate in religious services; and to otherwise be active members of their communities.

RECOMMENDATION: Congress should direct CMS to make changes to definitions, policies, and practices so as to ensure that HME supplies, along with rehab and assistive technologies, are covered by Medicare even if such supplies or technologies allow the beneficiary to leave the home and might be used outside the home.

RATIONALE: During 2001, President Bush announced a "New Freedom Initiative" for persons with disabilities. Part of this initiative includes helping individuals with disabilities by "increasing access to assistive technologies, expanding educational opportunities, increasing the ability of Americans with disabilities to integrate into the workforce, and promoting increased access into daily community life."

Without access to appropriate HME in the community, persons with disabilities will not be able to fulfill their potential in the workplace, to get to school to develop new job skills, or to meet their family responsibilities of performing many of activities of daily living. Congressional pressure on CMS and DMERCs to ease the “in-home” restriction will allow disabled persons to be more independent and take advantage of federal government programs like the New Freedom Initiative, the Ticket to Work and Work Incentives Improvement Act, and the Americans with Disabilities Act.
OVERSEE CMS’ USE OF INHERENT REASONABLENESS AUTHORITY

ISSUE: In the mid-1980s, the Health Care Financing Administration (HCFA), now the Centers for Medicare & Medicaid Services (CMS), was given the authority to change Medicare reimbursements for home medical equipment (HME). This authority, known as inherent reasonableness (IR), permits CMS to adjust, up or down, reimbursement levels for individual items if the payment levels are found to be grossly deficient or excessive. Under CMS’s original IR authority, if an adjustment to reimbursement was made, CMS was required to publish the new rate in the Federal Register, consult the parties affected, and allow 60 days for public comment.

The Balanced Budget Act of 1997 (BBA) expanded CMS’s IR authority, allowing CMS to make reimbursement adjustments of 15 percent in one year without public notice and comment and without input from affected parties. Moreover, CMS believes it may transfer IR authority to the Durable Medical Equipment Regional Carriers (DMERCs), the CMS contractors who process HME claims, at its discretion.

In December of 2002, CMS issued an interim final rule on implementation of IR authority. Under the interim rule, CMS is required to alert the public and allow a 60-day comment period on any price changes. In addition, CMS has added a new methodology to ensure that the IR adjustment is based on “valid and reliable data.” These steps include:

- Developing written guidelines for data collection and analysis;
- Ensuring consistency in any survey to collect and analyze pricing data;
- Developing a consistent set of survey questions to use when requesting retail prices;
- Ensuring that sampled prices fully represent the range of prices nationally;
- Considering the geographic distribution of Medicare beneficiaries;
- Considering relative prices in the various localities to ensure that an appropriate mix of areas with high, medium, and low consumer prices was included;
- Considering criteria to define populous state, less populous state, urban area, and rural area;
- Considering a consistent approach in selecting retail outlets within selected cities;
- Considering whether the distribution of sampled prices from localities surveyed is fully representative of the distribution of the U.S. population;
- Considering the products generally used by beneficiaries and collecting prices of these products; and
- When using wholesale costs, considering the cost of the services necessary to furnish a product to beneficiaries.

The interim rule became effective February 11, 2003.

While the interim final rule requires notice and comment prior to any IR determination and establishes a new methodology to determine whether payment for certain items are “grossly deficient or excessive,” there are still concerns that DMERCs or CMS could abuse IR authority, cutting reimbursement rates so as to sacrifice quality, limit access, and curtail patient choice.

Moreover, Congress recognized the “double-dipping” potential of competitive bidding, which lowers reimbursement through market competition, and IR, which lowers reimbursement through automatic cuts. To protect HME items from being subject to cuts under both competitive bidding and IR, the “Medicare Prescription Drug, Improvement and Modernization Act” (P.L. 108-173) restricts the use of IR for HME items that have been subject to competitive bidding.
**RECOMMENDATION:** At a minimum, Congress should monitor and oversee CMS’s and the DMERCs’ use of their IR authority to ensure that it is being utilized in an appropriate context, require involvement of HME suppliers and beneficiaries in development of reimbursement policies, and ensure that CMS is complying with the standards specified in the interim final rule for identifying IR adjustments.

**RATIONALE:** The Congressional restriction to CMS’ IR authority on competitively-bid items makes good policy given that the competitively-bid price will be, in most cases, the lowest reimbursement level that could be offered by a supplier. Under CMS’s expanded IR authority, drastic cuts in HME reimbursement could result through unilateral action by either CMS or the DMERCs, with little or no input by either beneficiaries or HME suppliers. Moreover, CMS could expand its IR authority to cuts in reimbursement of over 15 percent by spreading the cuts over more than one year.
RESCIND COMPETITIVE BIDDING FOR HOME MEDICAL EQUIPMENT

ISSUE: The “Medicare Prescription Drug, Improvement and Modernization Act,” (P.L. 108-173) contains a provision that would phase-in the implementation of a national competitive bidding program for home medical equipment (HME). Upon implementation of competitive bidding, the Medicare program will no longer reimburse HME suppliers through a specified fee schedule, but instead award suppliers who submit the lowest bid with the contract to supply the region with the particular product.

Specifically, the legislation phases-in implementation of competitive bidding starting with 10 of the largest Metropolitan Statistical Areas (MSAs) in 2007; 80 of the largest MSAs in 2009; and additional areas after 2009. In developing the competitive bidding program, the Centers for Medicare & Medicaid Services (CMS) will be allowed to exempt rural areas and areas with low population density.

In addition, CMS is prohibited from awarding a contract unless the supplier meets quality standards and financial standards (with special consideration to small suppliers), and unless there are assurances that real savings will be achieved and that beneficiaries will have a choice of suppliers. To participate in the bidding program, HME suppliers are required to waive their right to administrative or judicial review of the competitive bidding process.

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

In June 2005 an industry-financed study conducted by Economist Dr. Kenneth Brown of the University of Northern Iowa found that savings estimated to accrue from national competitive bidding will not materialize as most of the savings have already been achieved through imposition of a fee schedule based on reimbursement under the Federal Employees Health Benefits Program.

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

RATIONALE: Competitive bidding raises significant concerns, including loss of quality and service and the potential negative impact on beneficiary access and choice. Specifically, competitive bidding for HME supplies:

- Reduces beneficiary choice by allowing only those suppliers with winning bids to serve Medicare beneficiaries;
- Reduces quality since, under competitive bidding, price becomes the main buying criteria;
- Raises costs over the long run by promoting supplier monopolies that reduce competition; and
- Creates beneficiary confusion and additional burdens if the beneficiary is already receiving supplies and service from a supplier who can no longer serve in the area as a result of competitive bidding.
ENSURE ADEQUATE REIMBURSEMENT FOR HOME MEDICAL EQUIPMENT, PARENTERAL AND ENTERAL NUTRITION, AND OXYGEN SUPPLIES

ISSUE: Home medical equipment (HME), parental and enteral nutrition (PEN), and oxygen supplies help individuals remain in the comfort of their own homes while receiving needed health care services. HME, PEN, and oxygen services in the home also help avoid costly hospital and nursing home stays. The Medicare Prescription Drug, Improvement and Modernization Act (P.L. 108-173), however, freezes the consumer price index (CPI) updates for the HME, PEN, and oxygen fee schedules for 2004-2008. Moreover, in 2005, payment for certain items will be reduced by a specific amount.

For motorized wheelchairs, diabetic test strips, hospital beds/air mattresses and other items, payments will be reduced by the percentage difference between the Medicare payment and reimbursement under the Federal Employee Health Benefit Program (FEHBP) Plan. In September 2004 the Department of Health and Human Services’ Office of the Inspector General (OIG) reported that Medicare payments for oxygen items are higher than those under FEHBP and Medicare managed care by 10 to 23 percent. Effective October 25, CMS imposed new rules governing coverage of power mobility devices that eliminate the certificate of medical necessity but do not provide an acceptable alternative; provide insufficient time for providers to adopt a new set of billing codes; likely will impose considerable new administrative burdens on physicians and suppliers; and provide insufficient oversight to ensure consistency relative to new local coverage determinations. In response to concerns from Congress and advocacy groups, CMS delayed imposition of the requirement to use new codes.

Relative to oxygen, in late March 2005 CMS issued new rates that became effective in April. Payment reductions vary by state; average reduction for stationary oxygen is 8.6 percent and for portable units the average reduction is 8.1 percent.

In 2005 Rep. David Hobson (R-OH) introduced legislation related to DME; HR 3559 is designed to modify current law on competitive bidding to benefit beneficiaries and small providers. In essence, the bill would allow any provider that submits a bid under the existing allowable to participate as a Medicare supplier at the winning bidder's price. The bill has several other provisions, including one that would have CMS implement DME quality standards at the same time as the competitive bidding program begins.

RECOMMENDATION: Congress should rescind the freeze in the HME fee schedule and amend the Medicare program to automatically adjust and update HME, PEN, and oxygen payment levels by the change in prior year’s CPI. Congress should closely scrutinize OIG analysis of HME payments to ensure accuracy and thoroughness.

RATIONALE: Keeping reimbursement rates for HME, PEN, and oxygen services below CPI threatens patient access to care because the reimbursement for these services will not keep pace with medical inflation.
IX.

FACT SHEETS ON HOME CARE
WHAT IS HOME CARE?

"Home care" encompasses a broad spectrum of both health and social services that can be delivered to the recovering, disabled or chronically ill person in the home environment. These services include the traditional core of professional nursing and home care aide services as well as physical therapy, occupational therapy, speech therapy, medical social services and nutritional services.

Hospice is a special component of home care. Hospice care involves medical, social, psychological and spiritual care for terminally ill patients and their families. A concept aimed at relieving the pain and suffering and providing the most comfortable environment possible, hospice care is designed to allow a terminally ill person to die with dignity.

The home care industry is separate and distinct from the industry that supplies medical equipment. Although a relatively few home care organizations sell and rent medical equipment as a sideline to the services they provide, the great bulk of the medical equipment is marketed by other organizations, which are generally referred to as "home medical equipment (HME) dealers." The HME industry, in an attempt to improve its public image, has engaged in significant media efforts to blur the distinctions between it and the home care industry. It is important to maintain these distinctions because the two industries have markedly different missions and track records.

Generally home care is appropriate whenever a person needs assistance that cannot be easily or effectively provided only by a family member or friend on an ongoing basis for a short or long period of time. There are many situations and conditions for which home care and hospice are especially appropriate. Because of ever-advancing technology that is yielding equipment and people trained to use the equipment, every day more people are able to leave institutions or never enter them. They can be cared for effectively and efficiently at home even if they have illnesses that at one time were only treatable in a hospital or institutional setting.

Among those who can benefit from home care services are people in the following situations:

- because of age, illness or disability they need additional assistance to live independently at home;
- have conditions such as congestive heart disease, kidney disease, diabetes, muscle-nerve problems or respiratory disease;
- are terminally ill and want to die in dignity and comfort at home;
- are able to be discharged from a hospital or nursing home but need additional care at home; or
- require short-term assistance at home because of same-day or outpatient surgery or maternity-related incapacity.

While many people are choosing home care and services because of financial considerations, there are sound medical and humane reasons for medical treatment at home. Recent studies have shown that people improve and recover faster at home than in institutions. For instance, when chemotherapy is required for treatment of cancer conditions, the smaller doses that can be administered at home have less adverse patient reactions than massive doses delivered in hospital settings. Also, surveys consistently validate the fact that whenever people have a choice they prefer home care.

Home care and hospice services are provided for people of all ages. More and more older people electing to live independent, non institutionalized lives are taking advantage of home care and
hospice services as their physical capabilities diminish. Younger adults who are disabled or recovering from acute illness are choosing to be cared for at home whenever possible. Infants and children requiring even the most sophisticated treatment for serious childhood illness are able to return to loving families and a secure home environment thanks to advanced technology and pediatric home care services.
WHO PROVIDES HOME CARE?

Home care services are provided by home care agencies. Home care agencies are public organizations, or private nonprofit or for profit organizations, that have developed over the past century around a core of professional nursing services and home care aide services. Many home care organizations also provide a wide variety of other services, including physical therapy, occupational therapy, speech therapy, medical social services and nutritional services. Home care agencies bring these services into the home, singly or in combination, in order to achieve and sustain an optimum state of health, activity, and independence for individuals of all ages who require such services because of acute illness, exacerbation of chronic illness, or long term or permanent limitations due to chronic illness and disability. There were 17,666 home care organizations in the United States in 2002 (U.S. Census Bureau, 2002 Economic Census, October 2004). Home care agencies can be categorized into three main groups: home health agencies, home care aide organizations and hospices.

HOME HEALTH AGENCIES

Most home care agencies are "home health agencies." Home health agencies are primarily or exclusively concerned with the treatment or rehabilitation of patients who need skilled nursing care or therapy. Their patients are predominantly under the care of a physician and the skilled care they receive through the home health agency is furnished in accordance with a physician's order. These agencies offer a multidisciplinary program of care—usually, nursing and home care aide services at a minimum. The Medicare-certified agency is the prototype home health agency. At the end of 2004, there were 7,679 Medicare-certified agencies in the United States, down from a high of 10,444 at the end of 1997.

HOME CARE AIDE ORGANIZATIONS

"Home care aide organizations," (sometimes called paraprofessional organizations) are primarily or exclusively concerned with the delivery of care to functionally impaired persons who need help with personal care, such as bathing, and with homemaking services. NAHC has identified some 1,600 home care aide organizations (including units of larger organizations) in the late 1980s. While not a definitive count, the statistic suggests that the number of these organizations remains rather small.

HOSPICES

"Hospices" provide palliative care for patients in the final stages (usually the last 6 months or less) of a terminal illness through a team composed of physicians, nurses, social workers and counselors who are concerned with the physical, psychological, social, and spiritual welfare of the patient. While the hospice concept is ancient, the development of the modern hospice can be dated from the 1960s, when attention was turned to the management of the pain and symptoms associated with terminal illness. There are approximately 2,870 hospices in the US, of which more than 2,670 are Medicare-certified.
Note: Medical equipment is supplied by a separate and distinct industry. Although a relatively few home care organizations sell and rent medical equipment as a sideline to the services they provide, the great bulk of the medical equipment is marketed by other organizations, which are generally referred to as "home medical equipment dealers." Some 6,000 to 7,000 companies sell and rent home medical equipment. Find/SVP, a New York-based market research organization, estimated the home care products market at $1.6 billion in 1992, and predicted it would grow at an annual rate of 9.6 percent to reach $2.4 billion by 1996.

PERSONNEL

Home care agencies employ a variety of professionals and paraprofessionals to deliver home care services.

NURSES

Registered nurses (RN) and licensed practical nurses (LPN) provide the direct skilled nursing services for the patient, supervise other caregivers as required, coordinate patient care with the physician and train family members and friends in functions they can perform to assist the professional caregivers and maintain the patient when professional services no longer are necessary.

HOME CARE AIDES

These trained paraprofessionals provide services associated with the personal care of the patient. When assistance with bathing, grooming, dressing, cooking and cleaning are needed, home care aide services can be indispensable. Home care aides are supervised by the nursing staff of a home care agency.

SOCIAL WORKERS

Social workers assist the patient and family in vital areas including evaluation of the financial circumstances and ability to pay for necessary home care services. Knowledgeable in community resources, often the social workers are able to direct people to needed local support systems. Social work in the home setting also involves making sure that the emotional needs of the patient and the family are fulfilled.

THERAPISTS

Another important component of the home care team is the professional therapist. Physical, occupational, speech and respiratory therapists provide essential services according to the needs of the individual patient. The therapist also plays a vital role in educating nonprofessionals who may be available to assist the patient with exercises and routine care that can allow the patient to function in the home and recover more effectively.
PHYSICIANS

The physician is a key element in home care. Many times the physician will be the initiator of home care services by recommending them to a patient returning home from an institution such as a hospital or nursing home; or suggesting that home care services could allow a patient with increasing disability to remain at home. In most cases a physician will authorize a coordinated plan of treatment for home care services and periodically review the delivery and effectiveness of those services, sometimes recommending changes.

Other members of the team providing care can include people who offer services such as day care, respite care, meals on wheels and transportation. Pharmacists and dietitians are also members of the home care team.

DAY CARE

A center outside the home where people may gather for social interaction, meals, entertainment and recreation. Day care programs vary from community to community. Some provide full-day activities and others operate on a part-time basis.

RESPITE CARE

Short-term, intermittent home care, while it provides no specific medical or therapeutic services, gives the friend or family member who is the primary caregiver in the home some time off. Essentially an adult-sitting service, respite care can be an important factor in easing the caregiving strain on a patient's family or friends.

MEALS ON WHEELS

In many communities "meals on wheels" programs deliver nutritionally balanced, prepared meals to elderly people in their homes. A good hot meal once a day delivered by a friendly, caring service can be vital to an older person who does not have assistance in the home for meal preparation.

TRANSPORTATION

Many communities, either through private or public services, provide transportation services for patients receiving home care. While those people receiving care at home are ill or disabled, few are actually bed or homebound, or unable to go outside at all. With assistance such as transportation services, many home care patients can do their own shopping and take occasional excursions for entertainment or other activities. A home care social worker is most likely to know the sources of such services.
PHARMACISTS

Pharmacists provide consultation to home health agencies on drugs being presented and dispensed to home care patients, as well as possible drug interactions.

DIETITIANS

Dietitians consult with home care providers on diets for patients and their families and suggest appropriate modifications to foster recovery and optimal functioning.
HOW IS HOME CARE PAID FOR?

ISSUE: Home care is paid for by a variety of sources. Often it is paid for by the individual or the family, but both private and public insurance programs cover some home care costs. Benefits and requirements vary greatly, however. For those whose insurance does not cover home care, some agencies offer a sliding-scale fee schedule so that a family need pay only what it can afford.

Major payment sources and what they will cover include Medicare, Medicaid, Social Services Block Grant, Older Americans Act, private health insurance, Veterans Administration, workers' compensation, health maintenance organizations (HMO), CHAMPUS, social services organizations and patient/private pay.

MEDICARE

For those 65 and over, this federal health program pays for home health services, some kinds of homemaking services and agency-provided medical supplies and equipment if the patient meets the following requirements. The patient must be under a physician's care, homebound and in need of part-time or intermittent skilled nursing care, or physical or speech therapy. Once the patient meets those requirements he or she is eligible for a range of services including skilled nursing, home health aide, speech therapy, occupational therapy, medical social work and medical supplies and equipment. Medicare also reimburses for hospice benefits that include palliative and support services delivered to terminally ill patients. The plan of care must be designed and periodically reviewed by the physician. The services provided must be part-time or intermittent (that is, not full time). The illness or condition must be of a nature that will respond favorably to a physician's treatment. Services must be provided through a Medicare-certified home health agency.

MEDICAID

This medical assistance program for low-income people is a joint federal-state program administered by the state. Each state has its own set of eligibility requirements. Under Medicaid, home health services must include part-time nursing, home health aide and medical equipment and supplies at the state's option, it may cover physical therapy, occupational therapy, speech therapy and audiology. States are required to provide home health services to all categorically needy recipients 21 years and older, and to all other Medicaid recipients who are entitled to skilled nursing benefits under the state plan. States are permitted to offer home health services to all other recipients. In addition, in 1981, Congress authorized certain waivers to expand Medicaid by allowing states to provide a broad range of home- and community-based services to individuals who otherwise would require, and have paid for by Medicaid, institutional care.

SOCIAL SERVICES BLOCK GRANT

States receive allotments of funds on the basis of the state's population, within a federal expenditure ceiling. There are not requirements for use of Title XX funds, and states are provided relative freedom to spend federal social services block grant funds on state-identified service needs. In-home services that may be available include home care aide, chore and personal care.
OLDER AMERICANS ACT

Under Title III of the Older Americans Act, in-home services include home-delivered meals, home care aide, personal care, chore, escort and shopping services.

PRIVATE HEALTH INSURANCE

Policy coverage varies. Generally, private insurance coverage is limited to physician-directed medical services, courses of therapy and medical equipment. For the elderly, coverage under long-term care insurance plans is increasing, but patients still must be aware of limitations on coverage, such as prior hospitalization and pre-existing condition. Many policies only cover services that already are covered by Medicare.

VETERANS ADMINISTRATION

Veterans with a 50 percent or more service-connected disability are eligible for home health care coverage. Services must be authorized by a physician to be eligible and are provided through the VA's own network of VA hospital-based home care units. Since 1981, the VA does not authorize payment for nonmedical services provided by home care aides.

WORKERS' COMPENSATION

Any person needing home care services as a result of injury on the job is eligible. Workers' compensation representatives have information on eligibility.

HEALTH MAINTENANCE ORGANIZATIONS

HMOs and Comprehensive Medical Plans (CMP) with Medicare contracts must provide the full range of Medicare-covered services that are available in the geographic area, including home health services. Coverage is usually limited to physician-directed medical services and therapy. In exchange for comprehensive services, the patient agrees to restrictions on the use of providers outside the plan.

CHAMPUS

On a cost-shared basis this program covers skilled nursing care and other professional medical home care for dependents of active military personnel, retirees and their dependents and survivors.

SOCIAL SERVICE ORGANIZATIONS

Organizations that operate with private charitable funding, such as United Way support, may offer a wide range of services encompassing most of the health and supportive home care services.
Depending on eligibility, agencies may require some payment, or a donation, or provide service at no charge.

PATIENT/PRIVATE PAY

Home care services can be personally paid for. In fact, most home care expenses are still paid from out-of-pocket sources, primarily due to the stringent limitations on coverage of home care included in public and private financing programs. The scope of services and the price are worked out between the family and the agency.

If the cost of a family's home care program is to be reimbursed, the agency will bill its insurance source directly. The patient, or responsible party, will receive a bill only when a portion of a bill is not paid by the insurer, as in the case of deductibles.

No matter how home care is being paid for, patients should keep accurate records. Home care costs qualify as medical expenses and are tax deductible, within certain limits, from federal income tax.
On December 19, 2005, the House agreed to a conference report on S. 1932. However, the Senate amended the report, removing a few provisions as the result of a point of order raised associated with the “Byrd Rule.” The amended agreement passed the Senate on December 21, 2005, and was returned to the House for further action. On February 1, 2005, the House agreed to the Senate amendment by a vote of 216 to 214. S. 1932 was signed into law (Public Law 109-171) on February 8, 2006, by President Bush.

**TITLE V -- MEDICARE**

**Subtitle A – Provisions Relating to Part A**

**Section 5008. Post Acute Care Payment Reform Demonstration Program.**

The Secretary of the Department of Health and Human Services is required to establish a three-year demonstration program to assess the costs and outcomes across different post-acute care sites by January 1, 2008.

**Subtitle B – Provisions Relating to Part B**

**Section 5101. Beneficiary Ownership of Certain Durable Medical Equipment (DME).**

Requires the supplier to transfer the title of durable medical equipment in the capped rental category to the beneficiary after a 13-month rental period, but retains a beneficiary option for purchasing power-driven wheelchairs when initially furnished. Automatic payment to the suppliers every six months for maintenance and servicing would be eliminated. Such payments (for parts and labor not covered by the supplier’s or manufacturer’s warranty) would only be made if the Secretary determined them to be reasonable and necessary. This amendment would apply to items for which the first rental month occurred on or after January 1, 2006.

Provides that rental payments for oxygen equipment (including portable oxygen equipment) are converted to ownership at 36 months. The supplier is required to transfer the title of the equipment to the beneficiary after a 36-month rental period. After transfer of the title, monthly payments for oxygen contents (in the case of gaseous and liquid oxygen) will continue to be made, as provided for under current law, for the period of medical need. Payments for maintenance and servicing (for parts and labor not covered by the supplier’s or manufacturer’s warranty) will be made if the Secretary determines them to be reasonable and necessary. This provision takes effect on January 1, 2006. In the case of an individual receiving oxygen equipment as of December 31, 2005, the 36 month period begins January 1, 2006.

**Section 5107. Revisions to Payments for Therapy Services.**

Does not extend the moratorium, however, the Secretary is required to implement an exceptions process for expenses incurred in 2006. Under the process, a Part B enrollee, or a person acting on behalf of the enrollee, may request an exception from the physical therapy and occupational therapy caps. The individual may obtain an exception if the provision of services is determined medically necessary. If the Secretary does not make a decision on a request within 10 business days of receipt, the Secretary is deemed to have
found the services medically necessary. The Secretary is required to waive such provisions of law and regulations (including those related to the Paperwork Reduction Act) as are necessary to implement these amendments on a timely basis. The amendments may be implemented by program instruction or otherwise. The legislation specifies that there can be no administrative or judicial review of the exceptions process (including establishment of the process). It also requires the Secretary, by July 1, 2006, to implement clinically appropriate code edits for physical therapy services, occupational therapy services, and speech language pathology services. The edits are to identify and eliminate improper payments. The edits are to include edits of clinically illogical combinations of procedure codes and other edits to control inappropriate billings.

Subtitle C – Provisions Relating to Parts A and B

Section 5201. Home Health Payments.
Eliminates the update for home health payments in 2006. It also extends the 5% additional payment for rural home health episodes or visits beginning on or after January 1, 2006 and before January 1, 2007. Starting in 2007, home health agencies will submit to the Secretary health care quality data in a form, manner, and time period specified by the Secretary. In 2007 and subsequent years, a home health agency that does not submit the required quality data will receive an update of the market basket minus two percentage points. This reduction would only apply to the fiscal year in question. Directs the Secretary to design procedures for making the data available to the public. The Medicare Payment Advisory Commission is directed to submit a report to Congress no later than June 1, 2007 on a value-based purchasing program for home health services. The report is to include recommendations on the structure of the program, determining thresholds, the size of value-based payments, sources of funds, and the relationship of payments and improvements in health care quality.

Section 5202. Revision of Period For Providing Payment for Claims that are not Submitted Electronically.
Directs Medicare contractors to delay the payment of claims that are not submitted electronically. The contractors are directed to pay 95% of all “clean” claims within 29-30 days of receipt for paper claims.

Section 5203. Time Frame for Part A and B Payments.
Delays Medicare Part A and B payments by nine days. Claims that would otherwise be paid on September 22, 2006, through September 30, 2006 would be paid on the first business day of October 2006. No interest or late penalty would be paid to an entity or individual for any delay in a payment during the period.

Section 5204. Increase in Medicare Integrity Program Funding.
Increases Medicare Integrity Program funding $100 million for fiscal year 2006. As part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Congress acted to increase and stabilize federal funding for anti-fraud activities. As required by Section 1817(k) of the Medicare law, an expenditure account was established within the Federal Hospital Insurance Trust Fund. Certain amounts were appropriated from the Trust Fund for specific activities, including the Medicare Integrity Program (MIP).

TITLE VI – MEDICAID
Chapter 2 – Long-Term Care Under Medicaid
Subchapter A – Reform of Asset Transfer Rules
Section 6011. Lengthening Look-Back Period; Change in Beginning Date for Period of Ineligibility.

Section 6011(a). Amends section 1917(c)(1)(B)(i) of the Social Security Act to lengthen the look-back date to five years, or 60 months, for all income and assets disposed of by the individual after enactment. For income and assets disposed of prior to the enactment date, the look back periods of 36 months for income and assets and 60 months for certain trusts would apply. Therefore states will now be required to delay Medicaid eligibility as specified above for certain Medicaid long-term care services for individuals applying for care in a nursing home, and, at state option, for certain people receiving care in community-based settings, who have transferred assets for less than fair market value on or after a “look-back date.” The beginning date for the period of ineligibility will change from the date of the asset transfer to the date of application for Medicaid. The section identifies hardship exceptions in certain cases.

Section 6012. Disclosure and Treatment of Annuities.

Amends Section 1917 of the Social Security Act and requires individuals applying for Medicaid-covered LTC services, upon Medicaid application and recertification of eligibility, to disclose to the state, a description of any interest the individual or community spouse has in an annuity (or similar financial instrument, as specified by the Secretary), regardless of whether the annuity is irrevocable or is treated as an asset. Also amends Section 1917(c)(1) of the Social Security Act by adding that the purchase of an annuity be treated as a disposal of an asset for less than fair market value unless the state is named as the remainder beneficiary in the first position for at least the total amount of Medicaid expenditures paid on behalf of the annuitant or is named in the second position after the community spouse or minor or disabled child and such spouse or a representative of the such child does not dispose of any such remainder for less than fair market value. Includes annuities purchased by or on behalf of an annuitant who has applied for Medicaid-covered nursing facility or other long-term care services in the definition of annuities that are subject to asset transfer rules.

Section 6014. Disqualification for Long-Term Care Assistance for Individuals with Substantial Home Equity.

Amends Section 1917 of the Social Security Act to exclude from Medicaid eligibility for nursing facility or other long-term care services, certain individuals with an equity interest in their home of greater than $500,000. A state may elect, without regard to Medicaid’s requirements concerning statewideness and comparability, to substitute an amount that exceed $500,000 but does not exceed $750,000. These dollar amounts are increased, beginning in 2011, from year to year based on the percentage increase in the consumer price index for all urban consumers (all items, United States city average), rounded to the nearest $1,000. The Secretary establishes a process for waiving this provision in the case of a demonstrated hardship. Individuals whose spouse, child under age 21, or child who is blind or disabled (as defined by the Section 1614 of the Social Security Act) lawfully resides in the individual’s home would not be excluded from eligibility. This provision would not prevent an individual from using a reverse mortgage or home equity loan to reduce the individual’s total equity interest in the home. The provision applies to individuals who are determined eligible for Medicaid nursing facility or other long-term care services based on an application filed on or after January 1, 2006.

Section 6015. Enforceability of Continuing Care Retirement Communities (CCRC) and Life Care Community Admission Contracts.

Amends Section 1919(c)(5) of the Social Security Act to provide an exception for state-licensed, registered, certified, or equivalent continuing care retirement communities (CCRCs) or a life care community (including nursing facility services provided as part of that community) to allow them to
require in their admissions contracts that residents spend their resources (subject to Medicaid’s rules concerning the resources allowance for community spouses, described above), declared for the purposes of admission, on their care before they apply for Medicaid. For applicants with community spouses, only that part of the entrance fee that is not protected for by the community spouse’s resource allowance would be considered in the computation of the spousal share available to Medicaid. Also amends Section 1917 of the Social Security Act to consider certain entrance fees for CCRCs or life care communities to be countable resources, and thus available to the applicant, for purposes of the Medicaid eligibility determination to the extent that: (A) the individual has the ability to use the entrance fee, or the contract provides that the entrance fee may be used, to pay for care should other resources or income of the individual be insufficient to pay for care; (B) the individual is eligible for a refund of any remaining entrance fee when the individual dies or terminates the CCRC or life care community contracts and leaves the community; and (C) the entrance fee does not confer an ownership interest in the continuing care retirement community or life care community.

Section 6016. Additional Reforms of Medicaid Asset Transfer Rules.
Section 6016(a). Amends Section 1917(c)(1)(E) of the Social Security Act by adding that a state shall not round down, or otherwise disregard any fractional period of ineligibility when determining the ineligibility period with respect to the disposal of assets.

Section 6016(b). Amends Section 1917(c)(1) of the Social Security Act by adding that for an individual or an individual’s spouse who disposes of multiple fractional assets in more than one month for less than fair market value on or after the applicable look-back date, states may determine the penalty period by treating the total, cumulative uncompensated value of all assets transferred by the individual (or individual’s spouse) during all months as one transfer. States would be allowed to begin such penalty periods on the earliest date which would apply to such transfers.

Section 6016(c). Amends Section 1917(c)(1) of the Social Security Act to make additional assets subject to the look-back period, and thus a penalty, if established or transferred for less than fair market value. Such assets would include funds used to purchase a promissory note, loan or mortgage, unless the repayment terms are actuarially sound, provide for payments to be made in equal amounts during the term of the loan and with no deferral nor balloon payments, and prohibit the cancellation of the balance upon the death of the lender. In the case of a promissory note, loan, or mortgage that does not satisfy these requirements, their value shall be the outstanding balance due as of the date of the individual’s application for certain Medicaid long-term care services.

Section 6016(d). Amends Section 1917(c)(1) of the Social Security Act by adding a provision that would redefine the term ‘assets,’ with respect to the Medicaid asset transfer rules, to include the purchase of a life estate interest in another individual’s home unless the purchaser resides in the home for at least one year after the date of purchase.

Subchapter B – Expanded Access to Certain Benefits –

Section 6021. Expansion of State Long-Term Care Partnership Program.
Amends Section 1917(b)(1)(C)(ii) of the Social Security Act to: (1) require that existing Medicaid long-term care (LTC) insurance partnership programs not allow consumer protection standards to be less stringent (determined by the Secretary) than those applying under the state plan amendment as of December 31, 2005; and (2) allows certain individuals in states with state plan amendments approved after May 14, 1993 to be exempt from estate recovery requirements if the amendment
provides for the disregard of any assets or resources in the amount equal to the amount of insurance benefits made to or on behalf of an individual who is a beneficiary under a LTC policy (including a certificate issued under a group insurance contract), if the following requirements are met:

(I) The policy covers an insured who was a resident of such state when coverage first became effective under the policy. In the case of a LTC insurance policy exchanged for another such policy, this requirement applies based on the coverage of the first such policy that was exchanged;

(II) The policy is a qualified LTC insurance policy (meeting specifications defined in Section 7702B(b) of the Internal Revenue Code of 1986) issued not earlier than the effective date of the Medicaid state plan amendment;

(III) The policy meets the following requirements specified in the National Association of Insurance Commissioner’s (NAIC) Long-Term Care Insurance Model Regulations and Long-Term Care Insurance Model Act (as adopted as of October 2000);

(IV) If at the date of purchase the purchaser is younger than age 61, the policy must provide for compound inflation; if the purchaser is at least age 61 but not older than age 76, the policy must provide some level of inflation protection; and if the purchaser is age 76 or older, the policy may, but is not required to, provide some level of inflation protection;

(V) The state Medicaid agency provides information and technical assistance to the state insurance department on the insurance department’s role of assuring that any individual who sells a LTC insurance policy under the partnership receives training or demonstrates evidence of an understanding of such policies and how they relate to other public and private coverage of LTC;

(VI) The issuer of the policy provides regular reports to the Secretary that include, in accordance with the Secretary’s regulations (after consultation with the National Association of Insurance Commissioners, issuers of LTC insurance policies, states with experience with LTC insurance partnership plans, other states, and representatives of consumers of LTC insurance policies) notification regarding when all benefits and their amounts under the policy have been paid, when the policy otherwise terminates, and other information that the Secretary determines is appropriate to the administration of the partnership programs. These regulations shall specify the type and format of the data and information to be reported, and the frequency with which such reports are to be made. The Secretary, as appropriate, provides copies of the reports to the state involved.

The Secretary develops recommendations for Congress to authorize and fund a uniform minimum data set to be reported electronically by all issuers of LTC insurance policies under qualified state LTC insurance partnerships to a secure, centralized electronic query and report generating mechanism that state, the Secretary, and other federal agencies can access.

Chapter 3 – Eliminating Fraud, Waste, and Abuse in Medicaid

Section 6031. Encouraging the Enactment of State False Claims Acts.
Requires that if a state has in effect a law relating to false or fraudulent claims that meets requirements specified in the bill, the FMAP, with respect to any amounts recovered under a state action brought under such a law, is decreased by 10 percentage points. The provision is effective January 1, 2007, except in the case of a state which the Secretary of HHS determines that state legislation is required for compliance.
Section 6032. Employee Education about False Claims Recovery.
Requires a state to provide that any entity that receives annual Medicaid payments of at least $5 million, as a condition of receiving such payments, must: (1) establish written policies for all employees (and any contractor or agent) of the entity that provide detailed information on state and federal false claims laws and whistle-blower protections under such laws, (2) include in such written polices detailed provisions regarding the entity’s policies and procedures for detecting and preventing fraud, waste, and abuse, and (3) include in any employee handbook for the entity a specific discussion of such laws, the rights of employees to be protected as whistleblowers, and the entity’s policies and procedures for detecting and preventing fraud, waste, and abuse. The provision is effective January 1, 2007, except in the case of a state which the Secretary of HHS determines that state legislation is required for compliance.

Section 6034. Medicaid Integrity Program.
Establishes a Medicaid Integrity Program, under which the Secretary of HHS shall enter into contracts with eligible entities to carry out its activities, including review of the actions of individuals or entities, audit of claims for payment, identification of overpayments, and education with respect to payment integrity and quality of care. Appropriations for the program total $5 million in FY2006, $50 million in each of FY2007 and FY2008, and $75 million in each fiscal year thereafter (with a mandated increase of 100 employees whose duties consist solely of protecting the integrity of the Medicaid program). States are required to comply with any requirements determined by the Secretary to be necessary for carrying out the Medicaid Integrity Program. In each of FY2006-2010, $25 million is appropriated for Medicaid activities of the HHS Office of Inspector General (in addition to any other amounts appropriated or made available for its Medicaid activities, to remain available until expended). Also establishes a national expansion of the Medicare-Medicaid data match project (referred to as the Medi-Medi Program) as a required activity of the Medicare Integrity Program. The Medi-Medi program data match project analyzes claims data from both programs together to detect aberrant patterns that may not be evident when billings are viewed in isolation. It is primarily supported by “wedge” funds from the Health Care Fraud and Abuse Control Account (HCFAC) within the federal Hospital Insurance (Medicare Part A) trust funds. In addition to HCFAC appropriations for the Medicare Integrity Program, the Medi-Medi Program is appropriated $12 million in FY2006, $24 million in FY2007, $36 million in FY2008, $48 million in FY2009, and $60 million in FY2010 and each fiscal year thereafter.

Section 6035. Enhancing Third Party Identification and Payment
Substitutes the term “managed care organization” for “health maintenance organization” and amends the list of third parties named in Section 1902(a)(25) of the Social Security Act for which states must take all reasonable measures to ascertain the legal liability to include self-insured plans, pharmacy benefit managers, and other parties that are legally responsible (by statute, contract, or agreement) for payment of a claim for a health care item or service. It also amends that section to include these entities in the list of health insurers that states must prohibit from taking an individual’s Medicaid status into account when enrolling the individual or making payments for benefits to or on behalf of the individual. Requires a state to provide assurances satisfactory to the Secretary of HHS that it has laws in effect requiring third parties to provide, upon request of the state, information to determine health insurance coverage (in a manner prescribed by the Secretary) and to cooperate with payment and recovery efforts by Medicaid. The provision is effective January 1, 2006, except in the case of a state which the Secretary of HHS determines that state legislation is required for compliance.
Section 6041. State Option For Alternative Medicaid Premiums and Cost Sharing.

Section 6041(a). Allows the states to impose premiums and cost-sharing for any group of
individuals for any type of service (except prescribed drugs which are treated separately), through
Medicaid state plan amendments (rather than waivers), subject to specific restrictions. Premiums
and cost-sharing imposed under this option are allowed to vary among classes or groups of
individuals, or types of service. Premiums and cost-sharing provisions in current law for workers
with disabilities are not affected. For individuals in families with income between 100 and 150%
Federal Poverty Level (FPL): (1) no premiums may be imposed, (2) cost sharing for any item or
service cannot exceed 10% of the cost of the item or service, and (3) the total aggregate amount of
all cost-sharing (including cost sharing for prescribed drugs and emergency room copayments for
non-emergency care; see below) cannot exceed 5% of family income as applied on a quarterly or
monthly basis as specified by the state. For individuals in families with income above 150% FPL:
(1) the total aggregate amount of all cost sharing (including cost sharing for prescribed drugs and
emergency room copayments for non-emergency care) cannot exceed 5% of family income as
applied on a quarterly or monthly basis as specified by the state, and (2) cost-sharing for any item or
service cannot exceed 20% of the cost of the item or service.

Exempts premiums for the following groups: (1) mandatory groups of children under 18, including
individuals in foster care receiving aid or assistance under Part B of Title IV and persons receiving
adoption or foster care assistance under Title IV-E, regardless of age; (2) pregnant women; (3)
terminally ill persons receiving Medicaid hospice care; (4) individuals in medical institutions who
are required to pay for costs of care all but a minimal amount of their income for personal needs,
and (5) women who qualify for Medicaid under the breast and cervical cancer eligibility group.
States may exempt additional groups from premiums.

Cost-sharing is not permitted for: (1) services provided to mandatory groups of children under 18,
including individuals in foster care receiving aid or assistance under Part B of Title IV and persons
receiving adoption or foster care assistance under Title IV-E, regardless of age; (2) preventive
services provided to children under 18 regardless of family income; (3) services provided to
pregnant women that relate to pregnancy or to other medical conditions that may complicate
pregnancy; (4) services provided to terminally ill individuals receiving Medicaid hospice services;
(5) services provided to individuals in medical institutions who are required to spend for costs of
care all but a minimal amount of their income for personal needs; (6) emergency services; (7)
family planning services and supplies, and (8) services to women who qualify for Medicaid under
the breast and cervical cancer eligibility group. States may exempt additional individuals or services
from service-related cost-sharing.

Section 6041(b). Beginning with 2006, the Secretary is required to increase nominal amounts for
service-related cost-sharing by the annual percentage increase in the medical care component of the
consumer price index (CPI) for all urban consumers (U.S. city average), as rounded up in an
appropriate manner.
Section 6063.
Establishes a five year demonstration project in which up to 10 states could provide a broad range of home- and community-based services (HCBS) to children who would otherwise require services in a psychiatric residential treatment facility. The demonstration would test the effectiveness of improving or maintaining the child’s functional level, and the cost-effectiveness of providing these types of services as an alternative to psychiatric residential treatment services. The projects must follow the existing requirements of the HCBS waiver, and be budget neutral. $218 million has been appropriated for FY2007-FY2011 to carry out the demonstration. The funds available for this demonstration total: $21 million in FY2007; $37 million in FY2008; $49 million in FY2009, $53 million in FY2010; and $57 million in FY2011.

Section 6071. Money Follows the Person Demonstration
Authorizes the Secretary to conduct a demonstration project in states to (1) increase the use of home and community-based care instead of institutions by relocating individuals from institutions into the community, (2) expand the state’s capacity to provide home and community-based long-term care services for individuals who choose to transition into the community; and (3) to ensure that procedures are in place to provide quality assurance and continuous quality improvement, that is at least comparable to other Medicaid home and community-based services.

States awarded a demonstration would receive additional federal funding for the costs of home and community-based, long-term care services (under a HCBS waiver and/or the state plan) for 12 months following a demonstration participant’s transition from an institution into the community. In a given fiscal year, funding would be capped at the amount of a state’s grant award. After the 12 months of grant funding, the state would be required to continue providing services through a Medicaid home and community based long-term care program.

Individuals may participate in the demonstration if they meet the following criteria: (1) they are residents of a hospital, nursing facility, ICF-MR, or an institution for mental disease (IMD) (but only to the extent that the IMD benefit is offered as part of the existing state Medicaid plan); (2) they have resided in the facility for no less than six months or for a longer time period specified by the state (up to a maximum of two years); (3) they are receiving Medicaid benefits for the services in this facility; (4) they will continue to require the level of care of the facility but for the provision of HCBS services. After relocating into the community, the individual must reside in one of the following: a home owned or leased by the individual or his/her family; an apartment with an individual lease in which the individual (or family) has domain and control over the space; or a community-based residential setting where no more than four unrelated individuals reside.

$250 million is appropriated for the portion of FY2007 which begins on January 1, 2007, and ends on September 30, 2007; $300 million in FY2008; $350 million in FY2009; $400 million in FY2010; and $450 million in FY2011 to carry out the demonstration project. Funds not awarded to states in a given fiscal year would continue to be available in subsequent fiscal years, through September 30, 2011.

Section 6086. Expanded Access to Home and Community-Based Services for the Elderly and Disabled.
Establishes home and community-based services as an optional Medicaid benefit that would not require a waiver and that meets certain other requirements for individuals whose income does not exceed 150% of the federal poverty level. The scope of services may include any services permitted
under Section 1915(c)(4)(B) of the Social Security Act which the Secretary has the authority to approve, and would not include an individual’s room and board. The state may provide this option to individuals without determining that but for the provision of such services, the person would require the level of care provided in a hospital, nursing home, or ICF-MR. States that offer this new benefit must establish needs based criteria to determine an individual’s eligibility for HCBS services, and the specific HCBS the individual will receive. The state must also establish needs-based criteria for determining whether an individual requires the level of care provided in a hospital, nursing home, ICF-MR, or under a waiver of the state plan, that is more stringent than the needs-based criteria for the HCBS option established by this provision. The needs-based criteria must be based on an assessment of an individual’s support needs and capabilities, and may take into account the inability of the individual to perform two or more activities of daily living (ADLs) as defined in the Internal Revenue Service (IRS) code (i.e., bathing, dressing, transferring, toileting, eating, and continence), or the need for significant assistance to perform these activities, and other risk factors determined to be appropriate by the state.

For this new benefit, a state may allow an individual or the individual’s representative to receive self-directed home and community-based services. If the state permits self-direction, there must be an assessment of the needs, capabilities and preferences of the individual. There must also be a service plan developed jointly with the individual that is approved by the state. The service plan must specify the services to be self-directed, identify the method of self-direction, specify the roles of various parties, and, if offered by the state, an individualized budget for the value of the services and supports to be self-directed. The provision of home and community-based services must meet state and federal guidelines for quality assurance. The state must also establish standards for the conduct of the independent evaluation and assessment to safeguard against conflict of interest.

Section 6087. Optional Choice of Self-Directed Personal Assistance Services (Cash and Counseling).

Allows a state to cover, under the Medicaid program, payment for part or all of the cost of self-directed personal assistance services (other than room and board) based on a written plan of care to individuals for whom there has been a determination that, but for the provision of such services, the individuals would require and receive personal care services under Medicaid state plan or home and community-based services under a HCBS waiver. Self directed personal assistance services may not be provided to individuals who reside in a home or property that is owned, operated, or controlled by a provider of services, not related by blood or marriage.

The state must ensure that the necessary safeguards have been taken to protect the health and welfare of individuals receiving these services and to assure financial accountability for funds expended for these services.

A state may provide self-directed personal assistance services under the state plan without regard to the Medicaid requirements for statewideness (under Section 1902(a)(1) of the Social Security Act), and may limit the population eligible to receive these services and the number of persons served without regard to Medicaid requirements regarding comparability (Section 1902(a)(10)(B) of the Social Security Act).

Individuals participating in such services would be permitted, within an approved self-directed services plan and budget, to purchase personal assistance and related services, and hire, fire, supervise, and manage the individuals providing such services. At the election of the state, a participant is be allowed to (1) choose as a paid service provider, any individual capable of
providing the assigned tasks including legally liable relatives, and (2) use the individualized budget to acquire items that increase independence or substitute (such as a microwave oven or an accessibility ramp) for human assistance, to the extent that expenditures would otherwise be made for the human assistance.

The approved self-directed services plan developed under option must meet the following requirements: (1) The participant (or his/her guardian or authorized representative if appropriate) exercises choice and control over the budget, planning, and purchase of self directed personal assistance services, including the amount, duration, scope, provider and location of service provision; (2) There is an assessment of the needs, strengths, and preferences of the participants for such service; (3) An individual’s plan for self-directed services and supports, which has been developed and approved by the state, is based on a person-centered assessment process that builds upon the participant’s capacity to engage in activities that promote community life; respects the participant’s preferences, choices and abilities; and involves families, and professionals in the planning or delivery of services or supports as desired or required by the participant.

In establishing and implementing the self-directed services plan and budget, appropriate quality assurance and risk management techniques must be used which recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and which assure the appropriateness of the plan and the budget, based on the individual’s resources and capabilities.

A state may employ a financial management entity to make payments to providers, track costs, and make reports under this program. Payment for the activities of the financial management entity is reimbursed at the same rate as other Medicaid administrative activities (generally federal Medicaid administrative reimbursement is 50 %, though certain activities may be eligible for 75 % reimbursement). This provision becomes effective on January 1, 2007.

**Labor, Health and Human Services, and Education**

**Fiscal Year 2006 Appropriations**

**Public Law 109-149**

On December 30, 2005, President Bush signed into law H.R. 3010, the “Department of Health, Labor, and Human Services, and Education, and Related Agencies Appropriations Act, 2006.” H.R. 3010 includes funding for telehealth. Specifically, it provides $3,000,000 to the Office of the Advancement of Telehealth to carry out programs and activities under the Health Care Safety Net Amendments of 2002 (Public Law 107–251). Of that amount, $1,500,000 can be used to fund telehealth resource centers that provide assistance with respect to technical, legal, regulatory service delivery or other related barriers to the development of telehealth technologies. The Congress urged the Department of Health and Human Services’ Health Resources and Services Administration (HRSA) department to place a high priority on the needs of rural States with populations of less than 1,500,000 individuals in the awarding and geographical placement of the telehealth resource grants. $750,000 will be used for network grants and demonstration or pilot projects for telehomecare and another $750,000 will be used for grants to carry out the licensure provisions in Section 102 of Public Law 107–251.
HOME HEALTH LEGISLATION 2003

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003
(HR 1; PL 108-173)

HOME CARE

Section 421-One-year increase for home health services furnished in a rural area.
Provides a one-year, five percent additional payment for home health services furnished in a rural area. The temporary additional payment begins for episodes and visits ending on or after April 1, 2004, and before April 1, 2005.

Section 701-Update in home health services.
Changes the time frame for the home health inflation update from the federal fiscal year to a calendar year basis beginning with 2004. Home health agency payments are increased by the full market basket percentage for the last quarter of 2003 (October, November, and December) and for the first quarter of 2004 (January, February, and March). The update for the remainder of 2004 and for 2005 and 2006 is the home health market basket percentage increase minus 0.8 percentage points.

Section 702-Demonstration project to clarify the definition of homebound.
The Secretary is required to conduct a two-year demonstration project under which beneficiaries enrolled in Medicare Part B with specified chronic conditions would be deemed to be homebound in order to receive home health services under Medicare. The Secretary is required to select three states in the northeast, Midwest, and western regions of the United States in which to conduct the demonstration. Up to 15,000 beneficiaries can participate. The demonstration is required to begin within six months of enactment. Within one year of completing the demonstration, the Secretary is required to report to Congress recommendations and findings regarding the demonstration and its impact on the Medicare program. The provision is effective upon enactment.

Section 703-Demonstration project for medical adult day care services.
Requires the Secretary to establish a three-year demonstration project in not more than five states that license or certify providers of medical adult day care services, under which a home health agency, directly or under arrangement with a medical adult day care facility, provides medical adult day care services as a substitute for a portion of home health services otherwise provided in a beneficiary's home. Payment for the episode will equal 95 percent of the amount that would otherwise apply, subject to budget neutrality provisions. The agency or facility is prohibited from charging the beneficiary separately for the medical adult day care services. Participation of up to 15,000 Medicare beneficiaries is on a voluntary basis. When selecting participants, the Secretary is required to give preference to home health agencies that are currently licensed to furnish medical adult day care services and have furnished such services to Medicare beneficiaries on a continuous basis for a prior two-year period. The Secretary is required to evaluate the project's clinical and cost effectiveness and submit a report to Congress no later than six months after completion of the demonstration. The provision is effective upon enactment.
Section 704—Temporary suspension of OASIS requirement for collection of data on non-Medicare and non-Medicaid patients.

Suspends the requirement that home health agencies must collect OASIS data on private pay (non-Medicare, non-Medicaid) patients until the Secretary (1) reports to Congress on the benefits of these data, the value of the data compared to the administrative burden of data collection in small agencies, and the use of the OASIS information by both large and small agencies, and then (2) publishes final regulations regarding the collection and use of OASIS. The provision does not prohibit home health agencies from collecting OASIS data on private pay patients for the agencies' own use.

Section 705—Medicare Payment Advisory Commission (MedPAC) study on Medicare margins of home health agencies.

The conference agreement requires MedPAC to study payment margins of home health agencies paid under the Medicare home health prospective payment system, using cost reports filed by agencies. The study is required to examine whether systematic differences in payment margins are related to differences in case mix, as measured by home health resource groups (HHRGs), among agencies. MedPAC is required to submit a report to Congress on the study within two years of enactment.

Section 953—GAO report on flexibility in applying home health Conditions of Participation to patients who are not Medicare beneficiaries.

Requires the GAO to report to Congress on the implications if the Medicare conditions of participation for home health agencies were applied flexibly with respect to groups or types of patients who are not Medicare beneficiaries. The report is due no later than six months after enactment.

Section 307—Pilot program for national and state background checks on direct patient access employees of long-term care facilities and providers.

Requires the Secretary to establish pilot projects in no more than 10 states for the purpose of expanding background checks for workers with direct patient access who are employed by Medicare and Medicaid long-term care providers, including nursing homes, home health agencies, hospices, long-term care hospitals, and other entities (except for those paid through a self-directed arrangement). Funding in each of fiscal years 2005 and 2006 is set at $25 million.

<table>
<thead>
<tr>
<th>How Will the Medicare Reform Bill Affect Home Health Payments?</th>
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<tbody>
<tr>
<td><strong>Episodes Ending Between</strong></td>
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<tr>
<td>Oct 1, 2002-Sept 30, 2003</td>
</tr>
<tr>
<td>Oct 1, 2003-Mar 31, 2004</td>
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<tr>
<td>Apr 1, 2004-Dec 31, 2004</td>
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For episodes ending on or after October 1, 2003, but before April 1, 2004, there is a 3.3% market basket index (inflation) increase.

The Medicare reform bill mandates that inflation increases be made on a calendar year basis. Also, for episodes ending on or after April 1, 2004, but before January 1, 2005, the 3.3% market basket index inflation increase will be reduced by 0.8%. Rates for calendar year 2005...
and 2006 will be increased by market basket minus 0.8%. The legislation provides a 5% rural add-on for episodes ending between April 1, 2004-March 31, 2005.

HOSPICE

Section 408-Recognition of attending nurse practitioners as attending physicians to serve hospice patients.
Expands the definition of attending physician in hospice to include a nurse practitioner. A nurse practitioner is not permitted to certify a beneficiary as terminally ill for the purposes of receiving the hospice benefit. The provision would be effective upon enactment.

Section 409-Rural hospice demonstration project.
Requires the Secretary to establish a demonstration project in three hospice programs to deliver hospice care to Medicare beneficiaries in rural areas. Those Medicare beneficiaries who lack an appropriate caregiver and are unable to receive home-based hospice care could receive hospice care in a facility of 20 or fewer beds that offers a full range of hospice services within its walls. The facility will not be required to offer services outside of the home. The limit on the aggregate number of inpatient days provided to Medicare beneficiaries who elect hospice care is waived under the demonstration. Payments for the hospice care will be made at the rates that would be otherwise applicable to Medicare. Upon completion of the demonstration project, the Secretary is required to submit a report to Congress, including recommendations, regarding the extension of the project to hospice programs serving rural areas.

Section 512-Coverage of hospice consultation services.
Provides coverage of certain physicians' services for certain terminally ill individuals. Beneficiaries entitled to these services are those who have not elected the hospice benefit and have not previously received these physicians' services. Covered services are those furnished by a physician who is the medical director or employee of a hospice program. The covered services are: evaluating the beneficiary's need for pain and symptom management, including the individual's need for hospice care; counseling the beneficiary with respect to end-of-life issues and care options; and advising the beneficiary regarding advanced care planning. Payment for such services equals the amount established for similar services under the physician fee schedule, excluding the practice expense component. The provision would apply to consultation services provided by a hospice program on or after January 1, 2005.

Section 946-Authorizing use of arrangements to provide core hospice services in certain circumstances.
Permits a hospice to: (1) enter into arrangements with another hospice program to provide care in extraordinary, exigent, or other non-routine circumstances, such as unanticipated high patient loads, staffing shortages due to illness, or temporary travel by a patient outside the hospice's service area; and (2) bill and be paid for the hospice care provided under these arrangements. The provision is effective for hospice care provided on or after the date of enactment. Allows hospices to contract for highly specialized clinical services in certain circumstances. Both provisions effective December 8, 2003.
DURABLE MEDICAL EQUIPMENT

Section 302—Payment for DME; competitive acquisition of certain items and services.
For DME, prosthetic devices, prosthetics and orthotics, payments are held at the 2003 fee schedule rate from 2004 through 2008. After 2008, for those items not included in competitive bidding, the update will be the consumer price index (CPI).
For 2005, the payment amount for certain items (oxygen and oxygen equipment, standard wheelchairs, nebulizers, diabetic lancets and testing strips, hospital beds, and air mattresses) will be reduced to reflect payments for such items under the Federal Employees Health Benefits Program (FEHBP). An Office of Inspector General report on oxygen will be available in the spring of 2004.
For class III medical devices, the update in 2004, 2005, and 2006 is equal to the increase in the consumer price index for all urban consumers (CPI-U) for the 12-month period ending June of the prior year. In 2007 the percentage change for class III medical devices is to be determined by the Secretary of HHS (Secretary) after taking into account recommendations made by the Comptroller General. In 2008, the update is determined by the amount paid in 2007 updated by the CPI. In subsequent years, the CPI is the update.
The bill phases in competitive acquisition programs for DME beginning with 10 of the largest metropolitan statistical areas (MSAs) in 2007; 80 of the largest MSAs in 2009; and remaining areas after 2009. Items covered under the program include items used in infusion and drugs; medical supplies; home dialysis supplies; therapeutic shoes; enteral nutrients, equipment, and supplies; electromyogram devices; salivation devices; blood products and transfusion medicine; and off-the-shelf orthotics. Excluded from competitive acquisition are: inhalation drugs; parenteral nutrients, equipment, and supplies; and class III devices. Rural areas and areas with low population density within urban areas that are not competitive could be exempted from competitive acquisition, unless a significant national market exists through mail order for a particular item or service.
The Secretary is required to determine a single payment amount for each item or service in each competitive acquisition area. Medicare payment must be equal to 80 percent of the payment amount determined, with beneficiaries paying the remaining 20 percent (after meeting the Part B deductible). Payment for any item or service is made only on an assignment-related basis: the supplier bills Medicare and accepts Medicare payment as payment in full.
For covered items and services furnished beginning January 1, 2009, items and services included in the competitive acquisition program would be paid as determined under that program and the Secretary would be able to use this payment information to adjust the payment amounts for DME, off-the-shelf orthotics, and other items and services that are supplied in an area that is not a competitive acquisition area.
The inherent reasonableness authority is retained but may not be used by the Secretary in circumstances where the competitive acquisition program information is used to adjust payments. The Secretary shall establish and implement quality standards and establish an accrediting organization for DME suppliers. Establishes clinical standards for suppliers; requires that patients receive a face-to-face examination and a prescription in order for coverage requirements to be met. The provision is effective upon enactment.

DRUGS AND BIOLOGICALS

Section 303—Payment reform for covered outpatient drugs and biologicals.
Certain categories of drugs and biologicals will continue to be paid at 95 percent of the average wholesale price (AWP), including pneumococcal, influenza, and hepatitis B vaccines; a drug or biological furnished before January 1, 2004; blood clotting factors furnished during 2004; a drug or biological furnished during 2004 that was not available for Part B payment as of April 1, 2003; a
drug or biological (other than erythropoietin) furnished in connection with renal dialysis services that are separately billed by renal dialysis facilities; and radiopharmaceuticals and blood products. In general, payments for other drugs furnished in 2004 will equal 85 percent of the average wholesale price (determined as of April 1, 2003). Beginning in 2005, drugs and biologicals, except for pneumococcal, influenza, and hepatitis B vaccines and those associated with certain renal dialysis services, will be paid using either the average sales price methodology or through the competitive acquisition program. Infusion drugs furnished through covered durable medical equipment starting January 1, 2004, will be paid at 95 percent of the AWP in effect on October 1, 2003.

Section 642-Extension of coverage of Intravenous Immune Globulin (IVIG) for the treatment of primary immune deficiency diseases in the home. Includes intravenous immune globulin for the treatment in the home of primary immune deficiency diseases as a covered medical service under Medicare. Items or services related to the administration of the derivative are not included in the definition. Intravenous immune globulin is to be paid at 80 percent of the lesser of actual charge or the payment amount. This provision applies to items furnished on or after January 1, 2004.

PHYSICIAN SERVICES

Section 601-Revision of updates for physicians' services. The anticipated 4.5 percent cut in 2004 and additional cut in 2005 would be blocked. Instead, physicians would receive at least a 1.5 percent update to the conversion factor in 2004 and 2005. This will likely translate into an average increase in payment of about 1.5 percent in 2004 and 2005. However, the actual increase in payment for physicians prescribing home health care in particular geographic areas is also dependent on other weighting factors. The national base payment to physicians for home health and hospice related services will increase as follows:

<table>
<thead>
<tr>
<th>Physician Services</th>
<th>2003 Base Rates</th>
<th>2004 Base Rates</th>
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<tbody>
<tr>
<td>Care Plan Oversight HH</td>
<td>$123.23</td>
<td>$123.96</td>
</tr>
<tr>
<td>Care Plan Oversight Hospice</td>
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<td>$131.05</td>
</tr>
<tr>
<td>Certification HH</td>
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<td>$73.93</td>
</tr>
<tr>
<td>Recertification, HH</td>
<td>$57.02</td>
<td>$57.13</td>
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</tbody>
</table>

THERAPIES

Section 624-Two-year moratorium on therapy caps; provisions relating to reports. Application of the Part B therapy caps is suspended as of the date of enactment through calendar year 2005. The implementation of this provision shall not be deemed to have any retroactive impact upon beneficiaries who exceeded their caps prior to the date of enactment. The Secretary is required to submit outstanding reports by March 31, 2004, relating to the alternatives to a single annual dollar cap on outpatient therapy and the utilization patterns for outpatient therapy. The General
Accounting Office is required to identify conditions or diseases that may justify waiving the application of the therapy caps and report to Congress by October 1, 2004.

**Section 647-MedPAC study on direct access to physical therapy services.**
Requires the Medicare Payment Advisory Commission (MedPAC) to study the feasibility and advisability of allowing Medicare beneficiaries in fee-for-service direct access to outpatient physical therapy services and those physical therapy services that are furnished as comprehensive rehabilitation facility services. This study, together with recommendations for legislation or administrative actions, must be submitted to Congress no later than January 1, 2005.

**PART B DEDUCTIBLE**

**Section 629-Indexing part B deductible to inflation.**
The Medicare Part B deductible will remain $100 through 2004. The deductible will be $110 for 2005, and in subsequent years the deductible will be increased by the same percentage as the Part B premium increase. The deductible amount will be rounded to the nearest dollar. The provision is effective upon enactment.

**CHRONIC CARE DEMONSTRATIONS**

**Section 648-Demonstration project for consumer-directed chronic outpatient services.**
Requires the Secretary to establish no fewer than three demonstration projects that evaluate methods to improve the quality of care provided to Medicare beneficiaries with chronic conditions and to reduce expenditures that would otherwise be made on their behalf by Medicare. The methods are required to include permitting beneficiaries to direct their own health care needs and services. The Secretary is required to establish the demonstrations within two years of enactment. Demonstrations are required to be located in an urban area, a rural area, and an area that has a Medicare population with a diabetes rate that significantly exceeds the national average. The Secretary is required to evaluate the clinical and cost effectiveness of the demonstrations.

**Section 649-Medicare care management performance demonstration.**
The Secretary is required to establish a three-year demonstration program to promote continuity of care, help stabilize medical conditions, prevent or minimize acute exacerbations of chronic conditions, and reduce adverse health outcomes. Four sites will be designated for the demonstration, with at least two in urban areas and one in a rural area. Any Medicare beneficiary enrolled in part A and B who has one or more chronic medical conditions specified by the Secretary (one of which may be a cognitive impairment) and is unable to manage his own care or has a functional limitation and resides in a demonstration area may participate in the program if the beneficiary identifies a primary care physician who agrees to manage the complex clinical care of the beneficiary under the demonstration.

**Section 721-Voluntary chronic care improvement under traditional fee-for-service.**
Requires the Secretary to establish and implement chronic care improvement (CCI) programs to improve clinical quality and beneficiary satisfaction and achieve spending targets under Medicare for beneficiaries with certain chronic health conditions. The CCI program is required to (1) Have a process to screen each targeted beneficiary for conditions other than the specified chronic conditions, such as impaired cognitive ability and comorbidities, in order to develop an individualized, goal-oriented care management plan; and (2) Provide each targeted beneficiary participating in the program with the care management plan; and
(3) Carry out the plan and other chronic care improvement activities. The care management plan is required to be developed with the beneficiary and, to the extent appropriate, include: (1) A designated point of contact responsible for communications with the beneficiary and for facilitating communications with other health care providers; (2) Self-care education for the beneficiary (through approaches such as disease management or medical nutrition therapy) and education for primary caregivers and family members; (3) Education for physicians and other providers and collaboration to enhance communication of relevant clinical information; (4) The use of monitoring technologies that enable patient guidance through the exchange of pertinent clinical information, such as vital signs, symptomatic information, and health self-assessment; and (5) The provision of information about hospice care, pain and palliative care, and end-of-life care.

The Secretary must ensure that aggregate Medicare benefit expenditures for targeted beneficiaries participating in the chronic care improvement program do not exceed estimated Medicare expenditures for a comparable population in the absence of such a program. Appropriations of such sums as necessary to provide for contracts with chronic care improvement programs would be authorized from the Medicare trust funds, but in no case would the funding be permitted to exceed $100 million over three years.

Section 723-Chronically ill Medicare beneficiary research, data, demonstration strategy.
Requires the Secretary to develop a plan to improve quality of care and to reduce the cost of care for chronically ill Medicare beneficiaries within six months after enactment. The plan is required to use existing data and identify data gaps, develop research initiatives, and propose intervention demonstration programs to provide better health care for chronically ill Medicare beneficiaries. The plan is required to: (1) Integrate existing data sets including the Medicare Current Beneficiary Survey, the Minimum Data Set, the Outcome and Assessment Information Set, data from the Quality Improvement Organizations, and claims data; (2) Identify any new data needs and a methodology to address new data needs; (3) Plan for the collection of such data in a data warehouse; and (4) Develop a research agenda using the data. In developing the plan, the Secretary is required to consult with experts in the fields of care for the chronically ill (including clinicians) and is required to enter into contracts with appropriate entities for the development of the plan. The Secretary is required to implement the plan no later than two years after enactment. Appropriations are authorized from amounts in the Treasury not otherwise appropriated, such sums as may be necessary in fiscal years 2004 and 2005 to carry out this provision.

HEALTH TECHNOLOGY

Section 731-Improvements in national and local coverage determination process to respond to changes in technology.
Coverage. Requires the Secretary to make available to the public the factors considered in making national coverage determinations of whether an item or service is reasonable and necessary. The Secretary is required to develop guidance documents similar to those required by the Federal Food, Drug, and Cosmetic Act. The provision establishes a time frame for decisions regarding national coverage determinations of six months after a request when a technology assessment is not required and nine months when a technology assessment is required and but a clinical trial is not requested. Following the six- or nine-month period, the Secretary is required to make a draft of the proposed decision available on the HHS website or by other means; to provide a 30-day public comment period; to make a final decision on the request within 60 days following the conclusion of the public comment period; make the clinical evidence and data used in making the decision available to the public when the decision differs from the recommendations of the Medicare Coverage Advisory Committee; and in the case of a decision to grant the coverage determination, assign a temporary or permanent code and implement the coding change. In instances where a request for a national
coverage determination is not reviewed by the Medicare Coverage Advisory Committee, the Secretary is required to consult with appropriate outside clinical experts. The Secretary is also required to develop a plan to evaluate new local coverage determinations to decide which local decisions should be adopted nationally and to decide to what extent greater consistency can be achieved among local coverage decisions, to require the Medicare contractors within an area to consult on new local coverage policies, and to disseminate information on local coverage determination among Medicare contractors to reduce duplication of effort. The provision is effective for national determinations as of January 1, 2004, and for local coverage determinations made on or after July 1, 2004.

Coding. Requires the Secretary to implement revised procedures for issuing temporary national HCPCS codes under Medicare Part B no later than July 1, 2004.

Section 942-Improvement in oversight of technology and coverage.

(a) Council for Technology and Innovation
Requires the Secretary to establish a Council for Technology and Innovation within CMS composed of senior CMS staff and clinicians with a chairperson designated by the Secretary who reports to the CMS administrator. The chairperson will serve as the executive coordinator for technology and innovation and will be the single point of contact for outside groups and entities regarding Medicare coverage, coding, and payment processes. The council is required to coordinate Medicare's coverage, coding, and payment processes as well as information exchange with other entities with respect to new technologies and procedures, including drug therapies.

(d) Process for adoption of ICD codes as data standard.
Although no provision was agreed to by the conferees, conferees urged the Secretary to accept and implement the recommendation of the National Committee on Vital and Health Statistics and issue a notice of proposed rule making to initiate the regulatory process for the concurrent adoption of ICD-10-CM and ICD-10-PCS. ICD-10 would replace the 23-year-old ICD-9-CM coding classification system.

REGULATORY REFORMS

Administrative Improvements, Regulatory Reduction, and Contracting Reform

Section 902-Issuance of regulations.
Imposes maximum three-year deadline on issuance of final rules based on proposed or interim final rules and requires that the Secretary of Health and Human Services (Secretary) establish and publish a regular timeline for issuance of final regulations. Also requires that a measure in a final regulation that is not a logical outgrowth of the proposed regulation or interim final regulation is to be treated as a proposed regulation. The provision is effective upon enactment.

Section 903-Compliance with changes in regulation and policies.
Bars retroactive application of any substantive changes in regulation, manual instructions, interpretative rules, statements of policy, or guidelines. Exceptions are available in cases where needed to comply with statutory changes or in the public interest. The provision is effective upon enactment.

Penalties and interest will not be charged in cases where a provider or supplier follows faulty written guidance provided by the Secretary or a Medicare contractor when furnishing items or services or submitting a claim (unless the inaccurate information was due to a clerical or technical operational error).
Makes clear that a provider or supplier is not subject to any penalty or interest on a repayment plan if the provider or supplier reasonably relied on the guidance. This provision applies to a sanction imposed with respect to guidance provided on or after July 24, 2003.

**Section 904—Reports and studies relating to regulatory inconsistencies.**
Requires the General Accounting Office (GAO) to study the feasibility and appropriateness of the Secretary providing legally binding advisory opinions on appropriate interpretation and application of Medicare regulations. The Secretary is required to report to Congress on the administration of Medicare and areas of inconsistency or conflict among various provisions under law and regulation; the report is to include recommendations for legislation or administrative action that the Secretary determines appropriate to further reduce such inconsistency or conflicts.

**Appeals and Recovery**

**Section 931—Transfer of responsibility for Medicare appeals.**
Requires the Secretary and the Commissioner of Social Security to develop a plan to transfer the Medicare administrative law judge (ALJ) function from the Social Security Administration to the Department of Health and Human Services for Medicare appeals, not later than April 1, 2004. A GAO evaluation of the plan is required within six months of the plan's submission. ALJ functions are required to be transferred no earlier than July 1, 2005, and no later than October 1, 2005. The Secretary is required to place the ALJs in an administrative office that is organizationally and functionally separate from the Centers for Medicare & Medicaid Services (CMS) and the ALJs would be required to report to, and be under the general supervision of, the Secretary.

**Section 932—Process for expedited access to review.**
Requires the Secretary to establish a process where a provider, supplier, or a beneficiary may obtain access to judicial review when a review entity determines, within 60 days of a complete written request, that it does not have the authority to decide the question of law or regulation and where material facts are not in dispute. Interest is assessed on any amount in controversy and is awarded by the reviewing court in favor of the prevailing party. The conference agreement is effective for appeals filed on or after October 1, 2004.

**Section 933—Revisions to Medicare appeals process.**

(a) **Requiring full and early presentation of evidence**
Requires providers and suppliers to present all evidence for an appeal at the reconsideration level that is conducted by a qualified independent contractor (QIC) unless good cause precluded the introduction of the evidence. Provision effective on October 1, 2004.

(b) **Use of patients' medical records**
Provides for the use of beneficiaries' medical records in appeals reconsiderations by QICs. Provision effective upon enactment.

(c) **Notice requirements for Medicare appeals**
When claims are denied in either the initial determination or in subsequent appeals, a written notice of the decision is required for the beneficiary, notifying them of their right to appeal the decision. When a redetermination (the first level of appeal) is denied or when a reconsideration is decided (the second level of appeal), a written notice is required to include the specific reasons for the redetermination as well as information regarding the beneficiary's appeals rights. For appeals (to either an ALJ or departmental appeals board), the notice of the decision is required to be in writing and written in a manner understood by the beneficiary, to include the specific reasons for the determination, the procedures for obtaining additional information regarding the decision, and notification of the right to appeal and how to initiate such an appeal.
Requires that the QIC submit information that is needed for an appeal of a decision. This provision is effective upon enactment.

(d) Qualified independent contractors
Clarifies eligibility requirements for QICs and their reviewer employees. The required number of qualified independent contractors is reduced from not fewer than 12 to not fewer than four. The provisions regarding the eligibility requirements of QICs and QIC reviewers are effective as if included in the Benefits Improvement and Protection Act (BIPA) at enactment.

Section 934-Prepayment review.
Permits Medicare contractors to conduct random prepayment reviews only to develop a contractor-wide or program-wide error rate or in such additional circumstances as the Secretary provides for in regulations that are developed in consultation with providers and suppliers. Non-random payment reviews are permitted only when there is a likelihood of sustained or high level of payment error. The Secretary is required to issue regulations regarding the termination and termination dates of non-random prepayment review. Variation in termination dates is permitted depending upon the differences in the circumstances triggering prepayment review.

Section 935-Recovery of overpayments.
In situations where repaying an Medicare overpayment within 30 days would be a hardship for a provider or supplier, this provision requires the Secretary to enter into an extended repayment plan of at least six months duration, but not more than three years (five years in the case of extreme hardship, as determined by the Secretary). Interest will accrue on the balance through the repayment period.

Prohibits the Secretary from recouping any overpayments until a reconsideration level appeal (or a redetermination by the fiscal intermediary or carrier if the QICs are not yet in place) is decided. Interest will be paid to the provider if the appeal is successful or interest will be paid to the Secretary if the appeal is unsuccessful.

Limits extrapolation to those circumstances where there is a sustained or high level of payment error, as defined by the Secretary in regulation, or documented educational intervention has failed to correct the payment error.

Medicare contractors are permitted to request the periodic production of records or supporting documentation for a limited sample of submitted claims to ensure that the previous practice is not continuing in the case of a provider or supplier with prior overpayments.

Permits the Secretary to use consent settlements to settle projected overpayments under certain conditions. Specifically the Secretary is required to communicate to the provider or supplier that medical record review has indicated an overpayment exists, the nature of the problems identified, the steps needed to address the problems, and afford the provider or supplier 45 days to furnish additional information regarding the claims reviewed. If, after reviewing the additional information, an overpayment continues to exist, the Secretary must provide notice and an explanation of the determination and then may offer the provider two mechanisms to resolve the overpayment: either an opportunity for a statistically valid random sample or a consent settlement (without waiving any appeal rights).

Requires the Secretary to establish a process to provide notice to certain providers and suppliers in cases where billing codes were overutilized by members of that class in certain areas, in consultation with organizations that represent the affected provider or supplier class.

If post-payment audits are conducted, the Medicare contractor is required to provide the provider or supplier with written notice of the intent to conduct the audit and findings of the audit. The contractor must also permit the development of an appropriate corrective action plan, inform the provider or supplier of appeal rights and consent settlement options, and give the provider or supplier the opportunity to provide additional information, unless notice or findings would
compromise any law enforcement activities. Requires the Secretary to establish a standard methodology for Medicare contractors to use in selecting a sample of claims for review in cases of abnormal billing patterns. In general, the provisions are effective upon enactment. The limitation on extrapolation would apply to samples initiated after one year following the date of enactment. Requires the Secretary to establish the process for notice of overutilization of billing codes not later than one year after enactment. Requires the Secretary to establish a standard methodology for selecting sample claims for abnormal billing patterns not later than one year after enactment.

Section 936-Provider enrollment process; right of appeal.
Requires the Secretary to establish in regulation a provider enrollment process with hearing rights in the case of a denial or non-renewal. Before changing provider enrollment forms, the Secretary is required to consult with providers and suppliers. The agreement also establishes hearing rights in cases where the applications have been denied. The enrollment process will be established within six months of enactment. The consultation process on provider enrollment forms is required for changes in the form beginning January 1, 2004. The provision of hearing rights applies to denials that occur one year after enactment or an earlier date specified by the Secretary.

Section 937-Process for correction of minor errors and omissions without pursuing appeals process.
Requires the Secretary to establish a process so providers and suppliers can correct minor errors in claims that were submitted for payment within one year after enactment.

Section 939-Appeals by providers when there is no other party available.
In the case where a beneficiary dies before assigning appeal rights, the provision permits a provider or supplier to appeal a payment denial by a Medicare contractor. The provision is effective for items and services furnished on or after enactment.

Section 940-Revisions to appeals timeframes and amounts.
Adds 30 days to the timeframe for deciding an appeal at the redetermination and reconsideration levels of appeal (that is, the first two levels of appeal). The conference agreement also indexes the amount in controversy for appeals to the consumer price index for urban areas (CPI-U), rounded to the nearest multiple of $10, beginning in 2005.

Section 940A-Mediation process for local coverage determinations.
Requires the Secretary to establish a mediation process using a physician trained in mediation and employed by CMS to mediate disputes between groups representing providers, physicians, and suppliers and the medical director for the Medicare contractor in any area that the relevant CMS regional administrator determines that there is a systematic pattern and a large volume of complaints from such groups regarding decisions of the medical director, or there is a complaint from the co-chair of the advisory committee for that contractor. Requires the Secretary to include in the contract with Medicare Administrative Contractors the performance duties expected of a medical director including professional relations. The provision is effective upon enactment.

Section 953-Annual publication of list of National Coverage Determinations.
Requires the Secretary publish an annual list of national coverage determinations made under Medicare in the previous year.
CONTRACTING REFROM

Section 911-Increased Flexibility in Medicare Administration.
The Medicare contractor authority is consolidated adding a new Section 1874A into the Social Security Act, permitting the Secretary to competitively contract with any eligible entity to serve as a Medicare Administrative Contractor (MAC). Eliminates distinctions between Part A contractors (fiscal intermediaries) and Part B contractors (carriers) and takes the separate authorities for fiscal intermediaries and carriers and merges them into a single authority for the new contractor. Competitive bidding for the MACs would be required to begin October 1, 2005, and all contracts should have been bid under the new structure by September 30, 2011.

Section 912-Requirements for Information Security for Medicare Administrative Contractors.
Requires Medicare administrative contractors (as well as fiscal intermediaries and carriers until the MACs are established) to implement a contractor-wide information security program.

EDUCATION AND OUTREACH

Section 921-Provider Education and Technical Assistance.
(a) Coordination of Education Funding.
Requires the Secretary to coordinate educational activities through the Medicare contractors and to report to Congress with a description and evaluation of the steps taken to coordinate provider education funding.

(b) Incentives to Improve Contractor Performance.
Requires the Secretary to use specific claims payment error rates (or similar methodology) to provide incentives for contractors to implement effective education and outreach programs for providers and suppliers. The GAO is required to submit a study that details the adequacy of the methodology and makes recommendations. The Secretary is required to report to Congress by October 1, 2004, regarding how he intends to use the methodology in assessing Medicare contractor performance.

(c) Provision of Access to and Prompt Responses from Medicare Administrative Contractors.
Requires the Secretary to develop a strategy for communicating with beneficiaries, providers and suppliers, beginning October 1, 2004. Medicare contractors are required to provide responses to written inquiries that are clear, concise, and accurate within 45 business days of the receipt of the written inquiry. The Secretary is required to ensure that Medicare contractors have a toll-free telephone number where beneficiaries, providers, and suppliers may obtain information regarding billing, coding, claims, coverage, and other appropriate Medicare information. Medicare contractors would be required to maintain a system for identifying the person supplying information to beneficiaries, providers, and suppliers and to monitor the accuracy, consistency, and timeliness of the information provided. The Secretary is required to establish and make public standards to monitor the accuracy, consistency, and timeliness of written and telephone responses of Medicare contractors as well as to evaluate the contractors against these standards.

(d) Improved Provider Education and Training.
Authorizes such sums as necessary to be appropriated for fiscal years beginning with FY 2005 to be used to increase education and training activities for providers and suppliers regarding billing, coding, and other appropriate items and may be used to improve the accuracy, consistency, and timeliness of contractor responses. Beginning October 1, 2004, Medicare contractors are required to tailor education and training activities to meet the special needs of small providers or suppliers. Technical assistance is permitted to be included in the education and training activities. The
provision defines a small provider as an institution with fewer than 25 full-time equivalents (FTEs) and a small supplier as one with fewer than 10 FTEs.

**Section 922 - Small Provider Technical Assistance Demonstration Program.**
Requires the Secretary to establish a demonstration program to provide technical assistance to small providers and suppliers, upon request, to improve compliance with Medicare requirements. Providers participating are expected to pay 25 percent of the cost of the technical assistance. The GAO is required to evaluate the demonstration no later than two years after it begins and submit a report to the Congress and the Secretary, including recommendations regarding the continuation or extension of the demonstration.

**Section 923 - Medicare Beneficiary Ombudsman.**
Creates a new section 1810 establishing a Medicare Beneficiary Ombudsman. The Secretary is required to appoint an Ombudsman not later than one year after the date of enactment who will receive complaints, grievances, and requests for information from Medicare beneficiaries, and provide assistance in these matters and matters relating to appeals decisions, and the income-related premium adjustment as well as assistance to beneficiaries with any problems disenrolling from a Medicare+Choice plan. Requires making the 1-800-MEDICARE line available to all individuals seeking information about, or assistance with, Medicare rather than listing individual telephone numbers for Medicare contractors in the Medicare handbook. The Comptroller General is required to study the accuracy and consistency of information provided on the 1-800-MEDICARE line and to report to Congress not later than one year after enactment.

**Jobs and Growth Tax Relief Reconciliation Act of 2003 (HR 2; PL 108-27)**

**MEDICAID AND SOCIAL SERVICES**

**Section 401 - Temporary State Fiscal Relief.**
Increases the federal Medicaid matching payments (FMAP) to the states by $10 billion for the period April 1, 2003-June 30, 2004. Each state receives a 2.95 percentage point increase in its FMAP for this period.

**Section 406 - Temporary State Fiscal Relief**
Provides $5 billion to the states for each of fiscal years 2003 and 2004, which can be used for health care and other social services at the state’s discretion.
The 2002 legislative session began with passage by the House of legislation that would eliminate the 15% cut in home health payments (implemented on October 1, 2002), extend the 10% rural add on until January 2005, create a new hospice consultation benefit, eliminate the OASIS requirement for non-Medicare/non-Medicaid patients, and provide many regulatory reforms. Similar legislation was introduced by the Chair and Ranking Member of the Senate Finance Committee. However, passage of this legislation fell victim to partisan gridlock over the creation of a prescription drug benefit. The Administration, senior groups, and some in Congress insisted that relief for Medicare providers should not be granted unless Congress first created a prescription drug benefit, but Congress could not agree on the size and structure of such a benefit.

The following legislation that could help alleviate the widespread shortage of home health nurses was signed into law. An effort will be made in 2003 to obtain an appropriation of funds to implement the new law.

**Nurse Reinvestment Act (H.R. 3487, P.L. 107-205)**

**Title I: Nurse Recruitment**

**Section 101** – Defines “health care facility” to include home health agencies and hospice programs.

**Section 102** – Permits the Secretary of HHS to make grants to support State and local advertising campaigns to promote the nursing profession.

**Section 103** – Expands eligibility for the nursing loan repayment program to include service at any health care facility with a critical shortage of nurses. Restricts service to nonprofits after FY 2007. Provides nursing scholarships in exchange for two years of nursing services at facilities with a critical shortage of nurses.

**Title II: Nurse Retention**

**Section 201** – Authorizes the Secretary of HHS to award grants or contracts to schools of nursing or health care facilities to expand nursing education and practice opportunities and creation of career ladders.

**Section 202** – Directs Secretary to award grants for geriatric care training programs.

**Section 203** – Authorizes establishment of student loan program to increase the number of qualified nursing faculty and provides loan forgiveness in exchange for service on nursing faculty.

**Section 204** – Requires GAO report on national variations in nursing shortages; differences in nurse hiring practices between profit and nonprofit private entities because of the inclusion of for-profit private entities in the loan repayment program; and whether the scholarship program increases applications to nursing schools.
The 2001 legislative session got off to a promising start, with early progress on a number of health care and home health priorities. However, the events of September 11, 2001, shifted the congressional focus dramatically. As a result, most pending legislation affecting health care providers took a back seat until the start of the 2002 legislative session. The following pieces of legislation that impact home health and hospice providers were signed into law:


Title VII: Health Care Provisions - Subtitle A: TRICARE Program Improvements - Amends the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) to direct the Secretary to establish a sub-acute care benefits program for the same types of health care authorized under CHAMPUS. Requires such program to include a uniform skilled nursing facility benefit and a home health care benefit as provided under title XVIII (Medicare) of the Social Security Act.

**Administrative Simplification Compliance Act (P.L. 107-105)**

SEC. 2. Extension of Deadline for Covered Entities Submitting Compliance Plans -- Extends by one year the deadlines for compliance by health care providers, health plans other than small health plans, and health care clearinghouses with the standards for electronic health care transactions and code sets adopted under part C (Administrative Simplification) of title XI of the Social Security Act (SSA) by the Secretary of Health and Human Services only if, before the current deadline, such entity submits to the Secretary a plan for compliance with such standards.
HOME HEALTH LEGISLATION 2000

MEDICARE, MEDICAID, AND SCHIP BENEFITS IMPROVEMENT AND PROTECTION ACT (H.R. 4577, incorporated into P.L. 106-554)

Title V, Subtitle A – Home Health Services

Section 501 – 1-Year Additional Delay in Application of 15 Percent Reduction on Payment Limits to Home Health Services
The 15 percent reduction in payment rates scheduled for October 1, 2001, is delayed until October 1, 2002.
The Comptroller General of the General Accounting Office (GAO) (rather than the Secretary of Health and Human Services) would be required to submit a report by April 1, 2002, analyzing the need for the 15 percent or other reduction.
Additionally, if the Secretary of HHS determines that updates to the PPS system for a previous fiscal year (or estimates of such adjustments for a future fiscal year) did (or are likely to) result in a change in aggregate payments due to changes in coding or classification of beneficiaries’ service needs that do not reflect real changes in case mix, effective for home health episodes concluding on or after October 1, 2001, the Secretary of HHS may adjust PPS amounts to eliminate the effect of such coding or classification changes.

Section 502 – Restoration of Full Home Health Market Basket Update for Home Health Services for Fiscal Year 2001
The provision would modify the home health PPS updates. During the period October 1, 2000, through March 31, 2001, the rates promulgated in the home health PPS regulations on July 3, 2000, would apply for 60-day episodes of care (or visits) ending in that period. For the period April 1, 2001, through September 31, 2001, those rates would be increased by 2.2 percent for 60-day episodes ending in that time period.

Section 503 -- Temporary Two-Month Periodic Interim Payment Extension
The provision would provide for a one-time payment to home health agencies that were receiving periodic interim payments as of September 30, 2000, equal to four times the last two-week payment the agency received before implementation of the home health PPS on October 1, 2000. The amounts would be included in the agency's last settled cost report before implementation of the PPS. This payment will be made by CMS as soon as is "practicable."

Section 504 -- Use of Telehealth in Delivery of Home Health Services
This provision would clarify that the telecommunications provisions should not be construed as preventing a home health agency from providing a service, for which payment is made under the prospective payment system, via a telecommunications system, provided that the services do not substitute for "in-person" home health services ordered by a physician as part of a plan of care or are not considered a home health visit for purposes of eligibility or payment. Moreover, nothing in this provision shall be construed as waiving the physician certification requirement for payment for home health services, whether or not such certification is provided by telephone.

Section 505 -- Study on Costs to Home Health Agencies of Purchasing Nonroutine Medical Supplies
The provision would require that, not later than August 15, 2001, the Comptroller General of the
GAO shall submit to Congress a report regarding the variation in prices home health agencies pay for nonroutine supplies, the volume of supplies used, and what effect the variations have on the provision of services. The Secretary of HHS would be required to make recommendations on whether Medicare payment for those supplies should be made separately from the home health PPS.

Section 506 -- Treatment of Branch Offices; GAO Study on Supervision of Home Health Care Provided in Isolated Rural Areas
The provision would clarify that neither time nor distance between a home health agency parent office and a branch office shall be the sole determinant of a home health agency's branch office status. The Secretary would be authorized to include forms of technology in determining "supervision" for purposes of determining a home health agency's branch office status. Not later than January 1, 2002, the Comptroller General would be required to submit to Congress a report regarding the adequacy of supervision and quality of home health services provided by home health agency branch offices and subunits in isolated rural areas and to make recommendations on whether national standards for supervision would be appropriate in assuring quality.

Section 507 -- Clarification of the Homebound Definition under the Medicare Home Health Benefit
The provision clarifies that the need for adult day care for a patient's plan of treatment does not preclude appropriate coverage for home health care for other medical conditions. The provision also clarifies the ability of homebound beneficiaries to attend religious services without being disqualified from receiving home health benefits. In addition, the Comptroller General will conduct a study on the effect of the provision “on the cost of and access to home health services” under Medicare. A report on the study will be presented to Congress no later than 1 year after enactment.

Section 508 -- Temporary Increase for Home Health Services Furnished in a Rural Area
For home health services furnished in certain rural areas during the two-year period beginning April 1, 2001, Medicare payments are increased by 10 percent, without regard to budget neutrality for the overall home health prospective payment system. This temporary increase would not be included in determining subsequent payments.

Title V, Subtitle C – Changes in Medicare Coverage and Appeals Process

Section 521 -- Revisions to Medicare Appeals Process
Provides that an expedited determination would be available for a beneficiary who received notice:
1. that a provider plans to terminate services and a physician certifies that failure to continue the provisions of the services is likely place the beneficiary's health at risk; or
2. that the provider plans to discharge the beneficiary.
New steps are instituted in the appeals process by implementing a "redetermination,” an expedited in-house review by the regional home health intermediaries. The redetermination would be required to be completed within 30 days of a beneficiary's request. The Secretary would enter into three-year contracts with at least 12 qualified independent contractors (QICs) to conduct reconsiderations, thereby replacing the current intermediary reviewers with an outside body of reviewers.

Title III, Subtitle C -- Hospice Care

Section 321 -- Five Percent Increase in Payment Base
The provision would increase, effective April 1, 2001, the base Medicare daily payment rates for
hospice care for fiscal year (FY) 2001 by 5 percentage points over the rates otherwise in effect. This increase would continue to apply after fiscal year 2001. The temporary increase in payment rates provided in BBRA 99 for FY 2001 and FY 2002 (.5 percent and .75 percent, respectively) would not be affected. In addition, the hospice wage index for Wichita, Kansas' metropolitan statistical area for FY 2000 would be adjusted.

Section 322 -- Clarification of Physician Certification
Effective for certifications of terminal illness made on or after the date of enactment, the provision would modify current law to specify that the physician's or hospice medical director's certification of terminal illness would be based on his/her clinical judgment regarding the normal course of the individual's illness. The Secretary would be required to study and report to Congress within two years of enactment on the appropriateness of certification of terminally ill individuals and the effect of this provision on such certification.

Section 323 -- MedPAC Report on Access to, and Use of, Hospice Benefit
The provision would require MedPAC to examine the factors affecting the use of Medicare hospice benefits, including delay of entry into the hospice program and urban and rural differences in utilization rates. The provision would require a report on the study to be submitted to Congress 18 months after enactment.

Title IV, Subtitle C – Other Services

Section 425 – Full Update for Durable Medical Equipment (DME)
The provision would modify updates to payments for durable medical equipment. For 2001, the payments for covered DME would be increased by the full increase in the consumer price index for urban consumers (CPI-U) during the 12-month period ending June 2000. In general, in 2002 and thereafter, the annual update would equal the full increase in the CPI-U for the 12 months the previous June. The provision specifies that, for the period January 1, 2001, through June 30, 2000, the applicable amounts paid for DME are the amounts in effect before enactment of this provision. The amounts in effect for the period July 1, 2001, through December 31, 2001, would be the amounts established under this section increased by a transitional allowance of 3.28 percent.

Older Americans Act Amendments of 2000 (H.R. 782, incorporated into P.L. 106-501)

Title III – Amendments to Title III of the Older Americans Act of 1965

Section 310 – Consumer Contributions and Waivers
Authorizes a state to implement cost sharing by recipients for all services, with specified exceptions, provided for in the Act. Requires cost sharing to be on a sliding scale based solely on individual income and the cost of delivering services. Provides for waivers of cost sharing requirements upon demonstrations by area agencies that: (1) a significant proportion of recipients in the area have incomes below the threshold established in state policy; or (2) cost sharing would be an unreasonable administrative or financial burden. Allows solicitations of voluntary contributions for services provided under the Act. Requires states and area agencies to develop plans to ensure that the participation of low-income older individuals receiving services will not decrease with the implementation of cost sharing. Directs the Assistant Secretary to take corrective action to assure that services are provided to all older individuals without regard to cost sharing criteria if there is a disparate impact upon low-
income or minority older individuals in any state or region regarding provision of services. Authorizes the Assistant Secretary, subject to certain requirements, to waive any of the following provisions of the Act with respect to a state: (1) specified statewide uniformity requirements under title III; (2) area or state plan requirements; (3) restrictions on the amount that may be transferred between supportive and nutrition services programs; and (4) a requirement that certain amounts of a state allotment be used for the provision of services with respect to states that reduce expenditures under a state plan.

Not later than 1 year after enactment, and annually thereafter, the Assistant Secretary of the Administration on Aging will conduct a comprehensive evaluation of the practices for cost-sharing to determine its impact on participation rates with particular attention to low-income and minority older Americans and older Americans living in rural areas. If the Assistant Secretary finds a disparate impact on any of these groups, the Assistant Secretary shall take “corrective action” to assure that such groups fully participate in OAA programs.

Section 314 – In-home Services and Additional Assistance
Repeals provisions of the Act regarding: (1) in-home services for frail older individuals; (2) additional assistance for special needs of older individuals; and (3) supportive activities for caretakers who provide in-home services to frail older individuals.

Section 316 – National Family Caregiver Support Program
Establishes a three-year grant program for: (1) support services for family caregivers (including grandparents and older relatives) and development and testing of innovative approaches to sustaining the efforts of families and other informal caregivers of older individuals; and (2) activities of national significance to promote quality and continuous improvement in the support provided to family and other informal caregivers of older individuals through program evaluation, training, technical assistance, and research.

The Assistant Secretary of the Administration on Aging shall evaluate the effectiveness of these grant programs and disseminate this report to the states so that useful approaches can be identified and incorporated into the program.

Title VI – Amendments to Title VI of the Older Americans Act of 1965

Section 604 – General Provisions
Establishes a Native American caregiver support program.

Title VII – Amendments to Title VII of the Older Americans Act of 1965

Section 704 – State Long-Term Care Ombudsman Program
Revises the provisions regarding the State Long-Term Care Ombudsman program.

Section 707 – Native Americans Programs
Authorizes appropriations for Native American elder rights and protection program.
HOME HEALTH LEGISLATION 1999

MEDICARE, MEDICAID, AND SCHIPP REFINEMENT ACT OF 1999
(H.R.3426, incorporated into P.L. 106-113)

Title III, Subtitle A -- Home Health Services

Section 301 -- Adjustment to Reflect Administrative Costs Not Included in the Interim Payment System; GAO Report on Costs of Compliance with OASIS Data Collection Requirements.
The bill provides that a home health agency be paid $10 to defray the costs of OASIS for each beneficiary served by the agency during the agency's cost reporting period beginning in fiscal year 2000.
This provision mandates that Medicare pay the agency 50 percent of the estimated aggregate amount payable to the agency by April 1, 2000. The balance is payable when the cost reports are settled.
The General Accounting Office (GAO) is required to submit a study to Congress no later than 180 days after enactment of the Act which includes an assessment of the costs incurred by agencies in complying with OASIS and an analysis of the effect of OASIS on patient privacy.

Section 302 -- Delay in Application of 15 Percent Reduction in Payment Rates for Home Health Services Until One Year After Implementation of Prospective Payment System.
The 15 percent reduction in payment rates scheduled for October 1, 2000, is delayed for one year after implementation of the prospective payment system.
Not later than six months after the date the Secretary of HHS implements PPS, the Secretary shall submit to Congress a report analyzing the need for the 15 percent reduction or any reduction in PPS payment amounts.

Section 303 -- Increase in Per Beneficiary Limits
The per beneficiary limits under the interim payment system are increased by 2 percent for those agencies with per beneficiary limits below the national median. Effective for cost reporting periods beginning during or after fiscal year 2000.

Section 304 -- Clarification of Surety Bond Requirements.
This provision limits the surety bond requirement to four years, or in the case of a change of ownership or control, an additional period determined by the Secretary but not to exceed four years from the change of ownership or control.
The surety bonds are set at the lesser of $50,000 or 10 percent of Medicare and Medicaid payments to the agency. One bond shall satisfy the requirement for both Medicare and Medicaid.

Section 305 -- Refinement of Home Health Agency Consolidated Billing.
This provision eliminates the requirement that home health agencies bill for durable medical equipment.

Section 306 -- Technical Amendment Clarifying Applicable Market Basket Increase for PPS.
This provision makes clear that scheduled reductions in market basket adjustments for home health agencies shall take place in "2002 and 2003," rather than "2002 or 2003."
Title I, Subtitle D – Hospice

Section 131 – Temporary Increase in Payment for Hospice Care
For each of fiscal years 2001 and 2002, hospice payment rates (otherwise in effect for those years) are increased by 0.5 percent and 0.75 percent, respectively.

Section 132 – Study and Report to Congress Regarding Modification of the Payment Rates for Hospice Care
Requires the General Accounting Office to conduct a study on the feasibility and advisability of updating the hospice rates and certain capped payment amounts, including an evaluation of whether the cost factors used to determine the rates should be modified, eliminated, or supplemented with additional cost factors. The report and recommendation are to be submitted to Congress within 1 year of enactment.

Title I, Subtitle C – Other Services

Section 223 – Implementation of the Inherent Reasonableness (IR) Authority
The Secretary is prohibited from using inherent reasonableness authority until after (1) the GAO releases a report regarding the Secretary’s recent use of the authority; and (2) the Secretary has published a notice of final rulemaking in the Federal Register that responds to the GAO report and to comments received in response to the Secretary’s interim final regulation published January 7, 1998. In promulgating the final regulation, the Secretary is required to (1) reevaluate the appropriateness of the criteria included in the interim regulation for identifying payments which are excessive or deficient; and (2) take appropriate steps to ensure the use of valid and reliable data when exercising the authority.

Section 228 – Temporary Increase in Payment Amount for Durable Medical Equipment (DME) and Oxygen
Provides temporary adjustments to the DME fee schedule payments equaling 0.3 percent in FY 2001 and 0.6 percent in FY 2002. The Secretary is prohibited from including the additional payments for FY 2001 and 2002 in updates for future years.

Section 229 – Studies and Reports
Directs MedPAC to conduct a comprehensive study to review the regulatory burdens placed on all classes of health care providers under Parts A and B of the Medicare program. The purpose of the study is to determine the costs these burdens impose on the nation’s health care system and the impact on patients and providers, and their ability to deliver cost-effective quality care to Medicare beneficiaries.

THE VETERANS MILLENNIUM HEALTH CARE AND BENEFITS ACT (P.L. 106-117)

PRIVATE

Section 101 -- Requirement to Provide Extended Care Services
Creates a four-year plan requiring the Department of Veteran Affairs (VA) to provide extended care services to veterans needing it for a service-connected disability and to any veteran who is 70 percent disabled by service-related injuries.
Requires the Secretary to provide community-based primary care, adult day health care, respite care, palliative and end-of-life care, and home health aide visits to enrolled veterans. Respite care would be furnished in the patient's home or in a VA facility. At the end of four years Congress will determine whether these provisions should be eliminated, expanded or left intact. In the event that these provisions were to expire, veterans would continue to be eligible for such services under existing law. A copayment will be developed and assessed by the VA.

Section 102 -- Pilot Programs Relating to Long-Term Care
Directs VA to carry out three long-term care pilot programs over a three-year period. The goal of these pilot programs is to determine the effectiveness of different models of providing all-inclusive care with the aim of reducing the use of hospital and nursing home care. Each model would be carried out in two VA regions designated by the Secretary. The pilots would provide a comprehensive array of services to include institutional and noninstitutional long-term care services, and appropriate case-management.

Under one pilot model, VA would provide long-term care services directly through VA staff and facilities. A second model would employ a mix of VA provided care and care provided under cooperative arrangements with other service providers (who VA reimburses exclusively by providing in-kind services). Under a third model, VA would serve as a case-manager to ensure that veterans receive needed long-term care services through arrangements with non-VA entities. VA would collect data relevant to such programs and, after the completion of the program, provide Congress a report describing the services provide.

NATIONAL DEFENSE AUTHORIZATION ACT FOR FISCAL YEAR 2000
(P.L. 106-65, SECTION 703) ; THE DEPARTMENT OF DEFENSE APPROPRIATIONS ACT FOR FISCAL YEAR 2000 (P.L. 106-79, SECTION 8118)

These two provisions reject the Department of Defense policy that limits the duration and scope of home health services provided to disabled individuals. These provisions provide that members and retired members of the military services and their dependents have access to all medically necessary home health services through the health care system of the military services regardless of the health care status of the individual seeking care.
Making Omnibus Consolidated and Emergency Supplemental Appropriations for Fiscal Year 1999 (P.L. 105-277)

Interim Payment System
Section 5010—Increase in per beneficiary limits (PBL) and per visit payment limits for payment for home health services.

Per Beneficiary Limits (PBLs)
Agencies with a 12-month cost reporting period ending in fiscal year 1994 whose PBLs are below the national median have their PBLs increased by 1/3 of the difference between their PBL and the national median.
Agencies without a 12-month cost reporting period ending in fiscal year 1994, but for which the first cost reporting period begins before fiscal year 1999, have their PBLs increased from 98 percent to 100 percent of the national median.
Agencies whose first cost reporting period begins during or after fiscal year 1999 receive as their PBL 75 percent of the national median.

Per Visit Limits
Per visit limits are increased from 105 percent of the national median to 106 percent of the national median.

15 percent Reduction in Payment Limits
The automatic 15 percent reduction in home health payment limits is delayed until October 1, 2000, for all agencies.

Prospective Payment
Implementation of a prospective payment system is delayed until October 1, 2000, for all agencies.

Periodic Interim Payment (PIP)
PIP is extended until October 1, 2000.

Change in Home Health Market Basket Increase
The home health market basket is reduced by 1.1 percentage points for fiscal year 2000 through FY2003.

Criminal Background Checks
Section 124—A nursing facility or home health care agency may submit a request to the Attorney General to conduct a search and exchange of records regarding an applicant for employment if the employment position is involved in direct patient care.

Centers for Medicare and Medicaid Services—Program Management
$2,000,000 of the funds available for research, demonstration, and evaluation activities is available to continue demonstration projects on Medicaid coverage of community-based attendant care services for people with disabilities which ensure maximum control by the consumer to select and manage their attendant care services.
Balanced Budget Act of 1997 (P.L. 105-33)

Commissions

Section 4019 -- Community Nursing Demonstration Projects.
The Community Nursing Organization Demonstration Projects, which test a prepaid, capitated, nurse-managed system of care, are extended for an additional period of two years. Fraud and Abuse Provisions

Section 4021 -- National Bipartisan Commission on the Future of Medicare.
The bill establishes a new Commission to make recommendations to Congress concerning the long-term financial condition of the Medicare program. The Commission, which will begin work in December 1997 and file its recommendations by March 1, 1999, will also examine the impact of chronic care on the Medicare program. This part of the Commission's mandate is expected to include making recommendations related to chronic home care needs of the elderly and disabled populations.
The Commission will be composed of 17 members. Four Commissioners will be appointed by the President. Six will be appointed by the Majority Leader of the Senate, and six by the Speaker of the House. An additional Commissioner will serve as Chair and will be appointed jointly by the President, the Senate Majority Leader, and the Speaker.
This Commission is expected to be composed of Members of Congress and the Administration.

Section 4022 -- Medicare Payment Advisory Commission.
The BBA abolishes the Prospective Payment Assessment Commission (ProPAC) and the Physician Payment Review Commission (PPRC) and consolidates their work into one new group, called the Medicare Payment Advisory Commission.
The Commission will serve as an advisory body to Congress in all areas of Medicare payment and coverage policies, including payment policies under Parts A and B, the Medicare Choice program, and access and quality of care issues.
The Commission will be composed of 15 members, appointed by the Comptroller General of the GAO. A majority of the members must be non-providers.

Fraud and Abuse

Section 4301 -- Permanent Exclusion for Those Convicted of Three Healthcare-related Crimes.
The bill establishes a new "three strikes and you're out" policy for providers convicted of three healthcare-related crimes. Under this provision, the penalty for a health care provider found guilty of defrauding any federal health program for a second time would be increased from a five-year exclusion to a 10-year exclusion. A third conviction would trigger a mandatory lifelong exclusion from participation in federal health programs.

Section 4302 -- Authority to Refuse to Enter into Medicare Agreements with Individuals or Entities Convicted of Felonies.
The budget package gives the Secretary of HHS the authority to exclude from participation any health provider convicted of a felony. This section takes effect on date of enactment.
Section 4303 -- Exclusion of Entity Controlled by Family Member of a Sanctioned Individual.
Effective beginning 45 days after date of enactment, the bill authorizes the Secretary of HHS to prohibit an entity owned or controlled by an immediate family member of an excluded individual from participation from any federal healthcare program.

Section 4304 -- Imposition of Civil Monetary Penalties.
Effective on date of enactment, this provision adds a new civil monetary penalty for cases in which a person who contracts with an excluded provider knows or should have known that the provider was excluded from participation in a federal healthcare program.

Section 4311 -- Improving Information to Medicare Beneficiaries.
This provision requires that each explanation of benefit (EOB) form contain HHS' toll-free number to report fraud and abuse. Moreover, under this provision, a beneficiary will be given 30 days to request an itemized bill for Medicare services from the appropriate carrier or fiscal intermediary.

Section 4312 -- Disclosure of Information and Surety Bonds.
Effective January 1, 1998, this provision requires home health agencies to post a $50,000 bond to participate in the Medicare program. The provision also mandates that home health agencies disclose identification of all officers, directors, physicians, and principal partners owning five percent or more of the agency. Durable medical equipment suppliers are also subject to the disclosure and surety bond requirements.

Section 4313 -- Provision of Certain Identification Numbers.
Under this provision, within 90 days of filing the disclosure report on ownership interest, Medicare providers are required to supply HHS with both the employer identification number and Social Security numbers for each person or entity with an ownership interest. In addition, health care providers who have at least a five-percent ownership interest in a contractor or subcontractor must disclose their employer identification numbers and Social Security numbers. HHS will then forward these numbers to both the Social Security Commission and the Department of the Treasury for verification.

Section 4314 -- Advisory Opinions Regarding Certain Physician Self-referral.
This provision allows providers to request written advisory opinions from HHS concerning whether an arrangement violates the prohibition against physician self-referrals (known as "Stark I and II"). These opinions will be binding on both HHS and the requesting party.

Section 4315 -- Replacement of Reasonable Charge Methodology with Fee Schedules.
Under this provision, the Secretary of HHS is authorized to implement a statewide or other area wide fee schedule for payment of specified items and services paid on a reasonable charge basis. The specified items and services are medical supplies, home dialysis supplies and equipment, therapeutic shoes, parenteral and enteral nutrients, equipment and supplies, electromyogram devices, salivation devices, blood products, and transfusion medicine.

Section 4316 -- Application of Inherent Reasonableness to all Part B Services Other Than Physician Services.
This provision requires the Secretary of HHS to promulgate regulations describing the factors to be used in determining cases in which application of payment rules under Part B result in the determination of an amount that is not inherently reasonable. The regulations, however, cannot increase or decrease payment amounts by more than 15 percent from the preceding year for a particular item or service.
Section 4317 -- Requirement to Furnish Diagnostic Information.
This provision requires health providers to furnish diagnostic information to non-physician practitioners when ordering specified items or services furnished by such providers. This requirement would apply to diagnostic x-rays, diagnostic lab tests, durable medical equipment, prosthetic devices, braces, and artificial limbs.

Section 4318 -- Report by GAO on Operation of Fraud and Abuse Control Program.
This provision requires the General Accounting Office to report on the operation of the new Medicare fraud and abuse control program by no later than June 1, 1998.

Section 4319 -- Competitive Bidding Demonstration Project.
This provision requires the Secretary of HHS to establish competitive acquisition areas for Part B services. The Secretary could establish different competitive acquisition areas for different classes of items and services. The areas would be chosen based on availability and accessibility of entities able to furnish items and services and probable savings to be realized.

Section 4320 -- Prohibiting Unnecessary and Wasteful Medicare Payments for Certain Items.
This provision specifies that reasonable costs do not include costs for entertainment, gifts, costs for fines and penalties under federal or state law, or certain educational expenses for spouses or dependents of providers, their employees or contractors. Moreover, personal use of motor vehicles are specified as a non-reimbursable charge under Medicare.

Section 4321 -- Nondiscrimination in Post-Hospital Referral to Home Health Agencies.
This provision requires that hospitals, as part of their discharge planning process, provide a list of all home health agencies that serve the area in which the patient resides and who request to be listed by the hospital as available. In addition, the legislation requires hospitals to maintain and disclose information to the Secretary of HHS on referrals made to entities in which that hospital has a financial interest. This information must include the nature of the hospital's financial relationship to the provider, the number of individuals discharged from the hospital who required that provider's type of services, and the percentage of these individuals who received services from the hospital-based provider.

Section 4407 -- Hospital Transfers.
Effective for discharges occurring on or after October 1, 1998, the current law that applies to transfers from one PPS hospital to another PPS hospital would be extended, for patients within a specified group of 10 diagnostic related groups (DRG), to transfers from a PPS hospital to a PPS-exempt hospital or unit, skilled nursing facility, or home health care. Under this policy hospitals will be paid on a per-diem basis, rather than receiving the full DRG payment, for patients in the specified DRGs who are transferred after short hospital stays. The provider receiving the patient would be paid under its own Medicare payment policy.

Hospice Provisions
Section 4441 -- Payments for Hospice Services and Data Collection.
For each of FY 98 through FY 2002, payment updates will be the market-basket percentage increase minus one percentage point. Hospice providers will also be required to submit to the Secretary of HHS such data as the Secretary determines is necessary regarding the costs of providing hospice care for each fiscal year, beginning with FY 99.
Section 4442 -- Payments for Home Hospice Care Based on Location Where Care is Furnished.
Beginning with cost-reporting periods starting on or after October 1, 1997, hospice claims for services furnished in an individual's home must be submitted on the basis of the geographic location at which the service is furnished, rather than the location of the billing office.

Section 4443 -- Hospice Benefit Periods.
The final bill restructures the hospice benefit periods to include two 90-day periods, followed by an unlimited number of subsequent periods of 60 days each. This provision is effective for benefits provided on or after date of enactment.

Section 4444 -- Items and Services Included in Hospice Payment.
The bill amends the current definition of hospice care to include the existing enumerated services as well as any other item or service that is specified in the patient's plan of care and which Medicare may pay for. This provision is effective for benefits provided on or after date of enactment.

Section 4445 -- Contracting with Independent Physicians or Physician Groups for Hospice Care.
The bill deletes physician services from a hospice's core services and allows hospices to employ or contract with physicians for their services. This provision is effective upon date of enactment.

Section 4446 -- Waiver of Certain Staffing Requirements for Hospice Care Programs in Non-urbanized Areas.
The bill allows the Secretary of HHS to waive requirements with regard to hospices having to provide certain services as long as they are not located in urbanized areas and can demonstrate to the satisfaction of the Secretary that they have been unable, despite diligent efforts, to recruit appropriate personnel. For these hospices, the Secretary could waive specifically the provision of physical or occupational therapy or speech language pathology services and dietary counseling. This provision is effective upon date of enactment.

Section 4447 -- Limitation on Liability of Beneficiaries for Certain Hospice Coverage Denials.
This provision, which is effective for benefits provided on or after the date of enactment, extends the limitation of liability protection to determinations that an individual is not terminally ill.

Home Health Payment Reform
Section 4601 -- Recapturing Savings from Home Health Freeze.
The budget bill recaptures the savings resulting from the freeze of the home health cost limits included in the 1993 budget by eliminating consideration of any cost increases that occurred between July 1, 1994, and July 1, 1996, when updating future cost limits.

Section 4602 -- Interim Payments for Home Health.
The budget bill establishes a new interim payment plan for home health services for FY 98 and FY 99. Beginning October 1, 1997, home care agencies will be paid the lesser of their actual, allowable costs; the per-visit cost limits reduced to 105 percent of the national median; or a new blended agency-specific per-beneficiary annual limit, applied to the agency's unduplicated census count of Medicare patients.

Section 4602(c) -- Blend.
The blended per-beneficiary limit will be calculated based 75 percent on 98 percent of the agency's own costs per beneficiary and 25 percent on 98 percent of census-region data. These calculations
will be made using cost reports for cost-reporting periods ending in FY 94 including non-routine medical supplies, and updated by the home health market-basket index. The per-beneficiary limits for new providers and those providers without a 12-month cost-reporting period ending in FY 94 would be equal to the median of limits for all home health agencies. The Secretary of HHS will establish by April 1, 1998, the per-beneficiary limits that will be effective for FY 98.

Section 4603 -- Home Health Prospective Payment.
A prospective payment system (PPS) for home health must be designed and implemented by October 1, 1999. The reimbursement system is not defined other than stating that it must consider an appropriate unit of service and number of visits with potential changes in the mix of services provided. Certain elements of the system would not be subject to administrative or judicial review. The Secretary of HHS is also required to reduce cost limits and per-beneficiary limits in effect on September 30, 1999, by 15 percent, regardless of whether PPS is ready to be implemented on October 1, 1999. Periodic interim payments (PIP) would also be eliminated on October 1, 1999.

Additional Home Health Provisions

Section 4604 -- Site of Service.
Effective for cost reporting periods beginning on or after October 1, 1997, home health payments will be based on the location where the home health service is furnished, rather than the location of the billing office. Additional Home Health Related Provisions.

Section 4611 -- A to B Shift.
The bill gradually transfers from Part A to Part B home health visits that are not part of the first 100 visits following a beneficiary's three-day stay in a hospital or skilled nursing facility and during a home health spell of illness. The transfer would be phased in over a period of six years, beginning on January 1, 1998. For 1998, 1/6 of the payments that would have been made under Part A, prior to this change, are transferred into Part B. For 1999, 2/6; for 2000, 3/6; for 2001, 4/6; for 2002, 5/6; and for 2003, 6/6. In addition, the Medicare Part B premium would also be recalculated to reflect the increase attributable to the transfer. This increase would be phased in over a period of seven years, between 1998 and 2004. For 1998, the Part B premium would be increased by one-seventh of the extra costs due to the transfer; for 1999, the Part B premium would be increased by two-sevenths of the extra costs; for 2000, three-sevenths; for 2001 four-sevenths; for 2002, five-sevenths; for 2003, six-sevenths; and for 2004, the total of the extra costs due to the transfer.
Part A, beginning January 1, 1998, will cover only post institutional home health services for up to 100 visits during a home health spell of illness, except for those individuals with Part A coverage only who would be covered for services without regard to the shift.
Post institutional home health services are defined as services furnished to a Medicare beneficiary: (1) after an inpatient hospital or rural primary care hospital stay of at least three days, initiated within 14 days after discharge, or (2) after a stay in a skilled nursing facility, initiated within 14 days after discharge.
A home health spell of illness is defined as a period of consecutive days beginning with the first day that the individual receives post institutional home health services and ending with the close of the first period of 60 consecutive days thereafter on each of which the individual is neither an inpatient of a hospice or rural primary care hospital nor an inpatient of a skilled nursing facility, nor is receiving home health care.
Claims administration for transferred visits would continue to be done by Part A fiscal intermediaries (FIs).
The threshold for hearings before an administrative law judge on disputed claims would be $100 for home health services under Part B, consistent with the threshold for Part A home health claims.
NAHC was successful in gaining the provisions that provide for seamless administration of the home care benefit by fiscal intermediaries, ensure access to home care for individuals with Part A coverage only, and provide consistent appeals protections.

Section 4612 -- Part-time/Intermittent Standard.
This provision clarifies the part-time/intermittent standards for the home care benefit and conforms to current regulatory practice.

Section 4613 -- Homebound Standard.
The budget bill directs the Secretary of HHS to conduct a study of the criteria that should be applied, as well as the method for applying such criteria, in the determination of whether an individual is homebound for the purpose of qualifying for home health services. The bill requires the Secretary of HHS to report back recommendations to Congress by October 1, 1998.

Section 4614 -- Normative Standards.
The Secretary of HHS is authorized to deny the frequency and duration of home health services where that care is "in excess of such normative guidelines that the Secretary shall establish by regulation." This provision allows the Medicare program to utilize norms of care for limiting coverage to individuals.

Section 4615 -- Venipuncture.
The bill revises the definition of skilled home health services, effective six months after the date of enactment, to specifically exclude venipuncture (blood drawing) as a qualifying service for the Medicare home care benefit.

Section 4616 -- Reports to Congress Regarding Home Health Cost Containment.
The bill requires the Secretary of HHS to submit to the appropriate Congressional committees by October 1, 1997, an estimate of projected Medicare expenditures for home health services for each of FY 1998 through FY 2002. Each year, if actual expenditures exceed the estimates, the Secretary of HHS shall make recommendations to Congress regarding beneficiary copayments or other methods to reduce the growth in expenditures.

Section 4743 -- Medicaid Home and Community-based Waivers.
The bill eliminates the requirement of prior institutionalization with respect to habilitation services furnished under a Medicaid waiver for home and community-based services.
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (P.L. 104-191)

This legislation addresses portability and continuity of coverage issues in private health insurance coverage. It limits the ability of insurers to restrict beneficiaries on the basis of a pre-existing condition, and guarantees renewal of coverage to groups and individuals as long as they have paid their premiums.

Title III, Subtitle C -- Tax-Related Health Provisions; Long-Term Care Services and Contracts

This section makes changes in the tax code establishing certain incentives for the purchase of private long-term care insurance policies. Benefits under long-term care policies will be tax free and eligible long-term care premiums along with qualified long-term care services, including home care, will be treated as medical expenses for the purpose of the itemized medical expenses deduction.

Section 232 -- Penalty for False Certification for Home Health Service
This section establishes a new civil monetary penalty for physicians who falsely certify that a beneficiary meets all of Medicare's requirements to receive home health care. The amount of this penalty will be equal to three times the amount of payments for the home health services provided or $5,000, whichever is greater.

OMNIBUS APPROPRIATIONS ACT OF 1996 (P.L. 104-134)

Section 516 -- Survey and Certification of Medicare Providers
This section increases the time between home health recertifications from once every 12 months to once every 36 months. The legislation also expands The Centers for Medicare and Medicaid Services's (CMS's) deeming authority. These provisions were designed to provide CMS the budget flexibility to begin to alleviate the backlog of initial certifications and avoids the need to implement user fees as a way to finance traditional CMS functions.

OMNIBUS CONSOLIDATION APPROPRIATIONS ACT OF 1997 (P.L. 104-208)

Title II -- Department of Health and Human Services
This title earmarks $158 million for survey and certification activities in fiscal year (FY) 1996. This amount represents an additional $10 million increase for survey and certification activities over fiscal year FY 1996 levels.
Although Congress passed the Balanced Budget Act of 1995, H.R. 2491, which contained sweeping changes in the structure of Medicare and Medicaid, the legislation was vetoed by the President. H.R. 2491 contained important changes in the home care benefit, the most significant of which was the inclusion of a prospective payment system for home care.
Congress did not pass any home health legislation in 1994. The primary reason was the absence of a reconciliation bill, which is the usual vehicle for home health amendments. And although there are sometimes significant items in the Labor/HHS appropriations bill, that was not the case in 1994. Much of the legislation that would have affected home health care was focused on the larger issue of health care reform. But the 103rd Congress adjourned without passing any elements of reform legislation.
OMNIBUS BUDGET RECONCILIATION ACT OF 1993 (P.L. 103-66)

Section 13564 — Reduction in payments for home health services.
This section essentially freezes the home health cost limits for two years. On July 8, 1993, new cost limits were published in the Federal Register that apply to cost report periods beginning from July 1, 1993, through June 30, 1994. The new legislation provides for the continued use of these same limits until the cost caps are updated effective with cost reporting periods beginning on and after July 1, 1996. In addition, the wage index that applies to a home health agency during its July 1993-June 1994 cost reporting period will also be continued for the following two reporting periods. It is intended that the new cost limits will apply over the period of the freeze with as little change as possible (except for reductions necessitated by the elimination of the hospital add-on). The legislation provides that the amount of any cost limits exception that may be granted cannot exceed what would have been allowed if the cost limits had not been frozen.

Section 13564(b) — Elimination of Hospital Add-On.
This section eliminates the hospital add-on effective with reporting periods beginning October 1, 1993. Thus, hospital-based home health agencies will be able to continue to use the add-on for at least the balance of their current reporting period and until they begin a reporting period that begins on or after October 1, 1993.

Section 13504 — Reductions in Payments for Hospice Services.
This section changes the inflation factor that is used to update hospice payments each October. Instead of using the hospital market basket (HMB) as the measure of inflation, this section provides for the use of the following update factors: October 1993, HMB minus 2.0 percent; October 1994, HMB minus 1.5 percent; October 1995, HMB minus 1.5 percent; October 1996, HMB minus 0.5 percent. In October 1997, Medicare would resume using the full HMB in updating the hospice payment rates.

Section 13601 — Medicaid personal care mandate.
This section repeals the mandate requiring personal care services to be covered under states' Medicaid programs. The mandate was to have gone into effect on October 1, 1994.

Section 13567 — Extension of social HMO demonstrations.
This section extends the social health maintenance organizations (SHMO) demonstrations for an additional two years. These demonstrations, which provide health and long-term care on a capitated basis, are presently authorized to continue through 1995.

Section 13552 — Extension of Alzheimer's disease demonstration projects.
This section extends for one more year and $3 million the Alzheimer's disease demonstrations that had been authorized for $40 million for three years in OBRA-86 (P.L. 99-509, Section 9342) and extended for two years and $15 million by OBRA-90 (P.L. 101-508, Section 4164(a)(2)). The demonstration projects were designed to determine the cost and effectiveness of providing comprehensive services including home- and community-based services to Medicare beneficiaries with Alzheimer's disease or related disorders.
Section 13568 — Timing of claims payments.
This section modified requirements for claims payments by establishing separate payment floors for claims submitted electronically and otherwise, and extended the time limit for processing clean claims before interest must be paid. The change in timing for claims processing conforms to earlier modifications brought about indirectly through the appropriations bill, which became effective in October 1992. Under these standards, no Medicare claim that is submitted on paper can be paid any earlier than the 27th day after submission. For electronic billers, the payment floor is 14 days. This section also gives CMS 30 days to process clean claims or begin making interest payments; the previous standard was 24 days.

Section 13562 — Ban on physician ownership and referral.
This section extends the self-referral ban that exists under Medicare law that prohibits physicians or immediate family members with a financial relationship with clinical laboratories from referring Medicare patients to those entities. The self-referral ban is extended to other designated health services that include home care, clinical laboratory services, physical therapy services, occupational therapy services, radiology or other diagnostic services, radiation therapy, durable medical equipment, parenteral and enteral nutrients, equipment and supplies, outpatient prescription drugs, and inpatient and outpatient hospital services.

The extended ban on self-referrals is subject to numerous exceptions including the in-office ancillary services exemption that applies to all the designated health services except durable medical equipment (excluding infusion pumps) and parenteral and enteral nutrients, equipment, and supplies.

Additionally, exceptions relating to compensation arrangements include rentals of office space and equipment, employment relationships, and personal services arrangements, among others designed in a manner comparable to those set under the current anti-kickback safe harbor regulations.

The bill provides an effective date of January 1, 1995, to allow physicians and their immediate families sufficient time to sever ownership or compensation arrangements. It should be noted that the legislation does not ban ownership and compensation, it only affects the ability of a physician to refer Medicare patients with a prohibited ownership or financial relationship exists.
CONGRESS did not pass a budget reconciliation bill in 1992 because of the five-year budget agreement reached in 1990. The annual reconciliation bill is the major vehicle for home care legislation as Congress rarely passes stand-alone legislation. Despite the absence of reconciliation, several important home care provisions were included in Labor/HHS Appropriations Act, which was signed into law on October 6, 1992. In addition, Congress reauthorized the Older Americans Act.

LABOR/HEALTH AND HUMAN SERVICES/EDUCATION APPROPRIATIONS (P.L. 102-394)

Prohibit Postpayment Claims Sampling—Language was included in both the Senate and House reports on Labor/HHS Appropriations that denounced the Centers for Medicare and Medicaid Services use of sampling in postpayment review of Medicare claims and directed CMS to stop the practice (S.Rept. 102-397, pp. 164-5; H.Rept. 102-708, p. 110). The appropriations conferees viewed the report language sufficient to condemn the practice.

Rejection of Survey and Certification User Fees—Congress rejected the Administration's proposal to impose a fee on providers to cover the costs of Medicare surveys and certification and approved an appropriation of $149 million for survey and certification activities.

Encouragement of Electronic Claims Transmissions—In an effort to encourage providers to transmit Medicare claims to contractors electronically, Congress established a payment floor of 14 days for electronically transmitted claims and a payment floor of 27 days for claims submitted on paper.

Ryan White CARE Act—The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act received $300 million for FY93 appropriations. Of that amount, $185 million was directed toward emergency assistance grants to high-impact cities.

In-Home Services to Frail Elderly—Congress appropriated $7 million for in-home services for the frail elderly under the Older Americans Act (Title III-D).

Home Health Demonstration Projects—Congress did not include further funding for the Health Care Services in the Home Demonstration program, which is a demonstration program being conducted under the Health Resources and Services Administration in Hawaii, South Carolina, North Carolina, Mississippi and Utah. Senate report language stated the unobligated FY92 funds were "expected to allow current grantees to complete this demonstration in FY93" (S.Rept. 102-397, p. 42).

OSHA Seat Belt, Driver Safety Regulations—Congress directed the Occupational Safety and Health Administration (OSHA) to reconsider its proposed rules on seat belt use and driver awareness education, which were published July 12, 1990. Congress expressed particular concern about the impact of the regulations on employers and about the imposition of sanctions against employers who have made a good faith effort to comply with the standards (H.Rept. 102-974, p. 49).
OLDER AMERICANS ACT AMENDMENTS OF 1992 (P.L. 102-375)

Reauthorizes the Older Americans Act through 1995, and requires: that the National Academy of Sciences' Institute of Medicine conduct a study on home care quality; that providers of in-home services promote the rights of the frail elderly individuals who receive such services; that a White House Conference on Aging be held no later than December 31, 1994; that the National Center for Health Statistics conduct studies on demographic information related to paraprofessionals working in the home and nursing home settings; and that the Department of Labor conduct a study on employment conditions of in-home and nursing home paraprofessionals.

The Act also includes provisions related to case management of services funded under the OAA. The bill provides a comprehensive definition of case management services for OAA purposes. It also requires that OAA case management services not duplicate such services provided through other federal and state programs, that they be coordinated with services provided through other federal and state programs, and that such services be provided by a public agency or a nonprofit private agency that does not provide other OAA services under Title III of the Act. An exception to the service-provision limitation is included for nonprofit private agencies located in rural areas that obtain a waiver.
HOME HEALTH LEGISLATION 1991

Congress did not pass a budget reconciliation bill in 1991 because of the five-year budget agreement reached in 1990. The annual reconciliation bill is the major vehicle for home care legislation as Congress rarely passes stand-alone legislation. Despite the absence of reconciliation, several important home care provisions were included in the 1991 Labor/HHS appropriations bill.

LABOR/HEALTH AND HUMAN SERVICES/EDUCATION APPROPRIATIONS (P.L. 102-170)

Prohibit Postpayment Claims Sampling—Language originating in the Senate Report of the Labor/HHS appropriations bill denounced the Centers for Medicare and Medicaid Services's use of sampling in postpayment reviews of Medicare claims (S.Rept. 102-104, p. 172). The appropriations conferees viewed the Senate report language sufficient to condemn the practice.

Rejection of Survey and Certification User Fees—Congress rejected the Administration's proposal to impose a fee on providers to cover the costs of Medicare surveys and certification and approved an appropriation of $150 million for survey and certification activities.

Ryan White CARE Act—The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act received $280 million for FY92 appropriations, an increase of $59.4 million over the previous year.

Home Health Demonstrations Grants—A $2.9 million appropriation was approved to continue for two years the Health Care in the Home Demonstrations program, under the Health Resources and Services Administration. These demonstrations have been underway for the past three years in Hawaii, South Carolina, North Carolina, Mississippi and Utah.

Home Health Care and Alzheimer's Disease Pilot Grants—A $4 million appropriation was approved for 10 state pilot projects to provide home care and other services to individual with Alzheimer's disease. The pilots were authorized by P.L. 101-557, § 102.

NATIONAL DEFENSE AUTHORIZATION ACT (P.L. 102-190)

Section 702(a)—Creates a new hospice benefit for active military and their families either in military hospitals or under CHAMPUS. Hospice care may be provided in facilities of the uniformed services to a terminally ill patient who chooses to receive hospice care rather than continuing hospitalization or other health care services for treatment of the patient's terminal illness.

Section 702(b)—Allows hospices to contract with CHAMPUS to provide hospice services. The reimbursement is to be determined by the Secretary of Defense.
HOME HEALTH LEGISLATION 1990

OMNIBUS BUDGET RECONCILIATION ACT OF 1990 (P.L. 101-508)

MEDICARE

Section 4207(d)—Home Health Wage Index: The conference agreement includes a provision which permanently reinstates the use of the hospital wage index for determining home health agency cost limits, with a transition period to the 1988 hospital wage index for cost reporting periods beginning on or after July 1, 1991.

For home health agency reporting periods that begin between July 1, 1991, and June 30, 1992, the wage index would be based two-thirds on the 1982 wage index now in use and one-third on the new index. For the 12-month period beginning July 1, 1992, the blend would be based on one-third of the 1982 index and two-thirds of the 1988 index. For cost reporting periods beginning on or after July 1, 1993, the 1988 wage index, or any later version that may be in effect, would be used.

The Omnibus Budget Reconciliation Act of 1989 (OBRA-89) had included a provision which required the Secretary of Health and Human Services (HHS) to continue to use the hospital wage index until the cost reporting period beginning on or after July 1, 1991.

Sections 4207(b)(3) and 4008(a)(2)—Waiver of Liability: The waiver of liability presumptive status as applied to medical and technical denials will be extended for five years, through December 31, 1995, for home health agencies. The waiver for hospices was also extended for five years. The waiver for home health and hospice providers was scheduled to expire on November 1, 1990.

Section 4207(h)—Prohibition of User Fees for Survey and Certification: This provision prohibits HHS from imposing, or requiring states to impose, on home health agencies, hospices, hospitals or other entities (excluding those required by the Clinical Laboratory Improvement Amendments of 1988) a fee to offset the costs of surveys to certify compliance with the conditions of participation under Medicare Part A or B.

Sections 4207(j) and 4801(a)—Home Care Aide Requirements: The conference agreement includes an amendment which would make any home care agency ineligible to train and test home care aides if, within the previous two years, the agency: (1) is found to be out of compliance with training and testing standards; (2) has been subjected to a partial or extended survey; (3) has been assessed a monetary penalty of $5,000 or more for deficiencies relating to quality of care; or (4) has been subject to suspension of payment or temporary management for noncompliance.

The conference agreement also includes an amendment which would permanently bar agencies from training and testing home care aides if, between October 1, 1988, and September 30, 1990, the agency: (1) was terminated from the Medicare program; (2) was assessed a civil monetary penalty of $5,000 or more for deficiencies relating to quality of care; (3) was subject to suspension of payment or temporary management for noncompliance; or (4) pursuant to state action was closed or required to transfer patients.

Section 4006—Hospice 210-Day Limit: This amendment eliminates the 210-day cap on the Medicare hospice benefit and allows for unlimited days of coverage. This amendment would be effective for services furnished on or after January 1, 1990.

This amendment will not change the requirement that a patient have a prognosis of six months or less to live, nor does it change the aggregate cap which limits the amount of Medicare
reimbursement a hospice can receive each year.

Section 4751—Patient Self-Determination: Effective one year after enactment, Medicare providers, including home health agencies and hospices, will be required to inform patients of their rights under state law to make decisions concerning medical care, including: (1) the right to accept or refuse medical or surgical treatment; and (2) the right to formulate advance directives recognized under state law, such as through appointment of an agent or surrogate to make health care decisions on his/her behalf (durable power of attorney) and written instructions about health care (living will). As a condition of participation, all providers will (1) inquire whether an adult patient has formulated an advance directive, and (2) document whether an advance directive exists in the medical record. In addition, all providers, including home health agencies and hospices, will be required to provide patients with the provider's written policies concerning the implementation of advance directives. Civil monetary penalties will be applied for noncompliance.

Section 4207(b)(2)—Prohibition on Payment Cycles: Effective upon enactment, HHS is prohibited from issuing any final regulation, instruction or policy change which is primarily intended to have the effect of slowing down claims processing or delaying the rate at which claims are paid. An existing provision expired September 30, 1990.

Section 4207(g)—Case Management Study: The budget agreement requires HHS to resume three case management demonstration projects authorized by the Medicare Catastrophic Coverage Act (MCCA) of 1988 (P.L. 100-360), but later lost when the Act was repealed. Under the demonstration projects, appropriate entities will provide case management services to Medicare beneficiaries with selected catastrophic illnesses.

Section 4207(c)—Prospective Payment Study: The conference agreement directs the Centers for Medicare and Medicaid Services (CMS) to conduct research and sets deadlines for CMS to report back to Congress on whether to move cost-based providers, including home health agencies, to some form of alternative reimbursement. HHS is to submit a report to Congress that includes a proposal for prospective payment for home health agencies by September 1, 1993. The Prospective Payment Assessment Commission is to analyze HHS's proposal and report to Congress by March 1, 1994.

In developing this proposal, HHS is to:
1. take into account the need to provide for appropriate limits on home care expenditures;
2. provide for changes in patient case mix, severity of illness, volume of cases and the development of new technologies and standards of medical practice;
3. take into consideration the need to increase payment for outlier cases, those cases which exceed the average length or cost of treatment;
4. take into account the varying wage-related costs among agencies; and
5. analyze the feasibility and appropriateness of establishing the episode of illness as the basic unit for making payments.

Section 4007—Delay in Hospice Payment Update: The conference agreement includes an amendment which would delay the update in the daily hospice payment rates from October 21 until January 1, 1991. However, hospices will receive the 5.2 percent increase in daily rates from October 1-20, then drop back to the old rates until January 1, 1991, when the increased rates will again apply.

Section 4158—Part B Payment Reductions: All payments to Medicare Part B providers will be reduced by 2 percent for services furnished on or after November 1, 1990, and on or before
Section 4153(d)—Home Health Supplies: Home health agencies who are caring for Medicare home health beneficiaries who need catheters, catheter supplies, ostomy bags and related supplies must offer to furnish these supplies directly to the beneficiary under the home health benefit. Previously, home health agencies were required to furnish ostomy supplies only, as part of OBRA-89 amendments which exempted all of these items from the "Six-Point Plan" reimbursement system.

Section 4156—Coverage of Injectionable Drugs for Osteoporosis: The conference agreement includes an amendment which provides coverage under Part B for drugs, and its administration for osteoporosis. The administration of this and any drug is already covered under the home health benefit. This provision is in effect from January 1, 1991, through December 31, 1995.

MEDICAID

Section 4711—Home and Community Care as an Optional Statewide Service: This amendment would allow states to offer, under a capped program, without demonstrating budget neutrality, home or community-based services to elderly beneficiaries with the inability to perform two out of three activities of daily living. The five-year optional program is capped at $580 million. The legislation defines "home and community care" as one or more of the following services furnished, according to an individual community care plan, to an individual who has been determined, after an assessment, to be eligible: home care aide services, chore services, personal care services, nursing care services (provided by or under the supervision of a registered nurse), training for family members, adult day health services, and in the case of individuals with chronic mental illness, day treatment and clinic services, and any other such items as HHS may approve.

Eligibility—An eligible individual is: (1) 65 years or older; (2) determined to be functionally disabled; and (3) eligible for Medicaid including, at the state's option, the "medically needy." A state may continue to maintain its current waiver programs and choose this new option. Also a state may substitute the new option for its existing waiver program provided that it grandfathers current-program clients in the new programs. Of course, due to different eligibility rules, new beneficiaries who would have qualified under the terminated waiver program may not qualify under the new program.

Functionally Disabled—Functionally disabled individuals are defined as persons who (1) are unable to perform without substantial assistance at least two of the specified three activities of daily living (toileting, transferring and eating); or (2) have a primary or secondary diagnosis of Alzheimer's disease and are unable to perform without substantial assistance at least two of the five specified activities (bathing, dressing, toileting, transferring, and eating).

Assessments—Assessments will be based on a uniform minimum data set and assessment instrument specified by HHS. HHS is required by July 1, 1991, to specify a minimum data set of core elements and common definitions for use in conducting the assessments and to establish guidelines for using the data set. Also by July 1, 1991, HHS is to designate one or more instruments for use by the state in conducting comprehensive functional assessments.

Appeals Procedures—Each state which elects to provide this benefit must provide for an appeal procedure for individuals adversely affected by eligibility determinations.
Periodic Review—Individuals' assessments must be reviewed and revised, as may be appropriate, not less often than once every 12 months.

Conduct of Assessments by Interdisciplinary Teams—Assessments and reviews are to be conducted by an interdisciplinary team designated by the state. These must be under contracts with public or nonpublic organizations which do not provide, directly or through an affiliate, home or community care or nursing home care.

Individual Community Care Plans (ICCP)—An ICCP is defined as a written plan which (1) is established and periodically reviewed and revised by a qualified case manager; and (2) specifies the care to be provided and indicates the individual's preference for the types and providers of services.

Qualified Case Management Entity—A qualified case management entity is defined as: (1) a nonprofit or public agency or organization which has experience in establishing, reviewing and revising care plans for the elderly and in providing case management services to the elderly; (2) is responsible for assuring that the care as specified for in the plan is being provided; (3) in the case of nonpublic agency, does not provide home or community services or nursing facility services; (4) has procedures for assuring quality case management services that include a peer review process; (5) completes the ICCP in a timely manner, and meets other standards established by HHS to assure competency.

Appeals Procedures—The legislation requires that the state provide for an appeal procedure for any individual who disagrees with the ICCP.

Minimum Requirements for Home and Community Care—Home and community care providers must meet the following requirements: (1) individuals providing the care must be competent; and (2) specify patient rights to the beneficiary (similar to current Medicare bill of rights). Minimum requirements are established for community care settings as well.

Certification—States will be responsible for certifying compliance of providers of home and community care no less frequently than once every 12 months. Periodic review of provider performance will be conducted.

Investigation of Complaints and Allegations of Abuse—States will be responsible for the investigation of complaints regarding the violation of certification requirements and allegation of individual neglect and abuse.

Disclosure of Results of Inspections and Activities—This section requires the states and HHS to make available to the public information on all surveys, reviews and certifications.

State and Secretarial Authority—Both the state and HHS will be permitted to terminate from the program and impose civil monetary penalties on home and community care providers who no longer meet the requirements.

Payment for Services—States are required to pay for home and community care at rates which are reasonable and adequate to meet the costs of providing care, efficiently and economically, in conformity with applicable state and federal laws, regulations, and quality and safety standards. It further amends the Medicaid law to specify that HHS could not limit the amount of payment that
may be made for home and community care.

**Effective Date**—This new waiver authority is available to states effective with services provided on or after July 1, 1991, without regard to whether or not final regulations have been promulgated by that date.

**Section 4705**—Hospice Payments: Effective as if included in OBRA-89, the conference agreement includes a retroactive provision which further clarifies that an additional amount should be paid for dual eligible nursing facility residents electing hospice under Medicaid.

**Section 4717**—Clarifying Effect of Hospice Election: This section adds to the Medicaid law a clarification that, in electing hospice care, a Medicaid beneficiary waives payment for services for which payment may otherwise be made under Medicare.

**Section 4746**—New Jersey Respite Care Demonstration: The conference agreement extends the New Jersey respite care demonstration project through September 1992. This project was originally authorized under OBRA-86 and is designed to determine the extent to which respite services will delay or avert the need for institutional care.

**Section 4741**—Respite Care: The agreement clarifies that HHS has no authority to limit the number of hours of respite care that a state may offer under a budget-neutral "2176" waiver.

**Section 4720**—Personal Care Services: The agreement provides that, in Minnesota, for fiscal years 1991-1994, federal Medicaid matching funds are available for personal care services prescribed by a physician, provided by a qualified person, supervised by a nurse, and furnished in a home or other location; but does not include such services furnished to an inpatient or resident of a hospital or nursing home. It further requires that in fiscal year 1995 and beyond, Medicaid's definition of home health services is to include personal care services prescribed by a physician, provided by a qualified individual, supervised by a registered nurse, and furnished in a home or other location, not including such services furnished to an inpatient or resident of a nursing facility.

**Section 4744**—Frail Elderly Demonstration Project Demonstrations: This section expands from 10-15, the number of demonstrations to provide health care on a capitated basis to frail elderly at risk of institutionalization.

**RYAN WHITE COMPREHENSIVE AIDS RESOURCES EMERGENCY (CARE) ACT OF 1990 (P.L. 101-381)**

**Title I**—Provides for $87.8 million in the form of grants for cities hardest hit by the AIDS crisis. The 16 eligible cities, in order of severity of need are: New York, Los Angeles, San Francisco, Houston, Washington, DC, Newark, Miami, Chicago, Philadelphia, Atlanta, San Juan, Dallas, Boston, Fort Lauderdale, San Diego, and Jersey City.

Funding under Title I of the bill, to be administered through the Health Resources Services Administration (HRSA) under the US Public Health Services, is intended to help eligible areas operate programs that enable persons with HIV disease to receive appropriate care on an outpatient and ambulatory basis.

Title I also establishes a HIV Health Services Planning Council in each state. These councils can be an existing entity with demonstrated experience in (1) planning for HIV health care services needs and (2) implementing coordinated delivery of HIV health care services within the eligible
geographic area. The councils are to include representatives of other providers, including health care providers. The duties of the planning councils include the development of a comprehensive plan for the organization and delivery of health services to eligible individuals.

**Title II**—Provides for another $87.8 million to states in the form of grants to promote HIV-related care through the development of HIV community-care consortia, home- and community-based care, therapeutic drug subsidies and maintenance of health insurance. Also administered through HRSA, this title provides for direct grants to states for the provision of health care services, including home- and community-based care. Monies under this title also can be used to establish and operate HIV-care consortia in areas most affected by HIV disease. These consortia would consist of public and nonprofit private, health care and support service providers and community-based organizations operating in the areas determined to be most affected by the AIDS disease. They must agree to use the funds for the planning, development and delivery, either through direct service or through contract, of comprehensive outpatient health and support services. These services may include case management services, medical, nursing, dental, home health and hospice care and essential support services such as attendant care, home care aide, personal care, intravenous drug therapy, day or respite care, durable medical equipment, transportation and nutritional services. The home- and community-based care must be provided pursuant to written plans of care prepared by a case management team. The case management team will include appropriate health care professionals with priority given to entities that participate in the consortia, if one exists, and to entities that provide care to low-income individuals. Co-charges for services provided under the CARE bill will be imposed on individuals according to their income. None will be assessed if the recipient's income is at or below the official poverty line.

**Title III**—Provides $130 million to states for HIV testing and counseling services and another $44.9 million to community health centers for HIV-related care, including early intervention programs.

**HOME HEALTH CARE AND ALZHEIMER'S DISEASE AMENDMENTS OF 1990 (P.L. 101-557)**

Home Health Care Demonstration Projects—Reauthorizes and expands the home health care demonstration projects first authorized in the 1987 amendments to the Older Americans Act. The grants would continue to provide skilled nursing care, and be expanded to include home care aide services, for low-income individuals who, with the availability of such assistance, can avoid institutionalization or prolonged hospitalization. Expands the number of grants available to 10.

Alzheimer's Demonstrations Projects—Provides grants to states to provide home- and community-based care, including respite care, for individuals with Alzheimer's disease or related disorders.
OMNIBUS BUDGET RECONCILIATION ACT OF 1989 (P.L. 101-239)

MEDICARE

Sections 6001 & 6101—Gramm-Rudman-Hollings Reduction: Home health agencies were subject to a 2.092 percent reduction in their Part A Medicare payments until December 31, 1989. Medicare Part B providers were subject to the 2.092 percent reduction until March 31, 1990, after which Medicare Part B providers will be subject to 1.42 percent reduction throughout the remainder of the fiscal year, October 1, 1990.

Section 6222—Home Health Wage Index: In determining home health cost limits, the wage index in use prior to July 1, 1989 (hospital wage index), will continue to be utilized until cost-reporting periods beginning on or after July 1, 1991.

Section 6112(e)—Home Health Supplies: This provision continues to include 38 ostomy and catheter supplies as home health supplies. It requires home health agencies to offer to furnish ostomy supplies to individuals who require them as part of the home health service. This is effective with respect to items supplied on or after January 1, 1990.

Section 6005—Increased Payments for Hospice Care: Medicare hospice payments will be increased by 20 percent. Payments in subsequent years will be indexed to the hospital market basket. The provision further provides that written certification for hospice care be obtained no later than eight days after care is initiated, provided a verbal order is given by the physician within two days. The effective date for the increased payments is January 1, 1990. Additionally, the provision provides for the Secretary of Health and Human Services (HHS) to conduct a study of high-cost hospice care provided to Medicare beneficiaries and to evaluate the ability of hospice programs participating in Medicare to provide this care. On the basis of this study, HHS is required to develop methods to compensate hospices for high-cost care provided to Medicare beneficiaries. HHS to report to Congress by April 1, 1991.

Section 6214—Determining Eligibility of Home Health Agencies for Waiver of Liability for Denied Claims: Amends the current policy for purposes of calculating the waiver of liability presumption so that denials would be deemed final if (1) the initial denial is not appealed by the home health agency within the allotted 60-day time period; or (2) upon a reconsideration decision by the fiscal intermediary. The provision further states that HHS is to monitor the proportion of denied claims for which reconsideration is requested and report to Congress if the proportion of denials reversed upon reconsideration increases significantly. This provision is effective with determinations for quarters beginning on January 1, 1990.

Section 6224—Peer Review Organizations: This section requires that Peer Review Organizations (PRO) establish procedures for the involvement of health care practitioners who are not doctors of medicine in the review of services provided by members of their profession. This is effective with contracts entered into after enactment.

Section 6204—Physician Ownership of, and Referral to, Health Care Entities: This provision will require entities to report to HHS with information concerning the entity's ownership arrangement,
including the covered items and services provided by the entity and the names and all of the Medicare provider numbers of all of the physicians who are interested investors or who are immediate relatives of interested investors. HHS is to specify the form and manner of such reporting. It further specifies that such information shall be furnished not later than one year after the date of enactment. Only clinical laboratories will be subject to a general prohibition against the referral of a beneficiary to an entity which the physician, or members of his or her immediate family, are interested investors. HHS must submit to Congress, not later than 90 days after the end of each quarter, a report which provides a statistical profile (by state and type of item and service) comparing utilization of items and services by Medicare beneficiaries served by entities in which the referring physician has a direct or indirect financial interest, and by Medicare beneficiaries serviced by other entities. Additionally, the General Accounting Office (GAO) is to conduct a study of ownership of hospitals and other Medicare providers by referring physicians.

Section 6218—General Accounting Office Study of Administrative Costs of the Medicare Program: GAO will be required to conduct a study of the administrative burden of Medicare regulations and program requirements on providers of services (including home health agencies), fiscal intermediaries and carriers. No later than March 31, 1990, GAO is to submit a report to Congress that includes (1) an assessment of current administrative costs to such entities and of trends in such administrative costs since 1982, and (2) a comparison of the administrative burden to such entities in providing services to individuals who are not Medicare beneficiaries. For purposes of such an assessment, administrative costs shall include personnel costs, training costs, the costs of data and communications systems as affected by changes in requirements of the Medicare program and costs to such entities for noncompliance with such requirements resulting from the failure of HHS to provide entities with adequate notice of changes in program requirements.

Section 6220—Amendments Relating to the Bipartisan Commission on Comprehensive Health Care: This amendment provides that the commission may also be known as the "Claude Pepper Commission," after the late Senator Claude Pepper. It also extends the deadline to March 1, 1990, for the two reports that the commission must submit to Congress.

Section 6112—Durable Medical Equipment: Fees will be frozen in 1990 and there will be no national cap on fee schedules.

**MEDICAID**

Section 6408(c)—Hospice Payment for Room and Board: When a hospice patient is residing in an intermediate care facility (ICF) and/or a skilled nursing facility (SNF), Medicaid will be required to pay an additional amount to take into account the room and board furnished by the facility equal to at least 95 percent of the rate that the state would have paid under the plan for facility services in that facility for that person. The effective date is for calendar quarters beginning on or after July 1, 1990.

**MEDICAID ELIGIBILITY EXPANSION ITEMS**

Section 6401—Phased-In Coverage of Pregnant Women and Infants up to 133 percent of the Federal Poverty Level: This section requires states (including Arizona) to offer Medicaid coverage to pregnant women and infants under one years old up to 133 percent of the federal poverty level.
Section 6401—Phased-In Mandatory Coverage of Children up to 100 percent of the Federal Poverty Level:  States will be required to extend Medicaid coverage to all children born after September 30, 1990, up to age six in families with incomes below 133 percent of the federal poverty level.

MEDICARE CATASTROPHIC COVERAGE REPEAL ACT OF 1989 (P.L. 101-234)

P.L. 101-234 repeals all provisions of the Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360), including the home care-related provisions for an IV therapy drug benefit, intermittent care, hospice care and respite care. Retained were minor and technical provisions, including the extension of the home health waiver of liability.

Enacted were several transitional provisions designed to protect some patients and providers from the abrupt termination of repealed benefits. Among those provisions were two relating to home care and hospice providers. The first extends through 1990 the full benefits of catastrophic coverage for enrollees in risk-based health maintenance organizations (HMO). Congress determined this necessary because the 1990 rates already had been adjusted for risk-based HMOs. The second transitional provision indicates that the repeal of the hospice benefit extension "shall not apply to hospice care provided during the subsequent period (described as in effect on December 31) with respect to which an election has been made before January 1, 1990."
HOME HEALTH LEGISLATION 1988

MEDICARE CATASTROPHIC COVERAGE ACT OF 1988 (P.L. 100-360)

Section 426—Waiver of Liability: The favorable presumption under the waiver of liability for home health agencies and hospices is extended through October 1990. The extension applies to medical necessity denials as well as to intermittent care and homebound denials. In addition, the Secretary of Health and Human Services (HHS) is prohibited from modifying the criteria for these waivers.

Section 206—Extending Home Health Benefits: Nursing care and home care aide services may be provided seven days per week (with one or more visits per day) for up to 38 days, after which additional days of care can be provided under exceptional circumstances. There is no prior hospitalization requirement.

Section 202-203—IV Drug Therapy: Under Part B, effective for services provided after January 1, 1990, home IV antibiotic drug therapy services including nursing visits, pharmacy and related items (such as medical supplies, IV fluids, delivery and equipment) will be covered under Medicare. Other IV drugs would be covered only if the HHS Secretary determines that providers can administer them safely and effectively in a home setting. The HHS Secretary is expected to complete a review of the safety and effectiveness of home IV cancer chemotherapy drugs as soon as possible. IV drug therapy services would not be subject to the Part B deductible or coinsurance. Coverage and reimbursement for the drugs used for this service are not included in the definition of home IV drug therapy, but would be reimbursed under the Medicare Catastrophic Drug Benefit. The drug benefit deductible and coinsurance would be waived if the therapy was initiated during a hospital admission.

To be a qualified home IV drug therapy provider, an entity must meet the following standards set by HHS Secretary: (1) is capable of providing or arranging for services and items mentioned above and the drugs; (2) adheres to written protocols with respect to service provisions and (3) can assure that only trained personnel provide covered home IV drugs (and any other services for which training is required to safely provide the service); (4) maintains clinical records on all patients; (5) makes services available on a 24-hour basis; (6) coordinates services with the patient's physician; (7) conducts a quality assessment and assurance program, including drug regimen review and patient care coordination; (8) assumes responsibility for the quality of services provided by others under arrangement; (9) is licensed, or approved as meeting the requirements for licensure, if state or local law provides for licensure for home IV drug providers; (10) meets other requirements the HHS Secretary deems necessary.

There will be limitations on physician referrals to a home IV provider in cases where the doctor receives compensation from, or has an ownership interest in, the provider. The HHS Inspector General will be required to conduct a study of physician ownership of, and compensation by, other suppliers of Medicare-covered services to which they make referrals.

Reimbursement would be calculated based on whichever is the lower charge, the provider's actual charge or the fee schedule amount. The HHS Secretary would be required to establish a fee schedule through regulation before January 1, 1990, that would provide payment on a per-diem basis. In establishing the fee schedule, the HHS Secretary could consider cost information, charge information and payment rates for similar items and services covered under Medicare. The HHS Secretary would not, however, require routine cost reports. Report language indicates that the HHS Secretary is expected to use broad flexibility in establishing a fee schedule that assures adequate
access to services while preventing excessive payment.

A care plan must be developed by the physician prescribing the home IV drug therapy. In addition, through 1992, prior approval by a Peer Review Organization (PRO) would be required as a condition of payment. PROs would be required to complete review determinations within one working day of a request. To assure the validity and uniformity of PRO reviews, the conference agreement requires the HHS Secretary to establish criteria that would be used by PROs in conducting reviews with respect to the appropriateness of home IV drug therapy services.

**Section 205—Respite Care:** Services covered would include home care aide services (performed by aides who have successfully completed a training program approved by the HHS Secretary), personal care services and nursing services provided by a licensed professional nurse. Eighty hours per year will be covered. Care provided on any one day for less than three hours would be counted as three hours. Services must be provided under the supervision of a registered nurse, home health agency or others under arrangement with the agency.

Those eligible for respite care coverage must meet the following qualifications: (1) Medicare Part B beneficiary who is dependent on a daily basis on a primary caregiver who is living with the beneficiary and is assisting the beneficiary without compensation in performing at least two activities of daily living (ADL); (2) without this assistance could not perform these two ADLs; and (3) the covered expenses must exceed the catastrophic limit (estimated to be $1,370 in 1990) or the newly created Medicare drug benefit deductible ($550 in 1990).

Services would then be available to the beneficiary for a 12-month period from the date the beneficiary was determined to have incurred such expenses. If a beneficiary meets a second limit within the 12-month period, he or she would be entitled to a new 12-month period. In no situation could a beneficiary carry over hours not used in a previous 12-month eligibility period, nor could a beneficiary use more than 80 hours of care per year.

The beneficiary would be responsible for a 20 percent coinsurance even if the beneficiary's costs have exceeded the catastrophic limit; however, the 20 percent coinsurance payment would be counted toward the limit. Payment will be made on the basis of hourly rates based on reasonable costs of furnishing care.

A physician is required to certify that the beneficiary is chronically dependent during the immediate preceding three-month period. Payment will not be made unless the care is deemed reasonable and necessary. The HHS Secretary is required to take appropriate efforts to assure high quality and provide for the appropriate utilization of in-home care.

The HHS Secretary is to study and report to Congress within 18 months after enactment on the advisability of providing out-of-home services, such as adult day care centers or nursing facility services, as an alternative to in-home care. The provision applies to services furnished on or after January 1, 1990.

**Section 101(1)(4)—Medicare Hospice Extension:** Provides for a subsequent extension (time period not specified) beyond the 210-day limit for Medicare-certified hospice providers, if the beneficiary is recertified as terminally ill by the medical director or the physician member of the interdisciplinary group of the hospice program. This provision is effective for services provided on or after January 1, 1989.

**Section 427—Home Health Advisory Commission:** Requires the Centers for Medicare and Medicaid Services (CMS) Administrator to appoint an 11-member Advisory Commission on Home Health Claims. The commission is to study and report to Congress within one year after enactment on the reasons for the increase in the denial rate for home health claims in 1986 and 1987, the ramifications of such increase and the need to reform the process involved in such denials. At least five of the commission members must be representatives of home health or
visiting nurse agencies. The remaining six must consist of representatives of senior citizens' groups, physicians' groups and fiscal intermediaries, with no more than three of the six representing fiscal intermediaries.

**Section 425—Case Management Study:** The HHS Secretary must establish four demonstration projects within 12 months after enactment, under which an appropriate entity (one of which must be a PRO) agrees to provide case management services under the Medicare program to Medicare beneficiaries with selected catastrophic illnesses, particularly those with high costs. The demonstration projects are to evaluate the appropriateness of, and determine the most effective approach of, providing case management services for Medicare beneficiaries with high medical bills. The HHS Secretary is to waive limitations or restrictions on benefits necessary to conduct the demonstration. The demonstrations will be conducted for a two-year period. The HHS Secretary is to make an interim report within a year after the demonstrations begin and a final report upon completion.

**Section 207—Research on Long-Term Care Services for Medicare Beneficiaries:** The HHS Secretary is required to provide for research relating to the delivery and financing of long-term care services for Medicare beneficiaries. The study is to include at least the following: (1) the financial characteristics of Medicare beneficiaries who receive or need long-term care; (2) how financial and other characteristics of Medicare beneficiaries affect their utilization of institutional and noninstitutional services; (3) how beneficiaries and relatives are affected financially and other ways because the beneficiary requires or received long-term care services; (4) the quality of long-term care services (in community and custodial settings) and how the provision of such services may reduce expenditures for acute care services; and (5) the effectiveness of, and need for, state and federal consumer protections that assure adequate access to and protect the rights of beneficiaries receiving long-term care (other than in a nursing home). The provision defines long-term care to include nursing home care, home care, community-based services and custodial care. The HHS Secretary would submit interim reports December 1990 and December 1992, with a final report due June 1994. The provision also requires the Secretary of Treasury to conduct a study of federal tax policies to promote the financing of long-term care due to Congress by November 31, 1988.

**Section 401-408—U.S. Bipartisan Commission on Comprehensive Health Care:** Establishes a commission to examine shortcomings in the health care delivery and financing mechanisms that limit or prevent access to all individuals of comprehensive health care, and make recommendations to Congress on federal programs, policies and financing needed to assure the availability of comprehensive health care services for all U.S. citizens. Both the terms "comprehensive health care services" and "comprehensive long-term care services" include home care services. The commission is to submit to Congress no later than six months after enactment a report on its findings regarding comprehensive long-term care services for the elderly and disabled. Within one year, the commission is to report to Congress on its findings regarding comprehensive health care services for the elderly, disabled and for all individuals. Both reports are to include detailed legislative initiatives.

**Section 208—Study of Adult Day Care Services:** Effective upon enactment, this provision requires the HHS Secretary to survey adult day care services to collect information on (1) the scope of such services; (2) the characteristics of entities providing the services; (3) licensure, certification and other quality standards applied to those providing the services; (4) their cost and financing; and (5) the characteristics of people receiving such services.
The HHS Secretary is to report to Congress within one year on recommendations for appropriate standards for Medicare adult day care services.

**CHANGES FROM THE OMNIBUS BUDGET RECONCILIATION ACT OF 1987 (OBRA-87, P.L. 100-203) INCLUDED IN THE MEDICARE CATASTROPHIC PROTECTION ACT OF 1988**

**Section 411—Data Used to Determine Home Health Agency Cost Limits:** Beginning July 1, 1989 (July 1, 1988, in OBRA-87), the HHS Secretary is to utilize, for home health agencies cost limits, a wage index that is based on verified data (audited data in OBRA-87) obtained by home health agencies. The amendment will penalize agencies that refuse to provide data or deliberately provide false data.

**Section 411—Home Health Prospective Payment Demonstration:** The effective date for the demonstration has been changed to begin on April 1, 1989, rather than July 1, 1988.

**Section 411—Training for DME Suppliers:** All durable medical equipment (DME), whether provided by a home health agency or a DME supplier, must be furnished by individuals who have met training standards set by HHS. The 1987 budget reconciliation law required only home health agencies providing DME to meet the standard.
HOME HEALTH LEGISLATION 1987

OMNIBUS BUDGET RECONCILIATION ACT OF 1987 (P.L. 100-203)

Section 4001—Gramm-Rudman-Hollings: The reduction to home health agencies under the Gramm-Rudman-Hollings sequestration was in effect only until December 31, 1987. The sequester was continued for inpatient hospital services and physician services until March 31, 1988.

Section 4024—Homebound Requirement: Clarifies that an individual does not have to be bedridden to be homebound. Includes those whose ability to leave home without assistance or supportive device is restricted due to illness. Clarifies that limitations on individuals’ absences from home do not apply to absences for the purposes of medical treatment. Absences must be infrequent, of short duration and require considerable effort by the beneficiary.

Section 4032—Denials and Reconsiderations of Claims for Home Health Services: Effective with claims received on or after January 1, 1988, the intermediary must furnish the provider and beneficiary promptly with a written explanation of the denial and of the statutory and regulatory basis for the denial. Effective with claims filed on or after October 1, 1988, the HHS Secretary shall take into account, when evaluating fiscal intermediaries and carriers, whether or not they process 75 percent of reconsiderations within 60 days, and 90 percent of reconsiderations within 90 days, and the extent to which determinations are reversed on appeal.

Section 4035—Publication and Notification of Policies: No rule, requirement or other statement of policy that establishes or changes substantive legal standards governing the scope of benefits; the payment for services; or the eligibility of individuals, entities or organizations to furnish or receive services shall take effect unless it is promulgated by the HHS Secretary by regulation. The HHS Secretary shall publish in the Federal Register, not less frequently than every three months, a list of all manual instructions, interpretative rules, statements of policy and guidelines of general applicability. Effective June 1, 1988, each fiscal intermediary and carrier shall make available to the public all interpretative materials, guidelines and clarifications of policies that relate to payment for such benefits.

Section 4037—Medicare Hearing and Appeals: Hearings will be conducted by administrative law judges (ALJ) under the Social Security Administration until September 1, 1988, or upon receipt by Congress of a report regarding the administrative review hearings by the Secretary, whichever is earlier. This study, to focus on whether telephone hearings allow for a full and fair evidentiary hearing, is due six months after enactment.

Section 4039(e)—Moratorium on Home Health Prior Authorization: Prohibits the HHS Secretary from implementing a national program of voluntary or mandatory prior authorization for home health and post-hospital extended care services claims until six months after Congress receives final results of the Administration's evaluation of studies required by OBRA (1986). The report is due February 1, 1989; therefore implementation could not be prior to July 1, 1989.

Section 4026—Study of Urban/Rural HHA Cost Limits: The HHS Secretary must study and report to Congress by June 1, 1988, whether cost limits for home health agencies (HHA) located in rural and urban areas accurately reflect cost differences and the appropriateness of modifying the limits to take into account the proportions of patients from urban and rural areas.
Section 4026—Data Used to Determine HHA Cost Limits: In determining the cost limits, the HHS Secretary is required to utilize a wage index that is based on audited wage data obtained from HHAs, not hospitals. Such audited data cannot be from cost reporting periods before July 1, 1985.

Section 4027—Home Health Prospective Payment Demonstration: The HHS Secretary will provide for a demonstration project to develop, test and evaluate various methods of paying HHAs on a prospective basis. The project shall be designed in a manner to enable the HHS Secretary to evaluate the effects of various methods of prospective payments (including payments on a per-visit, per-case, and per-episode basis) on program expenditures, as well as beneficiaries' access to quality care. An interim report is due to Congress within one year after enactment. A final report is due four years after enactment. The demonstration is to begin no later than July 1, 1988.

Section 4021—Home Care Quality:
1. Conditions of Participation—Beneficiary Rights
   
   Informed. Beneficiaries have the right to be fully informed in advance about the care and treatment to be provided by the agency. Beneficiaries will have the right to participate in the planning of care and treatment and any changes that might occur. Family members of those judged incompetent would be consulted.

   Grievances. Beneficiaries have the right to voice grievances about care without reprisals.

   Confidentiality. Clinical records will be confidential to ensure appropriate release or review under federal or state law.

   Property. Beneficiaries have the right to have their property treated with respect.

   Informed of All Services and Any Other Services Provided by the Federal Government. Beneficiaries must be informed, orally and in writing, about all items and services to be provided, the availability and extent of coverage for those items and the costs for services for which the beneficiary is responsible. This information must be provided prior to the beneficiary's care by the agency.

   Informed of Rights and Obligations. HHAs would be required to notify beneficiaries of their rights and obligations under the Medicare statute, in writing and in advance of start of service. This includes the right to be informed about Medicare costs, charges and coverage, as well as their right to appeal any denial.

2. Conditions Relating to Agency Administration

   Notification of Changes in Ownership and Management. HHAs will be required to notify the state agency responsible for their licensure of changes in ownership or management of the agency. This information should be considered as part of the licensure process, in particular with regard to those decertified as part of other health care facilities, or those previously convicted of fraud.

   Durable Medical Equipment and Supplies. With respect to durable medical equipment furnished to individuals for whom the agency provides items and services, suppliers of such equipment may not use any individual who does not meet minimum training standards established by the HHS Secretary by October 1, 1988, for the demonstration and use of any such equipment.

   Inclusion of Plans of Care in Records. Mandates the inclusion of plans of care in beneficiaries' records to ensure the maintenance of the most complete and accurate clinical records possible.

   Compliance with Laws and Regulations and Professional Standards. Requires that all HHAs provide services in accordance with all relevant professional standards and principles.
3. Conditions Relating to Provision of Service
As a condition of participation, by January 1, 1990, non-licensed health care professionals (home care aides) will have to (a) have completed or be enrolled in and making progress towards completion of a training program that meets minimum standards and (b) must be competent to provide such services. HHAs would have to provide regular review and in-service education so as to assure competency.

The minimum standards to be established by the HHS Secretary no later than October 1, 1988, would have to include: (a) requirements regarding the content of the training curriculum, (b) minimum hours of training, (c) the qualification of training instructors and (d) the procedures by which competency is to be determined. These standards are not meant to supersede any state requirements.

The above standards may permit recognition of training programs, either within or by other agencies, so long as those agencies have not been out of compliance with all Medicare conditions of participation within the previous two years. Medicare certification—which can be awarded even when an agency has not met all participation requirements—is not sufficient to grant recognition of a program offered by the agency. Those individuals who completed a training program prior to January 1, 1989, may be deemed as completing an HHS program, if the program offered met the standards under this section at that time.

Standards for determining the level of competency should receive careful consideration by the HHS Secretary. The individual must be competent to perform only those tasks for which he or she is responsible, such as turning the patient, or transferring him or her from the bed to a wheelchair. The HHS Secretary is not precluded from allowing HHAs in the establishment of a minimum standard, as part of an HHS-approved training program, to determine on their own decisions regarding competency; however, the HHS Secretary must include specific methods (such as HHS review) for ensuring that competency determinations made by the agencies about their own aides are accurate and in compliance with HHS standards.

Section 4022(a)—Standard Survey: Each HHA shall be subject to a standard survey performed without notice and up to, but not beyond, 15 months after the previous survey. The statewide average may not exceed 12 months. The survey shall be conducted by an individual who meets minimum requirements established by the HHS Secretary not later than July 1, 1989.
Survey agencies would be allowed to survey within two months after any change in agency's ownership, management or administration. This is not mandated; however, a survey is required to be conducted when a significant number of complaints are reported to any appropriate federal, state or local agency.

The content of the survey would be based on protocol that is developed, tested and validated by the HHS Secretary no later than January 1, 1989. The protocol must include visits to a sample number of beneficiaries in their homes. (These visits are to be used to evaluate the qualitative impact of services provided on the functional capacity, as reflected in their plans of care. Agencies do not have to demonstrate that the services provided resulted in a complete recovery of the beneficiary, but that quality care should result in the highest possible functional capacity given the restraints of the beneficiary's illness or injury.)
To ensure that individual assessments are conducted accurately and effectively, the HHS Secretary must provide for the training of federal, state and local surveyors.

Section 4022(b)—Extended Survey: Each HHA that is found, under a survey, to have `provided substandard care, shall be subject to an extended survey, not later than two weeks after the completion of the standard survey. The HHS Secretary must develop protocol for an extended survey, including at a minimum, a review of the agency's compliance with all of the Medicare...
conditions of participation.

**Section 4023—Enforcement:** Decisions about enforcement would begin with the HHS Secretary's determination about the type of deficiency, based upon findings of standard, extended or partial survey, or an investigation of complaints. 

*Deficiency jeopardizes the health and safety.* If the health and safety of beneficiaries are determined by the HHS Secretary to be immediately jeopardized, the Secretary may: (1) appoint temporary management to oversee the operation of the agency or (2) terminate the agency's certification of participation. Temporary management would remain in place until such time as the HHS Secretary determines that the agency has a management in place to comply with all relevant requirements. Termination would mean denial of all existing and new beneficiary claims. The HHS Secretary also is authorized to provide for intermediate sanctions, including civil monetary penalties.

*Deficiency does not jeopardize the health and safety.* When deficiencies are not found to be jeopardizing to health and safety of beneficiaries, the HHS Secretary may impose one or more intermediate sanctions for no longer than six months. If the agency still has not come into compliance in this time, certification will be terminated.

Payments may be made during this six-month period if three conditions are met: (1) the surveying agency finds it more appropriate to take alternative action rather than terminate; (2) the agency submits and the HHS Secretary approves of a plan of corrective action; and (3) the agency agrees to repay any payments received if corrective action is not taken in accordance with the plan. The HHS Secretary has the authority to develop and implement additional sanctions (civil monetary penalties, suspensions of Medicare payments and temporary management).

**Section 4025—Maintenance of Toll-Free Hotline and Investigative Unit:** Surveying organizations will be required to establish and maintain a toll-free hotline for complaints and questions. They also will be required to maintain a unit to investigate complaints. Such a unit will possess enforcement authority, including data collection authority. Data collection may include survey and certification data and patient medical records, but with patient consent only.

**Section 4079—Community Nursing and Ambulatory Care on Prepaid, Capitated Basis:** Requires the HHS Secretary to conduct demonstrations in at least four sites of community nursing and ambulatory care services furnished on a prepaid, capitated basis. Projects would begin no later than July 1989, and would be conducted for a period of three years. The HHS Secretary is required to report to Congress no later than January 1, 1992.

**Section 4009(e)—Waiver of Inpatient Limitations for Connecticut Hospice:** Provides that the existing two-year waiver from the 20-80 percent inpatient-home care day requirement is permanently waived.

**Section 4039(f)—Delay in Publishing Regulations with Respect to Deeming the Status of Home Health Agencies:** The HHS Secretary is prohibited from publishing earlier than six months after publication of proposed regulations, final regulations providing that an entity may be deemed a home health care agency for the purposes of Medicare on the grounds that it has been certified by a private accreditation agency.

**Section 4114—Medicaid Waiver for Hospice Care for AIDS Patients:** Provides, for Medicaid services only, that a hospice may be allowed to exclude days of inpatient care provided to individuals with AIDS from the days counted towards the 20 percent inpatient day limit. The HHS Secretary is required to establish procedures for making this allowance.
Section 4102—Home- and Community-Based Services for the Elderly: Establishes a new state waiver authority, separate from the existing "2176" waiver authority under the Medicaid program. Payments may be made for part or all of the cost of home- or community-based services (other than room and board), approved by the HHS Secretary, that are provided pursuant to a written plan of care to individuals 65 years or older, with respect to whom there has been a determination that institutionalization would be required in the absence of such services.

OLDER AMERICANS ACT AMENDMENTS OF 1987 (P.L. 100-175)

Section 140—Creates a new Part D of Title III, In-Home Services for Frail Elderly. Services include homemaker and home health aide, visiting and telephone reassurance, chore maintenance, in-home respite care and adult day care as a respite for families, and minor modification of homes. Frail elderly individuals are defined as those having a physical or mental disability, including Alzheimer's disease or a related disorder with neurological or organic brain dysfunction, that restricts their ability to perform daily tasks or threatens their capacity to live independently.

Section 141—Creates a new Part E of Title III, Assistance for Special Needs. Activities include transportation, outreach, targeting services to those with the greatest economic or social need, long-term care ombudsman services, and other services where there is unmet need.

Section 143—Creates a new Part F of Title III, Preventive Health Services. The services include: routine health screening; group exercise programs; home injury control services, including screening of high-risk home environments and educational programs on injury protection in the home environment; nutritional counseling and educational services; screening for the prevention of depression, coordination of community mental health services, educational activities, and referral to psychiatric and psychological services; educational programs on the benefits and limitations of Medicare and various supplemental insurance coverage, including individual policy screening and health insurance-needs counseling; and counseling regarding follow up health services based on any of the services provided for above.

Section 144—Creates a new Part G of Title III, Prevention of Abuse, Neglect and Exploitation of Older Individuals.

Section 602—Establishes a two-part grant program for home care services under the Public Health Service Act. Part I, Health Care Services in the Home, provides in-home health services to help low-income individuals avoid institutionalization or prolonged hospitalization. Part II, establishes grants for in-home services for individuals with Alzheimer's disease or related disorders.
HOME HEALTH LEGISLATION 1986

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (P.L. 99-272)

Section 9123—Increased payment in daily rates for hospice care; eliminated sunset provision of the program.

Section 9205—Extended presumption of waiver of liability for home health agencies.

Section 9502—Modified requirements for waiver provisions for home- and community-based care.

Section 9503—Added hospice care as an optional Medicaid benefit.

Section 9508—Revised requirements for optional targeted case management services.

Section 9520—Required HHS to establish a task force regarding alternatives to institutional care for technology-dependent children.

Section 9601—Required HHS to establish a task force on long-term health care policies.

SIXTH OMNIBUS BUDGET RECONCILIATION ACT OF 1986 (P.L. 99-509)

Section 9315—Required HHS to restore the aggregated method of applying the home health cost limits; also required that cost limits be based on the most recent data available. Cost limits also must take into account costs of current billing and verification procedures, as appropriate. GAO is to study the relative merits of applying the cost limits on a per discipline or an aggregate basis.

Section 9305(g)—Extended presumption of waiver of liability to "technical denials" (i.e., denials because beneficiaries did not meet the homebound requirement or did not have a need for intermittent skilled care). New favorable presumption for technical denials is in addition to the existing favorable presumption for claims that are not medically necessary or are for custodial care.

Section 9305(f)—Presumption of waiver also was extended to hospices for claims denied on the basis of medical necessity.

Section 9353(e)—Extended PRO review to home health agencies. PROs will review home health services and complaints.

Section 9305(h)—HHS must develop a uniform needs assessment to evaluate an individual's functional capacity and available resources to meet those needs.

Section 9305(k)—HHS must implement four demonstration projects regarding prior and concurrent authorization for home health services.

Section 9305(a)—HHS is required to develop guidelines and standards for hospital discharge planning.
Section 9313(a)—Clarified that providers may represent Medicare beneficiaries in appeals of denied claims.

Section 9311—Maintains periodic interim payment for home health agencies while eliminating it for hospitals under prospective payment. Established deadlines for payment of "clean" Medicare claims, with interest required when deadlines are not met.

Section 9305(i)—HHS is required to include in prospective payment reports information on the adequacy of quality assurance procedures for post-hospital services.

Section 9313(b)—Allows Medicare beneficiaries to appeal denials for home health services that do not meet the homebound and intermittent care requirements.

Section 9337—Extended Part B coverage to occupational therapy services furnished by an independently practicing therapist in the therapist office or beneficiary's home.

Section 9341—Specified that national coverage determinations are not subject to review by an administrative law judge and limited judicial review. Also added carrier and judicial review of a Part B claim.

Section 9342—HHS must conduct between 5 and 10 demonstration projects to determine the cost and effectiveness of providing comprehensive services including case management, respite care and other in-home services to Medicare beneficiaries with Alzheimer's disease or related disorders.

Section 9408—Permits states to provide optional coverage of respiratory care services at home to ventilator-dependent individuals without having to provide the same amount, duration and scope of services to other Medicaid beneficiaries.

Section 9411—Extended eligibility for home- and community-based services under Medicaid waiver authority to all individuals who, but for such services, would require institutional care which could be reimbursed under Medicaid. States may target waived services to groups by illness (e.g., AIDS) or condition (e.g., chronic mental illness, ventilator dependency).

Section 9435—Clarified rules for hospice payment for individuals who are eligible for both Medicare and Medicaid.
DEFICIT REDUCTION ACT OF 1984 (P.L. 98-369)

Section 2321—Established a 20 percent beneficiary deductible for durable medical equipment provided by a home health agency.

Section 2336—Permitted physicians who have a financial interest in a sole community home health agency to carry out certifications and plan of care functions for patients served by the agency under certain circumstances. Also deleted uncompensated officers or directors from the list of disqualified physicians.

Section 2343—Allowed a waiver of the hospice "core services" requirements if the hospice has shown good faith in trying to hire its own nurses.

Section 2348—Reduced period in which Medicare would pay for services provided to beneficiaries following termination of participation agreements with home health agencies or hospices.

OLDER AMERICANS ACT AMENDMENTS OF 1984 (P.L. 98-459)

Authorized funds to address the increasing demands for in-home services; required the Commissioner on Aging to establish linkages with peer review organizations to strengthen the involvement of the Administration on Aging in the development of policies relating to community-based long-term care.

INDIAN HEALTH CARE IMPROVEMENT ACT (S. 2166)

Expanded Indian Health Service facilities eligible for Medicare reimbursement to include (in addition to hospitals and skilled nursing facilities) health centers, clinics and home health services.

PAYMENT RATE FOR HOSPICE ROUTINE HOME CARE AND OTHER SERVICES (H.R. 5386)

Increased hospice payment rate for routine home care.

PREVENTIVE HEALTH SERVICE AMENDMENTS (P.L. 98-555)

Authorized grants and loans to meet initial costs of establishing and operating home health services in areas in which those services are inadequate, or not readily accessible. Funds also were approved for training programs for paraprofessionals to provide home health services.
ORPHAN DRUG ACT (P.L. 97-414)

Section 6(b)—Required a report to Congress on the results of studies currently evaluating home- and community-based services.

Section 6(c)—Required analysis of results of studies on alternative reimbursement methodologies for home health services.

Section 6(d)—Required investigation of methods to stem fraud and abuse in Medicare and Medicaid home health programs; also required report to Congress.

Section 6(e)—Required demonstrations to test—(1) methods for identifying patients at risk of institutionalization who could be treated more cost effectively in a home health program, including hospitalized Medicare patients who are candidates for early discharge due to availability of home health services, and persons in the community who could avoid institutionalization if they had access to home health services; and (2) alternative reimbursement methodologies for home health agencies to determine the most cost-effective and efficient way of providing home health services, including fee schedules, prospective reimbursement and capitation payments.
TAX EQUITY AND FISCAL RESPONSIBILITY ACT OF 1982 (P.L. 97-248)

**Section 105**—Requires the HHS Secretary to issue regulations establishing a single reimbursement limit for home health agencies, based on the costs of freestanding facilities, and provided for exceptions.

**Section 134**—Expanded state ability to cover under Medicaid certain disabled children age 18 or under who live at home. Provision applies to children who would have been eligible for SSI and hence Medicaid, if they had been institutionalized.

**Section 122**—Provided Medicare Part A coverage of hospice services.
OMNIBUS BUDGET RECONCILIATION ACT OF 1981 (P.L. 97-35)

Section 2122—Eliminated occupational therapy as a basis for initial entitlement to home health benefits.

Section 2144—Reduced Medicare reimbursement limits applied to home health agencies from the 80th to the 75th percentile, or such comparable or lower limit as the HHS Secretary may determine.

Section 2176—Provided for Medicaid waivers to provide home- and community-based services for certain individuals.
OMNIBUS RECONCILIATION ACT OF 1980 (P.L. 94-499)

Section 930—Provided for coverage under Medicare of unlimited home health visits; eliminates the three-day prior hospitalization requirement for home health services under Part A; eliminates the $60 deductible for home health services under Part B; includes the need for occupational therapy as qualifying criteria for home health benefits; allows proprietary home health agencies in states without licensure laws to participate in Medicare; eliminates the authority of HHS to establish additional standards solely on the basis of the tax status of an agency; provides authority for HHS to require bonding or the establishing of escrow accounts to the extent necessary; and requires HHS to establish regional intermediaries for home health agencies.

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